

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. The creation of a state based exchange allows CT to exercise authority over eligibility, enrollment, insurer participation is preferable. If it is eventually merged with state and local government employee coverage this would expand the size of the risk pool.

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.

The key concern is a sufficiently large risk pool in order to mitigate risk and leverage pricing.

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?

Federally Qualified Health Centers are employers in Connecticut and a recent economic impact analysis ¹ documents that they directly generate 1,940 full time jobs. They are often the largest employers in their communities and struggle with absorbing the costs of providing health insurance coverage to their employees in light of the mandate

¹ *The Economic Impact of Connecticut's Community Health Centers*, March 21, 2011, Capital Link Inc.

that they provide services to patients regardless of ability to pay. Only 2 FQHCs are currently employers with fewer than 50 employees, Two FQHCs currently have between 51-100 employees so it would be beneficial to them to increase participation to include larger employers.

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

Nine FQHCs currently have more than 100 employees and would be able to purchase insurance coverage for them through the Exchange if this expansion were to be approved.

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?

The hybrid market is preferable to maximize the amount of consumer choice possible.

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

An additional mechanism to mitigate adverse selection would be to prohibit insurers that participate in the exchange from establishing separate affiliates to sell only outside the exchange and to prohibit higher commissions for plans sold outside the exchange. Both of these would discourage insurers from steering enrollment elsewhere and safeguard the “level playing field” and prevent the siphoning off of the healthiest covered lives.

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

Connecticut might consider the ACA remedy for “market disequilibrium” which is a transitional reinsurance program followed by an assessment of plans and insurers with low-risk enrollees and accompanying payments to those with high risk employees.

C. Simplify Health Insurance Purchase

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

It would not be difficult to identify the organizations/providers that have been high performers in conducting patient education/outreach to the uninsured, underserved and hard to reach populations to enlist their assistance in developing requirements/qualifications for Navigators.

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

Brokers and agents will have a key role in assisting small employers in understanding Exchange offerings but policies to mitigate the risk of brokers steering purchasers to plans outside the Exchange are critical to the sustainability of the Exchange.

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?

Insurers in the health insurance exchange will be required to contract with community health centers so health center patients will be protected from being excluded from private insurance coverage under the Exchange. All of Connecticut’s community health centers are in the process of pursuing recognition as Patient Centered Medical Homes and will be key players in the exchange as health homes. The inclusion of preventive services with no additional out of pocket charges to consumers and incentivizing chronic disease prevention are important

requirements the Exchange should include. Preventive services and parity with the benefits offered through the Medicaid program are essential components for the Exchange.

Connecticut should use its certification authority to promote exchange participation among high value plans. Too many plan offerings with all the marketing that would come with them will confuse the public and may not add value.

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 a compromise set of state benefits requirements to apply to both the exchange and plans operating outside the Exchange.

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

See answer to 2 above.

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)

The efforts to offer convenience and avoid administrative complexity that are used for the Exchange should also be implemented for the Medicaid programs not only to benefit enrollees in government programs but also to facilitate transitions between the Exchange and other programs. All efforts should be focused on reducing administrative burdens in the Exchange and other programs for purchasers as well as enrolled individuals. In addition, the Exchange will be a “gateway” to the public programs and Connecticut should anticipate/facilitate movement back and forth between programs and for people who change jobs.

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?

It should be clear how the Exchange will interact with the broader health care system and the hundreds of thousands of residents who seek care in that system.

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

F. Self-Sustaining Financing

1. How should the Exchange’s operations be financed beginning in 2015?
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 adverse selection issues discussed above, the number/variety of plans and the size of the risk pool are the key drivers with regard to viability and sustainability. Bigger seems better!

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?

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?

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?

The Exchange should encourage participation to increase enrollee choices and healthy competition but it is critical that if plans are allowed to cover only local areas rather than the entire Exchange that areas with lower income enrollees and racial minorities not be disproportionately affected/ negatively impacted by the distribution of plans.

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)?
4. What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?
5. What should be the role of the Exchange in premium collection and billing?
6. What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?

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