STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

# Connecticut Health Insurance Exchange
# Board of Directors Special Meeting

CT Historical Society
One Elizabeth Street, Hartford, CT

Thursday, January 24, 2013
**Meeting Minutes**

**Members Present:**
Lieutenant Governor Nancy Wyman (Chair); Grant Ritter; Dr. Robert Scalettar; Mary Fox, Cee Cee Woods; 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:** None

**Other Participants:**
Health Insurance Exchange (HIX) Staff: Kevin Counihan, Julie Lyons, Grant Porter, Jim Wadleigh, Steve Sigal, Peter Van Loon and Virginia Lamb.

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

I. **Call to Order and Introductions**
Lt. Governor Wyman opened the meeting at 8:31 a.m.

II. **Public Comment** – There was no public comment

III. **Announcements-- Lt**. Governor Wyman read resignation letters from Board Members Michael Devine and Mickey Herbert and thanked them for their service to the Exchange. Senator McKinney and Rep. Cafero and will be appointing their replacements.

**Cee Cee Woods arrived at 8:35 a.m.**

## IV. Review and Approval of Minutes

Lt. Governor Wyman requested a motion to approve the minutes from the December 20, 2012 minutes. Motion was made by Grant Ritter and seconded by Cee Cee Woods. ***Motion passed unanimously.***

## V. CEO Report

Mr. Counihan reported that the Center for Consumer Information and Insurance Oversight (CCIIO) had recognized the Exchange's relationship with the Office of Healthcare Advocate (OHA) for oversight of its Navigator program as a Best practice that could be modeled in other states. This is the third time the Exchange has been recognized at CCIIO for best practices. The Exchange is also currently working with the OHA to establish training and management for the navigator and in-person assistor programs. Vickie Veltri and Jason Madrak were thanked for their efforts. Eighteen states including the District of Columbia have been conditionally approved as state based exchanges (SBE); two have been approved as partnership exchanges. The remaining 30 states are expected to default to the Federal Exchange. CMS and CCIIO scheduled a two day seminar in Baltimore for SBE's to review the IT, operations, outreach and policy issues and challenges. Five senior staff from Connecticut's Exchange will be attending. Debt ceiling discussions in Washington continue to be monitored for their potential impact on the Exchange. Connecticut's Exchange was selected to participate in Enroll America, a national organization working to promote enrollment, outreach and ACA awareness. Seven Healthy Chats are scheduled beginning in Norwich on February 17. Board members who volunteered for Health Chat panels were thanked.

**Commissioner Bremby arrived at 8:39.**

Mr. Counihan reported meeting with the staff of the All-Payer Claims Data Base (APCD) and noted that Colorado is one of the lead states for APCD. Their system produces a series of on line reports on: primary care visit rates, in-patient utilization, variations in care access and utilization, and evidence of adverse selection and preventable hospitalization for chronic illnesses. Additional information on Connecticut's APCD will be shared at future meetings.

Exchange staff has also been heavily involved in a series of multi-stakeholder meetings with representatives from the Exchange's Advisory Committees, the Connecticut Insurance Department (CID) and the carriers. The purpose of these meetings is to develop recommendations for the Exchange's standard plan benefit design. Mr. Counihan commented on the stakeholders' commitment to the value that health coverage is a fundamental right and their dedication and sense of shared responsibility and collaboration for implementing health reform in Connecticut. All groups were thanked for their cooperation and collaboration**.** Lt. Governor Wyman requested that the future dates of Healthy Chats be provided.

