

# Connecticut Health Insurance Exchange



WEEKLY UPDATE

March 23 2012

## Exchange Meetings with Health Plans

Over the past two weeks, staff from the Exchange and the Connecticut Insurance Department (CID) met with health insurers that currently offer coverage in the state's individual and small group markets. The meetings -- which to date have been held with Aetna, Anthem, ConnectiCare and United Health Care -- provided the Exchange and CID with an opportunity to update health plan representatives on the current activities of the Exchange, the plans going forward, the working relationship between the Exchange and CID, and the need for operational coordination between the Exchange, CID and the health insurers that will offer coverage on Connecticut's Exchange.

Discussion topics included the timeline for setting up the Exchange, the essential health benefits requirements, the SHOP Exchange, and recent regulations and guidance issued by the US Department of Health & Human Services.



## Consumer Outreach

Mintz & Hoke continues to conduct initial interviews with key stakeholders to gain insight into current perceptions and needs. Three additional webinar discussion forums have been added to the schedule. To extend the reach of recruitment for input and feedback opportunities, Mintz & Hoke is requesting referrals from all stakeholder contacts.

Summaries from each discussion forum to date have been posted to the website [www.healthreform.ct.gov](http://www.healthreform.ct.gov). A summary of initial findings to date and strategic implications for communications is being prepared and will be made available to the Board for feedback shortly.

## KMPG Update

This week KPMG hosted a successful kick-off meeting. This meeting allowed the key individuals from other agencies (DSS, CID, OPM) the opportunity to meet the KPMG team, learn about their methodology and ask questions around the project scope. Following the kick-off meeting, KPMG met individually with representatives of DSS, CISD and CORE-CT and others to initiate requirements gathering processes.

KPMG's March board meeting project update is available on the our website ([www.healthreform.ct.gov](http://www.healthreform.ct.gov)).

## Education Focus: Active vs. Passive

The last Weekly Newsletter kicked off our efforts to provide summaries of important topics identified in the ACA. A central function within Plan Management is the model the Exchange will follow in selecting which health plans to offer. Please see the following pages for information on Active and Passive Purchasing Models.

## Upcoming Meetings

- ◆ Pre-Planning Federal Review April 4th with Formal Planning
- ◆ Next Board Meeting is scheduled for April 19
- ◆ StateReform webinar: **Building It from the Group Up: A Conversation with State Health Insurance Exchange Leaders.** Thursday, April 12 at 2:30. This may be a informative review on how California, Colorado and Alabama took on the challenge of building their Exchanges. [Click here to register!](#)

## Exchanges in the News

[CQ Weekly: Health Care's Days in Court](#)

[NGA: Summary of Establishment and Eligibility Rules for State Exchanges](#)

[The Heartland Institute: White House Expands Health Insurance Exchange Request by \\$111 Billion](#)

[The Commonwealth Fund: Nearly All States Have Taken Action on Affordable Care Act's Patients' Bill of Rights and Other Early Health Insurance Market Reforms](#)

# ACTIVE VS. PASSIVE PURCHASING

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Health Insurance Exchanges are the centerpiece of the sweeping insurance reforms enacted by the Patient Protection and Affordable Care Act (ACA). While Congress specified a destination for state Exchanges — offering qualified health plans that are “in the interests” of individuals and small businesses — it left some discretion to states on how to get there.

Stepping into this discussion, Exchange theorists have created useful models for examining the roles an Exchange could play in state insurance markets, ranging from a “**passive market organizer**” to an “**active purchaser**.” The passive market organizer model, also known as the “clearinghouse,” limits an Exchange’s role to ensuring compliance with federal standards and facilitating the purchase of insurance through the use of information on quality, benefits, premiums and providers, utilizing a web-based platform to streamline the enrollment process. Under the active purchaser model, an Exchange might attempt to use its leverage in the market — much like a large employer — to get the best prices through a competitive procurement, or to advance other health policy goals.

