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**Governor Gary R. Herbert's Testimony to House Energy and Commerce Committee
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Good morning. I am Gary R. Herbert, Governor of the State of Utah.

I would like to thank Congressman Upton and the other members of the committee for your invitation to testify.

Let me begin by stating that I am a firm believer in the principles of Federalism embodied in the 10th Amendment.

States are not powerless agents of federal authority. I believe that – as Governor of the great State of Utah – I should take every opportunity to assert the rightful authority of our state to advance Utah solutions to Utah problems.

A balance of powers between the states and the federal government is not only right and proper, but essential if we are ever to find solutions to the complex problems we face.

Justice Louis Brandeis famously described states as laboratories which can engage in "...novel social and economic experiments without risk to the rest of the country."

In Utah, we began our health system reform efforts five years ago, long before the Patient Protection and Affordable Care Act arrived on the scene. The lessons we've learned in our novel experiments in health system reform can serve as a guide to other states as they begin their own reform efforts. In fact, we have already been contacted by officials in numerous other states asking us to share our experiences with them.

The federal government has taken the opposite approach. The federal government decreed the one-size-fits-all law of the land, and has left to the states the details of how to shoehorn the Affordable Care Act's voluminous dictates and mandates into their agencies and budgets.

The Governors who are responsible for so much of the implementation of the Affordable Care Act were never invited to the table when it was being proposed by the Obama Administration or debated in Congress. I find that unconscionable.

Utah has repeatedly demonstrated we can find Utah solutions to Utah problems, particularly in the area of health care. Our health system reform efforts have been targeted to respond to Utah's unique business and demographic needs.

Unlike many other states, a majority of Utah's uninsured population are employed. Most work for small businesses which do not offer health insurance benefits. Over 80% of Utah's businesses are small businesses, and less than 50% of Utah small businesses were offering health insurance coverage as of 2009. In order to reduce our uninsured population, we needed to make insurance coverage accessible to our state's small employers.

Utah also has the youngest population in the country. Many of our uninsured are so-called "young immortals", persons between the ages of 18-34 who are generally healthy and employed but who have deemed traditional health insurance coverage to be either unnecessary or too expensive. In order to reduce our uninsured population, we also needed to expand choice in our small group market.

In Utah, we have chosen a path of business- and consumer-oriented health system reform which responds to Utah's needs.

Years ago, most U.S. businesses made the switch from a defined benefit to a defined contribution model for their employee retirement benefits offerings. Incidentally, Utah is leading the nation by having moved our state employees toward a defined contribution retirement benefit, as well.

As part of our health system reform efforts, Utah small businesses now have the option of using a defined contribution model for their health benefit offerings. A defined health benefit left businesses with unpredictable and ever-escalating costs. Through access to Utah's new defined contribution market, employers can manage and contain their health benefit expenditures.

With the creation of the Utah Health Exchange, Utah employees also benefit from expanded access, choice, and control over their health care options. Rather than the traditional one-size-fits-all approach inherent in the defined benefit model, employees can now use the defined contribution from their employers to shop for health insurance tailored to their individual needs and circumstances. The Utah Health Exchange currently gives Utah small business employees more than 100 plan choices, all of which retain the pre-tax and guaranteed-issue advantages of traditional small group insurance.

After the planned pilot phase, the Utah Health Exchange is now fully operational. In just the first month, we have already helped more than 1,000 employees get health insurance they have chosen. Each month, enrollment continues to climb. Our figures show that 20% of businesses participating in our defined contribution market through the Utah Health Exchange are offering health benefits for the first time.

We have used market principles to create a Utah solution to Utah's problems.

Governor Patrick and I hold the distinction of presiding over the only states in the nation with functional health insurance exchanges at this time.

The Commonwealth Connector in Massachusetts was designed to serve a business community and citizen population vastly different from what we have in Utah. Hence, our exchanges are constructed in vastly different ways.

The federal government simply should not be in the business of telling Utah, Massachusetts, Mississippi, or any other state how to run their current or future exchanges, or even force them to have an exchange.

The Affordable Care Act not only mandates exchanges for every state, but it gives the states little leeway in constructing exchanges that work for diverse needs and populations. Worse, the Affordable Care Act feigns a posture of giving flexibility to the states, while its requirements are, in reality, quite rigid.

Just as Henry Ford offered his customers a choice of any color car they wanted as long as that color was black, the Affordable Care Act allows states flexibility in constructing their exchanges as long as they do it the way Washington tells them. Minimum Essential Benefit mandates, obligatory quality improvement activities for carriers, compulsory federal subsidy determination mechanisms; these are just some of the examples of the lack of flexibility of the new national health care program.

The next major problem in need of market forces is the state's Medicaid program. Medicaid is poised to wreak havoc on the state's budget for years to come, threatening our ability to fund critical services, such as transportation and education.

Even before the Affordable Care Act, Medicaid was already a large and growing part of the Utah state budget. Medicaid's share of the overall general fund has been growing and is projected to grow even larger, creating real problems for the state. In the 1990s, it was as low as 9%. In Fiscal Year 2010 it was 18%. By FY 2020, it is estimated to exceed 30%, without federally mandated expansion.

