



Via E-mail only

Connecticut Health Insurance Exchange
C/o Amy Tibor

Dear Ms. Tibor:

Thank you for accepting our comments to the Mercer Health Insurance Exchange Planning Report, dated January 19, 2012. Our comments are focused on the consumer issues raised by Mercer’s findings and with the need for additional and deeper investigation, and discussion with consumer stakeholder groups before decisions are made by the Board in the near future.

In the absence of a set of guiding principles or values from the Exchange Board, the Office of the Healthcare Advocate (OHA) evaluated Mercer’s report against a framework that (OHA) uses to guide its decision-making process on behalf of Connecticut healthcare consumers. I strongly urge the Board to adopt a similar set of principles and policies and objectives to carry out those principles as referenced in Section 2(d)(2) of Public Act 11-53.

As a general comment on methodology, the Mercer report makes a number of projections about insurance usage and costs. It would have been helpful for a sensitivity analysis to have been carried out, so that we can see which of the assumptions would have the greatest effect on projections if they prove to be incorrect.

OHA’s statement of principles is attached to this report. The chart below represents our general comments with respect to sections of the Mercer Report cross-referenced to our statement of principles. Following the chart is a more detailed comments section on specific provisions of the Mercer Report.

Issue	Comment	OHA Principles
Affordability and cost control	There is some inconsistency in the way that the report handles the potential for the HIE to influence healthcare costs. On page 14, para. 4, it suggests that it will be difficult for the HIE to have an impact on premiums, but on page 15 under ‘Recommendations’ it	I-D: innovation II-C: evidence-based IV-A: healthcare

	says that insurance products should ‘consider and attempt to improve the underlying drivers of healthcare cost’. There is also a reference to the major cost drivers (p. 14). I would want to know more about Mercer’s thinking in this area – what is the relative contribution of each driver; what do they think is the potential for modifying the underlying drivers; on what sort of timescales; and can costs can be reduced without reducing quality?	costs
Enrollment for subsidized coverage	What problems (if any) can we anticipate in making sure consumers who are eligible for the various subsidies and programs actually claim/enroll? How universal is Medicaid enrollment at present amongst those who are eligible? Whose responsibility will it be to maximize enrollment for ACA subsidies?	I-B: access II-A: red tape
Consumer assistance: Adjudication service	The adjudication service for waivers, eligibility determination and hardship waivers (p. 280) is going to be a crucial consumer issue, so how is that to be taken forward?	I-B: access I-C: chilling effect III-A: cost shifting III-B: precautionary action
Exchange fees	The report flags up that products disseminated through the HIE will be subject to a fee in order to fund the Exchange, but does not reach a conclusion about whether it is preferable for the Insurer or the consumer to pay the fee. I would like to see the pros and cons of these alternatives highlighted and some principles established, e.g. if it were decided that the consumer should pay the fee then the ‘sticker’ price of the plan should include the fee (so that the consumer would be clear what the plan was going to cost) and the level of the fee should be clearly stated (to promote transparency).	III-D: ethical practice
Advertising on the Exchange site:	The issues of conflict of interest from advertisements, as well as undue influence on consumer choice, both seem important, but the report doesn’t mention the impact that advertising could have on consumer confidence in the Exchange (p. 287ff). This is an area that requires further discussion.	III-D: ethical practice
Consumer research	The report makes a positive mention of the possibility of carrying out consumer research to help the HIE to set up the Exchange in a way which responds to consumer needs. It could certainly be helpful to have some CT consumer research carried out to assist with some of the selection of options e.g. above-mentioned the issue of consumer confidence and Exchange website advertising. Mercer might have some thoughts about who would carry out consumer research, and for what purpose, but it would be helpful to a discussion at the Consumer Advisory Committee to take it forward.	II-B: patient outcomes II-C: evidence-based

Three major issues remain for comment:

Basic health Program

OHA fully supports the analysis of whether a Basic Health Program should be adopted for Connecticut for individual's whose income falls between 138 and 200% of the federal poverty level. Mercer's analysis indicates that adoption of a Medicaid lookalike BHP would yield a net savings to the state of Connecticut because of the enormous federal subsidies that will flow to the state. (In essence, for each individual enrolled, the BHP provides a subsidy of 95% of the cost of a silver plan premium in the Exchange.) The savings will potentially allow the state to increase reimbursement rates to providers of BHP members. Though some entities have criticized the BHP because of potential reimbursement rates that fall below those in the commercial market, the BHP provides coverage where there currently is none and for which providers are currently obtaining no reimbursement. The affordability of exchange plans to the BHP-eligible group calls into serious question whether these individuals would actually enroll in any coverage absent the BHP. Remaining out of the exchange without a BHP option will offer providers less relief than a BHP lookalike. Further, a BHP is likely to offer more comprehensive benefits than an exchange plan, providing hospitals and providers with a revenue source that would not be provided under an exchange plan's coverage options. Finally, the BHP-eligible population is likely to have higher morbidity, as acknowledged by Mercer; removing the BHP-eligible population from the exchange is likely to reduce the risk profile of the remaining exchange-eligible population, reducing the premiums for individuals enrolled in the exchange. Note that the Speaker's Working Group on Small Business Healthcare also found that establishing a BHP could reduce premiums for small businesses in the exchange. The fiscal rationale for the BHP is clear.