One of the core functions of the Connecticut Exchange is certifying that the insurers that are interested in participating on the Exchange, and the qualified health plans they offer, meet minimum ACA standards. Recent regulations issued by the U.S. Department of Health and Human Services (HHS) stresses the flexibility states have “to determine whether offering health plans is in the interest of individuals and employers.”

HHS invites state Exchanges to consider four strategies, which follow along the passive-active continuum:

- ◆ An “any qualified plan strategy,” in which all plans that meet ACA minimum certification requirements are offered by the Exchange;
- ◆ A competitive bidding or selective contracting process;
- ◆ Negotiations with health insurance issuers on a case-by-case basis; or
- ◆ Implementation of selection criteria beyond the minimum certification standards

## *Opportunities of an Active Purchaser Model*

Under the **active purchaser model**, the Exchange would attempt to use its leverage — much as a large employer might — to get the best price through a competitive procurement, or attempt to influence the market by contracting with a select group of health plans or by setting health plan requirements that exceed the minimum standards of the ACA.

Some observers have carved out a subset of less aggressive active purchaser activities and labeled them “selective contractor,” of which the Massachusetts Connector, discussed briefly below, is often cited as an example..

An Exchange could pursue any number of goals through an active purchaser model, including:

- ◆ Ensuring a broad range of choices in terms of actuarial value and provider networks
- ◆ Aiding consumer decision-making by reducing the complexity of the current market choices and making them more coherent and comparable
- ◆ Setting minimum standards to drive quality improvement
- ◆ Working with, and adopting standards shared by, large public or private purchasers
- ◆ Advancing longer-term goals consistent with ACA initiatives to improve population health

# ACTIVE VS. PASSIVE PURCHASING

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## *Opportunities of a Passive Purchaser Model*

Under the **passive market organizer** approach, also known as a “clearinghouse,” any health plans meeting minimum ACA standards for insurers and qualified health plans could participate. The Exchange would act as an impartial source of information on health plans available in the market, providing the structure and tools that enable consumers to compare health plans and purchase coverage, and undertake basic administrative functions for consumers.

### Two Case Studies of Active Purchasers

In **Utah**, the Utah Health Exchange serves the small employer market. In the fall of 2011, the Utah Exchange was serving roughly 100 small employers with about 3,000 covered lives. The Exchange acts as a market organizer; it is open to any willing insurer that meets minimal requirements (three of the 6 major insurers currently participate). The Exchange does not negotiate on price, set minimum quality standards, or limit plan offerings. In 2011, consumers had a choice of 146 insurance products.

In **Massachusetts**, the Health Connector serves 176,000 subsidized individuals through a program called CommCare, and 38,000 unsubsidized individuals through a program called CommChoice. These are two separate and distinct programs and markets that provide two very different models for an Exchange:

- ◆ CommCare is a health insurance program for low and moderate-income Massachusetts adults who otherwise do not have access to health insurance. CommCare members get free or low cost health insurance through Medicaid managed care organizations. There are five health plans to choose from, and the benefits (i.e., what is covered and the cost sharing for services) are set by the Health Connector Board.
- ◆ CommCare actively seeks the lowest premiums possible through a competitive bidding process. The Connector sets an actuarially justified range for premiums, and within that range, the Connector then sets a rate ceiling below which insurers must bid.
- ◆ CommChoice is a commercial health insurance program for uninsured Massachusetts residents. The program offers unsubsidized health insurance to Massachusetts residents and small businesses. The Connector reviews health plans offered by commercial insurance companies and approves plans that meet service and cost standards. Under the CommChoice program, the Connector does not negotiate rates, but does utilize a solicitation and selection process, picking plans that offer “good value” to Massachusetts residents and businesses.

Along the passive/active continuum lie a range of options for Connecticut to consider. As the Advisory Committees, and ultimately the Exchange Board, weighs the various options and determines the preferred approach, a number of critical factors will need to be considered.

How best can Connecticut promote choice among a range of high-value qualified health plans? What approach will encourage carriers to participate and to offer qualified health plans that meet the diverse needs of Connecticut residents?

How can the Exchange best help consumers select a qualified health plan that works best for them and their families?

These are but a few of the questions and factors that the Advisory Committees and the Board will want to consider.