JAN 2012

Exchange Plan: 2011 Progress for Implementation of the Connecticut Health Insurance Exchange

Connecticut Health Insurance Exchange

CEO Report

Contents

INTRODUCTION

Pursuant to section 12 of Public Act No. 11-53, the following report provides an update on the plan to establish the Connecticut Health Insurance Exchange (Exchange). While the body of this report addresses each of the statutory requirements set forth in section 12 of the Act, this introduction summarizes the activities undertaken over the past year and the major work efforts underway in 2012. During calendar year 2011, Connecticut made considerable progress in establishing a state-based Health Insurance Exchange that will best serve the interests of Connecticut residents and businesses.

March 2010

- President Obama signed the Affordable Care Act (ACA) into law requiring states to establish and operate a Health Benefit

June 2011

- Public Act 11-53 established a quasi-public insurance Exchange and governance structure
- Authority to be governed by a 14 member Board of Directors

September 2011

- Exchange Board held its first meeting

January/February 2012

- Advisory Committees being established to address critical issues regarding the development and operation of the Exchange

Fall 2012

- Connecticut must apply for Federal certification by completing Certification Application and demonstrating Operational Readiness

January 1, 2013

- Exchange must be certified for operation by the federal government.

INPUT FROM STAKEHOLDERS

In the spring of 2011, public forums and stakeholder meetings were held across the State to solicit initial input from a wide range of individuals, community groups and industry organizations. Six public forums were held to provide the general public and interested parties with basic information on how the State is planning for an Exchange, to provide information on activities to date, and to solicit feedback on how Connecticut's citizens envision their Exchange development. Along with these public forums, over 80 stakeholder organizations, organized by professional category, were invited to participate in focused discussions to enable key constituencies to advise the State on a number of important Exchange issues. The input from these meetings, as well as ongoing advice from a wide range of individuals, organizations, and the Exchange Board of Directors, has helped the State in the development of Exchange planning efforts to date.

ESTABLISHMENT OF ADVISORY COMMITTEES

To build from our initial outreach efforts and formalize stakeholder involvement in Exchange development, the Board formed four Advisory Committees comprised of 15 members to ensure a broad array of interests are represented in Exchange formation. The Advisory Committees will serve to support an open, transparent process that will solicit and incorporate as much stakeholder input as possible, both short and long term, from the private and public sectors.

These Committees have been organized by topic areas and tasked to look critically at issues and options regarding the development and operation of the Exchange in the following topics:

1) Health Plan Benefits and Qualifications
2) Small Business Health Options Program (SHOP) Exchange
3) Consumer Experience and Outreach
4) Brokers, Agents and Navigators

Each Advisory Committee has been co-chaired by a Board member and an external stakeholder.

The input from stakeholders is critical to the successful establishment of an Exchange that works best for the people and businesses of Connecticut. Accordingly, for many of the issues that this plan is required to address, pursuant to Public Act 11-53, recommendations have not been finalized. While we have made significant progress and gathered valuable information that will help inform our discussions, the Advisory Committees' work over the next several months will help us develop the preferred approach for these and many other issues. In addition, federal policies and regulations on a wide range of health reform issues, many of which apply to the Exchange, have not yet been finalized. Pending the finalization of these regulations, the Exchange Board will need to carefully weigh its options and consider the implications before making final decisions.

EVALUATING OPTIONS ALLOWED UNDER PATIENT PROTECTION AND AFFORDABLE CARE ACT

Another key to guiding Exchange development and implementation strategy was to establish a baseline understanding of the current market conditions and the advantages and disadvantages of various options afforded states under the Patient Protection and Affordable Care Act (ACA). To assist with this evaluation, the State contracted with Mercer Health and Benefits, LLC (Mercer) to conduct background research and analysis. The reports prepared by Mercer have provided a foundation of information – some of which has been used in the development of this report – which the Exchange will build from in the development of policy and the establishment of the Exchange.

EXCHANGE GOVERNANCE

With regard to governance and administration of the Exchange, the passage of Connecticut's Public Act 11-53 in June 2011 provided the necessary legal authority and infrastructure to move ahead with the development of a fully-functioning State-administered Health Insurance Exchange. The Act established the Exchange as a quasi-public authority governed by a 14-member Board of Directors. Lieutenant Governor, Nancy Wyman, was appointed chair of the Exchange Board of Directors.

Since initially convening in September 2011, the Exchange Board has been involved primarily in vendor procurement, planning grant research activities, and hiring the initial leadership team. An executive search firm has been brought on board to ensure that necessary staff is assembled within time frames required to support key federal deadlines. The initial Exchange team includes the positions of: Chief Executive Officer (CEO), Operations and Finance Officers, Legal Counsel, Policy and Plan Management Director, Marketing and Communications Director, Information Technology (IT) Officer and related support staff to administer the Exchange. An acting CEO has been in place since December 2011 and has assumed responsibility for work needed to meet the aggressive

federal deadlines until a permanent CEO is hired. As required under the Exchange statute, the permanent CEO will be recommended by the Board of Directors, and selected by Governor Malloy.

