Utah Health Exchange Development and Experience to Date
Summary of Utah Invitational Meeting – May, 2011

Three Arkansans joined representatives from 30 other states and one U. S. Territory attending the *Utah Health Exchange Invitation Only Event For State Officials* in Salt Lake City, Utah on May 12-13, 2011. Attending were State Representative Barry Hyde of the Insurance and Commerce Committee of the Arkansas General Assembly, Arkansas Health Benefits Exchange Planning Director Cynthia Crone, APN, and Planning Specialist Bruce Donaldson, CHC. Crone and Donaldson work at Arkansas Insurance Department. The trip was funded by the Arkansas Health Benefits Exchange Planning Grant awarded to the Arkansas Insurance Department by the US DHHS Center for Consumer Information and Insurance Oversight (CCIIO). In addition to State guests and more than 40 Utah elected or appointed officials and contractors, CCIIO Exchange Director Joel Ario and seven additional federal officials from DHHS and IRS were present.

Utah Governor Gary R. Herbert welcomed meeting participants. Utah officials and contractors presented sessions on Utah's Exchange Development. In 2007, Utah lawmakers set out to develop a consumer-driven health care system and insurance market that would provide: Greater choice, expanded access, individual responsibility, increased affordability, higher quality and improved health. The average age in Utah is 26-28 years and greater than 80% of Utah's population is urban. The population is healthy (age/habits) when compared with populations of other states. Unemployment rates are low. Most of the population works in small businesses and fewer than 50% of small firms offer health insurance. Roughly 300,000 individuals (10.6% of Utah's population) are uninsured. Many are "young immortals" (ages 18-34).

Utah officials visited Massachusetts to study the Connector Exchange, but determined that the Massachusetts model was not right for Utah. Work began to develop a model that better fit Utah. During the first planning year, five workgroups were engaged in planning: Community, Business, Hospital, Non-hospital Providers, and Insurance Workgroups. In the second year, six bipartisan task-oriented working groups advanced planning: Accessibility and Access; Transparency and Quality, Oversight and Implementation; Technology; Marketing and Outreach, and Education and Adoption. An overview of Utah Exchange Development Legislation follows:

- 2008 - Exchange was established as an "on-line mechanism that allows consumers to compare, shop for, and enroll in a health plan". It included an All Claims Data Base so consumers could access information about their providers, and a multiple source premium aggregator.

- 2009 - Established the Utah defined contribution market—employers were required to contribute a defined level of funding rather than a pre-determined benefit. The Utah Defined Contribution Risk Adjuster Board was established. *The prospective risk adjuster plan is designed to provide a universal application and address underwriting, group risk, individual risk and reinsurance pooling. It*'s *too early to know results.*

- 2010 – Provisions intended to correct and enhance the traditional small group market and the defined contribution market included pricing parity between the defined contribution markets.

In August 2009, a limited Utah Exchange for employers with 2-50 employees was launched; three carriers announced participation (Select Health, Regence Blue Cross Blue Shield, and Humana). A fourth carrier (United Healthcare) joined in 2010. In May, 2010, a large group pilot project was announced following requests from large employers. A full launch to all small employers occurred in September 2010. Utah implementers stressed the importance of piloting an Exchange before going Statewide. All plans participating in the Utah pilot have continued to participate.

Two keys to Utah's success were maintaining a role for Health Insurance Producers and enacting a defined contribution market by employers. The defined contribution market allows employers to set payment amounts and employees to control and choose how funds are spent to meet their needs. Choice and accountability move to the employee side of the equation. Offerings are simplified and expanded with preservation of employer tax advantages. The goal was participation by 1000 employer groups. There were no mandates or subsidies; there were predictable costs with private sector partners. *By May 1, 2011 the Utah Exchange had participation by 146 plans by 4 insurers. With five months' experience, there are 114 employers (25% previously uninsured) and 2,985 covered lives. Employer monthly contributions range from $0 - $1,683 with a mean of $360/employee. Rates are audited to be comparable with traditional small group rates. There is a flat fee collected from consumers for paying commissions to producers ($37 per month per covered life to brokers + $6 technology fee to go to vendors). The overall plan cost for products sold through the Exchange is comparable to plan costs off the Exchange. It was noted that Utah's producer workforce is aging with fewer coming in.*

Key issues in "keeping the playing field level" were presented. Challenges and unexpected issues included: incomplete applications, products offered, rates, and underwriting practices. Insurance Department and Auditing requirements monitored underwriting, products, rates, referrals from insurers, agents, the Exchange, and staffing. Three key successes were: including stakeholders, interagency collaboration, and plan choice. Three key lessons learned (what implementers would have done differently) were to include agents from the inception, create a scalable system, and insure adequate funding. Throughout development of the Utah Health Exchange, private partnerships were leveraged to assist with State dollar investments. This was particularly true for technology functionality.

Utah is now embarking on *Exchange 2.0*. They plan to: 1) fine tune the small employer approach, 2) expand marketing and outreach; 3) focus on scalability. Lessons learned suggest a need to engage brokers as a valuable partner, embrace private solutions instead of hiring programmers, ensure solution is scalable, ensure a level playing field inside/outside the Exchange, Beta test, plan extra time and go slow. High level *2.0* goals are to use "Consumer-Centric" modules, information form All Claims Data Base, and achieve seamless interface with public programs. Cloud technology and employer compilation of applications are sought. The next generation of exchanges are expected to have modular design, interface via push/pull information exchange with private, state and federal sources, and provide a means where individuals can populate their account information from external sources. The need for

access to "decision support" for consumers and electronic applications for state, federal, and private plans/programs was shared. Consumers need readable/understandable data to help determine purchases, e.g. "What information does consumer use in making healthcare decisions"? Public is interested in issues such as, "Will I be able to keep my same provider?" Exchange will need to supply complex data – recognizing that numbers generally "scare" people.

