VERBATIM PROCEEDINGS

STATE OF CONNECTICUT
PUBLIC FORUM
RE: HEALTH INSURANCE EXCHANGE
BOARD OF DIRECTORS MEETING

JANUARY 24, 2013

1 ELIZABETH STREET
HARTFORD, CONNECTICUT

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Verbatim proceedings of a Public Forum on Health Insurance Exchange held on January 24, 2013 at 8:36 a.m., at the 1 Elizabeth Street, Hartford, Connecticut...

CHAIRPERSON NANCY WYMAN: First of all, what I first wanted to do was welcome back Bob Tessier. Thank you, it’s so good to see you again. You’re looking dapper with your new goatee.

MR. BOB TESSIER: Thank you Governor. It’s good to be here. Good to be anywhere.

CHAIRPERSON WYMAN: For a housekeeping order everybody that wants to speak to please speak into the black mic so that everybody hears what’s going on. And at this point is there any public comment? And I don’t think there is. Can you hold on one second please?

Okay.

A VOICE: (Indiscernible, too far from mic.).

CHAIRPERSON WYMAN: Well, we don’t have any -- right, five voting members. We need seven. So we might not be voting on anything, we might just be talking a lot today. You know, so that everybody knows, we don’t
have any public comment so I’m going to skip over it anyway and explain that I have two letters of resignation from Board members so I would like to read them.

One is from Michael Divine (phonetic) and it says, “Dear Lieutenant Governor. It is with deep regret that I must submit my resignation from the Connecticut Health Exchange due to increased business travel. I have thoroughly enjoyed my time as a member of the Board of Directors and I feel that we are embarking on a noble quest. Although I will miss all of you I feel a great sense of satisfaction knowing that the Health Exchange is operating at such a high level and in such capable hands.

I wish all of you much luck and great happiness in bringing the Connecticut Health Exchange to the consumer market. Sincerely, Michael Divine.”

Michael did call and I believe most of you already had known about Mickey Herbert and, “The purpose of this letter is to tend my resignation immediately from the Board of Directors of the Connecticut Health Exchange. It was a pleasure and honor to serve on the Exchange Board for the past 15 months. I am proud to have played a small part in the continuing effort to provide assessable, affordable, high-quality healthcare to all Connecticut
citizens.

Although my Board participation is ceasing you can count on me to be fully supportive of that continuing effort. Best wishes and best regards, Mickey Herbert.”

So I have -- so that you know, I have been in contact with both of the people that appointed. One was Senator McKinney and one was appointed by Representative Cafero and asking them to replace each of these two gentlemen. And I thank them publicly for their help.

I think we’re down to looking for one more voting member, since we have one. So, you know what we’re going to do? We’re just going to have to skip over the minutes and we’ll go, Kevin, right to your --

A VOICE: (Indiscernible, too far from mic.).

CHAIRPERSON WYMAN: -- okay. Mary’s here?

So I’m skipping over the review of the minutes and I request approval of the minutes of December 20th? May I have a motion?

A MALE VOICE: So moved.

A FEMALE VOICE: Second.

CHAIRPERSON WYMAN: So moved and seconded.
All in favor?

VOICES: Aye.

CHAIRPERSON WYMAN: Opposed? The minutes are adopted. Now, I’ll turn back to you Kevin. I’ll remind people again, speak into the black mic. And Kevin, it’s up to you.

MR. KEVIN COUNIHAN: Thank you Lieutenant Governor. And happy new year to everyone. The Exchange staff as, I think everyone can imagine, remains very busy. We’ve had a couple of interesting updates that I would just like to inform the Board of. The first is that we have received a third best practice recognition from CCIIO. This relates to the new relationship that we’ve developed with OHA that will oversee our navigator program. We are in the process of working with OHA with respect to establishing the training and the management of that and the details of it, but the concept of working with that agency is something that CCIIO thought it was something that should be considered or perhaps replicated by other states as a best practice with respect to the navigator program. So a special thanks to Vicky and Jason and our team for both initiating this and implementing it.

I think we pretty much know nationally that we’ve got 18 states that will be adopting state-based
exchanges. That includes the District of Columbia. There are two that have been approved for partnership exchanges, that being Arkansas and Delaware. And there may be some others, although the deadline for that is running out really within the next week. That would mean that there would be probably about 30 states, if not, a couple more that may be defaulting to the federal exchange. So we will be watching this stuff obviously very, very closely.

To be honest, this is about five to six times more than CMS was expecting when the law was passed in 2010 and it’s obviously putting an enormous strain on CMS resources and others. So we’ll be watching this very carefully.

There are also some considerations being discussed that there may be some modifications in some form or fashion to the ACA as part of the debt ceiling limit discussions. Some of that was considered as part of the fiscal cliff and we know that some programs were cut back such as new co-op states and such. So we’ll be watching that carefully.

