# Consumer Conversations: Connecticut's health insurance exchange
# Questions for CT Health Insurance Exchange

October 26, 2012

Some initial questions gathered from consumers and advocates, in no particular order:

## Access to care

1. How will the exchange coordinate with Medicaid?
   a. To ensure that people applying get into the right program, including members of the same family that are eligible for different programs
   b. To ensure that as people's income change and they move between Medicaid and the exchange – that they can keep their doctor, and keep their costs down
   c. When incomes drop, that people are notified that they now qualify for Medicaid at no cost
2. Can I buy insurance for a family member (i.e. a 27 year old child)?
3. Will the exchange replace coverage offered by colleges?
4. How will dental and vision coverage work?
5. How will you connect with Medicare for people turning 65 or who have disabilities? How can I keep the same doctors?
6. Are all plans going to cover the whole state or will there be regional/local plans?
7. Will you limit the number of bids in each geographic area or allow any number and mix of bids anywhere in the state?
8. Will you standardize benefit limits, exclusions, and substitutions to the Essential Health Benefit package?
9. Will you use just the Affordable Care Act minimum drug formulary requirements or improve them to ensure that additional lower cost options are included?
10. How will you monitor that there are enough of the right kinds of doctors, and other providers in each plan close to where people live? What standards will you use to ensure access to care? How and how often will those be measured and what will you do if a plan is found to be inadequate? (This is a huge issue in Medicaid and a lot of individual insurance policies. You can get coverage, but no one takes it.) Will you just take the plans' word for their provider networks or will you conduct secret shopper surveys? (This has also been an

issue in CT's Medicaid program. A secret shopper survey found that callers were only able to get an appointment with one in four providers listed in HMO panels.)

11. How will you make sure that safety net (essential community) providers are included? How will you define and identify those providers?

## Process/Transparency

1. Why is this the first time you are taking consumer input? How can you build a system this important without engaging your customers?
2. Are you testing the prototype portal with customers – small businesses and consumers? If not, why?
3. Why are there no independent consumers or advocates on either the exchange Board or the QHP committee making these important decisions? There are insurance representatives on both and insurance stockholders on the Board.

## Consumer protections

1. How will my private information – applications, medical history, etc. – be kept private and secure? Who will be able to see it? How long will it be kept in the system?
2. Under the ACA, plans are no longer able to exclude people with pre-existing conditions or charge them more, or charge women more, and there are limits on how much more they can charge based on age – but what if they do? Who will be watching? How will I even know if it happens? What will be done about it?
3. If I am denied a service by my plan, who do I call? The exchange, OHA, CID, legal aid, or the navigator who signed me up.
4. A lot of people have had individual insurance before and had bad experiences. It is very expensive and covers little. How will the exchange products be different?

## Affordability

1. Why are you not planning to negotiate with plans to get a better price like the MA connector does? People need affordable options. Insurance companies should compete for our business just like they compete for big companies' business.
2. And if you're not going to negotiate, why do you need so many staff? We are all going to have to pay for that bureaucracy in our premiums and our federal taxes.
3. How will you ensure that plans are not cherry picking healthy people to enroll and discouraging people with pre-existing conditions, women, older people or others who may cost more?
    a. I understand that plans' rates will be adjusted to account for plans that attract people with higher medical needs, shifting money from plans with healthier people. How is that going to happen?
4. Will you standardize out-of-network benefits and charges?

5. Will you standardize cost-sharing? Even if they are equal on average, co-insurance is a bigger barrier to accessing care than copayments. People are reluctant to get a treatment if they can't find out what it will cost ahead of time. No one wants to negotiate prices with providers – isn't that the plan's job?
6. Will the same rules for plans apply inside and outside the exchange, keeping a level playing field and not creating a race to the bottom among plans?
7. Will you allow plans to charge people more if they don't want to participate in wellness programs or meet certain outcomes like losing weight or quitting smoking?
8. Will you charge smokers more?

## Quality

1. What standards are you going to hold plans to beyond the minimum in federal law?
2. How will you promote alignment with other purchasers for delivery reform (PCMHs) and lower costs, improve quality, patient experience of care, and health outcomes?
3. How will you ensure plans have resources to support wellness initiatives?
4. How will you guard against any plan policies or payments, intended or unintended, that discourage providers from taking some patients?
5. Will you require that plans include a risk assessment? Will you require a standard tools and protocol for the assessment?
6. Will you monitor financial incentives for wellness to ensure they are fair, evenly applied and are actually rewarding risk reduction behaviors (as opposed to a tool for adverse selection)? Will you limit the incentives and disincentives?

## Customer service

1. Who will people pay every month – the exchange or the insurer? What if the payment is late or gets lost?
2. How will you know if I am close to my out-of-pocket max? Do I have to keep receipts?
3. How will I be able to find out if a specific treatment or condition or drug is covered?
4. Can I shop around in the exchange site before I register and give any information? I don't want to be on a spam list, or I am looking for a friend or family member.
5. Can I get a list of independent, trained counselors (navigators, assistors) near me – people who are not paid by insurance companies and who can talk about ALL my options objectively?
6. Who will help me input information into the web portal to select plans and find out how much it will cost? The best plan for me depends on my health needs and I'm not comfortable sharing health issues (HIV, diabetes, income) with strangers.
7. Will I be able to customize the plan sort? Some people will want to shop based on price, others on value, others on coverage of a particular service or condition, others by doctor, others by drug, etc.
8. Will you sort plan options by value so better value plans come up higher in searches? If so, how will you measure value – who decides this? If not, how will searches be ordered?

9. Will you outline the differences between plans, even within the same metal tier i.e. by total out of pocket maximum, covered services, network capacity?
10. Will you standardize options for plans to simplify options, especially those that have no meaningful difference (e.g. family structure, age bands rating factors,)?
11. Will you limit the number of products each insurer can offer at each metal tier? Will you restrict products to those with a "meaningful difference" between them so they can't just swamp out competitors and confuse consumers with details that don't matter?