



January 10, 2011

Mr. Jeremiah Samples
West Virginia Office of Insurance Commissioner
1122 Smith Street
Charleston, West Virginia 25301

Dear Mr. Samples,

On behalf of consumers, social workers, organized labor, nurses, teachers and other school employees, and public policy researchers, we are submitting the following comments on the development of the West Virginia health insurance exchange. We commend you and the Office of the Insurance Commissioner (OIC) for using this open and transparent process. The Request for Comments, coupled with the six public meetings that the OIC has conducted over the last two months, should serve as a benchmark for public participation by other state agencies.

We appreciate the opportunity to submit these comments, and we look forward to working with the OIC to develop a West Virginia health insurance exchange that improves the quality of health insurance for small businesses and individuals, while containing future cost increases.

Sincerely,

Hersha Arnold Brown
State Government Relations Director
American Cancer Society

Sam Hickman
CEO
NASW, West Virginia Chapter

Kenny Perdue
President
West Virginia AFL-CIO

Ted Boettner
Executive Director
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David Haney
Executive Director
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Beth Baldwin
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Gary Zuckett
Executive Director
WV-CAG

Perry Bryant
Executive Director
WAHC



Comments on the Planning and Development of the
West Virginia Health Insurance Exchange
Comments on behalf
American Cancer Society,
American Friends Service Committee,
National Association of Social Workers - West Virginia Chapter,
West Virginia AFL-CIO,
West Virginia Center on Budget and Policy,
West Virginia Citizen Action Group,
West Virginia Education Association,
West Virginia Nurses Association, and
West Virginians for Affordable Health Care

1. Exchange Goals:

a. Mission:

The mission of the West Virginia health insurance exchange (exchange) is to enroll as many as two hundred fifty thousand West Virginians into either Medicaid or private insurance plans. Consumers, both small businesses and individuals, should be able to enroll in high quality health insurance plans that also contain the cost of health insurance. High quality insurance plans include those with health promotion programs, effective chronic disease management programs, and patient-centered medical homes.

b. Policy Goals:

The goals of the exchange should be to improve the health and well-being of West Virginians, while holding the cost of health insurance coverage to levels at or below the medical rate of inflation, and ultimately to levels at or below the consumer price index. The exchange should reduce administrative costs, be seamless so people can move from job to job, between private insurance and Medicaid and between Medicaid and CHIP without disruption of coverage. The exchange should be business-friendly, acting as the Human Resources Department for small businesses and aggregating premiums for employers. The exchange should be consumer-friendly by limiting the number of plans offered and standardizing insurance options so employers, their employees, and individual consumers can easily compare plans and easily select one that best fits their needs. The Exchange should make decisions regarding eligibility for subsidies and for Medicaid coverage using public data sources and requiring little or no paperwork from consumers.

2. Exchange Structure and Governance:

a. Location:

Some experts have recommended that the exchange should be located in an independent state agency.¹ One such expert, Timothy Jost, recommends that the exchange not be housed in the offices of the state insurance commissioner.

“Although the exchange must coordinate closely with the state insurance department or commissioner, it should not be housed in the insurance department. It is quite possible that not all insurance plans will be certified for participation in the exchange, and selecting among plans would be inconsistent with the impartiality that must be shown by an insurance commissioner. Moreover, the fundamental role of an exchange is to market insurance products, while the basic role of an insurance commissioner is to regulate insurance and protect consumers.”²

The OIC makes the argument for housing the exchange in the OIC by asserting that having one agency regulate policies sold both inside and outside the exchange is both effective and efficient, and that utilizing the expertise of the existing staff within OIC to regulate rates and forms, agent licensing, etc. will reduce the cost of operating the exchange, and save consumer premiums.

However, the OIC appears to underestimate the inherent conflict between the regulatory role of the OIC, grounded in ensuring the solvency of insurance companies, and the almost contradictory exchange function of containing premium increases for small businesses and other consumers. If the Exchange is housed in the OIC, it will be imperative to establish a firewall between the OIC’s regulatory function and exchange function. More than an independent exchange Board is needed in order to separate these two functions within the OIC.

