

## CONNECTICUT HEALTH INSURANCE EXCHANGE PLANNING GRANT STAKEHOLDER MEETING HEALTH CARE PROVIDERS

**DATE:** May 13, 2011 and May 16, 2011

**LOCATION:** Office of Policy and Management, 450 Capitol Avenue

### INVITED TO ATTEND:

Connecticut State Medical Society  
Connecticut State Medical Society IPA  
Connecticut Medical Management  
Connecticut Nurses Association  
Connecticut Dental Association  
Connecticut Pharmacists Association  
Community Health Care Association of Connecticut  
Connecticut Association of Health Care Facilities  
Connecticut Hospital Association  
Connecticut Association of Not-for-Profit Providers  
Radiological Society of Connecticut  
Connecticut Alliance of Sub-Acute Care Facilities  
Sharon Hospital  
Connecticut Academy of Physician Assistants  
Community Health Resources (Behavioral Health)  
Harbor Health Services (Behavioral Health)  
Connecticut Naturopathic Physicians Association  
Connecticut Podiatric Medical Association  
Connecticut Association of Optometrists  
Connecticut Dental Hygienists Association  
Connecticut Chiropractic Association  
Connecticut Society for Respiratory Care  
Community Health Center  
Connecticut Dietetic Association  
Connecticut Community Providers Association

### MEETING ATTENDEES:

Kathy Grimaud, CEO, Community Health & Wellness Center of Greater Torrington  
Thomas J. McLarney, Medical Director, East Hartford Community HealthCare, Inc.  
Carole Bergeron, Executive Director, CNA  
David S. Katz, President, CSMS  
Ken Ferrucci, Vice President, Public Policy and Government Affairs, CSMS  
Ken Lalime, Executive Director, CSMS-IPA  
Ashley Pliszka, Intern, CHCACT  
Ellen Zappo, Director of Marketing and Communications, CPA  
Jim Williams, Assistant Executive Director, CSDA  
Peter Peterson, DMD, Board of Governors, CSDA  
Linda Erlanger, Advocacy Consultant, COHI  
Evelyn Barnum, CEO, CHCACT  
Leo A. LeBel, President Elect, CAN  
Mag Morelli, President, CANPFA  
Gale Mayeran, HR Director, Southington Care Center

## MEETING ATTENDEES:

Michael Thompson, Executive Director, CT Academy of PAs  
Drew Morten, Past President, CT Academy of PAs  
Cindy Lord, Past President, Legislative Committee, Liaison to Health Care Coalition of CT, CT Academy of PAs  
Stephen Frayne, Senior Vice President, Healthy Policy, CHA  
Roberta Cook, Board Member, CCPA/HHS  
Heather Gates, Board Member, CCPA/CHR  
Matthew V. Barrett, Executive Vice President, CAHCF  
David Houle, Executive Vice President, CFO, Hebrew Health Care, Inc.  
Russell Schwartz, Vice President, Avon Health Center and West Hartford Health & Rehab Center  
Jennifer Jackson, CEO, CHA  
Terry Edelstein, CEO, CCPA  
Teresa Dotson, Public Policy Coordinator, CDA  
Ed Pinn, OD, Managed Care Chairman, CAO  
Francis Vesce, DC, First Vice President, CCA  
Matt Vinikas, Site Director, Meriden, CHC, Inc.  
Gina Carucci, President, CCA  
Jerry Hardison, OD, CAO  
Bryan Lynch, OD, CAO  
David B. Daiura, DC, ACA Delegate, Insurance Committee Chair, CCA  
David Boomer, Consultant, The Kowalski Group  
Ann Aresco, ND, CNPA  
Margaret Flinter, Senior Vice President, Clinical Director, Community Health Center, Inc.  
Daniel Davis, DPM, Insurance Representative, CPMA, APMA

