



Randolph S. Wojnarowicz
Market Director

February 7, 2012

Dear Sir or Madam:

WellCare Health Plans (“WellCare”) is pleased to submit comments on the *Mercer Health & Benefits, LLC Final Report* (the Mercer Report) released on January 19, 2012. We look forward to collaborating with the State of Connecticut in ensuring that Exchange meets the goals of the Affordable Care Act (ACA) by providing affordable and continuous coverage for individuals and families, and especially for America’s most vulnerable populations. Our comments focus on the implementation of a Basic Health Program (BHP), separating individual and employer exchange markets, ensuring Exchange product affordability for consumers, supporting plan product design flexibility, and achievement of key timeline milestones.

Nationally, WellCare is one of the country’s largest health care companies dedicated solely to serving Medicaid and Medicare beneficiaries. We currently serve over 2.4 million enrollees nationwide and offer a variety of products including prescription drug, Medicare Advantage, Medicaid, and Children’s Health Insurance Program (CHIP) plans for families, children, and the aged, blind, and disabled, including nursing home level of care recipients. WellCare’s mission is to be the leader in government sponsored health care programs in partnership with enrollees, providers, and the government agencies we serve. This mission drives our business and we design our products and support services in accordance with that mission. We have a long-standing commitment to our Federal and state partners to deliver value, access, quality and cost savings/predictability. It is from this vantage point that we offer these comments.

Basic Health Program

Recommendation: WellCare encourages the State of Connecticut to consider implementing a Basic Health Program (BHP) to support reduced out-of-pocket costs and improved access for individuals with lower family incomes, while achieving state financial savings.

WellCare appreciates Connecticut’s recognition and analytical support of the BHP through its contract with Mercer. Creation of a BHP is a state opportunity to support affordability, quality and stability of care for low-income populations. The BHP focuses on providing health care for low-income, nonelderly individuals who do not qualify for Medicaid, but cannot afford private insurance. This population may move frequently or “churn” between employer coverage, the Exchange, Medicaid, and being uninsured. As described by author Stan Dorn of the Urban Institute, “For two reasons, raising the income threshold to 200 percent FPL would reduce the number of subsidy recipients moving between programs. First, many more people will qualify for subsidies at lower income levels, where ESI offers are less frequent. Second, significant income volatility is more widespread at lower income levels, where unstable and shifting employment arrangements are more common.”¹

The BHP reduces churning and gaps in coverage, reduces individual out-of-pocket spending, and provides better benefits, which ultimately improves access to care and overall enrollee health. Therefore, WellCare strongly recommends against any delay in Connecticut’s implementation of a BHP. As stated

¹ Dorn, Stan. Robert Wood Johnson and the Urban Institute, “Basic Health Program Option under Federal Health Reform: Issues for Consumers and States,” March 11, 2011: <http://www.rwjf.org/coverage/product.jsp?id=72024>.



by the Robert Wood Johnson Foundation, “A state-purchased plan could provide richer benefits to those eligible under the exchange; a BHP could be designed to reduce the negative effects of churning...; and BHP could specifically address the needs of low-income people in its selection of providers and add-on services, such as transportation or mental health benefits.”²

The Mercer Report found that “...the State of Connecticut may be able to implement the BHP option at no cost to the State general fund... Based on these estimates, there is a projected excess of BHP subsidies over BHP costs of \$80 PMPM, or approximately 22% of the BHP premium.”³ The Mercer findings were consistent with those of the January 2011 Sustinet Health Partnership Board of Directors Report to the Connecticut General Assembly, the June 2011 Community Service Society report (projecting a 10% BHP surplus for New York), and the September 2011 Urban Institute analysis on BHP.⁴

WellCare recommends that any BHP “surplus” funds be used in a “member-centric” capacity including reductions in enrollee cost sharing and/or the use of non-nominal incentives to reward desired behaviors (e.g. getting screening tests) once members are enrolled. For example, a member’s successful participation in care management or disease management programs could be rewarded with incentives such as gift cards for health-related services. Similarly, individuals who comply with preventive service guidelines could receive pre-loaded debit cards or coupons to purchase health care-related items. In our experience, these types of incentives can have a measureable effect on member behavior.

WellCare supports the BHP for low-income individuals who would likely face higher out-of-pocket costs purchasing coverage on the Exchange or choose to remain uninsured. Without a BHP, a bronze-level option with a lower premium cost may appeal to lower-income individuals who have higher price and premium sensitivity; however, such coverage would leave individuals with health care costs equal to 40% of actuarial value; and even higher costs should they become ill or need care for chronic conditions. The ACA precludes individuals selecting a bronze-level plan from qualifying for a cost-sharing subsidy, thus leaving them fully responsible for the payment of the 40% out-of-pocket costs. Should these individuals fail to pay these out-of-pocket costs, either providers will be saddled with the bad debt or providers will refuse to treat these members, essentially denying them access to care, rendering them effectively uninsured. Therefore, the absence of a BHP may leave a higher number of technically insured, but truly underinsured individuals.

