

REQUEST for STAKEHOLDER COMMENT

Design and Development of an Insurance Exchange in Connecticut

The following information is organized by general topic area, with a list of questions we would like you/your organization to answer as you feel appropriate. These questions are followed by background briefings to provide a general understanding of the topics. To encourage productive discussion during each meeting, we are providing you this information in advance of your meeting. While these topic areas are the specific issues for which public comment is requested, please feel free to offer any other comments on policies related to the Exchange and the insurance market as well.

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QUESTIONS

Please provide us with your thoughts and insights on the questions listed below as you feel appropriate.

A. Establish a Responsive and Efficient Structure

1. Should Connecticut consider joining a multi-state Exchange? Under a regional Exchange, would Connecticut benefit most from a separate or merged risk pool?

This could be considered but requires study and careful analysis that can inform decision-makers about the advantages and disadvantages of a multi-state Exchange compared with a Connecticut Exchange. Participation in a regional exchange has the potential of creating a larger pool which could negotiate with insurers for better terms on coverage, cost, value and quality. It could possibly provide consumers with access to a larger array of plans and health care providers and there might be some cost savings from administrative efficiencies. However, care would need to be exercised to ensure that Connecticut residents' existing rights and protections are not diminished and that a multi-state arrangement does not require adverse cross subsidies with Connecticut citizens paying more than they would with a Connecticut-only Exchange. Another factor for consideration is timing and the considerable difficulty of securing joint agreements across state lines on all issues. Establishing a multi-state Exchange might not be feasible by 2014.

2. Should Connecticut administer the Exchanges for the individual and small group markets separately or jointly? If jointly, should Connecticut maintain separate risk pools for the two Exchanges, or merge the risk pools.

AARP has no preference regarding merger of the individual and small group pools. Generally, consumers will be best served by creation of an Exchange pool large enough to allow strong and active negotiation with the plans that want to be included in the Exchange on cost, value and quality. A larger pool will be generally more effective as a means of spreading the risks and costs and might yield administrative cost efficiencies for both markets. As with Q 1, this decision should be made after careful study of the potential ramifications for both segments, including actuarial analysis.

3. Should Connecticut open the Exchange to businesses with 2-100 employees in 2014, or should it allow businesses with 2-50 employees in 2014 and increase participation to businesses with 51-100 employees in 2016?

Please see answer to question 2.

4. Should Connecticut seek to expand access to businesses with more than 100 employees in 2017, with HHS approval?

Connecticut should consider this issue closer to 2017, when it can be viewed in light of its actual Exchange experience. The response to this policy question should be based on a study of the impact opening the Exchange to large employers would have on individuals and small employers already in the Exchange. Expanding the Exchange to large employers could potentially reduce or improve the Exchange's stability. An expansion of access to the Exchange should be considered from the perspective of what it may mean for large employers' workers both in terms of the quality of coverage to which they have access and their personal premium and out-of-pocket costs.

B. Address Adverse Selection and the External Market

1. Should Connecticut allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange? Under a dual market scenario, what additional rules should Connecticut establish to prevent insurers from discouraging participation in the Exchange? What hybrid models might Connecticut consider, and what characteristics do they offer that would benefit Connecticut?

Decisions about how to structure the market when an Exchange is in place should be guided by an assessment of Connecticut's individual market today and how to optimize it for consumers in the changing environment. The characteristics of today's market participants and those entering the market as of 2014, plan offerings and enrollment today, and how that may change

once the Exchange opens should inform decisions about how to minimize adverse selection and spread risk as widely and fairly as possible across those buying coverage in the individual market. To prevent adverse selection and unfair competition and to discourage cherry picking, Connecticut should set the same rules for insurance offered inside and outside the Exchange, or limit the individual insurance market to the Exchange. The latter approach would have the advantage of increasing the size of the Exchange pool and the Exchange's bargaining leverage. [However, at a minimum, policies available outside the Exchange should be identical in terms of costs and coverage to Exchange policies. Regulation of Navigators, agents and brokers should prohibit any compensation system that would incentivize sales of non-Exchange policies.

2. Are there any additional mechanisms to mitigate adverse selection that Connecticut should consider implementing as part of the Exchange?

Connecticut should fully utilize the permanent risk adjustment program as well as the temporary reinsurance and risk corridor programs authorized by the ACA to eliminate adverse selection. The requirements for risk adjustment, and the temporary reinsurance and risk corridor programs, as well as the requirement that plans pool risk inside and outside the Exchanges, are critical tools to limit adverse selection and encourage plans to participate in the Exchange. However, these tools will not be sufficient if states do not apply the same rules to plans inside and outside the Exchange.

