Connect for Health Colorado: Key Policy Decisions

Among the sweeping reforms found in the Patient Protection and Affordable Care Act (ACA) is the requirement that all states establish new marketplaces that enable Americans to shop for and purchase health insurance coverage. These marketplaces are intended to help people fulfill one of the ACA's basic requirements — that everyone have access to health insurance by 2014. Every state is required to have a marketplace, but states were able to choose whether to establish their own or defer that responsibility to the federal government. This report examines the steps Colorado took in developing its marketplace and highlights a number of key policy decisions. The report is intended to serve as a guide to other states that may transition from the federal or partnership model to a state-based marketplace and those states redesigning their state-based marketplace.

Origins and Structure of Connect for Health Colorado

The Colorado General Assembly established the Colorado Health Benefit Exchange, now doing business as Connect for Health Colorado (C4HCO), in 2011 with the passage of Senate Bill 11-200. SB11-200, which passed with bipartisan support and significant stakeholder involvement, created C4HCO as a "nonprofit unincorporated public entity." Although C4HCO is considered an "instrumentality of the state," it does not have authority to promulgate rules and regulations, setting it apart from state agencies. C4HCO is bound by Colorado's open meetings and open records laws.

C4HCO is governed by a bipartisan Board of Directors (Board) consisting of nine voting members and three non-voting members. SB11-200 delineates that the voting members represent various perspectives, including representatives from small business, health insurance, health care providers, and consumers. The three non-voting members represent the Colorado Department of Health Care Policy and Financing ("HCPF," which oversees the Colorado's Medicaid and Child Health Plan Plus programs), the Colorado Division of Insurance, and the Governor's office.

Connect for Health Colorado: Board of Directors Policy Decision Process

The C4HCO Board held its first meeting in July 2011. Initial Board meetings centered on the development of governance principles. These policies set forth the procedures for conducting Board meetings, holding votes on Board decisions, and determining disclosure and recusal requirements when financial conflicts of interest are present.

In early 2012, the C4HCO Board began a lengthy process of discussing and voting on major policy decisions that have shaped the development of the marketplace. These decisions ranged from high level structural decisions, such as whether to combine the small-group and individual insurance risk pools, to detailed, technical decisions, such as whether to limit plan options within the small group market.

In April 2012, C4HCO formed four advisory groups to provide guidance and open forum discussions on the various policy decisions pending before the Board. The four advisory had focused on health plan matters, the individual exchange, the small business marketplace (SHOP), and outreach and communications. Each advisory group consists of approximately 25 members

and meetings were open to the public. Advisory group members represent provider groups, health plans, the business community, and patient and consumer advocacy organizations. These groups have been reconstituted now that the marketplace is open for business.

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Since beginning this process, the C4HCO Board has taken formal action on more than sixty major policy decisions. This report highlights four Board-level policy decisions made over the course of 2012-2013 and analyzes the potential implications of those decisions now that C4HCO is fully operational.

MINIMUM INTEROPERABILITY WITH STATE SYSTEMS

One of the first C4HCO Board decisions, made in March 2012, concerned how and to what extent the Colorado insurance marketplace should be integrated with Colorado's public benefits information technology (IT) infrastructure that operates the state's Medicaid, Colorado Child Health Plan *Plus* ("CHP+"), food assistance and other human services programs. The early discussions centered on whether the state should move toward horizontal integration, which would include both state medical and financial programs, or vertical integration, which would limit the integration to medical programs. C4HCO staff recommended the Board adopt a policy of "minimum interoperability" with state systems, which would not provide for systems integration beyond that which would allow C4HCO and HCPF to meet their legal requirements under federal law. The intent behind the recommendation was to develop a marketplace eligibility and enrollment IT infrastructure separate from the Medicaid and CHP+ eligibility system but still retain certain data interfaces to ensure people could transfer seamlessly between systems. C4HCO staff stated that "[a]dditional interoperability would create substantial implementation risks given tight implementation deadlines and simultaneous changes to the state systems."[1] C4HCO's Board unanimously adopted the policy of minimal interoperability between C4HCO and state systems.

Distancing Colorado's state-based health insurance marketplace from public assistance programs, including Medicaid, was also a response to the highly charged political environment surrounding health reform implementation. Passage of SB11-200 centered on the premise that Colorado was taking its own unique path to reform health care. Consequently, there was a strong desire to brand C4HCO as something separate from the government sponsored health programs, and focus on expanding consumers' private insurance options.

The minimally interoperable application process used during the first open enrollment period contributed to some of the enrollment and eligibility challenges consumers experienced. Applicants applying for coverage through C4HCO who indicated they were interested in applying for financial assistance (either in the form of Medicaid or Advanced Premium Tax Credits) were required to leave the C4HCO web portal and complete a Medicaid application. Individuals denied Medicaid were then transferred back to the C4HCO web portal and required to provide a Medicaid denial code to complete their tax credit application.

