

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? *No. We may need the flexibility to change scope, requirements and plan eligibility. Different minorities may have different needs.*
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. *Both pools need to be sufficiently scaled so that market efficiencies leverage better pricing. Networks can be different for small groups so that basic PCP and subspecialty participation requirements are met. There also must be parity for dental and behavioral needs of patients*
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? *Connecticut should open the Exchange to businesses with 2-100 employees in 2014. We believe this will increase participation in the health insurance exchange by the APA community, many of whom own successful small businesses- dry-cleaning, nail salons, etc.*
4. Should Connecticut seek to expand access to businesses with more than 100 employees in 2017, with HHS approval? *Yes. The larger employees should have bronze, silver, gold and platinum and the smaller employers must have a basic plan.*

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? While we believe that the hybrid market would allow greater choice, we also feel that, initially, to increase participation of minority communities, all insurance should be sold through the exchange. This means that the exchange must pay special attention to ensure that insurance plans offer the basics and that health equity and disparities are actually being mitigated for rural and urban communities.
2. Are there any additional mechanisms to mitigate adverse selection that Connecticut should consider implementing as part of the Exchange? Regulatory diligence should govern commissions so that insurers may not steer enrollment outside to affiliated plans making the pricing of plans inefficient.
3. How should the temporary reinsurance program be approached in Connecticut? What issues should Connecticut be aware of in establishing these mechanisms? Care must be exercised so that rural populations aren't disadvantaged due to cherry picking geographical areas for primary care and sub specialty care. Plans with low risk members may be assessed so that high risk enrollee plans can be risk adjusted financially. These pools can also be used to address racial and ethnic disparities through risk adjustment payments and incentives,

C. Simplify Health Insurance Purchase

1. What issues should Connecticut consider in establishing a Navigator program? One issue of special concern, we think, is to properly train these "navigators" to help navigate potential customers through the healthcare system. Training may be expensive, and time consuming. On this point, we think the ethnic Commissions should play a vital role in increasing participation and access by acting as navigators. The goal should be to reduce racial and ethnic disparity elimination goals need to be created for all plans with a time phased implementation schedule. Racial and ethnic requirements should be developed for the qualifications of Navigators, monitored and reported.
2. What should Connecticut consider regarding the role of insurance brokers and agents? Insurance brokers and agents must be required to not steer purchasers away from the exchanges so that it is sustainable. Penalties should be imposed as a deterrent.

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? Connecticut should establish additional requirements. Connecticut residents have unique needs and these needs may differ from the federal requirements. The DPH should establish additional requirements based on these goals: prevention, chronic disease management, participation in self management incentives, contracting with FQHC's is all important. Access to Dental and behavioral services are equally important.
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? A stripped down, bare bones plan with universal primary care access , a donut hole plan with a major medical rider can be offered as a public option – only within the exchange.
3. How would the Basic Health Program impact other related programs in Connecticut? It would be a compromise set of benefits- and be the core of the public option.

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) Consumers and patients may be expected to move between plans without administrative complexity. Risk reserves can be retained to underwrite and assist providers and plans with proven adverse selection.

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? An effective outreach strategy must account for the cultural and linguistic differences among Connecticut's minorities. So, for example, we believe that offering information on how to navigate through the healthcare system in different languages may be a start to engage consumers of healthcare. A brochure is easy enough to produce. We also believe the ethnic Legislative Commissions will play a vital role in successful outreach. They are an indispensable entity to successful health care reform. Additionally, training doctors and nurses on appropriate cultural sensitivity training may increase participation by minorities.
2. How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements? Reports from Consumer focus groups, consumer forums, point of service surveys, health care advocate complaints should be aggregated and published. Priority should be given to racial and ethnic disparity reporting and the specific impact that it has on life expectancy. Benchmarks and Goal setting must be part of a performance improvement process that will require the Office of the Healthcare advocate and the Legislature to be accountable for the care of all its residents.
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? The plans should be required to provide a reporting set of data on racial and ethnic disparities. The plans should be required to share with consumers the availability of language and culturally appropriate services that may be available elsewhere in the state.

F. Self-Sustaining Financing

1. How should the Exchange's operations be financed beginning in 2015? Private, State and Federal funds and any combination thereof.
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? The larger the pool the better. Capping malpractice awards can greatly influence provider participation in networks. Risk pool adjustments can create safe harbors for providers. Consumers opting into the exchange can agree to no fault insurance.
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? Private, State and Federal funds and any combination thereof.

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

1. Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?
Create a measurement of a set of standards for health equity by race/ethnicity. Provide a strategic plan for elimination of health disparities.

Provide a measurement, mapping and reporting primary care access for medical, dental, and behavioral services.

Provide reporting for alternative medicine and therapies for minority communities.

Provide a formulary analysis on pharmacy programs for promoting better consumer care.

2. 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? *Coverage We do not believe limiting the number of plans offers any advantages. If we're to presume that markets are most efficient when it is perfectly competitive, then it follows that restriction on the number of plans reduces the efficiency of the exchange. But having said that, the exchange must guarantee access and also cover a basic set of services that is risk adjusted and meets the standards set by the state.*
3. 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)? *No.*
4. What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange? *Utilizing the local FQHC's services.*
5. What should be the role of the Exchange in premium collection and billing? *No*
6. What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange? *There needs to be a standardization and alignment of data reporting of all state agencies and the HIE.*

BACKGROUND by TOPIC AREA

The general information on each topic area below is intended for brief reference only.

