CT HEALTH INSURANCE EXCHANGE
(d/b/a Access Health CT)
CEO ANNUAL REPORT TO THE GOVERNOR
ON THE EXCHANGE PLAN
JANUARY, 2014

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Introduction

Pursuant to section 12 of Public Act No. 11-53, the following report completes the update to the plan to establish the Connecticut Health Insurance Exchange (Exchange) d/b/a Access Health CT (AHCT). While the body of this report addresses each of the statutory requirements set forth in section 12 of the Act, this introduction summarizes the activities undertaken over the past year and the major work efforts underway heading into 2014.

> Our **Vision**: The Connecticut Health Insurance Exchange supports health reform efforts at both the state and national level that provide Connecticut residents with better health, and an enhanced and more coordinated health care experience at a reasonable, predictable cost.
>
> Our **Mission**: To increase the number of insured residents, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value

Our **Guiding Principles**: While building an Exchange requires work across a diverse spectrum of functions and disciplines, we will continue to make sure that all activity is aligned to four simple principles for our organization, each with its own goal and objectives:

(1) Exceptional Consumer Experience

Goal: *Consumer Focus*

Objectives:

a. Accessibility. AHCT should strive to reduce the number of residents without health insurance and improve access to health care for all residents

b. Integration. AHCT should be designed to integrate public program information, eligibility and enrollment outreach and operations to ensure maximum healthcare coverage for Connecticut residents and seamless transitions between public programs and the Exchange

c. Equity. AHCT should work to address longstanding, unjust disparities in health access and health outcomes in Connecticut

(2) Sustainability

Goal: *Long term stability*

Objectives:

a. Affordability. Access to health care is only possible when it is affordable. Affordability of coverage, within the Exchange and within the state, is essential to improving the state's health care system and economy

b. Viability. Board decisions should lead to health insurance which is viable for the state and the health care industry as well as for residents

c. Stability. AHCT should promote solutions that respect existing strengths of our state's health care system and promote stability within the Exchange

(3) Flexibility

Goal: *Responsiveness to change market and social conditions*

Objectives:

a. AHCT should be nimble and flexible in responding to the quickly changing insurance market, health care delivery system, and general economic conditions in Connecticut, while being sensitive and responsive to consumer demands

b. Board decisions should be designed to support transformative change in the delivery of healthcare through the collaboration of all constituents in the system

(4) Transparency

Goal: *Open conduct of business*

Objectives:

a. AHCT is accountable to the public, and its activities should be transparent, its services easily available, and its information easily understandable by the populations it assists

b. The Board should design its governance arrangements and operations to be the simplest and most open way of delivering its functions, giving regard to its vision mission, and principles

AHCT has made significant progress in the planning and establishment of the Connecticut Health Insurance Marketplace, culminating in a successful launch of the AHCT Integrated Eligibility Enrollment System on October 1, 2013. The launch was supported by a robust consumer outreach and marketing campaign that has delivered enrollment results ahead of expectations by the end of the calendar year. With three months left in the initial open enrollment period, which ends March 31, 2014, AHCT is confident that it will exceed its goal of enrolling at least 100,000 Connecticut residents.

For background, the Establishment Planning Grant awarded to the state of Connecticut in September 2010 provided funds necessary to begin researching the variables and complexities involved in organizing a new Health Insurance Marketplace, as well as exploring the dynamics of improving system affordability, quality, and delivery for the state's residents and businesses.

To build on the work conducted under the Planning Grant, Connecticut applied for a Federal Establishment Grant and was awarded $6.7M in August of 2011, and was awarded an administrative supplement to that grant in 2012 in the amount of $1.5M for a total initial Establishment Grant of $8.2M. These funds allowed Connecticut to shape strategy successfully and meet necessary development milestones and benchmarks.

As a result of the planning grant, AHCT made significant progress in planning for future business operations and developing an implementation plan that described specific goals, milestones, and timeframes. Specifically, AHCT leveraged the funds to staff core positions required to set up and establish the state Exchange (hereinafter referred to as "Marketplace.") AHCT created a dynamic approach to staffing the organization, utilizing both consultants and permanent as well as durational staff, to ensure coverage and resources for successful ongoing operations while simultaneously managing the design, development, and implementation of the AHCT system solution. Early on, AHCT utilized existing state contracts to facilitate the temporary-to-permanent hiring of staff.

As a result of the significant planning progress made, the State of Connecticut applied to CMS for a Level II Exchange Establishment Grant and was awarded $107.3M in August of 2012. These funds have allowed AHCT to development, design, and build the Health Insurance Marketplace and to manage the activities related to the development and implementation as well as the on-going operations of the Marketplace. These funds will continue to support AHCT operations through calendar year 2014. A substantial portion of these funds have been used to develop an IT system that facilitates critical functionality including eligibility, enrollment, and information exchange among individual consumers, employers, insurance carriers, and state and Federal government agencies.

In December of 2012, AHCT submitted a Level I Establishment Grant application for the implementation of the In-Person Assister (IPA) program. This request for an additional $2.1M was necessary for the development and implementation of a robust, hands-on assistance program for Connecticut residents in order to assist the uninsured individuals seeking health insurance coverage via the Marketplace during the critical open enrollment timeframe and first year of AHCT operations. CMS awarded this establishment grant to AHCT in February of 2013 for the requested amount.

AHCT has worked diligently to ensure the necessary financial processes and procedures were developed and implemented in support of AHCT. In the spring of 2013, AHCT submitted an administrative supplement request for additional funds to support efforts not included in the original Level II grant application, related mainly to additional technology requirements and marketing outreach expenses. A Notice of Grant Award (NGA) was received from CMS in late August in the amount of $24.9M. During that same timeframe, AHCT submitted a second administrative supplement request for additional funds to support IPA program efforts not included in the original IPA grant application, primarily related to IPA training and security requirements. This supplement request also included a request to extend the grant project period for the IPA program through July of 2014. An NGA was received from CMS in September in the amount of $497k. In addition, the IPA grant project period was extended through July 31, 2014.

Access Health CT Governance

With regard to governance and administration of the Exchange, the passage of Connecticut's Public Act 11-53 in June 2011 provided the necessary legal authority and infrastructure to move ahead with the development of a fully-functioning State-administered Health Insurance Exchange. The Act established the Connecticut Health Insurance Exchange, currently doing business as Access Health CT (AHCT) as a quasi-public authority governed by a 14 member Board of Directors. Lieutenant Governor Nancy Wyman was appointed chair of the AHCT Board of Directors.

In June 2012, the Legislature enacted Public Act 12-1 amending CGS 38a-1081, the section of the enabling statute that established the Connecticut Health Insurance Exchange and set out the its governance structure. The amendments contained in Section 217 and 218 of PA 12-1, brought AHCT's enabling statute into even closer alignment with Section 1311(d) of the Affordable Care Act (ACA) and with 45 CFR 155.110 (1.2a), 1.2(c),and (1.2(d). Specifically, the state's HealthCare Advocate who previously was an *ex officio* non-voting member of the Board, became an *ex officio* voting member of the Board (PA 12-1, Section 217 (b)(1)(H)). In addition, Section 217 (b)(2)(A) through (b)(2)(C) clarified certain conflict of interest restrictions on Board members, while, Section 218 clarified certain conflict of interest restrictions applicable to AHCT employees.

