DISABILITY LAW CENTER OF ALASKA

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February 8, 2011

Senator Dennis Egan
Chair, Senate Labor & Commerce Committee
Beltz 105
Juneau, Alaska 99801

Re: SB 70, Alaska Health Benefit Exchanges

Dear Senator Egan and Members of the Senate Labor & Commerce Committee:

My name is Mark Regan. I am Legal Director of the Disability Law Center of Alaska, which is the State-designated organization for protection and advocacy of Alaskans with disabilities. I would like to make three points this afternoon in support of the Labor & Commerce Committee's moving forward with Senate Bill 70, the bill that would establish a health benefit exchange that would help people find coverage in the individual and small group insurance markets.

The first point is that it is hard for people with disabilities who have chronic conditions to find private insurance in the individual and small group health insurance markets, and an Exchange can help them find the coverage they need on the same general terms as everyone else who needs to find individual or small-group health insurance.

The second point is there is nothing about an Exchange that requires the State of Alaska to enforce an individual mandate requiring citizens to have private health insurance coverage. SB 70 is a version of the National Association of Insurance Commissioners' model Act, which reflects federal requirements, but if the individual mandate in federal law survives the court challenges to it, enforcing the mandate will be a federal responsibility, not a State one.

Third, and finally, I want tentatively to suggest that even if the individual mandate is found unconstitutional by the U.S. Supreme Court, there is still likely to be a binding federal requirement that there be Exchanges in every State, whether operated by the State of Alaska or by a nonprofit entity set up by the federal government; and that it probably would be best for Alaskans with disabilities if the State does the operating.

<u>An Alaska Health Benefit Exchange is a good way for people to find health insurance</u>

First, an Exchange would make sure Alaskans with disabilities are in the same system as other people who need help finding affordable private coverage in the individual and small group health insurance markets. According to the Kaiser Commission's 2008-2009 data, 128,000 Alaskans were uninsured in that year, 19% of the total population, which is two percentage points higher than the country as a whole. Alaskans with disabilities sometimes have special trouble getting coverage because they have chronic conditions

that would lead insurance companies either to reject them outright – through a "pre-existing condition exclusion" – or lead private insurance companies to price the coverage that would be available at a level people simply can't afford. But the high cost of coverage can be a problem for everyone. Even if you don't have a chronic condition, it can still be hard to afford coverage without assistance from someone, typically an employer, as anyone who has tried to pay the full cost of insurance under COBRA will remember. The existing individual and small group insurance market is a limited one and it is hard for people to find coverage through it.

An Exchange, like the Exchange contemplated in SB 70, is likely to be helpful in several important ways. People can use it to search for insurance policies that they otherwise wouldn't know about. Insurance companies can compete in terms of price and networks of doctors and other providers of medical services. Because there will be a lot of people participating – we hope – the average cost of coverage should be lower than it would be in a high-risk pool like the pools the State is now operating. Furthermore, the federal government will be assisting people of low- to- moderate incomes with subsidies for premium and cost-sharing payments they need to make, and those subsidies will be available mainly for coverage people would purchase through an Exchange. Again according to Kaiser Commission 2008-2009 data, 90,900 uninsured Alaskan adults had family incomes below 400% of the poverty income guidelines and so, other things being equal, would have been eligible for subsidies under the Act. So an Exchange would be available for people with disabilities on the same terms as everyone else, and the subsidies low-to-moderate income families might need would be available there too.

<u>An Alaska Health Benefit Exchange would not be enforcing a federal health insurance mandate</u>

Second, an Exchange would not be in the business of enforcing any federal requirement that people have insurance coverage. Note that the list of the Board's duties in section 2 of SB 70, proposed AS 21.54.220(a), does not include enforcing a penalty against anyone for not having health insurance coverage. In fact, it's the other way around, Instead of penalizing people, the Board's duties include helping people demonstrate that they would be <u>exempt</u> from any penalty of this sort [proposed AS 21.54.220(a)(14) and (15)], and administering a system through which federal subsidies would be made available so people could afford coverage [proposed AS 21.54.220(a)(17)]. If the individual mandate survives the court challenge to it, the responsibility for enforcing the mandate rests with the federal government, not the State.