In this recession, Medicaid enrollment has skyrocketed. In December 2007, enrollment stood at 158,267 individuals. In December 2010, enrollment stood at 230,812 individuals, a 46% increase in 3 years.

The Affordable Care Act accelerates growth in Medicaid and compounds the budget pressure. The Act prohibits the normal state tools to control costs. It requires Maintenance of Effort, meaning the state must participate at federally-dictated levels. The Act limits cost-sharing. The Act confiscates state pharmacy savings.

Perhaps worst of all, the Affordable Care Act dramatically expands Medicaid eligibility in 2014. Enrollment is projected to grow approximately 50% under the mandated expansion. The Act only pays for part of new costs, meaning states must cover the rest. In Utah, these new costs are estimated to be as high as \$1.2 billion over 10 years.

I have come to Washington to present solutions to help ease the burden on our state.

First, I call on the Obama Administration to support an expedited appeals process to the Supreme Court for the healthcare litigation which has been decided by the lower courts. Along with 28 of my fellow Governors, I have sent a letter to the President asking for his support.

Second, I would ask that Congress exercise its authority to find legislative solutions to the onerous mandates imposed on the states by the Affordable Care Act.

Third, we have proposed specific solutions for reform. This will require that the Center for Medicare & Medicaid Services (CMS) support the waiver requests that we have or will be submitting. Our message is simple: To have any hope of success, Utah needs flexibility to make this mandated model work in our unique state for our unique demographics and needs.

Our reforms fall into four distinct areas: administrative simplification, provider incentives, patient accountability, and expand premium subsidy options.

The first example is in the area of administrative simplification. CMS sent us a memo that essentially requires us to use paper to communicate with enrollees in the program. In our efforts to be more innovative and efficient, we developed an approach which uses electronic technology to communicate with our clients, reducing costs by as much as \$6 million a year.

If CMS allows Utah the flexibility we need to be efficient—in this one area alone—we estimate that all the states adopting this technology could save more than \$600 million per year. This seems like a no-brainer. However, CMS has been slow to respond. Utah's simple request for this issue has been sitting with CMS since last July.

The second example highlights the need to change incentives for providers. We are also trying to get waiver approval for a comprehensive reform to the way we reimburse providers for Medicaid services. We should pay for value, rather than volume.

We are developing a home-grown solution to this problem. We want to contract with Accountable Care Organizations (ACOs) to move toward a more provider-based care model. These contracts will better align financial incentives for providers to keep people healthy instead of just providing services.

If we are allowed to proceed, this model will be a tipping point for the Utah market, and we expect to shortly see private insurance companies follow suit, benefitting and strengthening our overall health care system.

In conclusion, I emphasize again that real health care reform will rise from the states, not be imposed by the federal government.

From the days of our pioneer forefathers, Utahns have been finding Utah solutions to Utah problems. I am here today to assert our right and responsibility to continue to do so.

Addendum 1

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.

Addendum 2

Medicaid Electronic Notification Proposal

Program and Goals – The Department of Workforce Services (DWS) is an integrated, one-stop service delivery agency that administers workforce programs, labor exchange, unemployment insurance, and eligibility for multiple social service programs – Medicaid, CHIP, SNAP, TANF, and Child Care. Through administrative modernization, DWS expects to reduce administrative costs by \$9.2 million over the next 18 months.

Electronic Notification – The core of this effort is to move to a more automated, self-directed eligibility model using the new “myCase” system. Under the proposed system, customers will have easier and real-time access to services and case information, cycle times for determination will decrease and result in greater program integrity. The administrative savings come from three cost centers: 1) Electronic correspondence – the cost of a paper-based notice is currently \$.52, which could be virtually eliminated, 2) Staffing – a more automated system will allow more determinations per worker, and 3) Reduced telephony costs.

Summary of myCase – myCase is an electronic customer interface launched in November, 2010. Currently, it is being used by over 50,000 customers and growing rapidly. Over 160,000 notices have been read online, with 2.5 million page views. Utah would like to be a national leader in the development of this eligibility model and its application to Medicaid.

Federal Reaction – FNS (who oversees the Food Stamps program, SNAP) has been supportive at the national regional level. DWS appreciates their support with both system development and the potential need for support on additional waivers and policy interpretations. Unfortunately, we have struggled to get permission from CMS for full implementation of electronic correspondence for Medicaid clients.

Timelines –

- July 1, 2010 waiver request sent to FNS
- July 12, 2010 electronic correspondence request letter sent to Department of Health (DOH) to be sent to the Regional CMS office.
- Received waiver approval from FNS - December 7, 2010
- Received conditional support from CMS on December 14, 2010. The condition of the support would require DWS to send a paper notification with all eligibility decisions (resulting in no cost savings).
- Drafted response for CMS as a rebuttal on the conditions. DOH received the DWS rebuttal and sent the response on to regional CMS office.
- December 17, 2010, DOH notified DWS that there should be no further action taken on the request until the CMS Office of General Counsel reviewed and made a decision.
- December 17, 2010 - present, CMS (both the regional and national offices) have requested clarification and answers to questions, but there has been no word yet on a final decision from their Office of General Counsel.