Under CGS 38a-1084, Duties of the Exchange, AHCT is specifically directed to establish and operate a Small Business Health Options Program (SHOP) Exchange (subsections 13 and 14) through which qualified employers may access coverage for their employees. In addition, under CGS 38a-1084 subsection (3), the Exchange is directed to implement procedures for the

certification, recertification, and decertification of health benefit plans as qualified health plans using guidelines established under Section 1311 of the ACA and section 38a-1086. Under Qualified Health Plans, CGS 38a-1085(a), the Exchange is required to make qualified health benefit plans available to qualified individuals and qualified employers for coverage beginning on or before January 1, 2014.

AHCT staff has worked in tandem with its Board of Directors to ensure that the governance structure is in compliance with the ACA and any and all relevant state and Federal regulations. Since first convening in September 2011, the Exchange Board has met monthly and has primarily focused on Exchange strategy and policy development, vendor procurement, research activities, the hiring of an experienced Exchange leadership team, and the development of the Exchange's Qualified Health Plan (QHP) requirements.

The Connecticut Health Insurance Exchange first adopted Bylaws in January 2012. The Exchange revised its Bylaws, effective July 26, 2012, to effect the changes of Public Act 12-1 on Board Governance. Those changes included: vesting the powers of the Exchange in twelve voting members; extending the initial term of office from one to two years for the board member appointed by the House Majority leader; making the Healthcare Advocate a voting member of the Board; increasing the number of *ex officio* voting members from three (3) to four (4); decreasing the number of *ex officio* non-voting members from three (3) to two (2); and increasing the number of board members required for a quorum from six (6) to seven (7). The Bylaws mirror the provisions in the law with respect to the appointing authority or *ex-officio* status of board members and the required expertise and terms of office of the board members. The Bylaws also mirror the law with respect to Board officers and the requirement that all appointed Board members take an oath before serving. Finally, the Bylaws establish three standing committees: Finance, Audit and Human Resources and allow the Board to establish such other *ad hoc* committees as it requires. The Board may delegate to any standing or *ad hoc* committee such Board powers, duties and functions falling within that committee's area of cognizance that the Board deems proper.

In September 2012, the Board of Directors voted to amend the Exchange bylaws to create a Strategy Subcommittee to discuss and realize the Board's vision and strategically focus on ways to ensure the success of the Exchange.

The AHCT Board of Directors adopted a Policy in May 2013 to acquire operating funding by charging a market assessment and/or user fees from health carriers. AHCT has also adopted a Procedure for Exchange Assessments and Fees. In addition, the Exchange is working with the Connecticut Insurance Department to develop a Procedure for Enforcing Exchange Assessments and Fees.

The All-Payer Claims Database (APCD) was originally established by PA 12-166 as part of the Office of Health Reform and Innovation (OHRI). The purpose of the APCD is to collect, store, analyze, and release health insurance claims data from public and private payers of health claims within the state of Connecticut. PA 13-247 eliminated OHRI and transferred responsibility for the APCD to AHCT. In December 2013, the AHCT Board adopted policies and procedures to govern the APCD, as well as a data submission guide with specific requirements for reporting entities. AHCT will procure a data management vendor to perform various functions of the APCD.

AHCT continues to monitor the Federal and/or State laws, regulations, and guidance for required changes to the Legal Authority and Governance of the Exchange.

Access Health CT Progress in 2013

AHCT has made significant progress in the planning and establishment of the Connecticut Health Insurance Marketplace, culminating in a successful launch of the AHCT Enrollment System and supported by a robust consumer outreach and marketing campaign which has delivered enrollment results ahead of expectations.

AHCT successfully implemented and deployed the technology solution for use by both AHCT and the Connecticut Department of Social Services (DSS) to support the MAGI eligibility requirements on October 01, 2013. This shared technology solution for qualified health plans (QHP), Advanced Premiun Tax Credits (APTC), Cost Sharing Reductions (CSR), Medicaid, and CHIP eligibility determination is currently serving as the core of an integrated eligibility platform that will eventually support HHS agencies and their associated social services benefit programs. DSS is leveraging this unique opportunity to replace its antiquated Eligibility Management System (EMS). The state plans a phased implementation for other HHS programs following this AHCT and Medicaid/CHIP system roll outs.

The recruitment of skilled and experienced staff to lead AHCT has been fundamental to the success and progress of AHCT. All executive leadership positions were filled in 2012, including Chief Executive Officer, Chief Operations Officer, General Counsel, Chief Financial Officer, Chief Information Officer, Chief Marketing Officer, and a Director of Plan Management. In 2013, AHCT added an Operations Manager, Security Manager, Testing Manager, an extended Legal and Policy team, and an Executive Director of the APCD Program. Additional durational employees were added in support of Outreach and Education, including the In-Person-Assister staff.

In summary, AHCT accomplished the following milestones in 2013:

- Contracted with and on-boarded the individual Call Center vendor, MAXIMUS, in February. MAXIMUS provides call center services that will serve and assist consumers in their eligibility determination for a Qualified Health Plan and State Social Service Programs including MAGI Medicaid and CHIP.
- Participated in a Final Detailed Design Review (FDDR) with the Centers for Medicare & Medicaid Services (CMS) in March, resulting in approval to move forward with implementation.
- Launched an extensive marketing and branding campaign to promote consumer awareness regarding the Affordable Care Act (ACA) and the mission of AHCT to serve the people of Connecticut.
- Developed and implemented a robust Navigator and In-Person Assister Program instrumental in driving enrollments
- Developed and implemented an AHCT sales team that has focused on the education of brokers as a source for driving enrollment in the individual market.

- Contracted with and on-boarded the selected Small Business Health Options Program (SHOP) vendor, HealthPass, with its technology partner, bswift, in April.
- Deployed System Release 1.0 Plan Management functionality in June. This release included plan management functionality.
- Contracted and on-boarded the printing vendor, Sir Speedy, in May and the scanning vendor, Scan Optics, in June. These two vendors support the AHCT paper channel for eligibility determination and verifications.
- Developed an Accounting Policy and Procedure Manual, which details procedures for the following AHCT cost categories: Administration and Financial Oversight; Budgeting; Reporting; Bank Reconciliations; Capital Assets; Procurement; Accounts Payable; Payroll; Travel and Expense Reimbursement; and Journal Entries.
- Submitted all required Federal Progress Reports and Metrics.
- Successfully opened the AHCT Call center on September 3, 2013.
- Opened two Enrollment Center Storefronts in New Britain and New Haven. These consumer focused enrollment centers were the first in the nation.
- Successfully opened the AHCT Insurance Marketplace on October 1, 2013.
- Successfully opened the SHOP Marketplace on October 1, 2013.
- Developed policies and procedures for all AHCT Operations.
- On-Boarded the Executive Director for the All Payer Claims Database (APCD), and created Access Health Analytics, a division of AHCT. As a result, APCD policies and procedures, as well as a data submission guide were developed.

- Created a Vendor Management Council to review new vendor requirements and existing contract change requests.
- Implemented a process to log, track, and resolve technical and operational issues. Through coordinated stakeholder engagement (AHCT, System Integrator, and BEST), AHCT closed over 600 issue tickets.

The accomplishments of Access Health CT over the past two years have been many. Connecticut is one of the few states in the nation to launch a successful Health Insurance Marketplace on October 1, 2013. In three months, AHCT surpassed the state's enrollment goal established by the Congressional Budget Office for ACA enrollment, and did it three months ahead of schedule. AHCT's consumer outreach and marketing plans have been executed with a high degree of success, generating the customer leads necessary for consistent growth.

