

Exchanges

Principles and Issues

August 20, 2010

State Exchanges

We support the development and implementation of effective health insurance Exchanges under the Patient Protection and Affordable Care Act (PPACA).

We believe the Exchanges should be an objective, neutral, consumer-friendly market facilitator where consumers can go to find information about, and purchase, health coverage in a competitive marketplace with transparency of premiums and standardization of benefits. It should be an unbiased entity that facilitates the offering and purchase of health coverage.

Exchanges should maximize choice for the diverse needs of potential enrollees. At the same time, the Exchanges and the Navigator should provide user friendly mechanisms for consumers to easily exercise that choice of finding the right health benefit plan. Exchanges should preserve the current exemplary regional health plan companies for individuals and small groups.

The Navigator will perform a critical function to assist consumers in understanding the choices available through the Exchanges and helping them make informed choices. The Navigator should be empowered and have the requisite expertise to advise consumers about a health plan company's quality and cost, including the breadth and quality of provider networks.

We believe the role of the Exchanges is to foster a competitive marketplace based upon price and quality within the parameters of the health care reform law. It should operate in an administratively efficient manner and to the maximum extent feasible, not duplicate functions or expenses performed by health plan companies, the Division of Insurance and other entities. Ultimately, all administrative expenses incurred by the Exchanges will be borne indirectly by consumers.

Elements of Successful Exchanges

Access

Access to coverage for everyone is the primary purpose and focus of the Exchanges. Access for the entire community will maximize quality and minimize cost.

Affordability

Price is the key to getting most people covered. Most need coverage for unexpected illness and conditions or traumatic events and do not need chronic care coordination. Price is the key to broad-based coverage for those without chronic conditions. However, effective care coordination programs are required to bend the cost curve for all. Unless the Exchanges enable consumers to evaluate and select health benefit plans that address care coordination, the costs of coverage will remain unsustainable in the long run.

Value

In order to be successful the Exchanges must focus on value-based competition among health plan companies. Value is driven by both health plans and providers. Value in health care is a calculus of price and quality. As Dennis Cortes of the Mayo Clinic has said, “Value is quality of care over the cost of providing that care. The true cost is best measured over time and can be related to the lifetime of an individual, an episode of care, or a condition over time. The numerator, quality, has the components of outcomes, safety and service. These components can be defined and measured. Viewed this way, value also equates to efficiency and to productivity in health care.”

Consumers will define value differently based upon their life circumstances. For most consumers without chronic care needs, price will be the major determinant of value. However, the Exchanges must also work for people with complex medical conditions. For a significant number, especially those with chronic conditions, choice and access to a health care provider and effective care coordination programs will rank higher than price alone. If quality is not a focus, value will dissipate. Thus, it is imperative Exchanges foster a competitive marketplace based on price and quality. The Navigators will provide personalized assistance in selecting a plan for consumers based on their individual needs.

Stability and Efficiency

We believe Exchanges will become the primary mechanism in which consumers in the individual and small group commercial markets will find health coverage. In order to successfully accomplish that objective, the Exchanges must develop resources and expertise that does not currently exist or exists only in a rudimentary way. Therefore, the Exchanges should limit their functions to the areas in which the Exchanges have unique responsibility and expertise. They should not duplicate activities or functions performed by other entities and should not undertake functions outside the core purpose. Avoiding duplication is a key for minimizing the administrative costs of the Exchanges for consumers, who will bear the expenses incurred by the Exchanges indirectly. We believe funding for the Exchanges should be as broad-based as possible.

Phased Implementation

The existing insurance “marketplace” in Colorado consists of several well defined risk pools: the medically underwritten individual insurance market; the guaranteed issue small group (1 to 50) employer market; employer groups over 50; and the uninsured. Creating Exchanges that will encompass these different populations by 2014 is a daunting task. Therefore, we believe a phased-in approach to implementing Exchanges is reasonable and will ensure their success. We believe implementing manageable portions of the Exchanges well, creates a foundation from which expansions and mergers of the Exchanges may occur in the future with less consumer disruption.

Functions/Attributes of the Exchanges

Structure and Governance

The Exchanges should be a semi-independent, quasi-government authority managed outside the civil service and state procurement structure. If they are organized as a non-profit corporation, the board of directors should be appointed as outlined below.

- Exchanges should be governed by a board of directors that has relevant expertise, representing a broad spectrum of stakeholders, is appointed by elected officials, and is accountable for its actions. The board should include representatives from consumers, the employer community, health plan companies, and other interested stakeholders.
- The governing statute should create a technical advisory group to make recommendations about implementation of the Exchanges.
- Exchanges must have the authority to contract with other entities for administrative services.
- The Exchanges should have rigorous conflict of interest policies. The governance structure for the Exchanges should be objective and third-party with respect to health plan companies and not an entity that regulates them.

Rationale: The Exchanges will perform an important public function. While cogent reasons exist for placing the Exchanges in a quasi-public entity or a private non-profit entity, appropriate oversight and accountability for its activities is critical. Also, the Exchanges will be providing information about a competitive market. Therefore, they cannot be perceived to be biased toward any of the health plan companies participating within the Exchange.

Regulatory Authority

We believe the market role and the regulatory role should be separate. Exchanges should not duplicate the regulatory authority of the Division of Insurance (DOI) over health plan companies (except for the authority under PPACA to select participating health plan companies).

- Separate roles for Exchanges and the DOI. The DOI should have exclusive authority to exercise its traditional regulatory functions (e.g. solvency, governance, consumer protection, and marketing practices).

Rationale: The Colorado Division of Insurance is an effective state agency with resources and expertise to regulate health plan companies. Conferring regulatory authority on the Exchanges would incur unnecessary expense and could lead to inconsistent or conflicting regulations between the Exchanges and the DOI.