The organizations submitting these comments are prepared to engage with the OIC, the Governor and the legislature on ways to ensure that these two very different functions are completely separate and do not impair the smooth functioning of the exchange.

b. Exchange Governance:

It is inherently wrong for one entity to sit on both sides of a bargaining table. United Healthcare, for example, should not be a member of the exchange governing Board deciding on reimbursement rates for insurance policies sold within the exchange that United Healthcare will be selling. It is illogical to assume that allowing the fox to guard the chickens will result in higher value for the premiums paid by small businesses and other consumers.

¹ Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, Commonwealth Fund, (September 2010). Accessed December 30, 2010 at <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx>

² Ibid.

The OIC has recently recommended an exchange governing Board comprised of the Insurance Commissioner, the Directors of Medicaid and CHIP, the Chairman of the Health Care Authority, three representatives of consumers, and one representative each from the insurance industry, medical providers, and insurance agents/navigators. The composition of this governing Board would provide the most representation by those with financial conflict-of-interests of any independent exchange Board established or proposed to date in the country.

California has established a five-member Board that specifically excludes representatives of the insurance industry, medical providers and insurance agents; three groups that would have representation equal to the consumer representation on the Board as proposed by the West Virginia OIC. Massachusetts has an 11 member Board with only one seat represented by an entity that has a financial interest in the decision of the board. Additionally, the West Virginia OIC staff has reported that Pennsylvania is contemplating having no representatives with financial conflict-of-interest, while Wisconsin would limit these representatives to one, and Mississippi to two. West Virginia would lead the country with three under the current OIC proposal.

If there is any doubt that placing board members with financial conflict-of-interest on a board results in decisions that are detrimental to the interest of consumers, one need only examine Utah's experience. Utah's exchange has an "advisory" board that has disproportionate representation by insurance agents. The Utah exchange has decided that insurance agents should be compensated at \$37 per member per month. To put this in perspective PEIA is reimbursing Cabin Creek Health Systems a capitated rate of slightly more than \$30 per member per month for unlimited, high quality primary care. In other words, the Utah exchange advisory board that contains numerous insurance agents puts a higher value on reimbursing insurance agents than is puts on providing high quality, primary care in West Virginia.

An alternative exchange governing Board recommended by all of the organizations submitting these comments would include: a representative the West Virginia AFL-CIO, West Virginians for Affordable Health Care, and another representative from a statewide consumer organization; and two representatives of small businesses. One would represent the interest of small businesses that employ fewer than ten employees, while the other representative would represent the interest of employers with more than ten employees. No board members should have a financial conflict-of-interest, and every Board member should have a clearly defined fiduciary responsibility to operate the exchange for the benefit of the beneficiaries participating in the exchange.

The exchange should be exempt from state personnel and purchasing laws and regulations, although the exchange should be required to report to the legislature on any contract over \$50,000 and include justification for the selection of any vendor who receives more than \$50,000 in payment in any 12-month period.

The exchange governing Board's enabling legislation should also establish two advisory councils to the Board. One comprise of the commercial insurance companies that are planning to, or after 2014 actually do, sell their products through the exchange. Insurance agents should be provided a prominent place on this advisory council. The second advisory council would include representation from the various medical provider associations. Each advisory council would have an opportunity to periodically make presentations to the exchange Board.

c. Considerations for regional exchanges:

Establishing a regional exchange would have significant advantages, given West Virginia's small population and poor health status. There are, however, several considerations that should be considered in deciding whether to join a regional exchange. For example, what are the insurance laws and regulations, including consumer protections, in each of the states that may be included in the regional exchange? How will competing regulations be enforced, and who will enforce these regulations? Can enrollment systems accommodate different eligibility rules for the Medicaid and CHIP programs? Will all participating states have a multi-payer claims databases, and will these databases be combined? If they are combined, who will control the multi-payer claims database, and how will other states access the database?