Consumer and Stakeholder Engagement

In 2013 AHCT completed the final marketing plan for consumer and stakeholder engagement. The outlined strategy has and continues to be executed and built upon throughout 2013. One of the key components of this plan was AHCT's outreach strategy and engagement with consumers and stakeholders, for which AHCT's marketing firm, Pappas MacDonnell, developed an extensive network of contacts in the form of community-based healthcare providers, consumer advocates, and community leaders throughout Connecticut.

AHCT understands the critical importance of employing numerous customer outreach and assistance channels and has implemented a comprehensive Navigator program in Connecticut. The Exchange finalized its Navigator Program Design, and received approval from the Board of Directors and the Brokers, Agents & Navigators Advisory Committee. The Program Design included the framework for Navigator and In-Person Assister training and certification, as well as the general guidelines for the Navigator and In-Person Assister roles. AHCT has worked closely with the Office of the Healthcare Advocate (OHA) in order to adequately support its network of Navigator and In-Person Assister organizations and the RFP review process, and finalized a Memorandum of Understanding (MOU) in early 2013 to officially establish that collaborative relationship.

AHCT also recognized the importance of outreach to Connecticut's American Indian population. There are two federally recognized tribes in the state: the Mohegans (1,700 members) and the Mashantucket Pequots (800 members). AHCT finalized its Tribal Consultation Plan and Policy to govern its engagement with the Mohegan Indian Tribe of Connecticut and the Mashantucket Pequot Tribe of Connecticut. This policy was approved by the AHCT Board of Directors in November, 2012, and AHCT nominated a staff member to serve as Tribal Liaison in future

interactions. There are many policy considerations that impact Connecticut's tribes and their members, and AHCT will continue to consult with tribal representatives and/or their respective Tribal Council as needed.

In early 2013, AHCT found there was a lack of consumer knowledge about the ACA and about the State Based Marketplaces, which resulted in a need for unplanned messaging and consumer education on the ACA, its benefits, and how it worked. Through our Awareness and Favorability Benchmark Research conducted in June of 2013, it was determined that the vast majority of Connecticut residents were not even aware of the ACA's existence, nonetheless understood its benefits and what was available to them under the law, thus requiring an extensive marketing and outreach campaign. Following the go-live date of October 1, 2013, a second Awareness and Favorability Benchmark research effort was conducted to gauge whether consumer awareness had increased. The results showed that consumer awareness had increased 65% through the combination of both paid and unpaid media, as well as word-of-mouth. Overall, the research illustrated that Connecticut residents viewed AHCT positively in spite of critical news coverage of the Federal implementation of the ACA.

MAXIMUS, the Call Center vendor was on-boarded in mid-February 2013. Start-up planning and operations took place immediately and the call center began taking education calls on September 3, 2013, and enrollment calls beginning on October 1, 2013. MAXIMUS acquired office space in Hartford, Connecticut to be in close proximity to AHCT in order to best serve the local CT community. Maximus utilizes both English and Spanish-speaking contact center representatives (CCRs), and a language line is also available to assist callers speaking any other languages. In addition, there are in-house brokers available to better serve callers that are applying and selecting plans and benefits.

As Connecticut continues to manage its first open enrollment period, and implement its state-based Health Insurance Marketplace solution, the establishment of a vibrant and effective Navigator and In-person Assister Program has been critical to ensure both AHCT's short and long term success. Attracting, educating, and enrolling individuals across the state's diverse and varied communities has been essential to positively impact the health and wellness of the state's residents, garner broad participation from insurers, and ensure the financial sustainability of AHCT.

Navigators and In-Person Assisters (IPAs) have played a key role in AHCT's outreach and consumer assistance efforts. The IPAs are the cornerstone of a robust Connecticut Health Insurance Marketplace consumer assistance network, and continue to educate individuals about consumer assistance mechanisms available in the State. As planned, the Navigator organizations and IPAs have facilitated enrollment in qualified health plans offered by the AHCT

Marketplace and have provided critical information in a manner that is culturally and linguistically appropriate to the needs of the population being served.

June 2013 marked the beginning of AHCT's media activity for the year. In the weeks leading up to open enrollment, a full scale media campaign was conducted, with the focus shifting from education to enrollment. TV, radio, newspaper, billboards, and online advertising elements were all utilized. This activity was set against the back drop of substantial in-person outreach. AHCT attended more than 30 summer festivals, 20 health fairs, and 75 Healthy Chats and established a branded presence at Connecticut beaches and key retail locations that included various supermarkets and Wal-Marts. Some of the festivals AHCT participated in included the Feria de la Familia, Haley Harvest Festival, Apple Harvest Festival, and the Bridgeport and Waterbury Farmers Markets.

In the fall of 2013, AHCT also unveiled commissioned murals in New Haven, Bridgeport, and Hartford. The unveiling ceremonies included municipal speakers, youth group dance and singing performances, health screenings, nutrition information, and fun family activities. The combination of these outreach elements ensured that AHCT raised broad media awareness across the state, while also reinforcing the direct interactions with potential customers.

AHCT has expanded its television presence to ensure it reaches as many Connecticut residents as possible. The first of three television spots aired on all of the major networks in Connecticut on June 18, 2013, and sought to reinforce the friendly, approachable and helpful brand identify that AHCT is building, while promoting a few of the key value propositions for consumers such as potential savings on premiums, and access to name brand health insurance coverage.

AHCT's outreach and engagement strategy included the establishment of storefronts, branded as AHCT enrollment centers, in two Connecticut towns with a very high concentration of uninsured residents; New Britain and New Haven. Each enrollment center is fully staffed with AHCT certified enrollment staff and trained and certified In-Person Assisters and Brokers--all of whom are able to provide direct consumer assistance to review and enroll consumers in a qualified health plan and/or apply for subsidized coverage through Medicaid. Since the store openings, nearly 5,225 people have visited and over 2,550 visitors have completed applications. The enrollment centers have been a great resource to the public for education, enrollment, and post enrollment. Post enrollment, a number of visitors have returned with questions about next steps, carriers and payments, and many even bring friends or family to learn more.

In conjunction with enrollment center staff and trained and certified In-Person Assisters and Brokers, AHCT held 35 mobile enrollment fairs throughout the State in 2013. These enrollment fairs were held in every county in Connecticut, targeting the most uninsured or underinsured

cities in each county. The fairs resulted in a total of 1869 visitors with 864 people completing the enrollment process.

A search engine optimization (SEO) campaign was also implemented in order to increase website visibility and brand awareness while driving more targeted visitors to the site. AHCT has engaged its marketing partner, Pappas MacDonnell, to track site traffic and analyze the number of visitors, length of visit, etc. with the goal of making site improvements and increasing consumer awareness of AHCT. Pappas MacDonnell also continues to closely monitor media placement and performance with the goal of adjusting the schedule in real time to achieve optimal efficiency.

Throughout the fall of 2013, AHCT focused its marketing efforts heavily on two targeted populations: the Spanish Speaking and the Young and Invincible populations. The following initiatives were launched to increase awareness of the ACA and drive traffic to AHCT among these populations:

Spanish Speaking

Reaching the Spanish speaking population in Connecticut has always been a goal for AHCT, as the population is mostly uninsured or underinsured. In order to achieve this, AHCT has created a targeted marketing campaign called Mercado de Salud CT. The campaign includes digital and print advertisements that run in both English and Spanish and direct mailers that are either bi-lingual or specifically targeted to Spanish speaking households. AHCT has also run highly effective Spanish commercials on Univision, Uni-Mas, and Telemundo. In addition, a long-form program aired on Univision that guest starred AHCT's Spanish speaking employees as they shared educational information about the ACA. This program also included a Question and Answer session with AHCT's Spanish speaking employees. AHCT's Spanish speaking employees also appeared multiple times with a local radio DJ for a highly effective Question and Answer session.