LEVEL ONE ESTABLISHMENT GRANT

To build on the work from the federal planning grant and to further Exchange development, the State applied for a federal Level One Establishment Grant. In August

2011, Connecticut was awarded $6.7 million from the Center for Consumer Information and Insurance Oversight (CCIIO) to provide resources dedicated to the development of an administrative structure, business operations and related informational technology, as well as consumer assistance program assessment and support.

The Exchange recently awarded two major contracts; one to assist with the development of the business requirements and related IT systems (KPMG), and a second vendor (Mintz & Hoke) to assist with the development of an effective outreach and marketing strategy. These two engagements have recently begun and are discussed briefly below.

These efforts, as well as others, will need to be completed over the next year as the State moves ahead with the establishment of an Exchange.

In the fall of 2012, Connecticut will need to submit an application to the federal government to request certification to operate a State- based Exchange.

Successful execution of these plans over the next 12 months will determine whether the State will be able to continue to establish an Exchange that works best for the residents and businesses of Connecticut.

KPMG, our technical assistance vendor, will assist the Exchange with the iterative process of moving from planning through procurement and implementation activities. This interdisciplinary vendor, who began work in early February, is focusing on both business process functions and related IT systems. The projected completion date of this work is August 2012, which will enable the Exchange to procure the necessary systems, resources and infrastructure to provide for a successful Exchange open enrollment starting in October 2013.

Mintz & Hoke Communications Group was selected through a competitive procurement and will be instrumental in helping the Exchange develop the necessary outreach and marketing strategy to ensure understanding and subsequent success in reaching and engaging the diverse citizenry of Connecticut. It is critical that we build a consumer-centric model that generates a cultural shift in approach for outreach and engagement. Mintz & Hoke has begun the initial outreach to stakeholders, by facilitating “discussion forums” aimed at gathering input from key stakeholders as the Exchange planning process continues. Seven meetings have been scheduled throughout the state.

GOVERNING LEGISLATION OF THIS REPORT

Pursuant to Section 12 of Public Act No. 11-53, this report addresses ten (10) key issues designated in the Act.

Sec. 12. (NEW) (*Effective from passage*) (a) Not later than January 1, 2012, and annually thereafter until January 1, 2014, the Chief Executive Officer of the Exchange shall report, in accordance with Section 11-4a of the General Statutes, to the Governor and the General Assembly on a plan, and any revisions or amendments to such plan, to establish a health insurance exchange in the State.

Such report shall address:

1. Whether to establish two separate exchanges, one for the individual health insurance market and one for the small employer health insurance market, or to establish a single exchange;
2. Whether to merge the individual and small employer health insurance markets;
3. Whether to revise the definition of "small employer" from not more than fifty employees to not more than one hundred employees;
4. Whether to allow large employers to participate in the Exchange beginning in 2017;
5. Whether to require qualified health plans to provide the essential health benefits package, as described in Section 1302(a) of the Affordable Care Act, or include additional state mandated benefits;
6. Whether to list dental benefits separately on the Exchange's Internet website where a qualified health plan includes dental benefits;
7. The relationship of the Exchange to insurance producers;
8. The capacity of the Exchange to award Navigator grants pursuant to Section 9 of this act;
9. Ways to ensure that the Exchange is financially sustainable by 2015, as required by the Affordable Care Act including, but not limited to assessments or user fees charged to carriers; and
10. Methods to independently evaluate consumers' experience, including, but not limited to, hiring consultants to act as secret shoppers.

As noted in the Introduction, recommendations have not been finalized for each of these ten (10) key issues. Rather, the Exchange's Advisory Committees will focus on these and other issues over the next several months. Their efforts, in conjunction with considerable work and research that has been done to date, will guide the Exchange in developing the preferred approach for Connecticut. The Advisory Committees will also incorporate federal policies, regulations and guidance as these are issued over the course of the year.

The narrative that follows provides background information, discussion points, and preliminary direction on each of the above ten (10) key items required to be addressed in the plan for establishment of a Health Insurance Exchange for the state of Connecticut.

Item 1:

Whether to establish two separate Exchanges, one for the individual health insurance market and one for the small employer health insurance market, or to establish a single Exchange.

KEY INFORMATION

The Patient Protection and Affordable Care Act (ACA) allows states the option to establish two separate exchanges – a Small Business Health Options Program (SHOP) Exchange for employers and the American Health Benefit Exchange for individuals and families – or a single exchange to serve both markets. The decision to administer a single exchange does not require the individual and small group markets to be combined for risk pooling purposes (discussed further below). That is, Connecticut may choose to designate a single administrative entity to operate the exchange for both individuals and employers, while still maintaining separate risk pools for the individual and small group markets.

DISCUSSION

Many of the requirements of the SHOP exchange are virtually identical to the requirements of the individual market exchange; including, but not limited to, the health plans that will be offered, the summary of benefits information to be provided to consumers/employees, the rating of health plans based on quality and price, and health plan reporting requirements.

Both the SHOP and individual exchange may only offer "qualified health plans" within specified benefit levels: Platinum, Gold, Silver, and Bronze. The benefit levels will vary based on "actuarial value," which is a summary measure of the amount of medical claims paid by the health plan (excluding a member's point-of-service cost sharing), expressed as a percentage of the total medical claims incurred for a standard population.