There are plans for interoperability with Medicaid through Utah Department of Workforce Services, the Medicaid enrollment contractor. At present the State (Workforce Services) Call Center has 75,000 calls per month with 18,000 "on-line chats" per month. The Utah Exchange currently links to public program sites for information, questions, or applications. In 2012, the Exchange plans to implement "financial help link" to Screening application which will lead to full public programs online application. In 2014, a "no wrong door", enhanced screening application with full public programs eligibility determined through eREP is planned. Utah, as the nation, is awaiting simplification of rules for enrolling and tracking old vs. new Medicaid eligibles.

CCIIO's Joel Ario applauded Utah for sharing their past and future strategies and the States for their bipartisan attendance/participation in this meeting. He stressed this window of opportunity to plan quality State exchanges and encouraged state collaboration in Exchange and quality rating engine development and implementation. He also stressed the flexibility afforded by CCIIO to States in developing State-run Exchanges.

Utah's Lt. Governor Greg Bell provided closing comments for the meeting, stressing that States, not the Federal Government, need to lead in Exchange development. At Utah's invitation, meeting attendees then discussed the potential for collaborative efforts to meet requirements of the Affordable Care Act or request waivers, including timeline waivers, from implementation requirements. .

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Arkansas can learn much from Utah's experiences. As we advance in Exchange Planning for Arkansas, several key differences between Arkansas and Utah are noted:

- State Population Demographics: Arkansas is more rural and poor with nearly double the numbers and percentages of uninsured residents, and worse overall health indicators;
- Arkansas is only now beginning Health Benefits Exchange planning, with need to be in compliance with ACA 1/1/14 (Utah began small group, private market only Exchange Planning in 2007); Like Utah, AR planners are expressing interest in an All Payer Claims Database;
- There is currently no Arkansas enabling legislation or other authority for a Health Benefits Exchange (Utah had Exchange legislation in 2008, 2009, and 2010).

The Utah Health Exchange – A Brief Overview

The overarching philosophy of Utah's approach to health reform is that the invisible hand of the marketplace, rather than the heavy hand of government is the most effective means whereby reform may take place. The Utah Health Exchange is part of Utah's overall health system reform effort and is designed to enhance consumer choice and the ability of the private sector to meet consumer needs.

The Exchange formally opened in August 2009 for the individual/family product market as well as a limited launch for the small group market. A full launch of the small group market and a pilot version for the large group market took place in September 2010.

What is the Exchange?

The exchange is an internet-based information portal. It connects consumers to information they need to make an informed choice, and in many cases allows them to execute that choice electronically.

Why do we need an exchange?

Utah's approach to health system reform is to move toward a consumer-based system, where individuals are responsible for their health, health care, and health care financing. A major step in that direction is the development of a workable defined contribution system.

The Exchange is a critical component in moving towards a consumer-based system. For example, in order for a defined contribution system to function efficiently, consumers need a single shopping point where they can evaluate their options and execute an informed purchasing decision. For a consumer-based market to succeed, brokers, agents, employers, and individuals must have access to reliable information to allow consumers to make side-by-side comparisons of their options.

What is the overall goal of the Exchange?

The overall goal of the Exchange is to serve as the technology backbone to enable the implementation of consumer-based health system reforms.

How does the Exchange accomplish that goal?

To accomplish this goal, the Exchange has three core functions:

1. Provide consumers with helpful information about their health care and health care financing,
2. Provide a mechanism for consumers to compare and choose a health insurance policy that meets their families' needs
3. Provide a standardized electronic application and enrollment system

Doesn't this exist already in the private sector?

It could be argued that the information that a consumer needs exists in the present system, however, in Utah we are missing two key elements. In order for consumerism to really take hold, we need to create a system where the information is available in a standardized format that allows comparisons and is located at a single shopping point.

Why did Utah choose to go with an exchange model?

Utah's approach to health system reform relies on the fundamental principles of personal responsibility, private markets, and competition. To promote competition in the health care system, consumers need three things – accurate and relevant information, real choice, and the opportunity to benefit from making good choices. The exchange model enhances private competition in the health care system by providing all three elements of increased competition.

In addition to the benefits to the consumer, the exchange model also offers relief to employers who will no longer need to bear the full burden of running a health plan for their employees.

What is unique about Utah's approach?

Utah's approach to developing an exchange is unique in that it builds on existing technology instead of starting from scratch. This allows the state to incorporate and build on private solutions. Utah's approach is also designed to support the existing roles of entities in the health system, including insurers, producers, and health care providers.

What is a defined contribution market?

When it comes to employment-based health insurance, Utah recognizes that the traditional approach to purchasing a group plan is not consistent with our underlying philosophies of health system reform. In 2009, Utah created a new defined contribution market for health insurance. In this market, employees choose their own insurance company, network, and benefit structure and employers simply decide how much to contribute toward the employee's policy. It is apparent that while this market greatly enhances consumer choice and competition among insurers, it is also a more complicated system with many more people needing information than in the traditional group market.

What functions can the Exchange actually do now?

At present, the Exchange is ready and able to support the new defined contribution market for Utah's small employers. The Exchange serves as the technology backbone that makes such an innovative market possible. The Exchange has the capacity to handle employer enrollment, communicating information to insurers about risk, compiling and displaying price information to employees, executing the employees' enrollment in their choice of plan, and facilitating the collection and distribution of premiums. The end result is that employees have the necessary information and purchasing power to make an informed health insurance choice.