In early 2014, a Spanish version of the AHCT System Application will be available to Connecticut consumers.

Young and Invincible

A major part of the successful concert and events promotion campaign has been targeted to the Young Invincible population. The Pitbull concert promotion, sponsored by AHCT, was a great success in gaining qualified leads and phone numbers for the Short Message Service (SMS) campaign, a texting campaign which launched on October 1, 2013. AHCT has also strategically purchased air time with ESPN, ESPN2, FX, MTV, Comedy Central, BET, TBS, and

SPIKE and continues to engage this population on popular social media websites like Facebook and Twitter.

Governing Legislation of this Report

Pursuant to section 12 of Public Act No. 11-53, this report addresses 11 key issues designated in the Act.

Sec.12. (NEW) (*Effective from passage*) (a) Not later than January 1, 2012, and annually thereafter until January 1, 2014, the chief executive officer of the Exchange shall report, in accordance with section 11-4a of the general statutes, to the Governor and the General Assembly on a plan, and any revisions or amendments to such plan, to establish a health insurance exchange in the State.

Such report shall address:

1) Whether to establish two separate Exchanges, one for the individual health insurance market and one for the small employer health insurance market, or to establish a single Exchange;
2) Whether to merge the individual and small employer health insurance markets;
3) Whether to revise the definition of "small employer" from not more than fifty employees, to not more than one hundred employees;
4) Whether to allow large employers to participate in the Exchange beginning in 2017;
5) Whether to require qualified health plans to provide the essential health benefits package, as described in Section 1302(a) of the Affordable Care Act, or include additional state mandated benefits;
6) Whether to list dental benefits separately on the Exchange's Internet web site where a qualified health plan includes dental benefits;
7) The relationship of the Exchange to insurance producers;
8) The capacity of the Exchange to award Navigator grants pursuant to section 9 of this act;
9) Ways to ensure that the Exchange is financially sustainable by 2015, as required by the Affordable Care Act including, but not limited to assessments or user fees charged to carriers; and
10) Methods to independently evaluate consumers' experience, including, but not limited to, hiring consultants to act as secret shoppers.
11) The status of the implementation and administration of the all-payer claims database program established under section 144 of Public Act No. 13-247.

While key decisions were reached for several of these key items in 2012, others were finalized in 2013. The Exchange Board of Directors, staff, and established Advisory Committees focused on the remaining issues in 2013, with the results of those efforts highlighted in the following issue summaries. The continued efforts and research by all has guided AHCT in finalizing the planning and implementation for Connecticut's state-based Health Insurance Marketplace.

The narrative that follows provides some background information, and final decisions on each of the above eleven (11) key items required to be addressed in the plan for establishment of Connecticut's Health Insurance Marketplace.

Item 1:

Whether to establish two separate Exchanges, one for the individual health insurance market and one for the small employer health insurance market, or to establish a single Exchange.

Background

The Patient Protection and Affordable Care Act (ACA) allows states the option to establish two separate Marketplaces – a Small Business Health Options Program (SHOP) Marketplace for employers and the American Health Benefit Marketplace for individuals and families – or a single Marketplace to serve both markets. The decision to administer a single Marketplace does not require the individual and small group markets to be combined for risk pooling purposes. That is, Connecticut may choose to designate a single administrative entity to operate the Exchange for both individuals and employers, while still maintaining separate risk pools for the individual and small group markets.

Discussion

Many of the requirements of the SHOP Marketplace are virtually identical to the requirements of the individual Marketplace; including, but not limited to, the health plans that will be offered, the summary of benefits information to be provided to consumers, the rating of health plans based on quality and price, and health plan reporting requirements. While there will be differences in the manner by which health insurance is made available and purchased within the individual market and the small group market, there is considerable overlap in the administration of the individual and SHOP Marketplaces.

CMS's Center for Consumer Information and Insurance Oversight (CCIIO) acknowledged that states have the option to establish separate governance and administrative structures, however, CCIIO noted that "a single governance structure for both the individual market functions and

SHOP will yield better coordination, increased operational efficiencies, and improved operational coordination."[1]

As part of our assessment of this item, AHCT reviewed the manner by which other states have established their Exchange Marketplaces. Every state that has moved forward with the establishment of a Marketplace, either through legislation or executive order, has opted for a single governance and administrative structure. To date, no state has opted to separate the governance and oversight of the SHOP from the individual Marketplace.

Decision

In 2012, the AHCT Board of Directors, with the recommendation from the Small Business Health Options Program (SHOP) Advisory Committee, made the decision to establish a single administrative Exchange, responsible for operating both the SHOP and individual Marketplaces.

This decision was made after careful consideration of the market implications, the leveraging of infrastructure and resources to serve both Marketplaces, and in the interest of achieving administrative efficiencies.

Further to the decision to establish a single Marketplace, the Board also made the decision to outsource the operations and technological solution of the SHOP Marketplace. This decision was made upon the recommendation by the SHOP Advisory Committee. The Committee carefully weighed AHCT's two options: (1) Outsourcing to a third party vendor or (2) modifying the current system integrator contract to include development of a SHOP solution and managing all operations within AHCT.

The committee determined that given the inherent risk associated with the time, cost, and functionality required for the SHOP Marketplace solution's development and implementation for a go-live date of October 1, 2013, the option to outsource was the best option to move forward. Outsourcing the SHOP program would allow AHCT to take advantage of: (a) a vendor's existing core competency of administering a commercial small business marketplace; (b) an already existing vendor technology platform; and (c) the vendor's experience in working with the broker and small business communities in the commercial market. In addition, this option ensures that the individual marketplace system integrator maintains its focus and resources on development and implementation of the individual marketplace solution.

Item 2:

Whether to merge the individual and small employer health insurance markets

[1] Department of Health and Human Services, Federal Register, Volume 76, Number 136, July 15, 2011, Proposed Rule, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," Page 41873

Background

The Patient Protection and Affordable Care Act (ACA) allows states to combine the small group market and the individual market risk pools.

Discussion

The primary rationale for merging the markets is to equalize and stabilize premiums across both markets. If premiums are lower in the small group market prior to the merger, then small group premiums will increase while individual premiums will decrease (or vice versa). The degree of change in each market would depend on the relative differences of costs within the separate markets prior to the merger.

Complicating this decision is the fact that both the small group and individual markets will undergo significant changes as a result of the requirements of the ACA, and those changes will affect the two markets differently.