Five senior staff are attending a two-day seminar with CMS and CCIIO in Baltimore beginning Monday. The core functional areas involved are IT, operations and
outreach, policy, and there’s a separate session for CEOs, which may act more as a group therapy session as much as anything.

(Laughter)

MR. COUNIHAN: But we’re clearly very enthusiastic about talking to our colleagues from other states and sharing our learnings and learning from them.

With respect to marketing, Connecticut was invited to a select group of states to participate in an update from Enroll America, which is an organization that is working nationally to try to communicate enrollment and outreach and awareness of the ACA. We are beginning our second phase of healthy chat town hall meetings beginning on February 19 in Norwich and we have got seven of these lined up. We go to Norwich, Willimantic, Manchester, Meriden, Torrington, Danbury, and Enfield. And we will be having more as well, so we’re very enthusiastic about those next round of healthy chats.

I also want to thank the Board for so many of you that have volunteered to participate on panels. So, thank you very much for that support.

Last week I was in Colorado to meet with the All Pair Claim Database folks as well as their exchange management team and learned a great deal about
the promise that the APCD can provide as a decision support tool for both consumers, small businesses, policy makers, legislators, and others. And I look forward to sharing more of those with you. Colorado has a series of reports already that are available online. They show such things as primary care visit rates, inpatient utilization, variations in care access and utilization, evidence of adverse selection, and preventable hospitalization for chronic illnesses. So that type of data is something that we’re very much looking forward to being a part of serving our residents and small businesses and providers and health plans.

Lastly, I think as many of you know in this room, that our team has been involved in a multi-stakeholder group of AC representatives, CID, health plans, involved in developing recommendations on plan standardization. You’re going to be hearing a great deal about that. But more importantly, I just want to thank all of those groups for the great cooperation and collaboration that was involved to get us where we are today.

A fundamental tenant of health reform is the concept of shared responsibility and collaboration. One of the risks I think that we all face in implementing
health reform is a concern that if something isn’t perfect the first time that it means that it’s fundamentally flawed. And if we’re expecting perfection out of health reform or out of an exchange or out of the website or out of the plan design we’re all going to be disappointed. It has to be part of a broader commitment to the concept and the values that we owe insurance coverage as a fundamental right to our citizens in making this as affordable and comprehensive as possible. And I believe, and I think as a staff, we believe, that the collaborative atmosphere that we’ve experienced over the past three weeks to get us where we are in plan standardization is a great symbol for that type of sense of shared responsibility. So the staff and I personally are extremely grateful and thankful to that team.

CHAIRPERSON WYMAN: Thank you also from me. Can you just make sure that the dates of when the travel -- where you’re going is given to all of us? For the different --

MR. COUNIHAN: For the healthy chats?

CHAIRPERSON WYMAN: -- healthy chats.

Okay? You don’t have to give them to us now, just make sure that the Board members, for those that want to attend, can.
MR. COUNIHAN: Okay.

CHAIRPERSON WYMAN: Okay? Kevin, thank you very much and think everybody. I’m going to move onto, as you know also, besides the fact that we talked about Mickey and David, Jeanette has left us and has moved on to other endeavors and I publicly would like to thank her for the work that she’s done for us.

So right now what I would like is a motion to elect Vicki Veltri as our Vice Chairman. I’m recommending that, she has done such a great job to help already even without the title. Now that I gave her a title she can do twice as much work. Didn’t you say that?

Oh, so moved, I got it. Okay. Second, okay. Are there any other nominations? Then I’m going to move that nominations be closed and ask for all in favor of Vicki Veltri as Vice Chairman, except for Vicki.

VOICES: Aye.

CHAIRPERSON WYMAN: No, I’m just kidding. Congratulations.

MS. VICKI VELTRI: Thank you.

CHAIRPERSON WYMAN: Thank you. And thank you all very much.

MS. VELTRI: Thank you.

CHAIRPERSON WYMAN: Thanks for taking it
on. We do appreciate it. Okay. And at this time I’m
going to go up to the finance updates. Steve, do you want
to?

MR. STEVE SIGAL: Thank you Lieutenant
Governor. I’m Steve Sigal, the Chief Financial Officer of
the Exchange and I wanted to take this opportunity --
CHAIRPERSON WYMAN: Steve, can you talk a
little bit closer into your mic? Thank you.
MR. SIGAL: -- is it on?
CHAIRPERSON WYMAN: Yes, it is.
MR. SIGAL: Okay. Sorry.
CHAIRPERSON WYMAN: No problem.
MR. SIGAL: I wanted to take this
opportunity to update the Board on the Exchange continuing
interaction with a variety of departments in the Health
and Human Services Agency. Since the e-mail I shared with
the Board on January 4th regarding the status of the
grantee change to the Exchange from the Office of Policy
and Management and access to the grant award funds much
has occurred. This resulted from the significant delays
the Exchange encountered.

