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Connecticut's Health Insurance Marketplace

Board of Director's Meetings

March 14, 2013

Agenda

I. Welcome and Introductions
II. Public Comment
III. Review and Approval of Minutes
IV. Operations and Information Technology Update
V. Plan Management Update
VI. Marketing Update
VII. Overview of Sustainability Models
VIII. State Innovation Model Initiative
IX. Revision of Standard Plans

WELCOME AND INTRODUCTIONS

PUBLIC COMMENT

REVIEW AND APPROVAL OF MINUTES

OPERATIONS AND INFORMATION TECHNOLOGY UPDATE

Agenda

- Program Summary
- Risks
- Operations Update
- Information Technology Update
- Background:
  - Timeline
  - Operational Dashboard
  - IT Dashboard

PROGRAM SUMMARY: Yellow

Schedule Risk: The agreed-upon or required schedule will not be met.

Resource Risk: Resources such as people, budget, equipment, or other limited assets are not leveraged efficiently and effectively to achieve program success.

Quality Risk: Product (deliverables/solution) of the program will not meet the intended requirements or needs.

Scope Risk: Objectives of the program are not well defined/understood and progress/completion can not be effectively measured.

Issues: Critical concerns that impact above risks and require Board guidance

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SCHEDULE RISKS

Level	Risk Definition	Remediation Approach	Resolution Date	Responsible Party
1a	Required documents for the CMS Detail Design Review are outstanding.	Daily monitoring and tracking of document completion.	03/15/13	AHCT CIO
1c	To comply with new CMS minimum benchmark date, must meet requirement for "70% completion" of IT build by April 1, 2013.	AHCT requires guidance from CMCS/CCIIO on the definition of "70% complete."	TBD	AHCT CIO
1o	Behind schedule contracting an IV&V vendor.	IV&V Vendor planned to be on board by 4/15/13 and submit an initial IV&V report by 6/30/13	04/15/13	AHCT CIO
8d	Need access to Department of Labor and Department of Motor Vehicles'' data for eligibility verification.	AHCT Legal developing a high-level MOU with DOL.	05/15/13	AHCT CEO

QUALITY RISKS

Level	Risk Definition	Remediation Approach	Resolution Date	Responsible Party
3b, 3i, 3j	System Integrator deliverables have not met quality expectations.	Tighter requirements on System Integrator to provide progress updates and to submit partial-drafts ahead of due dates.	Ongoing	AHCT CIO
1a, 2d, 3b	Emerging operational questions may impact system design.	Disciplined process to identify and answer questions	Ongoing	AHCT COO

SCOPE RISKS

Level	Risk Definition	Remediation Approach	Resolution Date	Responsible Party
2d	Operational and systems integration with DSS not finalized.	System modifications to streamline transfer of data between the DSS and AHCT systems are being developed.	Ongoing	AHCT COO
2d, 3b	Design for AHCT Worker Portal screen does not match the flow of the streamlined paper application.	Workers must be able to follow the paper streamlined application to input information into the AHCT system.	03/29/13	AHCT COO

Operations Update

- Operating Model – Developing people and process to handle paper, call center, web, and in-person entry into “no wrong door” integrated eligibility system
  - James Michel hired as Operations Manager
- Call Center – Contract signed and Maximus on board
- Small Employer Health Options Program (SHOP) – Contract being negotiated
- Policy – Standard Plan Design redefined to incorporate new Federal regulations
- Human Resources – Updated policy and procedures to provide foundation for growth in staff
- Management Team – Stressing communication and coordination

Information Technology Update

- IV&V vendor selection underway
- Wave I testing process starting on 3/20
- Advisory Committee Consumer Website presentation planned for 3/20 at Middlesex Community College
- Federal onsite security team review planned for 3/19 – 3/21
- Federal Detailed Design Review planned for 3/27 & 3/28
- Design Completed on 3/30

Activity	Date
AHCT Demonstration for Advocates	03/20/13
CMS Preliminary Detail Design Review	03/27/13
CMS Milestone - 70% of IT Build complete	04/01/13
CMS Final Detail Design Review	04/22/13
CMS Milestone "Last date to enter testing"	05/01/13
Release One	06/04/13
CMS Final Determination of State Based Exchanges	07/02/13
AHCT User Acceptance Testing Start	08/02/13
AHCT QHP Review of Plan Data	08/15/13
Implementation Readiness Review	08/31/13
Release Two / AHCT Start of Open Enrollment	10/01/13
Release Three	12/13/13
Release Four	03/07/14

PLAN MANAGEMENT UPDATE

Plan Management Update

- Integration of business and technical requirements between the Exchange and each participating carrier to facilitate the successful administration of products
- Functions include:
  - Develop and maintain effective relationship with carriers
  - Draft QHP application
  - Certification of QHPs
  - Collection / Publishing of benefit & rate information
  - Managing contracts with QHPs
  - Monitoring ongoing compliance
  - Supporting open enrollment process

Plan Management Timeline

Action	Due Date*
Standard Plan Design Release	3/14/2013
Update QHP Solicitation	**3/18/2013**
Draft QHP Application Sent to Responders	3/18/2013
Draft QHP Contract Sent to Responders	3/18/2013
Responses, Evaluation and Negotiation of QHP Contract/Agreement	3/18/2013 – 7/30/2013
Issuer Filings due to Connecticut Insurance Department (CID)	**4/1/13**
Questions from Issuers on QHP Solicitation Due	4/1/13
Exchange Responses to Issuers QHP Questions	4/8/13
QHP Application Due to Exchange	4/30/13
Evaluation and Negotiation of QHP Applications	5/1/13 – 7/30/13
CID Review Period Ends	7/30/13
Certification of QHPs	7/30/13 – 8/14/13
Issue Contract/Agreement between Issuers and Exchange	7/31/13 – 8/14/13
Issuer Review of Plan Data to be Published via Exchange	8/15/13

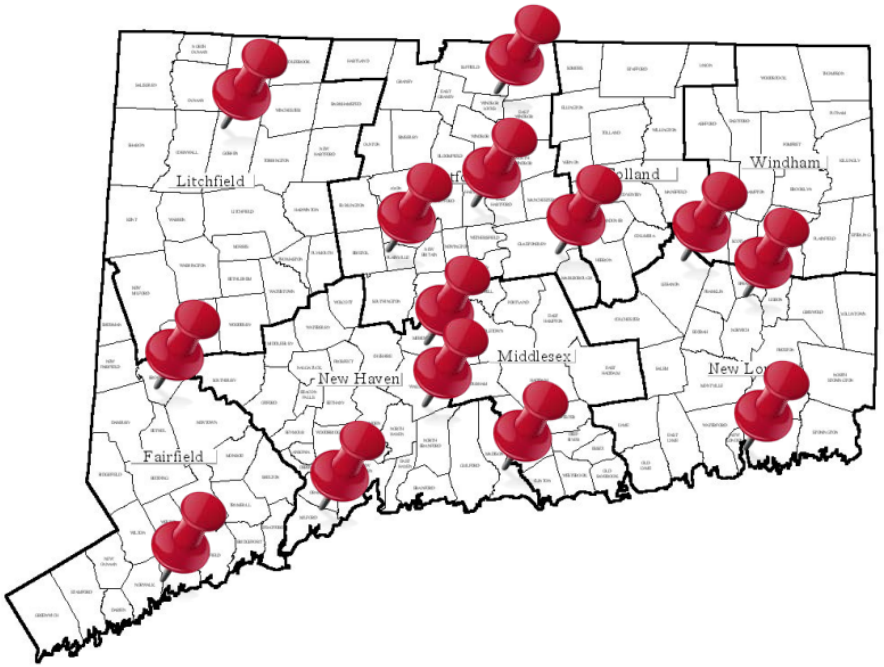
Plan Management Activities

Time Period	Major Activity
March 2013	• Draft QHP Application & Contract • Carrier Engagement Workgroup - Webinars on Initial Open Enrollment / Special Enrollment and Review Draft QHP Application & Contract; Dental Benefits - Adult and Pediatric • Identification of Manual Processes Required to Support Plan Management
April 2013	• Catalog, Research and Respond to Carrier Questions on QHP Solicitation • Carrier Engagement Workgroup - SERFF Benefit and Rate Templates; Review of Shopping Experience • Testing of Benefit Data in SERFF System

