As approved by the Board of Directors on March 14, 2013

STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

State Capitol Building
201 Capitol Avenue, Room 310

Thursday, February 21, 2013
Meeting Minutes

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

Members Absent: Cee Cee Woods

Other Participants:
Health Insurance Exchange (HIX) Staff: Kevin Counihan, Julie Lyons, Grant Porter, Steve Sigal, Peter Van Loon and Virginia Lamb; Kate Gervais; Tony Pinto; Paul Lombardo; Mary Ellen Breault

The Meeting of the Connecticut Health Insurance Exchange Board of Directors was called to order at 8:59 a.m.

I. **Call to Order and Introductions**
Lt. Governor Wyman opened the meeting at 8:59 a.m.

II. **Public Comment**
Jane McNichol provided a public comment. Lt. Governor Wyman suggested that staff look at the recommendations presented.
Angela Lewis-Shakes provided a public comment.
Sheldon Taubman provided a public comment.
Kevin Galvin provided a public comment.

III. **Review and Approval of Minutes**

Lt. Governor Wyman requested a motion to approve the minutes from the January 24, 2013 meeting. Motion was made by Robert Tessier and seconded by Vicki Veltri. ***Motion passed unanimously.***

IV. **CEO Report**

Kevin Counihan, CEO reported the Exchange's new brand name – **Access Health CT** – and location at 280 Trumbull St. Staff and team members from Deloitte and KPMG are now working together under one roof. Secretary Barnes was thanked for housing the Exchange until the move.

Since the last Board meeting:

- New vendors have been selected or are in the process of being selected – consistent with the Exchange's strategy to outsource as much of operations as possible.
- Connecticut's Exchange was selected by CMS to be one of 5 states to begin "Wave 1" testing with the Federal data hub. Mr. Counihan thanked Jim Wadleigh, Peter Nichol and the IT/Ops team as well as Nagen Suriya and the Deloitte team, and Roger Albritton and the KPMG team for their work.
- The Exchange was awarded a $2.6 million grant from CMS to initiate its In-Person Assistor Program. This program is an integral part of the Navigator Program. In the award notification, CMS commented on the high quality of the Exchange's application. Jason Madrak and his team were congratulated for their work.
- Julie Lyons and her policy team have worked hard to support the health plans in meeting the Exchange's Qualified Health Plan criteria. Several of the plans have complimented the Exchange on its support in addressing implementation issues as they surface. Julie Lyons and her team were thanked for their work.
- DSS continues to be a valued partner. Mr. Counihan thanked Commissioner Bremby, Lou Polzella and their team for their support in implementation efforts.
- On Tuesday, the first of the second series of "Healthy Chat" Town Hall Meetings began in Norwich. The Lt. Governor, Vicki Veltri, Mary Fox, and Grant Ritter, and Jill Zorn were thanked for being on the panel. Kecia Stauffer and Danielle Williams were thanked for their efforts in organizing the Chats.
- Connecticut has been approached by another state – one that is not implementing a state-based exchange – about the possibility of using the Connecticut Exchange's infrastructure to support their Exchange in 2015. The Board will continue to be updated as these discussions evolve. There is an expectation of seeing continued opportunities for other alliances.
- The Exchange has rated itself as "Yellow" in its implementation status. While understandable given the complexity of ACA implementation, this status is a little disappointing and does not meet the Exchange's expectations. Recent decisions and progress should return the Exchange to a higher status shortly.
- With roughly 7 months remaining before open enrollment, the Exchange has reached a new level of intensity of work. This new level requires a disciplined focus on those activities that produce the greatest return. As such, the Exchange has deferred certain

functionality to focus on those activities which best support the consumer and meet ACA requirements.