What you have up there is a slide that
reviews the chronology that you have seen parts of before.
The headline here is that the grantee change took 63 days
when the Exchange was told to expect 30 to 45 days. And access to the funds to 27 days when the Exchange was told to expect 10 days. Further difficulties were experienced from the de-obligation of OPM’s award before granting the new award to the Exchange.

The rationale for the delay was that the Center for Consumer Information Insurance Oversight, CCIIO, told us that we were the first Exchange to undergo this change. There are others that will be following us to do the same thing. An unknown to CCIIO, the grant management office treated the grantee change as if it was a new grant award request. One good thing that came out of it is that the Exchange’s experience will be a lesson learned for the CCIIO group and they’re changing their instructions as a result of our experience.

CHAIRPERSON WYMAN: I’m so glad that we’re here to teach them.

(Laughter)

MR. SIGAL: Yeah. Next slide? So there were unintended consequences, as I shared in the January 4th e-mail, the unanticipated delays led to the Exchange borrowing $5,000,000 from the State. It was allowed under part of our enabling legislation when we were first authorized.
The good news is that we actually received our first drawdown of funds yesterday and repaid the State yesterday off of our books and it should show up in the State’s bank account today.

CHAIRPERSON WYMAN: We appreciate that tremendously. Thank you. It showed up yesterday, not that we’re counting.

(Laughter)

MR. SIEGAL: Okay. Any questions? That was my status update.

CHAIRPERSON WYMAN: Thank you very much Steve. Okay. We’re going to move right along. I’ll asked, Peter, if you can give us an update on the operational areas?

MR. PETER VAN LOON: Thanks Lieutenant Governor. As Kevin said, we’ve been busy. I’d like to tell the Board that we are on track in terms of people, process, and technology. But staff takes no comfort in that and the fact that every day we learn something new, everyday we find other opportunities to engage people so that we cannot for a second think that just because at this point in time we’re looking good that we can let down our guard or cease our work or even let up tomorrow.

Our work has not been without challenges.
In the Board package that you got last week you can see that. We did not meet our design confirmation due dates of the end of December, we think for extremely valid reasons. As a result we put ourselves as red and behind on our development. That was a week or so ago. Since the end of December we’ve been working with Noggin Surrea (phonetic) of Deloitte and our good colleagues there to adjust and adapt. Jim is going to go into a little bit more detail because in the interest we think we are back red, but again -- excuse me. I mean back green. Thanks Jim. It’s good to have Jim around.

(Laughter)

MR. VAN LOON: The -- we’re back green for today and we’ll continue to keep our focus on this from now through the 1st of October and as soon as the 1st of October comes up we’ll be set with a whole other set of challenges as far as actually serving the people of the state.

What I’d like to go through today is just a distilled version of the dashboard. Now, I have slides for the dashboard, and our risks. You have the updated copies in the packets that we gave, but I’d like to just give you the update right here. But let me go back, Grant.
Update for that dashboard, and that dashboard that we do have up here is the distilled version. The main things in operations right now, our call-center contract is being negotiated. We look to have our vendor up and running officially by the 1st of March and unofficially working with our IT folks sooner than that. The small employer health options program, the contract was put out for bid last month. Just two days ago or -- two days ago we got three people that put in proposals. We’re evaluating those proposals and at this juncture we can’t share the names of those, but we will be working with different -- the shop AC and others to evaluate those.

As Kevin said, we’ve also spent a little bit of time the last month working to develop our standard plan designs. Grant and I will cover that in detail just a little bit later.

The other thing that’s continued to be kicked off and spun up to a higher degree is Julie Lyons and her team working with the plans on the tactical implementation of our relationships with them. Technical in the fact of, what are the data elements that need to be passed back and forth? People, who do we need to talk to? And process, how do we make all this stuff work? Julie
will give you an update on that.

Efforts going forward, continue the technology. I’ve been working kind of one step behind the technology development to work with the Department of Social Services on the operating model because we’re very much joined at the hip here and we have to be. And another opportunity for us is to continue to adjust and adapt to the emerging federal guidelines as they come up.

And so that’s the basic operations and we’ll go -- if there are no questions, I’ll go right through these two slides. I’d be more than happy to go into the detail, but I want to turn it over to Jim to tell you a little bit more about what we’ve been doing on a technological basis.

CHAIRPERSON WYMAN: Jim? Thank you.

MR. JIM WADLEY: Good morning. My name is Jim Wadleigh, I’m the Chief Information Officer for the Exchange. I want to give you this month’s technology update.

All of the teams continue to make significant progress. What we see here is -- continues to be our systems development lifecycle with all of our key dates. We are still on track for our two releases with a June and October implementation.
What have we accomplished over the last month? We’ve continued our design sessions. We will complete tomorrow our design confirmation for the Exchange and I’ll talk a little bit in a minute about what that is.