3. Functions:

a. Navigators:

Navigators are intended to assist uninsured and underinsured individuals and small businesses in finding insurance options that best serve these consumers. While the OIC should adopt training criteria for the selection of navigators, the OIC should not adopt overly restrictive requirements that would limit navigators to insurance agents. The OIC should review the Medicare Part D navigators as a template for the requirements for the exchange navigators. Additionally, the OIC should review the American Cancer Society's medical navigator program to learn how they effectively train lay persons to guide newly diagnosed cancer patients through the maze of the health care system.

b. Reaching culturally diverse populations:

Reaching culturally diverse populations in West Virginia will be a challenge for the exchange. Engaging organizations that represent diverse populations early in the process, and continuing to engage these organizations throughout the process is essential. A partial list of organizations and contact information that the OIC should contact and work with include:

1. Enroll West Virginia: Renate Pore at renatepore@gmail.com

2. West Virginia Council of Churches: Rev. Dennis Sparks at sparks@WVCV.org and Jeff Allen at jsallen@wvcc.org .
3. Partnership of African American Churches: Rev. James Patterson at patterson@paac2.org
4. Legal Aid of West Virginia: Kate White at kwhite@lawv.net
5. WVU Extension Service: Elaine Bowen is probably the right person at the Extension Service. If she isn't the right person, she'll know who is. Her email address is epbowen@mail.wvu.edu .
6. West Virginia State Independent Living Council: Ann Meadows at ann.meadows@wvsilc.org
7. Fair Shake Network: Jan Lilly Stewart at wvfn@msn.com .
8. Representatives of the Family Resource Networks (FRNs). There is no FRN Association. The OIC should contact several FRNs to insure that they are adequately engaged in reaching diverse populations in West Virginia.
9. Tuesday morning group: Rev. Mathew Watts at hopewdc@aol.com .
10. Direct Action Welfare Group: Evelyn Dortch at Evelyn@wvdawg.org .
11. Human Resource Development Foundation (HRDF): Phil Leinbach at pleinbach@hrdfwv.org .
12. Human Resource Development and Employment (HRDE): Don Savage at dsavage@hrdfwv.org .
13. Appalachian Council, AFL-CIO: Gary Darlington at gdarlington@appcouncil.com.

c. Role of insurance agents (producers):

Insurance agents have a significant role to play in the exchange. As noted above, they should be provided significant representation on the commercial insurance advisory council. They should be paid for enrolling small businesses and individuals in the exchange. The difference that an insurance agent receives for enrolling consumers in exchange products and products sold outside the exchange cannot be substantial, or agents will have a vested interest in enrolling consumers in products sold outside the exchange. This would have the detrimental effect of keeping healthy consumers outside the exchange and add to the adverse selection inside the exchange. Professor Jost has even recommended that insurance agents be compensated the same fixed dollar per

member per month for policies sold inside and outside the exchange.³ There is, however, less work involved in enrolling consumers in products sold inside the exchange. Careful attention should be paid to ensuring that insurance agents are interested in and rewarded for enrolling consumers in products sold in the exchange.

4. Enrollment and Eligibility:

a. Definition of small businesses:

It is unclear whether the OIC is planning to conduct actuarial studies on the impact of retaining the definition of small businesses at 100 or fewer employees or reducing the definition to 50 or fewer employees. It would be extremely helpful to have this analysis prior to making a decision on this issue, and the organizations submitting these comments strongly urges the OIC to conduct an actuarial study of whether West Virginia should retain the 100 employee threshold, or reduce the threshold to 50 or fewer employees.

The issue of whether to maintain the 100 or fewer employee threshold or to reduce it to 50 should focus on whether maintaining the larger threshold will increase adverse selection or not. The evidence that we have seen to date suggest that adverse selection will not be an issue by allowing employers with 50 to 100 employees the option of participating in the exchange. There are options available other than reducing this threshold to address concerns regarding adverse selection.

Massachusetts, for example, found a small but growing number of individuals were “gaming” the system by purchasing health insurance when they became ill, and then dropping coverage after their illness had been treated. As a result, Massachusetts developed a limited enrollment period to keep individuals from “gaming” the system. Massachusetts did not adopt a similar restrictive enrollment period for business suggesting that they did not find similar activity among businesses.

What little data exists regarding West Virginia also suggest that maintaining the 100 or fewer employee threshold may not increase adverse selection. In 2006 WORKFORCE Research issued a report on the benefits offered by West Virginia employers by the number of employees and by industry sector. They found that slightly more than 52 percent of West Virginia private sector employees worked for an employer that had 49 or fewer employees. There were approximately 42,000 employers in this group employing slightly more than 287,500 employees, while there were only 1,100 employers employing between 50 and 99 employees. These larger employers employed an additional 77,000 employees. If West Virginia maintained the 100 or fewer employee threshold, 67 percent of West Virginians private sector employees would be eligible to participate in the exchange.⁴

³ Ibid.

