Connecticut Health Insurance Exchange Plan

Calendar Year 2012 Update

Annual Report from the Exchange Chief Executive Officer to the Governor and the General Assembly on a plan for the establishment of a Health Insurance Exchange in the state of Connecticut (CGS Sec. 38a-1089).

January, 2013

Contents

Introduction

Pursuant to section 12 of Public Act No. 11-53, the following report updates the plan to establish the Connecticut Health Insurance Exchange (Exchange). 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 2013.

> Our **Vision**: The Connecticut Health Insurance Exchange supports health reform efforts at both the state and national level and to 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 continue to make sure that all activity is aligned to five (5) simple goals for our organization:
>
> (1) Create an easy and simple consumer experience for shopping and comparison of insurance options
> (2) Promote innovation and new options for health benefit coverage in the State
> (3) Provide empathetic and responsive customer service
> (4) Work with our health plans, brokers, and navigators to provide more affordable products and broad distribution support
> (5) Launch a substantive and targeted communications and outreach campaign that promotes awareness of health reform and new options for consumers and small businesses in the State

During calendar year 2012, Connecticut made considerable progress in the establishment of a Health Insurance Exchange.

The Centers for Medicare and Medicaid Services (CMS) awarded the Exchange an administrative supplement to its previously awarded Level One Establishment Grant in June of 2012, in the amount of $1.5M, for a total Level One Establishment Grant of $8.2M. These additional funds have allowed Connecticut to successfully shape its strategy and planning for future business operations, as well as develop an in-depth implementation plan to meet CMS required development milestones and benchmarks. These funds were primarily allocated to the following areas:

- Establishment of organizational structure and leadership staffing
- Assessment and analysis of business operations and IT systems
- Assessment of consumer support capabilities and requirements
- Market research and strategy development

As a result of that progress, the State of Connecticut applied to Centers for Medicare and Medicaid Services (CMS) for a Level Two Establishment Grant and was awarded $107.3M in August of 2012. These funds are allowing Connecticut to further its planning, development, and design of a stated-based Health Insurance Exchange through the hiring of additional staff and consultants to manage the activities related to the development of, and on-going operations of the Exchange through calendar year 2014. A substantial portion of these funds is being used to develop an IT system that facilitates critical Exchange functions including integrated eligibility determination, enrollment, and information interchange among individual consumers, employers, insurance carriers, and state and Federal government agencies.

After a successful Design Review with CMS in the Fall of 2012, the Exchange submitted its Blue Print Application Package with all applicable attestations and overall work plan. Based on this submission, the Exchange received conditional approval from CMS on December 7, 2012, as a State-based Exchange for the plan year 2014.

Lastly, the Exchange worked diligently to ensure the necessary financial processes and procedures were developed and implemented in order for the Exchange to assume management responsibility for all grant funds. In October, 2012, the Exchange filed a Grantee change application to CMS in order to change the grantee on the Level One and Level Two Grants from the State of Connecticut's Office of Policy and Management (OPM), directly to the Exchange. As a result, CMS issued two new establishment grants (both Level One and Level Two) directly to the Exchange in December, 2012.

Exchange 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 Exchange as a quasi-public authority governed by a 14 member Board of Directors. Lieutenant Governor Nancy Wyman was appointed chair of the Exchange 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 Exchange's governance structure. The amendments contained in Section 217 and 218 of PA 12-1, brought the Exchange'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 Exchange employees.

Under CGS 38a-1084, Duties of the Exchange, the Exchange 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.

The Connecticut Health Insurance Exchange 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 Exchange leadership team was hired throughout 2012, and included the filling of the following positions: Chief Executive Officer, Chief Operating Officer, Chief Finance Officer, Chief Information Officer, General Counsel, Director of Policy and Plan Management, and Chief Marketing Officer.