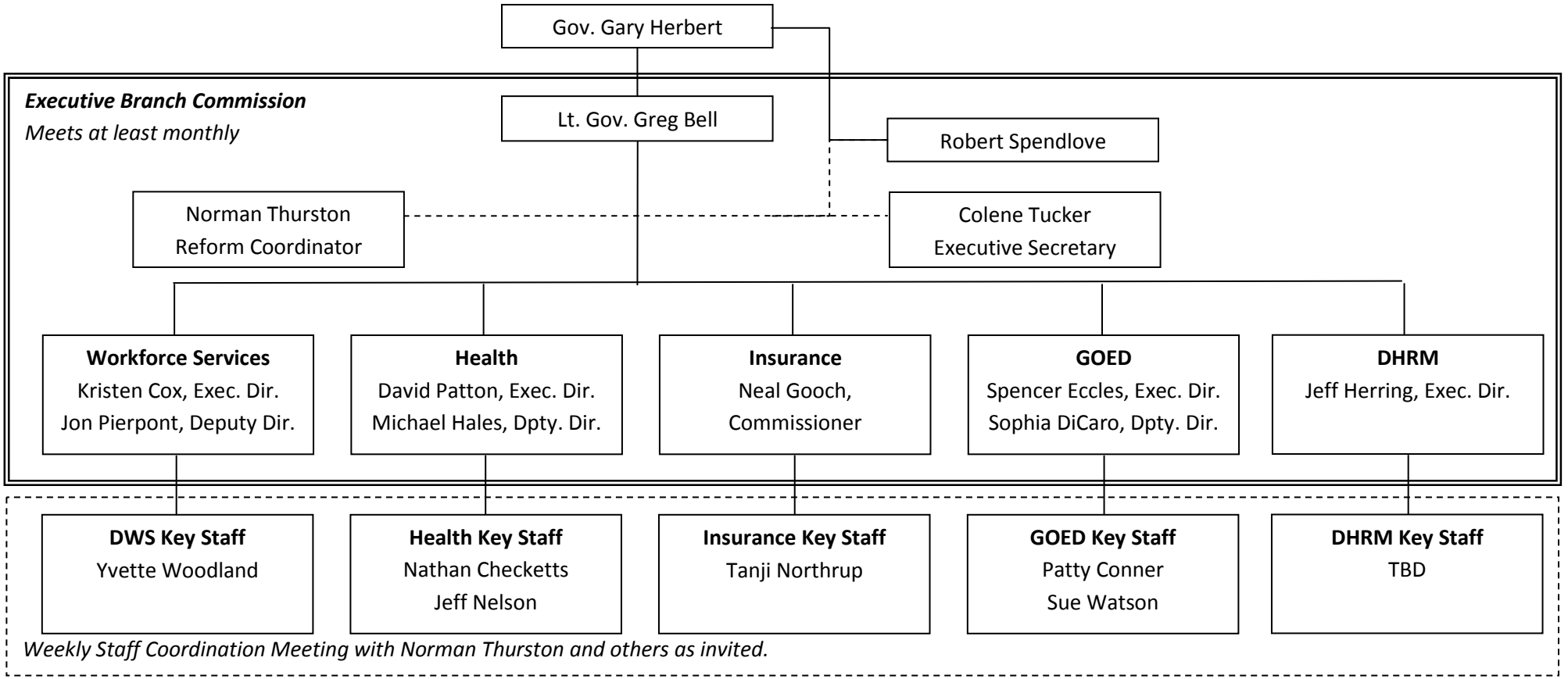
In addition to supporting the defined contribution market, the exchange also supports consumer choice in the traditional individual market. In this regard, the primary role of the Exchange is to connect consumers with private companies that can help them identify and purchase the product they need. On the Exchange, consumers are given three options to shop for and buy a policy – use a private online shopping service, buy direct from a participating insurer, or search for an agent to get in-person assistance. Currently, there are four private online shopping services, five insurers and hundreds of agents available through the Exchange.

Where will the Exchange take us in the future?

It is important to remember that a robust Exchange will be more than just a place to "apply for health insurance". While the initial focus of setting up the Exchange has been to establish a stable defined contribution market, this is just the first stepping stone in the process toward a consumer-oriented system.

In order to facilitate consumer choice in the long run, it is clear that the Exchange must provide information that is relevant to not only health care financing but also quality and transparency of the health care system. The Exchange will also evolve into a tool for patients to make better decisions about their health and health care by providing access to information about cost and quality and health and wellness.

The value of the Exchange is the sum of all its parts and each "part" is essential to the long term success of the Exchange and to the success of Health System Reform.


Gov. Gary Herbert
Executive Branch Commission
Meets at least monthly
Lt. Gov. Greg Bell
Robert Spendlove
Norman Thurston
Reform Coordinator
Colene Tucker
Executive Secretary
Workforce Services
Kristen Cox, Exec. Dir.
Jon Pierpont, Deputy Dir.
Health
David Patton, Exec. Dir.
Michael Hales, Dpty. Dir.
Insurance
Neal Gooch,
Commissioner
GOED
Spencer Eccles, Exec. Dir.
Sophia DiCaro, Dpty. Dir.
DHRM
Jeff Herring, Exec. Dir.
DWS Key Staff
Yvette Woodland
Health Key Staff
Nathan Checketts
Jeff Nelson
Insurance Key Staff
Tanji Northrup
GOED Key Staff
Patty Conner
Sue Watson
DHRM Key Staff
TBD
Weekly Staff Coordination Meeting with Norman Thurston and others as invited.