Mr. Counihan noted that the Exchange is cognizant of the special responsibility of states like Connecticut to make the ACA successful operationally and reduce the number of uninsured. The Exchange cannot let challenging deadlines or the likely impact of sequestration and the $85B in cuts that will likely impact CMS's support to state exchanges derail the success of health reform. The ACA represents the broadest expansion of health care access since the introduction of Medicare in 1965. The Exchange has a responsibility both to the residents and small businesses of Connecticut and to the success of health reform nationally to make Connecticut's Exchange successful. Finally, Mr. Counihan stated that the staff at Access Health CT as well as its partners at DSS, Deloitte, and KPMG are committed to doing just that.

V. **Operations and Information Technology Update**

Peter Van Loon, COO, provided an operations and information technology update. Several staff members recently traveled to CMCS in Baltimore and came away with a better understanding of the Exchange's federal partners. Three separate CMS sections are evaluating the Exchange's progress– the Center for Medicaid and Chip Services (CMCS), the Office of Information Services (OIS) and the Center for Consumer Information and Insurance Oversight (CCIIO). The Exchange is now responsible for reporting to each of these areas. The Exchange received several new sets of deadlines and progress milestones that have now been fitted into the overall work plan. While CIIOO is looking at the Exchange's original milestones, OIS is focusing on IT and has developed certain absolutely minimum IT target dates. Several of these dates have already been met by the Exchange. Others are being worked on. By the end of May or early June, OIS will make a recommendation to CCIIO on the Exchange's ability to be open for business on October 1. CCIIO will then make its recommendation to the White House as to the Exchange's readiness. The Exchange has redoubled its communications efforts to all of three CMS sections working in collaboration with Lou Polzella and Kristin Dowty from DSS.

Another key deadline is the "implement readiness review" which the Exchange must pass by the end of spring to summer to go live on October 1. Mr. Van Loon has been working with other COOs and CCIIO to determine the scope of the implementation readiness review. The COOs have been providing input but review details are not yet in place. Based on discussions with CMS, the Exchange is required to define its operating model. We have identified this task as red on the dashboard. Day long sessions have begun with DSS to divide the labor and set expectations. Mr. Van Loon thanked Lou Polzella and Vance Dean for their efforts.

The Call Center contract was signed and Maximus is onboarding this week. Kristin Dowty, Ann Marie Chatman and Danielle Williams were recognized for their contributions working with Dave Lynch project lead. The Small Employer Health Options Program is the next initiative. Three proposals are currently being reviewed by a cross functional team. Several members of the Advisory Committees are assisting in the process.

Work is continuing to move forward on the standard benefit design with assistance from a team from the advisory committees. The Exchange's Human Resources Department continues to recruit staff but with an eye to staffing judiciously to meet the Exchange's long term needs and requirement for sustainability. Consultants or temporary employees are being used to

supplement Exchange staff to meet immediate needs. Consultants are also providing an update to policies and procedures to provide foundation for staff growth. The Exchange's senior management team meets weekly to address implementation issues as well as work on planning and development. The team is joined by senior management from Deloitte and KPMG.

Mr. Van Loon provided the IT update. Some non-critical functionality has been deferred to early 2014 to allow greater focus on developing critical functionality. Despite these deferrals, the Exchange remains ACA compliant. These deferrals include automation around recertification/decertification of health plans; automation of appeals management processes; and, some reporting processes which need to be done manually. The Exchange is working with Deloitte and other stakeholders on these deferrals. A detailed IT design review with CMS is scheduled for late March. This review is preparatory to their final detailed IT design review in April. The process for selecting the Independent Verification and Validation (IV&V) vendor has begun. The IV&V vendor will conduct the IT audit required by CMS. This audit process will begin in late spring in conjunction with testing. Members of the Consumer Advisory Committees continue to work with the Exchange's staff and consultants on the consumer experience with the web interface. The interface has been redone and there will be a demonstration scheduled for March 20th for the Advisory Committees, Board and public.

The overall status of the CTHIX program was presented. The yellow status is a result of delays in design completion, funding navigators, resource constraints and incorporating evolving federal guidance. The program is on track for October 1. Mr. Van Loon referenced the scheduling risk indicating that the Exchange was awaiting federal guidance. That guidance was just received the prior afternoon. It is being re-evaluated and the Exchange will come back to the Advisory Committees and Board with amendments to previous decisions based on that guidance, if necessary.