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### Background

The public engagement plan for Connecticut (the State) in planning for an Insurance Exchange consists of public forums held throughout the State as well as stakeholder meetings organized by professional group category. Over 85 organizations were invited to attend a stakeholder meeting to discuss Exchange topics such as structure, operations, market reforms, accountability, transparency, and sustainability. Questions were sent to each organization prior to their meeting. The feedback the State received from these questions was used as the framework for the discussion. Meetings were conducted by a neutral facilitator and recorded/transcribed. This document reflects an integration of initial written comments from the invited organizations listed above, as well as discussion from the meeting. It is intended as a summarized snapshot of the initial perspective(s) of the groups that participated. **It is not intended to represent final thoughts or positions.**

ESTABLISH A RESPONSIVE AND EFFICIENT STRUCTURE	
<b>Should Connecticut consider joining a multi-state Exchange?</b>	
<b>Worth looking into.</b>	<ul style="list-style-type: none"> <li>• Look at other states, especially Massachusetts, in deciding</li> <li>• Consider what you can do with the strength within your state and try to build from there</li> <li>• Pros include spreading administrative costs; larger provider networks; increased choice and flexibility               <ul style="list-style-type: none"> <li>– Could help in arranging coverage across state lines</li> <li>– Could be beneficial to increase risk pool</li> </ul> </li> <li>• Cons include limiting state authority; patient protections in Connecticut; unique understanding of the issues facing our state               <ul style="list-style-type: none"> <li>– May be wide variations in medical cost index</li> <li>– With multiple states and regional is its lowest common denominator</li> </ul> </li> </ul>
<b>Consider provider licensing issues.</b>	<ul style="list-style-type: none"> <li>• Connecticut is not yet part of the Nursing Compact – for nurses from one state to have licensure in another state more easily</li> <li>• There could be issues for patients of Naturopathic Physicians as not all states license NDs</li> </ul>
<b>Consider just merging administrative functions.</b>	<ul style="list-style-type: none"> <li>• Consider still having different plans that would be available but one exchange handling all of them</li> </ul>
<b>Learn from other states.</b>	<ul style="list-style-type: none"> <li>• Connecticut lags behind the other states when it comes to how we use data and how we have advanced actual delivery of healthcare, therefore, Connecticut might benefit disproportionately by being in a joint Exchange</li> </ul>
<b>Should CT administer the individual and small group markets separately or jointly?</b>	
<b>Jointly, with a single risk pool.</b>	<ul style="list-style-type: none"> <li>• Small group market may have different issues than the individual market</li> <li>• An employer's assistance needs may be different than the individual</li> <li>• May be more efficient/cost effective to merge the risk pools</li> <li>• The economy of scale is a good idea</li> </ul>
<b>What employer size should Connecticut allow into the Exchange?</b>	
<b>Up to 100, as early as 2014.</b>	<ul style="list-style-type: none"> <li>• Many of the provider groups are small employers with over 50 employees and expressed interest in participating in the Exchange</li> <li>• Even if there is a year difference between launching the two to 50 versus the 51 to 100, there is an opportunity to address issues with less people in the entire Exchange allowing the transition to possibly go smoother</li> <li>• It is going to be harder to enroll the smaller groups; the bigger the group the more resources they will have on hand to facilitate the process, therefore, sticking to the small groups is not necessarily going to be easier</li> </ul>
<b>Consider expanding past 100.</b>	<ul style="list-style-type: none"> <li>• Most FQHCs are over 100 and may want to participate</li> <li>• Most health providers have more than 100</li> </ul>
ADDRESS ADVERSE SELECTION AND THE EXTERNAL MARKET	
<b>Should CT allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange?</b>	
<b>Need more information.</b>	<ul style="list-style-type: none"> <li>• Hopefully this will get addressed by people who understand the financing behind the healthcare market as opposed to preference from a consumer perspective</li> <li>• Need more information about the different populations that will be affected</li> </ul>
<b>Jointly.</b>	<ul style="list-style-type: none"> <li>• Simplicity</li> <li>• Choice</li> <li>• Efficiencies</li> </ul>