## VI. Board Governance Issues

Lt. Governor Wyman thanked Jeannette DeJesús for her service on the Board and as the Board's Vice-Chair. Lt. Governor Wyman requested a motion to elect Vicki Veltri as Vice-Chair of the Board of Directors. Motion was made by Mary Fox. Robert Tessier seconded. ***Motion passed unanimously.***

**VII. Finance update**

Steve Sigal, CFO presented the finance update. Changing the grantee from the Office of Policy and Management (OPM) to the Exchange resulted in significant delays in the Exchange's accessing its previously awarded grant funds. The review process for changing grantee status took 63 days not the 30 to 45 days CCIIO initially advised the Exchange it would take. Access to funds following the change in status took an additional 27 days not the 10 days CCIIO initially advised. Essentially the federal system treated the change of grantee status from OPM to the Exchange as if it were a new grant award to the Exchange. Near the end of this period, the Exchange was faced with a serious cash flow problem. Fortunately, the Exchange's enabling legislation, authorized the Exchange to borrow $5 million dollars from the State of Connecticut for such purposes. This temporary loan allowed project work to continue uninterrupted. Upon receipt of the federal funds, the state was fully repaid. The Exchange's experience was a lessoned learned for CCIIO in negotiating the federal bureaucracy. Connecticut was the first Exchange to go through this process.

**Secretary Barnes arrived at 8:45 a.m.**

**VIII. Operations and Information Technology Update**

Peter Van Loon, COO provided an operations update. The Exchange is on track with its people, process and technology. Last year, the Exchange did not meet design confirmation due dates for extremely valid reasons. But, since the end of December, the Exchange has been working closely with Deloitte and design confirmation is now on track. The Call Center contract is in negotiations. The Exchange expects to have the contract signed and the vendor officially on board by March 1 and the contractor to unofficially begin working with IT even sooner. The RFP for the SHOP was released on January 22. Proposals have been received and are currently being reviewed. Considerable time has been spent working on the standard plan designs. And, Julie Lyons, Director of Plan Management has been working closely with the carriers on implementation. Efforts going forward include continuing to develop the operating model with the Department of Social Services (DSS) and continuing to adjust and adapt to compliance with emergent federal Guidelines.

Jim Wadleigh, CIO presented the technology update. All IT teams continue to make significant progress. The Exchange remains on track for two releases with June and October implementation. Design sessions are complete. Design confirmation continues and software construction has begun. Communications with the Federal Data Services Hub have been tested. This is a significant milestone. DSS integration design confirmation is on track to be completed by mid-March. The Go Live date of October 1, 2013 remains unchanged.

Mr. Wadleigh explained that design is the deliverable that provides an end functional view of the Exchange's system. The design process includes review of: the key elements of portal screens, use cases, business rules and a myriad of technological artifacts that go into the hosting design. More time spent on design, results in a reduction in construction and testing defects and a reduction in change controls. The result is a much better end product. The design needs to be right, as it leads to everything going forward. The Exchange extended the date for completing the design process to allow for greater stakeholder participation, including participation from representatives of the Exchange's Advisory Committees. Having consumer representation in the design sessions has contributed in a positive way to a better Exchange

product. Deloitte will be making significant modifications to their out of the box screen design and user interface to incorporate consumer recommendations. Continuing federal guidance has also resulted in changes to the design and the schedule. While the design deliverable is later than originally scheduled, the product is significantly improved and Deloitte is on track with the revised schedule.

Mary Fox asked about the key variables consumers are concerned with. Mr. Wadleigh responded that the design is planned to allow up to 20 different sort selections for comparison. There will also be a link to provider directories next to each carrier allowing consumers to search for participating providers before making their plan selection. In addition, ACOs providing innovative solutions will also be able to be accessed by consumers before they select.

Dr. Scalettar asked whether there were any implications for functionality beginning October 1? Mr. Wadleigh responded that there have been negotiations with CCIIO over what functionality can be deferred post October 1 that will not impact consumer experience or integrated eligibility. It was determined that about 30% of the functionality can be deferred. Connecticut is the first state to approach CCIIO with deferring some functionality. Dr. Scalettar asked about financial implications. Mr. Wadleigh stated that there are no financial implications. Dr. Scalettar thanked everyone for candidly addressing functionality issues with CCIIO. Mr. Wadleigh reported that plan management implementation is scheduled for June 4, 2013. The core HIX Functionality implementation date continues to be October 1, 2013.

