

April 18, 2011

Ms. Tia Cintron
State of Connecticut
Office of Policy and Management
450 Capitol Ave. MS #52 LTC
Hartford, CT 06106

Dear Ms. Cintron:

We are writing in response to your March 16, 2011 request for comments on the Exchange.

We are pleased that the Malloy Administration has invited our input. We have reviewed your questions and analyzed all three Bills pending before the General Assembly that would authorize the creation of an Exchange. In addition, we have considered the approaches being taken in other states. We are providing our comments in advance of our May 3 meeting, as you requested; however, we reserve the right to raise additional issues at and after that meeting, as well. Thus, while we appreciate this opportunity to comment, we hope that this will be the beginning of the ongoing conversation that is contemplated by federal law. Notwithstanding our comments, we also strongly urge the administration to hold a public hearing on the exchange proposal to access the wisdom of all the public, not only our small group of advocates.

A. Structure

It is our position that Connecticut should run one Exchange that combines the individual and small group markets. This will facilitate interaction between HUSKY and any health insurance, as well as between the individual and small group markets, so when people lose jobs or become ineligible for a subsidy – regardless of whether they are in an individual plan or a small group plan – they will already be in the Exchange at the right point of entry to ensure that all of their needs are met. Our only concern with this point is that consumers should be able to tell easily whether a plan is for individuals or small business so as to avoid confusion. This can be managed through the way plans are presented on the Exchange.

Insurers should be required to make available both individual and group policies that have overlapping provider networks and formularies so that consumers can move back and forth between individual and group plans easily. Similarly, the Exchange should ensure that there are at least some individual and small group plans that overlap with HUSKY so, for example, HUSKY enrollees who have been seeking treatment at Community Health Centers may continue to do so.

We also feel strongly that Connecticut should create a single pool of all Exchange-enrolled individuals and small businesses to assist the Exchange in building purchasing power.

For similar reasons, we support opening the Exchange to businesses with up to 100 employees as early as 2014.¹ Having a robust Exchange that includes businesses up to 100

¹ We believe that small groups should be defined to include businesses with one (1) employee whose premium will be paid by a business rather than on an individual basis. When these businesses grow, this will avoid forcing them to switch policies. At the very

employees will boost the size of the pool and businesses' participation in the Exchange. A large Exchange will be ready to expand to businesses with more than 100 employees in 2017, with HHS approval. It also will increase the size of the pool, whether or not the individual and small business markets are pooled, thereby increasing bargaining power and, presumably, savings.

However, we do not believe that a multi-state or regional Exchange is in Connecticut consumers' best interests, at least at the outset. First, Connecticut has worked hard to develop a set of coverage mandates that are critical to our residents, and that may be lost in a multi-state or regional Exchange. Second, Connecticut Navigators will have the network to work with Connecticut consumers, but may not have the ability to work as well with other states where they may not be familiar with the terrain.² Third, the Exchange will be screening for, and enrolling in, HUSKY. This process would be needlessly complex if other states were included in the Exchange. While it might make sense at some point in the future to consider a multi-state or regional Exchange, for these reasons, we believe that we should start with a Connecticut Exchange.

B. Adverse Selection

Although we are not opposed to a dual market in which individual and small group insurance is offered both within and outside of the Exchange, steps must be taken to guard against adverse selection in both the individual and small group markets. Insurers who offer plans both within and outside of the Exchange should be required to charge the same premium in both markets.³ In all significant respects, plans offered outside and within the Exchange should be as identical as practicable including having the same cost-sharing rules, the same provider networks (so an insurer cannot locate all of the AIDS specialists or a greater number of behavioral health specialists within the Exchange, for example). Commissions paid to brokers should be the same in both markets, as well. Health insurers offering plans in both markets should be required to fairly and affirmatively offer, market and sell all products in both markets. In addition, plans offered in both markets should have the same open and special enrollment rules. Cost-sharing rules should be the same for the same plan in both markets. These rules should apply to both individual and small employer plans. Robust monitoring and evaluation of the entire Connecticut market, inside and outside the Exchange, is critical to guarding the integrity of the Exchange against adverse selection. (See Monitoring and Evaluation Section, p. 8).

