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?**

   A state-based Exchange will ensure that the Exchange is responsive to characteristics unique to Connecticut, including the specific dynamics of the individual and small group markets and the structure of public programs. Because insurance is regulated on a state level, an Exchange will generally be more flexible if it operates under the laws of a single state instead of a multiple states. Conflicting state regulations and statutes may make any kind of regional regulatory harmonization difficult to implement and maintain.

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.**

   Connecticut may wish to share Exchange information technology infrastructure for the individual and small group Exchanges to achieve administrative efficiencies, but the Exchanges and markets should remain separate for rating purposes. The individual market generally has a higher risk profile than the small group market, presenting a greater potential for adverse risk

selection and inherently higher administrative costs for individual coverage compared to small group coverage. Small groups have different eligibility, enrollment, and general administration needs than individuals, and employers with more than 20 employees generally require a different type of customer support service. A likely result of combining the two markets would be to increase the rates for small groups, which could destabilize the small group market.

Maintaining separate risk pools also has the potential to encourage a full spectrum of participating health plans that have core competencies in dealing with the distinctly different Exchange populations.

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?

   We believe that Connecticut should select 50 employees as the initial size limit for the small group market. The 51+ employer group market is already very competitive and enjoys significant market leverage. Groups over 50 employees typically have the option to self-insure their benefits, and it is reasonable to expect that the lowest cost groups would opt to self-insure and the highest cost groups would find the community rates within the Exchange to be most attractive, making products within the Exchange increasingly more expensive for those small groups electing coverage. Limiting the small group market to groups with fewer than 50 employees will also minimize market disruption and avoid overtaxing the Exchange's administrative systems as it gets up and running.

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

   We do not believe that the Exchanges should be expanded to large employers with more than 100 employees. Large employers generally enjoy market leverage and economies of scale that permit them to select and enroll in high quality private health plans for their employees at competitive prices. Further, large employers are generally either self-funded or fully experience rated (meaning that their insurance rates are based largely on their actual costs). Making large employers eligible for the Exchange increases the potential for adverse selection within the Exchange, since only the highest cost large employers can be expected to find the adjusted community rates within the Exchange to be attractive relative to their other marketplace options.

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?

   Preserving a market outside the Exchanges is not only beneficial for consumers, but is also supported by the express language of the Patient Protection and Affordable Care Act (PPACA). Specifically, Section 1312 of the law outlines clear Congressional intent that

consumers should be empowered to enroll or select a plan outside of an Exchange, and that Exchanges should be voluntary. Exchanges should supplement, but not replace, the existing small group and individual markets. We believe that eliminating the external individual market would reduce competition, stifle innovation and lessen the ability of consumers to purchase insurance plans designed to fit their specific needs.

The provisions in the PPACA that protect against adverse selection tend to make the adoption of additional rules unnecessary. Specifically, requiring that all of the same rules apply to plans sold inside and outside the Exchange or requiring that the same plans be sold inside and outside the Exchange without exception would likely serve to reduce consumer choice and competition. For example, some licensed health plans may not meet the requirements to become qualified health plans (QHPs). A rule that these plans must meet the QHP requirements to compete in the outside market could theoretically exclude them from competing in the state. Regarding plan design requirements, we believe that Exchanges should promote innovation and increase consumer choice. If a state does impose any design restrictions on Exchange plans, these same limits should not apply in the outside market.

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

PPACA already provides a number of mechanisms to mitigate adverse selection against an Exchange. This includes the equal application of health care reform requirements to insurers operating inside as well as outside the Exchange, including:

- Adjusted community rating rules (adjusted only by age, tobacco use, geography, and family status)
- Individual and small group plans must cover the same essential health benefits
- Limits on individual out-of-pocket cost-sharing limits
- Treating all individuals as part of one risk pool (same for small group enrollees)
- Charging the same premium rates for a plan offered inside and outside the Exchange
- The operation of the risk adjustment and reinsurance programs

Perhaps the most significant protection against adverse selection against the Exchange is the fact that federal subsidies are only available through the Exchange.
Ultimately, the viability of the non-group market will be highly dependent on the development of open enrollment rules, inside and outside the Exchange, that encourage consumers to obtain and maintain continuous coverage.

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

We believe that the framework for a risk adjustment methodology for Exchanges should be established at the national level to ensure uniform standards and promote efficiency and consistency. The American Academy of Actuaries should be consulted for its recommendations on federal standards for risk adjustment, reinsurance, and risk corridor mechanisms.

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?

   Exchanges should enhance competition, promote ongoing innovation, and increase consumer choice. To best achieve these goals, we believe that all qualified health plans should be permitted to participate in the Exchange. Participating health plans should be encouraged to differentiate their plan offerings to appeal to a wide variety of consumers with different needs and preferences, while remaining consistent with federal standards regarding specified actuarial values. For example, at a particular actuarial plan value (e.g., Silver), some consumers might wish to purchase a high deductible health plan that would be compatible with a health savings account, while others may prefer a plan that offers more first-dollar coverage of pharmacy benefits and lower deductibles.

   Connecticut should avoid excessive, burdensome requirements for becoming a Qualified Health Plan (QHP) that do not help demonstrate the basic goals of solvency, quality and efficiency.

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?