Our software construction has begun. A significant milestone for us is we have communicated with the federal data services hub, so that is the service that will allow us to talk to things like Homeland Security, the Internal Revenue Service, and other data sources that we will need to do our eligibility determination. We have run approximately 150 scripts and of the nine services that the Exchange feels that they will need to contact we have tested all nine of those, so that is a significant milestone for us working with the federal government.

The Department of Social Service integration design confirmation is on track to be completed in mid-March. And our go live date of October 1st, stays unchanged.

So Peter spoke just a second ago on our design being read and what I wanted to discuss is what went into that so that you understand what goes in, and I could sit here and talk for an hour on a day in the life of what goes on in technology and as I tell my wife, I live it on a daily basis. I usually go home and don’t
want to re-explain it.

(Laughter)

MR. WADLEIGH: I choose to move forward and talk about our next steps. So first, let me talk about what is design. Design is a deliverable that provides us with an end to end functional view of our system and it includes key elements of all of our portal screens, our business rules, our use cases, and a myriad of technological artifacts that go into our hosting design and things like that.

We have found that the more time, from my experience, that we spend with design and getting it right we experience a reduction in construction -- construction and testing defects, as well as a reduction in change controls which will result in a much better product at the end. So we want to make sure that we get our design right, as it leads to everything going forward.

So what are some of the things that extended our deliverable and why did we do that? As we’ve communicated over the last couple of months we’ve had more stakeholder participation in our design sessions. So our Advisory Committee members, some of them that are sitting around the room, have participated in those design sessions. They have contributed in a positive way for a
better product. As a result of that, the out-of-the-box screen design and user interface we asked Deloitte to go back to the drawing board and make some significant modifications, all for the betterment of our customer experience. We will begin to see those and share those with our Advisory Committees, we’ll begin to see those tomorrow. We’ll begin to set up meetings over the month of February and share those and I’m very excited, because I’ve started to see some very positive changes in the design.

As many of my partners have communicated we continue to receive additional guidance from the federal government. With that additional guidance comes changes that we want to make sure that we modify our design to accommodate all of the additional information that the Department of Health and Human Services has come out with.

So again, I want to reiterate that our design confirmation, while late, is for the better, and tomorrow we are on track to receive all of that information from Deloitte.

MS. MARY FOX: May I ask a question?
CHAIRPERSON WYMAN: Sure.
MR. WADLEIGH: Yes Mary, you may.
CHAIRPERSON WYMAN: Mary, can you talk into
the black mic?

MS. FOX: This one?

CHAIRPERSON WYMAN: Yes.

MS. FOX: I’m just wondering, as you work
with different constituents, particularly people who will
be using this, or representing people who might be using
this system, are you getting input around some of the key
variables that consumers will be concerned with? So for
instance, last time I think we talked about there’ll be
three plans that come up based on the demographic data
that is put in by the individual. Will we have
opportunity, if individual cares a lot about their
community health delivery system, you know, particular
docs in the network, hospitals or clinics, will they for
instance be able to articulate, or put into the system
from the get-go the fact that they want, you know, a
community network? So for an ACO will that be
accommodated and will that come up on the screen with the
typical standardize plans that we’ve been talking about?

MR. WADLEY: First, thank you for the
question. So right now the design is planned to have up
to 20 different sort selections. As of right now I am not
aware that one of our sorts will be -- begin with our
carriers by provider. What we will have right next to
each carrier will be a link out to the provider
directories that will allow our consumers to go out to
those provider directories and do that search to find out,
do they have all of the carriers -- providers that they
are looking for with that carrier network?

MS. FOX: Before they select?
MR. WADLEIGH: Before they select.
MS. FOX: So can you imagine, you know, if
we have some innovative solutions around ACOs available in
October that that would come up in the course of events
early on in the various screens?

MR. WADLEIGH: They would have access to
all of that information before they hit the button that
says, this is what I want to purchase.

MS. FOX: Excellent. Thank you.

CHAIRPERSON WYMAN: Bob?

DR. ROBERT SCALETTAR: Jim, thanks for the
update and I appreciate the good reasons for missing the
date. Does that have any implication for functionality
from October 1? And if so, can you tell us what the good
trade-off for better consumer input and the consumer
experience means for any delay in critical functionality?

MR. WADLEIGH: Great question Bob. Yes.
And so, working with CCIIO and as jumping around on our
bullet here, you’ll see that we’re going down -- I leave
on Sunday to go down with the rest of our team to meet
with CCIIO. We’ve been in negotiations with CCIIO around
the process of what functionality do we feel that we can
defer post-October 1st that would not impact our consumer
experience, or our integrated eligibility. And where we
have ended up over the last couple of weeks is somewhere
in the ballpark of about 30 percent of the functionality
that we have defined in our requirements document we feel
can be deferred.