From a consumer perspective, there are a multitude of reasons that support adoption of a BHP over the offer of coverage under an exchange plan for this group of individuals. As Mercer itself acknowledged, approximately 50% of the individuals in the BHP-eligible income bracket will likely fall back and forth from Medicaid eligibility to BHP eligibility. A seamless Medicaid-BHP program allowing individuals to access comprehensive, low-cost insurance is preferable to the jarring effects of moving back and forth from the exchange, with less comprehensive benefits and significant costs that even with subsidies will likely make it nearly impossible for most individuals in this income bracket to afford exchange coverage. The advantages of tax credits for BHP-eligible individuals to enroll instead in the exchange are questionable since it is likely in the absence of a BHP that individuals will move in and out of the exchange, creating serious financial issues when tax credit reconciliation uncovers significant repayment liability for consumers.

Consumer Assistance

The core of the Affordable Care Act is targeted at improving healthcare access for consumers. Connecticut has some consumer assistance functions located at various entities. One of the core areas of the exchange, Core area 10, is to ensure that consumers are receiving the kinds of services outlined in and required to be provided by consumer assistance programs. This includes outreach, education, plan selection assistance, enrollment and eligibility questions, assistance with grievance and appeals and premium tax credits.

The coordination of Connecticut's consumer assistance programs is critical to the success of the Exchange. There is little mention in the Mercer report of the coordination of this activity and the need for such coordination to happen quickly and coherently and to ensure the level of expertise that consumers expect from offices like the Office of the Healthcare Advocate. As the initial award winner of a consumer assistance program grant under the Affordable Care Act, OHA is equipped to handle the Core 10 responsibilities of the exchange. The Exchange should make significant use of our program, a program that saved consumers \$11.5 million in calendar year 2011, in addition to advising consumers about their healthcare rights, helping provide plan selection, integrating assistance across public and private programs and providing support for other healthcare reform efforts.

Small Business

Mercer notes significant issues with small employer access to healthcare. Mercer's suggestions about CBIA are controversial given the need for additional comment to be vetted. Additionally, Finding #7 of the Speaker's Working Group on Small Business Healthcare Report suggests merging the small employer and individual marketplaces. While Mercer says the small group market is competitive (p. 14), the Speaker's Working Group Report notes that in the small group market, one insurer controls 31% of business and has only a few competitors. Clearly this is an area that needs more examination.

These comments reflect only some of our concerns. Because of the timeframe for comment submission, we are unable to complete a comprehensive response to the Mercer Report. However, we hope you remain willing to entertain comments and suggestions on an ongoing basis for this major initiative.

Very truly yours,

A handwritten signature in black ink, appearing to read "Stephen J. Ueffel". The signature is fluid and cursive, with the first name "Stephen" and last name "Ueffel" clearly legible.

State Healthcare Advocate

OHA PRINCIPLES FOR DETERMINING POLICY ACTION

Final Draft– Pilot Test Ready

The third prong of OHA's mission statement is to inform legislators of problems consumers face in accessing care and propose solutions to problems. OHA develops and proposes legislative interventions and it supports or opposes legislative proposals raised by others in furtherance of its advocacy role.

Establishing a basis for deciding policy action is useful when there are many decisions to be made in a short amount of time (such as the legislative session), the decisions are complex with multiple criteria, and the decisions require comparative consistency for public and political scrutiny. A basis will ensure that OHA's position on legislative proposals is consistent, defensible, and logically integrated with other decisions.

Proposed legislation will be analyzed in relation to the principles, legislative testimony will incorporate [relevant] principles, and OHA legislative briefs and communications will reference [relevant] principles.

I. Access to quality healthcare; for our State to be competitive, our people must be healthy¹.

- A. We help healthcare consumers maximize the value of their health insurance coverage.
- B. We intervene to ensure access, parity, transparency, quality, and safety in the delivery of healthcare services.
- C. We seek redress for practices that have a chilling effect on access to quality healthcare.
- D. We influence healthcare system reforms to expand access and improve quality.

II. Reduction in healthcare system waste; innovation is essential to maximize value.

- A. We identify bureaucratic red tape and redundancies that increase spending and impair navigation of our healthcare system.
- B. We champion solutions that reduce delivery fragmentation and improve patient outcomes.
- C. We support evidence-based improvements to our healthcare system.
- D. We pursue opportunities to measure outcomes and performance through improved data reporting and analysis.

III. Healthcare industry watchdog; cost shifting practices burden the State's economy, providers, payors, and consumers.

- A. We identify deceptive, misleading, unreasonable, and unfair practices and collaborate to solve them.
- B. We take proactive and precautionary measures to prevent healthcare consumer issues.
- C. We reconcile, remediate, and return cost-shifted gains to the public economy.
- D. We facilitate ethical practice and understanding across industry stakeholders.

IV. Social Justice; OHA has a duty to represent the collective voice of 3.5 million healthcare consumers.

- A. We protect the rights of patients marginalized by the complexity, inaccessibility, and cost of our healthcare system.
- B. We guard our agency's autonomy to advocate for healthcare consumers free of industry and political pressure.
- C. We promote and protect patients' rights of autonomy, beneficence, nonmaleficence, and justice.
- D. We translate experiences of individual healthcare consumers into systemic solutions and education for all.

¹ The [World Health Organization](#) (WHO) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."