⁴ *Employee Benefits in West Virginia: 2005-2006 Private Sector*, WORKFORCE Research, Information and Analysis, (April 2006).

If adverse selection is going to occur, it is far more likely to occur in the 42,000 employers employing 49 or fewer employees than the 1,100 employers employing between 50 and 99 employees. Therefore, we would recommend that any effort to mitigate against adverse selection be applied to all employers employing 100 or fewer employees rather than excluding those employers with between 50 and 100 employees. Measures that could be adopted if adverse selection is seen in this market could include limited enrollment periods or an extended waiting periods to re-enroll after a policy has been dropped by an employer.

Retaining the definition of what constitutes a small business at 100 or fewer employees may not only benefit the exchange, it will also be a benefit to the business community, particularly if the exchange can deliver on providing a higher quality insurance product while containing costs. Attracting businesses to the exchange has to be a premier goal of the exchange. Engaging the business community in a dialogue on this issue and conducting further financial analysis is essential, and should be conducted prior to any decision being made.

It is premature to recommend whether the exchange should be expanded to employers with greater than 100 employees in 2017 and beyond.

b. Initial Enrollment Period:

The initial enrollment period should be extensive. Enrollment should begin, as an example, on October 1, 2013 and extent to March 31, 2014. Individual and small businesses that enroll prior to December 31 would have their benefits begin on January 1, 2014. Those who enroll during the initial enrollment period after January 1 would have their benefits begin on the first day of the following month.

Enrolling as many as 125,000 individuals in the exchange and as many as 157,000 low-income West Virginians in Medicaid is truly a daunting task. Providing at least a six month initial enrollment period is warranted. We would recommend that future enrollment periods coincide with the Medicare Part C and D enrollment period which will be October 15 through December 7 in 2014 and beyond.

c. Online enrollment:

Enrollment in Medicaid and the exchange should be by computer and as simple and seamless as possible and not require burdensome paperwork from the beneficiaries. Checking for citizenship status, income and family size should be done electronically through public databases. The exchange should have sufficient staff to address eligibility issues for those whose records cannot be found in a public data base in a timely fashion.

To assure access to on-line enrollment, the exchange must work with community partners and/or insurance agents to assist beneficiaries in enrolling in Medicaid and the private products sold through the exchange.

Eligibility determination for Medicaid and subsidized products must be carefully planned with beneficiaries in mind. Enrolling Medicaid beneficiaries through the exchange is an enormous change from current practices and the need for careful planning and implementation cannot be underestimated.

5. Health Plan Participation:

a. Prudent purchaser approach

The core function of the exchange is to provide value for premium dollars spent by small businesses and individual consumers. Value is the combination of high quality insurance products while containing costs. Being a prudent purchaser of health insurance products offers the best opportunity for the exchange to obtain value for consumers' premiums.

We would strongly recommend that the exchange be a prudent purchaser of health insurance by vigorously setting the criteria that plans must meet in order to participate in the exchange. The exchange should, for example, improve the quality of health care policies sold in West Virginia by requiring effective chronic disease management plans, smoking cessation programs and weight management programs be offered by insurance products sold in the exchange. Many insurance plans are currently providing these important services, and the exchange should expect ALL plans to offer these benefits. The exchange should also expect that premium increases be contained, and only allow those companies that keep premiums at or below the medical rate of inflation (or other benchmarks that consider both the medical rate of inflation and other cost drivers) to sell policies in the exchange. Insurance companies that have a history of adopting unreasonable rate increases should also be excluded from participating in the exchange.

In addition, the exchange has the opportunity of improving the health of future West Virginians by requiring quality well-child programs as part of the products sold in the exchange. In developing well-child program standards, the exchange should work with child health experts to provide for an affordable product that protects and promotes the health of West Virginia's children. We have an opportunity to create base-line data and monitor progress in improving child health that can have an enormous impact on the future and change West Virginia's current dismal statistics as a state with low health status to one in keeping with national norms.

Some have expressed concern that the individual and small group markets in West Virginia, which are dominated by a small number of insurance carriers, may not allow the state to be a prudent purchaser of health insurance. However, the data

suggest that a number of insurance carriers will be interested in participating in both the individual and small group exchanges.