So what does that mean? What is
functionality that can be deferred? Now, I could sit here
and layout roughly 150 different requirements that we
think that are impacted. But at a high level some of
those key things are, we do not feel we need functionality
to certify a plan on October 1st, I mean to -- I’m sorry,
to decert. it. We do deem functionality on the certified
plan, that would be crazy. We do need functionality --

A MALE VOICE: We’re even.

MR. WADLEIGH: -- yeah, we’re even. As you
can tell, we’re working on a lot of stuff. We do not need
functionality to decertify a plan, October 1st. We also
do not feel we need functionality to recertify a plan come
October 1st. There are other things around financial
management that we feel that we can perform manually in
the timeframe of October to some point at a later date.
There’s also reporting. A significant amount of our
requirements is around reporting, that we feel that we can
do manually and not need to integrate immediately by
October 1st. So those are just a few of the things in
discussion with CCIIO that we feel that we can -- that we
can discuss with them.

One further note is we met with them a
couple of weeks ago and as of that meeting we were the
first state to come to them and say, we feel that we
should be deferring some functionality. We have worked
through what that functionality is and we want to come and
talk to you. They were very happy to hear that and so
much so that they have been shocked that other states have
not come knocking on their door to discuss what is all the
critical functionality that is needed just for October
1st.

DR. SCALETTAR: Just a quick follow-up.
First, there’s a question, and then a comment. On the
question side, so there are financial implications to the
delay in the functionality? Or there’s no --

MR. WADLEIGH: At this point in time Bob
there are no financial implications. I would say, at this
point in time, because we still need to work through our official change control process, which would go through our Steering Committee, clearly if we thought that there were we would bring that back to the Board and share it with them. But at this point in time through our conversations we are not expecting financial implications. The Deloitte contract is a set amount of functionality that we have asked to be delivered and moving that out not only helps us, but it helps them reach their goals as well.

DR. SCALETTAR: And on the statements, I’m sorry, I want to thank all of you, and certainly Kevin, for the leadership to be able to step forward and make those kinds of comments to CCIIO because it does feel like everybody is in the sprint to the finish and it’s hard to imagine everybody is going to get there. So the ability to be candid, the ability to go to CCIIO and say, here’s what I need to succeed, is a message that we need to feel very comfortable to give repeatedly and as we’ve seen already, it’s one that’s received well by them because they are so invested in the success. And those of us who are leaders around the country need to feel comfortable to say that time and again to CCIIO.

All right. Jim?

MR. WADLEIGH: So in summary --

(Laughter)

MR. WADLEIGH: -- I want to continue to

allay any fears. June 4th is our plan management

implementation date. October 1st continues to be our core

HIX functionality implementation date. Any changes in

that would be communicated in the future.

CHAIRPERSON WYMAN: Any other questions for

Jim? Anybody? Jim, thank you. Thank you all very much.

At this time we'll be moving on to Julie. Julie?

MS. JULIE LYONS: Thank you Lieutenant

Governor. My name is Julie Lyons and today I'm going to

provide you with information on plan management, including

the definition. I'll outline the key responsibilities

included in the scope of plan management and update you on

some primary activities the team has been driving since

our last Board meeting. Lastly, I'll inform you of some -

- of the major tasks we will face in the next few months

as we move closer to the rollout of the Exchange.

I look at plan management is a partnership

between the Exchange and one of our key stakeholders, the

issuers of benefits that will be offered on the Exchange.

In order for the Exchange to succeed in providing an
array of consumer options we need to engage the carriers
to ensure that we have a mutual understanding of what must
be supported according to federal regulations and
guidance, as well as Connecticut state law. We need to
make sure that we have the technology -- technical
information needed to program their systems recognizing
that we don’t have all of the final guidance from our
federal counterparts.

Some of the primary functions of plan
management are outlined on the side. And as we work
through these, we continue to keep a primary goal in mind
of ensuring that the end consumer will have access to
quality healthcare choices through the Exchange. We will
respond to carrier inquiries in a timely fashion, set up
webinars to outline policies and procedures and engage
them in discussion to resolve issues and problems. We
intend to provide regular and clear communications on
policies and procedures.

The QHP application must be drafted and
incorporate requirements outlined in the regulatory
guidance in the QHP solicitation. The application will
include a series of attestations to which carriers will
need to agree in order to become certified on the
Exchange. As an example, the ACA requires reporting of
certain performance information, such as enrollment and
disenrollment data, as well as the number of claims
denied.

As part of the certification process we
will ensure that carriers are able to comply with program
requirements. A significant requirement of becoming
certified will be the ability for the carriers to secure
approval from -- on the rates and the form filings from
the Insurance Department. When a plan is certified we
need to ensure that the information about the plan is
available for consumers to purchase through the Exchange.