MARKETING UPDATE

LET'S CHAT

www.healthychatct.com



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Middlesex Community College

100 Training Hill Road

Middletown, CT

5:00 to 7:00 PM

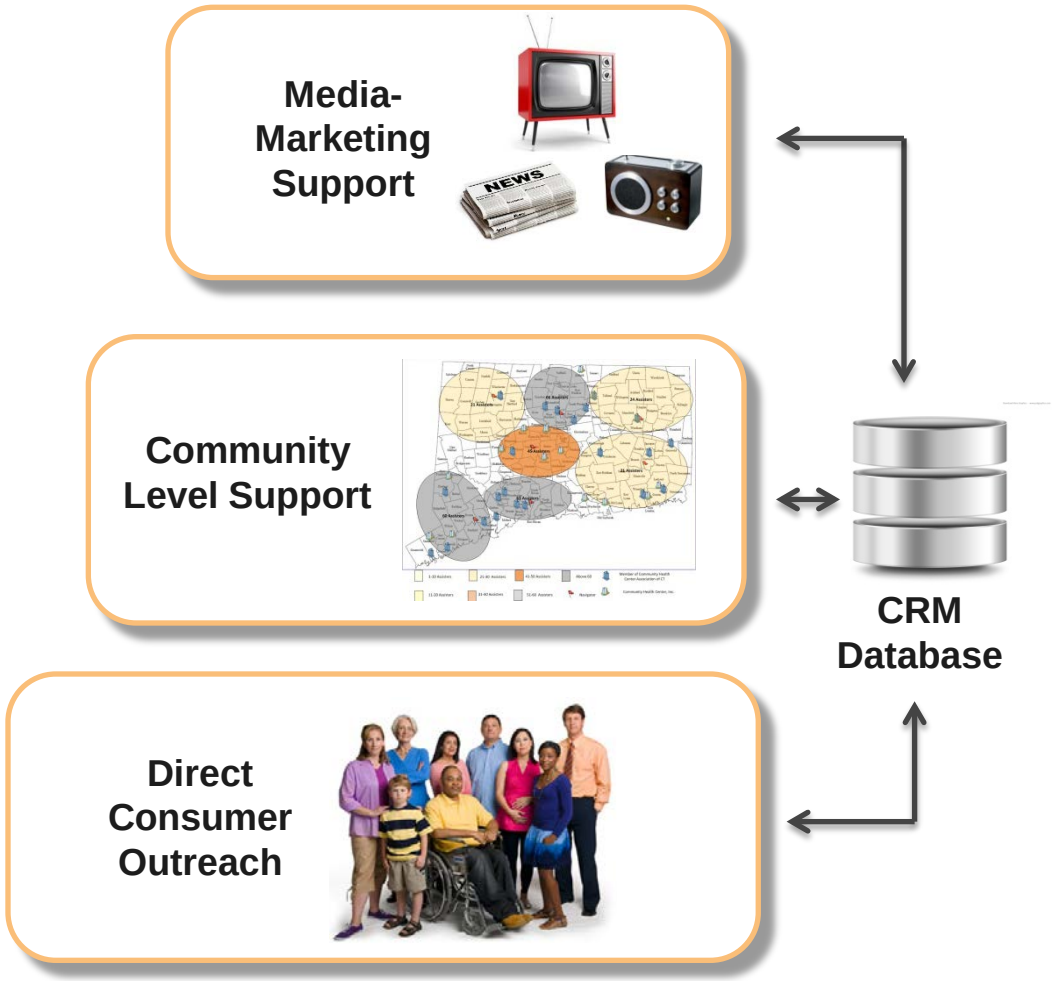
Tuesday, April 16
North Haven, CT
Holiday Inn North Haven

Wednesday, April 17
Norwalk, CT
The Norwalk Inn

Wednesday, April 24
Groton, CT
The Mystic Marriott

Thursday, April 25
Meriden, CT
Four Points by Sheraton

- Directly engaging and educating residents and small businesses is the foundation to our successful launch
- Targeted, local, and linguistically and culturally sensitive outreach will be a primary focus
- Community based efforts, as well as traditional marketing and media activity will provide additional support



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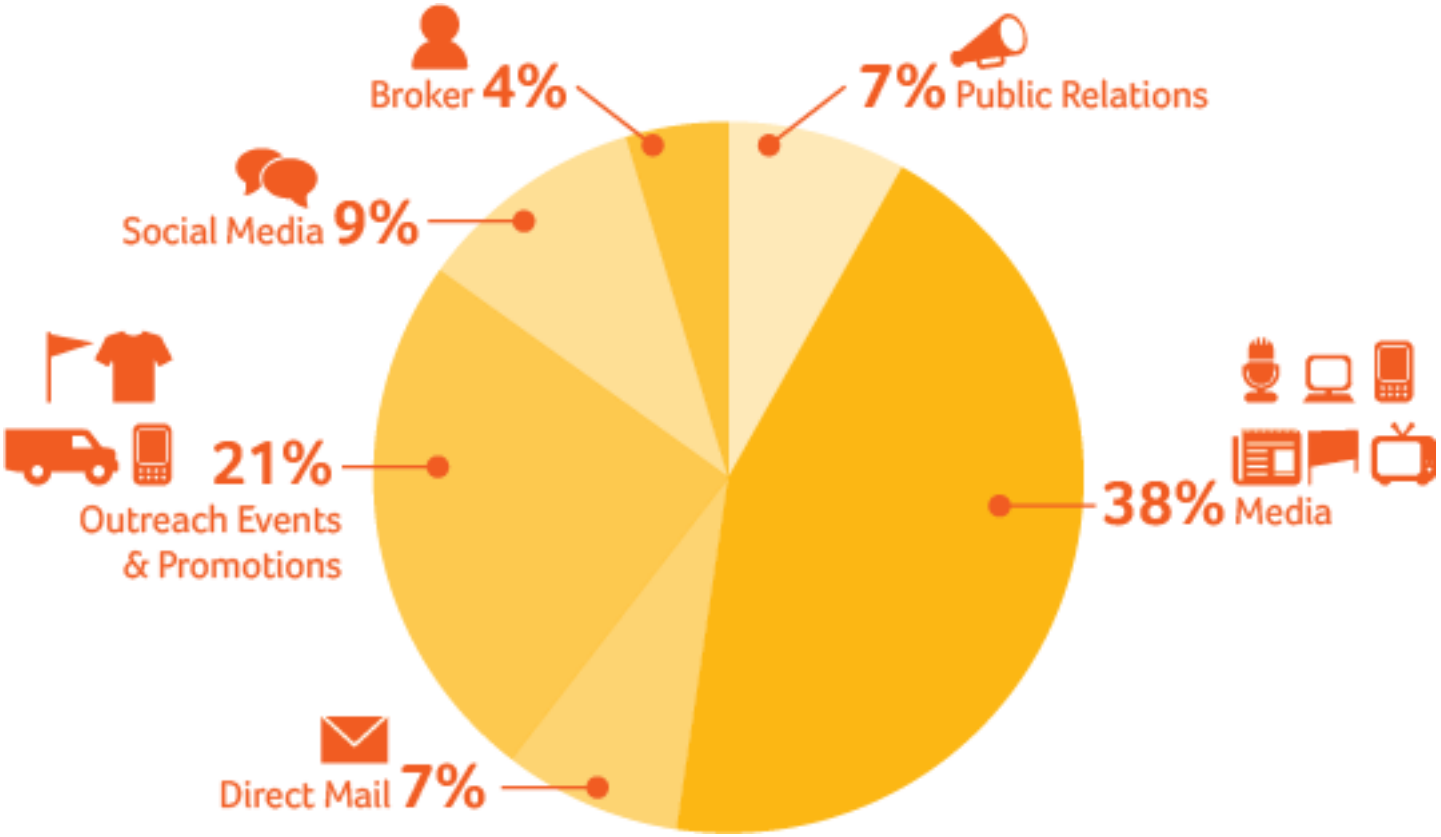
Educate, Engage, Enroll Tactical Components



