As approved by the Board of Directors on March 27, 2014

STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

Connecticut Historical Society
Hartford, CT

Thursday, February 20, 2014
Meeting Minutes

Members Present:
Lieutenant Governor Nancy Wyman (Chair); Vicki Veltri, Office of the Healthcare Advocate (Vice Chair); Secretary Benjamin Barnes, Office of Policy and Management (OPM) Deputy Commissioner Anne Melissa Dowling, Connecticut Insurance Department (CID), Commissioner Roderick Bremby, Department of Social Services (DSS), Robert Tessier; Paul Philpott; Maura Carley; Cecilia Woods

Members Absent: Commissioner Patricia Rehmer, Department of Mental Health and Addiction Services (DMHAS); Dr. Robert Scalettar

Members Participating by Telephone:

Other Participants:
Health Insurance Exchange (HIX) Staff: Kevin Counihan, Peter Van Loon, James Wadleigh, Julie Lyons, Steve Sigal, Jason Madrak, Tamim Ahmed, Virginia Lamb

The Meeting of the Connecticut Health Insurance Exchange Board of Directors was called to order at 9:00 a.m.

A. Call to Order and Introductions
Lt. Governor Wyman opened the meeting at 9:00 a.m.

B. Public Comment
No public comment

C. CEO Report

Kevin Counihan, CEO, reported that the Exchange's 100,000 enrollment goal mark was met last week. Qualified Health Plan (QHP) enrollment is now over 53,000 enrollees and growing. Carrier partners report paid enrollments significantly higher than the national average of about 80%. The senior leadership team has been working on a plan to reduce administrative costs going forward and on ways to ensure sustainability. We will come back to the Board with this plan after open enrollment ends.

Secretary Barnes arrived at 9:03.

Services deferred a year ago to meet the "Go Live" date are now being automated by Deloitte. Since October 1, staff has been handling these services with manual work-arounds. There are strong rumors from Washington that open enrollment may be extended beyond March 31st. The senior leadership team is preparing for this possibility. The Exchange has had further discussions with five other states on its "Exchange in a Box" concept. Ideally, AHCT might take on one or two states depending on AHCT capacity.

Cecilia Woods arrived at 9:05.

Commissioner Bremby arrived at 9:07 a.m.

D. Review and Approval of Minutes

Lt. Governor Wyman requested a motion to approve the minutes from the January 16, 2014 meeting. Motion was made by **Maura Carley** and seconded by **Secretary Barnes**. Maura Carley requested that the last sentence in the third full paragraph down on page 2 be corrected to "those aging off their parents' coverage will get a COBRA notice with a three year option and might benefit from reviewing their options for coverage." ***Motion passed unanimously as corrected*.**

E. Operations Update

Peter Van Loon, COO, reported as of midnight Tuesday, Exchange enrollment stood at 126,653 enrollees, including QHP and Medicaid. Of this total, 53,674 enrollees had selected a QHP with two-thirds qualifying for subsidies and one- third paying full cost. 59% of all enrollees purchased at the silver level. About 60% of total enrollees selected an Anthem plan; 37% a CBI plan and 3% a HealthyCT plan. Call Center customer service has improved; Medical redeterminations have begun. AHCT continues to work with DSS and carriers on enrollment issues. A process has been put in place with the carriers and DSS to expedite members with urgent medical needs so that they get needed proof of coverage for use with providers.

Commissioner Mullen arrived at 9:12 am.

Call Center abandonment rates and average wait time in seconds have decreased significantly. Potential risks include retention of durational staff through open enrollment; carrier and DSS technical processes; and the sheer volume of DSS redeterminations. Mr. Tessier asked about preparations for March call volumes as open enrollment ends. Mr. Philpott asked for an explanation of Medicaid redeterminations and if any of the 20,000 individuals receiving redetermination letters might qualify for a QHP subsidy in lieu of Medicaid? Mr. Van Loon responded this year that close to 500,000 Medicaid recipients will be redetermined using the new federal Modified Adjusted Gross Income (MAGI) rules. Some may no longer qualify for Medicaid, but may receive QHP with or without subsidies. Other individuals may be eligible for the first time ever under the new rules.

Grant Ritter arrived at 9:22.

