STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
d/b/a Access Health CT
Board of Directors Special Meeting

Legislative Office Building
Hartford, CT

Thursday, June 26, 2013
Meeting Minutes

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

Members Absent: Commissioner Jewel Mullen, Department of Public Health (DPH); Mary Fox.

Members Participating by Telephone: None

Other Participants:
Health Insurance Exchange (HIX) Staff: Kevin Counihan, Julie Lyons, James Wadleigh, Steven Sigal, Peter Van Loon, Virginia Lamb, Jason Madrak, Kate Gervais, Jeffrey DiGirolamo.

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

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

B. Public Comment
There was no public comment

C. Review and Approval of Minutes

Lt. Governor Wyman requested a motion to approve the minutes from the May 16, 2013 meeting. Motion was made by Vicki Veltri and seconded by Maura Carley. Ms. Carley asked that the notation of time when a member was not in the room be removed from the minutes. ***Motion passed unanimously as amended***.

D. CEO Report

Kevin Counihan, CEO, reported that AHCT continues to make solid progress. Wakely Actuarial Consulting's analysis should be completed in mid-July. IT issues that were marked red have now been addressed and are back to yellow. The marketing campaign has formally begun. The Exchange held a press conference on Monday, June 24, 2013. The Government Accountability Office has just released its report on the status of the federally facilitated exchanges (FFEs) and the federal data services HUB.

E. Operations and IT Update

Peter Van Loon, COO, provided an operations update and explained the mitigation plan that was put into place to address critical IT issues. This plan included additional leadership, testing and coding resources. IT monitoring will continue on a daily basis. Four categories of risks continue to be monitored and managed: schedule, resource, quality and scope. Updates were also provided on customer service, plan management, the operating model, call center, Small Employer Health Options Program (SHOP), training and education. Specific details were provided on the core education modules and the categories and number of individuals who will be trained.

Robert Tessier requested additional background on what led to IT being market red? Mr. Van Loon reported that additional federal guidance required a change in design. Any change in design at this stage of development puts the Exchange behind. Resources have been increased to deal with this issue.

Jim Wadleigh, CIO, provided an IT update. User acceptance testing for Release 1 is completed. Release 1 has been signed off on and is in production. Cycle 1 of 4 cycles of system integration testing has begun with completion of Cycle 1. Cycle 2 of system integration testing has begun and is on track for a June 28, 2013 end date. Code development is on track with a new end date of June 28, 2013; the final 10-15% of construction is delayed because of additional unplanned complexities in design. Cognizant Consulting Group has been hired to assist Access Health CT with User Acceptance Testing. Additional User Acceptance Testing is on track to begin on August 1, 2013. Mr. Wadleigh noted that the challenges the Exchange is facing are normal for a project of this magnitude.

F. Independent Verification and Validation Report (IV&V)

Matt Cullen, Senior Project Manager with First Data, provided a summary of First Data's engagement with DSS as its IV&V vendor. The purpose of the IV&V vendor is to provide a second set of eyes for CMS; to confirm that the solution functions as promised; and, to confirm that the solution is built properly. A description of First Data's engagement was reviewed. Key findings were: The HIX project has an established, well-organized and professional management team in place with the commitment, knowledge and experience necessary for successful implementation.; the management team is working effectively while dealing with the additional

complexity of integration with the DSS ConnectCT project; leadership communicates a clear vision of the project, and is responsive to information, findings and developments and is collaborative. There are some traceability issues but they are being managed. There are eligibility rules embedded in the application in Java code that need to be in the Corticon business rules engine. This is being addressed by Deloitte. Documentation continues to be worked on delineating the roles and responsibilities between the respective entities (AHCT, DSS, BEST, Maximus, HealthPass and Xerox). UAT testing is progressing.

Finance – Annual Report and FY '14 Budget

Steven Sigal, Chief Financial Officer, reported that the Exchange has submitted Supplemental requests for the Level II and Assister grants as well as submitted the 3rd quarter quasi-public financial and personnel status report. Finance has also completed the 2012 quasi-public Annual Report and completed and presented the FY 2014 budget to the Finance Subcommittee. Both will be presented to the Board for approval today. Finance also submitted documentation to CCIIO to support lifting of certain restrictions on IT funding in the Level II Grant; CCIIO approved this documentation.

