As approved by the Board of Directors on March 26, 2015

STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

Connecticut Historical Society

Thursday, February 19, 2015
Meeting Minutes

Members Present:
Lt. Governor Nancy Wyman; Vicki Veltri, Vice-Chair (Office of Healthcare Advocate); Maura Carley; Commissioner Jewel Mullen, Department of Public Health (DPH); Deputy Commissioner Anne Melissa Dowling, Connecticut Insurance Department (CID); Commissioner Roderick Bremby, Department of Social Services (DSS); Grant Ritter, Robert Tessier; Robert Scalettar, MD; and Cecelia Woods

Members Absent: Secretary Benjamin Barnes, Office of Policy and Management (OPM); Paul Philpott

Members Participating by Telephone: None

Other Participants:
Health Insurance Exchange (HIX) Staff: James Wadleigh, James Michel, Julie Lyons, Jason Madrak, Chad Brooker; Virginia Lamb
Wakely: Julia Lerche
Connecticut Insurance Department: Mary Ellen Breault, Director, Life and Health Division

The Meeting of the Connecticut Health Insurance Exchange Board of Directors was called to order at 9:07 a.m.

A. Call to Order and Introductions

Lt. Governor Wyman called the meeting to order at 9:07 a.m.

B. Public Comment

Darren S. Tishler, MD, F.A.C.S., Associate Professor and Director of Bariatric Surgery Program at Hartford Hospital as well as the State Access to Care Representative for the American Society for Metabolic and Bariatric Surgery provided a public comment.

C. Review and Approval of Minutes

Lt. Governor Wyman requested a motion to approve the minutes from the January 15, 2015 Regular Meeting. Motion was made by Cecelia Woods and seconded by Vicki Veltri. ***Motion passed unanimously.***

Lt. Governor Wyman congratulated AHCT for their work during open enrollment.

D. CEO Update

Acting CEO James Wadleigh reviewed current Access Health CT (AHCT) activities. AHCT recently completed a 15 week Open Enrollment period on February 15. AHCT is still compiling enrollment data and a press conference is scheduled for February 23 to discuss the results of open enrollment. As of February 13, 103,000 customers have been enrolled in private health insurance. The enrollment goal was approximately 100,000. There was strong traffic in the storefronts, and Community Enrollment Partners were very effective in their activities. Mr. Wadleigh shared that Connecticut was the first and only state to implement an auto-renewal process for consumers who had been enrolled in 2014. Connecticut was also the only state to utilize a mobile application to allow customers to enroll with the ability to upload verification documents. Mobile demonstrations have taken place with other states. The 1095-A tax form preparation process has delayed consumers' ability to file their tax returns. This is a priority for staff. AHCT is evaluating whether to hold a special enrollment period for individuals subject to the tax penalty for 2014, and who have not yet enrolled for 2015. There will be an announcement regarding this possibility at the end of February. Preparations have begun for the 2016 enrollment year. Open enrollment for 2016 begins November 1, 2015 and ends January 31, 2016[1].

E. 2016 Plan Design

Julie Lyons, Director of Plan Management, summarized the objectives for review of the individual and SHOP plan designs and to obtain board approval. The CID has set an April 30 rate filing deadline for all carriers on and off the Exchange as a result of an HHS Notice. AHCT will need to issue 2016 standard plan designs in time to allow the carriers to begin to price their options no later than early March. Another factor in the aggressive timetable is the fact that Open Enrollment is scheduled to begin November 1, of 2015. Standard plan design development also included a review of regulatory and sub-regulatory guidance and an external review of plan offerings available outside of the Exchange so as to ensure competitive plan offerings.

There are currently 21 plan designs sold on the SHOP market. SHOP membership as of January 31, 2015 is at 1,153. Ms. Lyons introduced Chad Brooker, Manager, Policy and Strategy, who provided a summary of the SHOP Plan Designs for the 2016 plan year. Mr. Brooker stated that the actuarial value calculator is an important but imperfect tool. There was a major change in the underlying assumption for outpatient costs between the plan designs for last year and this year. The outpatient costs that were used last year were based on a calculation that was largely focused on 2011 - 2012 costs for outpatient services. When the new costs for those outpatient services were updated this year during the actuarial value certification, the updated assumption increased significantly from $1,500 to $2,450 causing plans to be changed to reflect this increase. This has had a more dramatic effect in some plan designs versus others.