All MAGI applications will be run through the Exchange system. Commissioner Bremby explained that the existing rules engine for Medicaid – for Non-MAGI Medicaid – rests within DSS's EMS system. This system is slated for replacement by December, 2015. The MAGI calculator only exists within AHCT's Integrated Eligibility system. This calculation determines whether the recipient is still eligible for Medicaid or if they are eligible for a QHP or other subsidy. Once that is determined, it comes back to DSS to perform the actual work to effectuate

the determination. Some redeterminations such as those for aged, blind and disabled will not be made under the MAGI rules.

Ms. Carley asked what happens if mid-year an individual's income increases because of employment and they may no longer be eligible for Medicaid? Mr. Bremby responded that the change will have to be self-reported and the individual would have to go through the eligibility process again. Reporting changes is a condition of program participation. Mr. Wadleigh added that that is the same process for the APTC qualifying customers. Increases in income must be reported.

Julie Lyons, Director of Plan Management, provided an overview of network adequacy and the Exchange's requirement that networks be substantially similar. The Exchange's standard is that within the eight counties in Connecticut, the on-exchange network for a carrier is required to be 85 percent similar to its off exchange network for its similar product. For example, a carrier's PPO network on Exchange will be compared to its PPO network off Exchange. Similarly, its HMO network on Exchange will be compared to its HMO network off Exchange. Facilities such as hospitals and skilled nursing facilities are also held to the 85 percent standard but are compared separately from providers such as physicians. Three carriers (HealthyCT, CBI and United) are using the same network on and off the exchange and therefor automatically meet this 85 percent standard, even though in two cases their networks are generally less broad than Anthem's. Exchange analysis showed that Anthem's hospital network is almost 94 percent similar. All carriers have contracted with at least 85 percent of the hospitals in the state and those carriers who have not yet contracted with all hospitals, are continuing negotiations. Anthem has advised the Exchange that it believes its HMO network is 88 percent similar and its PPO network 85 percent similar. The Exchange, however, has had difficulty reconciling this information with the Exchange's on-line audit of Anthem's off network provider directories. Based on the Exchange's on-line audit, the Exchange found Anthem's HMO product 78.9 percent similar and its PPO product 79 percent similar. Anthem has stated that it believes the difference is due to a double count by the Exchange of some providers in the on-line directory since this directory was not set up for an aggregation of unique providers. In addition, the provider counts reported by Anthem, excluded providers in the bordering states of Rhode Island, Massachusetts and New York. Anthem is providing additional information to help reconcile these differences and the Exchange will report back to the board.

Vicki Veltri arrived at 9:32 a.m.

Secretary Barnes asked if the off exchange products are priced higher? Ms. Lyons replied that cost is the same but there may be differences in features such as tobacco rating. Mr. Barnes asked if carriers are compensating doctors differently off exchange versus on exchange? Ms. Lyons reported that the Exchange has no direct access to this proprietary information. Deputy Commissioner Dowling stated that there is also no CID oversight authority at the moment over network contracting but offered to look into this further. Ms. Veltri stated that it is not a secret that physicians are getting lower reimbursements on the Exchange. OHCA is also getting calls concerning access to care which goes to the accuracy of the provider directories. Mr. Ritter added that carriers will say that there is a higher risk for new insureds and that premium dollars will have to stretch further. They need to compensate the providers less because of increased utilization. This will only work for a couple of years, until it is clear that there is no selection effect and no extra bias in the new insureds. Ms. Veltri added that lower payments can cause access problems. The measure should be whether providers are taking patients not if they are on the carrier's provider list and there should be independent monitoring to determine this. Secretary Barnes asked if the current Anthem network negotiations have resulted in overpricing of products on the exchange? Is the more limited panel of providers reflected in the price? Ms. Dowling noted that all carriers must meet the medical loss ratio (MLR) and if they do not, rebates must be provided to insureds. Mr. Tessier asked if the MLR calculation at end of year is product by product or overall lines of business? Ms. Dowling replied that it

is by types of product – company, small group, large group, individual, etc. within a state. Mr. Philpott noted the problem of marketing an Exchange product with a substantially different network from the products sold off the Exchange and stressed the need for the Exchange to grow its unsubsidized market share. Lt. Governor Wyman asked how the consumers know whether their providers are participating on the Exchange? Ms. Lyons stated that there has been some confusion because consumers have had to access the carrier's web-site for this information. The Exchange is working with the carriers on providing direct links to the carrier's provider networks for each of the carrier's on-Exchange plans and these links should be up shortly. This should keep consumers from looking at the wrong provider directory for their plan. Mr. Counihan added that next month a presentation can be done for the board representing the customer experience. Mr. Philpott asked if the carrier's provider contracting is opt-in or opt-out? Ms. Lyons stated that it is opt-out. Ms. Veltri indicated that not every provider was given a letter. Ms. Carley asked if any carriers offered a product on the exchange that was not offered off the Exchange? Ms. Lyons reported that Anthem did not currently offer a PPO off the Exchange.