We believe that these strong protections must be in place to ensure against adverse selection. Without these provisions, the Exchange will be dominated by individuals who are eligible for tax credits that can be obtained only by buying insurance through the Exchange. In addition, consumers who seek to insure outside the Exchange may not be properly

least, we suggest that the self-employed be given the option to purchase small group coverage if they believe that their business is likely to expand. We do not believe that this is contrary to federal law, but if HHS approval is required, it should be elicited.

² Similarly, out-of-state Navigators may not be as familiar with Connecticut resources.

³ If insurers are required to charge the same premiums in both markets, then it is not necessary to require the Exchange to consider excess premium growth outside the Exchange compared to premium growth in the Exchange. However, if you decline to require insurers to charge the same premiums in both markets, this provision becomes important for adverse selection purposes.

screened for HUSKY eligibility. Only by equalizing the options available in the two markets will adverse selection be avoided.

We do not oppose a provision stating that employers reserve the right to determine employer criteria for coverage and the amount of the employer contribution.

C. Navigators

Connecticut should develop a strong system of Navigators to assist consumers to research and select plans. Not only is effective outreach critical to secure the full benefits of the ACA for state residents, it is important to the state budget to enroll Medicaid eligible residents as early as possible. From 2014 through 2016, the federal government will reimburse Connecticut for 100% of the costs of care for new Medicaid eligibles; by 2019 that reimbursement rate falls to 90%. It is common for previously uninsured patients to require more health care services when they first get coverage. Unmet health needs suggest that the costs of new enrollees will be higher in their first year on the program. It is in the state's best interests to have those higher costs fully reimbursed by the federal government rather than wait to enroll eligible residents until after 2017 when the state will be liable for more of the costs of that pent-up demand.

Navigator grants should be awarded by the Exchange, and Navigators should be required to engage in public education, provide fair and impartial information about plans, provide fair and impartial information about tax credits, facilitate enrollment, and provide referrals to consumer assistance agencies. In addition, Navigators should be required to provide assistance in linguistically and culturally appropriate ways.

In addition, Navigators should have no conflicts of interest. They should not be insurers or have any relationship with an insurer. In addition, any agent or broker who wishes to be a Navigator should not be permitted to sell insurance either on or outside of the Exchange. (Brokers will be paid a commission to act in the Navigator role and should not be compensated doubly through a Navigator grant). In addition, no Board member should be a Navigator. Navigators may be chambers of commerce, community or consumer-focused nonprofits, or other entities that have no other relationship with the Exchange. If the individual and small group markets are separated, we see no reason why all Navigators should have to demonstrate that they have existing or potential relationships with small employers; some Navigators can serve only the individual market, where it is most likely that linguistic and cultural competence will be a more important factor than relationships with small employers.

We also feel that Navigators will be a very important source of feedback for the Board of the Exchange. Any person or entity that receives a Navigator grant should be required to provide feedback to the Board no less than quarterly.

Navigators should offer services appropriately to the speech and hearing impaired as well as those of diverse languages and ethnicities. They should be physically available to persons with disabilities. And they must demonstrate an ability to reach disadvantaged, culturally or physically isolated populations.

We understand that identifying funding for Navigators will be a challenge. The State cannot use its Exchange grant for this purpose, nor will it have collected enough fees and other income to pay Navigators at the outset of the Exchange's operation. As described above, it is in the state's best interest to enroll every eligible Medicaid member as soon as

possible, and therefore to devote state resources to Navigator functions. We believe that it is important to pursue a variety of outreach strategies, including giving many small grants to virtually any group with a good idea, as Massachusetts has done. We should then measure the effectiveness of these strategies and focus our resources on those found to be most successful. It may make sense, on a provisional basis, to identify entities that would do this work anyway – unions, chambers of commerce, the Office of the Healthcare Advocate, nonprofit membership organizations, nonprofit advocacy organizations, and community-based organizations – and provide them with modest grants. These may be deemed Navigators as long as they meet the requirements determined by federal law.