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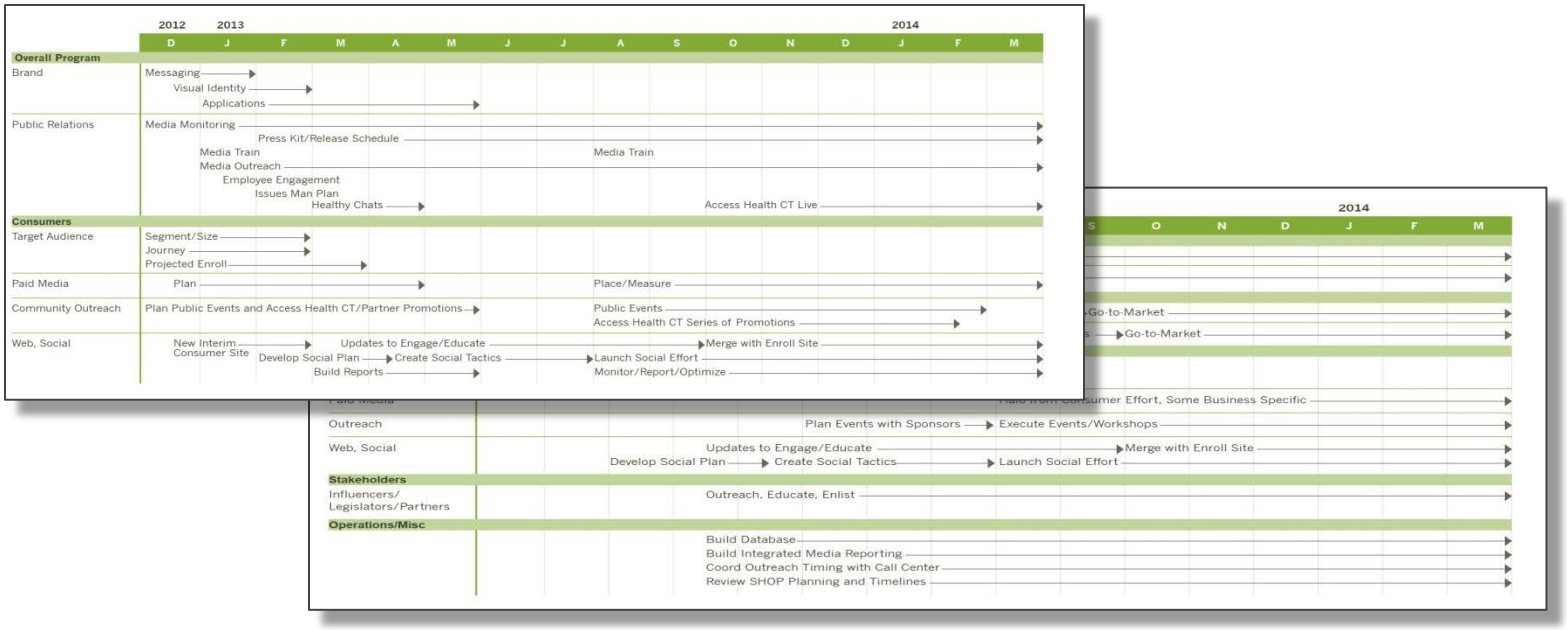
Project Timeline

- An overall project timeline is being finalized
- Majority of training , collateral and media development occur in May-July period
- Media and active enrollment focused efforts begin in August
- Awareness and education efforts are ongoing



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OVERVIEW OF SUSTAINABILITY OPTIONS

Agenda

- Executive Summary
- Policy: Acquiring Operating Funding
- Revenue Requirement
- Membership Projection
- Qualified Health Plan (QHP) Premium
- Revenue Options
- Recommendation

Executive Summary

- Self-Sustainability requirement as of 1/1/2015
- Hypothetical scenarios
- Estimated annual operating costs may range from $25 million to $30 million; believed to be less than similar exchanges
- Includes increased known costs combined with actual experience and clarified projections
- Membership estimates refined
  - 3 Scenarios: High, Moderate, Low
- 3 primary revenue sources
  - Market assessment
  - User fee
  - Medicaid cost recovery
- Secondary revenue sources not included in scenarios
- Requesting approval of recommendations

POLICY: Acquiring Operation Funds

- Policy for acquiring operating funding enumerates 3 approaches:
  - Market assessments
  - User fees
  - Other actions including advertising, cost recovery and other endeavors consistent with the purpose of the Exchange
- Both the Patient Protection and Affordable Care Act and the Connecticut enabling legislation for the Exchange contemplate user fees and market assessments
- Connecticut stipulates charging these to health carriers that are **"capable of offering a qualified health plan through the exchange"**
- The market assessment would be based on the entire small group and non-group market

POLICY: Acquiring Operation Funds

- State of Connecticut Legislative authority:
  - Sec. 38a-1083. Powers of exchange. . . .
    - (c) The exchange is authorized and empowered to: . . .