Mr. Wadleigh clarified that this change was not due to any specific claim or utilization trend as that information, as it applies to the 2014 coverage year, will probably not be available until next year. Mr. Brooker agreed. For this year's metric Wakely did a market analysis and decided that the underlying cost assumption for outpatient services should be increased to $2,450. Lt. Governor Wyman asked what caused the increase. Mr. Brooker replied that it is really a trend factor which plays a role adding that every plan design above the silver tier was affected. Jewel Mullen asked if the trends were around the utilization or actual cost of care. Mr. Brooker

[1] The dates for the 2016 Open Enrollment period were changed by an amendment to 45 CFR Section 155.410, adding (e)(2) published on 2/27/2015.

replied that it is probably related more to cost than utilization although they both do affect it. Julia Lerche, Wakely Consulting, added that the $1,500 used for 2014 and 2015 was an assumption developed by Gorman Actuarial. She pointed out that since the 2015 calculator used the same underlying claims data as the 2014 calculator Wakely thought it would make sense to maintain consistency as well in the outpatient co-pay/coinsurance conversion. Wakely does not have the backup data to know how the $1,500 was developed. The $1,500 that was used last year is not necessarily comparable to the $2,450 used this year for the conversion. It is not known if the Gorman assumption was developed using the same assumptions as Wakely used in their analysis. The $2,450 being recommended for 2016 plan designs is based on a national database that Wakely uses for a lot of plan design analysis. The 2016 numbers were developed using 2013 national claims data and Wakely can go back to look at what comprised the increases. The AV calculator uses national claims data as its underlying claims data. Wakely is also trying to match the outpatient category of services that are in the actuarial value calculator with the data that is being pulled to develop an underlying cost. All actuaries have gotten more information in terms of how the calculator works. Mary Ellen Breault, Director, Life and Health Division, CID, advised that over the past several years looking at the rate filings and claims experience being reviewed, there has been a trend of increasing outpatient costs due to more outpatient surgeries moving from an inpatient setting to an outpatient setting. The $2,450 does not seem out of line based on what has been seen in actual claims experience. Even though it is an increase, the $1,500 may have been a little too low and the assumptions are unknown. The $2,450 is more in line with what is being seen in actual pricing. Mr. Ritter agreed but feels that this should be offset by lower number of inpatient stays. Lt. Governor Wyman asked whether other states with a similar exchange have the same type of increase. Julia replied that the actuarial value calculator has changed and will result in a higher value because of the trends in the claims distribution.

Mr. Brooker continued with a summary of the differences in the new plan designs for SHOP proposed for the 2016 plan year. Mr. Tessier asked whether the difference between the platinum and the gold plans, with regard to the creation of the prescription deductible would allow a reduction in the cost-sharing for a number of other benefits. If they remained at the 2015 levels, did the Exchange consider the effect of the changes (what percentage increase in out of pocket costs do these changes represent), and how valuable is that deductible for prescriptions through a $50 deductible for platinum and gold plans. Mr. Brooker replied that it was not necessary for platinum which is why it was left off. At the Plans & Benefits Committee meeting, the members proposed eliminating the cap on prescriptions and increasing other fields. However, with no pharmaceutical deductible at, the actuarial value of the plan design would actually increase from 79% to 82.5%. This would fall outside the allowable 2% de minimis range and the plan offering would not be ACA compliant. The use of the $50 pharmaceutical deductible actually allows the actuarial value of the plan to be reduced by 2% and also allows some of the benefits to remain the same. Mr. Tessier further asked about the aggregate for each metal tier and to quantify the differences and out of pocket exposure consumers could anticipate with these new plan designs. Mr. Brooker replied that it is difficult to quantify the changes because each person's utilization is going to be different. The best quantification is the actuarial value. The calculator uses metrics that include the cost of those services and the utilization of those services. Where the actual value has decreased, the cost sharing may be slightly higher within that plan design over the course of a general coverage year although the premium price should be lower. To attain lower premium prices you have to increase the cost sharing component for the enrollee.

Mr. Brooker continued with the changes to the SHOP silver plans as well as the new addition of a silver HSA product. The Broker and SHOP advisory committees recommended that this plan design be offered as it is very common in the external marketplace and offered by several carriers inside the SHOP as silver optional plans. The HSA across the board institutes 10% co-insurance after the deductible. HSA plans are required to put all services after the deductible per IRS requirements.

