



Quality is Our Bottom Line

Connecticut Association of Health Plans Response to the Mercer Report Commissioned by the Connecticut Exchange Board.

We want to take this opportunity to thank the Connecticut Exchange Board, the Office of Policy & Management and the Office of Healthcare Reform & Innovation for requesting input and feedback from Connecticut's health insurance industry with respect to the Mercer report released to the CT Exchange Board on January 19, 2012.

Health plans in Connecticut and around the country are working to implement the Affordable Care Act (ACA) according to the requirements of the legislation and regulations to the benefit of our customers and members. ACA is comprehensive legislation designed to provide guidance as to how we can improve our health care system. An integral part of ACA is how benefits are delivered through exchanges. Effective implementation of exchanges will require the partnership of the federal government, states and participating health plans to develop a seamless marketplace where individuals and small employers can purchase their choice of Qualified Health Plans ("QHPs") when they first enroll in 2013 for coverage in 2014. Leading up to this time, it will be critically important that careful thought be given to the creation of exchanges that will work with the needs of individuals and small businesses.

The Connecticut Association of Health Plans (CTAHP) believes that any exchange should (1) facilitate the market offering to consumers of affordable insurance options (2) promote health plan competition and maximize product choice inside the exchange while not stifling competition and choice outside the exchange; (3) adopt fair, objective standards for health plan participation in the exchange and ensure a level playing field between carriers regardless of type or size; (4) not duplicate or create additional regulatory requirements; (5) feature a responsible, accountable governance structure that includes representation of all stakeholders, including health plans, and fiduciary accountability; (6) provide flexibility so that states can best serve their markets' consumers, with federal standards where they can support efficient operations; and (7) minimize disruptions to the existing marketplace.

CTAHP supports the concept of market-based exchanges that are focused on facilitating the market offering to consumers of affordable insurance options designed for specific consumer needs. However, this potential cannot be fully achieved without additional flexibility in plan designs. The Mercer report indicated that nearly 50% of the current plans in both individual and small group markets are below the ACA bronze level and therefore we recommend that the state work with HHS to allow a wider set of plan design categories beyond the Platinum-Gold-Silver-Bronze "metallic" levels. Connecticut should also implement mechanisms to better combat adverse selection beyond the reinsurance, risk corridors

and risk adjustment, such as setting firm open enrollment periods and penalties for not enrolling in and maintaining creditable coverage.

We believe that exchanges should build upon existing state and federal law and thereby mitigate the risk of creating administrative burden, higher costs and less choice for individuals and small employers. This is especially important given the many new regulatory elements of ACA, including several new consumer protections that exchanges will not need nor want to duplicate. Because exchanges are intended to be new competitive markets for health insurance that will enable individuals and small employers to meaningfully choose among competing health plans on an annual basis, exchanges will be most effective in this role if they are facilitators of coverage options approved for sale by insurance regulators that meet QHP standards. Exchanges should not be duplicative or conflicting regulatory entities that disrupt the market or limit the ability of individuals and small employers to enroll in a health plan that meets their specific needs.

In creating its own exchange, a state will be able to take advantage of state flexibility provided under federal law to thoughtfully create an exchange that will work with the needs of its individuals and small businesses and allows states to adapt as market conditions change. A competitive exchange that works in tandem with appropriate state agencies will facilitate access and promote plan choice, thereby helping individuals and small employers find a plan that meets their health care needs.

We also suggest that it is best for the exchange to develop guidelines that promote competitive exchange marketplaces. In order to maximize choice, competition and health plan participation, and minimize regulatory duplication and confusion and market disruption, all carriers with plans that meet the qualified health plan (QHP) standards required by the ACA and later promulgated by the Secretary should be permitted to offer such plans in an exchange. Having an exchange that engages in selective contracting will limit the number of plans available to individuals and small employers and undermine the incentive for plans to develop exchange offerings. This may leave many individuals and small employers unable to find a plan that is right for them on the exchange, which could drive them off the exchange, or to not enroll in coverage at all.