The Utah Health Exchange

Exchange 2.0

Norman Thurston & Patty Conner
5/13/11

2011

- Fine Tune Small Employer Approach
- Marketing and Outreach
- Focus on Scalability

Lessons Learned & Keys to Success

- Engage brokers as a valuable partner
- Embrace private solutions instead of hiring programmers
- Solution must be scalable
- Ensure a level playing field inside/outside the Exchange
- Beta tests are especially critical
- Plan extra time and go slow

The Utah Health Exchange 2.0 (2011-12)

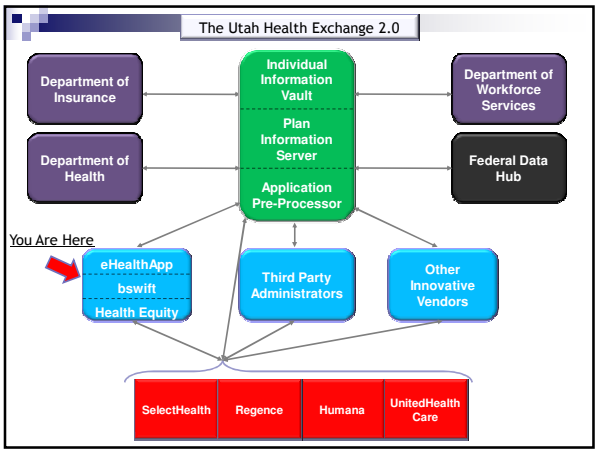
- High-level Program Goals
  - "Consumer-centric" module
  - Seamless Interface with Public Programs
  - Information from All Payer Claims Database (and other sources)

Vision for Exchange 2.0

- "The Cloud"
  - Individually owned accounts to gather & store personal information
  - Host plan information and rates for participating carriers
- Employers
  - Compile applications composed of group members

Vision for the Next Generation of Exchanges

- Modular Design
- Interfaces
  - Push/pull information: private, state, & federal sources
  - Individuals can populate their account information from external sources
- Access to "decision support" information
- Electronic applications for state, federal, and private plans/programs


The Utah Health Exchange 2.0
Department of Insurance
Department of Health
Individual Information Vault
Plan Information Server
Application Pre-Processor
Department of Workforce Services
Federal Data Hub
You Are Here
eHealthApp
bswift
Health Equity
Third Party Administrators
Other Innovative Vendors
SelectHealth
Regence
Humana
UnitedHealth Care

Creating Interoperability with Medicaid

Yvette Woodland
Department of Workforce Services

Nate Checketts
Department of Health

Department of Workforce Services: Uniquely Positioned

- Contractor of Single State Agency
  - Medicaid Determination Agency
- Administration of Multiple Programs
  - Medical programs, SNAP, financial, child care, UI, and training programs
- Service Delivery
  - Access, Options, Co-production
  - One Stop

Department of Workforce Services: Uniquely Innovative

- Yesterday
  - Imaging, Telephony, Data Brokering, Telecommuting, and On-line Application
- Today
  - eREP, On-line Chat, myCase, eNotices, and text messaging
- Tomorrow
  - Auto Import (Data – Brokered or Reported)
  - Improved connection to the Utah Health Exchange

Medicaid/CHIP and the Exchange

- Today
  - Link from Exchange to public program sites for information, questions, or application
- 2012
  - Need financial help link from Exchange will go to "Screening App" which will lead to full public programs online application
- 2014
  - No wrong door, enhanced "Screening App", full public programs eligibility determined through eREP
  - CMS promising simplification of old vs. new eligibles

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White Paper

The Utah Health Exchange: A Look in the Rearview Mirror

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State of Utah Health Reform Implementation Coordinator

February 15, 2011

Preface

Governor Jon Huntsman, Jr. was inaugurated in 2005 and stated that one of his priorities was to make health insurance available to more Utahns. Dr. David Sundwall, the executive director of the State Health Department was tasked to find staff resources to create a solution and I was asked to work on this project to help inform stakeholders and frame the debate.

Our first step was to organize a day-long health summit held at the University of Utah in May 2005. National experts were invited to inform policy makers and stakeholders about the latest national ideas on various health and insurance related problems. The goal of the summit was to form a consensus on which direction the Governor should take. One of the presentations was on a plan for a new helath care connector being negotiated in Massachusetts with a Republican governor and a Democratic legislature. We quickly realized that our approach would need to be different, but it might be possible to create a low-cost, Utah –based version that would focus on markets and private solutions and exclude the expansion of government programs.

With the support of many staff, legislators and governors, we have designed a revolutionary approach to health system reform in Utah. In this document I intend to give a reflection on the development and implementation of the Utah Health Exchange, a critical component of our overall plan for health system reform. I hope to highlight both the thinking behind our approach and the lessons learned.

Genesis – Identifying the Underlying Problem

While the focus of health system reform in Utah has grown to include several critical areas that are intended to bring more value into the system, at the outset the goal was to decrease the number of people without health insurance.

To help understand the problem, we analyzed detailed surveys of the uninsured and realized some commonalities. Most of the uninsured in Utah are in households with at least one working adult, who is often employed by a small business or if they are employed by a large business, they are part-time workers.

That raised the next question. Why do so few small businesses offer health insurance? Estimates indicated that in 2005 less than 40% of small businesses in Utah were offering health insurance as a benefit. A study of businesses in Utah showed us that the number one reason they choose not to offer a health benefit was the unpredictability of costs. Most small businesses are entrepreneurial and need to be able to project both revenues and costs out three to five years in order to

make plans to achieve their profitability goals.

To address these specific issues, we set out to create a new approach to the employee health benefit that would entice more employers to offer it and slow the decline in employers no longer offering coverage. Some of the critical aspects of the design of this new system include:

Generate predictability of costs for the employer – Small employers need to be able to forecast with a fair degree of certainty what their labor costs will be. We needed a system that gives the employer the ability to predict costs more effectively than the current system allows.

