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VIA EMAIL

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Ms. Amy Tibor
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Dear Ms. Tibor:

Thank you for providing us with a brief opportunity to review Mercer's final report to the Exchange Board and provide you with comments. Our comments are, of necessity, very brief since you are allowing us only three pages in which to provide comments – a limitation with which we are unable to strictly comply. Indeed, absorbing all 408 pages in only two weeks without the benefit of being able to ask questions and/or discuss points is impossible; if the Exchange Board truly wanted stakeholder input, the process would be more amenable to real participation. For these reasons, as well as the substance of the report, our conclusion is that this report is a very strong example of what happens when there is no strong consumer voice on the Exchange Board. This report is one-sided, focusing on the interests of insurers and CBIA, and evaluating proposals based on short-term costs to the State without consideration of the costs/benefits to consumers, both financial and otherwise. I would be pleased to discuss any of the following comments with you and/or any of the members of the Exchange Board in more detail.

1. CBIA is not an Exchange, nor is it currently qualified to become one. CBIA is an association of small businesses that offers insurance to its members. It charges as much as \$725 for membership. It also performs other functions, such as lobbying to promote business interests in Connecticut, often at the expense of others. Indeed, its own self-description focuses on CBIA's role in promoting business interests in Connecticut, often taking positions that are anathema to many small business owners in Connecticut. <http://www.cbiam.com/3about/>. For example, CBIA has a long history of lobbying against health insurance coverage requirements. CBIA's self-professed political role disqualifies it from functioning as an Exchange which, of necessity, must be non-biased and nonprofit. Even setting aside all of the well-founded public policy reasons not to vault CBIA's

status, CBIA's health plans would exclude small groups of one or two from the SHOP Exchange, although they are included in health reform. CBIA offers plans underwritten by only two insurers NOT including Anthem Blue Cross Blue Shield of Connecticut, which insures the greatest number of Connecticut's insureds, or Aetna. Mercer's repeated assumption that CBIA is an Exchange is erroneous and undermines the accuracy of Mercer's analysis; Mercer appears to be pitching for CBIA rather than providing an objective analysis. Indeed, we cannot be certain that Mercer has adequately considered alternatives to making CBIA the SHOP Exchange in light of Mercer's uncritical discussion of CBIA's qualifications. Further, Mercer appears to assume that the individual and SHOP Exchanges will not be merged – a decision the Board has not yet made. We are troubled by Mercer's unqualified support of CBIA, and are concerned about how this bias affected Mercer's analysis.

2. Similarly, Mercer has obtained much of its information from insurance carriers, as well as Ingenix and the Lewin Group, both of which are UnitedHealthcare subsidiaries. Even if Mercer does not have a self-interest that would lead us to be skeptical of its report, reliance on these sources does give us cause for concern regarding the independence of Mercer's analysis. Further, Mercer made no effort to obtain consumer input in working on this report and, as a result, many important points have been missed.
3. For example, Mercer says that adding mid-sized employers (50-100) to the SHOP Exchange before 2016 would subject mid-sized employers to modified community rating, which, in turn, would disrupt the market. To the extent that adding these employers to the SHOP Exchange would end discriminatory pricing in the only health insurance segment that is not regulated by the Connecticut Insurance Department, to many of us, this would be a positive step, not a negative one, "disrupting" the market in positive ways that would improve the insurance climate for small businesses in Connecticut. Mercer's inability to see the potential upside of changes like this causes us concern.
4. Mercer demonstrates that, in all likelihood, a BHP would be cost-neutral or nearly so to the State. Mercer states several unknowns here, including the cost of a Silver Plan. Since it appears that HHS is inclined to allow the States to determine the essential health benefits package, and since the options are existing plans, we do not understand why Mercer could not have estimated the cost of a Silver Plan using one of the state's benchmarks. Indeed, it would be helpful for Mercer (or another vendor) to evaluate the four benchmark options to assist the Exchange Board to select one.
5. What we do know, though, is that those currently on Medicaid who will, according to Mercer, migrate to a BHP will lose access to care if the BHP is not a Medicaid look-alike – in other words, if it is not free. In order to protect Medicaid recipients as they migrate to the BHP, the BHP must have the same premium and cost-sharing formulas as Medicaid. Any other formulation of the BHP could be disastrous, essentially forcing people who cannot pay premiums into plans that they cannot afford and, thus, will not use. In other words, they will become uninsured, thereby undermining one of the primary goals of health reform. We refer you to the comments being submitted by Sheldon Toubman of New Haven Legal Assistance, with which we agree in their totality.