**IX. Plan Management Update**

Julie Lyons, Director of Plan Management provided the plan management update. Plan Management is a partnership between the Exchange and one of the Exchange's key stakeholders – the insurance carriers who will be providing health coverage through the Exchange. Carriers need to be engaged to ensure that there is a mutual understanding of compliance with federal regulations and guidance and Connecticut state law in designing and offering their Exchange products. Technical information must be programmed into the carriers' systems recognizing that not all the federal guidance has been received.

**Commissioner Mullen arrived at 9:08 a.m.**

Plan Management functions were reviewed. These functions include: developing and maintaining effective carrier relationships; drafting the Qualified Health Plan (QHP) application; certifying QHPs; collecting/publishing accurate benefit and rate information; managing contracts with QHPs; monitoring ongoing compliance and supporting the open enrollment process. An operational kick off meeting was held with the carriers earlier in the month. Exchange and Carrier Workgroup meetings dates were reviewed. Major activity updates and plan management dates were also reviewed.

Vicki Veltri asked about the solicitation process. Ms. Lyons reported that the Exchange had received detailed questions from the carriers in response to the initial solicitation and in response to federal and Exchange guidance. Each carrier question is being researched and all questions will be answered with both the question and the answer posted on the Exchange's website. Feedback is also being incorporated in the carrier application. Dr. Scalettar inquired as to when the solicitation process will go beyond the letter of intent. Ms. Lyons responded that the specific schedule for response was outlined in QHP solicitation. The target date is the end of March.

Peter Van Loon addressed issues involved in the Standard Plan Design. The purpose of a standard benefit design is to make it easier for consumers to compare and contrast plans based on quality, network and price, since both benefits and cost sharing are by design held constant. Secretary Barnes inquired about quality. Mr. Van Loon responded that the Exchange can develop its own quality system and metrics for plans offered through the Exchange and can profile this information on its web portal. The controlling principles for developing the standard plan design were simplicity and consumer focus with an emphasis on access to primary care. The Team included two members of each advisory committee assisted by staff from the Connecticut Insurance Department and three carrier representatives. Meetings were collaborative and detailed. Carriers provided a great service in support of the team by providing feedback on what makes sense in the market. Dr. McLean addressed clinical aspects and consumer advocates continued to emphasize affordability. The parameters under which the team worked were reviewed including Connecticut state law, ACA Regulations and the actuarial value of the metal tiers.

Grant Porter provided more detail on the Actuarial Value (AV) Calculator and how it was used. Actuarial value is the percentage of total healthcare that is paid for by premium dollars for a typical population. In relationship to the standard plans defined, the actuarial value calculated refers only to essential health benefits and in-network coverage. The ACA specifies a specific actuarial value for each metal tier. Only a two point variation from that actuarial value is allowed. Additional subsidies based on the consumer federal poverty level, will help to make coverage more affordable for certain low income individuals. These individuals will qualify for cost sharing reductions in addition to premium subsidies. The specific functionality of the AV Calculator provided by CMS in late November 2012 was also reviewed. The current AV Calculator is not perfect and it is not final, but it is a good estimate of what actuarial values are likely to be. The AV Calculator uses nationwide data, but there will be an option to use Connecticut data in 2015. It allows users to adjust various parameters of a health plan including the deductible amount, coinsurance percentages, copay by service category and limits on services. The carriers informed the Exchange that they are also using the AV Calculator.

Analysis and development of standard plan designs were reviewed. Because the AV Calculator is based on actuarial science and recognition of shared responsibility, you cannot design a plan with no co-pays or no deductibles. Offsets are required. The Team's preference was for co-pays as opposed to co-insurance, since co-pays are more predictable for consumers.

The Team's recommendations on the summary of the metal tiers were also presented to the Advisory Committees for informational purposes. The Exchange and the Team believe the plans presented for the Board's consideration today represent the best dollar for consumers given the realities. The silver plan is being emphasized in the Exchange's presentation, because it will determine the advance premium tax credits. It is also expected that most people will purchase the silver plan. In addition, consumers will have the option of buying up or buying down from the silver plan.