Spending continues to ramp up, but due to certain planned deferments overall expenses for 2013 will be less than originally anticipated. This is a timing issue. Secretary Barnes asked what part of the unspent funds for the current fiscal year will never be spent or deferred for future operational expenses? Mr. Sigal responded that all unspent monies are included in the 2014 budget. The IT functionality that was deferred will emerge in 2014.

Jeff DiGirolamo, Associate Director of Expense Management, was introduced and presented the Fiscal 2014 budget. The budget cycle and manner of funding was reviewed. Key drivers include process, financial oversight and control and cost allocation. The budget needs to be compliant with the ACA, but more importantly needs to support a successful launch. Lastly, while 2014 is really the first year of operations, the budget must be built with flexibility to meet sustainability for 2015. As a quasi-state agency, public sector financial controls must be in place along with private sector controls to monitor the process. The cost allocation proposal for shared services with the Department of Social Services was reviewed. Four separate cost pools for allocation are being discussed. The financial calendar was reviewed which includes federal and state reporting as well as the finance process.

The proposed Fiscal year 2014 Budget of $74.9 million was presented to the Finance Subcommittee on June 11, 2013. The subcommittee approved the budget for presentation to the Board. The budget is divided into two separate components -- $34.9 million will support ongoing operations and $29.0 million will support the continued build of the technical and marketing infrastructure of Access Health CT. $5.0 million represents the development of the All Payers Claim Database (APCD). Detail was provided on some of the line items including "other" and staffing. Currently there are approximately 40 full time employees and by the end of the calendar year this number is expected to grow to 51 employees. By the end of the 2014 calendar year, there will be approximately 59 full time employees. This includes employees for the All Payers Claim Database. Lt. Governor Wyman asked about the APCD budget of $5,000,000 and whether it was for salaries only. Mr. DiGirolamo replied that it must also support APCD system development, marketing campaigns and personnel. The 2014 fiscal year budget operating/sustainability comparison was presented. Other state exchange budgets are similar to the FY 2014 budget being presented.

Mr. Barnes asked whether the $35 million operational portion of the budget supports the continued development of the technology reasonably expected to occur. Mr. DiGirolamo responded that there is a component currently built into the IT budget for maintenance and ongoing operation. There is an improvement component built into the DDI budget. Some of the design money will move into future years. Mr. Wadleigh noted that the Level II Supplement request covered additional improvements to the DDI portion.

Mr. Sigal stated that the 2012 Quasi-Public Annual Report must be approved by the Board prior to filing. The quarterly reports have been filed already.

Lt. Governor Nancy Wyman requested a motion to accept and submit the 2012 Annual Report to the Governor, Auditors of Public Accounts and the Legislative Program Review Committee as required under C.G.S. 1-12. Motion was made by Vicki Veltri and seconded by Benjamin Barnes. ***Motion passed unanimously.***

Lt. Governor Nancy Wyman requested a motion to adopt the Fiscal Year 2014 Annual Budget. Motion was made by Robert Scalettar and seconded by Robert Tessier. ***Motion passed unanimously***.

G. Marketing – Update

Jason Madrak, Chief Marketing Officer, provided a marketing update. June was the kickoff of the statewide marketing campaign. Additional paid media tactics include newspaper insertions in the *Hartford Courant* and *New Haven Register* and billboards in key cities with large numbers of uninsured. Connecticut is only the second state nationally to roll out its media campaign. Website activity from February 22 to June 5, 2013 was presented which included 27,000 visits to the www.accesshealthct.com site and 17,000 unique visitors during the same time frame. A summary of the face-to-face outreach campaign was provided. Activities have been launched within the last month and will continue to escalate. Social media will also be launched via Twitter, YouTube and Facebook. Information about AHCT's progress has appeared in the *The Wall Street Journal* and *The Boston Globe*. New content will be introduced on the website over the summer. The savings calculator is a popular website feature.