3. How should the temporary reinsurance program be approached in Connecticut? What issues should Connecticut be aware of in establishing these mechanisms?

C. Simplify Health Insurance Purchase

1. What issues should Connecticut consider in establishing a Navigator program?

Under the ACA, the role of the Navigators is established and funded by grants from the Exchanges to conduct public education and provide impartial information on available health plans, Medicaid and other public health assistance programs, and subsidies. The work of the Connecticut SHIP or CHOICES program likely offers insights relevant to the development of the Navigator program.

HHS is required to establish national standards for Navigators, but has yet to do so. To the extent permitted by HHS, Connecticut should consider establishing a system to train, certify and/or license Navigator staff or contractors and should establish standards to ensure compliance with the ACA requirement that Navigators not receive "any consideration directly or indirectly from any health insurance issuer in connection with" enrollment.

In selecting Navigators, Connecticut should consider the costs, their impact on premiums, and the experience and ability of potential Navigator entities. Navigators should be able:

- To conduct public education activities, including outreach to diverse, lower-income, culturally or linguistically isolated and difficult to reach populations;
- To distribute fair and impartial information, unaffected by conflicts of interest, concerning enrollment in qualified health plans, Medicaid, CHIP and other state health programs, all available subsidies, and transitions between plans, subsidies and assistance programs based on variations in income and other changes in circumstances; and,
- To provide information in a manner that is culturally and linguistically appropriate to the needs of consumers. They should be accessible to people with disabilities and be able to work with disadvantaged populations.

2. What should Connecticut consider regarding the role of insurance brokers and agents?

Section 1312(e) of the ACA requires the Secretary of HHS to Secretary to “establish procedures under which a State may allow agents or brokers— (1) to enroll individuals and employers in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and (2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.” HHS has yet to issue regulations or other guidance on this issue. Consumers should be able to purchase Exchange policies through agents and brokers, if this allowed by HHS and if consumers chose that option. Based on the experience in Massachusetts, we anticipate that many individual consumers will enroll through the Exchange’s web site or with Exchange staff. If agents and brokers are allowed to sell Exchange policies, safeguards need to be in place to ensure that they have no incentives to steer consumers towards or away from Exchange plans.

The ACA also requires Exchanges to keep insurance costs affordable, to prevent waste, and to publicly disclose administrative costs and the costs of licensing, regulatory fees, and any other payments required by the Exchange. In determining whether agents and brokers are involved in sales, consideration should be given on the financial costs for consumer. If they are involved, the costs of using and not using brokers and agents should be clearly disclosed to consumers and employers.

The ACA precludes Navigators from receiving “any consideration directly or indirectly from any health insurance issuer in connection with” enrollment. Accordingly, an alternative compensation system would need to be established for brokers and agents no longer able to received commissions or other compensation for sales. There would also need to be provision in place to prevent the conflict of interest that would result if Navigator-affiliated agents or brokers received commissions or other compensation in connection with the sale of insurance outside of the Exchange.

Brokers and agents active in the Exchange arena or with Navigators will need extensive knowledge of the complexities of eligibility and coverage under Medicaid, CHIP, and other state assistance programs. Existing training and licensing standards should be reviewed and, if appropriate, modified.

D. Increase Access to and Portability of High Quality Health Insurance

1. Should Connecticut allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should Connecticut establish additional requirements? If additional requirements, what would you recommend? What would be impact of those requirements?

The ACA specifically allows an Exchange to limit the number of insurers allowed to participate based on the best interests of consumers. AARP believes that Connecticut's Exchanges should utilize the same competitive, market-based strategies successfully used by large employers, including the State. Insurance plans should compete to be part of the Exchange as they do for business with large employers, based on costs, value, quality, and customer service. The Exchange will represent the interests of over 380,000 residents who are currently uninsured and thousands of small employers. This vast new market should engender robust competition among insurers. The Exchange should be empowered to use negotiations or competitive bidding to maximize the leverage of this market.

Limited participation will reinforce several policy imperatives. It helps assure that high standards can be set rather than a "least common denominator" approach that all can meet; it provides a strong basis for negotiation; it rewards with greater market share those plans that meet the highest standards; and it provides for a meaningful choice for consumers rather than a confusing array of options where "apples-to-apples" comparisons are difficult if not impossible to make. The Massachusetts Connector has done focus groups on this issue and found a strong consumer preference for a small number of options. Even though Massachusetts' Connector only offers consumers a choice among six insurers, even that is confusing for some consumers and makes selection difficult. If the Exchange only allows the best insurers to participate, consumers will feel confident that any plan they select will provide high value. In addition, benefit structure variations among Exchange plans should be limited to facilitate easy comparisons of benefit packages.