[1] C4HCO, *March 12, 2012 Board Meeting Minutes*, available at: http://connectforhealthco.com/wpfb-file/20120312-

However, in October 2013, many Coloradans did not receive a "real time" Medicaid determination, and many applicants had to wait anywhere from several days to several weeks or longer to receive their Medicaid determination through the mail. Only then could those individuals advance through C4HCO's application process. Because these individuals faced delays and were not automatically routed through the application process, the C4HCO call center reached out to these individuals before the December 23rd deadline for January 1, 2014 coverage and encouraged them to complete their application. Upgrades were made to the application process to ensure that most Coloradans received "real time" Medicaid determination during the later stages of the open enrollment period.

C4HCO seems to be effectively moving away from minimum interoperability toward greater technological interdependence. The C4HCO Board decided in December 2013 that the bifurcated eligibility process was challenging for consumers and should be replaced with an integrated, shared eligibility system. C4HCO and HCPF are working together to develop a shared eligibility system with plans to fully operationalize the system before the November 2014 open enrollment period.

States with state-based marketplaces should consider a technology infrastructure that integrates and streamlines marketplace and Medicaid eligibility systems to the greatest extent possible. In creating a shared eligibility system, states should ensure that marketplaces have access to data in the eligibility system and authority over ongoing marketplace maintenance and upgrades. Moreover, states should consider further integrating this platform with eligibility systems for other human services programs, such as food and cash assistance programs, so all individual and family needs can be served through a single streamlined process.

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EMPLOYEE AND EMPLOYER CHOICE ARCHITECTURE

During the summer of 2012, the C4HCO Board discussed what, if any, restrictions should be placed on employers and employees shopping for insurance in the SHOP. At issue was the desire to balance one of the primary purposes of the SHOP—to expand available coverage choices to small business employees—with the need to mitigate adverse selection. A number of stakeholders were concerned that if employers offered a wide range of insurance options, then sicker employees would gravitate toward more comprehensive options and drive up premiums because those plans would have a disproportionately sicker risk pool.

C4HCO's advisory groups met multiple times over the course of approximately two months and recommended the Board consider offering employers five options (employers would be free to choose multiple options):

1. The employer could choose a single Qualified Health Plan (QHP) from a single insurer for all employees.

2. The employer could choose a panel of QHPs from a single insurer, representing an actuarial value range as extensive as the insurer offers outside of the marketplace (i.e., mirroring non-exchange small group offerings from a single insurer).
3. The employer could offer employees the choice of any plan within a single actuarial value metal tier (bronze, silver, gold or platinum).
4. The employer could offer employees the choice of any plan that is offered in two adjacent metal tiers.
5. The employer could offer employees a panel of plans from two carriers, limiting the selection to three consecutive metal tiers from those carriers.

The C4HCO Board approved options one through four and rejected option five due to the uncertain impact on adverse selection. In late 2012, the C4HCO Board took action on a similar policy issue concerning minimum participation and contribution requirements for small businesses participating in the SHOP marketplace. The ultimate decision was to mirror C4HCO participation and contribution requirements with the outside marketplace so that C4HCO would not be at a competitive disadvantage.

These decisions affecting the SHOP marketplace demonstrate C4HCO's use of a broad-based decision-making process that included meaningful stakeholder engagement from consumers, insurers, providers and insurance producers. C4HCO was one of the first state-based marketplaces to confront these issues. States should maximize the use of stakeholder-led processes to explore various viewpoints and ensure that marketplace Boards are offered diverse stakeholder perspectives in pursuing a particular policy option. While this approach will not necessarily lead to across-the-board agreement, it ensures the Board is well informed of all positions before taking action. The consensus to maximize employee choice in Colorado's SHOP marketplace allows small business owners to offer their employees a health insurance plan that best fits their needs.

DIRECT HEALTH PLAN SALES

At its April 8, 2013 meeting, the C4HCO Board took up the issue of whether health insurance carrier dedicated sales teams should be allowed to sell marketplace products directly to Colorado consumers. A direct sales approach would allow Colorado health insurers to sell their marketplace lines of business to consumers utilizing in house web portals, call centers or in-house sales representatives.

C4HCO staff recommended the Board adopt a policy of allowing carrier dedicated sales teams to directly sell QHPs sold in the marketplace to consumers. Dedicated carrier sales teams currently sell to Colorado consumers who choose to work directly with a carrier rather than employ the services of a broker. Moreover, C4HCO staff believed a direct sales approach would likely boost enrollment numbers. The C4HCO Board unanimously approved the staff recommendation to implement a direct sales model.

