CT's Heath Insurance Exchange – Important Decisions, Rebuilding Public Trust

Why it matters for CT?
The individual mandate only works if there is a fair and open marketplace. The exchange will cover one in ten Connecticut residents. 140,000 people eligible for federal subsidies will have to purchase coverage in the exchange.

Public trust in the exchange is critical
People forced to buy insurance have to believe that they aren't wasting their money; that they are paying for more empty coverage. If the public doesn't trust the integrity of the exchange, more people will "choose" to pay the penalty, remain uninsured and end up in the publicly-funded safety net.

Operational decisions for Board
The Board must develop standards for which insurance plans get into the exchange including quality, administrative cost limits, limits on profits, regulation of marketing materials, transparency, provider panels, etc. The exchange must negotiate prices and benefits on behalf of consumers. An any-willing-plan website is little improvement over the current system. Individuals and small businesses don't have time or the information to make these decisions

It is critical that there be an **even playing field inside** and outside the exchange. There must be robust provider panels both inside and outside the exchange. It is important to ensure that providers specializing in high cost conditions are not concentrated in the exchange plans.

It is critical to get public education right
Insurance has been very complex and the public is very skeptical that any insurance is going to be there when they need it. It is critical that navigators hired by the exchange to help people understand the system be trusted. Brokers are only one potential set of navigators. It is critical that a diverse set of navigators be hired, appropriate to varying audiences. The typical one-size-fits-all option will not work. Effective public education campaigns provide small grants to many organizations, rather than a small number of large grants. They follow up by evaluating effectiveness and share best practices among all grantees. As many people as possible should have Insurance Exchange brochures in their bags and offices.

The Board will decide what services will be covered

Will the Board include all current state mandates? Does the state have funding to pay for the cost of those mandates for the 140,000 subsidized exchange members?

Coverage decisions should be based on the best research available to ensure covered services are cost effective, safe and only approved for appropriate patients. It is critical to address the "medicalization" of health insurance – covering services that should be funded from other funds such as education, housing, private fundraising or out-of-pocket.

Effective coordination with Medicaid

Many exchange applicants will be eligible for Medicaid, especially after the large expansion of the program in 2014 under national health reform. The federal government pays between 100% and 90% of the costs of care for newly eligible Medicaid applicants. It is critical that all Medicaid-eligible applicants be connected productively to that process. It is critical that the exchange follow up with people referred to Medicaid to ensure that they do not fall between the cracks.

For questions or feedback, please contact:

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