Lt. Governor Wyman asked for a comparison to the outside market. Mr. Brooker replied that in terms of costs, AHCT plans are rather competitive to those offered in the external marketplace. Within the individual market, AHCT plan designs are very competitively priced. However, some of the silver tier plans are in more expensive than what may be available in the external market but the benefits are much better. Further, Lt. Governor Wyman asked why HSA plans are being offered. Mr. Brooker replied that HSAs are very popular, and create a less expensive plan design that allows consumers to use pre-tax income to pay for those services, which are subject to the deductible, up to a certain cap established by the IRS each year. Mr. Veltri asked if Wakely looked at how in fact the plan design variations would affect projected premiums. Mr. Brooker responded that AHCT has engaged Wakely Consulting Group to look into this and results should be shared next week. There is a pricing calculator for this purpose. Mr. Brooker clarified that the pricing metrics used by each carrier are going to be slightly different.

Mr. Brooker then reviewed the changes to the bronze standard plan design for SHOP. Mr. Brooker added that there were some significant changes within the bronze tier in order to attain plan designs that are now compliant for 2016. Mr. Brooker responded to Mr. Tessier's concerns over the changes in the prescription drug coverage in the bronze plans. Mr. Brooker stated that in the external market review, a lot of the bronze plans had higher deductibles and all benefits were subject to the deductible. The bronze plans designs presented for the Exchange have much lower deductibles and are more generous than a lot of the plans offered in the external market place at this level. Mr. Tessier added that education needs to be provided to consumers regarding the bronze plans. Ms. Veltri added that education will be critical because this is these plans are also in the Exchange's offerings for individuals.

Mr. Ritter asked that SHOP options be revisited so that employer choice could be replaced with employee choice. Mr. Brooker replied that AHCT will be proposing to go to an employee choice model. However, significant employer education is needed to allow employees to have greater choices than currently allowed.

Mr. Brooker continued with the bronze HSA plan which has the most significant increase in the deductible due almost entirely to the change in the actuarial value calculator assumptions. In addition, the IRS has a different requirement than CMS for the out-of pocket maximum. Like the silver HSA, the Bronze HSA has a 10% co-insurance after the in-network deductible is met for almost all services. Lt. Governor Wyman requested a motion to adopt the SHOP standard plan designs for 2016 and to require issuers offering benefit plans on the SHOP in 2016 to offer

- the 2016 platinum standard plan design
- the 2016 gold standard plan design
- the 2016 silver standard plan design and the 2016 silver HSA standard plan design
- the 2016 bronze standard plan design and the 2016 bronze HSA standard plan design

Motion was made by Grant Ritter and seconded by Robert Tessier. ***Motion passed unanimously.***

Vice-Chair Veltri requested a motion to allow issuers offering benefit plans on the SHOP in 2016 to offer up to three non-standard plan designs in each of the Metal Tiers. Motion was made by Lt. Governor Wyman and seconded by Grant Ritter. ***Motion passed unanimously.***

Ms. Lyons provided a high level overview of how consumers can receive financial assistance to pay for premiums. Enrollment in the Individual Market by Metal Tier for 2015 was reviewed as well. Mr. Brooker followed with an in-depth analysis of the changes to the individual standard plan designs for the platinum and gold Tiers.

Lt. Governor Wyman requested a motion to approve the individual standard plan designs for the platinum and gold tiers as presented by Exchange staff. Motion was made by Robert Tessier and seconded by Vicki Veltri. Mr. Ritter asked for an explanation of the differences in prescription coverage between the platinum design for the individual versus the SHOP and what led to that difference. Mr. Brooker replied that arose through two different Advisory Committees having different goals. One of the biggest changes is that the deductibles are $50 higher in the individual plans than in the SHOP plans.

