As corrected and approved by the Board of Directors on May 16, 2013

STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Special Meeting

Hilton Hotel
315 Trumbull Street
Hartford, CT 06103

April 1, 2013
Meeting Minutes

Members Present by Telephone:
Lieutenant Governor Nancy Wyman (Chair); Grant Ritter; Dr. Robert Scalettar; Robert Tessier; Vicki Veltri, Office of the Healthcare Advocate; Deputy Commissioner Anne Melissa Dowling, CT Insurance Department (CID); Commissioner Roderick L. Bremby, Department of Social Services (DSS); Commissioner Jewel Mullen, Department of Public Health; Cecilia Woods

Members Absent:
Secretary Benjamin Barnes; Mary Fox; Paul Philpott.

Other Participants by Telephone:
Connecticut Health Insurance Exchange (HIX) Staff: Kevin Counihan, Steve Sigal, Jim Wadleigh, James Michel, Julie Lyons, Grant Porter, Peter Van Loon; Virginia Lamb, Susan Rich-Bye.

I. Call to Order, Introductions and Announcements

Lt. Governor Wyman called the meeting to order at 9:05 a.m.

Kevin Counihan, CEO, provided a brief update of last week's meeting with CMS and CCIIO on the Final Detailed Design Review of the Exchange's IT capability. Staff from Access Health CT, the Department of Social Services (DSS), Deloitte and KPMG attended. In addition, Lt. Governor Wyman, Commissioner Bremby and Bettye Jo Pakulis joined staff for the first day of the review. After the presentation, CCIIO told the Exchange that "Connecticut had hit it out of the park." The highlight of the presentation was the live demonstration of Connecticut's connection to the Federal Data Services Hub. This was the first opportunity CMS and CCIIO staff had to test their data interface with the states. Mr. Counihan thanked the Deloitte team and Jim Wadleigh, CIO

for suggesting this demonstration. Lt. Governor Wyman complimented the team's presentation reiterating that the reception from both CCIIO and CMS was wonderful.

II. Standard Plan Design Amendment

Peter Van Loon, COO, updated the Board on the need for changes to previously approved plan designs. These changes were required because of the new actuarial value calculator issued by the U.S. Department of Health and Human Services in February. Exchange staff reviewed this issue with the Advisory Team prior to the March 14th Board meeting and recommended changes to the Advisory Team that would bring the various plan designs within the actuarial values required by the Affordable Care Act (ACA). Staff's recommendations to the Board followed the Advisory Team recommendations with the exception of the recommendation on the pharmacy deductible for the standard silver plan. The staff recommended a $500 pharmacy deductible, while the Advisory team had recommended a $400 deductible. After discussion, the Board voted that the pharmacy deductible be lowered back to $400 and directed staff to determine from the Exchange's actuarial consultants whether they could certify the standard silver plan as meeting the 70 percent AV with this change. Subsequently, Gorman Actuarial advised the Exchange that this change would place the plan beyond the mandated AV, even taking into consideration the 2 percent allowable tolerance. They could not certify this plan. A compensatory change would be required. In addition Gorman Actuarial advised the staff that the Standard Silver Plan with the 73 percent cost sharing reduction, was still slightly high, and the Exchange would need to make adjustments to get the plan down to within 1 point of 73 percent or this CSR plan would be out of variance with regulations. Based on this input, the Exchange staff is recommending that to balance the reduction in the pharmacy deductible from $500 to $400 on the Standard Silver Plan Design, the out of pocket payment for this plan be increased from $6,000 to $6,250. In addition, Exchange staff is recommending that to get the Standard Silver Plan with Cost-Sharing Reduction to the required AV (73% +/- 1 point), the individual pharmacy deductible be increased from $250 to $300 and the individual maximum Out of Pocket Payment be increased from $5,000 to $5,200.

Given the lateness of receiving this information, Mr. Van Loon stated that he did not have the opportunity to take it back to Joint Advisory Team before this meeting.

Lt. Governor Wyman stated that it is difficult to see this type of increase and asked whether other states were experiencing these challenges with the final AV calculator. Mr. Van Loon reported that since many of the states are using a combined deductible for medical and dental services, they were not experiencing this problem. However, to address this problem, CMS was allowing Connecticut to use independent actuarial certification to calculate the value of its separate pharmacy deductible. Mr. Counihan noted that high cost states such as Connecticut were also having difficulty meeting the correct AV with lower out-of-pocket deductibles and co-pays. In fact, CMS also has to allow high cost states to adjust for this. Other states with this problem are Massachusetts, New York and Rhode Island.