   We believe that it would be prudent for Connecticut to thoroughly evaluate the Basic Health Plan (BHP) option, including the extent to which it would benefit consumers as well as the impact it would have on the Exchange. This will be an important decision to make early in the process, as it will impact the planning and construct of the Exchange.

   Recent reports from Health Affairs, Urban Institute, and Kaiser Family Foundation indicate that, nationally, the majority of purchasers on the Exchange will be highly subsidized, lower income, ethnically diverse and may closely resemble Medicaid consumers. It will be important to evaluate these findings in relation to Connecticut to determine the number of Exchange eligible consumers, their demographic characteristics, those between 133-200% FPL and the extent to which their incomes may fluctuate above and below eligibility levels. Further, in the absence of continuity of care policies (e.g. continuous periods of eligibility) there will be considerable movement between Medicaid and the Exchange as incomes fluctuate. These will be key factors as the State considers the BHP option.

   Connecticut would receive 95% of the subsidies and cost sharing that a BHP eligible consumer would have otherwise received on the Exchange. The State would be responsible for administering the program, contracting with Standard Health Plans and must use any savings to lower consumer premiums, cost sharing and/or increase benefits. Key economic considerations and indicators may include:

   - What formula will the federal government use to calculate the 95% subsidy?
   - To what extent may the state use Federal dollars for program administration?
   - To what extent can the state leverage its existing Medicaid infrastructure to administer the program and gain subsequent cost savings?
   - To what extent may federal funds and planning grants be used to implement the BHP?
   - Will Federal funding be adequate to cover projected plan costs? Will Federal funding exceed projected plan costs?

- To what extent will removal of the BHP-eligible population impact the success of the Exchange?
- Will the risk adjustment, reinsurance and risk corridor provisions in PPACA apply to the BHP?

Most significantly, Connecticut should evaluate the BHP from a consumer and public policy perspective to answer the following questions:

- Will a BHP provide better value to consumers than the subsidized benefit offerings available on the Exchange?
- Can the BHP act as is a vehicle to help individual consumers and families stay with the same provider as their income fluctuates?
- Will there be other Exchange product offerings and/or policies that will help to promote continuity of care for individuals and families?
- Will consumers be more or less likely to enroll in the BHP or the Exchange?

Consumers should be afforded the same level of protection whether in a BHP or in an Exchange plan. Should the State pursue the BHP option, participating plans should be required to be certified as a "Standard Health Plan", with a level playing field for all plans seeking certification and participation requirements similar to those required for Qualified Health Plans in the Exchange.

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)

Ensuring continuity of care and coverage in a reformed health care environment is critical. Private payers are well suited to design programs to help ensure continuity of care and healthy outcomes for consumers, whether they are in a private or publicly funded delivery model. We encourage an analysis to determine what, if any, continuity issues may exist in a reformed marketplace. Depending upon results of any analysis, a dialogue should take place between regulators and health insurers to determine if collaborative solutions exist or can be developed as needed.

E. Ensure Greater Accountability and Transparency

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?

We believe that Connecticut's Exchange should leverage existing state regulatory functions to the extent possible and avoid imposing unnecessary and excessive new regulatory burdens on health plans seeking to operate inside or outside of the Exchange. The Exchange should strive to ensure that all new requirements for the submission of information from health plans are restricted to that data which is necessary for the implementation and effective operations of the Exchange. In addition, Connecticut should strive to follow national standards for data components, particularly in areas in which state-by-state variation would add cost and complexity without adding incremental value, such as risk adjustment mechanisms, quality standards, and data standards for common transactions, including eligibility and enrollment.

F. Self-Sustaining Financing

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

As governing boards develop financial plans to meet the requirement that Exchanges be self-supporting by 2015, we believe that states should consider the imposition of user fees for those purchasing coverage through the Exchange, similar to the fees successfully established by other state Exchanges to support their ongoing operations. If other assessments are considered to support the Exchange, we believe they should be broad-based and levied on all health care industry participants who benefit from the Exchange, including providers, health plans, employers, agencies and other constituencies.

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?

The Patient Protection and Affordable Care Act (PPACA) requires that states mandating the coverage of certain benefits above what is federally required in 2014 reimburse the Exchange plans (or their enrollees, as applicable) for the additional costs associated with those benefits. Connecticut will need to pay these costs, so mandating additional benefits beyond the essential benefits package will need to be considered along with the State's other spending priorities.

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

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?

Exchanges should enhance competition, promote ongoing innovation, and increase consumer choice. To best achieve these goals, we believe that all qualified health plans should be permitted to participate in the Exchange.

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)?

Generally, we believe that some form of participation requirement makes sense for employer groups within the Exchange to assure a balanced risk pool. Requiring all employees of an employer within the SHOP Exchange to purchase from within one actuarial level also helps to keep costs down by mitigating adverse selection.

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

In Connecticut today, small employers already have a wide variety of choice among health plans and plan designs in a guaranteed issue environment. Maintaining a similar level of choice and competition will be critical to attracting small business employers to the Exchange. In addition, Connecticut should consider offering services that are designed to ease the administrative burden of small business employers, and carefully evaluate the potential effects of well-intentioned Exchange regulations that could ultimately result in increased prices and destabilization in the small business market.