D. Access to High Quality Health Insurance

Connecticut's existing coverage mandates should apply to all plans offered to both individuals and small business. Since we do not yet know what will be included as "essential benefits" by HHS, we do not know how many of these mandates will be benefits that are above and beyond the HHS standards. However, we feel strongly that these mandates should be preserved.

We feel quite strongly that the Exchange should limit the number of plans to include on the Exchange, use selective criteria in choosing those plans, and negotiate premium prices with carriers. Not only should plans provide the essential benefits package and the state mandates, but every insurer should be required to offer at least one bronze, silver, gold, platinum and catastrophic plan in the Exchange. Each plan should be made available as a child-only plan, as well.

Connecticut should take advantage of the Basic Health Program option outside the Exchanges to design a program that mirrors the benefits, cost-sharing and procedural protections of Medicaid for eligible populations with incomes between 133% and 200% of the federal poverty level. Individuals at this income level will find the cost-sharing requirements in the Exchange unaffordable, even with the subsidies in the ACA. The Basic Health Program provides an affordable option at no cost to the state; the federal funding formula for the Basic Health Program should cover all the Basic Health Program costs. Any excess federal funds should be used to increase provider reimbursement rates. This option is particularly important to the roughly 15,000 parents currently enrolled in the HUSKY A Medicaid program with incomes between 133% and 185% of the federal poverty level.

In 2014, Connecticut will have the option of continuing Medicaid coverage for these parents, but the ACA provides significant financial incentives to the state to move people with incomes over 133% of the federal poverty level out of Medicaid. A Basic Health Program that mirrors Medicaid would continue the coverage now available to these parents and make it easier to keep parents and children in Medicaid covered by the same health plan. The Basic Health Program would also make affordable health care available to other individuals.

Adopting this option would reduce the number of people in the Exchange and should, therefore, be planned for as the Exchange is being planned. But a Basic Health Program would benefit the Exchange. Research shows that families at the lower end of the income range between 133% and 200% FPL are subject to greater fluctuations in their income. Establishing the Basic Health Program will help reduce the "churning" that families would inevitably experience by needing to move back and forth between Medicaid and the Exchange during the course of a year.

E. Accountability and Transparency

Although you have not asked us for comment on the Exchange governance, we feel strongly about the conflict of interest provisions of the three Bills currently pending before the legislature, and we believe that eliminating conflicts of interest is essential to accountability. We are adamant that, if the Exchange is to have true independence, it must resist any attempt to be captive to the insurance industry, as well as health care providers and trade associations related to the industry or to providers. The involvement of insurance industry representatives on the Board of the Exchange creates a strong appearance of a conflict of interest, at the very least. Indeed, we also believe that agents and brokers that are going to sell products listed on the Exchange should not be on the Board of the Exchange. Similarly, vendors who seek business from the Exchange, including information technology, should not be permitted to serve on the Board of Directors. In addition, we support general language like that found in the California legislation to the effect that Board members cannot influence the making of a decision that he or she knows will have a financial effect on him or her, or on his or her family or business entity in which the member is a director, officer, employee, member, or agent. Abstention and/or recusal is not enough. No member of the Board of the Exchange should be able to have the ability to shift opinion in one direction or the other based on self-interest.

The Board of the Exchange should meet in public and should be subject to the Freedom of Information Act.

In addition, the Board should contain three consumer representatives – one individual, one small business, and one who is a representative of a health consumer organization. There should also be a consumer advisory committee that is fully staffed, and that meets periodically with the Board.

All audits of the Exchange, by whomever they are conducted, should be posted on the Exchange website. Similarly, any reports to the General Assembly should be available to the public along with meeting minutes and contact information for the Exchange Board.

Insurers should be required to operate transparently, as well. They should be required to make claims payment policies and practices publicly available on their websites, provide information on enrollment and disenrollment, data on the number of claims denied and denials reversed on appeal, data on rating practices, information on rights under the ACA, and other information required by HHS.