As detailed below, a significant portion of the Connecticut's population will transition between Medicaid, CHIP and Exchange coverage. Accordingly, preference should be given to insurers who also participate in the Medicaid program, and a Basic Health Program if this is included, and that are willing to provide for continuity of care and care providers when consumers transition among these programs.

2. Should Connecticut consider establishing the Basic Health Program? What would the Basic Health Program offer as a tool to facilitate continuity of coverage and care?

Connecticut should consider inclusion of a Basic Health Program (BHP). If properly designed, a BHP could have several advantages. Continuity of coverage and care could be maintained if

all programs (Medicaid, CHIP, BHP, subsidized and unsubsidized Exchange coverage) are structured so that those transitioning among the programs can do so seamlessly – with modifications of premiums and copays based on changes in income or other circumstances, but with continued access to the same network of health care providers and no gaps in coverage or care. A BHP would also be a way for CT to provide coverage for low-income legal immigrants who are barred from Medicaid because they have not been in the U.S. for five years.

3. How would the Basic Health Program impact other related programs in Connecticut?

The potential impact of a BHP on other programs warrants further in-depth study. Questions that need to be answered include:

- Will the BHP population have different medical needs and utilization patterns than the Medicaid and 200% FPL populations?
 - If the Exchange is limited to those at 200% FPL and above, how will this impact the size of the Exchange pool and its ability to obtain favorable terms for consumers? There are 315,000 individuals in Connecticut with incomes between the 2014 Medicaid limit (139% FPL) and 200% FPL. Their exclusion from the Exchange could have a significant impact on the Exchange's bargaining power that could result in higher premium and out-of-pocket costs for consumers.
 - What are the cost implications for consumers in terms of premiums and out-of-pocket costs for 139% to 200% FPL cohort if Connecticut chooses a BHP as compared to Exchange coverage? Would use of a BHP change the number of individuals seeking exemption from the individual mandate based on affordability? Increases in affordability exemptions would likely affect utilization of uncompensated care and cost shifting by health care providers.
 - How would use of a BHP impact coverage and costs (individual and state) for "lawful immigrants" who may be eligible for BHP coverage, but who may be excluded from purchasing coverage and receiving subsidies through the Exchange or from Medicaid?
4. How can Connecticut structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)

There should be a single, streamlined and seamless application process for coverage through the Exchange, Medicaid and other state assistance, including a BHP if Connecticut takes that option. Consumers will be best served by having a variety of portals available to them to compare and purchase coverage. This should include on-line comparison and purchase through the Exchange's web site as well as facilitated comparison and purchase through the Exchange's hotline or through a Navigator. If the Secretary establishes procedures, under § 1312(e) of the ACA, allowing agents or brokers to enroll individuals and employers in Exchange policies,

consumers should have the option to purchase coverage with or without the assistance of agents or brokers.

The enrollment system, including the Navigators, must be able to ensure rapid, seamless and gap free transitions for those whose income or other circumstances change. Over half of all Connecticut citizens have incomes below 400% of federal poverty level — the income level for federal subsidies under the ACA — and 13% of our population will be eligible for Medicaid under the ACA’s expansion of that program. Studies have documented that large portions of lower income households, particularly in today’s economy, will experience periodic changes in income that will impact their eligibility for Medicaid or subsidies through the Exchange and the level of their subsidy. Accordingly, we urge that the Exchange, in conjunction with the Department of Social Service, develop and implement procedures for prompt eligibility, benefit and subsidy redeterminations so individuals experiencing changes in income or other circumstances affecting benefits, subsidies or eligibility in the Medicaid program, the Children’s Health Insurance Program, a Basic Health Plan (if offered), any other applicable state or local public program, and premium tax credit under or cost-sharing reduction ACA, do not experience gaps in coverage or alterations in the individual’s health care providers or any ongoing plan of care or treatment.

In selection of insurers seeking participation in the Exchange or contracts under Medicaid and/or a BHP, continuity of coverage and seamless transitions would be best facilitated by giving significant preference to those insurers willing to participate in every market and to provide a uniform network of health care providers.

E. Ensure Greater Accountability and Transparency

1. What information should Connecticut include for outreach to most effectively engage consumers? How should the information be presented?