Currently, the individual and small group markets in Connecticut operate as separate risk pools with different rating and underwriting rules. In the small group market, coverage is provided on a guarantee issues basis (i.e., employers and employees cannot be denied coverage) and premiums are based on a modified community rating system, in which a group's claims experience or morbidity (i.e., the relative frequency of a disease or illness among group members) is not used as part of the rate development process. Conversely, in the individual market, carriers are allowed to base rates on an individual's health status or expected claims, and carriers may choose to deny coverage (i.e., there is no guarantee issue requirement) based on an applicant's health status.[2]

The rating rules, particularly for the individual market, have changed significantly in 2014. The change prohibits carriers from setting rates based on the health status of applicants, and require that policies be sold on a guarantee issue basis. In addition, the availability of premium subsidies for lower-income individuals and families are expected to greatly increase the number of people who purchase coverage. This new membership influx is expected to more than double the size of the individual market. It is anticipated that this newly insured population will include a greater proportion of people who have pre-existing conditions, or are in poorer health, thus significantly increasing the morbidity of the individual market. Comparatively, for the small group market, the rating rules do not change significantly and therefore the morbidity of the small group market is not expected to change significantly in 2014.

[2] Applicants that are denied coverage in the individual market are eligible to purchase coverage in Connecticut's high risk pool.

In a report for AHCT, Mercer Health and Benefits, LLC (Mercer) estimated that the morbidity of the small group market is currently 5% higher than the individual market (i.e., the small group market, on average, is less healthy than the individual market). However, as a result of the changes to the rating rules, Mercer estimates that the morbidity in the individual market will become 12% greater than the morbidity in the small group market in 2014.

Further, Mercer estimates that if the markets were merged, rates in the individual market would decline by 2%, while rates in the small group market would increase by 4%.

Decision

AHCT determined that the individual and small employer health insurance markets would not be merged. Instead, the risk pools would remain separate. Given the significant changes anticipated in both markets due to the implementation of several new provisions of the ACA, the added uncertainty with regard to the actual enrollment in the individual and small business markets in 2014, and the estimates that merging the markets may potentially increase rates in the small group market by up to 4%, the Board of Directors determined that it would be most appropriate to maintain separate risk pools for the near term.

AHCT will continue to monitor the market, and, based on future market conditions and operations experience, it may consider merging the two markets at a later date.

Item 3:

Whether to revise the definition of "Small Employer" from "not more than 50 employees" to "not more than 100 employees"

Background

Effective for plan years starting January 1, 2016 and after, the ACA requires the small group insurance market definition to be inclusive of groups with up to 100 employees. However, the law allows the restriction of the small group definition to 50 employees for plan years starting in 2014 and 2015.

Connecticut currently defines small groups as those with 1 to 50 employees.[3] Rates in the small group market are calculated on the basis of modified community rating, and they can only vary based on the group's demographic make-up. Allowable factors include age, gender, and family size.[4] In contrast to the small group market, rates in the mid-group market (i.e., groups with 51 to 100 employees) are based, in part, on the employer's health claims experience (i.e., the relative health risk or morbidity of a group's members).

[3] Connecticut Statutes, Chapter 700c, Sec. 38a-564
[4] Connecticut Statutes, Chapter 700c, Sec. 38a-567

Discussion

The majority of the analysis to date regarding the decision to expand the small group market prior to 2016 suggests that most states will continue to restrict the definition of "Small Employer" to not more than 50 employees until required to make the change. The rationale for this is largely due to risk mitigation. Businesses with 51 to 100 workers are more likely to have alternative coverage arrangements marketed to them, including self-insured plan arrangements combined with stop-loss reinsurance. Allowing businesses with 51-100 employees into the small group market immediately could raise premiums because of adverse selection, in which employers with healthy workforces choose to self-insure while businesses with less healthy workforces choose to take advantage of the non-health-rated coverage available through the newly expanded small group market.

An expansion of the small group definition to 100 will likely cause some healthier mid-sized companies to self-insure their employee healthcare costs in an effort to reduce overall costs. This is, in part, attributable to the fact that self-insuring in Connecticut is allowed at relatively low attachment points through the purchase of stop-loss insurance.[5] This significantly reduces the employers' exposure to the risk associated with high cost claims.

Opening the SHOP Marketplace to mid-sized employers prior to 2016 would require the State of Connecticut Insurance Department to expand the definition of the small group market, both inside and outside the Marketplace, to include employers with up to 100 employees. This would have subjected all mid-sized employers to the ACA's modified community rating rules in 2014, which could have potentially resulted in further premium disruption. At present, premiums in the mid-sized market are set differently utilizing companies' specific claims experience.

Decision

The resulting decision made by the AHCT Board of Directors was not to pursue a change to the definition of Small Employer to include up to 100 employees, prior to the January 2016 Federal requirement to do so. In future, AHCT will continue to monitor the market, and, based on future market conditions and operations experience, it may consider expanding the definition for the 2015 plan year.

Item 4:

Whether to allow large employers to participate in the Exchange beginning in 2017

Background

[5] Connecticut Insurance Department Bulletin Number PC-11 & HC44 requires that the employer's retention must be "at least $6,500 per individual or family."

Beginning in 2017 under the ACA, states have the option to allow health insurers to offer large employers, those with more than 100 employees the opportunity to purchase qualified health plans through the Exchange.[6] The large employer pool and its products and pricing can remain separate from the individual and small group pools. That is, while large employers could purchase coverage through the Marketplace in 2017, the definition of small groups would not need to be changed.

Plans offered through AHCT must be qualified health plans requiring, among other things, that products sold inside the Marketplace be offered at the same price as those sold outside of the Marketplace. As currently written, this provision may require large employers who purchase coverage through AHCT to set their premiums based on a modified community rating system.

Discussion

Self-insured plans are not subject to the State mandates that fully insured plans must include.

Mercer reports that in 2009, roughly 27% of employers with 100 to 499 employees in Connecticut chose to self-insure their health benefits. In Connecticut, 82% of employers with 500 or more employees self-insure their health benefits. These large employers choose to self-insure their health benefits for a number of reasons, but the single most important reason is to reduce costs.

Large employers are relatively sophisticated purchasers of employer-sponsored insurance and able to weigh various options regarding the provision of health benefits to their employees. If large employers are given the choice of a modified community rated plan within the Marketplace, an experience-rated product outside of the Marketplace, or self-insuring their health benefits, they will choose the lowest cost option. This has the potential to lead to considerable adverse selection against the community rated plans offered through AHCT.

Next Steps

Because the earliest that AHCT can expand to large employers is 2017, this issue, while important, is not a priority. It is likely this decision will not be contemplated until AHCT has been operating for a full year at a minimum, and, more importantly, the insurance markets have had time to adjust to the new rules required by the ACA. At that time, AHCT will further consider this market expansion and make a more informed decision.

[6] ACA Sec. 1312

Item 5:

Whether to require qualified health plans to provide the essential health benefits package, as described in Section 1302(a) of the Affordable Care Act, or to include additional state mandated benefits.

Background

The ACA requires AHCT to select a benchmark plan and offer qualified health plans that cover all of the essential health benefits (EHB) that are contained in that benchmark plan. The ACA instructs the Secretary of Health and Human Services (HHS) to provide additional details on the benefits and services categories that must be covered, at a minimum, under the EHB. The goal of benchmark selection and EHB offerings is meant to at least be equal in scope to the benefits provided under a typical employer health insurance plan. In defining these benefits, the law directs the Secretary to establish an appropriate balance among the benefit categories, and requires that the benefits be designed in ways that do not discriminate based on age, disability, or expected length of life.

Discussion

Instead of defining a federal EHB standard, the Secretary proposed, as a transitional approach, that the states define a state-specific EHB package. The Secretary's proposed approach seeks to balance comprehensiveness, affordability, and state flexibility by allowing each state to set an essential health benefits package that reflects plans typically offered by small employers and benefits that are covered across the current employer marketplace. HHS proposes that each state will be allowed to utilize a benchmark plan selected by the state to define what is included under the state's essential health benefits package.