Cecilia Woods inquired about how the combined deductibles in other states compared to our separate pharmacy and medical deductibles in Connecticut. Grant Porter responded that it is dependent on what is included in the deductible. Mr. Counihan added that when the ACA was created, it actually tried limiting deductibles for individuals and families. But, based on costs in certain parts of the country, the deductibles pursuant to the law would not fit within the AV

bands. To meet the AV requirements, CMS had to grant waivers to certain states, such as Connecticut, to increase the deductibles beyond those initially envisioned. For example, Massachusetts originally had a $2,000/$4,000 deductible on its base bronze plan that was used for the basis of the ACA. But when the AV calculator was established, Massachusetts also needed to get a waiver because of issues raised by the AV restrictions.

Ms. Veltri questioned why the changes to the silver plan cost sharing reduction were not determined until Friday. Ms. Veltri also asked about the practical impact of the change in the pharmacy deductible and the out-of-pocket costs for low income individuals. Mr. Counihan stated that the Exchange made the information available as soon as it was known. This information was just provided on Friday and underscored the complexities of the new AV calculator. Gorman Actuarial had to make additional adjustments to accommodate the Exchange's limitation on the hospital co-pay to two days. Mr. Porter noted that the impact of the maximum out of pocket payment was balanced by limiting the co-pays on hospitalization. Overall, this should result in a much greater benefit, but it also resulted in a $50 increase in the pharmacy deductible. Additionally Mr. Porter reported that for families falling between 200% and 250% of FPL, the only change would be the additional $50 per year pharmacy drug deductible. For a single individual earning approximately $24,000 and $30,000 per year, or between approximately 225 to 275% of FPL, the only impact would be the additional $50 pharmacy deductible. Individuals with incomes falling between 150% and 200% of the FPL will not have any change to their deductible levels. For people at 100% to 150% of the FPL, there is also no change in their deductible. This change relates only to the 73% cost sharing reduction plan. The 86% cost sharing reduction plan has no pharmacy drug deductible, and the 94% cost sharing reduction plan for those between 100% and 150% of FPL has no deductible at all.

Ms. Woods inquired if the angst being felt by Connecticut team about the impact of the AV calculator was shared with CMS and CCIIO? Mr. Van Loon stated that these concern had been shared but their response was that the law provides Secretary Sebelius with the authority to release the AV calculator, and that the February AV calculator is to be utilized. CMS/CCIIO's proposed solution was for the Exchange to work with its actuaries to make adjustments and validate those adjustments to the required AV. Ms. Woods stated her concern is for affordability and what will happen in the future. What thought has been given to monitoring compliance? Mr. Counihan replied that State based exchanges have an obligation to provide CMS and CCIIO with a series of reports that address enrollment, affordability and other metrics. CMS and CCIIO are relying on premium subsidies and rich reimbursements for cost sharing reductions for lower income people to provide affordability.

Lt. Governor Wyman inquired about the impact of these new numbers and whether they would restrict our negotiations with the carriers. Mr. Counihan responded that the carriers must work with same AV calculator as the Exchange, and it will apply to both the internal and external Exchange markets. The Exchange will work with the Connecticut Insurance Department (CID) and the carriers to make sure that the proposed rate increases are as tight as they can be, factoring in such things as risk adjustment, risk corridors and reinsurance. These programs are all designed to help ameliorate big rate increases but are complicated and not widely understood.

Lt. Governor Wyman inquired if this is the best plan and best cost that can be achieved for the people of our state. Mr. Van Loon replied yes. Deputy Commissioner Dowling affirmed that

the CID would be working very closely with the Exchange on rate reviews. Mr. Counihan cautioned that while the standard plan designs appear to be within the confines of the new AV calculator, there may still be some changes in the future.

Lt. Governor Wyman made a motion to amend the Standard Plan Designs presented by Exchange Staff to the Board on March 14, 2013. First, to reduce the pharmacy deductible from $500 to $400, and raise the maximum Out-of-Pocket Payment from $6,000 to $6,250 for the individual Standard Silver Plan design. Second, to increase the pharmacy deductible from $250 to $300, and raise the maximum Out-of-Pocket Payment from $5,000 to $5,200 for the individual Standard Silver Plan with Cost-Sharing Reduction(AV=73%, +/- 1 pt.) Dr. Scalettar asked whether the subsequent prenatal care conversation would have any bearing on this vote with respect to actuarial value. Mr. Van Loon responded no. Grant Ritter seconded the motion. A roll call vote was taken:

Cecilia Woods	Pass
Dr. Robert Scalettar	Yes
Vicki Veltri	Pass
Commissioner Roderick Bremby	Yes
Robert Tessier	Yes
Grant Ritter	Yes
Lt. Governor Wyman	Yes

Cecilia Woods	Yes
Vicki Veltri	Yes

Motion passed unanimously.