Ms. Lyons reviewed the Exchange's Essential Community Provider (ECP) standards for network adequacy for 2014 and 2015. The Exchange requires that for 2014, carriers contract with 90 percent of the Federally Qualified Health Centers (FQHC). This is a statewide standard. In order to meet this standard, each carrier must contract with 13 of the 14 FQHCs. Carriers must also contract with 75 percent of the ECP's on CMS's Non-Exhaustive and 35 percent of ECPs on the Exchange's Expanded ECP list. These standards must be met without duplication. The Exchange also requires carriers to contract with an ECP for all services that it offers and wishes to contract for at all of its locations so long as those services meet the carrier's credentialing standards. Progress continues to be monitored. For 2015, the Exchange will require that carriers contract with 90 percent of the FQHCs and 75 percent of the ECPs on the Exchange's Expanded ECP list. To date, only CBI has met the FQHC standard, but negotiations are ongoing between FQHC's and the other carriers. Both Anthem and CBI have met the 2014 standards for contracting with other ECPs and Healthy CT has met the standard for the Exchange Expanded List and has almost met the standard for the CMS Non-Exhaustive List. Ms. Lyons noted that the Exchange's standards are far more stringent than those in the federal exchange. CMS only requires that carriers meet a safe harbor contract standard of 20 percent and a minimum expectation standard of at least 10 percent of identified ECPs on CMS's Non-Exhaustive List. The federal standard for 2015 will move up to 30 percent of the ECPs on CMS's Non-Exhaustive list.

Carriers who have not met the Exchange's standard are required to provide a good faith statement as to why they are not able to contract with the ECP. For example, in some instances, some FQHCs have not been responsive to one of the carriers and AHCT has placed phone calls. Mr. Tessier noted that the overall picture shows that the ECP standards were met. Commissioner Mullens noted that the Department of Public Health manages contracts with FQHCs and offered DPH's assistance in the outreach effort. Next steps include: continuing review of network adequacy and ECP submission by carrier; demonstration of good faith effort; the Exchange's acquisition of software to automate analysis; development of a standard for reasonable access for 2015; and, ongoing dialog with carriers on network issues. Ms. Veltri asked whether the carriers could map out the current networks versus the exchange network in terms of geography and where the population is actually residing. Ms. Lyons stated this was the Exchange's goal in acquiring software.

F. IT Update

Jim Wadleigh provided the IT Update. February was primarily dedicated to preparing for March volume readiness including Call Center technology improvements with Maximus and Xerox. These improvements have focused on the worker portal. Supervisors can now work closely with customer service representatives (CSRs)

and help them immediately. Income clarification has been improved. Issues revolved around customers who were recently divorced or widowed. Qualification for APTC requires married individuals to file their tax returns jointly. Other system improvements include the ability for customers over 30 to purchase catastrophic coverage on the Exchange and a separate data feed from the Connecticut Department of Corrections to verify an applicant's incarceration status. Customer facing improvements include the Spanish translated website which will be available February 21. Extensive performance testing continues for release updates. Screens are rendering at .6 seconds. Between the Call Centers, there is a virtual private network which is a dedicated secure line between the AHCT data center and all of the vendors. Equifax will now be a secondary verification source to allow customers to continue to apply in the AHCT system should the Federal Data Services Hub not be available. Mr. Counihan added that Connecticut is the only state in the country to secure this secondary verification source. Other states are interested. The IRS team will be here next week to perform a security audit on the AHCT environment. This will be done on a three year cycle going forward. A new MOU is being reviewed by the Department of Labor (DOL) for income verification. Data feeds from DOL will allow consumers to more easily validate their income when it is different from previous IRS tax returns and qualify for coverage sooner. A single application sign-on is being developed between AHCT and the Department of Social Services ConneCT application. Customers will be able to sign on to either AHCT or the ConneCT application seamlessly. Testing is underway and should be done in March.