- We have informed FNS that until we hear back from CMS, our electronic correspondence implementation is on hold.
- February 15, 2011 – Representatives from DWS and DOH participated in a joint call with CMS regional and national officials to review progress, address concerns, and request an expedited decision.
- At present, there has still been no response on this issue.

On February 26 we are slated to release new functionality into myCase. This latest release will include the electronic correspondence “opt in” for customers. We’ve postponed the release date three times and postponing it again would impact our costs, training, and roll out of other critical functionality. Each month the release is postponed hampers Utah’s ability to reduce costs and deliver quality services to our customers in a 24/7 online environment. Our timeline is aggressive and we need an efficient process to meet these milestones.

We would like to work with CMS to quickly resolve the electronic correspondence issue and to develop a better process to expedite future potential waivers or permissions.

Addendum 3

Utah Medicaid Reform Proposal

Rising Medicaid costs threaten the stability of the budget –In the 1990s, Medicaid expenses accounted for 9% of Utah’s state budget. Currently, they account for 18% of the state budget and are projected to be well over 30% within the next ten years. Enrollment has increased 46% from December 2007 to December 2010.

Obamacare will just make this worse – In 2014, Utah Medicaid will be required to add another 100,000 people to the program, a 50% increase in enrollment. Enhanced federal funding for this group will run out within 10 years, costing the state an additional \$1.2 billion.

Obamacare also takes away the key tools that states could have used to address the rising costs. It contains a maintenance-of-effort provision which prohibits us from rolling back some of the expansions to optional populations put in place during better economic times. It freezes cost-sharing arrangements with patients to the old levels, such as \$3 co-pays for pharmacy and \$6 for inappropriate use of the emergency room. It also confiscates all of the savings that we have generated through our preferred drug list program, costing us \$6.3 million a year starting in 2010.

Proposed reforms – To get the costs under control and prevent a total collapse of the state budget, we have to change the way the program works. Utah is considering a proposal that would “fix” the bad incentives in Medicaid and restore some hope of cost control.

The basics of the proposal are:

- Replace existing managed care contracts with Accountable Care Organization (ACO) contracts – Providers would be paid on a capitated basis in a way that brings the doctor and the patient into the mix (as opposed to the old HMO model where we pitted doctors against insurers.)
- Require contracted ACOs to meet performance standards, including using Medical Homes.
- Increase Patient Responsibility – Create a sliding scale copayment schedule for patients based on their income.
- Budget management strategy – Peg the growth in Medicaid payments to the growth in state revenues. Use a Medicaid Rainy Day fund in good years to save up for the bad years.
- Expanding the Premium Subsidy Option – Allow Medicaid clients the option of taking a subsidy to purchase insurance through work or the Utah Health Exchange instead of being on Medicaid.

We may be able to do some of this under our existing waiver authority; however, we need the federal government to give us some additional flexibility in order to make these reforms successful. If we can test this model, there is a chance that we could provide insights that would

help every state improve their Medicaid program, saving hundreds of billions of dollars in state budgets alone, not to mention the savings to the federal government.

It's not just Medicaid – We are proposing reforms to our Medicaid program that are part of a larger effort to address problems with the system. Most insurers recognize the fundamental problem of paying for volume instead of value. If Medicaid takes the lead on changing the way providers are paid, private insurers will follow, lowering overall costs system-wide.

Addendum 4

The Utah Health Exchange: A Look in the Rearview Mirror

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State of Utah Health Reform Implementation Coordinator

February 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 health 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.

Note: 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.

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 taking 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.

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 the 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 it 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.

Note: 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.

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

Committee on Energy and Commerce

U.S. House of Representatives

Witness Disclosure Requirement - "Truth in Testimony"

Required by House Rule XI, Clause 2(g)

1. Your Name: Governor Gary R. Herbert		
2. Are you testifying on behalf of the Federal, or a State or local government entity? State	Yes X	No
3. Are you testifying on behalf of an entity that is not a government entity? NO	Yes	No X
4. Other than yourself, please list which entity or entities you are representing: State of Utah		
5. Please list any Federal grants or contracts (including subgrants or subcontracts) that you or the entity you represent have received on or after October 1, 2008:		
6. If your answer to the question in item 3 in this form is "yes," please describe your position or representational capacity with the entity(ies) you are representing: N/A		
7. If your answer to the question in item 3 is "yes," do any of the entities disclosed in item 4 have parent organizations, subsidiaries, or partnerships that you are not representing in your testimony? N/A	Yes	No
8. If the answer to the question in item 3 is "yes," please list any Federal grants or contracts (including subgrants or subcontracts) that were received by the entities listed under the question in item 4 on or after October 1, 2008, that exceed 10 percent of the revenue of the entities in the year received, including the source and amount of each grant or contract to be listed: N/A		

Signature: Gary R. Herbert

Date: 2/25/11