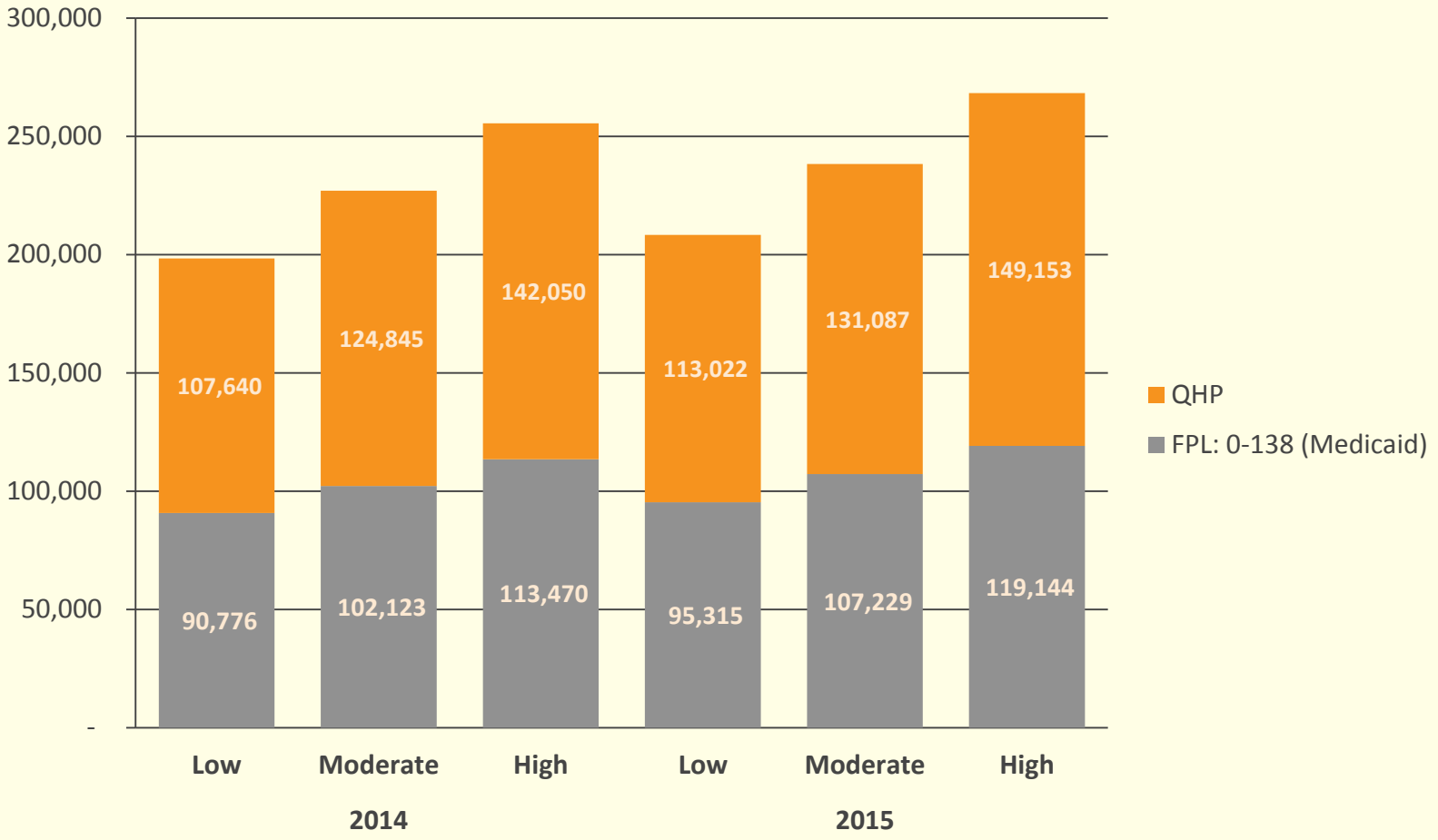
      (7) Charge assessments or user fees to health carriers that are capable of offering a qualified health plan through the exchange or otherwise generate funding necessary to support the operations of the exchange;

- Federal Patient Protection and Affordable Care Act authority
  - Sec. 1311(d):
    - (5) In establishing an Exchange. . . the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurers, or to otherwise generate funding, to support its operations.

Revenue Requirement

	2014			2015		
	Low	Moderate	High	Low	Moderate	High
Total Costs	$ 22,165,667	$ 22,754,629	$ 23,343,591	$ 22,189,670	$ 22,954,087	$ 23,718,488
Capital Investments	$ 1,750,000	$ 1,750,000	$ 1,750,000	$ 1,795,000	$ 1,795,000	$ 1,795,000
Total Revenue Required	$ 23,915,667	$ 24,504,629	$ 25,093,591	$ 23,984,670	$ 24,749,087	$ 25,513,488
PMPM	$ 21.61	$ 19.07	$ 17.15	$ 18.65	$ 16.59	$ 15.03

Membership Projection



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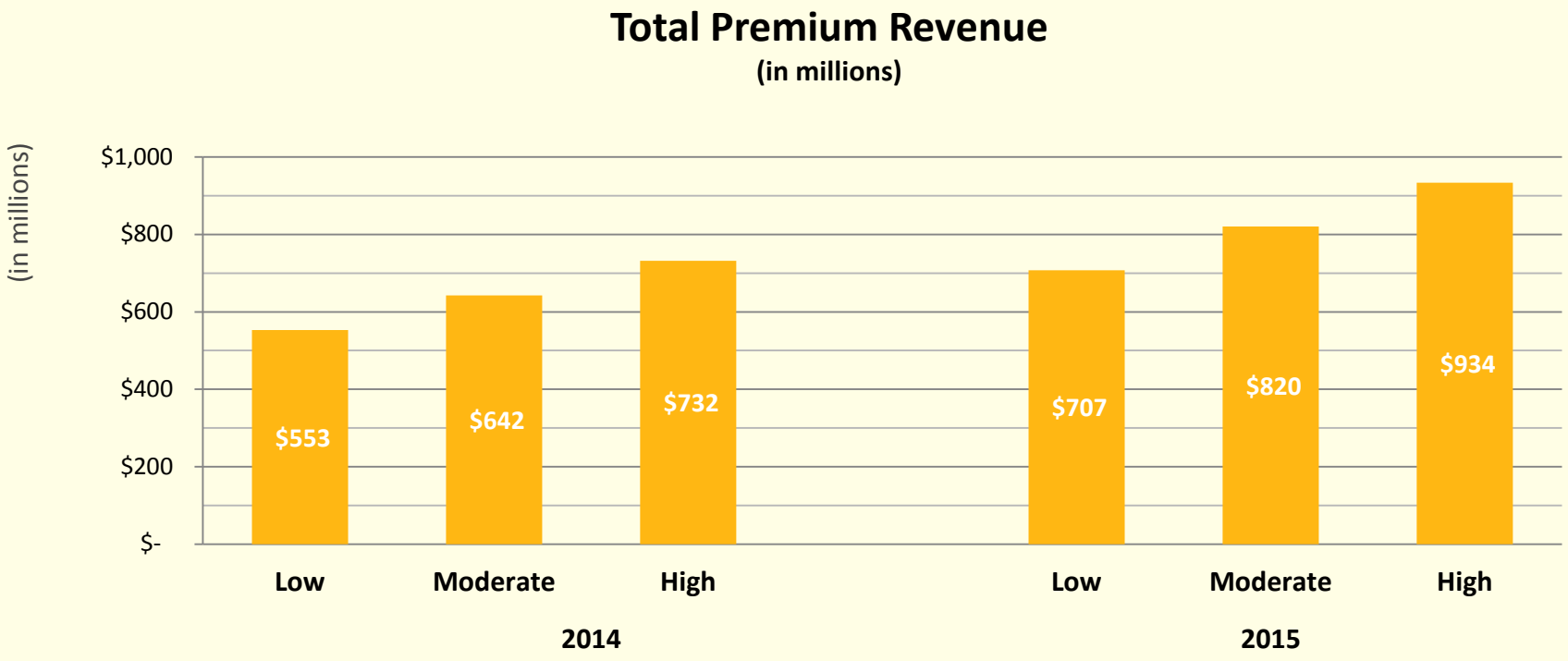
QHP Premiums



	2014 Low	2014 Moderate	2014 High	2015 Low	2015 Moderate	2015 High
Membership	107,640	124,845	142,050	113,022	131,087	149,153
Net Member months	1,106,583	1,284,806	1,463,029	1,286,026	1,491,666	1,697,307
Total Premium Revenue	$ 553,291,506	$ 642,402,945	$ 731,514,383	$ 707,314,033	$ 820,416,412	$ 933,518,791
Premium PMPM	$ 500	$ 500	$ 500	$ 550	$ 550	$ 550