Lt. Governor Wyman requested a motion to accept the recommendations of the committee for the platinum and gold plans for the individual standard plan designs for 2016 as presented by Exchange staff. Motion was made by Robert Tessier and seconded by Grant Ritter. Mr. Tessier asked whether the 20% co-insurance on Tier IV prescription drugs is something that is going to either reduce premium costs or at least hold them down. Mr. Brooker replied that this is the hope. Tier IV pharmaceuticals are very expensive and becoming more of a driver of cost. Commissioner Mullen asked if over time any of the Advisory Committees will be looking at whether or not the incentive to keep people out of emergency departments by encouraging them to use urgent care centers is proving to be a cost saving or whether there is some determination that use of these facilities does not actually lower costs or improve care coordination. Mr. Brooker replied that a lot of services can only be rendered through an emergency department. Lowering the co-pay in the emergency department will make it a little more palatable for people that need to use those services. ***Motion passed unanimously.***

Mr. Brooker continued with the Bronze tier plan designs. The individual bronze tier plans are identical to the SHOP plan designs. Lt. Governor Wyman requested a motion to approve the individual standard plan designs for the bronze tier. Mr. Tessier commented that there needs to be focus on the quality of the bronze plan and well as education between now and the next open enrollment period. Ms. Veltri added that even though it is identical to the SHOP and there is no control of the AV calculator, she has concerns for the individuals who have APTCs that can be used at the bronze level with no CSRs helping to lower their out of pocket costs. Mr. Wadleigh added that this becomes a key need with regard to the bronze plans as last year a number of customers were picking plans solely on premium price. The Exchange needs to do a much better job from an education perspective. Motion was made by Robert Tessier and seconded by Grant Ritter. Vicki Veltri voted nay. ***Motion passed.***

Mr. Brooker summarized the changes for the silver tier plans for the 2016 plan year. With the 70% silver plan design, in theory, anyone whose household income is greater than 250% of the federal poverty line could enroll in these plan designs. Mr. Brooker continued with the 73% CSR silver tier changes in the plan design available to those members with a household income between 200 % - 250% of the federal poverty line. Those members at that income level will see that their silver options will be replaced with the 73% CSR silver plans.

Commissioner Bremby left at 10:45 a.m.

Lt. Governor Wyman requested a motion to accept the recommendations of Exchange staff for the silver plan design at 70% and the silver CSR plan at 73%. Motion was made by Vicki Veltri and seconded by Maura Carley. ***Motion passed unanimously.***

Mr. Brooker continued with the 87% CSR silver tier plan design and its changes. It is available to those households whose income is between 150% and 200% of the federal poverty line. Those individuals likewise will not see the standard silver plan in their options. Their silver plan options will all be replaced with this 87% CSR silver tier plan design.

The 94% CSR silver tier plan is of special interest because it is available to those members who are the most economically challenged. The 94% CSR is more generous than the platinum and gold plans offered through the Exchange but consumers are only required to pay silver level premium pricing. There are significantly greater benefits without any additional costs. These plan designs are going to be replacing the 70% CSR silver tier plans for those members who are between 100% - 150% of the federal poverty line. It is important to note that due to the Medicaid expansion, those with household income levels under 138% will qualify for Husky D. For most consumers, these 94% CSR silver plans will be available from 138% to 150% of the federal poverty line, but for consumers who do not qualify for Medicaid Husky D due to immigration status or other eligibility reasons these plans are available to 100% of the federal poverty line. The changes to this level were summarized. Ms. Veltri noted that even though there have been positive changes for consumers who have to be in these plans she is concerned for those who currently may have to go into these plans in a few months.

Lt. Governor Wyman requested a motion to approve the silver CSR plan at 87% and silver CSR plan at 94%. Motion was made by Robert Tessier and seconded by Grant Ritter. Vicki Veltri voted nay. ***Motion passed.***

Mr. Tessier asked that now that the Board has approved the standard plan designs for 2016, could there be additional information from the IRS that may require some further tweaks to the designs. Mr. Brooker replied it is unclear when the final rule will be issued. The proposed rule was issued just after Thanksgiving and staff is still waiting on the final rule. The two factors to consider are the IRS rule for the out of pocket maximum cap and the HDHP out of pocket maximum limit for the bronze HSA product. AHCT supplied a public comment to CMS asking that the CMS out of pocket maximums be more in line with the IRS instead of their current rise which is four times the annual IRS HDHP increases.

F. Open Enrollment Update

Jason, Madrak, Chief Marketing Officer, provided an open enrollment (OE) update. OE concluded on February 15, and more information regarding enrollment results will be provided at a press conference on Monday, February 23. As of February 13, 2015, QHP membership stood at 103,007 with a total volume of enrollment at 536,436. There were 35,887 new QHP members and 153,828 new Medicaid enrollees for a total of 189,715 individuals new to the AHCT system. ConnectiCare had the largest number of new QHP enrollments in 2015. Additionally, 1,565 consumers enrolled in dental plans. As of this date, SHOP had 173 groups enrolled with a total of 1,148 members. The next milestone for SHOP enrollment is mid-year renewals.

