Connecticut Health Policy Project

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January 13, 2013

Grant Porter
Senior Analyst
CT Health Insurance Exchange
By email: grant.porter@ct.gov

Dear Mr. Porter:

I want to thank you for the opportunity, as a consumer advocate, to provide comments on the CT Health Insurance Exchange staff proposed standard plan design, Defining the Standard Plan Design – Individual and Family, December 28, 2102. However, I must repeat my concern at the lack of any public notice and the lack of meaningful public input into this process. I was fortunate to receive a copy of your memo soliciting comment from an insider to the process. Your memo soliciting comment was not published on your website or broadly distributed beyond a select group of insiders. As the Exchange has publicly espoused, wide consumer input is critical to making the Exchange successful. Unfortunately your processes and policies do not reflect those values.

The role of strongly interested, conflicted insurers and providers on the committees developing these plans is disturbing. The first group defining options includes a single representative, only one, of an insurer that is closely linked to providers, along with internal Exchange and insurance department staff. There are no consumer representatives to that group and other insurers who have submitted letters of intent to apply were not included. The options developed by that group were then shared with a slightly larger, but hand-picked, group of stakeholders. That group included additional insurer and provider representatives and a couple of consumers. However the consumer representatives did not have access to independent technical assistance in making hyper-technical decisions in a very short timeframe. As is becoming standard procedure for the Exchange, none of these committee meetings were open to the public. It is my understanding that requests to open this process to the public were denied by the group. As in previous policymaking, the Exchange continues to rely on deeply conflicted industry insiders, whose interests lie in cost shifting onto consumers.

The proposed consumer costs outlined in your memo are well beyond those typical in Connecticut's market. This is especially true for your Bronze level proposals – those most likely to be affordable to consumers – with $3,000 and $6,000 deductibles. Your memo notes that deductibles this high are not consistent with current state laws and regulations.[i]

	2011 CT average[ii]	Exchange staff proposal
Office visit copays	$23.79	$40 primary care $45 specialists
Deductibles – individual	$1,331	$1,250 to $3,000
Deductibles -- family	$2,615	$2,500 to $6,000

A comparison of your proposals with those now available in Connecticut's individual market through eHealthInsurance.com also finds more affordable current options[iii].

		Option 1 current market	Option 2 current market	Exchange staff proposal – most affordable Bronze level
copay	Primary care	$30	0	$30
	Specialist	$45	0	$45
	Tier 1 prescription	$15, not subject to deductible	0	$20
	Tier 2,3 prescriptions	50%, 100% after $200 deductible	0	$30/$45
Deductible	total	$500	$2,500	$3,000
	Prescriptions	$200 – Tier 2 & 3 only	$500	Included in total

While these are not strictly comparable, they offer important comparisons to what is already too expensive for Connecticut's uninsured to purchase. Each comparison is significantly more affordable than the options in Exchange staff's proposal.

The average uninsured family in Connecticut will pay 6 to 10% of their income on insurance premiums, and 19 to 20% of income on total health costs if they are unlucky enough to need care[iv]. It is important to note that more than one in four uninsured Connecticut residents will not qualify for federal subsidies.[v] They will rely on the Exchange for affordable options as they will be legally required to purchase coverage effective next January.

As to specific questions for the benefit package structure, I urge the Exchange not to employ coinsurance. As for insurers, consumers are wary of uncertainty. Coinsurance leaves the cost of care open-ended and, even if eventually equal in magnitude, serves as a greater barrier to accessing appropriate care than copayments.

The proposed $150 copayment for emergency room visits is excessive and unlikely to serve as the disincentive you may envision. The population in Connecticut most likely to resort to emergency rooms for care is Medicaid members, most often because they have not been able to access care in doctors' offices despite having coverage.[vi] In 2006 to verify Medicaid provider panels, DSS commissioned a secret shopper survey of health plan networks.[vii] Surveyors posing as HUSKY members were only able to secure needed appointments with one in four providers listed in the plan directories.

It is a common myth that people choose an emergency room for care out of convenience or habit. An earlier policy decision by the Exchange not to verify insurers' provider panel adequacy through a robust secret shopper survey may have the unintended effect of forcing Exchange patients into the Medicaid pattern, forcing access to care through emergency rooms.[viii] At the point that Exchange members are sick enough to consider an emergency room for care, the prospect of a $150 copayment versus

deductibles up to $6,000 are likely to be irrelevant – both are very large numbers to working families in Connecticut.

Limiting deductibles to hospital-based care provides better incentives to access appropriate, effective care. It is critical that consumers who are ill have no disincentive to get early treatment in an office-based primary care setting, providing better outcomes, less chance of missing work or school, and lower costs for everyone, than waiting until a problem becomes more serious and hospital care is needed. Unfortunately this is a common scenario for Connecticut's uninsured currently, necessitated by the lack of effective coverage. An important goal of expanding coverage is to change that dynamic and improve the physical and financial health of Connecticut's uninsured benefiting the entire health system. It is critical that the Exchange structure incentives to support that goal.

I understand the Exchange staff feels constrained by an Actuarial Value Calculator provided by CMS. It is my understanding that the state has the option of getting a formal actuarial analysis that confirms the actuarial value and that a certified analysis will likely be required by the insurance department eventually. It would be better to design a consensus package, in an open public process, tested with consumers, and assessed by all interested insurers (to ensure a level playing field) to be feasible. It is also critical as the Exchange develops benefit packages to consider how unfortunate prior policy decisions by the Exchange, such as a refusal to ensure adequate provider networks, will impact patterns of care in the real world.

Thank you for your consideration of my comments. If you have any questions, please contact me.

Sincerely,

Ellen Andrews, PhD
Executive Director, Connecticut Health Policy Project

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[i] Exchange memo footnote 2, p.2 of 6

[ii] Medical Expenditure Panel Survey, Agency for Health Care Research & Quality, US Dept. of Health & Human Services Note: employer-based coverage, not strictly comparable

[iii] eHealthInsurance.com, accessed January 2013, 0% coinsurance plans, individuals at various ages, living 06106 zip code, no tobacco use and not college students, Note: not strictly comparable, may not cover complete Essential Health Benefits Package -- effective 2014

[iv] Three out of four Americans accesses health care in a typical year, Kaiser Family Foundation's Health Reform Subsidy Calculator

[v] To assess the impact of the staff proposal on typical uninsured Connecticut families who will rely on the Exchange for affordable coverage, we used the Kaiser Family Foundation's Health Reform Subsidy Calculator,

http://healthreform.kff.org/subsidycalculator.aspx. We estimated costs for Connecticut families with three members at 250% of the federal poverty level (middle of subsidized uninsured population range) and 450% of the federal poverty level (typical of unsubsidized population range). Thompson-Reuters uninsured data analysis, CT Health Insurance Exchange

[vi] CT Office of Health Care Access, DPH, http://www.ct.gov/dph/lib/dph/ohca/publications/2010/final_draft_ed_issue_brief_december_2010.pdf

[vii] Mystery Shopper Project, Mercer for DSS, October 25, 2006

[viii] In November, over the recommendations of two advisory committees, at the urging of staff, the CT Health Insurance Exchange Board voted not to conduct secret shopper surveys to verify plan network adequacy.