	<ul style="list-style-type: none"> <li>• Economies of scale</li> <li>• Key concern is size of risk pool</li> </ul>
<b>Should CT implement any additional mechanisms to mitigate adverse selection?</b>	
<b>Require consistency of plans in and out of Exchange.</b>	<ul style="list-style-type: none"> <li>• Require that all insurers offering insurance in the state also participate and offer a plan through the Exchange</li> <li>• Prohibit brokers from collecting higher commissions for plans sold outside the Exchange</li> <li>• Prohibit insurers from: establishing separate affiliates to sell only outside the Exchange, from selling only low-level or catastrophic coverage outside the Exchange, and/or using marketing practices or benefit structures to attract healthy applicants to plans outside the Exchange</li> <li>• Consider the German approach which mandates all individual insurance is subject to risk adjustment with an exchange of funds</li> </ul>
<b>Plan for refinement of system.</b>	<ul style="list-style-type: none"> <li>• Flexibility and frequent refinement will be an important part of any risk adjustment process</li> <li>• Define time frames regarding flexibility and refinement in order to avoid being left with a broken system</li> </ul>
<b>Ongoing monitoring.</b>	<ul style="list-style-type: none"> <li>• Monitor grandfathered plans to make sure that they are not 'lemon dropping' or encouraging high-cost enrollees to move to the Exchange by stressing that more coverage or care could be provided in Exchange</li> </ul>
<b>Make information available.</b>	<ul style="list-style-type: none"> <li>• Transparency among data and outcomes information</li> <li>• Information is important when buying insurance, such as understanding what factors into the premium/rating</li> <li>• It is difficult to be on the buying side; to have only partial data and not be certain what is credible</li> </ul>

<b>SIMPLIFY HEALTH INSURANCE PURCHASE</b>	
<b>What issues should Connecticut consider in establishing a Navigator program?</b>	
<b>The importance of this function.</b>	<ul style="list-style-type: none"> <li>• Very important to create access</li> <li>• People are totally confused with Medicaid and they are going to be totally confused with <i>this</i></li> <li>• If people are too confused they will not engage in the Exchange, they will just wait to have it forced on them</li> </ul>
<b>Grassroots and broad-based.</b>	<ul style="list-style-type: none"> <li>• Not insurance brokers, but educators, grassroots</li> <li>• Use existing infrastructure at DSS</li> <li>• Engage assistance of organizations that have already been high achievers in outreach and education</li> </ul>
<b>Role of the provider.</b>	<ul style="list-style-type: none"> <li>• Access to Care Workers at CHCs may be similar</li> <li>• Nurses are already familiar with the operation, benefits, and processes of Navigator programs</li> <li>• Providers have to know so much about insurance these days, for example, one brings an outreach worker with them to meet with clients</li> <li>• Providers can play a role as long as they are providing neutral information; maybe they are not Navigators but they have a role</li> <li>• When Medicare D was put into place a lot of the pharmacists were able to help patients navigate which plan would be best by simply inserting all of their meds into a program and identifying the best plan</li> </ul>
<b>Consistent education and training.</b>	<ul style="list-style-type: none"> <li>• Clarity of communications</li> <li>• Having different groups with different educational roles confuses the public/consumers</li> </ul>