Preserve the tax benefit to both the employee and employer – The current tax code creates a huge disparity in treatment of health insurance that is purchased through an employer's group plan versus a policy purchased by an employee on their own. We needed to create a system that continues to allow both the employer and the employee to pay for health insurance with pre-tax dollars. This tax benefit could be as much as 45% of the cost of health insurance, considering state and federal income tax, payroll tax, and the phase-out of the earned income tax credit.

Bringing the consumer back into the equation – One of the most powerful forces for change is an informed consumer. Traditionally, the employee has been excluded from critical conversations about benefits and prices for group health insurance. To bring competition, discipline, and innovation into the process, we need to give more of the control to the employee.

Changing the Underlying Health Insurance Markets

With these preliminary goals in mind, the first key element in setting up the new system was to develop an entirely new health insurance market in the State of Utah. At the time, we had four main private-sector markets – individual/family market, small group market, large group commercial, and self-insured. Our intent was to create a new defined contribution market that is modeled after the defined contribution approach to retirement benefits. The defined contribution approach to retirement addressed the same problem that employers had with predictability regarding their retirement benefits.

In this new market, employers would designate a contribution amount for each employee to use toward the purchase of health insurance. The employee would then be allowed to select from plans offered by participating insurers in the same way that they have control over how their defined retirement contributions are invested. In addition to giving the employer control over their benefit costs, this also has the advantage of giving the employee full control over their health plan. They can choose the plan that best suits their needs. The employee also now has skin the game, in the sense that if they choose a more expensive plan, they pay the difference, but they also perceive the savings from choosing a less expensive plan.

As soon as we started designing this new system, we recognized that the two biggest challenges in creating this new choice-oriented market would be the potential for adverse selection and the need for a technology tool to help consumers evaluate their options and make good choices.

Adverse selection is primarily a problem for the carriers, so we brought them together and gave them an opportunity to identify a solution for potential selection issues.

Their solution was to design and implement one or more risk adjustment mechanisms to ensure that the funds that

flow to each carrier inside the Exchange more closely match the assignment of the risk. It turns out to be also a good move strategically. As we researched risk adjustment experiments, we found that in most cases where they failed, the blame was placed on the entity that developed the risk adjuster. It is easy for an insurer to walk away from a failing risk adjuster that is designed by someone else. It's a lot harder for them to make that case when they themselves have designed it. In our system, if the risk adjuster needs to be modified or updated, the carriers have the ability to make those changes.

On the second issue, facilitating consumer choice, we looked to the consumer experience in other industries that have similar challenges. The easiest example to understand is the travel industry. Over the past twenty years, consumers have been given a significantly greater opportunity to use the internet to make travel plans and execute them online.

We found that there are several private companies that have developed technologies to help consumers navigate the complex decision-making process and get the outcome that best meets their needs. In our presentations, we often pointed to Travelocity as being a prime example of a pioneer in the world of web-based consumer support. We set out to find a solution for employees choosing health plans that replicated the Travelocity service concept.

Using Technology to Facilitate Health System Reform

As we contemplated moving forward with this new market, it became apparent that we would want to develop an internet portal that could serve as the technology backbone for implementing health system reform in the State of Utah. This concept grew into the Utah Health Exchange. [1]

In addition to providing a web-based solution for the new defined contribution market, the portal could also provide technology solutions for other aspects of health system reform. Specifically, if we were going to the trouble of developing a consumer choice module for employees in the defined contribution market, we could also make that same functionality available to individuals buying policies on the open market or employers shopping for traditional group policies. Similarly, this would create a great opportunity and need for us to provide consumers with solid information on cost and quality. Eventually, this core portal could be expanded to support other aspects of health system reform.

As we considered how to structure the portal, we decided to take a modular approach. Initial development would eventually concentrate on three modules:

1) The Consumer Information Module

2) The Individual Market Shopping Tool

3) The Defined Contribution Module.

After making a realistic assessment of our capabilities and limited staff resources we decided to focus on the most critical component of the portal first – providing a workable solution for small employers. Because of that, the Defined Contribution Module was given the highest priority.

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[1] It should be remembered that an Exchange is a technology solution that is designed to facilitate the underlying health system reforms. In national discussions, people occasionally ascribe additional roles for exchanges, including such things as operating public programs, regulating markets, or even negotiating with carriers. While any of those goals could be a part of a state's underlying health reform, they should be thought of separately from the technology component, which is the real Exchange.

We set a goal of having something ready for a few employers to test by the fall of 2009. To make that happen as quickly as possible, we used an RFP process to identify existing private market technology solutions that could be applied to this module. Through that process, we found that the consumer comparison and choice technology that we needed already existed in the private market place.

In the insurance industry, just like the travel industry, there are several firms that have already developed tools to support health plan choice that could be adapted to meet our goals and needs. At the end of the process, we awarded contracts to two private companies, bswift, and HealthEquity, to work together to form the core technology for Defined Contribution Module. bswift's area of expertise is in facilitating consumer choice and HealthEquity brings the tools needed to handle to flow of funds. As a bonus outcome from the RFP process we also identified ehealthinsurance.com as a partner for developing the Individual Market Shopping Tool.

With these three private partners on board, in the summer of 2009, we launched the portal and christened it the Utah Health Exchange (often referred to as the UHE or the Exchange). In its initial form, the Exchange was launched with both the Defined Contribution Module and the Individual Shopping Module.

Development of the Consumer Information Module has begun, but is still not ready for prime time. When it is complete, the Consumer Information Module will be a technology resource to provide consumers with more transparency about the entire health care system, including health care providers as well as insurers. It will be able to display information on cost and quality in a way that helps the consumer make decisions and choices.

The Individual Market Shopping Tool

The Individual Market Shopping Tool is the easiest component of the Exchange to explain. Once word got out that ehealthinsurance.com would be our partner in this module, several other private entities with similar capabilities approached us with a desire to get involved. Since it was our purpose all along to foster competition in the private market, we had no justification to exclude any qualified partner.

