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Key Issues for Pennsylvania in Developing Health Benefits Exchanges

The following is a list of the major issues that consumer representatives\(^1\) of the National Association of Insurance Commissioners (NAIC) identified in a June 11\(^{\text{th}}\) letter to the federal government as it prepares to issue regulations and guidance to states about health benefits exchanges under the Patient Protection And Affordable Care Act (PPACA). The Pennsylvania Health Law Project also encourages the Commonwealth of Pennsylvania to explain how it will address these issues if it decides to apply for a state exchange planning grant. Though far from exhaustive, these issues contain basic questions that must be addressed fully and properly if a health benefit exchange is to operate effectively for consumers in both the near and longer-term. The issues identified include:

1. **Minimizing the potential for adverse selection**: This is the foremost critical issue in any design of exchanges. The current system has failed in large part because insurers have had enormous incentives to segment risks. We believe that the private insurance markets, inside and outside the exchanges, must be structured to discourage risk selection to the maximum degree possible. This includes both adverse selection against the exchange and adverse selection among plans participating in the exchange. A well-designed system should instead create new incentives for insurers (and providers) to compete on risk management, not selection, as well as their ability to improve the efficiency and quality of health care delivery.

If the markets and rules governing the exchange are improperly structured and become vulnerable to adverse selection, the exchanges would become increasingly unaffordable over time and fail to achieve the long-term goals of the

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new legislation to create a new marketplace that offers affordable, comprehensive options for individuals and small employers.

- To what degree will standards and requirements for plans and insurers outside the exchanges vary from those inside the exchanges? Previous experience has shown that different standards create an “unlevel playing field” that results in insurers seeking advantage through risk selection. To what extent can the federal government address this problem through regulation and/or by encouraging states to establish consistent rules?

- What will be the rules for ensuring that insurers are risk pooling across all plans, both inside and outside the exchange? How will the federal government help states enforce that requirement? What rules will govern ownership for insurers inside and outside the exchanges—i.e., could an insurer establish a separate legal entity to sell plans that are not qualified outside the exchanges, thereby skirting the risk pooling requirements of the statute?

- What will the rules be for state implementation of risk adjustment? How will the federal government aid states in ensuring that risk adjustment is effective, particularly with regard to plans outside the exchange? How will risk adjustment mechanisms be applied effectively to plans that operate solely outside the exchanges?

- Will the states be allowed to permit benefit and cost-sharing packages that vary outside the exchange from those inside, and if so, to what degree?

- If a state allows multiple exchanges, how will the authority and scope of each be determined? Will standards be in place to ensure that each exchange within a state is large enough to sustain a risk pool that is viable over the long-term and does not lead to beneficiary confusion and higher administrative costs?

- What will be required of states in ensuring that marketing and benefit design of qualified plans do not lead to adverse selection? What criteria must states use in making this evaluation? To what extent will plans and employers be discouraged from steering bad risks into the exchange, and held accountable if they do?

2. Governance: The governance of the exchanges is critical to their start-up and continued viability. The role of an oversight body and the staff leadership of the exchange must be clearly defined, and consumers’ interests must be
robustly represented on any governing board and as part of all decision-making processes.

- What is the relationship of the governing board to the state government?
- What will be the composition of the governing board? What will be the roles and responsibilities of board members? Will board members be compensated?
- To what extent can the board make changes in operations on its own?
- If a state has more than one exchange (including a separate “SHOP exchange”) or enters into a multi-state compact, what is the governance relationship among the exchanges (e.g., overlapping board membership)?
- Should the insurance industry be represented on the board? If so, what steps should be taken to deal with conflicts of interest that might arise with insurance companies and brokers?
- The health reform law requires exchanges to consult with stakeholders. What standards will be set to ensure that various stakeholders have a voice (through an advisory panel or other mechanism) beyond the governing board?

3. **Financing of the operations of the exchange**: The health reform legislation envisions the operations of state exchanges as self-funded, potentially through the use of assessments on insurers. Adequate financing, however, will be essential considering the numerous responsibilities given to an exchange, including certifying plans, implementing risk adjustment, determining eligibility for premium credits, and coordinating enrollment with public programs like Medicaid and CHIP.

- What sources of financing will be deemed acceptable by the federal government?
- How will the federal government assess whether the financing is sufficient to allow the exchange to be viable over the long-run and fulfill all of its responsibilities required under the legislation?

4. **The administrative and regulatory functions of the exchange**: Clearly defining what administrative and regulatory authority, if any, the exchange will have (as opposed to the authority that will be exercised by other state entities including an insurance department) is essential in establishing a
well-functioning exchange, a well-functioning health insurance market in the state, and containing costs over the long-term.

- What, if any, regulatory authorities will the exchange have, and how will its authority interact with the role of the state insurance department, the entity responsible for administering the risk-adjustment and reinsurance programs, the state insurance consumer assistance program, any entity including a state Medicaid agency that is responsible for enrollment, and other state agencies? Will any regulatory authority granted to an exchange be unique to it, or will the authority be shared with a government agency (e.g., premium rate review for qualified plans)?

- How will the exchange or the state handle appeals of denial of eligibility determination by either an individual or a plan? Individuals and plans should have access to administrative and judicial review of such determinations.

- To what extent will exchange authorities be encouraged to negotiate premium discounts for exchange participants, or regulate premium increases? This authority is critical to containing unreasonable rate increases. For example, the Massachusetts Connector authority has been successful at keeping premium increases below trend in part by negotiating rates directly with insurers.

- To what degree can exchanges control entry by insurers? The law not only limits entry into the exchanges to those plans that can meet the federal minimum requirements, but it also allows exchanges to consider whether including a plan is “in the interest of” participating individuals and employers.\(^2\) In promulgating guidance for states, the Secretary should ensure that exchanges have sufficient authority to limit access to those insurers that offer the best value to participants.

- To what extent can state allow its exchange to require participating plans to offer benefits or cost-sharing that are not in the essential benefits package (as defined by HHS)?

- What standards will govern the process for exchanges to certify, recertify, and decertify participating plans? Such a process must be transparent, with an opportunity for consumers, employers and providers to provide input.

- What authority will the exchange have to protect consumers? If the enforcement of consumer rights is left to the state (i.e., a body other than

\(^2\) PPACA, § 1311(e)
the exchange), what will be the role of the exchange in identifying problems and assisting consumers?

5. **Enhancing transparency and administrative simplification:** Existing insurance markets are not viable or sustainable, in large part because there is no transparency, and consumers and purchasers lack the information they need to make educated choices. Consumers need to have accessible, understandable information about the scope and quality of coverage. Meaningful competition driven by empowered consumers is absolutely critical in transforming the current health system to one that is more efficient and value-driven.

- How will the state or the exchange communicate information to the public about options, premiums, benefits, and the navigator program?

- To what extent will information about all relevant plan features and limitations (i.e., benefits, cost-sharing, provider networks, consumer satisfaction) be standardized and published in plain language, so that consumers can make apples-to-apples comparisons?

- What data will be used to create the new rating system required by the statute and how will it be independently verified and displayed to consumers?

- Will the state, either through an agency or the exchange, standardize forms and processes for all insurers (i.e., enrollment, appeals, etc.)?