Connecticut Health Policy Project

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Margo Lachowicz
CT Health Insurance Exchange
By email: cthix.inquiries@ct.gov

Comments on QHP Requirements for Initial Solicitation of Health Plan Issuers

Dear Ms. Lachowicz:

Thank you for this opportunity to comment on the CT Health Insurance Exchange's draft solicitation for health plans. The draft clearly represents a great deal of thought and is intended to create an "innovative and competitive marketplace".[i]

I also want to thank you for soliciting public comment on your draft. Unfortunately, as we were only given just days to submit comment on a complex array of issues with serious consequences for consumers, this is only an initial response. Further comments will be forthcoming.

In contrast, California and Maryland's exchanges used robust public comment processes in developing their health plan standards. [ii] Both states included several rounds of drafts, with written and in-person comment opportunities, over months. Consequently their policies and practices are well balanced, well reasoned and carry a high level of credibility across stakeholder groups.

I am pleased to read on page 3 of your draft that "Nothing in this solicitation precludes the Exchange from selectively contracting." I renew calls for the exchange to negotiate premiums with insurers on behalf of consumers. Massachusetts's Connector, which actively purchases coverage for customers, has made significant progress in controlling insurance costs. Active purchasing also provides important levers to improve the quality of offerings, encourage payment reform and support critical health care delivery reform.[iii] Other state exchanges are pursuing active purchasing in their first year of operation; Connecticut consumers and small businesses deserve the same level of service.

Your proposal and associated documents repeatedly reference an "iterative" process. A gradual process in which standards and competition between plans are delayed until future years does not make sense in Connecticut. Once an array of health plans is included in the exchange, it will be very difficult in later years to hold them to higher standards or achieve lower rates. Reducing profits or provider prices is unlikely. Potential confusion and disruptions in care would also make any changes difficult codifying an uncompetitive market. Cultural norms are very strong and Connecticut does not have a history of changing program design after implementation. Perhaps the largest problem is the lack of credibility such promises inspire in Connecticut stakeholders who have had repeated experiences of the strong status quo. Engaging those stakeholders is key to the success of the Exchange. "Trust us" is simply not sufficient.

Network adequacy is critical to effective coverage. If consumers and small businesses purchase insurance through the exchange and cannot access actual health care services, no one will be any healthier, precious resources will be wasted and the foundation of the exchange will be undermined. The proposed standards in the draft and Advisory Committee slides[iv] are an improvement on the floor in federal law, but are not adequate to ensure decent access. More disturbing however is the recommendation in the slides "Short of meeting such standards, staff recommends that carrier be allowed to evidence a good faith effort to contract with ECPs" [Essential Community Providers]. While this may satisfy administrative and health plan concerns, it is no comfort to consumers unable to access the health care they are paying for.

A far better, and well-vetted, standard for access is offered by the Network Adequacy Standards from Connecticut's Medicaid Managed Care contracts (attached, see especially Sections 3.08 to 3.10).[v] The standards were adopted to address the issue of effective access to care beyond nominal coverage. Echoing the wisdom of starting with standards, in the early years of Connecticut's Medicaid Managed Care Program, plans were occasionally "frozen" from enrollment in various counties if they did not have enough providers to deliver care. Despite plan protests, this served as an effective tool to improve network adequacy. Over time it became very rare for a plan to be frozen for enrollment.

It is also critical to monitor and verify the plans' reported provider networks. Medicaid also offers important lessons on this point. For years, reports of difficulty accessing care did not match the panels reported by health plans. In 2006 to verify the panels, DSS commissioned a secret shopper survey of health plan networks.[vi] Surveyors posing as HUSKY members were only able to secure needed appointments with one in four providers listed in the plan directories.

For the exchange, monitoring for availability of appointments for new patients is critical. Many, even most, of the exchange's customers will be previously uninsured and may not have a usual source of care. They will be seeking care as a new patient. Monitoring network panels for evidence of adverse selection is also critical. If providers who specialize in people with complex and expensive conditions are concentrated in some coverage options, those will be disadvantaged in the market. Risk adjustment balancing between plans is an imperfect and evolving science and not sufficient protection.

I urge you to consider a system of network adequacy standards similar to Connecticut's Medicaid Managed Care contracting standards together with robust monitoring and evaluation with enforcement by freezing enrollment into any exchange plan that does not meet the standards.