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

High-Level Conceptual Design

The Exchange has made a number of key program design decisions in 2012 that will affect the operational model of the Exchange. These decisions include:

- A "no wrong door" approach that will be utilized by both the Exchange and Connecticut's Department of Social Services (DSS) as an integrated eligibility and enrollment service for Medicaid, CHIP, Advance Premium Tax Credits (APTC), Cost Sharing Reductions (CSR), and enrollment in non-subsidized, commercial health insurance.
- The Exchange has contracted with and on-boarded Deloitte as the Systems Integrator to develop the single shared eligibility service. The system will eventually be extended to include non-modified adjusted gross income (non-MAGI) Medicaid, and non-health public assistance programs such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF) related services and data.
- The Exchange will leverage the existing Connecticut Insurance Department (CID) processes for health insurance plan management. The Exchange will refine the list of Qualified Health Plans (QHPs) and load certified QHPs' benefits information, rating tables, and other data published to the National Association of Insurance Commissioners' System of Electronic Rate and Form Filing (SERFF) system into the Exchange systems.
- The Exchange and CID will have procedures in place to ensure QHP issuers meet accreditation requirements as part of QHP certification per federal guidelines.
- The Exchange will leverage the Federal Risk Adjustment Program to calculate plan average actuarial risk and payments and charges, and to perform data collection and auditing functions.
- The Exchange contracted with MAXIMUS as the contracted vendor partner to run the Exchange Call Center.
- The State of Connecticut's Department of Administrative Services (DAS) Bureau of Enterprise Systems and Technology (BEST) will host the Exchange/Integrated Eligibility system.
- The number and types of QHPs offered through the Exchange and the criteria to select these QHPs from the broader set of approved health plans approved by CID is being

determined. The Exchange received specific direction from its Board of Directors (BOD) in November 2012 on the number of plans to offer. Five medical carriers and three stand-alone dental carriers have submitted non-binding letters of intent to develop plans to offer on the Exchange. It is the intent of the Exchange to leverage, at least in the first years of operation, the current process used by the State and CID to approve health insurance plans.

Consumer and Stakeholder Engagement

In 2012, the Exchange completed its initial phase of consumer and stakeholder engagement, and is nearing completion of its final marketing plan. One of the key components of this plan will be the Exchange's outreach strategy and engagement with consumers and stakeholders, for which the Exchange's marketing firm, Pappas MacDonnell, has begun developing an extensive network of contacts in the form of community-based healthcare providers, consumer advocates, and community leaders throughout Connecticut.

The Exchange's four Advisory Committees continue to meet periodically to provide insight on policy issues and ensure that consumer and stakeholder input is properly represented in the policy recommendations. The committees remain organized thematically:

--Consumer Experience & Outreach

--Health Plan Benefits & Qualifications

--Brokers, Agents & Navigators

--Small Business Health Options Program

The Advisory committees met monthly, and meetings are professionally facilitated, recorded, transcribed, and are open to the public. Recommendations from the Advisory Committees are provided to the Exchange Board for consideration and approval as appropriate.

The Exchange understands the critical importance of employing numerous customer outreach and assistance channels and will implement a comprehensive Navigator program in Connecticut. In 2012, the Exchange finalized its Navigator Program Design, received approval from the Board of Directors and the Brokers, Agents & Navigators Advisory Committee. The Program Design includes the framework for both Navigator and In-Person Assister training and certification, as well as the general guidelines for the Navigator and In-Person Assister roles. The Exchange plans to work closely with the Office of the Healthcare Advocate (OHA) in order to adequately support its network of Navigator and In-Person Assister organizations, and will finalize a Memorandum of Understanding (MOU) in January 2013 to officially establish that collaborative relationship. Following new rules released by CMS in late 2012, the Exchange developed a plan for the In-Person Assisters Program which will follow the design approved by the Board of Directors for the Navigator program. In addition, the Exchange applied for a Federal Grant to support the In-Person Assisters program and anticipates an award decision in early 2013.

Throughout November and December 2012, the Exchange conducted seven (7) town hall-style events in various Connecticut cities called "Healthy Chats." Overall, nearly 800 individuals attended and the Exchange generated a wealth of dialogue concerning health reform and Exchange implementation in the state and nationally. The Healthy Chats were hosted by a moderator from NBC television and a panel of experts that included Kevin Counihan (Exchange CEO), members of the Exchange's Board of Directors and Advisory Committees, and members of various professional entities that intersect with the Exchange (the Connecticut Insurance Department (CID), the Office of the Healthcare Advocate (OHA), various community health centers, and the Universal Healthcare Foundation of Connecticut, to name a few). Event materials were produced in English and Spanish, and a Spanish interpreter was present at all events to ensure that the two largest linguistic groups in Connecticut were appropriately represented. The Exchange partnered with NBC-CT to support these events through TV commercial advertisement, filming of two-minute "spotlight" interviews with CEO Kevin Counihan on various Exchange-related topics, and moderating the events. The Exchange plans to continue this partnership in 2013.

