

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 initial creation of a state based exchange allows CT to exercise control over eligibility, enrollment; insurer participation is preferable. Over time consider merging with other state and local government employee coverage to effectively expand the size of the risk pool. Additionally, it is generally recognized that a multi-state exchange is potentially problematic because protections/rights available to the insured in one state might not be available under the laws of another state even though a multi-state approach might be cheaper by pooling resources. For nurses, a multi-state approach could be especially problematic for two reasons. First, a number of states license individual nurses through what is called the "nursing compact." (Connecticut is not presently a compact state, but nearby states are, e.g., NH.) This allows for nurses licensed in one state to work in other states without being individually licensed in those states. Second, irrespective of whether states are or are not members of a compact,

many nurses (especially those living along the state's borders) are licensed in adjoining states. Potentially, in both these scenarios, it could mean certain insurance coverage might be unavailable to a nurse covered by a CT (or multi-state) exchange insurance who is injured or becomes ill while working "out of state." It isn't clear at this time whether such problems are likely to occur.

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.

Important concern is the size of the risk pool and its effect on prices. We believe nurses would benefit by having access to insurance coverage through either individual or small group policies. Many nurses are involved in entrepreneurial enterprises individually or in small groups. Having access to either individual or small group policies provides needed flexibility for these individuals. Nurses working in larger facilities such as hospitals are likely to already be covered by employee health policies. For this reason, we favor Connecticut jointly administering the two policy categories. Relative to the benefit of maintaining separate risk pools, the important concern here is the size of the risk pool and its impact on prices.

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?

The smaller the number of employees in a business the greater the financial burden of providing health care coverage. Small businesses do not have the buying power larger employee-based businesses have with pricing of health care coverage. So if costs are a concern to businesses with 100 or less employees, it would be advantageous to phase in smaller numbers followed by larger numbers. Then phase in larger employers.

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

Yes or sooner if possible. However, we believe that implementing the insurance exchange process should be done carefully and at a pace that will prevent major problems for individuals and businesses.

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?

Hybrids give consumers greater choice and protection. We favor a requirement that all individual insurance be provided through the Exchange because we feel this offers the best chance for a smooth, efficient process, clear oversight measures, and the least chance for problems or errors for the individual.

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

It is essential that the Exchange create mechanisms that ensure that those selling the plans provide accurate information in a user-friendly format to fairly market the plans.

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

Any proposal needs to recognize the imbalance that can occur with low risk versus high risk enrollees. We support a three-year temporary reinsurance program that would offer some additional protections for both insured individuals and insurers.

C. Simplify Health Insurance Purchase

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

Nurses are already familiar with the operation, benefits, and processes of Navigator programs as nurses have historically been involved in helping patients and families maneuver through the health care system for care of both acute and chronic conditions such as heart failure, cancer, and diabetes. We believe a Navigator program to assist and simplify health insurance purchases through the Exchanges will benefit everyone. If done well, it could reduce total costs, improve public acceptance of the Exchanges, and make individuals happier about the type and extent of their health care coverage. Nurses may be a group that Connecticut would want to consult with about setting up a Navigator program. Nurses have expertise in helping people weave through the complexities of the healthcare system and how to gain access to needed resources. Simplifying the process in such situations is our main goal.

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

Insurance agents and brokers will have a role in the development of insurance Exchanges. However, to prevent later problems, it seems prudent to set out clear rules for their participation ahead of program implementation. We are concerned that, either through mis-information or outright manipulation, agents and brokers might take

courses of action that circumvent the goals of the Exchange program or harm individuals by providing erroneous advice about the insurance coverage available through the Exchange. The development of policies designed to reduce the risk of brokers steering purchasers to plans outside the Exchange are important 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?**

It seems acceptable to allow any plan that meets Qualified Health Plan standards to be available. However, in the long-term interests of the health of Connecticut citizens, adding some specific requirements for wellness programs or activities for which a premium offset might be considered seems a desirable requirement. It is important to assure the inclusion of preventive services with no additional out of pocket charges to consumers and incentivizing practitioners regarding chronic disease prevention. The long-term total costs of care could be dramatically reduced by having such programs. Insurers in the health insurance Exchange should 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.

- 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?**

Make the plans convenient and easy to understand. Have information available that is clear to understand other programs as well (example: Medicaid programs). This will facilitate transitions between the Exchange and other programs, effectively 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.

4. How can Connecticut structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (Eg. as a person moves from Medicaid, subsidized and non-subsidized markets)

Achieving a seamless transition between CT's exchanges and public and private markets should require an overlapping transition period to assure that coverage doesn't lapse. There are likely a number of ways in which this could be accomplished.