Individuals and small employers should have the option to purchase affordable coverage outside the exchange which was clearly the intent of ACA despite formation of state health insurance exchanges. Section 1312(d)(3), titled "Voluntary Nature of an Exchange," goes on to further support the market outside the exchange by declaring that "nothing in this title shall be construed to restrict the choice of a qualified individual to enroll or not enroll in a qualified health plan or to participate in an exchange." Further, "nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an exchange." And Section 1312(d)(4) declares that no penalty or fee shall be applied to any individual by an exchange or a QHP offered via an exchange who cancels enrollment in a QHP to enroll in coverage outside the exchange. While outside of the exchange plans must still meet the requirements of the ACA, they should otherwise be able to offer any combination of the different plan levels available within the exchange (bronze, silver, gold, and platinum) that they choose, or not offer coverage outside of the exchange at all. There are protections included in the federal law to help

mitigate adverse selection in the exchange, and it is important for market rules to be the same inside and outside of the exchange to further prevent adverse selection.

Further, individual and small group markets should remain independent to better serve distinct markets because it will continue to best serve the consumers. It is important for states to maintain separate and distinct markets for individuals and small groups, regardless of whether or not a state decides to consolidate exchanges administratively to gain efficiencies. These separate markets would include separate risk pools, as combining risk pools for the individual and small group markets is likely to lead to higher rates for small groups due to adverse selection. Maintaining separate markets will also allow health insurers to tailor benefit designs to meet the needs of each market, and thus better serve individuals and small employers.

The ACA already adds many new protections for consumers. The ACA (1) establishes guaranteed issue of health insurance for individuals, beginning in 2014; (2) caps small employer deductibles at \$2,000 and requires actuarial value over 60 percent; and requires individual and small group insurers to spend at least 80 percent and large group insurers to spend at least 85 percent of premium revenue on direct medical care and efforts to improve quality of care. The ACA also already strongly regulates products to be offered through exchanges by: (1) requiring all plans to meet one of four actuarial value levels (or be a catastrophic plan only available to individuals under 30); and (2) establishing certification criteria for network adequacy, quality improvement, marketing, and other areas. Therefore, we believe that creating additional regulation through an exchange authority would be unnecessary and could prove counter-productive, particularly as exchanges first launch.

Employer plan choice will minimize market disruption and promote a healthy small group market inside and outside an exchange. Taking this approach will minimize disruption in the small group market and ease the transition to the exchange for small employers who currently offer coverage to their employees and who choose to renew their plans through a SHOP exchange.

With respect to the key findings and recommendations on the Basic Health Plan (BHP), CTAHP agrees that ensuring continuous, affordable health insurance coverage for all is essential to improving health and reducing costs. Low income individuals and families may have more difficulty staying continuously covered because of the churn they may experience between public and private coverage which proponents believe could be addressed by implementation of the BHP. Key consideration, however, must also be given to the impact implementation of a BHP could have on the exchange overall. Removing a specific segment of population from the exchange could reduce the assessment base needed to self-sustain the exchange in 2015. It could also result in healthy lives being removed from the exchange pool adversely impacting its health status. Of particular concern for those commercial carriers is the exacerbation of the current cost-shift to the private payers should the state rely on traditional Medicaid reimbursement methodology under a BHP program. Given that the next few years will be tumultuous and confusing for states, plans, employers and individuals, CTAHP urges significant caution in considering implementation of a BHP.

In response to the development of Essential Health Benefits, CTAHP fundamentally believes that health plan issuers must have the flexibility to design affordable health benefit plans that meet the needs of our customers. When determining what covered services should be considered "essential," it is not only imperative to balance the need for comprehensive, evidence-based coverage with the need to ensure access to affordable coverage, but it is also critical to ensure health plan issuers have the flexibility and freedom to meet evolving customer demand and to incorporate a constantly growing base of medical evidence. Throughout decades of experience, health plans have seen countless examples of how rigid government approaches to product mandates have not only driven up the cost of coverage, but have also proved to be harmful to customers by inhibiting the ability to cover services in ways that meets the needs of our customers and reflect evolving medical science.

Finally, funding for exchanges should be broad-based and spread across the general population or across all health care stakeholders. All stakeholders in the health care system stand to share in the benefits of exchanges – from an influx of new covered lives to anticipated improved operation of the health system. For example, one of the primary functions of exchanges will be to facilitate the ability of individuals to use their federal tax credits to purchase insurance. In addition, doctors and hospitals absorb substantial "bad debts" from uninsured individuals in their markets. Further, the state will collect additional premium tax revenues from the additional covered lives and these revenues should be dedicated to financing the exchange.

Thank you again for the opportunity to comment on this very important subject.