If a state does not exercise the option to select a benchmark health plan, HHS intends to propose that the default benchmark plan for that state would be the largest plan by enrollment in the largest product in the state's small group market.

According to HHS, the selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a 'typical small employer plan' in that State as required by section 1302(b)(2)(A) of the Affordable Care Act.

HHS intends to assess the benchmark process for 2016 and beyond based on evaluation and feedback.

Section 1311(d)(3)(b) of the ACA requires states to defray the cost of any benefits required by state law (i.e., state mandated benefits) that exceed the benefits and services offered as part of the essential health benefits benchmark package chosen by the state. CMS has given guidance that only additive benefit changes or the addition of benefits will result in the

requirement of the state to defray costs. Administrative changes, classification of benefits, network changes or those changes that are required to make plans compliant with the ACA are not included in the requirement to defray costs.

Decision

Through the summer of 2012, the Exchange Board's Advisory Committee on Health Plan Benefits and Qualifications, as well as the Advisory Committee on Consumer Experience and Outreach, devoted considerable time to reviewing the essential health benefit options available to Connecticut and recommended a benchmark plan. The Board of Directors approved the Advisory Committee's recommendation in September 2012. The benchmark plan is inclusive of all state mandated benefits passed by the legislature as of December 31, 2011.

Should the state pass any additional benefit mandates that are not already included in Connecticut's essential health benefit package the state could become liable for the actuarial cost associated with the additional mandated benefits. AHCT will monitor any legislation affecting mandated benefits on an ongoing basis.

The exchange anticipates the need to reevaluate the state's essential health benefits package for the 2016 plan year.

Item 6:

Whether to list dental benefits separately on the Exchange's Internet web site where a qualified health plan includes dental benefits;

Background

In accordance with the ACA, routine pediatric dental is considered an essential health benefit. The ACA further requires the Exchange to offer limited scope, stand-alone dental plans provided that the dental carriers furnish at least the essential pediatric dental benefits required under the law.

Exchanges have the option of either requiring their participating major medical carriers to embed the pediatric dental benefit in their qualified health plans or requiring carriers to separately price the pediatric dental benefit and make available separately priced dental plans to consumers.

Discussion

The Health Plan Benefits and Qualifications Advisory Committee, along with the Advisory Committee on Consumer Experience and Outreach conducted a thorough review of the advantages and disadvantages of (a) offering a stand-alone dental plan, listed and priced

separately; or (b) requiring insurers to offer a bundled health plan that includes a limited scope pediatric dental benefit.

The advantages of offering a stand-alone dental plan include:

- Increased Marketplace participation of dental carriers
- Increased transparency of premiums
- Increased likelihood that adults purchase a stand-alone dental plan
- Decreased disruption to current plan designs (dental is not typically included as part of major medical plans sold today)
- Reduced QHP premiums

The disadvantages of offering a stand-alone dental plan include:

- A more complicated enrollment process for consumers
- A more complex administrative process for AHCT.
- Would not allow integration between medical and dental benefits
- Increased cost to the consumer requiring pediatric dental benefits

Decision

Based on their analysis of how best to offer ACA-compliant dental benefits, the Advisory Committees recommended to the Board that AHCT offer stand-alone dental benefits and at the same time require carriers to embed the full pediatric dental benefit design in all Marketplace QHP plan offerings. In this way the application of any tax credits which enrollees may be eligible for can be facilitated. In addition, it serves as the only way that AHCT could ensure that all pediatric beneficiaries not only have access to such plan but in fact have enrolled in such pediatric dental plans. This assurance is required in order for the QHP offering (medical and dental) to satisfy the minimum essential benefits requirement.

Further, subpart K of the exchange establishment rule states that the Marketplace, in its certification requirement, has the authority to grant QHP status to only those plans and plan designs that AHCT determines to be in the best interests of Connecticut residents. Given the ease of application of the tax credits and the "one price" for both benefit features (which would prevent adverse selection by potential beneficiaries who may see a separate stand-alone dental price and refuse to sign up for such dental benefits), the lack of the true ability to ensure that such a stand-alone product would actually be purchased, and the ability to reduce the overall costs of such plans by spreading the burden of the risk among all beneficiaries, AHCT made the determination that it would not be in the best interest of Connecticut residents to offer stand-alone benefits.

In November of 2012, The Board approved the Advisory Committees' recommendation to require certified QHPs to embed pediatric dental benefits in all QHPs and to require AHCT to offer a separate stand-alone dental option for all others.

In executing this design, AHCT only approved such designs that featured the pediatric benefits embedded in the QHP offering. As such, there can be no doubt that all AHCT enrollees have the full complement of all 10 essential health benefits.

There is currently a slight deficiency with respect to stand-alone dental offerings. In the current system, there is no option for offering integrated stand-alone dental benefits. The stand-alone ability currently exists only as a link-out to the carrier's individual websites who are offering dental benefits. AHCT is currently developing an integrated stand-alone dental shopping experience for the Marketplace. This system enhancement will allow for a consumer to enroll in a QHP and/or a stand-alone dental plan through the same shopping experience. It is anticipated that this enhancement will be available during the next open enrollment period in November of 2014.

Items 7 & 8:

The relationship of the exchange to insurance producers; and

The capacity of the exchange to award Navigator grants pursuant to section 9 of this act.

Background

To accomplish its mission, AHCT must assist the people of Connecticut with applying for health coverage, with determining their eligibility for subsidized health care (Medicaid, HUSKY, and other Federal subsidies), aid people in their assessment of health coverage options, and facilitate enrollment in a qualified health plan. Instituting a proactive outreach, education, and enrollment program has been crucial to Connecticut's ultimate success in extending health insurance coverage to tens of thousands of uninsured residents.

In accordance with the requirements of the ACA, 45 CFR Parts 155 and 156, the Connecticut legislation establishing the Exchange, AHCT was required to establish a Navigator Grant Program that selects entities qualified to serve as Navigators, and awards grants to enable Navigators to:

- Conduct public education activities to raise awareness of the availability of Qualified Health Plans ("QHPs");
- Distribute fair and impartial information concerning enrollment in QHPs and the availability of premium tax credits,
- Facilitate enrollment in QHPs;

- Provide referrals for any enrollee with a grievance, complaint or question regarding the enrollee's health benefit plan, coverage or a determination under that plan or coverage, and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population of Connecticut being served by the Exchange.

Discussion

The establishment of a vibrant and effective consumer assistance program was critical to ensure both AHCT's short and long term success as the state's Health Insurance Marketplace. Attracting, educating, and enrolling individuals across the state's diverse and varied communities has been essential in order to positively impact the health and wellness of the state's residents, garner broad participation from insurers, and ensure the financial viability of the Exchange.

Brokers, agents, and the role of Navigators have played key roles in executing the outreach and assistance efforts for AHCT. Establishing an effective, efficient and sustainable outreach, education, and enrollment effort is an important initiative undertaken by AHCT in 2013. Determining how best to leverage the expertise of health insurance brokers and agents, community-based organizations, health centers and other key groups, and proactively including these individuals in the outreach and enrollment program was crucial to AHCT's overall success in the marketplace during its first open enrollment period beginning in October of 2013.

Producers (Agents and Brokers):

Producers in Connecticut play an important and influential role in the distribution of health insurance. Both individual consumers and business owners rely on Producers to sort through their health insurance options, provide health plan recommendations, and serve as their agents throughout the year in dealings with insurance companies.