Due to the success of the first series of Health Chats and as a means to elevate outreach and engagement with CT consumers, the Exchange plans to host another event series in the first quarter of 2013, as well as more targeted events in the second quarter. These sessions will include professional groups, community health centers, chambers of commerce, and other more specialized audiences.

The Exchange recognizes the importance of outreach to Connecticut's American Indian population. To that end, the Exchange finalized a 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 Exchange Board of Directors in November, 2012 and the Exchange has 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 the Exchange will continue to consult with tribal representatives and/or their respective Tribal Council as needed.

The Exchange was one of only six states to have completed their "Blueprint" submission in advance of CMS's November 16, 2012, deadline. Submission of this documentation to CMS/Center for Consumer Information and Insurance Oversight (CCIIO) was a key milestone for the Exchange. The Exchange's Blueprint was divided into 14 sections that essentially function as a road map for implementation of the ACA compliant Exchange in Connecticut. The Blueprint establishes the process, dates, functionality, and responsibilities for implementation. Connecticut's Blueprint submission was approved by the Secretary of Health and Human Services, Kathleen Sebelius, via the awarding of "Conditional Approval" to the state's Exchange in December, 2012. CMS indicated that it considers Connecticut one of its three "best practice states."

The Exchange has had an extremely productive 2012. The inherent ambiguity in the Affordable Care Act (ACA) makes the jobs of Exchange staff difficult at times, especially when the Exchange

is faced with complicated questions from the Board and/or its many stakeholders. Maintaining open and transparent communication has been and will continue to be a key for the Exchange staff as it "sprints" to open enrollment by October 1, 2013. The Exchange is confident, however, that Connecticut will be among the very small and elite group of states that meets its open enrollment deadline for the 2014 plan year.

All-Payer Claims Database

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 de-identified medical claims data to the State's APCD. The reported claims data would 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 the Connecticut Health Insurance Exchange, the Exchange partnered with OHRI by including a request for approximately $6.5M of establishment funding for the APCD Program within its $107M Exchange establishment grant application submitted to CMS. The Exchange was awarded the grant, including the APCD establishment funding in August of 2012.

To date, OHRI has convened several meetings of the APCD Advisory Group to begin the planning for the development of the APCD program and its implementation.

Governing Legislation of this Report

Pursuant to section 12 of Public Act No. 11-53, this report addresses 10 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.

Decisions have been reached for several of these key items, while some recommendations have not yet been finalized. The Exchange Board of Directors, staff, and established Advisory Committees will continue to focus on many of the remaining issues in 2013. Continued efforts by all, in conjunction with considerable work and research that has been done to date, will continue to guide the Exchange in finalizing the planning and implementation for Connecticut's state-based Exchange, which will be open for business on January 1, 2014.

The narrative that follows provides some background information, and updated recommendations or final decisions on each of the above ten (10) key items required to be addressed in the plan for establishment of Connecticut's Health Insurance Exchange.

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 Exchanges – a Small Business Health Options Program (SHOP) Exchange for employers

and the American Health Benefit Exchange for individuals and families – or a single Exchange to serve both markets. The decision to administer a single Exchange 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 Exchange are virtually identical to the requirements of the individual market Exchange; 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 Exchanges.

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, the Exchange reviewed the manner by which other states have established their Exchanges. Every state that has moved forward with the establishment of an Exchange, 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 Exchange from the individual Exchange.

Decision

In 2012, the Exchange 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 exchange markets.

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

Further to the decision to establish a single Exchange, the Board also made the decision to outsource the operations and technological solution of the SHOP Exchange. This decision was made upon the recommendation by the SHOP Advisory Committee. The Committee carefully

[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

weighed the Exchange'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 the Exchange.

The committee determined that given the inherent risk associated with the time, cost, and functionality required for the SHOP exchange 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 the Exchange to take advantage of: (a) a vendor's existing core competency of administering a commercial small business exchange; (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 exchange system integrator maintains its focus and resources on development and implementation of the individual exchange solution.

Item 2:

Whether to merge the individual and small employer health insurance markets

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, will change significantly in 2014. The change will prohibit 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 does not change significantly and therefore the morbidity of the small group market is not expected to change significantly in 2014.