Technology needs to be combined into one location on an infrastructure basis. The Exchange is working with BEST. This work is reported as a risk. With regard to scope, some risks need to be managed – e.g., the sharing of data with certain state agencies. Certain agencies believe they are not allowed by Connecticut statute to share data with the Exchange, because the Exchange is not a state agency. The Exchange is addressing this issue. The operating model between the Exchange and DSS requires further integration. A lot of the agencies are re-engineering. CMS is sensitive to that issue. The Exchange is working on reaching out to consumers and the ability to engage the in-person assistors and navigators. These programs will directly impact the quality of service provided by the Exchange. Mr. Van Loon reviewed the IE PMO Operations Dashboard noting that there are now two dashboards – operations and IT as the Exchange moves from development to implementation. IT is on track for October 1.

Lt. Governor Wyman asked whether the federal agencies previously mentioned were working together? Mr. Van Loon responded that there may be some lack of communication, but that the Exchange will put every effort into controlling the dynamic. Mr. Counihan noted that there is great pressure to get the Federal default exchange up and running for 30 states versus the five to six originally anticipated. Some resources previously used to support the state based Exchanges are now being diverted. Commissioner Bremby stated that Connecticut is leading the other states in a representative capacity with HHS. This should get the Exchange closer to where it needs to be.

Dr. Scalettar stated that during the earlier public comment period there were comments raised regarding potential impacts of the governor's proposed budget. Are any other items in the proposed budget being identified as a potential additional risk? Mr. Van Loon responded that as a result of the proposed budget, the Exchange could be serving a higher number of customers than originally expected. The Exchange is working with DSS to have the right working model that is more sensitive to the customer base and it has become more of a priority. As the call center is set up, additional resources may need to be added. Dr. Scalettar further asked if there will be other pieces of the budget that may impact on other agencies and how those would relate to the Exchange being able to deliver on time. Mr. Van Loon stated that he did not have this information and would have to do further research.

Secretary Barnes provided some clarification. The proposed budget changes to HUSKY eligibility for people who are between 133% and 185% of the federal poverty level will only immediately impact those who are newly eligible on January 2014. Pregnant women are eligible up to 250% of the federal poverty level, and they would continue to be eligible for Medicaid under the proposed budget. The impact of the proposed changes would be only for those newly eligible between 133% and 185% of the FPL. A portion of the existing group of adults in the 133% to 185% target range will be transitioned to the Exchange under the proposal after a one year period of notice so that the actual impact on the Exchange will be most significant in 2015. The proposal would add 40,000 people, more or less, to the Exchange gradually and more significantly in the second year. Other items in the governor's proposed budget include identified areas of state cost savings because expanded health insurance coverage will reduce the currently significant amounts of uncompensated care that is reimbursed by the state from the general funds.

Vicki Veltri thanked Secretary Barnes for this important clarification.

Secretary Barnes stated that there is a keen awareness about the concerns of affordability. As this legislation session moves forward and into the future, there is a commitment to make adjustments as necessary so that the success of the ACA and the Exchange is not thwarted by the lack of affordability.

VI. Plan Management Update

Julie Lyons provided a plan management update beginning with an updated timeline of activities to be completed to meet the open enrollment date of October 1, 2013. Current focus is on the certification of the qualified health plans with the carriers. The expectation is that the standard benefits will be approved at the next Board meeting. This will trigger the Exchange's supplying the carriers with an application and draft contract starting the certification process. Questions are expected during March and April and the carrier's QHP application is due to the Exchange on April 30. Through July, there will be evaluation negotiations on the applications. The Exchange's timelines are in sync with those of the Connecticut Insurance Department. By the end of summer, health plans should be certified. Major plan management activities were reviewed for February and March of 2013. Carrier meetings have been hosted on a variety of topics and held on a weekly basis.