We will work with our legal team to draft a
contract for the carriers for their signature and maintain
files with the supporting documentation. As part of the
ongoing QHP compliance we’ll create processes to monitor
things like network adequacy at appeals and grievances.
To support enrollment, data interchange systems are needed
to ensure that the carriers have specified information on
those electing their plans so they can produce their
materials for the consumers.

In support of the primary plan management
functions of developing an effective relationship with the
carriers we held an operational kickoff meeting earlier
this month and we held in eligibility and enrollment
webinar yesterday to review the end to end process flow, outline expected timelines for enrollment, processing, and discuss various enrollment scenarios. Our goal at this meeting was to educate the carriers on how we expect our systems to work and support the enrollment process as well as obtain their important feedback. We expect to hold weekly webinar sessions for the carriers with future topics including technical data interchange and with regard to the attestations that are required as part of the certification process.

Some of the major activities that have recently occurred on the Exchange are the receipts of the notices of intent from five medical carriers and four dental carriers. Throughout the month of January we have been working with our consultants to continue to develop system functionality to support receipt of benefit and rate data from carriers and a publishing tool of that information on the Exchange Web.

We also had an opportunity to meet with the Surf (phonetic) staff, along with representation -- representatives from the Insurance Department to discuss the standard templates being developed for carriers to submit their benefits -- excuse me, administrative formulary network and rate information to us. The Surf
team will be establishing weekly conference calls with us so that we can review the progress of the templates -
template development and discuss any concerns.

Over the next few months we’ll be involved in drafting the QHP application contract as well as a carrier reference manual to document our policies and procedures. You know, we continue to focus on the ultimate goal of being ready for October 1st, which is open enrollment. Thank you.

CHAIRPERSON WYMAN: You have a question?

MS. VELTRI: Thank you Julie. Just a couple of questions. So how is this process going along knowing that we’ve done a solicitation and we haven’t selected plans yet? So, I mean, we did a solicitation, right?

MS. LYONS: (Indiscernible, too far from mic.).

MS. VELTRI: Right, and people gave their letters of intent and then there has to be, I’m assuming, a review of those solicitations and selection of plans. So how is that moving alongside of this? And is there like a question and answer, like a bitter question-and-

MS. LYONS: Actually, we did receive some
questions that we’re researching responses for from two of
the issuers and it really goes hand-in-hand with all of
the technology. So it’s likely we will be publishing the
questions and the answers on our web, so you know,
complete transparent disclosure.

MS. VELTRI: Yeah. Exactly.

CHAIRPERSON WYMAN: Are you ready Bob?

DR. SCALETTER: I know it’s given the lay
press about who the responsive carriers have been, maybe
that’s worth sharing with the group publicly. And to
build on Vicki’s questions, when does it move to a more
definitive understanding of who’s in and who’s out?
Understanding that ultimately the Exchange will either
certify or not certified, but when do we get a chance at
the letter of intent?

MS. LYONS: Well, we’re going through the
initiation process and vetting out all of the concerns and
our first webinar was on the eligibility and the
enrollment process. The actual schedule is in the QHP
solicitation and I believe -- Grant, what is the final
date for accepting the final applications? I don’t
recall.

MR. GRANT PORTER: March.

MS. LYONS: March? And the March date is
consistent with the policy form filings and rate filings be submitted to the Department of Insurance. So it’s kind of a large coordination effort. We’re targeting for the end of March.

CHAIRPERSON WYMAN: Any other questions for Julie? Julie, thank you very much. I guess we’re going to move back to Peter to talk about the standard plan.

MR. VAN LOON: Yes. Thank you Lieutenant Governor. Grant and I have been working with the staff and a lot of different folks are doing the standard -- coming up with a standard plan design. Our purpose today is to review that process that we followed. We did come up with the recommended plan designs. Grant I think put those in a piece of paper on your desk today. And then hopefully, at the end of our presentation a vote to approve those standard plan designs.

By way of background, as we worked through the advisory committees and brought recommendations, got advice from them and brought recommendations to the Board, it was defined that the Board directed us to develop a standard plan design for one option coming from the carriers, with allowing the carriers -- encouraging the carriers to give also a non-standard option. So we spent our time working on the standard options.
Why standard option? Desire to allow the consumers to compare and contrast plans based on quality, network, and price, while holding the benefits and the cost-sharing constant.

MR. BENJAMIN BARNES: Excuse me Peter? What do you mean by quality in that context?

MR. VAN LOON: There are lots of quality measures that are out there now. We want to bring those to the fore, but also as part of our response going forward is to develop a quality rating system for the carriers in the state and we’re going to have to do that in the future. But the idea is that to the extent that we can showcase what is different opinions, validations of the carriers now, but also worked to develop our own quality rating system and put that up on the site.