6. We are even more concerned about Mercer's enthusiasm for moving current HUSKY beneficiaries into a qualified health plan (QHP). While we understand that this could produce significant cost savings for the State, it seems to us that this would simply shift costs from the State to individuals, all of whom would be relatively low income. Such a cost shift could lead such individuals to refrain from seeking necessary care, precluding prevention and allowing exacerbation of illnesses to the point at which they become more expensive to treat. Indeed, it could incentivize uninsurance, undermining the primary goal of health reform. Short-term cost savings to the State should not be the only measure of whether this shift from Medicaid to QHP is good policy. Again, we refer you to Attorney Toubman's comments for a fuller discussion of the BHP.
7. Mercer states that a BHP might result in an excess of federal reimbursement over cost (as in New York). This would allow the State to increase reimbursement rates to entice new providers into HUSKY and the BHP. Further, as Mercer notes, the Exchange risk level would improve with a BHP, and a BHP would encourage individuals to enroll through the Exchange because of lower premiums and cost sharing – or, in our view of what a BHP should look like, no premiums and cost sharing. Further, as people move between the under 138% of FPL to the over 138% of FPL bands, having a BHP makes the transition in and out of Medicaid much easier than it would be to make the transition back and forth between Medicaid and an Exchange-based commercial product with accompanying advance payment tax credits, especially if the BHP essentially were a Medicaid look-alike with no premium or cost sharing. See comments from Sheldon Toubman.
8. Mercer entirely erroneously states that the State would have to bear the cost of any of the so-called "mandates," or required coverage items. If, in the end, HHS delegates the choice of the essential health benefits package to the states, and if Connecticut chooses any benchmark other than the Federal Employee Benefit Health Plan, then the "mandates" will be included in the essential health benefits package and the State will bear no cost whatsoever. Mercer notes this on page 213, but does not update or alter its analysis as a result. This entire section of Mercer's report is outdated in that it assumes that HHS would define the essential health benefits package, which no longer appears to be the case. In addition, all cost reports that have been conducted related to the "mandates" only look at the cost of the mandate itself, without regard to the long-term consequences of failing to provide the benefit. For example, in Connecticut, a requirement that women be permitted an overnight stay after mastectomy might, in the long term, reduce costly hospital readmissions. Before Connecticut considers eliminating any "mandates," a proper cost-benefit analysis should be conducted to arrive at the real cost associated with these coverage requirements. Further, again, the reports upon which Mercer relies were conducted based on input from insurers and Ingenix, which is a UnitedHealthcare subsidiary – hardly unbiased sources.
9. Of course, people in the HRA (and Charter Oak) will migrate to a plan on the Exchange, as they should. The Exchange will cost less than at least the HRA because the risk will be spread over a larger number of lives, and many people enrolled in Charter Oak will be eligible for advance premium tax credits. In addition, people going into the Exchange will not have been required to go without insurance for six months before they could obtain insurance as they do with HRA (unless they are HIPAA eligible). They should, thus, be in better health

when joining the Exchange than they would have been had they instead gone without any insurance for six months before joining the HRA (or Charter Oak). This will result in a savings for the State. Funding that would have gone to the HRA or Charter Oak should be committed to funding the Exchange.