Secretary Bremby asked when there will be a sense as to what the premiums may be. Ms. Lyons responded that the expectation is that premiums would be knowable when CID completes its review of the rate filings which would be by the end of July.

Dr. Scalettar requested a high level summary of how the conversations and meetings are progressing with the carriers and what their concerns and issues may be. Ms. Lyons replied that there are two hour weekly sessions which require a significant amount of preparation by the Exchange, Deloitte and KPMG staff. Numerous questions are received on such topics as requirements for billing, premium collection, enrollment timeframes and the process for nonpayment and grace periods, etc. Questions has generally been very technical and directed at implementation issues. During the last session, the carriers stated that the sessions were very informative and the staff gives thoughtful consideration and responds in writing to carriers' questions. Additional research is being done following the webinars.

VII. **Marketing Update**

Jason Madrak, Chief Marketing Officer, provided a progress update on Marketing and Communications. The Exchange is at the campaign launch level now, moving away from its initial research, planning and strategy development phase. As the Exchange moves forward into the market place engaging with consumers and stakeholders, the strategy will be revisited and re-evaluated. The new brand name and logo has been officially announced – Access Health CT – Connecticut's Health Insurance Marketplace. There has been both a hard and soft launch. The soft launch incorporates several elements of the logo into communications materials while the hard launch this week will center on branding efforts. There has been a very aggressive public relations outreach through print, television, radio and web assets. There have been 5.5 million hits both in Connecticut and nationally. The next round of Healthy Chats has begun. There is an aggressive push in the Navigators and In-Person Assister programs. Strong strides have been made including a MOU between the Exchange and the Office of Healthcare Advocate (OHA). The Exchange received grant approval for its In-person Assistor (IPA) program and is recruiting for some IPA roles. Discussions continue on the RFPs for those wishing to participate in the programs.

Extensive consumer research and testing provided guidance for the Exchange's new identity. The Exchange is very comfortable that this name and logo will be able to connect with consumers. Different variations of the name and logo have been developed for use in the Exchange's business and outreach. Additional collateral is also being developed to fully integrate the brand into all aspects of Exchange business. A new website – www.accesshealthct.com -- has been launched which is consumer centric and the Exchange's existing website www.ct.gov/hix has been revamped to introduce brand elements with specific information including premium calculators. Pappas McDonnell was thanked for getting the website up and running in a very short period of time. Danielle Williams and Kecia Stauffer were thanked for their work in reviewing pages of content in a very short period of time. BEST was thanked for completing this work in a short period of time.

Healthy Chat events and locations were reviewed. The last series of Healthy Chats were held in the cities where the largest numbers of uninsured individuals lived. The next series will focus on the next seven cities with the largest uninsured population.

Mary Fox asked about the review of materials with respect to language and diversity, to ensure accurate representations and strong reach into a variety of communities. Mr. Madrak responded that in terms of the home page and imagery on the site, there is currently a carousel of images that are representative of a variety of individuals and it will evolve as the Exchange moves forward. Content will be fully translated into Spanish and other languages as well. Ms. Fox stated that with regard to the Healthy Chats, which are excellent and well represented from all the constituencies, there is still a concern that the Exchange is not reaching all in the relevant communities. There is a need to get closer to where people live and to give consideration to venue selection. Mr. Madrak replied that moving forward, the Healthy Chats will be a more stripped down series of events to actually address Ms. Fox's concern of getting in front of even more individuals, which should be more effective in getting the information out. Mr. Counihan commented that the Exchange is looking to hold the chats in the highest areas of uninsured consumers.

Commissioner Bremby commended Mr. Madrak and his staff for the first release of the website which is tailored to mobile access. Lt. Governor Wyman stated that a statewide group of ministers would like to meet with the Exchange to spread the word in their communities.

Commissioner Mullen left at 10:11 a.m.