As is stands today, individuals coming to the Exchange to buy a policy can shop in three different ways:

1) Online Comparison Shopping – They can choose one of five companies that offer side-by-side comparison shopping web-sites.

2) Online Buy Direct Shopping – They can also buy direct from one of the five insurance company web-sites that offer individual policies for sale through the Internet.

3) Find a Broker – The Exchange also has a tool that allows individuals to find a store-front insurance producer nearby where they can get help in person.

It is important to note that the plans offered through this module are the same plans available through the individual market. Given that our individual market functions relatively well, there was no need for insurers or regulators to create new rules or restrictions on policies that could be offered. [2]

While this adds significant value for consumers by facilitating their interaction with private partners, it is not a cure-all.

[2] I should note one exception – as part of the health reform legislation, we raised the bar for carriers to deny coverage in the individual market. Under the new rules, individuals under 225% of average risk cannot be denied coverage.

Products purchased through this module do not have the tax advantages of employer-sponsored plans. In the Utah individual market, these plans are not guaranteed issue plans, so consumers can be denied coverage. In that case, they are informed of their eligibility to participate in the federal or state high risk pools.

It's also critical to point out that these private partners do not charge the state for their services and did not receive any state development funds. They earn commissions just as they would through their normal line of business and do not increase the cost to consumers.

While this solution works very well for our current needs, we have to consider that as it stands today, the Affordable Care Act also contains several provisions that will create a significant disruption in our individual market and our Exchange approach might need some additional functionality to meet guidelines. We are currently evaluating the impact on our market and developing a contingency plan.

The Defined Contribution Module

The Defined Contribution Module is the most well-known and publicized module of the Exchange. This module was launched with a very aggressive timeline. We needed to have small employer beta test up and running by late summer, 2009, with a full launch for small employers in the fall of 2010. We were also asked to conduct a pilot program for large groups in 2011 to see if we could be ready to handle all large groups by the fall of 2011.

The limited launch that ran from the fall of 2009 through the full calendar year of 2010 resulted in a test group of eleven employers offering their employees a defined contribution health benefit. Having a relatively small number of participants was exactly what we needed to be able to test the technology and work out any bugs. We learned a lot in the process.

We have identified seven essential functions that need to be in place for a Defined Contribution Module to work.

1) Creation of Application Packets – The Exchange must be able to accept employer information electronically and create a basic application packet that can be sent to the insurance carriers for evaluation and acceptance. This packet needs to include employees' basic health information collected on an electronic version of the state's uniform health questionnaire.

2) Risk Assessment, Underwriting, Rate Setting – Once the employer packet is approved for participation in a defined contribution plan, the technology must facilitate communication with the insurance carriers in the underwriting and rate setting process. Rates received from the carriers must be posted so that employers and employees see the correct prices based on their group's risk. (In Utah, we use the same underwriting rules as in the traditional small group market, plus or minus 30% rate bands.) Once the pricing information is loaded, employers have any opportunity to review the rates and set the defined contribution amounts for the employees.

3) Employee Shopping and Choice – Employees must be given an opportunity to come into the system, evaluate their options, and make their plan choice. While every component is critical, this is the one that makes or breaks the effectiveness of the Exchange. Our goal is to provide the consumer with the tools they need to evaluate their options and make an informed choice. The current technology allows employees to filter or sort based on type of plan, benefits structure, insurance carrier, the inclusion of a particular provider, price, and other elements. This is critical, because with over 140 possible

plan choices, it can be an overwhelming experience to evaluate so much information and make a good choice. It is our belief that this is where technology makes the biggest difference.

4) Enrollment – Once the employee choices have all been executed, the technology must be able to create an enrollment file that documents which employees and dependents are enrolled in which plans. This information is then transmitted to the carriers so they can create accounts, print cards, and be ready to process and pay claims for their respective enrollees.

5) Eligibility Reporting – The system also needs to have the capacity to enroll new hires and make changes at other times, such as special qualifying events or terminations and communicate those changes to the carrier and report current and accurate eligibility information to inform other processes in the system, such as financial payments.

6) Financial Transactions – The system must make an accounting for the premium dollars. In this new market, there are more destinations for those dollars that in the traditional group plan. Most importantly, the premium dollars have to be risk adjusted and forwarded to the corresponding carriers.

7) Customer Service/Support – The last function to cover is a process for customer service and user support. Ideally, most employee needs would be served by their employer's producer, who would be fully aware of the functions of the Exchange and is licensed to make recommendations about plan choice. However, the Exchange needs to have the ability to provide information and support to all users. We are currently in the process of evaluating and redefining our approach to filling this role, but it is becoming apparent that this is more of a policy decision than a technology issue.

As mentioned earlier, one of the critical elements to make this new defined contribution market work is the ability to apply an effective risk adjuster and our approach was to turn that over to the participating carriers. In statute, we created the Utah Defined Contribution Risk Adjuster Board as the formal process for that to happen. This board is composed of carrier representatives, government representatives, and a representative from the business community.

The duty of the board is to develop a plan of operations governing the defined contribution market that addresses problems related to risk and protects the market from adverse selection. Since the details of the operation of this market are fairly dynamic as we continue to learn and adjust, I have left out many of the specifics. However, the current version of the plan of operations would have most of those details.

Similarly, the staff operating the Exchange frequently needs input on difficult operational and implementation issues. To provide additional support in a less formal setting, the Utah Health Exchange Advisory Board was created, composed of representatives from insurers, producers, community organizations, and government.

Critical learning from the Defined Contribution Module Launches

We used the learning from the limited launch to improve the technology in preparation for a full launch in the fall of 2010. We have also learned a few important things in this full launch that have required us to plan additional improvements.