Well-structured cost sharing standards are critical to ensuring that consumers can access care appropriately and prevent health problems from becoming more serious and more expensive. For example, even if they are equal on average, coinsurance is a greater barrier to accessing care than copayments. Consumers tend to be more reluctant to incur an unknown cost (even a percentage of an unknown cost) rather than a clearly defined price to access care. While theoretically coinsurance places downward pressure on prices, that rarely works in health care. Few consumers investigate prices before treatment and even fewer have relative value information to ensure they are maximizing their resources. Also consumers are very reluctant to negotiate prices with providers; they expect insurers to do that for them. High deductible plans have similar drawbacks and evidence that they serve to control

costs is lacking. Under any cost sharing standardization, it is critical to have a robust, verifiable, accountable process to monitor when consumers are close to the out-of-pocket limits set in law. Expecting consumers to monitor those costs or just trusting the plans is not reasonable. Standardizing cost sharing to reduce any disincentives to accessing appropriate care and to minimize uncertainty for consumers is critical.

Well-designed wellness programs have great potential to improve health outcomes and reduce costs.[vii] However design is critical to realizing that potential. It is critical to avoid incentives that encourage adverse selection such as the gym memberships mentioned in your draft. It is also important to base incentives on achievable goals based on real effort rather than one-size-fits-all clinical standards. People vary considerably in their ability to reduce health risks. Factors such as low income, genetics, and living circumstances over which people may have little control can influence success rates. It is also critical to monitor incentives closely to see if they are working to improve health status or are simply punitive and/or resulting in adverse selection. Limits on potential risks and rewards are important to encourage consumers to engage and it is critical to ensure that consumers have all the tools necessary to achieve success in wellness. For example, imposing penalties for smoking without covering smoking cessation treatment is not constructive.

Your draft proposal to standardize rating factors is important. Standardized options will reduce consumer confusion, improves the generally unpleasant experience of shopping for insurance, and allows people to make choices based on value.[viii] It is important to support innovative benefit designs, but the standardization options mentioned do not impact the potential for innovative payment or delivery reforms. Standardization in the exchange would also reduce opportunities for adverse selection and, through competitive pressure, improve the quality of the market outside the exchange as well.

A large question not addressed in your draft is how plans will connect with Connecticut's Medicaid program. Incomes of low-income state residents fluctuate considerably, causing people to move between programs often. An important addition to your solicitation is a question about how insurance plans will transition people coming from or going into the Medicaid program to ensure continuity of care.

Your draft solicitation includes only HEDIS, CAHPS and MLR accreditation and standards. While important, these systems are limited in their ability to discriminate between plans. More robust accreditation, perhaps specific to the Connecticut exchange, would build consumer confidence in your products.

Your draft does not require a quality improvement strategy for applying health plans. The quality of American health care does not match what we pay for it. I urge you to, at the least, require that plans offered in the exchange have a realistic plan to improve the quality of care.

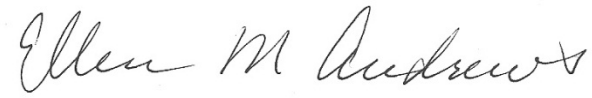
Sole reliance on the Connecticut Insurance Department's process for rate review is not adequate. CID has approved very large, contentious and controversial rate increases in the past. CID has not earned high public confidence. It is important for the exchange to have a separate and robust rate review

approval process that is conservative in approving increases and prioritizes affordability for consumers over insurance industry profitability.

Finally, your draft relies heavily on reporting and attestations by health plans, taking a great deal on faith. There is little in your draft of holding plans to high standards. Issues subject only to reporting include transparency, health care quality and outcomes, rate justification, and plan performance. Historically reporting has been of limited value in changing health plan behavior. Setting high but achievable standards and holding the plans to those standards is key.

Thank you for this opportunity for comment and thank you for your work to improve health care for all state residents.

Sincerely,



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[i] Exchange draft solicitation, page 4.
[ii] Personal communications, Consumers Union, Center on Budget and Policy Priorities, MD Women's Coalition for Health Care Reform, November 2012.
[iii] Why Connecticut's Exchange Needs Active Purchasing, CT Health Policy Project, November 2012.
[iv] CT Health Insurance Exchange Joint Advisory Committee Meeting, November 20, 2012.
[v] State of Connecticut, DSS, Medicaid Managed Care – HUSKY A, SCHIP Managed Care – HUSKY B, and Charter Oak Managed Care Request for Proposals, January 2008.
[vi] Mystery Shopper Project, Mercer for DSS, October 25, 2006

[vii] Katherine Baicker, David Cutler and Zirui Song Workplace Wellness Programs Can Generate Savings *Health Affairs*, 29, no.2 (2010):304-311.
[viii] Why Connecticut's Exchange Needs Active Purchasing, CT Health Policy Project, November 2012.