MR. BARNES: Okay. Thank you.

MR. VAN LOON: Principles. How did the team go about this? First thing is desire to be simple. Simple for the consumers to understand and also simple for the consumers and the carriers to administer.

Consumer focus. The idea is that the consumers require appropriate care and value for the money that they’re spending, both in terms of premium dollars and cost sharing aspects, deductibles, coinsurance, and
co-pays. The team also emphasis to primary care, the idea being that we want people and incent people to get and maintain -- get care and maintain their health.

Who was the team? The staff went to the Advisory Committee co-chairs in late December and made the suggestion, and it was approved that the Advisory Committee, since they’re all eager and interested in the standard plan designs, to contribute members. And we got two from each to help the staff. We also were fortunate in the fact that we had the Connecticut Insurance Department, Maryellen Breault and her team, working with us day in and day out keeping us honest quite honestly as to issues when we thought was something would be a good idea, but we found that it was not quite in line with the State regulations. So we were able to adjust and adapt in real time.

We had carriers on board also. The actuary from Aetna, Bruce Campbell, Jan Bacher (phonetic) an Anthem actuary, and Alex Hutchinson from Health ACT, the new co-op. And there was some concern about that, but in the words of our advisory team members who actually requested that the carriers be on board, they provided a great service to us and in support of the team working. We got some free actuarial advice, which we appreciated,
and also a chance to vet out what made sense in the market
and what did not.

The meetings were extremely collaborative.

When I say that, we had brokers discussing the impact of
benefit plans that maybe a consumer advocate would
appreciate, and there was honest and frank discussions
about how that could work. And the best part I liked is
that folks learned from each other as we moved forward.

We got into a lot of detail. A Dr. McLean (phonetic) was
one of the team members and would broach some various
clinical aspects that the team appreciated. The consumer
advocates continued to bring up, as everyone did, the
concept of affordability across the board and the
recognition that even as we set standard plan designs
that’s not addressing the whole totality of affordability,
but it was an interesting group.

We had several meetings that went long,
both in person and on the phone and in the webinars, and
we did a lot of real-time work. Next slide please?

What were the parameters under which the
team worked? First and foremost -- I shouldn’t say, first
and foremost, our friends in D.C. might take exception.
Anything we came up with had to work -- had to work
underneath Connecticut state law and regulations. We had
some ideas about some co-pays that we didn’t have to -- we were quickly adjusted to reality by the Insurance Department and we changed those.

Of course, we have to work under the ACA regulations. Some of the main disciplines under that that we had to work with is actuarial value requirements and the metal tiers, and Grant is going to go into that in detail. All of this was inclusive of Connecticut’s essential health benefits. Nothing in the plan design was meant -- excludes essential health benefits at all. It was a primary foundation that our benefits are the vehicle through which people access those essential health benefits.

ACA is very strident about the fact that preventive services are free and to be encouraged and it also limits some out-of-pocket maximums. And all of these things we had to take into account. One of the primary disciplines that we had to follow was actuarial science and that was embodied in a tool that we had to practice actuarial science and that was the actuarial value calculator. And the fact that that was the tool by which we were able to meet the requirements of actuarial value for each metal tier for the basic bronze, silver, gold and platinum plans that also the silver plans that deal with
cost-sharing subsidies to folks that are under the 250 percent of the federal poverty level.

Now, those are our parameters. I’d like to turn it over to Grant to go a little bit more into detail about the actuarial value, the calculator, and how we used it. Grant, do you want to change position?

MR. PORTER: No. Thanks Peter. So first, I’m going to began with discussing briefly what we mean by actuarial value. Probably a lot of knowledge around this table about what it is, but some of the public who are watching may be less familiar, so I’ll just go into a little bit of detail. And then I’ll touch on the AV calculator, the actuarial value calculator that was provided to us by the federal government, which was a tool that embodied actuarial science to allow us to construct our standard plan designs in line with the different metal tiers and it’ll also go with what those metal tiers are. And then I’ll touch on each of the different metal tiers that we defined, the standard plans that we defined for those metal tiers.

So first, what is actuarial value? You can think of it as the total percentage -- the percentage of total healthcare that is paid for by your premium dollars. So a 70 percent actuarial value plan means that your
premiums are paying for 70 percent of your healthcare
costs on average for a typical population. That also
means that 30 percent of those costs are being borne by
the member through their out-of-pocket expenditures.
Again, this is based on averages and using a typical
population.

So does any one single individual expect
that 70 percent of their health care expenditures will be
borne by their premiums that they pay monthly? No, but on
average, if you look at the entire population, that’s what
you can expect. So there’s this idea that you’re paying
for part of your care up front through your premiums,
another portion of it will be paid out of pocket through
different -- either the deductible, your coinsurance, or
your co-payment.