	<ul style="list-style-type: none"> <li>• Certification program for the Navigator</li> <li>• Lessons from Medicare part D – uniform education across all different populations/groups is critical</li> </ul>
<b>Linguistically and culturally appropriate.</b>	<ul style="list-style-type: none"> <li>• Cultural diversity in CT</li> <li>• Cultural diversity of the physician/healthcare professionals</li> <li>• How patients are educated on health literacy issues</li> <li>• Provide information that is linguistically and culturally appropriate</li> </ul>
<b>Knowledgeable about benefits.</b>	<ul style="list-style-type: none"> <li>• Looking at their life situation and knowing how to direct them to the best product without a conflict of interest</li> <li>• Be able to advise on all options in the Exchange, including medical, dental, behavioral health, registered dietician, naturopathy, chiropractic, etc.</li> </ul>
<b>What should Connecticut consider regarding the role of insurance brokers and agents?</b>	
<b>Importance of their role for small employers.</b>	<ul style="list-style-type: none"> <li>• Traditionally brokers have provided the level of education and information necessary in making informed decisions and choices on health care. They fill a role of educating and advising employers on health insurance and other aspects of the human resource benefit package, may know the business entity, field of business, benefit trends in the industry, and also assist in the other aspects of employee transitions such as enrollment process, ERISA, etc.</li> <li>• Key role in assisting small employers in understanding Exchange</li> <li>• Establish a partnership</li> </ul>
<b>Develop policies to address concerns.</b>	<ul style="list-style-type: none"> <li>• Concern is over “selling” to people versus encouraging proper coverage</li> <li>• Having policies in order to mitigate the risk of brokers steering purchasers to plans outside the Exchange is critical</li> <li>• Set out clear rules for their participation ahead of program implementation</li> </ul>
<b>Differences between Navigator and Broker.</b>	<ul style="list-style-type: none"> <li>• Compare what Navigators do for individuals and what brokers do for small business</li> <li>• Navigators may have more focus on health issues compared to brokers who do more cost and benefit comparison</li> </ul>

<b>INCREASE ACCESS TO AND PORTABILITY OF HIGH QUALITY HEALTH INSURANCE</b>	
<b>Should CT allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should CT establish additional requirements? If additional requirements, what would you recommend? What would be impact of those requirements?</b>	
<b>Concern about cost.</b>	<ul style="list-style-type: none"> <li>• Concern about increasing cost by mandating a lot of benefits</li> </ul>
<b>Choice is good</b>	<ul style="list-style-type: none"> <li>• Generally speaking, more choice is going to be valuable</li> <li>• It might be tough to understand in the beginning, but eventually it will be better for the consumer</li> <li>• All plans that meet QHP standards would allow greater choice – Navigators will assist people in comparing information</li> <li>• Competition is always good and will keep the cost down</li> </ul>
<b>Choice can be confusing.</b>	<ul style="list-style-type: none"> <li>• Too many offerings would be confusing</li> <li>• With Medicare Part D, not only were there a lot of choices, but each choice appeared to be intrinsically very difficult to understand</li> <li>• Consider if we can extract any lessons from Medicare Part D as far as making it a simple process but still offering a number of plan choices</li> </ul>

INCREASE ACCESS TO AND PORTABILITY OF HIGH QUALITY HEALTH INSURANCE	
<b>Keep current requirements.</b>	<ul style="list-style-type: none"> <li>• It is very possible that our standards in CT are much higher than the basic qualified plan. The hope is that we would fully recognize all of the mandates and insurance requirements that exist within CT</li> <li>• Additional benefits mandated in CT need to be the same in an out of the exchange</li> </ul>
<b>Include specific benefits.</b>	<ul style="list-style-type: none"> <li>• Prescription drug benefit should be part of every plan</li> <li>• Should be required to contract with Community Health Centers</li> <li>• Preventative services</li> <li>• Should include skilled coordinator to patient ratio</li> </ul>
<b>Consider factors other than benefits.</b>	<ul style="list-style-type: none"> <li>• Consider geography: is the participating plan able to cover the entire state or what is the minimum geographic region?</li> <li>• Consider provider panels / networks</li> <li>• Include various provider types</li> <li>• Standard definition of medical necessity</li> <li>• Information disclosure</li> <li>• Standard coding</li> </ul>
<b>Should CT consider establishing the Basic Health Program? What would the BHP offer as a tool to facilitate continuity of coverage and care?</b>	
<b>Look carefully at cost.</b>	<ul style="list-style-type: none"> <li>• It comes down to the numbers of enrollees – remember that you often get more people than you expected, so look at the high side when analyzing</li> <li>• If you do not adequately reimburse services now, you will not address access, and that will affect costs in the long term</li> </ul>
<b>Do not just create a plan; create a new model of care.</b>	<ul style="list-style-type: none"> <li>• Utilize the Sustinet information that goes beyond just creating a plan, but creating a new model of healthcare. Do not go forward with a BHP unless you are going to look at it from a different model perspective</li> </ul>
<b>Concern about access to care.</b>	<ul style="list-style-type: none"> <li>• Balance between concern over the creation of a two-tiered system of health care based on economics, and the questions of whether subsidies provided in an exchange model will be sufficient to allow low-income individuals to purchase coverage</li> <li>• If a BHP came with lower provider payments, would participants be relegated to “second class status” and therefore a lesser level of care?</li> <li>• Is this going to be the same experience we’ve had with Medicaid, with difficulty accessing specialists?</li> </ul>
<b>Do not put this population outside the Exchange.</b>	<ul style="list-style-type: none"> <li>• This is the bread and butter population of the community health centers, which are expanding all over the state as a result of the stimulus money</li> <li>• The ACA requires that any insurance in the Exchange must contract with the community health centers, and it has to treat them as if they were Medicaid patients, meaning full prospective payment and a comprehensive set of services for medicine, dentistry, behavioral health, etc.</li> <li>• Experience with Charter Oak indicates that it does not work well when there is a separate distinctive plan run by DSS (Charter Oak was a negative experience for most patients)</li> </ul>
<b>How can CT 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)</b>	
<b>Provide information.</b>	<ul style="list-style-type: none"> <li>• Make information available on other programs (such as Medicaid)</li> </ul>
<b>Create overlap.</b>	<ul style="list-style-type: none"> <li>• Rapid, seamless, gap-free transitions</li> <li>• Move between plans without administrative complexity</li> <li>• Anticipate/facilitate movement back and forth between programs and for</li> </ul>