Mr. Tessier stated that after two months away from the Exchange, the amount of work that has been done is staggering and expressed appreciation to the staff, board members and Advisory Committees for their work. He requested further clarification on cost data. If health care costs more in Connecticut than in other parts of country, how confident is the Exchanged that the listed copays and deductibles will in fact equate to 30% of the consumer's total health care costs? Mr. Porter responded that the AV Calculator is imperfect and it probably inflates the

value of the plans. There are known issues with the AV Calculator that seem to overstate value. There is also an issue as to how rehabilitative services are computed on the AV Calculator, as well as an issue with generic drugs. But, it is a reasonable approximation for what can be expected. Mr. Van Loon further stated that the imperfections with the calculator are minimal based on input from carriers and in several months there will be a new calculator, when the final rules are issued. Unfortunately decisions need to be made now so that products can be offered by October 1. Mr. Tessier also asked whether the Exchange as it moves forward will have access to Connecticut specific data to verify accuracy? Mr. Van Loon responded yes and noted that staff will be coming back to Board for any required approvals following availability of new data. The ACA specifically states the Exchange can use Connecticut specific data in 2015.

Mr. Van Loon reported that the concept of affordability continuously came up. There is great concern that it may be difficult for some consumers to pay the deductibles. The ACA provides additional subsidies by the federal government to mitigate out of pocket costs for those on the lower end of the income scale. Those with incomes between 150 and 250 percent of the Federal Poverty Level (FPL) will be eligible for these cost sharing subsidies. These federal subsidies were reviewed with constituent stakeholders. The consumer advocacy panel indicated that even with these subsidies, out of pocket costs could still be a huge burden.

Ms. Veltri indicated that the AV Calculator is a math exercise and there is not much control without knowing what premiums will be, but if premiums are higher, subsidies will also be higher. Ms. Veltri also noted that the 30% of the consumers the Exchange is trying to reach are above the subsidy level and they also may be struggling with health care costs. Overall affordability issues still need to be addressed.

Deputy Commissioner Dowling stated that carriers are allowed to submit one other plan design per tier and noted that this alternate plan design may have more potential for affordability. Ms. Dowling questioned why plans were limited to only one alternative? Mr. Van Loon responded that the concept was to simplify the consumer shopping experience by making plans more easily comparable as discussed at the November Board meeting. Mr. Counihan noted that the Board's decision of one standard plan and one alternate plan per metal tier with varying cost sharing provisions within the tier would give consumers 40 options to evaluate. In the second year, carriers will be allowed to offer two non-standard options for each metal tier.

Secretary Barnes asked how this would impact people; when premium information will be available; and, whether the cost sharing reduction options were available to plan tiers other than the silver tier? Can a consumer elect a bronze plan and still receive subsidies? Mr. Van Loon reported that the integrated eligibility system will be able to handle any number of options. The system will automatically determine those eligible for tax credits or cost sharing reductions, based on their reported and verified income. Mr. Porter reported that only the silver plans come with cost sharing reductions. Secretary Barnes emphasized the need to make consumers aware that they were only eligible for cost sharing reductions if they selected a silver plan. Mr. Van Loon stated that consumers would be educated on these options by navigators, brokers, and in-person assisters. Mr. Counihan re-affirmed that the Exchange's commitment to making consumers aware of all the benefits available through the Exchange. Every effort will be made to present this information in an as tangible manner as possible so that the average consumer can understand it. Actual examples will be provided.

Ms. Fox recommended that the issue of sustainability be discussed further and noted the need for the Exchange to develop a durable financial model. Ms. Fox also asked how the innovative designs the carriers seem anxious to put forward will be accommodated in the different metal tiers? How will these options come up for review and be presented to the consumer? Mr. Wadleigh responded that the system has been designed to default to the silver plans because this is where customers falling within the FPL will see their available tax credits. Premium will be the next sort and from there the consumer can elect to work through remaining items. Mr. Wadleigh noted that the carriers are asking the same question.