Uninsured individuals will likely go without insurance coverage until an emergent need arises. By delaying purchasing health insurance, these individuals will likely increase adverse selection in the Exchange. As the Mercer Report indicates, removing lower-income individuals from the Exchange may reduce adverse selection within the Exchange, “The level of premiums and cost sharing in a BHP and in an Exchange (with or without a BHP option) will have a direct impact on the risk of the population that enrolls. Specifically, higher premium and cost-sharing levels increase the level of adverse risk selection among the enrolled population – i.e., higher monthly premiums encourage healthier individuals to opt-out of the Exchange to avoid purchasing benefits they are not likely to use. ...it is reasonable to conclude that the risk of the enrolling population up to 200% FPL would be better under a BHP at lower member premium levels, than the risk of the same population subgroup that would likely enroll under an Exchange

² Ibid.

³ Mercer Government Human Services Consulting, *Health Insurance Exchange Planning Report* to the State of Connecticut, January 19, 2012, p. 28.

⁴ Ibid., p. 29.



at higher member premium levels.”⁵ In fact, the Mercer Report indicates that removing individuals from the Exchange risk pool “may actually improve with the implementation of a BHP.”⁶

To reduce the State’s BHP administrative costs, WellCare encourages Connecticut to pursue Medicaid and CHIP federal financial participation (FFP) for any BHP administrative function that would have an impact on other affordability programs. Furthermore, if BHP programs streamline eligibility with Medicaid and CHIP, any resulting reduction in enrollee churn may also reduce administrative burdens to the State’s Medicaid and CHIP programs.

Separation of Individual and Small Business Exchanges

Recommendation: Consistent with the findings of the Mercer Report, WellCare recommends Connecticut keep the individual and Small Business Health Options Program (SHOP) exchanges separate.

Individual and small group markets, and each market’s respective risk pool, should be kept separated to best serve consumers and promote plan participation. WellCare believes that keeping the markets separated will increase consumer choice for several reasons. First, keeping markets separate will allow plans to tailor benefits to the needs of consumers. Secondly, separation will allow plans that do not currently participate in the small group market to participate in the individual exchange; whereas smaller health plans may not be able to participate in a merged exchange market. (For similar reasons, we would be concerned with any State mandate that required health plans to participate in both the individual and SHOP exchanges as that would likely reduce small plan participation.) By increasing plan participation, consumers have more exchange choices overall.

Essential Health Benefits Affordability

Recommendation: WellCare encourages the State to begin efforts on selecting an exchange essential health benefits (EHB) benchmark package expeditiously with consideration given to the importance of designing a package that is affordable.

As a provider exclusively focused on public programs, we are most concerned about the affordability of coverage; the impact of the EHB; and the HHS-proposed related benchmarks. We support the goal of the ACA to reduce the number of uninsured individuals and families but echo the concerns of the Institution of Medicine (IOM) that “if cost is not taken into account, the EHB package becomes increasingly expensive and individuals and small businesses will find it increasingly unaffordable. If this occurs, the principal reason for the ACA—enabling people to purchase health insurance, and covering more of the population will not be met.”⁷

WellCare recommends that Connecticut review each of the HHS-proposed benchmarks with an eye to the exemption in the ACA that voids the individual mandate when the premiums (net of subsidies) exceed 8 percent of the purchaser’s household income. We are concerned that if the Exchange products are priced at the current cost of certain benchmark packages, these plans will exceed 8 percent of the income of the majority of individuals with incomes above premium-subsidy levels (above 400 percent of the federal poverty level), triggering the individual mandate affordability exemption (i.e. will not be mandated to

⁵ Ibid., p. 30.

⁶ Ibid.

⁷ IOM Report—*Essential Health Benefits: Balancing Coverage and Cost*. October 7, 2011.



purchase insurance). The result could be a smaller pool of Exchange participants or a less healthy case mix in the Exchange risk pool than originally anticipated, thus resulting in less affordable coverage. This result would appear contrary to the intent of the ACA.

Given the importance of keeping the EHB and related benchmarks affordable, WellCare recommends that Connecticut explore financial and actuarial mechanisms that would prevent EHB benchmarks from becoming too costly for individuals, families, and employers to purchase in the Exchange. WellCare strongly encourages the State to consider criteria for selection of a benchmark plan that will serve as the standard for QHPs inside the Exchange to ensure that the following issues drive the designation of an EHB benchmark:

