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.

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; or
- Does not limit networks and/or apply excessive benefit requirements.
- Does assure a level playing field by ensuring that every plan in the exchange is regulated equally, with the same capitalization standards and licensing subject to financial and market conduct exams.

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

(4) The exchange should encourage insurer competition and innovation by:

- Promoting a variety of distribution methods, as provided in federal law, and allowing for broad plan participation in the exchange; and
- Allowing the sale of coverage inside and outside of the exchange by supplementing, not replacing, the current market, thus enhancing consumer options.

(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.

- Do not include businesses with over 50 employees in the exchange until the deadline of 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.

(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 because:

- Many of the new requirements do not exist in the State today, such as the medical loss ratio requirements, and their effects will need to be measured;
- The state has fiscal liability for adding on mandated benefits; and

- Many of the new requirements are required to be reviewed and adjusted by the federal government.

(7) The exchange should be allowed 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 an exchange 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 small employers; rates of insured versus uninsured; and employers that do not provide insurance and choose the penalty.

(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, hired by the Governor, 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.