Drug Benefits: Mr. Porter reviewed the Standard Plan Design Drug benefits noting that the benefits are comparable throughout the different levels. There is a $10/$25/$40 copay with a 50% co-insurance on specialty drugs. The deductible for generic drugs has been waived. Cost sharing reduction plans were reviewed.

Mr. Porter confirmed that the essential health benefits, except stand-alone dental benefits, are inclusive of prescription drug coverage. Lt. Governor Wyman noted that the State realized major cost savings by bidding its prescription coverage separately from its medical coverage. The Lt. Governor asked that the Exchange explore with the federal government whether this would be possible in the future. Mr. Tessier agreed with the Lt. Governor. Given specialty drug co-pays at 50% and the number of drugs being added to specialty pharmacy currently and those projected to be added in the future, prescription costs will be unaffordable for many. There is a real opportunity for savings. The Lt. Governor also asked why there is the same copay for in-hospital and out-patient hospital care, when the cost for out-patient care is less expensive and noted that going forward, the Exchange needed to look at steering people toward using less expensive out-patient services.

Grant Ritter stated that in many situations a lower co-pay may not influence choice of provider. For example, the consumer often is not the one to decide where surgery will take place. It may be their surgeon's decision. Commissioner Jewel Mullen also observed that while the different metal tiers give consumers some choice about their overall health care costs, directing consumers to sites of care requires actionable information at the time the decision to seek care is made. This information is often not available to the consumer. Their doctor's office may not even know the costs for care at other providers. It will be important to work with hospitals and provider groups on this issue.

A key lesson learned in this process was the need to compromise and balance competing values. Setting the standard plan design based on the Actuarial Value Calculator is not the same as setting a premium. The time and information available to make decisions is limited. The standard plan designs must be provided to the carriers now so that they can develop their plans and rates for submission to the CID for its review and approval. Affordability must continue to be addressed. Additional questions raised outside of the standard plan designs included education, the consumer shopping experience, and the Exchange relationship with Medicaid and non-standard plan parameters.

Mr. Van Loon reviewed the next steps. In February, out of network deductibles and co-insurance will need to be addressed by the Board. The Board will also need to review the stand-alone dental plan. Emerging rules from CCIIO and any new Connecticut legislation may require further adjustments to plan design.

Ms. Veltri commented that additional flexibility and potential options should be made available the Board as soon as this information is known. Ms. Veltri also noted that the Office of the Healthcare Advocate is fully committed to developing the ground effort with the Exchange with regard to the in-person assister program to help consumers get educated.

**Secretary Barnes left at 9:58 a.m.**

Lt. Governor Wyman requested a motion to approve as presented by Exchange staff the standard plan designs for each of the four metal tiers of the Qualified Health Plan. Motion made by Grant Ritter and seconded by Cee Cee Woods. ***Motion passed unanimously.***

Mr. Counihan thanked the Board for the vote and the committee for their work specifically Grant Ritter, Vicki Veltri, and Mary Ellen Breault, Peter Van Loon and Grant Porter. Lt. Governor Wyman further thanked all the advisory committee members and Mr. Counihan for his leadership.

Vicki Veltri announced that the Exchange and the OHA will be posting on their websites four positions for the independent assister program. Dr. Scalettar requested an update on the navigator program under the OHA and how the funding for the navigators and in-person assisters would work.

Mr. Counihan reported that there will be a CMS phone call regarding the in-person assistor program on January 24, 2013 to discuss funding. Ms. Veltri has already responded to questions presented by CMS. The Exchange's written responses must be in by January 30 and the Exchange is tracking well to getting the funds. The Exchange continues to explore foundation interest in supporting the navigator program. The challenge of securing navigator funding also continues to be brought to CCIIO's attention by Exchange CEOs.

**X. Adjournment 10:25**

Lt. Governor Wyman requested a motion to adjourn the board meeting. Motion was made by Dr. Robert Scalettar and seconded by Vicki Veltri. ***Motion passed unanimously.*** The meeting adjourned at 10:25 a.m.

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

Agenda
Presentation