Next steps for the overall marketing campaign were reviewed including monitoring media performance; investigating and securing retail locations; training of navigators, assisters and outreach staff; production of fall campaign elements and collateral support; and, implementation of a tracking and performance monitoring system. The majority of the marketing campaign anticipates face to face interactions. The community events calendar was reviewed. The social media launch was also reviewed. AHCT is using public relations channels to build awareness, including mentions in over 3,000 publications during the past six month period.

Mr. Philpott requested that Mr. Madrak come to the Brokers, Agents and Navigators Advisory Committee to provide a summary of the monitoring and tracking performance system.

Kate Gervais, Manager, Navigator and Assister Outreach Program, provided an update on the navigator and assister program. The program's focus is assisting the uninsured and underinsured to secure health coverage. AHCT is working in partnership with the Office of the Healthcare Advocate to reach these populations. Outreach

will be culturally and linguistically appropriate and is intended to leverage the assisters' existing community relationships. The assister program is funded through federal funds from CCIIO. The Navigator program by law cannot be funded with federal dollars. To date the Connecticut Health Foundation has awarded AHCT a $125,000 grant to support the Navigator Program. Total program costs are estimated at $650,000. Efforts are underway to raise these additional funds.

The Navigator Request for Proposal response yielded 26 applications. Six navigator organizations will be selected based on rigorous criteria. Navigators will help coordinate the assisters and help the assisters develop outreach strategies. Assisters will help Connecticut residents complete their application and enroll, but cannot offer recommendations on particular plans. Only licensed brokers can make recommendations. The assister RFP response yielded 422 assister applications representing 718 grant requests. Assisters cover thirty-two distinct languages and represent all geographic areas in the state. 300 assister organizations have been selected and will be notified by July 1. The assister placement map by zip code was reviewed. A navigator and assister certification process will follow rigorous training.

Anne Melissa Dowling asked if there will be an on-line listing of the navigators and assisters? Ms. Gervais responded yes and Mr. Madrak added that there will also be a list of AHCT certified brokers

H. Essential Community Providers

Peter Van Loon reported on the network adequacy plan for Essential Community Providers (ECPs). The ACA requires that ECPs be included in a Qualified Health Plan's (QHP) provider network. In November 2012, the Board adopted as its ECP network adequacy standard the requirement that the carriers include in their provider networks: 75% of the ECPs in a county and 90% of the federally qualified health centers (FQHCs) in the state. At the time, the Exchange was relying on the federal 340b list (a federal discount pharmacy program list) to identify ECPs. After analyzing this list, Exchange staff determined that it included only 29 unique entities, 14 of which were FQHCs and 15 of which were "other ECPs" and that this list of providers could not adequately meet the needs of Connecticut residents. Because, there was no official ECP list for the state, and because the federal government had yet to develop its list, Exchange staff began working with the assistance of DSS, DPH and other organization to create an ECP list for Connecticut. In late March, the federal government released its own ECP list, which it labeled non-exhaustive (March 2013, CMS Non-Exhaustive List). In addition to having substantially more providers and more geographically disperse providers, the Exchange list includes the full range of providers necessary to provide essential health benefits (EHB). The federal government's list does not. Providers on the Exchange's list also have the capability of providing the continuum of service required for mental health care. Discussions followed with the Health Plan Benefits and the Consumer Advisory Committees about how to use these lists to ensure network adequacy given carrier concerns about contracting and credentialing their networks in time for October 1, 2013. The Advisory Committees and Exchange staff jointly support the following recommendation: first, carriers must contract with 75% of the March 2013 CMS Non-Exhaustive list by January 1, 2013; second, use of the Exchange's full list of Essential Community Providers as of May 2013 will be phased in over two years – 35% of the providers are to be contracted by January 1, 2013 and 75% by January 1, 2015. The later compliance percentages are to be calculated net of the providers on the March 2013 CMS Non-Exhaustive list; carriers must show consideration for geography and access to the variety

of provider types; and, carriers will be given consideration, if they cannot meet these standards but demonstrate good faith efforts.