Prenatal Care Discussion

Mr. Van Loon clarified that after checking the guidance for preventive care under the ACA, all preventive care is covered with no cost sharing to enrollees regardless of where received or who provides the care. In addition, Exchange staff reached out to the Connecticut State Medical Society (CSMS) on how prenatal care was being handled. CSMS reported that prenatal care is being covered as preventative care with no co pay either through a global payment or on individual services.

Lt. Governor Wyman asked Mr. Van Loon to confirm her understanding that this would mean that a woman going to gynecologist instead of a primary care physician will receive all preventative care services at no cost. Mr. Van Loon said yes. Lt. Governor Wyman questioned whether all of the prenatal visits incurred during a pregnancy plus one post-delivery visit would be considered preventative care with no cost sharing? Mr. Van Loon replied that under the current global payment scheme, that is how it is treated now. Dr. Scalettar stated his understanding that the vast majority of deliveries are not billed as a global service and some research may need to be done on this topic. There are a variety of circumstances where prenatal visits could be handled separately from delivery.

Commissioner Mullen and Dr. Scalettar stated that it is very clear that the Board feels strongly that prenatal services be covered without a co-pay or cost sharing and that it is critical that this is understood by the carriers. Prenatal care, particularly for those of lower socioeconomic status, is one of the few preventative services that is truly correlated with improved outcomes. This must be understood and articulated so that there is no confusion on this issue whatsoever.

Mr. Van Loon stated that staff would reach-out to the provider community and dovetail with the American College of Obstetricians and Gynecologists and the OB/GYNs in the state. Dr. Scalettar stated that he wanted something further. He believes that it is the sense of the Board to be crystal clear that prenatal services are not subject to co-pays. There should be no barriers to care whether it is billed globally or whether it is billed by visit. If it is related to prenatal care, there is no cost to the subscriber. Lt. Governor Wyman stated that it should be in all plan documents that all prenatal care will not have any co-pay.

Ms. Veltri asked if there needed to be a vote to make it clear. Mr. Counihan asked Virginia Lamb, General Counsel, whether the Board had the power to effectuate that policy or whether it must come from the Legislature. Ms. Lamb responded that it can be set as part of the plan design. The question is its impact on the EHB and the AV.

Commissioner Mullen suggested that before the term "all prenatal care" is considered, the Exchange be informed through the OB/GYN community as to what is considered "all" prenatal care. There are reasons to think more and to consider as well what might impact cost and healthcare quality. Lt. Governor Wyman stated that there is a need to find a description from the OB/GYNs and word that into the policy that would allow women to have prenatal care without any costs. Commissioner Mullen stated that she would be happy to participate in this conversation. Commissioner Mullen also noted as a point of information, that Connecticut is among the states in the country with the highest rates of assisted reproductive technology and low birth weights associated with those pregnancies. When you talk about the cost of care in this state and the cost of providing people with health insurance, there is a need to consider what is considered part of routine prenatal care. There are a lot of nuances. Lt. Governor Wyman asked if Board members wanted to work on this issue, under Mr. Counihan's leadership, to get a good description so there is a strong comfort level going forward.

Mr. Van Loon stated the need for a clinical perspective, and asked if Dr. Scalettar could help with that wording. Lt. Governor Wyman asked if Dr. Scalettar and Commissioner Mullen would like to help address these questions and they volunteered to assist. Mr. Tessier asked if there would be a report back at the next Board meeting on this issue. Peter Van Loon replied that it will be on the agenda.

Mr. Van Loon also advised the Board on certain administrative corrections to the plan designs. There were errors in two co-pays – the co-pay on the platinum plan for advanced radiology increased from $50 to $75; the co-pay on the gold plan for the routine eye exam decreased from $30 down to $20. Home health care visits changed from 200 visits for up to two hours to 100 visits for up to 4 hours. Mr. Van Loon noted that based on state insurance plan data, less than 1% of subscribers are expected to use any more than 100 visits in a year.

Lt. Governor Wyman requested a motion to adjourn the meeting. Motion was made by Robert Tessier and seconded by Vicki Veltri. ***Motion passed unanimously.***

The meeting adjourned at 9:58 a.m.

III. **Public Comment**

There was no public comment.

Agenda