- **Affordability:** Connecticut should analyze the impact on premiums of the benchmark plan selection to ensure that coverage will be affordable and to avoid large numbers of individuals being exempted from the mandate to purchase coverage.
- **Budget Neutral Risk Adjustment:** Ensure that the system of risk adjustment envisioned by the ACA will be functional and effective in the selection of the EHB benchmark plan. The risk adjustment process depends on all the plans offered being within a limited range of benefit design as stipulated by the ACA. Failing to normalize the benefit structure along actuarial principles will make budget neutral risk adjustment impossible.
- **Promote Small Plan Participation:** Include accommodations, such as network adequacy, in defining QHP criteria to encourage the participation of many types and sizes of plans, regardless of market power, to offer coverage in a state Exchange. As a result, smaller plans, like those exclusively focused on the public program market, would be better able to compete with larger insurers and more likely to participate in the Exchange. Participation by these plans will not only offer additional choice and competition but will also improve continuity of coverage for beneficiaries churning in and out of the exchange.
- **Based on Evidence:** Connecticut should follow the recommendations of the IOM and fully evaluate and tailor an EHB package that promotes value based insurance design and promotes quality of care based on scientific and clinical evidence. This evaluative process would encourage review of existing state insurance mandates that may be outdated and promote affordability, as each added benefit brings with it an added cost.⁸

After the State chooses an EHB benchmark, WellCare recommends Connecticut avoid changing the benchmark in the future unless it is to eliminate mandates determined to be outdated with evidence. If the State frequently changes the EHB benchmark, it would likely disrupt the market and provide significant administrative burdens to health plans. We recommend that should the State choose to change its benchmark that it engages stakeholders, including health plans and consumers, and conduct a formal impact evaluation, before changing an Exchange EHB benchmark.

Plan Design Flexibility

Recommendation: WellCare supports plan product design flexibility to ensure products: meet the unique needs of individuals, especially for those with chronic conditions and low-income populations; promote consumer choice; improve provider access; and use innovation to foster quality improvement.

If qualified health plans participating in the Exchange are required to provide the identical scope of services and are prevented from substituting benefits across categories, products will look similar and consumers will likely only be able to compare Exchange products based on brand and price. Allowing plans to tailor products to unique populations increases product differentiation and promotes consumer choice. WellCare supports substitution in benefits both within the 10 ACA-required EHB benefit categories and across benefit categories.

Plan design flexibility may also help solve emerging access to care issues. There are many in the policy field who are concerned with the impact the implementation of the Exchange and Medicaid expansion will have on access to providers in 2014. If plans have design flexibility, they can supplement their networks with other providers (e.g. using nurse practitioners to supplement primary care providers) likely reducing anticipated access to care issues.

Health plans have generally implemented innovative care management tools aimed at quality improvement, better outcomes, greater value and affordability. Management tools, such as disease management, use of reminder systems, provider and patient education efforts, and financial incentives, provide added value to health care and plans should have the flexibility to add these features to plan design and further design innovation. As stated by the IOM “these practices help hold down premiums, as do higher levels of deductibles and cost-sharing.”⁹

Similarly, WellCare supports flexibility in designing prescription drug benefits. The HHS Bulletin on EHB benchmarks indicates HHS intends to use Medicare Part D standards related to drug category and class lists, requiring all plans to offer at least one drug in the same category or class as included in the EHB benchmark, even if the plan formulary varies. As a Part D plan sponsor in 49 states and the District of Columbia, WellCare promotes the Part D program, in general, as a flexible federal program. As described above, we believe that plans can offer a variety of products with different options, including prescription drug options, to promote consumer choice.

Critical Timelines: EHB Selection and Provider Service Areas

Key Concerns: Plans need to know state benchmark selections as well as provider service areas as quickly as possible.

While WellCare supports state flexibility in determining the EHB benchmark, state selection adds another significant milestone to the Exchange implementation timeline. Without information on what benefits a particular Exchange will provide, health plans are unable to build products. Similarly, plans need to know how the State will define provider service areas for purposes of the Exchange. The success of state Exchanges will greatly rely on the readiness of health plans; and plans need sufficient time to develop Exchange products and have them filed and approved by state regulatory entities. Product development is a time consuming process that can take as long as 12-18 months and may include market research, benefit

⁹ IOM Report—*Essential Health Benefits: Balancing Coverage and Cost*. October 7, 2011.



design, rate development, contractual work with providers and third-party vendors, regulatory filings, system updates, marketing, and web development.

Conclusion

All of the issues raised above (e.g. creating a BHP, separating individual and small group markets, affordability, promoting plan design flexibility) will have an impact on the Exchange marketplace. Connecticut should be cautious to ensure markets are competitive and that all plans, regardless of size and scope, are able to participate. Promoting product differentiation, affordability, and choice of plans all aim to support the needs of the consumer. Creating a BHP achieves these goals for consumers with additional challenges.

We hope our responses will serve as the beginning of an ongoing conversation regarding how we can work in partnership with the State of Connecticut to implement the ACA. WellCare is dedicated to improving the health of our members, and we know from our experience that one of the best ways to achieve member health is to ensure consistent health insurance coverage.

Thank you for your consideration. If your staff would like further detail on any of our recommendations, please feel free to contact me at 203.497.2803.

Sincerely,

Randolph S. Wojnarowicz
Market Director