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Revenue Options

	2014			2015		
	Low	Moderate	High	Low	Moderate	High
Membership	107,640	124,845	142,050	113,022	131,087	149,153
Total Premium Revenue	$ 553,291,506	$ 642,402,945	$ 731,514,383	$ 707,314,033	$ 820,416,412	$ 933,518,791
Medicaid Cost Recovery	$ 2,024,732	$ 2,123,189	$ 2,221,645	$ 2,400,636	$ 2,536,518	$ 2,672,401

Scenarios: All include consideration of Medicaid

	Low	Moderate	High	Low	Moderate	High
Option 1: User Fee only	3.96%	3.48%	3.13%	3.05%	2.71%	2.45%
Option 2: *Market Assessment only	0.68%	0.67%	0.65%	0.62%	0.58%	0.57%
	$ 21,890,935	$ 22,381,441	$ 22,871,946	$ 21,584,034	$ 22,212,570	$ 22,841,087
Option 3: User Fee + Market Assessment						
User Fee 1%	$ 5,532,915	$ 6,424,029	$ 7,315,144	$ 7,073,140	$ 8,204,164	$ 9,335,188
Market Assessment	$ 16,358,020	$ 15,957,411	$ 15,556,802	$ 14,510,894	$ 14,008,405	$ 13,505,900
	0.51%	0.48%	0.44%	0.41%	0.37%	0.34%
	$ 21,890,935	$ 22,381,441	$ 22,871,946	$ 21,584,034	$ 22,212,570	$ 22,841,087

*Small Group and non Group Market Premium (~~$3 B)

Access Health CT Recommendation:

- Access Health CT recommends approval of the “Policy: Acquiring Operating Funding”.
  - The market assessment option together with Medicaid cost recovery and other opportunities that may arise provides a broad basis for achieving financial sustainability.
  - The market assessment provides:
    - Less impact on cost to members
    - Promotes shared responsibility
    - Consistency with the vision and mission of the Exchange
    - Incentives for health plan participation
    - Pricing competitiveness outside the Exchange

STATE INNOVATION MODEL INITIATIVE

REVISION TO STANDARD PLAN DESIGNS

Agenda

I. Process and Overview of Federal Regulations, February 25, 2013

II. CCIIO's final AV calculator

III. Recommended Revisions to the Standard Plan Designs

IV. Additional Plan Designs

V. Protecting the Affordability of Premiums

VI. Vote

Process for Defining Standard Plan Designs

- Team of eight, two from each Advisory Committee, established to make recommendations:
  - Recommendation supported by majority of members (vote: 5-3 in favor of group recommendation)
- Connecticut Insurance Department and carriers provided input and analyses
- **Governing principles**
  - **Simplicity**: Standard plans should be simple to understand and to administer
  - **Consumer Focused**: Enable consumers to get the basic care they need with the minimum cash expense
  - **Primary Care Emphasis:** Enable people to maintain or improve their health
- **Operational Parameters**
  - **Connecticut State Law:** designs must comply state regulations and laws (e.g. state mandates and limits on copayments)
  - **ACA Regulations**: Metal tiers and AV calculator, Essential Health Benefits, maximum out of pocket
  - **Actuarial Value**: Plans must be within 2 points of the allowed actuarial vale for each Metal Tier (within 1 point for Cost Sharing Reduction plans)

Main Concerns of the Working Group

- Overall Affordability
- Ensuring primary care is obtained and promoted

Overview on Federal Regulations:

- Beginning in 2014, health plans are statutorily required to meet the specified actuarial values ("AV") of one of the four metal tiers (+/- 2 percent):
  - Platinum: 90%
  - Gold: 80%
  - Silver: 70%
  - Bronze: 60%
- The actuarial value of a health plan represents the cost of medical care paid by the carrier
- In order to establish a baseline for consumers to compare plans, carriers must validate plans against the federal AV Calculator
  - Beginning in 2015, states may adjust the AV calculator to reflect state level data, if approved by Department of Health and Human Services ("HHS")
- Requirement to use the AV calculator applies to health plans sold in the individual and small group market, both inside and outside of the exchanges
- A draft AV Calculator, issued as part of the proposed federal rules on November 24, 2012, was used by the Exchange's working group to develop Connecticut's standard plan designs
- A final AV calculator was released with the final rules on February 25, 2013

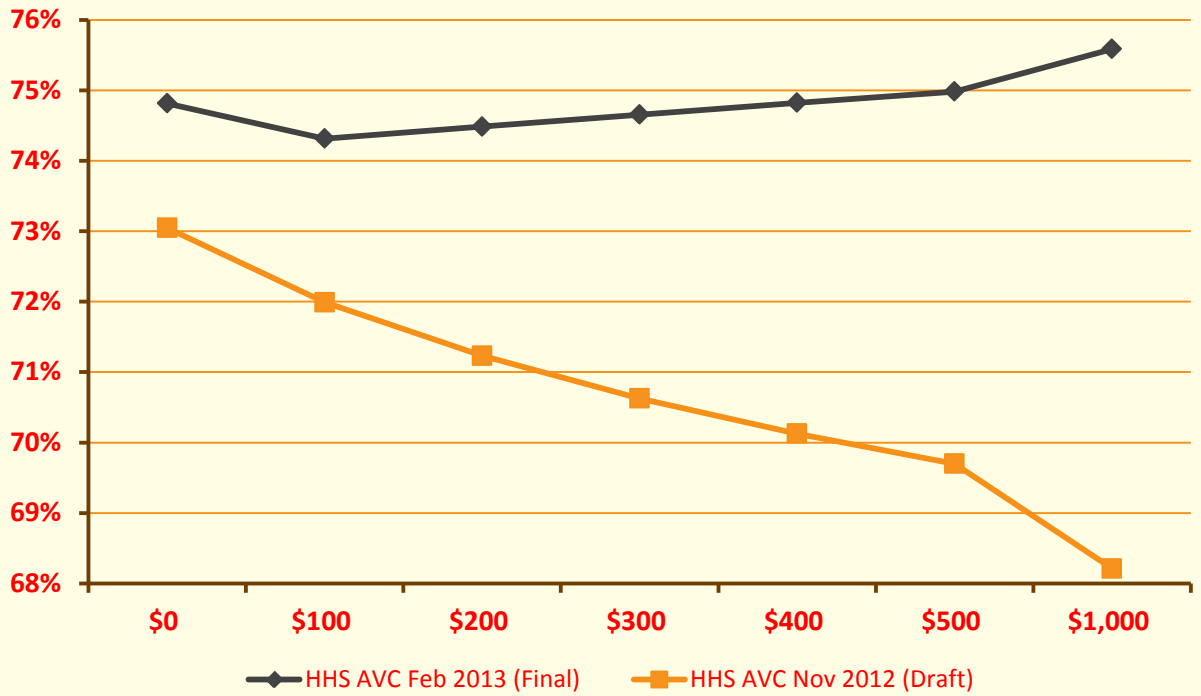
Revision to Standard Plan Designs

- **Final AV Calculator released on February 25, 2013**
  - CCIIO made technical corrections to AV calculator released in November in response to comments received
  - In general, final AV calculator purported to provide a more accurate accounting of a plan designs actuarial value
  - Corrections to AV calculator include more accurate treatment of:
    - Skilled nursing facilities
    - Rehabilitative services
    - Generic drugs
    - Maximum Out of Pocket
  - **However**, final AV calculator gives counter-intuitive results for Rx deductible
  - Bronze, Silver, and Silver CSR-73 plan designs cannot be validated against final AV calculator