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 will be essential to have clearly written materials and trained outreach staff that explain the plans and how they integrate with other plans e.g. Medicaid. Materials need to clearly state eligibility requirements, what is covered and how to apply, where to call for more information, web site etc. Pamphlets or brochures could be made available through health care providers (e.g., hospitals, school nurses, physician offices, etc.) and social service agencies for distribution to interested and qualified parties. Public service announcements on television and radio could be highly effective ways to get the word out about the Exchanges.

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

Patient satisfaction surveys, ongoing reporting of enrollment data etc., other survey methodologies could be used to determine people's views about accountability, operations, and for them to submit suggestions for improvements. These could be done at the end of the first year of operations and then periodically (e.g., every six months) after that. (A first year survey will likely reveal glitches and problems that hopefully can be quickly corrected. Subsequent follow-up surveys would then be a better gauge of how the Exchange is functioning).

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?

From the perspective of nurses who care for the entire spectrum of patients and in all practice settings within the state, the more transparency the better. While we appreciate insurance companies' wish to keep their proprietary information private, doing so in other circumstances has led to abuses. We therefore urge that the

Exchange program strive to achieve maximum transparency in its processes, data, and operations.

F. Self-Sustaining Financing

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

Financing the exchange after 2015 should spread the costs over as many parties as possible: the insurers, the state, and contractors.

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?

Stress health promotion/screening strategies consider rewards for best practices, . accountability measures, etc. Community health centers have this in place through audits, reporting mechanisms etc. Just as with any government program, the Exchanges will be subject to considerable political pressures. To achieve success, the program should exert close oversight (both to prevent problems and to minimize costs) and share information about changes with the public and the legislature in as transparent a way as possible. Summary reports distributed on a periodic basis (e.g., every three months) would keep people informed, demonstrate responsibility and accountability, and maximize cost-effectiveness. These factors, if achieved, would provide the exchange program with credibility that will encourage people to participate.

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?

Two factors that should be addressed in any discussion of additional benefits (i.e., above the minimum essential benefits) are: expenditures for catastrophic care and "end of life" care. Studies in the healthcare literature consistently show that these two circumstances are the outliers in providing well-reasoned budget planning for health insurance plans. Planning for the Exchanges should address how catastrophic and end of life expenditures will impact the success of the Exchange.

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?

As we mentioned in our response to question F.3., one additional function of the Exchange could be to plan for and deal with catastrophic and end of life expenses for those insured by the Exchanges. Should another mechanism be found for dealing with

those costs? Should the Exchange serve as a liaison to hospice and palliative care services/facilities for such patients? Without some mechanism for dealing with these situations, the operational costs for the Exchange could spin out of control. In this regard, serving a liaison function could provide patients a more appropriate level of care at a lower cost and thus maintain the integrity of the Exchange program. This task could be tied to the Navigator functions of the Exchange. For more specific functions that should be considered in the Exchange, early diagnostic and prevention measures are critical. Two examples would be GI for Colonoscopy, GYN for Colposcopy when pap smears are abnormal.

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 number of insurers in the Exchange should be limited. Limits on the number of insurance providers would ensure better services, more program efficiency, and the lowest costs. Participation in the program should be something companies want to aspire to, not something to which they feel entitled. This will make for a stronger marketplace.

3. Should Connecticut consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating)

With regard to employer participation in the Exchange, it would seem beneficial to at least provide guidelines to which employers will be expected to adhere. Setting an example rather than putting in place rigid conditions or rules will benefit the Exchange program in the long run. For employers, this approach will provide them greater flexibility than they might experience with a heavy-handed approach, which could facilitate their willingness to become participants in the Exchange.

4. What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?

Keep expense reasonable. It might be worthwhile to consider offering employers an incentive for achieving broad coverage of the employees, reducing costs, and offering more than minimum coverage. For example, at the end of the year, they could get back 0.5-1% of the demonstrated savings as a “reward.” This “carrot” rather than “stick” approach allows for everyone to win: the employee, the employer, the Exchange program, and CT taxpayers.

5. What should be the role of the Exchange in premium collection and billing?

The goal here is the efficient use of resources in billing/collections while controlling costs. It may be premature to determine now how the Exchange might implement

premium collections and billings. However, we advocate for flexibility. That is, there ought to be several options available (e.g., paying “up front,” quarterly or semi-annual payments, employer deductions, monthly vouchers or billings). The accountability for the billing and collection functions will accrue to the Exchange, whether or not a decision is made to outsource these services.

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

Reporting expenses, audits, data collection and reporting of enrollment outcomes etc.

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