G. Marketing

Jason Madrak, CMO, provided a marketing update. February activity includes maintaining an active Q1 presence. The media spend is slightly below January's spend. All activity now utilizes testimonial based advertisements focusing on savings opportunities; ease of enrollment; and, availability of in person help. February advertising is taking advantage of high profile events including the Winter Olympic events. 121 commercial spots have aired and have reached 98% of Connecticut households because of the large viewership. Direct mail results were presented. Website performance remains strong. There was a giant spike in website traffic at the end of December. Account creation remains strong heading towards March. Field activity is producing solid results and the field staff is closing in on enrolling more than 5,000 individuals during the enrollment period. A cost analysis on all tactics will begin and be shared with the Board. The winter concert promotion campaign continues to show solid performance. Out of 128,251 Facebook entries, 36,991 individuals have asked for opt-ins for AHCT information. Mr. Counihan added that this media is helpful in attracting a younger mix. March enrollment focus includes the NIPA team coordinating final community outreach activity; field staff concluding enrollment fairs in mid-March; brokers being engaged to participate in final enrollment activities; and, CACs leveraging resources for March outreach efforts. The storefronts have been very effective in closing sales and enrolling. Mr. Madrak reported that the Spanish media campaign represents about 15% of the Exchange's overall spend and is focused on key communities as opposed to the broader, more expensive markets.

H. All-Payer Claims Database (APCD)

Tamim Ahmed, Executive Director of Access Health Analytics (AHA), reported that the Exchange posted the RFP for the APCD data management vendor on January 27. On February 14, AHA answered 216 questions from vendors. Sixteen vendors submitted intent to bid. Responses to the RFP are due by February 28. Vendor selection is targeted for the week of March 24. Mr. Ahmed also reviewed data submission preparation and HHS reporting compliance.

I. Finance Update

Steve Sigal, CFO, provided a finance update. Focus is shifting from being a "start up" to a "going concern" with

Roderick Bremby and Benjamin Barnes left at 10:48 a.m.

Emphasis on securing financial resources, business process improvements and meeting all regulatory requirements. Market based assessment notices went out and receipts have started to come in. The financial reporting system will be upgraded. A contract is being finalized. Regulatory requirements continue to be met. In addition to the IRS audit, the Office of the Inspector General of the Health and Human Services Agency has been at AHCT since December doing an enrollment eligibility audit. The fiscal year 2nd Quarter full year forecast displays an unfavorable variance versus the prior forecast of approximately $900,000. The forecast is still funded by grants but may impact what is available in the beginning of fiscal 2015. AHCT is in Level I Grant supplement discussions with CMS. Risks to the forecast include delayed payment from DSS which can impact the future sustainability margin; unexpected staffing needs; new federal mandates; and, uncertain contractual obligations. There will be a reconciliation process with regard to operating costs during 2014. What will be received from the federal government from DSS is difficult to predict. There is a risk of not getting additional funds. Directionally to 2015, the sustainability looks to be okay. The Q2 2014 forecast was reviewed. There has been an increase in consultant costs -- KPMG; Pappas and temporary labor costs. The operational versus build cost (design implementation) was also reviewed and the 2015 – 2016 lookout provided.

Vicki Veltri left at 10:55.

Robert Tessier asked whether the increased funding from DSS will be based on the Medicaid percentages versus QHP. The final split between QHP and Medicaid enrollment could have an additional several million dollar impact. Mr. Philpott asked where the premium assessment stood in relation to operating costs? Mr. Sigal responded that for 2014 which is the first assessment year, it is approximately 75% of the Exchange's operating costs.

J. Executive Session

Lt. Governor Wyman made a motion to convene an Executive Session pursuant to Section 1-200(6)(E) of the Connecticut General Statutes to discuss items exempt from disclosure under Section 1-210(b). Motion seconded by Grant Ritter**. Motion passed unanimously.**

The Lieutenant Governor asked Kevin Counihan, Virginia Lamb, Peter Van Loon, James Wadleigh, Steve Sigal and Bettye Jo Pakulis to remain for the Executive Session.

Commissioner Mullen left at 11:01

The Board came out of Executive Session at 11:20 a.m.

K. Adjournment

Motion to adjourn the board meeting was made by Robert Tessier and seconded by Cecilia Woods. ***Motion passed unanimously.*** The meeting adjourned at 11:22 a.m.

The next Board Meeting will take place on March 27, 2014 at 9:00 a.m. at the Connecticut Historical Society.