			Cost Sharing Reduction Plans				
	Bronze	Silver	Silver-73	Silver -87	Silver -94	Gold	Platinum
Draft Calculator	62.7%	71.2%	74.0%	87.8%	94.4%	81.8%	90.4%
Final Calculator	68.7%	74.5%	77.2%	87.8%	93.5%	81.8%	89.2%
Difference	6.0%	3.3%	3.2%	0.0%	-0.9%	0.0%	-1.2%

Computed AV, Draft versus Final AV Calculator

for Given Rx Deductible with a Separate $2,500 Hospital Deductible



- **Conclusion:**

  The above trend line is actuarially impossible

  Therefore, staff concludes that the AV calculator cannot accurately approximate the AV of a plan that incorporates a separate Rx deductible

Unsatisfactory Options for Mitigating Technical Error in AV Calculator :

1. Raise Deductibles
   - given Connecticut's limits on copays, the only way to maintain a hospital-only deductible with a separate Rx deductible is to raise the hospital deductible to $6,000 (with separate $250 Rx deductible)
2. Transition from copayment plan to coinsurance plan
   - non-standard plans can accommodate different plan designs
3. Raise Copayments
   - copayments for Silver plan are already at allowed maximums for Connecticut
4. Make more services subject to deductible
   - original direction from Working Group and Board was to have a hospital-only deductible for standard Silver plan
   - non-standard plans can accommodate different plan designs

Recommended Approach for Mitigating Technical Error in AV Calculator:

1. Make adjustments to AV calculator
   - final regulation allows carriers/exchanges to make adjustments to results computed by AV calculator if AV calculator can neither accommodate a particular plan design nor accurately reflect generosity of the plan
   - actuarial adjustments must adhere to one of two methodologies outlined in final regulations and be certified by a member of the American Academy of Actuaries
   - Connecticut Insurance Department must accept actuarial certification
   - Process:
     - get confirmation from CCIIO (3/4 and 3/7)
     - Gorman Actuarial, LLC to perform actuarial adjustment (ongoing)
     - coordinate with Connecticut Insurance Department and carrier actuaries (3/8)

Revision to Standard Plan Designs

Preliminary Actuarial Analysis by Gorman Actuarial, LLC for adjustments to AV calculator for **SILVER**

$2,500 Hospital Deductible

Hospital Ded.	Rx Ded.	HHSAV	Adjusted AV
$2,500	$500	75.0%	**72.1%**
$2,500	$400	74.8%	**72.5%**
$2,500	$300	74.7%	**72.9%**
$2,500	**$200**	**74.5%**	**73.5%**
$2,500	$100	74.3%	**74.1%**
$2,500	$0	74.8%	**74.8%**

Given state limitations on copayments, a $2,500 hospital-only deductible is not possible with any Rx deductible less than $500

Gorman Actuarial could not validate original plan with adjustment to AV calculator

$2,750 Hospital Deductible

Hospital Ded.	Rx Ded.	HHSAV	Adjusted AV
$2,750	$500	74.6%	**71.7%**
$2,750	$400	74.4%	**72.1%**
$2,750	$300	74.3%	**72.6%**
$2,750	$200	74.1%	**73.1%**
$2,750	$100	73.9%	**73.7%**
$2,750	$0	74.5%	**74.5%**

Option:
Trade-off slightly lower hospital deductible, for higher Rx deductible

$3,000 Hospital Deductible

Hospital Ded.	Rx Ded.	HHSAV	Adjusted AV
$3,000	$500	74.3%	**71.4%**
$3,000	$400	74.1%	**72.03%**
$3,000	$300	73.9%	**72.3%**
$3,000	$200	73.8%	**72.8%**
$3,000	$100	73.6%	**73.4%**
$3,000	$0	74.2%	**74.2%**

Recommendation:
$3,000 hospital-only deductible with a separate $500 Rx deductible

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Standard Plans, Recommended Revisions

Working Group Recommendation: Proposed Changes to Standard Plans

BRONZE

- Recommendation for HSA-Eligible HDHP with a $3,250 fully integrated deductible with max OOP of $6,250
- Member pays 60% coinsurance after deductible, except for $30 copay on primary care/mental health office visits and $10 copay on generic drugs
- *Recommend an additional Standard Bronze plan offering Catastrophic Coverage*

SILVER

- Increase hospital-only/Rx deductibles from $2,500/$250 to $3,000/$500
- Decrease member's coinsurance on specialty drugs from 50% to 40%

GOLD

- Lower max OOP from $5000 to $3000
  - original $5,000 max OOP was not reflective of actual generosity of plan
- Increase Hospital-Only/Rx Deductibles from $500/$150 to $1,000/$200
- Increase ER copay from $100 to $150
- Decrease coinsurance on specialty drugs from 50% to 30%

PLATINUM

- Lower max OOP from $5,000 to $2,000
  - original $5,000 max OOP was not reflective of actual generosity of plan
- Adjusts 4-tier drug benefit from 10/15/30/50% to 5/15/30/20%

Standard Plans, Recommended Revisions, continued

Working Group Recommendation: Proposed Changes to Cost Sharing Reduction Plans
SILVER CSR-73 (exclusive to households between 200 and 250% of poverty) • Increase hospital-only/Rx deductibles from $2,250/150 to $2,500/$300 • Hospital copay applies to 2 days/admission, not 4 days/admission
SILVER CSR-87 (exclusive to households between 150 and 200% of poverty) • Adjusts 4-tier drug benefit from 10/15/30/40 to 5/15/30/40
SILVER CSR-94 (exclusive to households between 100 and 150% of poverty) • No change

Final Actuarial Values, Adjusted by Gorman Actuarial

			Cost Sharing Reduction Plans				
	Bronze	Silver	Silver-73	Silver -87	Silver -94	Gold	Platinum
Final AV	68.7%	71.9%	73.8%	87.8%	93.5%	81.6%	89.2%

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Revision to Standard Plan Designs

Coverage Examples:

		Annual + Monthly Cost			
			SILVER ALTERNATIVE – Cost Sharing Reduction Plans		
Scenario	**Description of Utilization**	**SILVER** >250% of FPL	**94% CSR** 100-150% of FPL	**87% CSR** 150-200% of FPL	**73% CSR** 200-250% of FPL
Young adult with asthma	2 preferred-brand drugs/month; 2 PCP visits/year; 1 specialist visit/year	$105/year + $400 Rx ded + $50/mo after Rx ded	$25/year + $30/mo	$60/year + $30/mo	$85/year + $300 Rx ded + $50/mo after Rx ded
Accident	2 generic drugs/year; 1 preferred-brand drug/year; 12 rehabilitative visits/year; 4 specialist visits/year (or 1 ER + 2 specialist) 2 PCP visits/year	$620 -$680/accident + cost of preferred Rx	$155-200/accident	$325-365/accident	$585-645/accident + cost of preferred Rx
Mental Health Patient	2 PCP visits/year; 1 specialist visit/year; 2.25 mental health visits/month; 2 generic drugs/month; 2 preferred drugs/month	$105/year + $400 Rx ded + $137.50/mo after ded	$25/year + $51.25/mo	$60/year + $75/mo	$85/year + $300 Rx ded + $137.50/mo after ded
Hospital Stay	4 days hospital/year; 4 specialist visits/year; 2 PCP visits/year; 1 high-tech imaging; 12 rehabilitative visits/year 4 preferred-brand drugs/year; 2 generic drugs/year;	$5,715/hospital stay + cost of preferred Rx	$750/hospital stay	$1,450/hospital stay	$4,195/hospital stay + cost of preferred Rx
Chronic Health Complication	multiple hospital stays i.e. Maximum OOP	$6,000 $12,000 for non-individual coverage	$2,000 $4,000 for non-individual coverage	$2,250 $4,500 for non-individual coverage	$5,200 $10,400 for non-individual coverage