Perhaps the most important thing we have learned is that it is difficult to put together and manage all of the information needed in an employer application. In the traditional market, this is typically done by

producers using a paper-based approach. When this is translated into an electronic format, there is still a tremendous need for the producer to be heavily involved in scrubbing the various components to ensure that everything is ready for submission.

Here are some of the other current issues and learning points from the launches:

1) Employee census – Businesses, especially small ones, are dynamic environments. During the course of a few weeks involved in processing the application, employees are hired, terminated, and become eligible or ineligible for benefits. The insurer has to know that they are basing their underwriting on the complete set of employees that are to be insured, yet this is a moving target. This is no different than what happens in the traditional small group market, but it is certainly something to take into account.

2) Employer Support – At the end of the process, many employers want assurance that the prices their employees will see in the Exchange are competitive with rates in the traditional market. In Utah, by statute, the plans inside the Exchange cannot be priced higher than the same plans outside the Exchange. However, this can be difficult to verify. Due to the nature of the Exchange, it's not easy to perform an apples-to-apples comparison with plans offered outside the Exchange. First of all, the exact plan that they may be considering outside the Exchange may not be one of the choices inside the Exchange. In addition, for reasons already mentioned about changing employee census, the rate quotes may not have been generated using the same employees. Finally, there is no way to predict what the employees will choose when given the choice.

3) Retrospective Risk Adjustment – In addition to the prospective risk adjuster, carriers may wish to do some back-end or retrospective risk adjustment. One of the challenges will be that claims information for employees in any given group could be housed across multiple carriers who may not be excited about sharing that information with each other. Fortunately, all of our participating carriers are also required to submit data to our All Payer Claims Database (APCD). So there is a single data source that has access to all of the claims related to Exchange participants. It stands to reason that the APCD could be a very useful tool in conducting retrospective risk adjustment for groups insured through the Exchange.

4) Engage Producers – The producers are the primary sales force for the defined contribution market. Rather than confronting and marginalizing them, it is better for everyone involved to engage them as early as possible in the process. An informed producer is likely to see how this new approach can benefit some or all of their existing clients as well as providing them a new sales tool to reach out to those small businesses that don't currently offer a benefit. Producers are also very helpful in guiding the development of the technology tools, ensuring that the process flows as intended, and watching out for errors or deviations in the system.

5) Premium Parity – In order to avoid a scenario where the defined contribution market is overloaded with high risk employers, it is essential that premiums for like products be the same inside and outside the Exchange. Initially, we did not have this requirement in the limited launch, and it became immediately apparent that this would be a problem. One of the specific areas of concern has to do with restrictions on renewal rates. In Utah, incumbent carriers face statutory

limits on premium increases at renewal. When currently covered small employers look at the Exchange, carriers should not get a free pass to rate them up beyond these limits. In our current approach, if an employer is currently insured with a participating carrier, all carriers are restricted from assessing a risk factor higher than their renewal risk factor from their incumbent carrier.

6) Engage Insurers – When all is said and done, the insurers have every incentive to make this work. It represents an opportunity to increase enrollment, which will reduce cost-shifting as well as providing additional premium. To the extent that there are concerns about risk, it is the insurers who have the proper motivation to address them. With this in mind, we have given a fair amount of latitude to the insurers to bring their expertise to the table to help in the design and development of the system.

7) Private Solutions – We now realize that it was very effective for us to contract with companies that have existing technology solutions that could be applied to the needs of the Exchange. However, we have also learned that this partnership works best when the application of the technology is close to the core competency of the partner. It's better to engage additional partners whose core competencies meet the need at hand instead of trying to apply technologies beyond what they are intended to do.

8) Do a Beta-test – Maybe this is the most obvious thing that we only thought about once we were into the process. It is essential to a successful development to continually test the system during development. A beta-test with real participants was very informative and made a huge impact on our eventual outcome.

Counsel for Other States

Can this be done faster using Utah as a template? I am convinced that this is the case. Based on our experience, we know what legislative action is required, and we also know what critical functions need to be in place for the Defined Contribution Module to work. This isn't to say that it would take time to develop those functions, but we now know that most (if not all) of them are already developed in the private market. If states can be clear about their needs, it should be straightforward to build.

What adaptations should states anticipate? It was not easy to develop the data interfaces and communications between the exchange tools and the insurers. While insurers that are participating in our Exchange understand how to deal with that now, new insurers will need some time to get up to speed.

STATE EXCHANGES: THE UTAH EXPERIENCE

By Representative David Clark

Presented to
Governor Herbert's
Utah Health Exchange Invitational
May 12, 2011

Strategic Steps for States

- Begin with a vision
- Understand the target
- Develop a plan
- Engage stakeholders
- Leverage existing resources
- Test before you go live

Begin with a Vision

In 2007, Utah lawmakers set out to develop a consumer-driven health care system and insurance market that provides:

- Greater Choice
- Expanded Access
- Individual Responsibility
- Increased Affordability
- Higher Quality
- Improved Health

Understand the Target

Utah's Uninsured Population (2007)

- 10.6% (roughly 300,000 individuals)
- Majority are employed
- Many are part-time workers with multiple jobs
- Most work for small firms
  - Less than 50% of small firms offering health insurance
- Many are "young immortals" (age 18-34)

Develop A Plan

- **States have a range of options** for how the Exchange operates from an **"active purchaser"** model, in which the Exchange operates as large employers often do in **using market leverage and the tools of managed competition to negotiate product offerings** with insurers, **to an "open marketplace"** model, in which the Exchange operates as a clearinghouse that is open to all qualified insurers and **relies on market forces to generate product offerings**.

U.S. Department of Health and Human Services Initial Guidance to States on Exchanges . Issued 11/18/2010.