A. Establish a Responsive and Efficient Structure

The ACA requires that all states establish an American Health Benefits Exchange for the individual market and a Small Business Health Options Program (SHOP Exchange) for the small group market. States may operate these independently or may combine them into a single Exchange. States may also form regional or multi-state Exchanges.

For the purpose of inclusion in the SHOP Exchange, the ACA defines small employers as an employer with 2-100 employees. However, until 2016, states may limit this definition to 2-50 employees; and after 2017 states may further expand participation in the SHOP Exchange.

B. Address Adverse Selection and the External Market

The ACA allows states to establish a “dual market” in which individual insurance may be purchased in and out of the Exchange, or to require that all health insurance plans sold on the individual market must be sold through the Exchange. States may also design “hybrid” solutions such as permitting supplemental coverage to be sold in external markets but requiring that all individual major medical coverage be sold in the Exchange.

The ACA establishes certain rules to protect against selection issues in a dual market, but does not deny states the ability to include additional requirements for insurance sold in the Exchange and an external market. State options include but are not limited to requiring that all insurers in the Exchange offer all four tiers of coverage, standardizing benefits packages, and restricting the sale of “catastrophic” insurance plans. However at a minimum, the following rules apply:

- Plans inside and outside of an Exchange must be in the same risk pool, have the same premium rate (for those sold by the same company), and meet the same minimum benefits standards.
- Insurers inside and outside the Exchange may not deny coverage on the basis of pre-existing conditions, medical status, or claims history.
- Premium variation based on age, geographic location, and smoking status must apply to plans sold both inside and outside the Exchange.
- Plans sold in the Exchange must have an open enrollment period and special enrollment periods to encourage participants to purchase coverage before they become sick.

The ACA requires that states establish a reinsurance program for the individual market inside and outside of the Exchange, for the first three years of Exchange operation. The NAIC will develop model legislation to carry out this provision. States must consider issues such as how to coordinate their high risk pools with this program.

C. Simplify Health Insurance Purchase

The ACA requires an Exchange to establish a “Navigator” program to conduct public education, advise individuals and small groups that enroll in the Exchange, help them enroll in health plan and access benefits, and provide referrals as needed to the health care ombudsman. The Navigator program must be established by awarding grants to a variety of groups, and must be financed through operational funds of the Exchange (not Federal funds received by the state to establish the Exchange).

With establishment of an Exchange, the existing relationship between brokers, carriers, and consumers is likely to change. The ACA leaves states flexibility to make decisions regarding these relationships, such as designating an official role for brokers within the Exchange apparatus, requiring certification, or regulating commissions.

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

The ACA requires that health plans that wish to participate in an Exchange (Qualified Health Plans) comply with certain requirements related to marketing, choice of providers, plan networks, and essential health benefits. Beyond this, states may establish additional requirements for plans that are offered on an Exchange.

The ACA provides states with the option of operating a Basic Health Program for individuals between 133% and 200% of the federal poverty level, in lieu of those individuals receiving premium subsidies for purchase of coverage. The benefits under the Basic Health Program must be at least equivalent to the essential health benefits and premiums may not be higher than those in the Exchanges.

With health care reform, individuals may be eligible for one of a variety of insurance options: Medicaid, CHIP, subsidized coverage through an insurance Exchange, and unsubsidized coverage through an Exchange. The ACA requires that there should be a single seamless process of applying for coverage for all of these programs – regardless of where a consumer enters the system.

E. Ensure Greater Accountability and Transparency

The ACA requires that Exchanges post information on the cost and quality of health plans. Specifically, states must develop an Internet website for standardized comparative information on plans, provide public ratings of participating Exchange plans, and use a standard format for presenting health plan options in the Exchange.

F. Self-Sustaining Financing

The ACA includes grant funding for planning and establishment of Exchanges, but beginning January 1, 2015, state Exchanges must be financially self-sustaining.

The ACA establishes a minimum essential benefit set to be sold inside and outside an Exchange. A state may choose to require additional benefits but must cover the cost of those benefits for individuals eligible for tax credits through an Exchange.

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

Under federal law, the Exchange is required to perform these functions:

- Certify, recertify, and decertify qualified health benefits plans under the guidelines established by the federal Department of Health and Human Services (HHS)
- Operate a toll-free customer assistance hotline
- Maintain a website that allows customers to compare qualified health benefits plans offered by different insurance carriers
- Assign a rating to each qualified health plan under the rating system that will be established by HHS

- Use a standardized format to present four coverage options (bronze, silver, gold, and platinum), plus the catastrophic plan design for young adults/exemptions
- Inform individuals about the existence of—and their eligibility for—public programs, including but not limited to Medicaid and Children’s Health Insurance Program (CHIP)
- Certify individuals who are exempt from the individual mandate on the basis of hardship or other criteria to be established by HHS
- Transfer information to the federal Secretary of Treasury regarding individual mandate exemptions and subsidies awarded due to a failure on the part of a small employer to provide sufficient affordable coverage
- Provide information to employers on their employees who are not covered
- Establish a network of navigators to raise awareness among customers of their coverage options and to help people select and enroll in health plans and subsequently access benefits