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Testimony of AARP on
H.B. 6323—An Act Making Conforming Changes to the Insurance Statutes Pursuant to the Federal Patient Protection and Affordable Care Act, and Establishing a State Health Partnership Program
February 14, 2011

AARP is a nonprofit, non-partisan organization with nearly 600,000 Connecticut members. AARP helps people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. On behalf of Connecticut members and adults 50+, we are pleased to offer the following written comments on H.B. 6323.

AARP strongly supports provisions of H.B. 6323 that implement the Affordable Care Act insurance market reforms. These reforms include covering adult children, up to age 26, on a parent's insurance policy (§§1-4); implementing medical loss ratio that will help ensure that a greater percentage of health care premiums are directed to health care services (§10); removing lifetime caps on health insurance products (§6); eliminating pre-existing condition restrictions for children 18 and younger (§5); and restricting the use of rescissions that retroactively cancel health insurance policies (§8).

Overall, we are also pleased with the structure of the state insurance Exchange outlined in sections 12-20.[1] AARP believes the governing body for the Exchange should include strong consumer representation and also provide the opportunity for additional issue-specific working or advisory groups to be created and to give ongoing input into the process. The governing board should avoid potential conflicts of interest by prohibiting insurers or health care providers—that are subject to regulation and oversight by the Exchange—from serving on the governing board. AARP is pleased that H.B. 6323 has strong standards for excluding insurers and providers from serving on the governing board. This language is preferable to S.B. 921, which simply allows for a conflicted board member to abstain from a particular vote.

However, H.B. 6323 does not designate interest-group specific representatives (i.e. consumers, employers, or Medicaid advocates). Although section 14 requires board expertise in a variety of areas, AARP would suggest including a designated consumer advocate for the board.

As to the operations of the Exchange, the focus is well framed in section 15. This is similar to the structure operating in Massachusetts that has worked well. AARP would recommend, however, that the language in Section 15(a)(15) make clear that assessments and user fees can be collected after January 1, 2015. Currently that sections states: "...Charge assessments or user fees to insurers on or before January 1, 2015, to meet the cost of administering the exchange." This could be misconstrued as not allowing such fees after January 1, 2015. To clarify the legislative intent, AARP would suggest changing that section to read: "Charge assessment or user fees to insurers *starting* on or before January 1, 2015."

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[1] There is inconsistency in the name of the Exchange; "State Health Partnership Program" in the title, "Connecticut Health Exchange" in §14, and then "Connecticut Health Partnership Exchange" starting in §21.

Next, AARP supports Section 15(a)(16) which allows the Exchange to limit the number of plans offered. AARP believes that limiting the number of insurance providers and products will allow consumers to make direct comparisons and encourage competition among the plans. The language in this section could be further strengthened by providing more detail on the criteria or the process used to screen participation in the Exchange. Exchanges should careful select and certify the plans sold through the Exchange using the same competitive, market-based strategies successfully used by large employers. Competition should be based on costs, value, quality, and customer service. The quality of health care providers included in each plan should be evaluated based on objective quality data. Costs and benefits should be established by negotiations or competitive bidding.

Moreover, section 15(b)(11), which requires collaboration with the Department of Social Services in situations where individuals transition from subsidies to Medicaid could be improved using the following language:

> Collaborate with the Department of Social Services, to the extent possible, to ensure that changes in individual or household income do not result in loss of coverage or disruption in the continuity of care or care providers as a result of changes in eligibility for (a) coverage through the Exchange, (b) coverage under medical assistance under Title XIX of the Social Security Act, and (c) tax credits and subsidies available through the Exchange.

The basic goal is a seamless transition as income changes; a recent analysis documents that there is significant variation in income during the course of the year for those with incomes under 400% FPL. Ideally, individuals moving in and out of Medicaid would be able to keep their same providers and treatment system through the Exchange with just adjustment in the amount of premium and co-pays.

With regard to Navigators (§17), the list in §17 (a) is good, but should be expanded to include information about Medicaid and any other state health assistance programs, their eligibility standards and providing assistance with applications. Also, if insurance brokers and agents are used as Navigators and they sell non-Exchange insurance products; there will need to be some system to prevent them from steering individuals to non-Exchange products. The potential problem here is that insurance brokers and agents often receive a commission for each sale and a portion of annual premiums. If the Exchanges are doing their job in limiting premium costs, the brokers and agents won't be able to make as much for Exchange sales.

Finally, AARP supports the minimum requirement in §18(a)(5) that plans "meet specified quality, quality improvement and accreditation standards." However, this criteria could be strengthened if the plans are required to at least disclose – under §18 (a)(6) – the objective quality data and minimum quality standards used in selecting, monitoring and modifying the health care providers they chose for their networks. For consumers to choose wisely, they will need to be able to tell if the provider network was built based on the low bids or high quality. Finally, §18(a)(8) should include reduction of disparities in access to care and quality of care based on race and ethnicity.