That is because the federal health care overhaul's minimum coverage provision is a federal, not a State, requirement. Under the new federal law, employers and other providers of health care make enrollment reports to HHS, not to a State. [PPACA, § 1502(a); see 26 U.S.C. § 6055.] A person who appears not to have enrolled gets a "notice of nonenrollment," but this comes from the Treasury, not from a State. [PPACA, § 1502(c).] The "shared responsibility payment" penalty is a payment to the

federal government to be included with a person's federal tax return. [PPACA, § 1501; see 26 U.S.C. § 5000A(b)(2).] The Secretary of HHS, not a State, serves notice of the penalty. [§ 5000A(g)(1).] The procedure for collecting the penalty, and for defending against collection, is the same general procedure as federal tax procedure. [Id..] The restrictions on criminal prosecution and on liens and levies are restrictions on federal tax enforcement procedures, not on state activities. [§§ 5000A(g)(2)(A) and (B).] Whether or not someone gets a hardship exemption is to be determined by HHS, not by a State. [§ 5000A(e)(5).] There is simply no occasion on which the Alaska Health Benefit Exchange would ever directly impose or collect a penalty on someone who fails to meet the federal minimum coverage provision.

Nor would moving forward with an Exchange force the State of Alaska to drop any argument that the federal individual insurance mandate is unconstitutional. In fact, just about every State which is a plaintiff in the Florida v. U.S. lawsuit has taken steps towards investigating how an Exchange would work – getting Federal planning grants for doing this and considering legislation on the subject – and one State which is challenging the individual mandate, Utah, already has an Exchange statute on its books. (Part of the Utah statute setting up an Exchange on this subject is at Utah Code, § 63M-1-2504, and the website's URL is http://www.exchange.utah.gov/.) In fact, Utah not only has an Exchange statute on its books, but it has a "health care freedom act" that says that no citizen of Utah should be required to purchase health insurance. [Utah Code, § 63M-1-2505.5.] If Utah can move forward with an Exchange under those circumstances, so can Alaska.

An Alaska Health Benefit Exchange in state law would keep Alaskans in charge

Finally, there is a question about what federal law is likely to require States to do – or, more accurately, what Federal law is likely to require to be done in every State by someone, State or nonprofit – once the litigation about the individual mandate is over. In the Florida v. U.S. case, the plaintiffs (including the State of Alaska) raised a direct challenge to the federal Act's Exchange provisions, saying that those provisions commandeered State government into enforcing federal law. Judge Vinson actually rejected that challenge, saying States had an option under the Act: set up an Exchange that satisfies federal standards, or watch and wait while the federal government sets up an Exchange through a public nonprofit agency of its own.

Now, it is possible that if the challenge to the individual mandate succeeds at the U.S. Supreme Court, it will be clear that the Act's current standards for Exchanges would have to be modified. Maybe the whole idea of an individual and small group market where there would be "guaranteed issue" – they can't turn you down because you have a pre-existing condition – and "community rating" – they can't charge you more money simply because you have a chronic health condition – would have to be rethought. The reason for this is that the individual mandate prompts relatively healthy people to participate in the system, and unless relatively healthy people participate in the system along with

people with disabilities and chronic conditions, the average cost of a policy within that system would go way up. So if the mandate is unconstitutional, there would need to be a discussion of other ways to get people to participate in the system. No one can be sure exactly what Congress would decide to do if the U.S. Supreme Court were to throw out the individual mandate.

But the idea of many people participating in the individual and small group health insurance market, and finding out information about which policies would be best for them, and getting subsidies to help them afford insurance, is such a good one that Congress will likely try to encourage this even if the individual mandate disappears. Before the health insurance overhaul passed Congress, there were several suggestions about how to encourage people to participate in the market without actually penalizing them for not doing it. For example, there was a suggestion that people could choose not to have health insurance – but they'd have to promise that they wouldn't ask for any federal subsidies if they did decide to buy insurance, and they'd have to deal with pre-existing condition exclusions if it turned out that they needed insurance after all. It's not clear which of those different suggestions Congress might adopt. But it is quite possible that there would be an Exchange requirement in federal law, no matter what, with the same option for States that is in federal law now – a State could operate an Exchange, or, if the State decided not to operate an Exchange, the federal government would operate one through a nonprofit.