Vicki Veltri stated that there is a need for a needs assessment, particularly with in-person assisters to determine where the uninsured live and how the Exchange can reach them. The OHA has entered into an MOU with the Exchange to conduct the in-person assister and navigator program for the Exchange. The teams will work in tandem to reach individuals who live in nontraditional insurance markets, underserved communities, individuals who require one-to-one assistance, etc. The in-person assistors and navigators are unbiased sources of information. Ms. Veltri noted that to do an RFP, we need to determine where the uninsured reside. About one-third of the uninsured are Medicaid eligible. The vision for the in-person assistor and navigator program is to have in person assistors operating in different regions in the state as hubs. The team expects to have hundreds of in-person assistors and navigators available.

i. Navigator Program/OHA Update

Vicki Veltri introduced Kate Gervais who is conducting a needs assessment. The assessment is based on Thomson Reuters data. Concentric circles are being formed around people we need to identify. Assistors will be placed in local communities. Support has been sought from people in these communities. There have been discussions with libraries, Boys and Girls Clubs and other groups concerned with this issue. The idea is to build the community's capacity to participate in this opportunity. A macro analysis was reviewed regarding the community level. The micro analysis was reviewed at the neighborhood level. IPAs will promote the message about how they can help make the community healthier. Waterbury was the starting point of going deep into the community. It was determined that people are almost completely unaware of the implications of the ACA, and even those involved in healthcare are unaware of the IPAs and navigators. Organizations we hope to include will be non- traditional, and they will need to conduct a lot of legwork to get individuals to apply. The Exchange will have to work hard to get the money to the right organizations. Ms. Veltri asked for more detail in Waterbury.

Lt. Governor Wyman left at 10:25 a.m.

Dr. Scalettar requested examples of the organizations referenced. Ms. Gervais responded that in Waterbury specific zip codes from the Thomson Reuters data were reviewed. One zip code was specifically an Albanian community, and the other was mostly an Orthodox Jewish community. Outreach will need to be specifically tailored to these different communities. Tony Pinto, a member of the SHOP Advisory Committee and a longstanding member of the Waterbury community was asked to respond further. Mr. Pinto has been assisting Ms. Gervais in Waterbury. Mr. Pinto stated that a local, known person understands the community better and is more effective. Very few people are aware of healthcare reform. They only know what is on the news. There is little information as to how it affects them personally. Specific communities can rely on someone they know who already helps residents with other programs.

Ms. Gervais provided other examples with regard to the IPA and navigator RFP. There is a church that indicated that they only use volunteers, and they asked if they could still participate in the program unpaid; in the orthodox community, a man cannot speak to a married woman, and she is purchaser of the insurance for her family. There are now strong contacts in practically all of the 12 communities where they are working.

Deputy Commissioner Dowling stated that she is encouraged by the thoughtfulness of this process. Ms. Dowling asked about the certification process for the IPAs and navigators to ensure consistency and protection of the Exchange's reputation. Ms. Veltri responded that IPAs and navigators have to go through a certification process. The RFP and design training need to be developed. There are certain requirements from the ACA. Training may need to be altered to fit the needs of the IPAs in the different communities. This will be a way to build long term consumer and community engagement beyond the Exchange. Information can be collected to learn the barriers facing those attempting to access healthcare.

Secretary Barnes inquired as to whether there have been any efforts to reach organizations involved in training regarding tax credits. The implications for tax liabilities must be relayed to applicants. Ms. Gervais responded that there have been discussions with the Connecticut Association of Human Services and other sites that have been coordinating the Volunteer Income Tax Assistance program (VITA) program and Supplemental Nutrition Assistance Program (SNAP) as well as EarnBenefits Online. Commissioner Bremby asked if the community action agencies had been contacted. Ms. Gervais replied that the Exchange is still trying to determine the best approach to the community action agencies. Commissioner Bremby offered DSS's assistance.