Standard Plans, "Other" Benefits

- For the most part the following so-called "other" benefits are not included in AV calculator and so needed to be defined independent of AV calculator

Working Group Recommendation: Proposed Changes to "Other" Benefits, Standard Plans
1. Eliminate copay for hospice care. • original: *was equivalent to one inpatient copay, i.e. $500 or $250*
2. Eliminate copay for home health care services. • original: *was equivalent of half of primary care copayment for the first 80 visits*
3. Include copay equivalent to primary care office visit for vision examination for Standard Gold and Platinum • original: *was $0 at Gold and Platinum tiers*
4. Increase coinsurance on Durable Medical Equipment/Prosthetics/Diabetic supplies to 10 percentage points less than metal tier actuarial value. • original: *was 50% across all metal tiers*
5. Copay for maternity care visits should be equivalent to specialist copay. • original: *was equivalent to primary care office visit copay*
6. Specialist copay applies to allergist office visit. However, an office visit for allergy injection only, the member is charged the primary copay. • original: *all allergy-related visits were charged specialist visit copay*

Standard Plans, Out-of Network Benefits

	Bronze	Silver[3]	Gold	Platinum
Deductible[1]	$6,500	$6,000	$3,000	$2,000
Co-Insurance	50%	60%	70%	80%
Maximum Out-of-Pocket[2]	$12,500	$12,000	$6,000	$4,000
Exceptions to Deductible	• preventive care services (subject to coinsurance) • for Silver, Gold, and Platinum ambulance and emergency room services ($150 copay applies to ER) • pediatric vision services			

NOTES:

1. The OON deductible will be integrated and apply to both medical and prescription drug benefits. For Bronze and Silver metal tier it will be set at twice the In-Network deductible.
2. The Maximum Out of Pocket ("MOOP") limit will be set at twice the In-Network MOOP.
3. The OON benefits for the Silver Cost Sharing Reduction plans will be the same as the Silver benchmark. Per federal regulations, the cost sharing reductions exclude reductions in premiums, spending on non-covered services, and balance billing amounts for non-network providers.

Dental, "High" & "Low" Standard Plans

	"Low" Plan	"High" Plan
Approximate metal tier	Silver+ approx. 70% AV	Gold+ approx. 85% AV
Diagnostic & Preventive	100% no deductible	100% no deductible
Basic Restorative Adult: 6 month waiting period	60% after deductible	80% after deductible
Major Restorative Adult: 12 month waiting period	50% after deductible	60% after deductible
Orthodontics Adult: not covered	50% after deductible	50% after deductible
Deductible	$50 per member (up to max of $150 for 3 children)	$50 per member (up to max of $150 for 3 children)
Annual Plan Maximum	n/a for children $1,000 per adult	n/a for children $2,000 per adult

NOTE:
Standard Dental plan design is subject to actuarial certification (currently under process by Wakely).

Dental, Wellness-Only Standard Plan

	Wellness-Only Plan
Approximate metal tier	n/a
Diagnostic & Preventative	100% no deductible
Basic Restorative Adult: 6 month waiting period	50% after deductible
Major Restorative and Orthodontics	discounts
Deductible	$50 per member
Annual Plan Maximum	$500 per member

Dental, Standard "High" and "Low" Plans

Working Group Recommendation: Define Standard "Low" and "High" Plan for Routine Dental

For the standard plans:

- Routine pediatric dental benefits should be embedded in the qualified health plan.
- The "Low" option will be paired with Bronze and Silver; the "High" option paired with Gold and Platinum.

For children, no waiting period or plan maximums are allowed.

For children, the deductible will apply per child and will be waived for Cost Sharing Reduction plans.

For stand-alone dental, the benefits will mirror the pediatric benefits, but adult plan will include a 6 month waiting period on basic restorative, 12 month waiting period on major restorative, and provide no coverage for orthodontics.

Dental, Standard "Wellness-Only" Plan

Working Group Recommendation: Define Standard Wellness-Only Plan

The exchange should promote stand-alone "wellness-only" dental plans:

- Wellness-only plans will be less comprehensive and lower cost alternative to the "High" and "Low" options.
- The wellness-only plan will only cover diagnostic and preventative services and basic restorative care (i.e. fillings and simple extractions) after a 6 month waiting period.
- The wellness-only plan will not cover any major services, but the dental carrier will offer discounted rates on in-network providers.

Revision to Standard Plan Designs

Working Group Recommendation: Additional Standard Bronze Plan, "Catastrophic Look-Alike"

The Exchange should define ONE (1) additional optional Standard Bronze plan for the individual exchange.

- The QHP would have its deductible set at the maximum $6,250
- Beyond required preventative services, the deductible would be waived for only for 3 primary care visits per year.
- Deductible would be adjusted to meet all State of Connecticut regulatory requirements

Unlike the ACA-defined "Catastrophic Coverage," this option will be eligible for premium tax credits and have no restrictions on eligibility. The QHP will be a lower costing option for subsidized and unsubsidized members alike.

Revision to Standard Plan Designs

Staff Recommendation: Promotion of Plan Innovation, Allow Additional Non-Standard Plans

To encourage product innovation at the carrier level and development of more affordable products, the Exchange should allow carriers the option to sell ONE (1) additional non-standard plan at each tier for a maximum of THREE (3) plans per tier.

The non-standard QHPs must:

- exhibit a meaningful difference from the standard plan designs
- exhibit a meaningful difference from the carrier's other non-standard QHPs

Takes Efforts to Secure Affordability of Health Care

- Working group repeatedly expressed concerns over the affordability of standard plan designs

Pay Now versus Pay Later:

- Health care is expensive and about 90 cents of every health care dollar (premiums and out-of-pocket costs) go directly to paying medical claims
- Inherent trade off between cost of premium and out-of-pocket expenditures
  - e.g. Increasing a plan's cost sharing requirements a plan's will a lower Actuarial Value. This is likely make a plan's premium's more "affordable"; but, the member could be exposed to significantly higher medical bills.
- **Premiums**
  - Advanced Premium Tax Credits ("APTC") make obtaining insurance "affordable"
  - Working Group concerned that if non-standard plan is less expensive the Standard Plan will be made unaffordable due to the second-lowest costing Silver being set by a non-standard plan
- **Out-of-Pocket Expenditures**
  - silver plan assumes member pays only 30% of their medical costs
  - maximum OOP significantly reduces household exposure to health-related bankruptcy
  - Working Group designed standard plan to minimize members exposure to high medical costs, by waiving deductible and maintaining reasonable copays on all non-hospital care

Guaranteeing the Affordability of Health Care:

- For subsidized population a member's premium costs are fixed at a specific percent of their income
  - Specific percent determined by federal statute and predicated on notion of shared responsibility
  - Maximum tax credit based on this percent and assumption that consumer will purchase the second-lowest costing Silver
  - If the second lowest costing Silver is not the Standard plan, then obtaining coverage equivalent to that offered by the Standard plan may be unattainable for many
    - The negative impact will be more significant at lower FPLs
    - Households could experience a double digit increase in the premiums they would be required to pay relative to situation if Standard was the lowest costing plan
    - Out of pocket expenditures may not be affordable
  - Additional information on calculation of tax credit and maximum required contributions provided in background material at end of slides