Geographic Scope

- Colorado should establish state-wide Exchanges with geographic rating areas.

- The Exchanges should have authority to participate in multi-state Exchanges in the future, only after ensuring that the needs of the consumers in Colorado will be enhanced through such a mechanism.

Rationale: Economies of scale, both for the start-up costs and costs of the operation of the Exchanges dictate Exchanges with statewide coverage for Colorado. Exchanges with state-wide coverage will have sufficient enrollees to constitute an adequate risk pool and a sufficient share of the commercial market to encourage health plan participation.

Employer Size and Merger of SHOP and standard Exchanges

- Consistent with a phased in approach, Colorado should exercise the option under PPACA to define a small employer as 1 to 50 for plan years before 2017.

Rationale: Colorado has a guaranteed-issue, highly regulated small employer group market. It currently has 287,000 enrollees according to the Division of Insurance. The rating and market rules for the small group market are significantly different in the group market over 50. It is generally thought that purchasers of large group policies are more sophisticated purchasers of insurance and may have the ability to hire consultants to assist with the process. Large groups can use their size to negotiate, so employer-sponsored plans typically are able to include a wide range of plan options. In the over 50 employee market, rates are able to reflect more of each group's specific experience and are, therefore, more appropriate to the risk. Employers appreciate that aspect of the rating process and can negotiate their rates with health plan companies. The 50 to 100 employee large groups would lose that flexibility if they were combined with the existing small group guaranteed issue market.

- Also, consistent with a phased in approach, Colorado should not merge the SHOP and individual Exchanges.

Rationale: The employer and individual health insurance markets are very different in both the reasons insurance is purchased and the nature of the risk insured. Initially merging the two Exchanges will eliminate all differences between the two and may encourage employers to stop providing health insurance and have their employees seek individual coverage through the Exchanges. Given the heavily subsidized nature of employer based health insurance (often 80 percent of cost), the elimination of the employer plan may also discourage a portion of the more affluent young population, currently insured through their employer's plan, from purchasing insurance in the individual market, since they will not qualify for a Federal subsidy and may find it more economical to pay the penalty instead of the individual health premium.

The individual Exchanges will include persons who were previously unable to obtain coverage due to medical conditions. Thus, the risk pool in the individual market may be more expensive than the employer pool. Small employers who continue to provide insurance for their employees should not bear any additional

increased expense and premium that could result from the merging of the Exchanges.

Selection of Health Plan Companies

The criteria for selection of health plan companies that participate in the Exchanges should be limited to those stated in PPACA. The discretion of the Exchanges to exclude health plan companies should be defined.

- Specify by law a definition of “interests” and permitted criteria in addition to Secretary’s for health plan companies’ participation in the Exchanges.
 - If the Exchanges do not include all health plan companies, the Exchanges should utilize criteria that maximize choice of type of plans (HMO, PPO, HSA etc.); nature of provider networks (group practice, IPA, FFS); geographic coverage (national, regional and area of state); and value to enrollees.
- Exchanges should establish a process that allows a health plan company to appeal a decision to exclude it from the Exchanges because of a failure to meet quality, access, financial and/or other requirements.

Rationale: Allowing a number of health plan companies to participate will give consumers more choices and foster competition. This competition should not be about “winners” and “losers” among health plan companies, but should be focused on creating value for consumers. Once in the Exchanges, eliminating a health plan company could disrupt a consumer’s existing relationship with a health care provider, and should be undertaken with caution.

Premiums

- Exchanges should not set or negotiate premiums.
 - Competition will be enhanced if the Exchanges makes available information regarding rates, benefits and quality ratings within the Exchanges
- Exchanges should not conduct a bidding process for premiums or benefit plans.

Rationale: Colorado has a premium review process that requires prior approval by the Commissioner. The law requires the premiums not be “inadequate, excessive or unfairly discriminatory”. Under PPACA, the Commissioner and the Secretary of HHS will receive information on “excessive” premiums and the Exchanges have the authority to act upon the Commissioner’s recommendation for exclusion of a health plan company for excessive or unjustified premium increases. Colorado has robust competition among many health plan companies competing for business. Thus, a premium negotiation and bidding process conducted by the Exchanges is unnecessary to drive price competition. Moreover, adding a premium negotiation role for Exchanges will increase unnecessary administrative expenses.

Eligibility & Enrollment

- The Exchanges determine eligibility of consumers to participate in the Exchanges including enrollment period, premium subsidy, and cost sharing reductions, but they should have limited enrollment functions in the commercial market.
 - The Exchanges should accept applications for enrollment and forward to health plan companies.
- Exchanges will play a significant role in facilitating enrollment in Medicaid & CHP.

Rationale: The Exchanges will avoid the administrative expense of implementing and operating enrollment systems. Having a consumer go to one place (health plan company) for enrollment and all subsequent activities such as demographic updates, request an ID card, check claims, renewal, etc. is more convenient for the consumer.

Benefit plans

- The Exchanges should preserve maximum flexibility for health plan companies to offer innovative health benefit plans that meet the needs of the community.
- The State and the Exchanges should establish a level-playing field by requiring health benefit plans offered inside and outside the Exchanges to offer the same benefits and meet the same market standards as stated in PPACA (e.g., benefit mandates, premium taxes and assessments, utilization review requirements, rating rules, etc.).

Rationale: PPACA requires that rating and risk pools are the same inside and outside the Exchanges. Therefore, the market rules including mandated benefits should be the same.

Funding of Exchanges

- The funding of the Exchanges should be sought from a broad base of sources (i.e., a combination of federal funding, state general revenue, carrier assessments, provider assessments, etc.).

Rationale: Funding should be as broad-based as possible because any assessments imposed by the Exchanges ultimately will be borne indirectly by consumers.