VIII. **Finance Update**

Steve Sigal, Chief Financial Officer, provided a finance update. The employee benefits plan is targeted for a March 1 enrollment process. The Grantee progress report for CCIIO was filed. Business insurance renewals have commenced with a new insurance broker of record. Given emerging risks and the newness of the Exchange, there was a need for a broker of Lockton's expertise and stature. Their services will be billed on a fee rather than a commission basis to create a closer working relationship with the Exchange. Pursuant to state and federal

government requirements, the Exchange's first audit has been completed with a report scheduled for the March Board meeting. A consultant was engaged to determine different revenue options for the Exchange. A sustainability report will be presented at the March board meeting. Establishment of the grant drawdown rhythm and process is taking place. The process is unique. Establishment of financial management processes with DSS and BEST is also taking place. Commissioner Bremby and BEST were thanked for their assistance.

A financial dashboard including design, development and implementation project was presented. It is an important view as the four previously mentioned federal agencies are concerned with the burn rate. Additional dashboards will be developed for additional expenditures.

Mr. Tessier inquired as to whether the slide shown was updated from the one in the Board's package. Mr. Sigal stated yes and Mr. Tessier requested a copy of the updated slide. Mr. Tessier inquired as to the term of the Exchange's fiscal year. Mr. Sigal responded that it is July to June. Mr. Tessier inquired as to the remaining budget. Mr. Sigal responded that it is $33.3 million.

Dr. Scalettar inquired as to the Exchanges' performance progress report, and whether it is done on a quarterly basis, and if it would be posted on the website. Mr. Sigal stated that it is the same report which is now semi-annual. There is a consolidated version that can be posted. Dr. Scalettar further asked if there is any insight as to whether the Exchange's already awarded funds were at risk with the potential federal sequestration. Mr. Sigal stated that the funds have been put aside and are not at risk.

Ms. Fox inquired as to the sustainability modeling, and whether the Board will be able to see financial models that are all inclusive. Mr. Sigal stated that it is intended to be a holistic financial model and it will include the Exchange's current knowledge. Mr. Sigal views it as being somewhat iterative over time. The March presentation will hopefully answer questions. Ms. Fox stated that modeling around cost savings would be extremely helpful. Mr. Sigal stated that the premiums to be charged by the carriers are not controlled by the Exchange. Even if the Exchange could suggest cost savings, whether or not there would be followed would be out of the Exchange's control.

IX. Strategy Committee Update

Ms. Fox provided a brief update of recent activities of the Strategy committee. Dr. Scalettar was elected as co-chair. In its first meeting, a representative spoke from a physician/hospital association and discussed their strategy in coordinating care, and innovations in the delivery of healthcare that may impact quality and cost. The intent is to educate the committee itself and share this with the Board and also to get a considerable amount of input from constituents. Common themes have emerged. The committee is not just looking for a description of the problems but also looking for the innovative solutions that can be leveraged with the Healthcare Cabinet being a valuable resource. Members of the Cabinet have been asked to present those ideas to committee members during upcoming meetings. Ideas will be brought before the Board.

Ms. Veltri inquired as to whether questions from the Healthy Chats will be posted on the website. Mr. Madrak responded that the staff is cataloguing the questions and crafting responses, which will be helpful to both the Exchange and the attendees. Ms. Veltri stated that it will also be helpful for the navigator program. Ms. Fox stated that the agendas and minutes of the Strategy Committee are published on the website. This committee has more detailed conversations which are not at the board level.

X. **Standardized Plan Design Recommendations**

Peter Van Loon reported on the recent work of the Standardized Plan Design Working group for each of the metal tiers. In November, the Board approved a Qualified Health Plan (QHP) which tasked the group to develop standard plan designs for each of the metal tiers. A working group convened in late December as a subset of all the advisory committees. That working group or joint team met through January and recommended a core benefit design that was approved by the Board in January. The group also met several times in February to determine out of network and dental benefits. Dental and other benefits will be presented at the next Board meeting. Out of network benefits, are being proposed today, but the group is concerned that if in network standards are not adequate, the proposed benefit levels will pose a heavy financial cost to consumers for out of network care. The Board previously established the general adequacy standards for Essential Community Provider as well as percentages for Federally Qualified Health Centers.