If those turn out to be the circumstances, I'd suggest that Alaskans' preference will be to have the State operate an Alaska Health Benefit Exchange, where the people running the system would be State people who likely would have good ideas about what is best for Alaskans. The alternative would be a federally sponsored nonprofit agency. So, if you want there to be an opportunity for Alaskan control over the Alaskan part of this problem, you should move forward with SB 70.

Thank you very much, again, for the opportunity to testify on this important issue.

Sincerely,

Mark Regan
Legal Director

February 8, 2011

RE: Hearing by (S) L&C Tuesday, February 8, 2011, 1:30 pm

Doris Robbins
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I support SB 70: *Alaska Health Benefit Exchange*

I understand that this hearing is regarding whether Alaskans will have an opportunity to set up a health benefit exchange which should provide clear options and some competition for health coverage or expenditures. The exchange would make clear information available to Alaskans of what their health care dollars buy.

Currently, Alaskans are not sure of what they are getting for their health dollars. The rules are murky and you never know when an insurer will end coverage or an unexpected medical bill will put you in financial jeopardy. This legislation should shine a light on what you are paying for, and set up options that will allow most Alaskans to know what they are getting without bait and switch tactics.

The exchange will act as a one-stop-shop for Alaskans to make choices that suit their needs and pocketbook. In addition, stipulations should be laid out clearly to show what is acceptable by us of insurance companies who want to do business in our state, as well as eventually providing competition across state lines. There should be no hidden fees, and all the rules on display to indicate what your health expenditures are buying for you.

In addition, while the governor has turned down federal cash for set-up costs, that was not "earmark" money. The available federal money has been taken by 48 other states, some suing against and some accepting the new federal health law. With the cooperation of our governor we can have the exchange start-up costs without dipping into the general fund. This is Alaska's deal and not connected to the federal health care law.

Do we act now to make changes or continue wading in our present expensive health care muddy water? If we do nothing the climate for paying for health care in Alaska will continue deteriorating as it slowly bankrupts us all whether we currently have coverage or not.

If we begin setting our own standards, we will bring more possibilities for all businesses to provide economical coverage for their employees, or allow individuals to get more for their independent health care dollars.

Please take the first step by sending SB 70 on to the next committee to get the conversation rolling. Then it is up to all Alaskans to speak out for an improved climate for medical coverage in this state.

Doris Robbins, speaking in my own behalf
Member of the Retired Public Employees of Alaska (RPEA)

SMALL BUSINESS MAJORITY

February 8, 2011

Dear Senators:

Alaska's small businesses are being crushed under high healthcare costs, forcing both business owners and workers to pay a heavy price. SB 70, legislation establishing the Alaska Health Benefit Exchange, is under consideration in the Senate Labor and Commerce Committee. It will go a long way toward lowering costs and improving access for small business owners. Alaska can and should take the lead in establishing this marketplace now so small employers can get the relief they need in the form of lower costs and more choice. With fewer dollars going to insurance companies and more kept in the pockets of small business owners, they will be able to invest in their businesses and hire new employees, helping Alaska's economy grow.

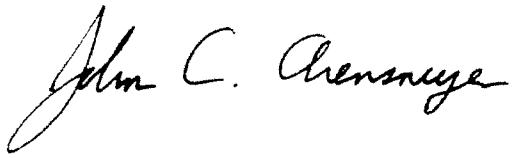
In the ongoing effort to ease this burden on small businesses, we urge you to stand up for Alaska's small business community and work to finalize this crucial legislation. Small employer exchanges have been established in Utah, Connecticut, New York City and Massachusetts. They have been supported by members of both parties and are proven to benefit small business owners and their employees. The idea of a small employer exchange has been around for a long time, and has broad support among business groups and members of Congress from both political parties.

A survey of Alaska small businesses we conducted found that only 21% pay for health insurance for their employees. Of those, 79% said they were struggling to do so. Moreover, nearly one-third (32%) of fishermen who are self-employed, a vital part of Alaska's economy, are uninsured. While insurance rates for small employers continue to climb, an exchange will help change this.

A well-run exchange will be the primary vehicle for making healthcare affordable and accessible for small businesses and their employees, as well as the state's self-employed entrepreneurs. It will allow small businesses to band together to purchase insurance, giving them the type of clout that large businesses enjoy when negotiating for coverage. Your leadership on this issue will guarantee the exchange is created the right way so small businesses receive the myriad benefits that a strong, robust exchange will provide. As important job creators in Alaska, small businesses need your quick action now more than ever.