In a report for the Exchange, 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

The Exchange 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.

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

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

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).

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 Exchange 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 Exchange, to include employers with up to 100 employees. This would subject all mid-sized employers to the ACA's modified community rating rules in 2014, which could potentially result in further premium disruption. At present, premiums in the mid-sized

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

market are set differently utilizing companies' specific claims experience.

Decision

The resulting decision made by the Exchange 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, the Exchange will continue to monitor the market, and, based on future market conditions and operational 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

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 Exchange in 2017, the definition of small groups would not need to be changed.

Plans offered through the Exchange must be qualified health plans requiring, among other things, that products sold inside the Exchange be offered at the same price as those sold outside of the Exchange. As currently written, this provision may require large employers who purchase coverage through the Exchange 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 in the Exchange, an experience-rated product outside of the Exchange, 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 the Exchange.

[6] ACA Sec. 1312

Next Steps

It is anticipated that once the Exchange is operational, the Board's Advisory Committees will review this issue further. Because the earliest that the Exchange 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 the Exchange has been operating, and, more importantly, the insurance markets have had time to adjust to the new rules required by the ACA. At that time, the Exchange will further consider this market expansion and make a more informed decision.

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 the Exchange to offer qualified health plans that cover all of the essential health benefits (EHB), which are described in broad terms in the federal law. The ACA instructs the Secretary of Health and Human Services (HHS) to provide additional details on the benefits and services to be covered under the EHB, which must equal the scope of benefits provided under a typical employer 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

For coverage purchased through the Exchange, Section 1311(d)(3) 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 identified by the Secretary as part of the essential health benefits package.

However, 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. This proposed approach issued by HHS obviates the requirement of Section 1311(d)(3) of the ACA that requires the state to pay

the cost of any state mandate that exceeds a federal definition of the essential health benefits package.

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

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, in accordance with the ACA. The exchange will monitor any legislation affecting mandated benefits.

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 Exchange 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 a 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 the Exchange.
- 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 the Exchange offer stand-alone dental benefits and require carriers to separately price the pediatric dental benefit.

The Board approved the Advisory Committees' recommendation in November 2012.

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

The Exchange will need to 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 will be 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, the Exchange is 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

As Connecticut continues to implement a state-based Health Insurance Exchange, establishing a vibrant and effective consumer assistance program will be critical to ensure both its short and long term success. Attracting, educating, and enrolling individuals across the state's diverse and varied communities will be 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 newly created role of Navigators, will play key roles in executing the outreach and assistance efforts required for the Exchange. Establishing an effective, efficient and sustainable outreach, education, and enrollment effort will be one of the more important initiatives undertaken by the Exchange. 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 is crucial to the Exchange's overall success in the marketplace.

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 insurance options available. Producers will increase the awareness of the Exchange, increase enrollment in the Exchange, and ultimately encourage the long term financial sustainability of the Exchange.

Navigators:

Navigators will consist of both public entities and private entities that will organize and deploy individuals to communicate, educate, and enroll consumers in Qualified Health Plans (QHPs) and publicly funded health care through the enrollment mechanisms provided by the Exchange. Navigators will be responsible for outreach, education and enrollment for the currently uninsured or underinsured populations (inclusive of both the individual and small employer marketplaces) and will present to those populations the options available under the ACA.

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, the Exchange will have 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 the Exchange will act in much the same manner as Producers who sell insurance products in the pre-Exchange market. 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. Producers are encouraged to continue to provide these value-added services to individuals and employers.

In addition to the standard Producer functions, Producers that enroll individuals in Qualified Health Plans through the Exchange will also be required to understand the basics of the Exchange's web portal, Advanced Premium Tax Credits, structure of the Small Business Health Options Program (SHOP) Exchange, 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 Exchange will be required to complete a training and certification program offered by the Exchange. The training will cover the range of Qualified Health Plan options and insurance affordability programs, and comply with Exchange's privacy and security standards.

Navigators in the Exchange 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 and Producers will serve an important role in educating and enrolling individuals and groups that typically will not enroll unless actively called upon and directly engaged.