Platinum plans will cover 90 percent of the average cost of care, which means an individual purchasing a Platinum plan can expect to have 90 percent of his/her medical costs covered by the premium, with the remaining ten percent paid through point-of-service cost sharing (i.e., co-payments, co-insurance, deductibles). Gold plans will cover 80 percent; Silver plans will cover 70 percent; and Bronze plans will cover 60 percent.

While there are multiple opportunities for coordination across markets, there are key differences that should be noted as well. Specifically, the individual market exchange may offer a "catastrophic" plan, or high deductible health plan, to certain individuals (i.e., under age 30 or people who are exempt from the individual mandate based on affordability of coverage).

These catastrophic plans will not be available in the small group market and will not be offered to employers purchasing through the SHOP exchange.[1]

[1] While high deductible health plans, as defined by the Internal Revenue Service, may be purchased by small employers, the ACA limits the size of the upfront deductible for small employer plans to no more than $2,000 for individual coverage and $4,000 for family coverage.

The law limits the maximum upfront deductible for health plans purchased by small employers. In 2014, small group health plans may not have an upfront deductible that exceeds $2,000 for single coverage and $4,000 for family coverage. These limits do not apply to the individual market, although the actuarial value standards noted above will effectively cap the amount of upfront deductible that may apply to individual coverage sold through the Exchange.

While there will be differences in the manner by which health insurance is made available and purchased in the individual market and the small group market, there is considerable overlap in the administration of the individual and SHOP exchanges. For example, the enrollment process will be comparable across markets, and carriers will offer comparable coverage in the individual market and small group market.

The proposed rules issued by CCIIO acknowledge a state's option to establish separate governance and administrative structures, however, the preamble to the rule notes that "we (CCIIO) believe that a single governance structure for both the individual market functions and SHOP will yield better coordination, increased operational efficiencies, and improved operational coordination."[2]

As part of our assessment of this issue, we also reviewed the manner by which other states have established their exchanges. Every state that has moved forward with the establishment of a state-based exchange, either through legislation or executive order, has opted for a single governance and administrative structure. To date, no state has opted to separate the SHOP exchange from the individual exchange.

NEXT STEPS

The Small Business Health Options Program (SHOP) Exchange Committee will move forward in developing recommendations on this issue. In doing so, the most relevant considerations will include:

1) Coordination across markets (i.e., individual and small group)
2) Leveraging infrastructure and resources to serve both exchanges
3) Achieving administrative efficiencies

We recognize that each market will have different needs, but these two programs may be best delivered through a coordinated approach that leverages administrative efficiencies, allows for shared resources, and enables closer coordination. In 2012, The SHOP Advisory Committee will work with the Consumer Experience and Outreach Committee to develop a final recommendation on this issue.

[2] Department of Health and Human Services, Federal Register, Volume 76, Number 136, July 15, 2011, Proposed Rule, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," Page 41873.

Item 2:

Whether to merge the individual and small employer health insurance markets.

KEY INFORMATION

The Patient Protection and Affordable Care Act (ACA) allows states to combine the small group market and the individual market risk pools. At this time, Massachusetts is the only state that has fully merged these risk pools.

The driving force behind merging the markets is a desire to protect and lower costs for individual policyholders who may have less negotiating power. From a very simple perspective, merging the markets will equalize premiums. Therefore, if premiums are lower in the small group market prior to the merger, then small group premiums will increase and individual premiums will decrease (or vice versa). The amount of the change in each market depends on the relative size of the markets prior to the merger. If the total market is dominated by small group, the change to individual premiums can be substantial (or vice versa).

DISCUSSION

Complicating this decision is the fact that both the small group and individual markets will undergo significant changes as a result of the requirements of the ACA. However, the regulatory changes will affect the two markets differently. In addition, the individual market will likely expand significantly in 2014 and beyond as a result of the individual mandate, the availability of premium subsidies, and the potential for reduced cost sharing through the Exchange.

Currently, the individual and small group markets in Connecticut operate as separate risk pools with different rating and underwriting rules. In the small group market, coverage is provided on a guarantee issues basis (i.e., employers and employees cannot be denied coverage) and premiums are based on a modified community rating system, in which a group's claims experience or morbidity (i.e., the relative frequency of a disease or illness among group members) is not used as part of the rate development process.[3] Conversely, in the individual market, carriers are allowed to base rates on an individual's health status or expected claims, and carriers may choose to deny coverage (i.e., there is no guarantee issue requirement) based on an applicant's health status.[4]

The rating rules, particularly for the individual market, will change significantly in 2014. In general, the same basic rating rules will apply to both the individual and small group markets for coverage effective January 1, 2014 and beyond. The change in the rating rules for the individual market will prohibit carriers from setting rates based on the health status of applicants, as well as require that policies be sold on a guarantee issue basis. In addition, the availability of premium subsidies for lower-income individuals and families may greatly increase the number of people who purchase coverage in the individual market.

[3] Connecticut Statutes, Chapter 700c, Sec. 38a-564

[4] Applicants that are denied coverage in the individual market are eligible to purchase coverage in Connecticut's high risk pool.