Engage the Stakeholders

YEAR 1—Perspective-Oriented Working Groups

- **Community Group**
- **Business Group**
- **Hospital Group**
- **Non-hospital Provider Group**
- **Insurance Group**

Engage the Stakeholders

YEAR 2—Task-Oriented Working Groups

- **Affordability and Access Group**
  - *Administrative Simplification Technical Advisory Group*
  - *Wellness and Healthy Behaviors Technical Advisory Group*
- **Transparency and Quality Group**
  - *Health Care Delivery and Payment Reform Technical Advisory Group*
  - *Infrastructure Technical Advisory Group*
- **Oversight and Implementation Group**
  - *Risk Adjuster and Defined Contribution Expansion to Large Employers Technical Advisory Group*
  - *Public Employees Health Plan and Other Associated Health Plans Participating in Defined Contribution Market Technical Advisory Group*

Leverage Existing Resources

Technology

- **Private-sector vendors**
  - *Enrollment and Plan Selection—bswift, Inc.*
  - *Financial/Banking Function—HealthEquity, Inc.*

Marketing and Outreach

- **Chambers of Commerce**
- **Professional and Trade Associations**
- **Earned Media**

Education and Adoption

- **Brokers and Consultants**
- **Human Resource Managers**

Test Before You Go Live

- Measure twice, cut once
- August 2009—Utah Health Exchange Limited Launch
- September 2010—Full launch to all Utah small employers
- Allows for technical fixes and incorporation of lessons learned
- Pilot projects are your friends!

Utah Health Exchange Timeline

March 2008 ***HB 133 establishes the Utah Health Exchange***

- On-line mechanism that allows consumers to compare, shop for, and enroll in a health plan
- Will incorporate All Payer Claims Database so patients may access information about providers
- Includes a multiple source premium aggregator

March 2009 ***HB 188 establishes the Utah Defined Contribution Market***

- Employer offers a pre-determined level of funding, rather than a pre-determined benefit
- Utah Defined Contribution Risk Adjuster Board established
- Three carriers announce participation in the Exchange (SelectHealth, Regence BlueCross BlueShield, Humana)

August 2009 ***Utah Health Exchange Limited Launch***

- Exchange is open to limited number of small employers (2-50 employees)
- Purpose is to test dynamics of the new defined contribution market as well as the processes of the Exchange technology

Utah Health Exchange Timeline

March 2010 ***HB 294 includes provisions intended to correct and enhance the defined contribution market and the Exchange***

- Pricing parity between traditional small group market and defined contribution market
- UnitedHealthcare announces participation in the Exchange (total of 4 carriers)

May 2010 ***Large Group Pilot Project announced***

- Full year earlier than anticipated, per requests from large employers (50 or more employees)
- Approximately 50,000 covered lives

September 2010 ***Full-scale launch to all Utah small employers***

The Utah Health Exchange in the Press

"Compared to what's being trotted around the Asylum on the Hill, *Utah's bipartisan reform project sounds downright dreamy. Simple and geared toward the consumer,* it was designed under the operating principle that Americans are capable of making their own decisions..." (Kathleen Parker, "Health Reform, Utah's Way," in *The Washington Post*, July 26, 2009)

"As Washington attempts to pass national health reform this fall, *Utah's experiment may become a model for lawmakers looking to create market-based reforms. It will clearly benefit small businesses* that now face unpredictable rate changes." (John Tozzi, "What Utah's Health Reform Means to Small Business," at BusinessWeek.com, Sept. 4, 2009.)

"The State of Utah recently launched a new program that... demonstrates why *state-level policy innovation—not top-down, federal planning—is the key to improving America's health sector*." (Grace-Marie Turner, "Innovation, Not Intervention" at *Forbes.com*, Sept. 18, 2009)

Why States Matter

"The battle over health care is shifting to the states, and the **design of insurance exchanges will be one of the most pressing issues for state legislators** when they convene early next year…**Utah and Massachusetts may well serve as bookends for other states." –** New York Times, 10/23/2010.

The Utah Health Exchange

Supporting Utah's Markets

Norman K Thurston, Ph.D.
Health Reform Implementation Coordinator
5/12/11

What is the Utah Health Exchange?

- Internet-based information portal
- Connects consumers to vital information
  - Single shopping point with reliable information
  - Side-by-side comparisons
- Consumers make informed choices about healthcare
- Execute choices electronically

Why an Exchange?

- Fundamental health reforms are the foundation
- Technology can facilitate reforms
- The Utah Health Exchange is designed to enhance consumer choice and the ability of the private sector to meet consumer needs
- Facilitate Private Transactions

Core Components of the Technology

- Health, Cost & Quality Information
- Individual & Family Products
  - Find a Broker
  - Buy direct
  - Comparison shop (a la Travelocity.com)
- Employer-sponsored plans
  - Backbone of the Defined Contribution Market
  - Facilitates transactions
  - Enables comparison and choice

The Defined Contribution Market

- Employers Set Payment Amounts
- Employees Have Control Over How Funds are Spent to Meet Needs
- Choice and Accountability Move to the Employee Side of the Equation
- Simple & Expands Offerings
- Preserves Tax Advantages
- Employees Get Control & Choice

Supporting Utah's Employers

- Small Business, 2-50
  - On-going open enrollment
- Groups of 51-99
- Larger Groups (100+)

How Does it Work?

- Private Partnership
- Leveraging Existing Technology

Current Status (May 1, 2011)

- Plan Choice:
  - 146 plans from 4 insurers
- 5-Month Enrollment:
  - 114 Employers (25% previously uninsured)
  - 2,985 covered lives
- Monthly Defined Contributions
  - Range: $0 - $1,683; Mean: $360 per employee
- Rates are audited to be comparable with traditional small group rates