A number of stakeholders expressed concern about the staff recommendation and Board decision, because allowing people to bypass C4HCO and sign up for a plan directly with an insurer means the consumer will never access the very marketplace designed to increase choice and provide a meaningful comparison shopping experience. A person who purchases a marketplace plan directly through an insurer is less likely to be aware of what level of tax credit they are receiving and how it impacts the cost of other plans. Consumers might make significantly different decisions

about insurance options if they had more information about how tax credits impact their total out-of-pocket costs. A number of stakeholders also expressed concern that consumers who purchase a marketplace plan directly from an insurer would not be able to use the various consumer shopping tools available on the C4HCO web portal, including a searchable provider directory, an Assistance Network (Navigator) directory, an insurance broker directory, health plan quality measure reports and side-by-side comparative plan information.

At the conclusion of Colorado's first open enrollment period in which more than 127,000 Coloradans enrolled in commercial insurance through C4HCO, it remains unclear how many of those enrollments originated from direct sales enrollments.

States should avoid policies that allow consumers to bypass the marketplace and its consumer-oriented plan selection tools. Allowing people to bypass C4HCO in favor of signing up for a plan directly with a carrier means they will never access the very marketplace designed to increase choice and provide a meaningful comparison shopping experience.

STANDARD COMPARATIVE PLAN INFORMATION

The C4HCO Board adopted a policy in July 2012 regarding what information would be displayed to consumers shopping for and comparing health insurance plans. The Board requested feedback from C4HCO staff and the advisory groups about whether plan information should be made available in the Colorado marketplace that exceeded the minimum requirements under federal law.

The federal law requires the following information to be displayed about each plan offering:

- Premium and cost-sharing information
- Summary of benefits and coverage
- Identification of whether the plan is a bronze, silver, gold or platinum plan
- The results of the enrollee satisfaction survey, as described in Section 1302 of the ACA
- Quality rating information
- Medical loss ratio information
- Cost-sharing transparency information reported to the marketplace
- The provider directory[2]

Upon the recommendation of the C4HCO staff and the advisory groups, the Board adopted the following additional requirements:

- A provider network search and filtering tool that allows consumers to search for plans that cover a specific provider, facility or group of providers
- Detailed information explaining plan limitations or exclusion
- Prescription drug formularies
- Domestic partner coverage information
- A filtering tool that allows consumers to search for plans that have special programs to treat specific health conditions and chronic diseases
- A clear display of supplemental benefits that exceed the Essential Health Benefits (EHB) package

[2] *See,* 45 CFR 155.204 (2012).

The Board's decision to exceed the federal minimum requirements on the consumer display information was an important response to stakeholder feedback obtained through the advisory groups. Consumers were well served by the wide range of comparative options and C4HCO continues to improve comparison tools for future open enrollment periods including placing an even greater emphasis on the Summaries of Benefits and Coverage.

While there are a number of tools to help consumers compare insurance plans, a number of stakeholders voiced concern that too many choices without meaningful information would overwhelm and needlessly confuse consumers. During its first open enrollment period, C4HCO had strong participation from Colorado's health insurers, with 10 insurers offering 150 plans in the individual exchange and 6 insurers offering 92 health plans in the SHOP marketplace. While many lauded the broad range of insurance offerings, it remains an open question whether too much choice does in fact create problems for consumers. Insurance is inherently complicated and variations from plan to plan can be inconsequential and difficult to identify.

Several states have limited plan choices by adopting an "active purchaser" model or by adopting standardized plans for their state-based insurance marketplace. Under the active purchaser approach, the marketplace has the authority to negotiate with insurers and set limits on the number of plans insurers can offer. Standardizing plans allowed some states to keep the number of plans on their marketplace at a manageable number and help ensure that consumers have a meaningful choice among plans. Colorado adopted a fundamentally different approach, allowing all insurance plans that meet marketplace certification standards to be sold in the marketplace.

States such as Colorado that adopt a market approach should consider whether there are additional steps they can take to ensure there are meaningful differences among plan offerings and that those differences are understandable and transparent. Plan standardization could help support consumers' decision-making process without compromising choice. States should also consider developing provider and prescription formulary search tools to ensure customers can get sufficient information about plan details to find and select the coverage that is right for them.

CONCLUSION

States looking at whether to develop state-based marketplaces -- and even states with existing state-based marketplaces -- should consider how to ensure their decision-making processes maximize opportunities to solicit stakeholder feedback and participation. Colorado's key marketplace policy decisions, several of which were highlighted in this report, demonstrate that meaningful stakeholder engagement will help marketplaces navigate the unprecedented policy decisions they face. Ultimately, States should always keep in mind the marketplace's fundamental mission to ensure that consumers are able to navigate their health insurance options and find a health insurance plan that provides the care that they need.