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Economic Transformation in Health

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The Massachussetts and Utah Approach on Exchanges

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The Massachusetts & Utah Approach on Exchanges: The Beginning

- 2006 - Massachussetts enacts legislation intended to reduce the number of citizens without health care coverage. The Commonwealth Health Insurance Connector is born.
- 2008-2009 - Legislation enacted in Utah calling for the development of an internet-based web portal to facilitate the purchase of private coverage for individuals and employers.
- 2010 - The Patient Protection and Affordable Care Act (PPACA) was enacted at the federal level calling for expanded tax credits to increase affordability, personal and employer responsibility for obtaining insurance, private market rating and insurance reforms, and the establishment of State Exchanges.

Personal and Employer Coverage Responsibilities

While all approaches intend to reduce the number of individuals without health insurance coverage and provide a market facilitation mechanism to improve individual and small group access to coverage, they differ in some major respects. What follows is a summary of these differences as provided by AHIP.

(M) Requires individuals to purchase coverage and employers to either offer health care coverage or pay an assessment if they do not. Employers with more than 10 employees must make a "fair and reasonable" contribution to coverage and pay a "free rider surcharge" if and when employees receive uncompensated care under certain circumstances.

(U) Does not include a coverage requirement for individuals or a participation requirement for employers. Employers choosing to obtain employee coverage through the Exchange are subject to participation requirements. Individuals may purchase coverage through links provided by the Exchange to carriers in the individual market.

Insurance Market Merger & Underwriting

(M) Coverage for both individual and small groups are available outside the Connector. Prior to the merger, markets were already very similar in that guarantee issue was required and adjusted community rating (no health status) was required in both markets.

(U) The Exchange has no impact on the existing individual and small group markets.

(M) Unlike the market in most states, at the time Massachusetts passed the law, premiums were higher in the individual market than in the small group market.

(U) The enacting legislation gives authority to new Utah Defined Contribution Risk Adjuster to establish rating methodologies for the Exchange, but includes no specific requirements.

Regulatory Authority and Functions of the Connector / Exchange

(M) Connector has independent regulatory authority for setting the minimum creditable coverage requirements and for establishing the affordability schedule for purposes of determining whether an individual is exempt from the mandate because coverage is not affordable.

(M) Connector selects the carriers that are permitted to provide coverage giving the Connector de facto authority over those products.

(U) The Exchange has no independent regulatory authority. The Utah Defined Contribution Risk Adjuster and its Board of Directors (BOD) have rulemaking authority, as do the Utah Insurance Department and Department of Health.

Structure & Governance

(M) Creates a new independent instrumentality of the state with a separate legal existence called the Commonwealth Health Insurance Connector (Connector). Establishes a Board of Directors (Board) with an Executive Director.

(U) Creates the Utah Health Exchange (Exchange), to be administered by the Utah Insurance Department, the Utah Department of Health, the Utah Defined Contribution Risk Adjuster and the Utah Office of Consumer Health Services (OCHS).

Exchange Duties & Functions

(M) Requires the Connector to develop standards for "minimum creditable coverage"; operate a health insurance service center for enrollment; collect and remit to insurers premiums and subsidies; publicize the existence of Connector; and establish procedures for determining the "affordability" of coverage.

(U) Requires the Commissioner annually to prepare and submit an evaluation of the state's health insurance market, including a report of the types of plans sold in the Exchange, the number of insurers participating in the defined contribution market in the Exchange, and the number of employers and covered lives participating in the defined contribution market in the Exchange.

Funding & Individual Responsibility

(M) Allows Connector to charge participating institutions and apply a surcharge to all health benefit plans for its administrative and operational expenses.

(U) Enabled legislation for the Exchange permitted consideration of funding sources including assessments imposed on facilities, providers, services and health insurance products.

(M) Requires residents over age 18 to have creditable coverage if it is "affordable." Penalty: individuals who do not indicate coverage on their tax return lose their personal exemption.

(U) No similar provision. Note: The Utah Health Exchange is a voluntary internet-based information portal available to consumers, employers and carriers.

Employer Responsibility

(M) Employers of more than 10 employees must make a "fair and reasonable" contribution for health coverage. Penalty: Imposes a penalty of approximately $295/employee on employers not making a "fair and reasonable" contribution.

(M) Imposes a "free rider surcharge" on employers that don't offer coverage for excessive employee use of uncompensated care.

(U) Employers participating in the new defined contribution arrangement market offered through the Exchange may not offer major medical health benefit plans that are not part of the defined contribution agreement.

Carrier Participation Requirement

(M) Gives the Connector de facto authority by virtue of having the discretion to select the plans that participate in the Connector.

(U) Health plans are required to provide the Exchange information for each plan submitted: benefits and options; mandates not covered by the plan; provider networks; wellness programs; prescription drug benefits; percentage of claims paid by the insurer within 30 days of submission; & adverse benefit determinations, among others.

(U) The DOI shall post on the Exchange the solvency rating for each insurer who posts a plan on the Exchange.

Employee Choice of Health Plans

(M) Allows employees enrolling in contributory plans to choose plans offered by the Exchange within the tier of benefits identified by their employer.

(M) Prohibits employees from buying a product outside the tier selected by their employer.

(U) Allows employees enrolled in employer defined contribution plans through the Exchange to choose their own plan and coverage option, including the ability to choose any of the health benefit plans made available through the defined contribution market in the Exchange.

Products Offered in Exchange

(M) Requires all offered health insurance plans to be authorized by the Insurance Commissioner and then to have received a Connector seal of approval certification.

(U) Requires insurers offering products to small employers in the defined contribution market to also offer a health benefit plan that is a federally qualified HDHP, has the lowest deductible permitted for an HDHP by federal law, and has an annual out-of-pocket maximum that does not exceed three times the amount of the annual deductible.

Producer Commissions & Private Market Contracts

(M) Gives the BOD authority to establish commissions.

(U) Prohibits a producer from accepting or receiving any compensation from an insurer or third-party administrator for the placement of a health benefit plan (other than a hospital confinement indemnity policy) unless, prior to the customer's purchase, the producer provides the required written disclosure, obtains the customer's signed acknowledgement or certifies to the insurer that the disclosure was made.

(M) Allows the Connector to contract with companies to perform Connector functions.

(U) Allows for the contracting with vendors to perform Exchange functions.

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