Mercer's report to the Connecticut Exchange estimates that in 2014 the influx of the previously uninsured subsidy-eligible population to the individual market will more than double the size of this market. However, because people with pre-existing conditions and those with poor health will be able to purchase coverage in the individual market in 2014 – and premiums will not reflect an individual's health status – the relative morbidity of the individual market will increase an estimated 12% over the current market.[5]

In the small group market, Mercer estimates that the current morbidity is 5% higher than the current individual market (i.e., the small group market, on average, is less healthy than the individual market). However, because the rating rules in effect in 2014 are comparable to the current rating rules in Connecticut's small group market, Mercer does not believe that morbidity in the small group market will change significantly in 2014.

As a result of the changes to the rating rules, the morbidity in the individual market is expected to be higher (i.e., become less healthy, overall) than the morbidity in the small group market in 2014. Specifically, Mercer estimates that the relative morbidity of the small group market will be 5% greater than the population overall, and that the relative morbidity of the individual market will be 12% greater. If the markets were merged, Mercer estimates that rates in the individual market would decline by 2%, while rates in the small group market would increase by 4%.[6]

NEXT STEPS

In 2012, there will be further action on this item. The Small Business Health Options Program (SHOP) Exchange Committee will move forward in addressing this issue and will develop a recommendation based on the following:

- Significant changes in the markets that will take effect in 2014.
- Uncertainty with regard to the actual enrollment in the individual market.
- Estimates that merging the markets may raise rates in the small group market by 4%.

In addition, research in the potential effects, both positive as well as negative, which may result from these merging markets, will be part of the Advisory Committee's responsibilities.

Item 3:

Whether to revise the definition of small employer from "not more than 50 employees" to "not more than 100 employees."

KEY INFORMATION

Effective for plan years starting January 1, 2016 and after, the ACA requires the small group insurance market definition to include groups with up to 100 employees. However, the law allows the restriction of the small group definition to 50 employees for plan years in 2014 and 2015.

[5] Mercer Health Insurance Exchange Planning Report, dtd. January 19, 2012 (p.24)
[6] Mercer Health Insurance Exchange Planning Report, dtd. January 19, 2012 (p.24)

Connecticut currently defines small groups as those with 1 to 50 employees.[7] Rates in the small group market are calculated on the basis of modified community rating, and they may only vary based on the group's demographic make-up. Allowable factors include age, gender, and family size.[8] In contrast to the small group market, rates in the mid-group market (i.e., groups with 51 to 100 employees) are based, in part, on the employer's health claims experience (i.e., the relative health utilization or morbidity of a group's members).

DISCUSSION

The majority of the analysis to date regarding the decision to expand the small group market prior to 2016 suggests that most states will continue to restrict the definition of "small employer" to 50 lives until required to do so. The rationale for this is largely due to risk mitigation. Businesses with 51 to 100 workers are more likely to have alternative coverage arrangements marketed to them, including self-insured plan arrangements combined with stop-loss reinsurance. Allowing businesses with 51-100 employees into the small group market immediately could raise premiums because of adverse selection, in which employers with healthy workforces choose to self-insure while businesses with less healthy workforces choose to take advantage of the non-health-rated coverage available through the newly expanded small group market.

A move to a modified community rating for mid-sized groups – as will be required when the small group market is expanded to 100 employees – will likely push some of the healthier mid-sized groups to self-insure in an effort to reduce costs.

Self-insuring in Connecticut is allowed at relatively low attachment points, which means that groups that choose to self-insure their health benefits do not need to assume significant risk associated with high cost claims.[9]

Mercer estimates that opening the SHOP Exchange to mid-sized groups in 2014 could increase enrollment in the SHOP by approximately 6,000 lives, or roughly five percent of the Exchange's total estimated enrollment.

The advantages of opening the SHOP to mid-sized employers prior to 2016, according to Mercer, include: a moderate increase in the number of enrollees in the Exchange over which to spread the Exchange's administrative costs; potential access to lower cost insurance for mid-sized groups with relatively high morbidity; and greater interest of insurers to participate in the SHOP market.

However, opening the SHOP Exchange to mid-sized employers prior to 2016 would require the State of Connecticut to expand the definition of the small group market, both inside and outside the Exchange, to include employers with up to 100 employees. This would subject all mid-sized employers to the ACA's modified community rating rules in 2014, which could potentially result in some premium disruption due to the requirement that these mid-sized employers would have their rates based on modified community rating. At present, premiums in the mid-sized market are set

[7] Connecticut Statutes, Chapter 700c, Sec. 38a-564
[8] Connecticut Statutes, Chapter 700c, Sec. 38a-567
[9] Connecticut Insurance Department Bulletin Number PC-11 & HC44 requires that the employer's retention must be "at least $6,500 per individual or family."

differently, using, in part, each group's claims experience.

As a result, an unintended consequence to expanding the small group definition could be an initial deterioration in the morbidity of the newly-expanded, small group market as mid-sized employers with relatively healthy workers would self-insure until their experience deteriorated and it then became financially advantageous to enroll in the fully insured small group market.

NEXT STEPS

In 2012, the Board's Advisory Committee on the SHOP Exchange will be asked to review this issue further. Additional research into the potential effects, positive as well as negative, which may result from expanding the small group market to include employers with up to 100 employees, prior to the January 2016 requirement, will be further analyzed and a final recommendation will be developed by the Advisory Committee.