	<ul style="list-style-type: none"> <li>people who change jobs</li> <li>• Overlapping transition period</li> <li>• Plan portability and a seamless transfer of any paid or earned premium</li> </ul>
<b>Information exchange.</b>	<ul style="list-style-type: none"> <li>• Fluid exchange of information between the various state agencies involved in not only the exchange, but HUSKY/Charter Oak/SAGA and other state programs and services (behavioral health programs included)</li> </ul>

**ENSURE GREATER ACCOUNTABILITY AND TRANSPARENCY**

**What information should CT include for outreach to most effectively engage consumers? How should the information be presented?**

<b>Patient education.</b>	<ul style="list-style-type: none"> <li>• Help create an engaged patient that understands not only the insurance but their responsibilities in their own health</li> <li>• Education about costs of health care system</li> <li>• Needs to be culturally and linguistically appropriate</li> <li>• Similar to Medicare D “CHOICES” program, for instance</li> </ul>
<b>Include different stakeholders.</b>	<ul style="list-style-type: none"> <li>• Discuss with small employers</li> <li>• Providers have to take a vital role</li> <li>• Health providers and social service agencies have information available</li> <li>• Discuss with Exchange Board</li> <li>• Involve consumer advocates</li> <li>• Materials available in health care provider offices</li> <li>• All the different types of providers in the State need to understand the system allowing them to appropriately refer patients</li> </ul>
<b>Use all different media.</b>	<ul style="list-style-type: none"> <li>• 24-hours access to call center</li> <li>• Have the call center open for “good” hours, have 24 hour access to online information</li> <li>• Use state websites</li> <li>• Major social media campaign</li> <li>• If we can bank at Stop &amp; Shop, we should be able to access our Exchange info there as well</li> <li>• Robust web presence and plenty of written material</li> <li>• Kiosks if possible</li> <li>• Shrink wrapping the buses</li> <li>• Very intensive marketing campaigns</li> <li>• Find a really good creative team to manage</li> </ul>