To effectively engage consumers, Connecticut should look at available research on efforts to enroll adults in subsidized coverage programs to learn what has and has not worked such as the 2008 HHS commissioned study, “Designing Subsidized Health Coverage Programs to Attract Enrollment:” <http://www.mathematica-mpr.com/publications/PDFs/health/subsidizedcoverage08.pdf>. The experience of the Massachusetts Connector and Utah’s Exchange may also provide additional information that can help guide new efforts in this area. Connecticut may want to undertake its own research to determine how best to design appealing products, information that is understandable to the target populations, and how best to different target groups.

At a minimum the Exchanges should make information available that facilitates easy comparisons based on cost, quality (including patient experience), and service, as some large employers often do for their employees. Information should be available in sufficient detail to allow consumers to drill down into particular scenarios that allow them to obtain coverage facts

relevant to their families' health care needs and preferences. Because consumers are most interested in information about their physicians, AARP encourages information at the physician or group level (aggregated to the plan), as well as information about health plan performance. Exchanges are required to develop a plan rating systems with a focus on safe, patient-centered, high quality care. In addition to providing over-all ratings for each plan, consumers should have access to objective quality data on the providers with each plans network and the quality measures and standards used by the plan in the establishing their network. Measures that compare participating health plans on a range of condition-specific and cross-cutting issues should be also included so that, for example, an individual with COPD can compare objective outcome data on how competing plans treat and manage that condition and that includes objective quality data on the specialists available in each plan's network. Consumer satisfaction data on quality of care, consumer services, disenrollment, grievances and appeals, and access to care and providers should be collected, independently and uniformly, and made publicly available. Information on medical loss ratios should also be provided.

Key initiatives must build ongoing education and outreach on a base of understandable consumer information about the importance and availability of coverage and about the options themselves. Awareness of the Exchange itself will require a major communications and marketing campaign. Many of those enrolling through the Exchanges may not have had insurance before and the process of choosing a plan and applying for coverage will be unfamiliar. It is particularly important for the Exchanges and Navigators to work with diverse groups that may be harder to reach due to language and cultural differences or lack of familiarity with health insurance. The outreach efforts need to be ongoing to maximize enrollment and reenrollment. Whether through the Navigator program, consumer assistance programs, or other health insurance counseling programs, it will be important to have places where people can call and/or meet face-to-face with someone who can guide them through the process.

Finally, governing bodies should include strong consumer representation and also provide the opportunity for additional issue-specific working or advisory groups to be created and to give ongoing input into the process. To avoid conflicts of interest, the governing board should not include insurers or health care providers that would be subject to regulation and oversight by the Exchange.

2. How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements?

In addition to a uniform and independent system to gauge consumer satisfaction, the Exchange should develop systems to collect and collate feedback and input through its advisory councils, the Office of the Health Care Advocate, and consumer advocacy organizations. This information should be used by the Exchanges relating to plan certification and inclusion within the Exchange. The state should also consider impartial evaluation of the work of the Exchange

to help determine how it can improve the consumer experience, particularly for difficult to reach populations, so that people are not only connected with coverage but learn how to use it.

3. What information, beyond that required under the ACA and implementing regulations, should Connecticut require of plans? How much of this information should be shared with consumers accessing the Exchange?

Please see our response to E.1. All of this information should be readily available to public.

F. Self-Sustaining Financing

1. How should the Exchange's operations be financed beginning in 2015?

The Exchange will need a stable and adequate source of financing to meet its obligations under the Act. There are a variety of sources that may be considered, among them state appropriations, surcharges on health benefit plans and insurers, user fees, provider fees, or a combination of these and other sources. One source of funding that could be re-directed for this purpose is that currently supporting the Health Reinsurance Association. In considering how to finance the Exchange, the goal should be to spread the costs as broadly as possible with an eye to both keeping the playing field level for Exchange and non-Exchange plans, and assuring that the costs associated with the Exchange are affordable to those using the Exchange, and those contributing to its financing. Advertising on the Exchange website is an idea that has been posed as one possible source of revenue for the Exchange. This funding method, however, could erode the perception of the Exchange as a fair and impartial source of information about coverage options and choices.

2. How might the state's financing strategies encourage or discourage participation in the Exchange; affect the reputation of the Exchange; and affect accountability, transparency, and cost-effectiveness?

If the financing structure comes only through Exchange sales, consumers' costs associated with Exchange plans will be higher than the cost of purchasing the same or similar coverage outside the Exchange and Exchange enrollment will suffer as a result.

3. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?

Until HHS defines essential health benefits, it is hard to address the question since we don't know the number and scope of benefits in question or the costs associated with them.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

- Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?

The Exchange should adopt minimum standards to address affordability; the quality and adequacy of the provider network, collection of data on race and ethnicity to determine disparities, and systems to reduce these disparities; quality improvement systems; data collection and reporting requirements to assess quality and efficiency; access to providers and emergency care; and marketing practices. Ongoing monitoring, evaluation, and enforcement are necessary to ensure high performance by participating plans.