Item 4:

Whether to allow large employers to participate in the Exchange beginning in 2017.

KEY INFORMATION

Beginning in 2017 under the ACA, states have the option to allow health insurers to offer large employers, those with more than 100 employees the opportunity to purchase qualified health plans through the Exchange.[10] The large employer pool and its products and pricing can remain separate from the individual and small group pools. That is, while large employers could purchase coverage through the Exchange in 2017, the definition of small groups would not need to be changed. Plans offered through the Exchange must be qualified health plans requiring, among other things, that products sold inside the Exchange be offered at the same price as those sold outside of the Exchange. As currently written, this provision may require large employers who purchase coverage through the Exchange to set their premiums based on a modified community rating system.

DISCUSSION

Mercer reports that in 2009, roughly 27% of employers with 100 to 499 employees in Connecticut chose to self-insure their health benefits. For Connecticut employers with 500 or more employees, the rate of self-funding was 82%. Large employers choose to self-insure their health benefits for a number of reasons, but the single most important reason is to reduce costs. In addition, self-insured plans are not subject to the State mandates that fully insured plans must include.

Large employers are relatively sophisticated purchasers of employer-sponsored insurance and able to weigh various options regarding the provision of health benefits to their employees. If large employers are given the choice of a modified community rated plan in the Exchange, an experience-

[10] ACA Sec. 1312

rated product outside of the Exchange, or self-insuring their health benefits, they will choose the lowest cost option. This responsiveness to financial incentives among larger employers has the potential to lead to considerable adverse selection against the plans offered through the Exchange.

NEXT STEPS

It is anticipated that in future, the Board's Advisory Committees will review this issue further. Because the earliest that the Exchange can expand to large employers is 2017, this issue is not a priority in the near term. It is likely that this decision will not be made until the Exchange is operating and the insurance markets have adjusted to the new rules required by the ACA. At that time, the Exchange can consider this market expansion and make a more informed decision.

Item 5:

Whether to require qualified health plans to provide the essential health benefits package, as described in Section 1302(a) of the Affordable Care Act, or include additional state mandated benefits.

KEY INFORMATION AND DISCUSSION

The ACA[11] requires the Exchange to offer qualified health plans that cover all of the essential health benefits (EHB), which are described in broad terms in the federal law. The ACA instructs the Secretary of Health and Human Services (HHS) to provide additional details on the benefits and services to be covered under the EHB, which must equal the scope of benefits provided under a typical employer plan. In defining these benefits, the law directs the Secretary to establish an appropriate balance among the benefit categories, and requires that the benefits be designed in ways that do not discriminate based on age, disability, or expected length of life. Instead, benefits must consider the health care needs of diverse segments of the population.

For coverage purchased through the Exchange, Section 1311(d)(3) of the ACA requires states to defray the cost of any benefits required by state law (i.e., state mandated benefits) that exceed the benefits and services identified by the Secretary as part of the essential health benefits package. The statute distinguishes between a plan's covered services and the plan's cost-sharing features, such as deductibles, copayments, and coinsurance.

On December 16, 2011, the Secretary issued a bulletin[12] that describes HHS' proposed approach to the EHB requirements. The Secretary's proposed approach seeks to balance comprehensiveness, affordability, and state flexibility by allowing each state to set an essential health benefits package that reflects plans typically offered by small employers and benefits that are covered across the current employer marketplace. HHS proposes that each state will be allowed to utilize a benchmark plan selected by the state to define what is included under the state's essential health benefits package.

[11] ACA, Section 1302

[12] http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html

Benchmarks for Essential Health Benefits

For 2014 and 2015, the US Secretary of HHS proposed that the following four plan types may be used by States as benchmarks in designing Essential Health Benefits:

1) Largest plan by enrollment in any of the three largest small group insurance products (e.g., HMO, PPO, POS) in the state's small group market;
2) Any of the largest three state employee health benefit plans by enrollment;
3) Any of the largest three national Federal Employee Health Benefit Plan (FEHBP) options by enrollment; or
4) Largest insured commercial, non-Medicaid Health Maintenance Organization (HMO) operating in the state.

The law lists the following categories of services that must be covered under the EHB:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

According to HHS, "the selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a 'typical employer plan' in that State as required by section 1302(b)(2)(A) of the Affordable Care Act. This approach is based on the approach established by Congress for the Children's Health Insurance Program (CHIP), created in 1997, and for certain Medicaid populations."[13]

HHS intends to assess the benchmark process for 2016 and beyond based on evaluation and feedback. Connecticut would be permitted to select a single benchmark to serve as the standard for qualified health plans and plans offered in the individual and small group markets.

If a state does not exercise the option to select a benchmark health plan, HHS intends to propose that the default benchmark plan for that state would be the largest plan by enrollment in the largest product in the state's small group market.

State Mandated Benefits

Section 1311(d)(3)(B) of the Affordable Care Act requires states to defray the costs of state-mandated benefits in excess of the essential health benefits for individuals enrolled in any qualified health plan through the Exchange either in the individual market or in the small group market. According to HHS, the approach for 2014 and 2015 would provide a "transition period for states to coordinate their benefit mandates while minimizing the

[13] Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin," December 16, 2011, page 8

likelihood the state would be required to defray the costs of these mandates in excess of EHB.