Paul Philpott asked how many ECPs on the Exchange list were already in the carrier's commercial networks? Mr. Van Loon indicated that the carriers have not yet provided this information. Mr. Philpott asked whether the carriers had raised credentialing requirement concerns? Mr. Van Loon confirmed that they had and that they had also reported that some ECPs did not want participate in a commercial contract. Mr. Barnes expressed concern that the list is so expansive that it will limit the ability of the carriers to set the provider networks in a way that enables them to offer the most cost effective insurance products particularly on the acute care side. Mr. Tessier stated that in most cases, the hospitals are already in the carrier's commercial networks. Ms. Veltri noted that the carriers will be absorbing a substantial volume of new people and there is a need for more capacity. Ms. Veltri also pointed out that the recommendation allows a carrier to demonstrate a good faith effort to meet the contracting standard.

Lt. Governor Wyman requested a motion to replace the previously adopted 75% contracting standard for Essential Community Providers with the new network adequacy standard developed jointly by the staff and Advisory Committees as detailed in a memo to the Board dated June 19, 2013. Motion was made by Vicki Veltri and seconded by Robert Tessier. ***Motion passed unanimously***.

I. Standard Plan Design – Update

Mr. Van Loon reported that several additional changes were required to the Standard Plan Designs to meet federal or state requirements. Staff and the advisory team are recommending dropping the dental wellness option; increasing the deductible on the Low Option Dental Plan from $50 to $75 to meet the required actuarial value of 70%, and decreasing the out of pocket maximum on the High Option Dental Plan from $500/$1000 to $300/$600 to meet the plan's required actuarial value of 85%. Staff and the advisory team are also recommending changes to the Bronze plans. For the Exchange's Bronze 1 plan, the home health care benefit needs to be changed from a -0- dollar copay after the deductible of $3,250 is met, to a home health care specific deductible of $50 followed by a co-insurance of 25%. The Bronze 2 plan will be dropped, because CID has determined the proposed plan can only be approved as a catastrophic plan. Mr. Ritter asked if catastrophic plans would be available on the Exchange? Mr. Van Loon said yes, several carriers were planning to offer catastrophic plans on the Exchange.

Lt. Governor Wyman requested a motion to approve the following changes to the standard plan designs for the Bronze Plans: first, to eliminate the Bronze Plan 2; and second, for Bronze Plan 1 to change the home health care benefit from $0 for each visit after meeting the $3,250 deductible to 25% coinsurance on each visit after payment of a $50 home health care specific deductible. Motion was made by Benjamin Barnes and seconded by Vicki Veltri. ***Motion passed unanimously***.

Chair requests a motion to approve the following changes to the standard plan designs for Dental: first to increase the deductible on the Standard Dental Plan from $50 to $75 to meet the required AV of 70%; second to lower the out of pocket maximum on the High Option Dental Plan from $500/$1000 to $300/$600 to meet the

required AV of 85%; and third, to eliminate the Wellness Dental Plan. Motion was made by Vicki Veltri and seconded by Grant Ritter. ***Motion passed unanimously***.

J. Executive Session

Lt. Governor Wyman requested a motion to go into Executive Session to discuss an employment matter pursuant to C.G.S. §1-200(6)(A) and a security issue pursuant to C.G.S. 1-200(6)(C). ***Motion passed unanimously***.

Lt. Governor Nancy Wyman requested a motion to approve spending additional funds for data security for the Navigator and Assister Program and a report to the Board on the final plan. Motion was made by Paul Philpott and seconded by Benjamin Barnes. ***Motion passed unanimously***.

K. Adjournment

Lt. Governor Wyman requested a motion to adjourn the board meeting. Motion was made by Paul Philpott and seconded by Robert Tessier. ***Motion passed unanimously***. The meeting adjourned at 11:40 a.m.

The next Board Meeting will take place on July 30, 2013 at 9:00 a.m.
Place to be determined.