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

<b>Various venues and groups to solicit feedback.</b>	<ul style="list-style-type: none"> <li>• Public hearing process</li> <li>• Produce a type of survey process (some participants suggested this, others think surveys are not effective)</li> <li>• Online</li> <li>• Through brokers</li> <li>• Public forums</li> <li>• Discussion with physicians and other providers</li> <li>• Ongoing reporting of enrollment data</li> <li>• Open door policy for comments</li> <li>• Direct communication with Exchange enrollees</li> <li>• More real time, not after the fact</li> <li>• A chat area where a consumer can communicate and read feedback from other consumers, such as one you would use when purchasing a product</li> </ul>
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	<ul style="list-style-type: none"> <li>• Standardization of the complaint process that should come back to the Exchange</li> <li>• A formal process for providers and patients to raise complaints and the State should really track those.</li> <li>• On the provider side, feedback good and bad, the ease of filing your claims, etc.</li> </ul>
<b>Make data accessible.</b>	<ul style="list-style-type: none"> <li>• Response on surveys can be low – consider point of service as you do patient satisfaction surveys, requesting completion right there at the point of service</li> <li>• Be careful to make data accessible and easy to use</li> <li>• Do not just collect data, but also turn it into information patients and/or providers can use; consolidate it and make it actionable</li> <li>• Data needs to be universal in order for it to all filter through the same system</li> <li>• The Dutch basically set up a system of a collective back in 2006 , as described in a recent Washington Post article</li> </ul>
<b>Oversee insurance companies.</b>	<ul style="list-style-type: none"> <li>• For example, ABC Insurance Company has one of their programs in your Exchange – how will ABC be ensured/informed that patients are actually able to access doctors; that they receive care, or that quality care was given to that patient?</li> <li>• Insurance participants in the Exchange ought to be willing to share information</li> </ul>
<b>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?</b>	
<b>Information should be transparent.</b>	<ul style="list-style-type: none"> <li>• Should share with all groups possible including providers</li> <li>• The more transparency the better</li> </ul>
<b>Use existing data.</b>	<ul style="list-style-type: none"> <li>• Cull some of the data that already exists rather than reinventing the wheel – we are already reporting on disparities and community health centers and already doing audits</li> <li>• There are other places that the data can be obtained as well (via DSS, DPH)</li> </ul>
<b>Broad range of info.</b>	<ul style="list-style-type: none"> <li>• Broad range of information including:             <ul style="list-style-type: none"> <li>– % claims denied</li> <li>– % appeals overturned</li> <li>– # grievances</li> <li>– results of satisfaction surveys</li> <li>– explanation on any restrictions on access to providers</li> <li>– full disclosure of provider network (paper/web)</li> <li>– Physician incentive arrangements</li> </ul> </li> <li>• Report card for plans</li> <li>• What information to share should be determined ongoing</li> <li>• Ensure you include both process and outcome data, and that it is explained to consumers</li> </ul>

**SELF SUSTAINING FINANCING**

**How should the Exchange’s operations be financed beginning in 2015?  
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?**

<b>Concerns about impact of taxes or fees.</b>	<ul style="list-style-type: none"> <li>• The least appealing approach seems to be taxing or assessing the insurers that are going to be in the Exchange because that is just going to trickle down to the consumer</li> <li>• If you begin taxing insurers to fund the operation of the Exchange, that somehow is going to be reflected in the pricing</li> <li>• CT is already anti-employer as far as level of taxes and all the other requirements to do business in the CT are concerned. By adding more expenses, we run the risk of driving businesses to another state.</li> <li>• It comes back ultimately to the taxpayers</li> </ul>
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	<ul style="list-style-type: none"> <li>• Seems surreal or perhaps undoable in this fiscal climate</li> </ul>
<b>Fee on plans.</b>	<ul style="list-style-type: none"> <li>• It has to come out of the plans that are playing in the Exchange; that is the only business model that makes sense – the plans derive the benefit from having a good provider network, investing in the services, and they either make it or they do not</li> <li>• To provide electronic health records to all primary care doctors, VT used a percentage of every medical claim transaction, which seems to have worked pretty well</li> </ul>
<b>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?</b>	
<b>Concern about unfair pricing.</b>	<ul style="list-style-type: none"> <li>• Ensure that insurers do not set artificially low fees for certain plans</li> </ul>
<b>Other benefits to include.</b>	<ul style="list-style-type: none"> <li>• The Connecticut Dietetic Association recommends including medical nutrition therapy, nutritional diagnostic therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional</li> <li>• Specialty care is more lucrative so therefore, it is always hard to get PAs to practice primary care, even when they have been educated in primary care</li> <li>• Allow practicing at maximum of scope of practice</li> <li>• Align public programs and payments with state of the art of service delivery</li> </ul>