10. Screening for all state-run health plans, including Charter Oak and the HRA (should they still exist), as well as CADAP and HUSKY B, should be done by the Exchange. Not only does this help to save on administrative costs, but it also ensures maximum federal financial participation. In addition, the CADAP formulary should be required to be covered by all plans; that way, as long as the State chose a state benchmark (i.e., not the federal employee plan), there would be no cost to the State for adding these drugs to the essential health benefits package.
11. It is our understanding that higher federal match will apply to low income adults already enrolled in Medicaid; we have asked that question in the past and been told that is the case, and that appears to be Mercer's understanding, as well. See page 54. That being so, Connecticut's federal reimbursement actually will increase substantially in 2014 and remain significantly higher than the status quo thereafter. CHIP federal match also will increase. This being the case, Connecticut can only gain from the health reform law's Medicaid expansion.
12. Connecticut should not pursue a multi-state Exchange. First, if Connecticut chooses an in-state plan as the essential health benefits package benchmark, we will retain the "mandates" at no cost to the State – a win for all of us. Second, the "partnership" that HHS has floated as an option is expressly directed at states that are not moving forward to create their own Exchanges, as an alternative to a fully federal Exchange. The guidance is not, we believe, fairly read to allow a state like Connecticut, with the creation of an Exchange well underway, to enter into such a partnership with HHS. And, ultimately, why would Connecticut want to sacrifice its independence and flexibility?
13. The data on underinsurance (page 67) and on the actuarial value of plans in service today (page 84) helps us to see the value of an Exchange to people who do already have insurance. The cost savings that will accompany lower rates of underinsurance should be accounted for when looking at the overall costs/benefits of reform.
14. Mercer's analysis of prescription drug benefits neglects to discuss or even mention the growth of specialty tiers. (Page 92). Indeed, Mercer later on in its report lists prescription drugs with coinsurance as one of the innovations the Board should consider. What they are referring to is specialty tiers. Nationally, specialty tiers are being used in 25% of plans, and 50% of large employer plans. When one uses a drug in a specialty tier, they pay a percentage coinsurance rather than a fixed dollar amount copay. This is pricing many patients out of the market for specialty drugs, which include biologics used to treat many diseases such as inflammatory bowel disease, multiple sclerosis, rheumatoid arthritis, immune deficiencies and many more. The out of pocket costs of consumers in plans with specialty tiers are astronomical; this should shift in consumers' favor under health reform due to out-of-pocket maximums so long as those out-of-pocket maximums include prescription drugs – which is not the case under all plans. New York already has passed legislation prohibiting the use of specialty

tiers, and such legislation is under consideration in many states, including Maine, Vermont, and Hawaii, to name only a few. In addition, legislation has been introduced in Congress to create an exceptions process for Medicare recipients who cannot afford specialty tier coinsurance. (HR 3613). An accurate sense of coverage, underinsurance, and access to care cannot be obtained without consideration of the growth of specialty tiers. The addition of specialty tiers is a disaster for people who need biologics and other expensive drugs in order to function. The Board should be mindful of the fact that, if people with chronic illnesses cannot access the care they need because that care becomes too expensive, their condition will deteriorate and their care will become far more expensive, while they become disabled and unable to contribute to the economy and, eventually, become eligible for Medicaid, which will cost the State far more. Connecticut should avoid the urge to be short-sighted.