While the ACA requires the Exchange to have a Navigator Program, the ACA did not allow establishment grant funding to fund the Navigator program. In accordance with the Exchange's Navigator and Broker Program, navigators participating in the Exchange will receive funding to support their activities through a competitive grant process. Therefore, Connecticut is actively exploring options for funding this grant program. With no operating revenue generated by the Exchange until the beginning of the open enrollment period, there is a need for other source(s)

of funding for navigator program grants. In 2013, the Exchange plans to apply for private grants from stakeholder foundations in support of 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 can be funded through a Federal establishment grant. As a result, 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, the Exchange has engaged its partners at the Department of Social Services (DSS) and the Office of the Healthcare Advocate (OHA) to help develop a robust In-Person Assistance program to complement and extend the Exchange's Navigator program.

Connecticut's in-person assistance program will be "distinct from the Navigator program." Whereas the Navigators must maintain expertise in eligibility and enrollment specifics, promote public education, and help consumers select health coverage that meets their needs—both in the individual and SHOP markets—the roles and responsibilities of Assistors will be shaped by the Exchange's specific needs when examining the full complement of outreach channels across the State. This program will fully leverage the training and monitoring processes being developed for the Navigator program.

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 Exchange is fully supported by federal grant dollars awarded to the Exchange by CMS.

Discussion

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

The Exchange's enacting legislation provides the Exchange with clear and simple revenue options for its sustainability beyond 2014. The Exchange has 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 the Exchange's review, there are 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, the Exchange would charge a market assessment to all health and dental carriers that are capable of offering a qualified health plan on the Exchange. It is anticipated that 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 premium 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 Connecticut Insurance Department (CID) and the Health Insurance Oversight System (HIOS) of CMS. 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 the Exchange.

For the user fee option, the Exchange 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 exchange as a function of premium charged for qualified health plans sold on the Exchange. The charge could be a flat fee, percentage of premium, or any other per sale charge method. One challenge with the user fee option is that the user fee would be an assessment only to those carriers participating in the Exchange, thus using solely this approach may give a competitive edge to those carriers not participating in the Exchange.

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 the Exchange. For example, the future provision of consulting services to other State based Exchange groups. While these secondary options are possible in the future, the Exchange will focus on the primary revenue generating options to support its operating costs in 2015.

Next Steps

Over the next few months, the Exchange will be refining its budget estimates and developing its policy for "Acquiring Operating Funding." It is anticipated that the Exchange policy will be broad based and incorporate all revenue options The Finance Subcommittee of the Exchange Board will work with the Exchange staff and be responsible for reviewing the revenue options and draft policy to ensure the best revenue generating options for Connecticut. It is anticipated that the policy and options will be presented to the Board of Directors for adoption in early 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 the Exchange. 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 will be offered subsidized health insurance through the Exchange, 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. People 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 will be able to purchase health insurance through the Connecticut Exchange, many of whom will be doing so for the first time. These new customers will 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

In order to better serve the future customers of the Exchange, collaboration with consumers has begun well in advance of the initial open enrollment period, planned for October 1, 2013.

In 2012, the Exchange, 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 the program implementation process. The plan includes consumer involvement and feedback in each step of the process. Incorporating feedback from consumers will allow for a more responsive customer support system when the Exchange goes live on October 1st, 2013.

Collaboration with consumers allows the Exchange 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 will be purchasing health insurance coverage. Incorporating consumers in the design phase of the program provides the Exchange more flexibility throughout the system design, and helps to develop assistance channels that will best serve its future customers. By setting the standard high for consumer involvement early in the design and implementation process, the Exchange has set the tone for future interactions with its customers.

Next Steps

As the iterative process of Exchange system development continues into 2013, the Exchange will be organizing a live, public demonstration of the online shopping website that will be in the final stages of design in early 2013. The goal of this demonstration, which will include consumer interaction through a question and answer session, will be to gather feedback from consumers on the functionality and visual layout of the website with enough time to incorporate those changes before the design phase ends and implementation begins.

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

Lastly, the Exchange plans to contract with a database management system so that each interaction between a consumer and any one of the Exchange's support systems (including the website, call center, brokers, In-Person Assisters, and Navigators) is tracked and analyzed for efficiency and effectiveness.

As part of the development of a comprehensive consumer assistance and outreach program, the Consumer Experience and Outreach Advisory Committee will continue to develop and refine key metrics to evaluate the consumer experience with the Exchange. These measures will provide the Exchange with critical information for its consumer outreach and assistance efforts as the Exchange evolves from a system and program development phase to a fully functioning, operational and self-sustaining firm.