Additionally, it should be noted that a large portion of uninsured Connecticut residents do not have insurance because it is expensive. The Advanced Premium Tax Credit (APTC) will make health insurance more affordable for many lower income consumers. Producers are currently positioned to assist these new consumers in understanding the APTC, and their insurance options. Producers have increased the awareness of the AHCT Marketplace, have increased enrollments, and ultimately will encourage the long term financial sustainability of AHCT.

Navigators:

Navigators consist of both public entities and private entities that have organized and deployed individuals to communicate, educate, and enroll consumers in Qualified Health Plans (QHPs) and publicly funded health care through the enrollment mechanisms provided by AHCT.

Navigators are responsible for outreach, education, and enrollment for the currently uninsured or underinsured populations.

Decision

In November 2012, the Exchange Board of Directors approved a "Navigators and Broker Program" to establish the framework for effective consumer outreach and engagement. In accordance with this program framework, AHCT has developed a robust consumer assistance network that includes a vibrant Navigator program working alongside the current Producer channel, and will refer individuals to these consumer assistance programs when available and appropriate.

Producers who enroll individuals and employers in Qualified Health Plans through AHCT act in much the same manner as Producers who sell insurance products in the pre-Exchange individual and small business markets. Producers will continue to provide individuals and employers with information regarding health insurance and assistance in enrollment in health plans. Additionally, many full-service brokerage firms provide assistance with claim and billing issues and assist employers in the creation of complete benefit packages.

In addition to the standard Producer functions, Producers that enroll individuals in Qualified Health Plans through AHCT will also be required to understand the basics of AHCT's web portal, Advanced Premium Tax Credits, structure of the Small Business Health Options Program (SHOP) Marketplace, Medicaid enrollment and where to direct individuals who require social services from programs such as Supplemental Nutrition Assistance Program (SNAP), formerly food stamps), and Temporary Assistance for Needy Families (TANF).

To ensure a smooth transition for optimal customer support, Producers who wish to place business through the AHCT Marketplace were required to complete a training and certification program offered by AHCT. The training covered the range of Qualified Health Plan options and insurance affordability programs, and complied with AHCT's privacy and security standards.

AHCT designated Navigator organizations, together with their local In-Person Assister organizations, will complement the services already provided by Producers by facilitating the enrollment of non-traditional populations that typically do not engage in the health insurance marketplace. These groups include people who are eligible for publicly funded health care (e.g. CHIP and Medicaid) and those individuals who do not have the means, ability, or knowledge to seek out and identify a traditional producer or insurance purchase channel. Navigators, IN-Person Assisters, and Producers have served an important role in educating and enrolling individuals and groups that typically do not enroll unless actively called upon and directly engaged.

While the ACA requires AHCT to have a Navigator Program, the ACA did not allow establishment grant funding for the program. In accordance with AHCT's Navigator and Broker Program, the navigators received program funding to support their activities through a competitive grant process. Therefore, Connecticut actively explored other sources of funding for the navigator program grants. In 2013, AHCT received grants from Connecticut organizations including the Connecticut Health Foundation, the Universal Health Care Foundation if Connecticut, and the Foundation for Community Health. This private grant funding from stakeholder foundations have supported this funding requirement.

In August of 2012, CMS provided guidance on a new outreach position, an "Assistor," to complement the Navigator Program. This new In-Person Assistor Program has been funded through a Federal establishment grant. Connecticut submitted an establishment grant request to CMS in December, 2012, to develop a comprehensive in-person assistance program so as to minimize the number of uninsured in the state and meet the anticipated demand for enrollment assistance. In support of this grant request, AHCT engaged its partners at the Department of Social Services (DSS) and the Office of the Healthcare Advocate (OHA) to assist in the development of a robust In-Person Assistance program to complement and extend the Navigator program. The Federal grant was awarded to AHCT in February of 2013.

In a short period of time AHCT's IPA Program has accomplished a great deal of program development and implementation goals. Specifically:

- Developed the Navigator and In Person Assister (NIPA) Program marketing and communications plans
- Met and presented to multiple organizations across the state at multiple events
- Developed and provided core IPA training curriculum
- Issued IPA and Navigator Contracts
- Performed background checks for all certified Navigator and IPAs
- Trained and deployed 282 In-Person Assisters
- Held more than 300 local enrollment events
- Implemented NIPA self-reporting tools
- Created a strong statewide network of support for under-served communities
- Engaged Assisters who speak a total of 33 languages

- Created micro-regions within Navigator regions to focus on specific areas and help Assisters work together
- Worked with Community organizations, Federally-Qualified Health Centers, and Hospitals to enroll consumers.

Navigators and In-Person Assisters (IPAs) have played a key role in AHCT's outreach and consumer assistance efforts. The IPAs are the cornerstone of a robust Connecticut Health Insurance Marketplace consumer assistance network, and continue to educate individuals about consumer assistance mechanisms available in the State. As planned, the Navigator organizations and IPAs have facilitated enrollment in qualified health plans offered by the AHCT Marketplace and have provided critical information in a manner that is culturally and linguistically appropriate to the needs of the population being served.

Item 9:

Ways to ensure that the Exchange is financially sustainable by 2015, as required by the Affordable Care Act including, but not limited to assessments or user fees charged to carriers.

Background

The ACA requires Exchanges to be financially self-sustainable by calendar year 2015. Through December 31, 2014, the funding for the establishment of the Marketplace is fully supported by federal grant dollars awarded to AHCT by CMS.

Discussion

In accordance with the requirements of Connecticut General Statute (CGS) 38a-1080 et seq. (the "Exchange Act"), AHCT is charged with reducing the number of individuals without health insurance in the state. To effect this goal, AHCT is authorized under Section 38a-1083(c)(7) to "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." Section 38a-1083(a) of the Exchange Act further directs AHCT to interpret its powers broadly to effectuate its purposes.

AHCT's enacting legislation provides AHCT with clear and simple revenue options for its sustainability beyond 2014. AHCT spent a great deal of time and effort in 2012 understanding those options, and reviewing them together with market factors such as continually evolving membership projections, updated operational cost estimates, and updated and clarified regulations under the ACA.

Based on AHCT's review, there were three primary approaches to generating its required operating revenue: (1) market assessments and (2) user fees, and (3) a combination of both a market assessment and user fees.

For the market assessment option, AHCT would charge a market assessment to all health and dental carriers that are capable of offering a qualified health plan on the Exchange Marketplace. The assessment would be applied to all health carriers licensed to issue individual and small group business in Connecticut. The assessment would be calculated as a percentage of gross written premiums reported by the carriers for their individual and small group businesses for the previous calendar year as reported to regulators on reports such as the Medical Loss Ratio Reports to the Health Insurance Oversight System (HIOS) of CMS and annual statement information to the Connecticut Insurance Department (CID). A benefit of a market assessment approach is the ease with which to calculate the assessment. Regardless of premium, a broad based market assessment will ensure stability in operating revenue for AHCT.

For the user fee option, AHCT would charge a user fee to all health and dental carriers that are offering a qualified health plan on the individual and/or small business marketplace as a function of premium charged for qualified health plans. The charge could be a flat fee, percentage of premium, or any other per sale charge method. One challenge with the user fee option was that the user fee would be an assessment only to those carriers participating in the Marketplace, thus using solely this approach may give a competitive edge to those carriers not participating in the Marketplace.