The ACA allows an Exchange to make advance determinations of eligibility for premium tax credits and cost sharing reductions. This would trigger advance payments from Treasury to the health plans in order to reduce monthly premiums and lower cost sharing when services are rendered in lieu of tax credits in the following year. This would be advantageous for many enrollees and would encourage maximum participation by making premiums and health care more affordable.

The Exchange will need to work very closely and collaboratively with the Departments of Social Services, Insurance and Public Health to ensure the seamless delivery of high quality insurance coverage and medical care. The Exchange should review existing law, regulation and policy for these agencies to determine if modifications would be appropriate.

- Are there advantages to limiting the number of plans offered in the Exchange, or is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

Consumers will be best served by creation of an Exchange pool large enough to allow strong and active negotiation with the plans that want to be included in the Exchange, in terms of cost, value and quality. This is the same approach large employers use — taking advantage of a large pool of employees to obtain good coverage at affordable rates from a small number of insurers. The Exchange should have the authority to select the QHPs that will best serve the interests of Connecticut citizens and employers. It should be able to limit the number of plans available to ensure consumers and employers receive value for premium dollars spent and to use negotiations and competitive bidding to achieve this result.

Limited participation will reinforce several policy imperatives. It helps assure that high standards can be set rather than a "least common denominator" approach that all can meet. It provides a strong basis for negotiation. It rewards with a significant share of a large market those plans that meet the highest standards. It facilitates plan comparison and selection for consumers. The Massachusetts Connector, which has done focus groups on this very issue, has found a strong consumer preference for a small "manageable" number of plans. By weeding out

lower value products, it increases consumer confidence in the Exchange and the value of the plans it has selected. It also simplifies Exchange oversight of the plans.

- Should Connecticut consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc)?
- What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?
- What should be the role of the Exchange in premium collection and billing?

The Exchange should make it as simple and convenient as possible for those enrolling in Exchange plans to make premium contributions. This may involve developing an automatic payroll deduction system for those who are employees of small employers, and to the option of a debit arrangement for their premium contributions for individuals enrolling directly in the Exchange. For workers participating in the Exchange through a small employer, it would be helpful if their employer set up a Sec. 125 program that allows them to deduct their premium contribution on a pre-tax basis. The premium contribution system should be designed to accommodate changes in the subsidy level if income changes during the course of the year.

The ACA allows for a system under which, in lieu of tax subsidies at the end of the year, premiums and copayment can be lowered throughout the year. This would very helpful for many consumers and would encourage participation from those who might otherwise be discouraged by the up-front costs.

- What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?

Where the Exchange has responsibility for reporting information about an individual, to an employer and/or a government agency, the consumer should receive a copy of the information being shared. The disclosure of the individual's information should be accompanied by information about their rights to correct and/or ask questions about the information and how they can do that.

H. Additional Comments on Issues Not Covered in Survey

Given that a number of individuals will transition between Medicaid, BHP, CHIP and Exchange coverage, it would be good to have uniform procedures, forms, etc. Even hearings would likely

be held by different agencies – DSS for Medicaid and probably BHP and someone else for Exchanges.

For Exchanges:

The ACA requires issuers offering group or individual coverage to implement an appeals process for coverage determinations and claims denials. At a minimum this must include an internal process with notice to enrollees of the available internal and external appeals and the availability of any consumer assistance or ombudsman services. Consumers must be allowed to review their file, present evidence and testimony, and receive continued coverage pending a decision. Internal appeal procedures must comply with existing ERISA standards and new standards being developed by DOL and HHS. External review procedures must comply with any applicable state external review process, include the consumer protections in the NAIC's Uniform External Review Model Act and be binding on the plan. Alternatively, if the state has no established external review process or the plan is self-insured, the external review process must meet minimum standards established by the Secretary. Establishment of an effective appeal process is a criterion for HHS certification as a Qualified Health Plan. Some states do not have appeal procedures that meet these standards. The ACA provides some grant funding for consumer information and ombudsman programs that could assist consumers with appeals.

AARP suggests:

- Quality assurance standards should include, at a minimum, internal and external quality review, meaningful grievance and appeals procedures, strong state monitoring and oversight (e.g., by an ombudsman), and strong sanctions for violations of quality standards.
- A clinically sound and well-communicated exceptions and appeals process must be in place. The process should allow appeal to an independent, objective third party and require as prompt a decision as a patient's condition mandates. (Prescription Drugs)