All Exchange Board members who have the option to do so should purchase their insurance through the Exchange.

F. Self-Sustaining Financing

Most states are charging user fees to insurers who list products on the Exchange. In addition, if the Exchange is performing tasks for small businesses such as handling enrollment and disenrollment, collecting premiums (including the employee share), administering COBRA, the small business should be charged a reasonable fee.

The Health Reinsurance Association (HRA) will become unnecessary once there are no longer pre-existing condition exclusions under individual plans beginning in 2014. Any funds in an account available to the HRA should be rolled into the account funding the

Exchange. Any funding that was provided to the HRA by the State should be funneled to the Exchange instead.

The Exchange should work closely with the Attorney General's Office and State's Attorney's Office to develop and implement a plan to prevent waste, fraud, and abuse, and to promote the financial integrity of the Exchange.

G. Additional Exchange Functions

The Exchange should ensure that every plan – both individual and small group – meets the cost-sharing limits of § 1302(c)(2) of the ACA. To the extent practicable, the Exchange should encourage insurers to offer both low and high deductible options.

The Exchange should develop standardized formats for offerings on the Exchange to make them easy to compare. It should be clear whether a plan is an HMO, restricting members to in-network providers and requiring a referral to a specialist, or a PPO or POS, with out-of-network benefits and no referral required. Terms like "HMO," "PPO," and "POS," as well as "in-network" and "out-of-network" should be clearly defined on the Exchange. In addition, the Exchange should develop one standardized application for insurance coverage. Further, there should be extensive testing of the Exchange, its marketing materials, the application form, and any other materials with diverse consumer focus groups, both individual and small business.

The Exchange should establish a means by which consumers can engage in in-person consultations and presentations by and about the Exchange in addition operating a website and a toll-free hotline.

The Exchange should require insurers to make an electronic provider network available so that consumers can search for their providers by name and determine in which plans their providers participate. Similarly, insurers should make their formulary available electronically so that consumers can search medications by name to determine which plan best meets their needs. In making the formulary available, if a drug is limited to certain uses or quantities, that information should be provided. No insurer should be permitted to change a provider network (unless the provider chooses to opt-out) or formulary between open enrollment periods.

The Exchange should provide a calculator on its website that will allow consumers to determine the actual cost of coverage after application of any tax credit or cost-sharing reduction.

Finally, the Exchange should follow up with all consumers who complete enrollment applications for HUSKY as well as for commercial insurance to ensure that the enrollment process was completed and the consumer is able to access benefits.

H. Additional Points

1. Governance

As set forth above, we believe that strong conflict of interest provisions are critical to the proper governance of an Exchange, and we believe the Exchange should limit the number of plans, use selective criteria in choosing those plans, and negotiate premium prices. Board members should have expertise in at least two of the following: individual

insurance, small business insurance, health plan administration, health care finance, delivery system administration, financing and administration of public programs (i.e., HUSKY) and health insurance plan purchasing. Again, we also believe that there should be consumer representatives on the Board of the Exchange.

Board members should be selected taking into consideration the cultural, ethnic and geographic diversity of the State.

The Exchange should be tax exempt and not-for-profit. If it is a quasi-government entity as proposed by all three Bills, it should allow collective bargaining, and should be required to meet all of the legal requirements applicable to employers regarding anti-discrimination, family and medical leave, worker's compensation, unemployment compensation, and other fair employment practices laws, both state and federal. Salaries should be in line with salaries for similarly situated and qualified state employees.

Finally, it should be made clear that state and federal privacy laws apply to the disclosure by the Exchange of any personally identifying health information, including utilization rates. We understand that the Exchange will be charged with disclosing to the Internal Revenue Service identifying information pertaining to exemption from the individual mandate and tax credits. However, this should not include health information tied to personal identifiers.

2. Cultural and Linguistic Competence

All written materials in any way associated with the Exchange must be made available to consumers in culturally and linguistically appropriate ways. Oral interpretation services must be provided in all languages that are primary to at least 5 percent of Connecticut residents. All insurers that offer policies on the Exchange must meet this same standard of linguistic competence.