<b>ADDITIONAL EXCHANGE FUNCTIONS</b>	
<b>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?</b>	
<b>May happen naturally.</b>	<ul style="list-style-type: none"> <li>• If you look at the original roll out of the HUSKY program when it was a sort of all willing insurer, there were more than ten plans and then, it did not take very long for plans to opt out</li> </ul>
<b>Beyond the Exchange’s minimum requirements, are there additional functions that should be considered for Connecticut’s Exchange? Why?</b>	
<b>Education, training, and information sharing.</b>	<ul style="list-style-type: none"> <li>• Education and training for employers, employees and individuals</li> <li>• Mechanisms that ensure that those selling the plans provide accurate information in a user-friendly format to fairly market the plans</li> </ul>
<b>Not initially.</b>	<ul style="list-style-type: none"> <li>• Not during the establishment of the exchange, but these should be determined annually moving forward</li> </ul>
<b>Patient -focused.</b>	<ul style="list-style-type: none"> <li>• Keep the existing state patient protections (some call them mandates, we call them patient protections)</li> <li>• Plan for and deal with catastrophic and end of life expenses for those insured by the Exchanges</li> <li>• Medication therapy management as an extra benefit<sup>1</sup></li> </ul>

<sup>1</sup> Comment made by Margherita R. Guiliano, R.Ph., CAE, Connecticut Pharmacists Association: “(Medication Therapy Management) really should be part of a basic health plan for individuals that meet certain criteria. As stated previously, medication mishaps account for hospitalizations and emergency room visits. Especially when dealing with patients on complex medication regimens, having access to a comprehensive active medication review can save the health care system significant money. I hope further thought will be given to this.”

<p><b>Wellness.</b></p>	<ul style="list-style-type: none"> <li>• What is going to be built into the plan to offer incentives to people to both participate and to move forward on multiple goals? For example, if you offer incentives to the employers for their employees to lose weight and/or exercise, etc., do employers get an offset at the end of the year in their premiums?</li> <li>• What kinds of incentives go to the providers, to the insurers?</li> </ul>
<p><b>Should CT 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)?</b></p>	
<p><b>Use existing rules.</b></p>	<ul style="list-style-type: none"> <li>• There may be some things that we want to just carry over that exist today</li> </ul>
<p><b>What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?</b></p>	
<p><b>Cost savings.</b></p>	<ul style="list-style-type: none"> <li>• Cost savings in general</li> <li>• People who are not in the Exchange and their employers are now going to look to the Exchange for a cheaper product with the same or better quality</li> </ul>
<p><b>What should be the role of the Exchange in premium collection and billing?</b></p>	
<p><b>None.</b></p>	<ul style="list-style-type: none"> <li>• May be too premature to decide</li> <li>• Billing for health insurance and health insurance claims administration is very complex and complicated</li> <li>• Unless there were standardization of benefit collection and payment, it appears to be overly burdensome</li> <li>• The Exchange should not be involved – that should remain the responsibility of the individual plans, which are capable of doing it</li> <li>• We can get back to the data collection as long as the information they provided from those plans is consistent the plan should continue to do it</li> </ul>
<p><b>What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?</b></p>	
<p><b>All payer claims data.</b></p>	<ul style="list-style-type: none"> <li>• If CT joined and participated in the all payer claims database association, we could effectively deal with the clinical, outcome, process measures for reporting</li> </ul>
<p><b>Map insurance penetration.</b></p>	<ul style="list-style-type: none"> <li>• Use UDS mapper to map penetration of insurance in poor neighborhoods and among low income population</li> </ul>