There are also secondary options including the selling of advertising, cost recovery from the State's Medicaid program, and other revenue generating endeavors consistent with the purpose of AHCT. For example, the future provision of consulting services to other State based Exchange groups. While these secondary options are possible in the future, AHCT will focus on the primary revenue generating options to support its operating costs in 2015.

Decision

In March 2013, AHCT prepared and presented AHCT's Sustainability Model to the Finance Sub-committee and subsequently thereafter, to the Board of Directors for review. Sustainability options were presented with the recommendation for a market assessment as the primary revenue source for AHCT beginning in 2015. The policy, Acquiring Operating Funds, which allows for AHCT to acquire operating funding through market assessments, user fees, or other actions including advertising, cost recovery, and other endeavors consistent with the purpose of AHCT, was adopted by the Board in May. The policy provides AHCT with a broad basis for achieving financial sustainability.

Also in May, the Finance team developed and presented a market assessment rate for the 2014 Sustainability Plan, which was approved by the Finance Sub-committee, and subsequently, the Board of Directors. Subsequent to that approval, the Finance team drafted and presented the procedure, "Procedure: Exchange Assessments and Fees," which finalized the sustainability procedures for applying the market assessment to the applicable health and dental carriers in Connecticut. The procedure outlined the steps to be taken by AHCT in the communication to and invoicing of the carriers to begin in January of 2014. The Board of Directors adopted this procedure in July of 2013.

Item10:

Methods to independently evaluate consumers' experience, including, but not limited to, the hiring of consultants to act as secret shoppers

Background

The consumer experience and satisfaction of Connecticut residents is one of the most critical organizing principles governing the development and operation of AHCT. Health reform presents a historic opportunity for Connecticut to build a consumer-centric model that generates a cultural shift in the manner by which health insurance is purchased and utilized.

For many people who have been offered subsidized health insurance through AHCT, it will be the first time they have individually purchased health insurance.

The need for consumer assistance reflects the fact that most Connecticut residents – and most U.S. residents, in general – have never purchased health insurance on their own. P eople often obtain insurance through their employer (perhaps choosing from among a limited number of plans) and others may receive publicly subsidized coverage from Medicaid, Medicare, or other State or Federal subsidized programs. As a result of the ACA, tens of thousands of new consumers are now able to purchase health insurance through AHCT, many of whom are doing so for the first time. These new customers need assistance with understanding their options and navigating the application in order to make informed decisions on the health insurance needs for themselves and in many cases, their families.

Discussion

Collaboration with consumers began well in advance of the initial open enrollment period. In 2012, AHCT, in collaboration with the Consumer Experience and Outreach Advisory Committee, established a plan to evaluate its customer assistance channels throughout the program design phase and during program implementation. The plan included consumer involvement and feedback in each step of the process. Incorporating feedback from consumers has allowed for a more responsive customer support system when the AHCT system went live on October 1, 2013.

Early collaboration with consumers allowed AHCT to incorporate consumer feedback in real-time on critical functions such as the call center operations and the consumer-facing website from which individuals, families, and small businesses are now purchasing health insurance coverage.

As the iterative process of system development continued into 2013, AHCT organized a live, public demonstration of the online shopping website during the final stages of design in early 2013. The goal of the demonstration was to gather feedback from consumers on the

functionality and visual layout of the website, and allow enough time to incorporate those changes before the design phase ended and implementation began. The result was a great deal of consumer feedback which allowed for changes to be made to the system during implementation.

In addition, AHCT conducted usability testing on the website with several consumer groups, who were selected to reflect the racial and ethnic diversity of Connecticut, as well as other factors including income and eligibility status so that there was participation reflective of the diverse target group of consumers across Connecticut.

As part of the implementation of a comprehensive consumer assistance and outreach program, AHCT will continue to develop and refine key metrics to evaluate the consumer experience with the Marketplace. These measures will provide AHCT with critical information for its future consumer outreach and assistance efforts as the organization continues to transition from a system and program development concern to a fully functioning, operational, and self-sustaining entity.

Decision

Incorporating consumers in the design phase of the program provided AHCT with more flexibility throughout the system design, and helped to develop the assistance channels that are serving our customers today. By setting the standard high for consumer involvement early in the design and implementation process, AHCT set the tone for future interactions with its customers.

Item 11:

Status of the implementation and administration of the All-Payer Claims Database program established under section 144 of Public Act No. 13-247

Background

In 2012, the State of Connecticut established the requirement for an All-Payer Claims Database (APCD) with the enactment of Public Act 12-166. This legislation was passed by the Connecticut General Assembly during the 2012 legislative session and was subsequently signed into law on June 15, 2012. As a result of this legislation, health insurers and other payers of health care services are required to report all medical claims data to the State's APCD. The reported claims data will be utilized to develop various types of reports to inform consumers, policymakers, researchers, and insurers about different aspects of the State's health care utilization, including: cost, quality, and other metrics.

Public Act 12-166 enabled the Office of Health Reform and Innovation (OHRI), a division of the Office of the Lieutenant Governor, to develop the APCD program, to seek federal and/or private

funding, to develop the regulations governing the APCD in conjunction with the Office of Policy and Management (OPM), to convene an APCD Advisory Group to guide the implementation process, and to contract with a data management vendor to implement the technical operations of the APCD.

Recognizing the synergies between the OHRI's APCD initiative and the mission of AHCT, AHCT partnered with OHRI by including a request for approximately $6.5M of establishment grant funding for the APCD Program within its Level II Establishment Grant application submitted to CMS. AHCT was awarded the grant, including the APCD development funding in August of 2012.

Discussion

Public Act 13-247, enacted in 2013, eliminated OHRI and transferred responsibility for the APCD Program to AHCT. This legislation maintained the same requirements and objectives for the APCD: collection of health claims data from public and private payers, and enabling consumers, state agencies, researchers, policymakers, and other stakeholders to use the data to improve health care in Connecticut. The APCD officially became part of AHCT in June of 2013.

AHCT has convened regular meetings of the APCD Advisory Group, which works collaboratively with AHCT to guide major decisions concerning the program. The APCD Advisory Group is comprised of representatives of state agencies, provider organizations, carriers, consumer advocates, researchers, and AHCT Board members. All APCD Advisory Group meetings are announced on the AHCT website and are open to the public.

Access Health CT created a division called Access Health Analytics (AHA) to manage the APCD. AHA currently has an Executive Director and a Data Manager who work with AHCT staff on APCD implementation.

AHCT and AHA staff developed APCD Policies and Procedures, as well as a Data Submission Guide (DSG) for reporting entities. The AHCT Board of Directors adopted the Policies and Procedures including the DSG on December 5, 2013.

Next Steps

AHA staff members are working with APCD Advisory Group members to develop enhanced policies and procedures governing data use, privacy, and security, all planned for Board approval in 2014.

AHA is in the process of selecting a vendor to perform data management functions for the APCD. It is anticipated that the vendor contract will be in place by the early spring of 2014. Shortly thereafter, the APCD will begin collecting data from reporting entities. The schedule for

data submission is detailed in the policies and procedures. Once data are collected, AHA and the data management vendor will prepare data to produce reports to be used by stakeholders.

AHA plans to use aggregated APCD data to provide information and tools to consumers by the end of 2014. As AHA collects more data and develops additional analytic capabilities, a variety of reports will be produced using APCD data. AHA will also develop processes for researchers to request limited data sets for use in studies on health care cost and utilization.