3. Consumers with Special Needs

There should be a separate toll-free number for persons with speech and hearing impairments. A sign language interpreter should be available at all meetings of the Exchange and at all public presentations made by or for the Exchange. All written materials available through the Exchange should be made available in Braille or in audio format.

In-person presentations should be made only in locations that are fully handicapped accessible, and audio and video versions of those presentations should be made available on the internet for those who are unable to attend.

Insurers must be prohibited from discouraging enrollment of individuals with complex health needs. Any insurer who is found to have done so one to five times should be assessed a penalty; any insurer who is found to have done so as part of a policy or practice should be disenrolled from the Exchange.

4. Electronic Communication with DSS

Although this may go without saying, if an individual applies through the Exchange and is found eligible for Medicaid, HUSKY B or the Basic Health Program, the Exchange must be able to communicate this information quickly and flawlessly to the Department of Social Services (DSS). This will allow DSS to timely provide these state-subsidized benefits.

Having applied for health insurance through the Exchange, it should not be necessary to apply again through DSS for benefits which the Exchange can grant. Similarly, anyone granted Medicaid or another medical benefit through application to DSS should have this information communicated to the Exchange without having to separately apply through the Exchange, allowing the individual to readily move between insurance programs if there are income fluctuations or other changes in circumstances affecting eligibility for a subsidized program. To ensure this kind of information can be efficiently exchanged between the Exchange and DSS, it is critical that the IT systems for the Exchange and IT enhancements in the DSS eligibility system be developed in a coordinated manner, and that there are agreements in place to protect confidentiality of personal data and protected health information.

5. Due Process Rights

Denials of any state-subsidized assistance by the Exchange implicate due process rights. Explicit federal statutory and regulatory provisions require written notice and the right to a hearing whenever Medicaid, HUSKY B or premium tax credit assistance is denied by the Exchange or provided in a lesser amount than claimed, and the federal statutory right to the Basic Health Program, if it is adopted by Connecticut as we urge, implicates the same rights.

Under the terms of the ACA, any application through the Exchange, under the "no wrong door" policy, must be automatically deemed an application for Medicaid, so if Medicaid is not provided, because the person is found to be eligible for some other state-subsidized benefit or not eligible for any state-subsidized benefit, a written notice must be issued by the Exchange. Since a notice has to be issued anyway, the goal is to streamline the notices so they address eligibility and non-eligibility for all the various programs covered by the Exchange all at once, minimizing the administrative costs of complying with constitutionally and statutorily required due process requirements. There also is a right to a hearing for any of these denials which are appealed, but those hearings can be held elsewhere, e.g., all Medicaid or HUSKY B appeals can be heard by DSS hearing officers, just as they are now when the denial notice is issued by DSS. If a central appeals panel for appeals from various state agencies is in place by then, as provided per pending legislation, the hearings could be heard by that entity instead.

A fair amount of planning should go into the development of the notice systems and the hearing referral systems, so as to serve the goal of efficiency in complying with these federal due process requirements. With sufficient planning time, we can ensure that only one notice has to go out for each applicant, substantially reducing the costs of such compliance.

6. Dental

The Exchange should ensure that there is at least one qualified dental plan available to supplement medical coverage. This dental plan must be qualified, i.e., it must include essential pediatric benefits unless pediatric dental benefits are otherwise available. Insurers may join to offer a health and dental plan jointly as long as the two plans are priced separately and offered for purchase separately.

7. Monitoring and Evaluation

A robust monitoring and evaluation plan is critical to the success of Connecticut's Exchange and to guard against adverse selection. Sufficient resources, time and attention must be devoted to ensuring that the Exchange is meeting the needs of consumers and small businesses as well as to ensure fair, competitive markets. The Exchange's monitoring plan must adapt over time to changing markets, changes in health care delivery and payment systems, and to new areas of concern as they are identified.