In the transitional years of 2014 and 2015, if a state chooses a benchmark subject to state mandates – such as a small group market plan – that benchmark would include those mandates in the State EHB package. Alternatively, a state could also select a benchmark such as a Federal Employee Health Benefit Plan (FEHBP) that may not include some or all of the state's benefit mandates, and therefore under Section 1311(d)(3)(B), the state would be required to cover the cost of those mandates outside the state EHB package. HHS intends to evaluate the benchmark approach for the calendar year 2016 and will develop an approach that may exclude some state benefit mandates from inclusion in the state EHB package."[14]

Sec. 14 of Public Act No. 11-53

The Office of Health Reform and Innovation, in consultation with the Exchange Board of Directors shall prepare an analysis of the cost impact on the state and a cost- benefit analysis of the essential health benefits package and coverage requirements under chapter 700c of the general statutes.

Not later than sixty days after secretary publishes the essential health benefits, the Office of Health Reform and Innovation shall submit such analysis.

Connecticut's Mandated Benefits

To assist the state in evaluating the potential cost implications of requiring qualified health plans to cover state mandated benefits that may exceed the EHB, Connecticut contracted with Mercer.[15]

NEXT STEPS

Based on the December 2011 EHB guidance issued by HHS, states have been provided considerable latitude to determine which benefits and services will be included in their essential health benefits package to be included in the Exchange's qualified health plans and in health plans offered in the individual and small group markets. This guidance provides the state with latitude that will temporarily obviate the requirement that the state pay the cost of state mandates that may have exceeded a federal definition of the essential health benefits package.

However, the state will need to determine the EHB for Connecticut. Because the EHB applies to all plans sold in the individual and small group markets, the State should consider establishing a multi-agency task force – including representation from the Exchange, the Department of Insurance, the Consumer Health Advocate, executive and legislative leaders, as well as other key stakeholders – to compare and contrast the four benchmark plan types that may be chosen as the EHB for Connecticut.

The decision regarding which benchmark plan to use will need to be finalized no later than September 2012, to allow insurers sufficient time to modify their plan designs, if necessary, to

[14] "Essential Health Benefits Bulletin," Page 9

[15] The state mandated benefits report prepared by Mercer was drafted prior to the mid-December issuance of HHS's Essential Health Benefits Bulletin.

reflect the EHB requirements. Subsequent to the decision regarding the EHB for Connecticut, the State will need to assess the potential cost of any State mandated benefits that may, in 2016, exceed the federal government's definition of essential health benefits.

The Exchange Board's Advisory Committee on Health Plan Benefits and Qualifications, as well as the Advisory Committee on Consumer Experience and Outreach, will also review the Essential Health Benefit options available to Connecticut. Their input and advice will help inform policymakers who will be responsible for determining which EHB package will work best for Connecticut. Since the EHB applies to the entire small group and individual markets, and is not limited to the qualified health plans offered through the Exchange, it will be important to solicit views representing a broad and diverse spectrum of stakeholders.

Item 6:

Whether to list dental benefits separately on the Exchange's Internet web site where a qualified health plan includes dental benefits.

KEY INFORMATION

The ACA[16] requires the Exchange to allow for the offering of limited scope stand-alone dental plans provided that the plans furnish at least the pediatric essential dental benefits required under the law. The ACA provides the Exchange with the option for a dental plan to be offered as a stand-alone plan or in conjunction with a qualified health plan.

DISCUSSION

Under proposed rules issued in July 2011 by CCIIO, the preamble to the rule notes that CCIIO received comments from certain groups requesting that the proposed rules require all dental benefits to be offered and priced separately from medical coverage, even when offered by the same issuer. This type of requirement would preclude insurers from offering a bundled health plan that covers the essential health benefits and a pediatric dental benefit under one premium. The discussion in the preamble to the rule notes that "while we (CCIIO) recognizethat requiring a QHP to price and offer dental benefits separately could promote comparison ofdental coverage offerings, we have significant concerns about the administrative burden this could impose on Exchanges and QHP issuers."[17]

NEXT STEPS

Over the next several months, the Exchange will assess the advantages and disadvantages of offering a stand-alone dental plan, listed and priced separately; or to alternatively allow insurers

[16] Section 1311(d)(2)(b)(ii) of the ACA.

[17] [15]Department of Health and Human Services, Federal Register, Volume 76, Number 136, July 15, 2011, Proposed Rule, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," Pg. 41895

the option of offering a bundled health plan that includes a limited scope dental benefits plan. The Exchange will need to make a decision by November, 2012. The Health Plan Benefits and Qualifications Advisory Committee will be responsible for making a recommendation on the best approach. In addition, the Advisory Committee on Consumer Experience and Outreach will be called upon to offer its perspective on the advantages and disadvantages, from the consumer's perspective, with regard to the manner by which stand-alone dental benefits are offered by the Exchange.

Items 7 & 8:

The relationship of the exchange to insurance producers; and

The capacity of the exchange to award Navigator grants pursuant to section 9 of this act.