15. Tiered networks are extraordinarily confusing and complicated, and it is unclear that they really save money, as has been well documented by media. <http://www.kaiserhealthnews.org/Stories/2012/January/17/Mass-Tiered-Insurance.aspx>. As explained in this account, it is very difficult to compare the cost of a tiered plan with a non-tiered one because copays and coinsurance will differ depending on which tier an insured's provider is in, so paying a lower premium may mean paying higher coinsurance, wiping out any cost savings. In addition, the press account states that, in most states, it would be impossible to get hospitals to join any but the highest tier, further limiting the savings.
16. While we certainly would welcome reasonable efforts to reduce the cost of small group insurance, Mercer's suggestions – specialty tiers, tiered networks – merely shift the cost of care from insurers and employers to employees and individuals. As a small business, we certainly hope that innovations such as patient centered medical homes and outcome-based reimbursement will help to bring down costs, but Mercer does not discuss such innovations here. Indeed, the Connecticut State Medical Society has applied to run a COOP, which Mercer also fails to mention. Thus, there are exciting innovations that might reduce costs while also providing better care to consumers. Mercer fails to discuss them. Instead, Mercer wishes the Board to adopt innovations that simply would be a disaster for consumers – especially those with chronic health care needs.
17. Mercer talks about the Navigator program as if there were going to be only one Navigator. (Pages 236-238). However, we would urge the Board to consider utilizing a range of community-based organizations with demonstrated effectiveness at working with hard to reach populations, including the ability to provide information and assistance in a linguistically and culturally appropriate manner. Massachusetts has utilized consumer-based groups to conduct outreach for its Exchange with great success. The Exchange Board should review existing networks of community-based organizations to see how their usefulness in assisting consumers to enroll through the Exchange can be maximized.
18. Mercer's discussion of the integration of the PCIP into the Exchange (page 250) is curious since the PCIP will cease to exist on January 1, 2014, as a matter of federal law. The PCIP was created by Congress to bridge people with pre-existing conditions from 2010 to 2014, when individual insurance would be available on a guaranteed issue basis. There will, therefore, be no "interaction"

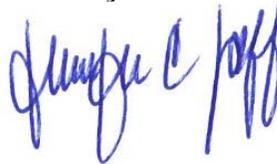
between the Exchange and the PCIP since the PCIP no longer will exist when the Exchange becomes fully operational.

19. We agree with Mercer that the most sensible means of raising revenue to fund the Exchange would be through a premium assessment. User fees would burden low-income Exchange participants, perhaps making them less likely to enroll in the Exchange. To avoid adverse selection, we would support applying this same assessment to policies sold outside of the Exchange, as well. In the alternative, we would support a fee on all insurance carriers in the State, whether or not they participate in the Exchange.
20. Finally, consistent with our concerns regarding the effect of Mercer's viewpoint – or at least the viewpoints of some of its sources – Mercer fails to factor in the positive effects of reform. As more people become insured, there will be less uncompensated care. As more people get care earlier in the progression of an illness – or even prevent an illness from occurring – overall health care costs will decline. Medical loss ratios should have a downward effect on premiums. Again, other innovations such as patient-centered medical homes and outcome-based reimbursement will help to bring down costs. Thus, while it is true that we are making an investment on the front-end of reform implementation, there will be savings over time. The economic benefits of reform – both short-term and long-term – should be considered by the Board in designing Connecticut's Exchange.

In closing, we appreciate the voluminous material that Mercer assimilated in this one report. However, we feel that there are positive effects of reform in general, as well as positive innovations that would benefit consumers, that Mercer has not fully identified and evaluated. Indeed, the entire thrust and tone of this report causes us grave concern that the absence of consumers and consumer advocates on the Exchange Board already is being felt. We will not reach anything approaching universal coverage and access if there is a BHP whose cost sharing rules are different from Medicaid's, or if Medicaid recipients are forced to migrate into QHPs. We will create new, severe problems of underinsurance if the only innovations we consider are those that shift costs from insurers to consumers.

Thus, we thank you for this opportunity to comment; but we also strongly urge you to ensure that consumers' voices are heard loud and clear as the Exchange Board tackles these extraordinarily critical policy decisions.

Sincerely,



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* Admitted to practice law in Connecticut, New York and the District of Columbia. Advocacy for Patients is a 501(c)(3) tax-exempt organization and does not charge patients for its services. Advocacy for Patients is funded by, among other sources, grants from foundations and companies that engage in health care-related advocacy, manufacturing, delivery and financing. A list of grantors will be furnished upon request.

Amy Tibor
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Cc: Victoria Veltri, State Healthcare Advocate
Lieutenant Governor Nancy Wyman
Jeannette DeJesus, Special Advisor to the Governor
Commissioner Thomas Leonardi