Potential Impact of Lower Cost Non-Standard Silver on Affordability

- Scenario: Two-Parent Household (age 40 and 45) with 2 kids under 19

Standard Silver
Base Premium: $295

Adults Only: $803
Adults + Children" $1,178

VS

Non-Standard Silver
Base Premium: $265

Adults Only: $721
Adults + Children: $1,057

For Subsidized Members Lower Premiums ≠ Greater Affordability

	Required Contribution		Unsubsidized Premium		Maximum Tax Credit		Cost to Household to Purchase Standard Plan if Lower Costing Non-Standard Plan Available			
									Relative Increase in Cost	
Household Income	Cost	% of Income	Standard	Non-Standard	If Standard is 2nd-Lowest Costing	If Non-Standard is 2nd-Lowest Costing	Minimum Contribution	Premium Payment, as % of Income	Dollar Increase in Premium Payment	Percentage Increase in Premium Payment
$35,325 (150% FPL)	$118	4.0%	$803	$721	$685	$603	$200	6.8%	**$82**	70%
52,988 (225% FPL)	317	7.2	803	721	486	404	399	9.0	**82**	25
70,650 (300% FPL)	559	9.5	1178	1057	619	498	680	11.5	**121**	22

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Guarantee Affordability of Health Care

Staff Recommendation: Guarantee Affordability of Standard Silver Plan

To protect the ability of subsidized consumers to purchase the standard plan designs and help enforce the statutory requirement that carriers use a single risk pool, staff recommends that the standard Silver QHP be the lowest priced Silver QHP offered by a carrier

BOARD VOTE

Exchange Staff recommends the following:

1.a. Approval of revisions to the SEVEN Standard plan designs (FOUR metallic tiers + THREE cost sharing reduction plans), including:

- i. adjustments to accommodate final AV calculator;
- ii. cost sharing parameters for ancillary benefits not included in AV calculator;
- iii. out-of-network benefits, and;
- iv. pediatric dental benefits.

1.b. Approval of additional standard Bronze plan as another Standard Plan Design.

1.c. Approval of Standard Plan designs for Dental High and Low, and to offer a Wellness Only Plan

2. Require standard Silver plan to be a carrier's lowest costing Silver plan sold in the non-group exchange to guarantee affordability of standard Silver plan.

3. Allow carriers the option to offer an additional non-standard plan at each metallic tier to promote plan innovation.

ADJOURNMENT

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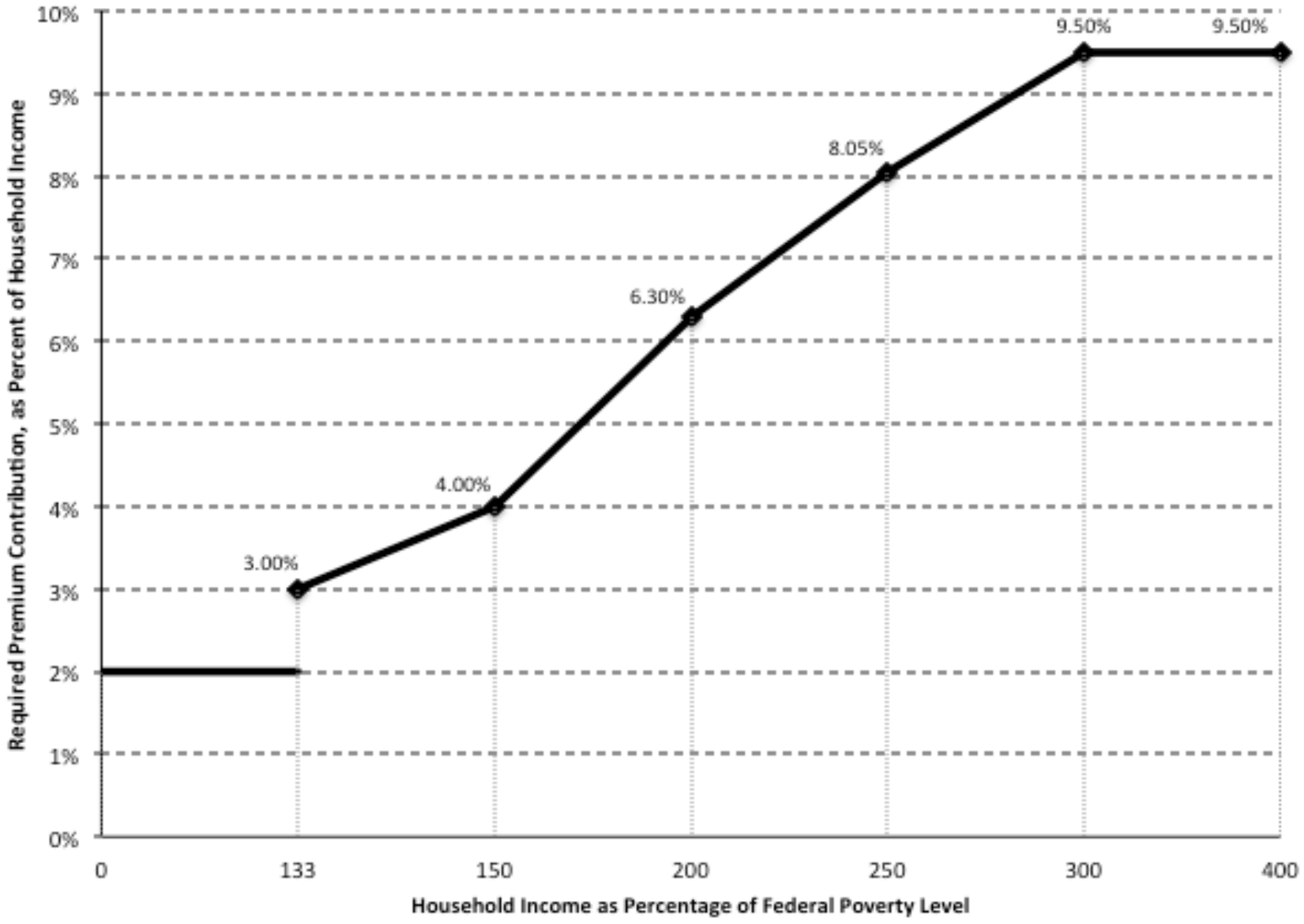
Background Materials: Premium Cap for Second-Lowest Costing Silver, as % of Household Income



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Background Materials: Premium Cap for Second-Lowest Costing Silver, by Household Income

Annual Income	Monthly Income	Household Size						
		Individual	2	3	4	5	6	7
12,000	1,000							
18,000	1,500	65						
24,000	2,000	132	84	< 133% of FPL				
30,000	2,500	209	150	104				
36,000	3,000	285	223	167	124			
42,000	3,500	333	303	239	186	144		
48,000	4,000		380	316	257	204	164	124
54,000	4,500		428	397	330	275	223	183
60,000	5,000		475	475	409	346	292	243
66,000	5,500			523	491	422	364	309
72,000	6,000			570	570	502	437	383
78,000	6,500			618	618	585	516	453
84,000	7,000				665	665	596	529
90,000	7,500				713	713	680	610
96,000	8,000					760	760	689
102,000	8,500					808	808	774
108,000	9,000					855	855	855
114,000	9,500						903	903
120,000	10,000			> 400% of FPL			950	950
126,000	10,500							998
132,000	11,000							1,045
138,000	11,500							1,093
144,000	12,000							
150,000	12,500							
156,000	13,000							

Household between 133 and 250% of FPL (i.e. eligible for Cost Sharing Reductions)

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Connecticut's Health Insurance Marketplace

Access Health CT is a new marketplace that offers individuals, families and small employers a range of qualified, approved health insurance plans from brand-name carriers.

Access Health CT is the only place where people and small businesses can qualify for a break on their health insurance costs, in the form of discounts for individuals and tax credits for business owners