In November 2008, the OIC issued the *Accident and Health Insurance Market Report for 2008* (the most recent data posted on the OIC's web site). This report found that 38 carriers had only 15,400 covered lives for major medical coverage in the individual market. The Congressional Budget Office estimates that many consumers in the individual market will enroll in the exchange where they will receive premium tax credits and possible other subsidies. The OIC projects that as many as 125,000 West Virginians will qualify for premium tax credits in the exchange. The concern that insurance companies will not participate in the exchange while facing the loss of their current individual customers and foregoing the potential to sell 125,000 individual policies (an eight-fold increase in the 2008 individual market) because they are not given a seat on the exchange board or will be subject to prudent purchasing, is unrealistic in our opinion.

The same 2008 OIC report found that the 27 carriers in the small group market had only 77,000 covered lives. Even if the definition of what constitutes a small business is reduced to those with fewer than 50 employees, 287,500 employees will be eligible to participate in the exchange. If the definition of small business is maintained at fewer than 100 employees, there will be a potential to have more than 350,000 covered lives in the small group exchange. It is difficult to believe that carriers will refuse to participate in the exchange, allowing their competitors to have free range of this market, simply because they are required to maintain reasonable premiums and sound health promotion programs.

b. Limited or unlimited plans in the exchange?

There is good data that when consumers are offered a plethora of insurance choices, they will frequently select against their own self-interest.⁵ Two Harvard researchers, for example, recently wrote: "These experiences suggest that exchanges should be structured to foster effective consumer choices, and thereby efficient outcomes, by providing consumer-friendly information about the coverage, cost, and quality of different plans. Ironically, one way to enhance the prospect of informed choices is to limit the number of options. Plans then compete on price, quality, or both in order to be included. Requiring plans to offer identical features would promote competition and facilitate decisions but limit choice."⁶

Providing small business and individual consumers a choice of four or five insurance companies with each offering at least two and as many as five different

⁵ Jonathan Gruber, *Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans*, Kaiser Family Foundation, (March 2009). Accessed on December 30, 2010 at <http://www.kff.org/medicare/7864.cfm>.

⁶ Richard Frank and Richard Zeckhauser, "Health Insurance Exchanges -- Making Markets Work," *New England Journal of Medicine* 2009 361(12):1135-37.

insurance products (platinum, gold, silver, bronze and catastrophic) provides sufficient options for consumers to make wise choices.

Similarly, standardizing products with established deductibles, co-payments, and coinsurance levels encourages insurance plans to compete on the basis of premium costs and quality, and provides real choices for consumers allowing them to select a product that is in their best self interest.

C. Plans sold outside the exchange?

The more selective the exchange is in determining which companies can participate in the exchange the more difficult it is to prohibit insurance companies from selling plans outside the exchange. We strongly recommend that the exchange be a selective purchaser of health insurance plans driving quality up while containing cost and allow plans to be sold outside the exchange with some limitations. These limitations would include requiring all companies that sell outside the exchange to offer at least a gold and silver plan. Companies should be prohibited from offering only bronze and catastrophic plans. Secondly, companies that sell plans inside the exchange should be prohibited from having affiliates and/or subsidiaries that sell plans only outside the exchange. Insurers should also be prohibited from using marketing and benefit designs to attract healthy people into plans sold exclusive outside the exchange.

If the OIC, Governor and legislature adopt an exchange that allows any insurance company to qualify for the exchange (and we strongly disagree with this approach), then the exchange, in order to avoid adverse selection, should become the exclusive marketplace, and insurers should be prohibited from selling plans outside the exchange.

6. Risk Sharing:

A. All payer claims database.

Updating the state's current multi-payer claims database is essential to ensuring that the risk adjustment tools operate effectively. The state should immediately attempt to develop a Memorandum of Understanding or similar arrangement to allow Medicare data to be incorporated into this database. The Center for Medicare and Medicaid Services has allowed only a few states access to the detailed claims experience of Medicare beneficiaries. Having this data is essential to understand the risk that may be shifted to insurers with high utilization in safety net hospitals.

Secondly, the OIC should ensure that there are adequate safeguards in place to ensure timely completion of data ware house activity and actuarial services.

7. Funding

Currently, all exchanges are funded through an assessment on insurers or on customers utilizing the exchange. State general revenue dollars should only be used to enhance the premium and cost sharing tax credits.