KEY INFORMATION

The Exchange will need to help people apply for health coverage, determine their eligibility for subsidized health care (Medicaid, HUSKY, and Exchange subsidies), aid people in their assessment of health coverage options, and facilitate enrollment in a qualified health plan. Instituting a proactive outreach, education, and enrollment program will be crucial to Connecticut's ultimate success in extending health insurance coverage to tens of thousands of uninsured residents.

Navigators will be responsible for:

- Conducting public education activities to raise awareness of the availability of qualified health plans through the Exchange;
- Distributing fair and impartial information concerning enrollment and the availability of premium subsidies and cost- sharing reductions;
- Facilitating enrollment in qualified health plans;
- Referring people to the appropriate agency or agencies if they have questions, complaints, or grievances; and,
- Providing information in a culturally and linguistically appropriate manner.

DISCUSSION

If the Exchange is to attract a sufficient volume of individuals, families and small businesses, it will be imperative to develop a multi-pronged outreach, education, and enrollment program. Such an effort will likely include a broad range of organizations and individuals, including, but not limited to, Exchange staff, social service agencies' staff, schools, community and faith-based organizations, employers, business groups, hospitals, community health centers, physicians, health insurers, brokers and agents, paid media and public service announcements.

In addition to establishing a web site, a customer service unit and call center, as well as walk-in centers to help people with the eligibility and enrollment process, the Exchange plans to contract with outside entities to assist individuals with eligibility and enrollment. The ACA requires the Exchange to establish a Navigator program. Navigators will be responsible for informing people of their health coverage options and helping individuals enroll in a health plan. Navigators are entities

such as trade, industry, and professional associations; chambers of commerce; unions; community based non-profit groups; brokers and agents; and other groups that have established or can readily establish relationships with employers, employees, consumers, or self-employed individuals.

The Exchange will establish a Navigator Program for awarding grants to Navigators. In addition to Navigators, the Exchange will need to determine how best to utilize brokers and agents to assist consumers. Brokers play an important role in the distribution of health insurance, particularly in Connecticut's small group market. Business owners rely on brokers to sort through their health insurance options, provide health plan recommendations at the time of renewal, and serve as their agents throughout the year in dealings with insurance companies.

In determining the appropriate role that brokers and Navigators may play in the operation of Connecticut's Exchange, a number of key questions will be considered. These include, but are not limited to:

- What type of assistance is currently provided by various organizations, and how might the Exchange involve these groups in its outreach, education, and enrollment efforts?
- What should be the role of Navigators, and should Navigators be credentialed or licensed as a condition for participating in the Exchange?
- If so, how might the credentialing or licensing be administered and what role should the Connecticut Department of Insurance (CID) play?
- What is the current role of brokers and agents in the individual and small group markets, and how can the Exchange best leverage that expertise?
- What should be the role of insurers with regard to outreach, education and enrollment?
- How can physicians, hospitals, community health centers, and other front-line entities support outreach and enrollment efforts?
- What types of information will people need to make informed decisions?
- How might the outreach, education, and enrollment needs of individuals differ from the needs of small employers and their employees?

Establishing an effective, efficient and sustainable outreach, education, and enrollment effort will be one of the more important initiatives undertaken by the Exchange. Determining how best to leverage the expertise of health insurance brokers and agents, community-based organizations, health centers and other key groups, and proactively including these individuals in the outreach and enrollment program, will be crucial to the success of Connecticut's Exchange.

NEXT STEPS

The Brokers, Agents and Navigators Advisory Committee will develop recommendations and report back to the full Exchange Board in late Spring 2012. Based on these recommendations, the Exchange will develop a Navigator program and determine the appropriate roles for brokers and agents.

The Committee will be responsible for developing recommendations on how best to structure the Navigator program and how best to leverage the expertise of brokers and agents. There are a number of Federally required components associated with the Navigators such as funding,

qualifications, selection criteria, education activities, licensing standards, and reporting that Connecticut will need to consider. This Advisory Committee is tasked with policy considerations around the role of brokers and Navigators, and to specifically address issues such as the types of potentially qualified entities, demonstration of existing relationships and capabilities for reaching the target markets, licensure and accurate information, conflict of interest standards, linguistic and cultural appropriateness, and other related items.

In addition, the Advisory Committee on Consumer Experience and Outreach will play a key role in developing recommendations on how best to leverage brokers, agents and Navigators to reach consumers and assist in enrollment activities. The Exchange's outreach and marketing contractor will also need to be involved in these discussions, as a proactive education and enrollment campaign is developed.

Item 9:

Ways to ensure that the Exchange is financially sustainable by 2015, as required by the Affordable Care Act including, but not limited to assessments or user fees charged to carriers.

KEY INFORMATION

The ACA requires Exchanges to be financially self-sustainable by calendar year 2015. Prior to this time, the Exchange will be funded by federal grant funds. Policymakers have a number of available options to generate revenue for Exchange operations. Identifying an appropriate method for providing support to this new entity can be a complicated process.