For bronze and silver tiers, the out of network deductibles of $8,000 bronze and $5,000 silver are twice the in network deductibles. While high, this incents consumers to use in network providers. For the gold and platinum tiers, the out of network deductibles are $3,000 and $2,000, respectively. These deductibles are also twice the cost of the in network deductible for the respective tier. The out of network co-insurance percentages for the different tiers are 50/60/70/80, respectively for bronze, silver, gold and platinum. Concerns were raised at the benefit design meetings about emergencies and the need to go out of network for services not covered in network. With respect to emergency care, the law requires that if there is an emergency out of network, coverage and payment will be handled as if the emergency had occurred in network. Virginia Lamb, general counsel, noted that the Exchange's product is a commercial product. The carriers will be bringing their commercial network of providers to the Exchange. That network will be supplemented by Essential Community Providers, so the networks offered by the plans should be more robust than the networks many consumers have access to today. This should make it easier for the consumer to stay in network. In addressing other out of network care, Ms. Lamb stated that if a medically necessary service is not contracted for in network, carriers will pay for out of network service at the in network rate.

Mr. Van Loon worked with the joint team, and the team recommendation was taken verbatim. There was also an information meeting with the Advisory Committees the previous evening. Ms. Veltri stated that there has been great consensus around the issue of affordability. Members especially had concerns about affordability once dental and other items are added. Mr. Van Loon stated there was a hope to have the standard benefits completed by the February Board meeting but with emergent rules from CMS from the previous day, there may be additional amendments.

Grant Ritter stated that it was his understanding that there was going to be alternative non-standard plans offered on the Exchange but with narrow networks. Commercial network is a rather broad term. Mr. Ritter asked Ms. Lamb if there is any assurance that the networks will stay broad. Ms. Lamb stated that the guarantee is that plans today have an NCQA accreditation. Carriers will be submitting their current NCQA accreditation with an add-on survey for certification as a QHP. As part of the NCQA process, physicians are credentialed on those plans. A substantial deviation in their provider network would not be consistent with their current accreditation. While the networks may not be exactly identical, they should be very similar.

Mr. Ritter stated that a physician's willingness to be on the Exchange network may be somewhat contingent on the rates. Therefore, Mr. Ritter asked is there a feeling that the rates will remain the same inside and out. Ms. Lamb responded that there is a concern that some carriers are trying to pay less to providers when providing care under Exchange products. Future conversations will be required on this topic. Ms. Veltri commented that there needs to be robust monitoring of the networks.

Co-Chair Veltri requested a motion to approve as presented by the Exchange staff the out-of-network benefits for each of the four metal tiers of the standard plan designs.

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

XI. **CID Rate Review Process**

Deputy Commissioner Dowling presented an overview of the Connecticut Insurance Department (CID) Rate Review Process and was joined by Mary Ellen Breault, Director of Life & Health at CID and by Paul Lombardo, the actuary who conducts rate reviews. All rate reviews are posted on the CID website. Rate filing requirements were presented as well as a review of transparency and trend. Every time there is a rate proposal sent to the department, review starts from the bottom up. The team figures out what is correct regardless of the carrier's position. Mr. Lombardo thanked the Board for allowing a rate review process presentation. Rate review is not an exact science. Access to rate filings on CID website was described. Consumer comments can be emailed to CID. A summary of public comments are given to the actuary. Less than one year ago, all domestic health carriers were required to notify policyholders of rate modification filings. This has increased the amount of public comment and is working very effectively.

Trend was reviewed-- the change in claims experience over time. How a rate is developed was also reviewed. PPACA requirements effective January 1, 2014 were reviewed as well as the 2014 pricing changes.

Ms. Veltri asked if there is a way to standardize the comment period. Mr. Lombardo replied that the comments are in the executive summary and there is a 20 day public comment period, but it will stay open until the filing is closed. CID has 30 days to reply.

Mary Fox left at 11:41 a.m.