Mr. Madrak discussed the considerable in-person assistance activity during open enrollment. Community Enrollment Partner locations served 3,900 visitors and enrolled 640 QHP customers and 1,358 Medicaid customers. More than 9,100 individuals have visited the storefronts since November 15, 2014. AHCT storefronts processed a total of 5,081 enrollments; 1,902 in QHPs and 3,179 in Medicaid.

Post-open enrollment activity will include another round of new member census research, gathering information on key demographic and attitudinal variables. Staff will return to the Board with recommendations regarding the results of this research.

With respect to the data, Ms. Veltri asked for a breakdown of Medicaid enrollments divided among redeterminations and new applicants, and the conversion rate. Mr. Madrak replied that this conversion information was prepared last year. Dr. Scalettar asked for a distribution on the entire QHP membership and whether there is any shift within plans. Mr. Madrak replied that Anthem was the dominant carrier in 2014. This year's distribution is more favorable to ConnectiCare due to premiums, as consumers are price-sensitive. Healthy CT is now more competitive than in 2014. A more detailed analysis of plan selection can be provided, along with a review of redeterminations for Medicaid.

Mr. Madrak added that consumer education on health plan selection is a high priority. Staff members are currently discussing the most effective ways to prepare and convey consumer education materials, including the media through which this information would be transmitted. At the next Board meeting, staff will present a consumer education plan. Dr. Scalettar recommended that this plan should include health literacy, how to purchase health insurance, and how to use your health insurance plans. Mr. Wadleigh added that staff members are working to develop a consumer decision support tool to assist with plan selection.

Mr. Tessier asked if the new member research methodology is the same as was used in 2014, and Mr. Madrak replied that it would be the same. Mr. Tessier also asked whether consumers benefitted from the increased number of plans offered in 2015, and if the research could include questions regarding plan satisfaction. Mr. Madrak replied that questions on plan selection and satisfaction would be added to the survey. Dr. Mullen asked if the survey would include questions regarding access to primary care physicians and health care providers generally. Mr. Wadleigh replied that there will be conversations with carriers to discuss network adequacy and access to care.

G. Operations Update

James Michel, Director of Operations, provided an operations update. Mr. Michel also summarized the status of AHCT's plans with respect to IRS Form 1095-A, and the Operations team's work to correct consumers' forms. Mr. Wadleigh provided an example of an issue which is causing challenges for the remaining 1,000 consumers. Mr. Michel reminded the board that Medicaid customers do not receive a 1095-A.

H. Finance Update

Steve Sigal, Chief Financial Officer, provided an update of Finance activities. The finance team remains focused on moving AHCT into a "going concern" model and securing financial resources. The Exchange Assessments and Fees procedure requires some technical "clean up" and will require approval and a Board motion to be published in the *Connecticut Law* Journal and posted on the AHCT website. This will be presented in March for a vote.

The 2015 Second Quarter Full year reforecast overview was provided. Mr. Wadleigh added that the organization has been in a start-up phase. He is hopeful that all Medicaid redeterminations will be complete in the next two quarters, which will allow for better budgetary planning.

I. Executive Session

Lt. Governor Wyman requested a motion to go into Executive Session to discuss matters exempt from disclosure under C.G.S. §1-200(6)(A). Motion was made by Vicki Veltri and seconded by Robert Tessier. ***Motion passed unanimously.***

James Wadleigh, Melinda Brayton and Brian Clemow, Esq. were invited into Executive Session at 12:13 p.m. Executive Session concluded at 1:35 p.m.

Lt. Governor Wyman called the meeting back to order at 1:35 p.m. Lt. Governor Wyman requested a motion to permanently appoint James R. Wadleigh, Jr. Chief Executive Officer of Access Health CT with contract negotiations to take place with the Human Resources Committee and Human Resources Director. Motion was made by Vicki Veltri and seconded by Robert Tessier. ***Motion passed unanimously.***

J. Adjournment

Lt. Governor Wyman requested a motion to adjourn the meeting. Motion was made by Vicki Veltri and seconded by Robert Tessier. ***Motion passed unanimously.*** Meeting adjourned at 1:39 p.m.

The next meeting will be held on March 26, 2015 at the Connecticut Historical Society.