Connecticut should keep the following standards in mind when comparing revenue options:

- **Stability:** Will revenue generated be predictable year-to-year and sufficient to cover operating expenses?
- **Simplicity:** Is the method of revenue generation easy for the Exchange to administer? If applicable, is compliance with any fee or assessment simple for consumers or other entities?
- **Fairness:** Are insurers, consumers, and other interests who benefit from the Exchange bearing an appropriate cost for its operation? Are insurers / consumers who do not access benefits through the Exchange contributing a disproportionate share of the Exchange's revenues?
- **Affordability:** Is the financing mechanism held at a reasonable level to ensure it is affordable to the parties charged?
- **Insurance market effects:** Does the mechanism for funding the Exchange inappropriately distort the health insurance market in Connecticut? Do health carriers enjoy a financial advantage over their competitors by either offering or not offering coverage through the Exchange?

DISCUSSION

There are a number of strategies that the State can utilize to provide financial support for the Exchange. Most of these require the imposition of some sort of assessment or fee upon health

coverage purchased through the Exchange, or if the State wanted to broaden its revenue base, it could assess a fee across all coverage purchased in the commercial insurance market.

Mercer, as part of its consulting contract with the State of Connecticut, reviewed a number of financing options. In their report, Mercer developed a high level budget estimate and the requisite revenues that would need to be generated to enable the Exchange to be self- sustainable by calendar year 2015, the first year in which the Exchange is required to be self- sustainable, per the requirements of the ACA.

One funding model recommended for consideration is for the Exchange to rely primarily on premium assessments applied to all health coverage purchased through the Exchange to support program administration. According to Mercer's budget estimates, the assessment would need to be approximately 2.8% of premiums to achieve a financially sustainable level of revenue. This funding approach is currently used by the Massachusetts Connector Authority, which retains a percentage of premiums to fund its on-going operations.

Another suggested option for financing is to charge a fixed fee when consumers utilize Exchange services. The fee could be structured as a single charge to a consumer upon enrollment or could be rolled into the monthly premium. This fee could be imposed per subscriber (i.e. policyholder) or per enrollee (i.e. policyholder and dependents). The Exchange could require the health carriers to pay this fee or require that the fee be attached to any health premium for coverage sold through the Exchange. Utah's state-based Exchange uses this type of funding model.

In addition to the above mentioned model options, additional revenue could be generated through a fee assessed on health insurers who sell individual and/or small group insurance in Connecticut but choose not to participate in Connecticut's Health Insurance Exchange.

Connecticut could also choose to require all health insurers offering coverage in the state to support the operations of the Exchange. A fee could be limited to health insurers who sell insurance in the small group and individual market, or could apply to all fully insured health coverage purchased in the state. The structure of this fee could be a flat amount for each carrier, adjusted to reflect the size of each carrier, or as a percentage of premiums sold in the state. Connecticut could utilize an existing tax imposed on all insurance premiums as a way to collect this revenue.

A non-traditional approach that the Exchange may consider as a supplemental revenue stream is the selling of advertising. In its simplest form, this strategy could encompass nothing more than selling advertising space on the Exchange website. In this model, revenue could be generated by charging the advertiser for the ability to display their advertisement on the Exchange website for a specified period of time or on a "pay-per-click" basis where the advertiser only pays when a consumer clicks on its link.

NEXT STEPS

Over the next several months, the Connecticut Exchange will be refining the initial budget estimate and reviewing financing options. The decision about how best to finance the Exchange will take into consideration the five key factors noted at the beginning of this section: (1) stability, (2) simplicity, (3) fairness, (4) affordability, and (5) the effect on the insurance market. A subcommittee of the Exchange Board will be responsible for developing a multi-year budget,

reviewing financing options, and recommending a financing strategy that works best for Connecticut.

Item10:

Methods to independently evaluate consumers' experience, including, but not limited to, the hiring of consultants to act as secret shoppers.

KEY INFORMATION AND DISCUSSION

The consumer experience and satisfaction of Connecticut residents is one of the most critical organizing principles governing the development and operation of the Exchange. Health reform presents a historic opportunity for Connecticut to build a consumer-centric model that generates a cultural shift in the manner by which health insurance is purchased and utilized.

For many people who will be offered subsidized health insurance through the Exchange, it may be the first time they have individually purchased health insurance.

The need for consumer assistance reflects the fact that most Connecticut residents – and most U.S. residents, in general – have never purchased health insurance on their own. People either obtain insurance through their employer (perhaps choosing from among a limited number of plans) or they receive publicly subsidized coverage from Medicaid or Medicare. Through the Connecticut Exchange, tens of thousands of new "customers" will be responsible for purchasing health insurance, many of whom will be doing so for the first time. These new customers will need assistance with navigating through their options and making informed decisions.

NEXT STEPS

The Consumer Experience and Outreach Advisory Committee will explore the issues related to the consumer experience including, but not limited to, the following questions:

- How will this diverse population be accessed appropriately, become comfortable with processes, and take advantage of assistance?
- How is value defined and what are the key perspectives, experiences, and interpretations?
- How will eligibility appeals be handled?
- What types of consumer services should be provided?
- How can the Exchange work with other agencies and entities to reach the uninsured?

As part of the development of a comprehensive consumer assistance and outreach program, the Consumer Experience and Outreach Advisory Committee will determine key metrics to evaluate the consumer experience. This information and these measures will be critical as the Exchange refines, over time, its outreach and assistance efforts provided to all Health Insurance Exchange customers.