Ms. Veltri requested the definition of unit cost which was described in detail by Mr. Lombardo and Ms. Breault. It is not necessarily a fee schedule or actual cost. It is what the carrier is

paying. Ms. Veltri stated that the rate request put on the website is an aggregated rate request which was confirmed by Mr. Lombardo. It is not necessarily what the consumer will see.

Dr. Scalettar posed a question: with respect to rate modification requests, who determines the administrative expense for retention? Mr. Lombardo replied that CID looks to financial statements to verify that amount. Financial statements identify true costs of care and administrative expenses.

Commissioner Broderick left at 11:47 a.m.

There is no set standard as to fee. Dr. Scalettar asked how CID determines whether an expense is a benefit or claim expense versus an administrative expense? Mr. Lombardo replied that it is a topic of great discussion. The ACA specifically defines claim expenses and what must be classified in the administrative expense portion. Claim expenses are allowed for wellness programs. The ACA defines the medical loss ratio. As an example, the industry in general was trying to push commissions into the claim portion of the premium. That was not successful. Ms. Breault stated that CID looks at pure rate ratio for purposes of establishing the rate increase.

Dr. Scalettar asked if there are any insights, research or experience showing how insurance departments are using APCD and what the impact is in effecting cost of care. Mr. Lombardo replied that with the APCD, there will probably be a broader picture of the cost of services being provided by different providers with maybe a potential on the impact on claims. Dr. Scalettar inquired as to public comments other than those stating that premiums are unaffordable. Mr. Lombardo responded that the bulk of the public comments are on affordability. However, there have been comments on some rate filings that included numbers and were actuarial in nature by the late Jennifer Jaffe, which were incorporated in the review process.

Mr. Ritter asked about the trend percentage being the most uncertain of the different values-- is it decomposed into different components? Mr. Lombardo responded yes. Mr. Ritter stated that his big fear going forward is that new exchange enrollees are expected to be much sicker and their utilization will be much higher than existing members. Carriers can make the trend higher going forward. Mr. Lombardo stated that anytime there is a way to side with the consumer with an assumption, CID does make that decision. There are significant differences in expectations from carrier to carrier. Their trend may not necessarily be approved.

Ms. Breault stated that under federal regulations, the carriers are required to have one pool for individuals and one for the small employer market. Rates are required to be same inside and outside of the Exchange. Ms. Breault stated that each carrier will have its own pool of business. There will be a risk adjustment program from the federal government to level premiums across the carriers.

Mr. Tessier asked if this was a transitional stop-loss program. Ms. Breault responded that it was not. There is a three year transitional reinsurance program. Mr. Tessier asked if the reinsurance program will that be something CID will take into consideration when reviewing rate requests for 2014 and going forward where the carriers may be projecting higher trends. Mr. Lombardo stated that CID must follow federal guidelines not yet finalized, requiring it to include in the evaluation the reinsurance and risk adjustment process.

Secretary Barnes stated that because of the ACA changes, the whole predictable basis for establishing trend is completely up in the air. The dynamics may be quite different. Further, he has a concern that it almost begs for a universal model in the individual pool given the reinsurance and risk sharing. He believes that there should be a uniform model in trend and inquired as to whether there is any thinking that can be done to go about developing something like that? Mr. Lombardo stated that he did not know how that could be done. The essence of rate regulation and the ACA was to basically create a general community rate in the marketplace. The calculations are extremely complicated and have not been finalized. The model will be built as it happens.

Mr. Lombardo stated that all policy filings beginning January 1, 2014 from carriers will be grouped into one pool, and rate increases will affect all individuals. It is going from separate policy forms rates and experience to one aggregate risk pool in the individual market both inside and outside Exchange. Ms. Breault stated that it is now happening in the small employer market. The rate is the base premium.

XII. **Adjournment**

Co-Chair Vicki Veltri requested a motion to adjourn the board meeting. Motion was made by Benjamin Barnes and seconded by Grant Ritter. ***Motion passed unanimously.*** The meeting adjourned at 12:08 p.m.

The next Board Meeting will take place on March 14, 2013 at 9:00 a.m.
at the State Capitol.

Agenda
Presentation