At a minimum, monitoring must include assessments of provider panel capacity between plans inside and outside the Exchange, ensuring effective access to care, including secret shopper surveys. It is critical that provider panels not contribute to adverse selection. For example if providers of care to people with expensive conditions are disproportionately included in Exchange plans they will attract higher cost patients and premiums within the Exchange will rise faster than outside. Risk adjustment methodologies for services and care management must be monitored to ensure that no incentive exists to avoid more costly patients.

Marketing practices and benefit design will require robust monitoring – both baseline, proactive monitoring and approval of activities, as well as mechanisms to identify and react to abuses. State approved marketing activities in the HUSKY program have been highly questionable, including free ice cream and haircuts to join one HMO. It is critical that competition between plans be based on providing appropriate care and marketing must reflect that.

Monitoring of benefit design is also critical. Cash rewards, gym memberships, mail order pharmacy options, weight loss and smoking cessation benefits offered only inside or outside the Exchange are some of the many ways that plans could steer patients to benefit their bottom line and undermine the viability of the Exchange. Value-based insurance design strategies, while laudable in moving the health care system toward quality-based purchasing, could be used to steer patients as well. For example, removing copays for medications to lower blood pressure has had impressive results in improving medication compliance. However, selectively removing copays for treatments for costly conditions only inside the Exchange could serve to drive those patients into the Exchange, differentially raising premiums.

8. Miscellaneous

In conducting our research, we came across several other provisions that we urge you to consider:

- a. There should be no fee or penalty assessed if an individual terminates insurance through the Exchange because he or she became eligible for employer-sponsored insurance.
- b. The Exchange should collect consumer evaluations, including but not limited to member satisfaction surveys and the use of "secret shoppers."
- c. The Exchange should establish uniform billing and payment policies for Qualified Health Plans.

- d. Insurers should be required to submit notice and justification of premium increases before the increase takes effect, with ample opportunity for consumers to participate in a public hearing on the rate increase.
- e. The Exchange should adopt and implement a quality improvement plan that provides incentives for improving health outcomes, preventing hospital readmissions, improving patient safety, reducing medical errors, and implementing wellness initiatives.
- f. The Exchange will be required to transmit a significant amount of information related to tax credits and exemptions from the individual mandate. In so doing, the Exchange should be required to make every effort to protect the confidentiality of consumers.
- g. The Exchange should develop a complaint process whereby consumers (both individuals and small businesses) may file complaints about and against the Exchange, as well as about Navigators and plans listed on the Exchange.
- h. Not only should the Exchange have a mechanism for coordination and information-sharing with DSS and the Insurance Department, but the Department of Corrections should interact with the Exchange to ensure that released inmates enroll in a plan through the Exchange within 30 days of release.

I. Conclusion

Again, we appreciate the opportunity to meet with you to discuss these critical issues, and to provide input, as the federal law contemplates. We trust that this will be the first of many meetings about the Exchange and other reform-related issues as to which consumers should have input, not only pursuant to federal law, but to ensure the smooth operation of reform implementation, as to which consumers are integral.

Respectfully submitted,

Ellen Andrews
Connecticut Health Policy Project

Jane McNichol
Legal Assistance Resource Center of Connecticut

Sheldon Toubman
New Haven Legal Assistance

Shirley Bergert
Connecticut Legal Services

Jose Ortiz
Hispanic Health Council

Jill Zorn
Universal Health Care Foundation of Connecticut

Ms. Tia Cintron
April 18, 2011
Page 11 of 11

Alicia Woodsby
National Alliance for Mental Illness, CT (NAMI-CT)

Domenique S. Thornton
Mental Health Association of Connecticut, Inc.

Jennifer Carroll
Connecticut Family Support Network

Mary Alice Lee
Connecticut Voices for Children

Susan Raimondo
National Multiple Sclerosis Society, Connecticut Chapter

Jennifer C. Jaff
Advocacy for Patients with Chronic Illness, Inc.

Cc: Victoria Veltri
Healthcare Advocate

Teresa Younger
Permanent Commission on the Status of Women