CT Health Care Reform Advisory Board

Business & Exchange Subcommittee

Summary of May 6, 2010 Meeting

Members Present: Rick Willard (Chair), Leadership Council of the National Federation of Independent Businesses; Bob Dakers, Office of Policy and Management (OPM); Paul Lombardo, CT Insurance Department (CID); Sue Peters, Aetna; Alexandra Thomas, Aetna; Deputy Commissioner Cristine Vogel, Department of Public Health (DPH);

Others Present: Alexis Fedorjaczenko, DPH; and Barbara Parks Wolf, OPM.

The meeting began at 10:30 am.

Rick Willard opened the meeting by asking if anyone had any comments regarding the summary of the previous meeting on April 22nd. There were no comments. Deputy Commissioner Cristine Vogel reminded the group that this is their last chance to meet to develop recommendations for consideration by the Advisory Board.

The following handouts were distributed for the meeting:

- Health insurance exchange overview
- Press release from Maryland on exchange subcontracting
- Exchange recommendations
- Preliminary Thoughts/ Recommendations re Exchanges

In response to a question about potential conflicts between federal and state regulations, Paul Lombardo explained that under the federal Patient Protection and Affordable Care Act (PPAC) state insurance departments have the authority to regulate the exchanges. Where state and federal laws and regulations conflict the federal government allows states to prevail when it benefits consumers.

There was discussion concerning use of state funds.

The group reviewed and discussed two handouts with proposed recommendations regarding establishment of a health insurance exchange. Below are draft recommendations as agreed upon by the subcommittee members.

Recommendations - Health Insurance Exchange

(1) The exchange should offer one-stop shopping that promotes consumer choice and empowers them with:

- Clear information comparing plans and offering plan specifics;

- Real-time decision support tools;
- Eligibility determinations for subsidies, Medicaid, SCHIP or other programs;
- Estimations of premiums once subsidies are applied; and
- Easy enrollment in or purchase of coverage.

(2) The exchange should leave regulation/enforcement to the state insurance commissioner and:

- Does not set up its own regulatory framework – this would add an unnecessary and costly bureaucratic layer and could create solvency or other problems for consumers;
- Maintains the appropriate balance between coverage levels and premium affordability;
- Assures plan solvency and a level playing field by ensuring that every plan in the exchange is regulated equally, subject to the same statutory and regulatory standards. .

(3) The exchange should allow individuals to maintain their current coverage, if so desired, and maximizes choice, consistent with federal law.

(4) The exchange should encourage plan competition, innovation, quality and cost control by:

- Promoting a variety of distribution methods, as provided in federal law, and allowing for broad plan participation in the exchange;
- Promoting the sale of coverage inside and outside of the exchange by supplementing the current market, thus enhancing consumer options;
- Implementing federal regulations related to quality improvement, adequate provider networks, and costs for plans offered throughout the exchange in a manner that improves quality and controls costs, but which do not impose requirements that are not proven methods of achieving these goals.

(5) The exchange should focus efforts on individuals and small groups (e.g., those with 50 or fewer employees, unless otherwise prohibited by federal law) because individuals and small employers with less than 50 employees are those most in need of additional access to insurance.

- Focus on small employers with 50 or fewer employees in the exchange until the deadline of moving to 100 or fewer employees in 2016;
- Any decision to include businesses with over 50 employees before 2016 or businesses with over 100 employees after 2017 should be made by the legislature and not delegated to the exchange and should only occur following a full assessment of the impact of this and other market changes under the federal health care reform law. (See #8)

(6) The exchange should study the impact of federal health care reforms on the State, its residents and stakeholders before layering on any additional requirements (see #8) because:

- Many of the new requirements do not exist in the State today, the details of which are still to be promulgated by HHS, and their effects will need to be measured;
- The need to balance coverage with premium affordability as well as the state issue that state has fiscal liability for adding on mandated benefits.

(7) The exchange should be allowed, as provided in federal law, to contract with other State and private entities to handle certain exchange functions such as:

- "Contract" with DSS to do determination work associated with eligibility for federal premium and cost sharing tax credits;
- Subcontract with entities, as is done by the Massachusetts Connector, to do work related to enrollment, premium billing and collection, etc, as well as potentially with one or more exchanges currently operated by business associations for small businesses to address this market.

(8) The director of the exchange should report annually to the Governor and the legislature regarding the effects of reform on, including but not limited to, small employers, other group markets, individual policy holders, rates of uninsurance and penalty enforcement and results.

(9) The exchange should have a multi-stakeholder "Board of Directors" with nine members serving four year staggered terms with the following representation:

- Actuary
- Health economist
- Small business (50 employees or less)
- Larger business (Over 50 employees)
- Labor
- Health plan benefit specialist
- Provider
- Policy holder in the individual market
- Ex-officio members: Commissioners/designees from the Departments of Social Services, Insurance, and Public Health and the Secretary/ designee of the Office of Policy and Management
- The Chair is appointed by the Governor

(10) Between the passage of the federal Patient Protection and Affordable Care Act and 2014, strong executive leadership is needed in the establishment of the exchange. The Governor, through the state agencies (Executive Order 43),

should be actively pursuing federal grants for the establishment of the exchange and all aspects of state implementation of federal health care reform.

- Such funding must be used for dedicated staff for planning and implementation, to establish the exchange;
- The Board of Directors for the exchange should be established no later than July 1, 2011.

The meeting was adjourned at 1:30 pm.