Attached are some specific comments and issues based on our research of other successful exchanges.

Sincerely,



John Arensmeyer
Founder & CEO

SB 70 Comments and Issues

1. Based on the successful experience of other small employer exchanges, it is vital that the Exchange collects all premiums from employers in the employer exchange and pays those to the insurers. Today the small employer writes one check to the insurer each month. It is simple. In the exchange, employees of employers will be able to pick their plan. This creates a complexity whereby the employer would have to write separate checks each month to different insurers. This is a complex new burden small employers will not want. The Connecticut and New York exchanges have proven they can administratively handle this task on behalf of employers and "keep it simple" administratively.

Here is suggested language:

> *(i)Provide consolidated billing and premium payment by employers including detailed information to employers on health plans and costs chosen by their employees;*
> *(ii)Establish an electronic interface and facilitate the flow of funds between insurers, employers, and employees, including subsidies and the use of "free choice vouchers;"*
> *(iii)Provide plan enrollment information to employers.*

2. Utah has established a mechanism whereby employers can contribute an amount on behalf of part-time and seasonal employees to the exchange, without setting up an employer insurance program. They say this is popular with employers. This way an employee can get contributions from multiple employers. Employers might be willing to make a fixed contribution, whereas they are not willing to obligate themselves to full coverage that they see as unaffordable for part-time or seasonal employees. However, overall the entire health system and all participants are better off if employers make even a small or modest contribution to employee health coverage.

Example from the Utah Exchange:

> *What is premium aggregation? Premium aggregation is a mechanism to pay insurance premiums with contributions from multiple sources. The unique feature of the Exchange allows employees aggregate the defined contribution from your employer, your premium contribution, and contributions from other sources, such as second employer, a spouse's employer, state assistance programs, etc.*

3. Will the Alaska Exchange be starting with the current definition of small group and limiting small employers to 50 employees or fewer? Or will you allow larger firms to buy insurance in the exchange, 51-100 or greater? One option is to allow the exchange to get up and running smoothly with employers with 50 or fewer employees (the present small group market definition) and to expand later after the exchange is past the startup phase. A related issue is whether self-employed can purchase from the small employer exchange (12 states currently allow this in their small group market).

4. We recommend based on lessons learned in other states with insurance pools and exchanges that insurance brokers/agents be used for the small employer exchange. Insurance agents are experienced, sell many products to small employers and are trusted advisors to small employers. While some have argued that exchanges could lower their costs by eliminating broker costs, this would create the unintended consequence of brokers steering all the low-risk employers to outside markets and undermining the stability of the exchange.

5. Given the Exchange is an independent agency and considerable funds will be flowing through the Exchange, an independent financial audit is a good idea.

6. Many experts have written on the topic of adverse selection and believe this is the Achilles' heel of insurance pools and exchanges, and why many have historically failed.

(1) One option is to have the Board study, review options and recommend measures to prevent or counter adverse selection.

(2) A second option is provided by the bill before the Montana Legislature that would create a level playing field between the insurance market outside the health insurance exchange and with the exchange pool.

Health plan design requirements inside the exchange—outside the exchange.

(1) Each health insurance issuer wishing to participate in the exchange may offer up to three different plan designs in each of the following benefit categories: platinum, gold, silver, and bronze (as defined in the federal act) in individual health insurance market and in the small employer group health insurance market.

2) All issuers participating in the exchange must offer at least one gold plan and one silver plan, both inside and outside the exchange, unless the issuer does not operate outside the exchange.

(3) If the issuer offers a bronze plan or a plan with an actuarial value of 60% or less to individuals or small employer groups outside the exchange, it must also offer at least one substantially similar "qualified" bronze plan option inside the exchange.

(4)

(a) All health insurance issuers that participate in the exchange and offer individual or small employer group preferred provider organization (PPO) health plans, other plans with incentives for using particular networks of providers, or managed care plans outside the exchange, must also offer such network-based plans inside the exchange.

(b) Health insurer issuers must comply with the network adequacy rules promulgated under chapter 36, Part 2, or the network adequacy rules for PPOs that the commissioner shall adopt pursuant to 33-22-1707 for plans issued both inside and outside the exchange.

(c) Health insurance issuers must use the same network of providers for their health plans offered inside and outside the exchange.