So in relationship to the standard plans
that we’ve defined the actuarial value that -- you
calculated using the AV calculator refers only to the
essential health benefits and in-network coverage. So it
doesn’t consider out of network coverage and benefits that
a health plan may decide to include that exceed the
essential health benefits.

Before I go forward, is there any question
sort of on the -- sort of the idea of actuarial value?
CHAIRPERSON WYMAN:  I just want to know, who’s typical?

(Laughter)

MR. PORTER:  There’s really -- there’s really no typical individual because health care costs are so skewed and that you have this sort of 80/20 rule were 20 percent of the population might be using 80 percent of the care, so the median and the mean are very much different. But actuarial value assumes those averages and those means.

So the ACA requires that to simplify the consumers’ experience that only certain actuarial values are allowed and we use these metal tiers, bronze, silver, gold, platinum. A bronze has a 60 percent actuarial value, meaning your premiums are paying 60 percent of your costs. Out-of-pocket expenditures are expected to pay 40 percent of those costs, silver 70 percent, gold 80 percent, platinum 90 percent.

As Peter mentioned, we’re allowed a two percent variation amongst those -- across those ranges, so a 60 percent bronze could really be -- fall between 58 and 62 percent. In addition to those metal tiers there are additional subsidies that will be offered to consumers at certain income levels and these are cost-sharing
reductions that reduce the out-of-pocket expenditures. So with the silver plan instead of expecting to pay 30 percent out-of-pocket to the average consumer it will be significantly less. And so there are three different levels for cost-sharing in these cost-sharing reduction plans for silver alternatives, which we’ll go into greater detail when we look at each of the different plans.

So I mentioned the AV calculator, the actuarial value calculator. This was a tool provided to us by the federal government. It was an Excel spreadsheet with some complex macros built into it. It was made freely available to the public, to the exchanges, to our advisory committees. We were informed by the carriers that that’s what they intend to use to develop their plans. They’ll have their own proprietary actuarial value calculators, but they’ll be validating against the federal government tool.

It was released to us in late November as part of some of the proposed regulations. It’s not finalized, it’s a draft, or a proposed calculator. But it’s reasonable, it gives us a good estimate of what we can expect these actuarial values to ultimately be with respect to the essential health benefits and in network services.
A point to note is that it uses nationwide data, not Connecticut specific data. So every state will be using the same data. We’ll have the option of using our own data in 2015, but for now we’re using nationwide data.

And the inputs -- it’s fairly complex. It allows us to do a lot. You can design fairly complex plans, you can choose exactly what level of deductible you have, whether it applies to both the medical or prescription drug benefits, whether it’s integrated. You can select different coinsurance percentages, you can select co-pays by specific service category and you can indicate if there’s any limits on services. It also allows you to consider a two-tier network, you can have different coinsurance or co-payments on a second-tier or a narrower network. We didn’t consider a two-tier network for the standard plans.

So in developing the standard plans and using this actuarial value calculator and the science behind it, the process that we followed was first, as Peter mentioned, public input and what we got from them and from the Advisory Committee, public comments that we received through the phone or e-mail was that affordability was key. They wanted reasonable out-of-
pocket costs and premiums. There was a desire for separate deductibles, so a deductible for medical expenditures and a separate deductible for prescription drugs. They wanted simple and transparent cost-sharing requirements and we’ll demonstrate how this was used in the development of our plans.

It took some time, but there was a recognition of trade-offs that because there’s this actuarial science built into how we calculate these different standard plans for each of the metal tiers, a recognition of a shared responsibility that there’s trade-offs that were needed. You can’t just have no co-pays and expect no deductible as well. If you want to minimize co-pays you need to offset that with a deductible of varying amounts. You may have to make certain things subject to a deductible and waive it for others to balance off some of those trade-offs that were required.

There was also a preference for care outside of institutions, and this will be demonstrated in both the bronze and silver plans, where the deductible is waived for primary care services and then more -- it’s waived for more types of services in the silver plan as we move up in the actuarial value and move up in the generosity of the plan, so how much is being paid through
your premiums, we were able to waive the deductible for more services. As I mentioned, there was a preference for co-payments as opposed to a coinsurance. Consumer advocates and others felt that it makes healthcare more -- health expenditures more predictable for the consumer. If you don’t know how much a primary care visit costs, if you’re not sure how much going to a specialist would cost, there’s no way to calculate what 30 percent of that final bill will be. But you’ll know that with a co-payment of $30 or $45, exactly what your bill will be and what that expense will be leaving you -- the doctor’s office or the hospital. Finally, as I mentioned, the separate deductibles.

So I’m not going to -- the next three slides go through the Excel spreadsheet of what the AV calculator was. I’m not going to go into these in any detail, but just sort of these next three slides just demonstrate the level of detail that we were able to use in constructing these health plans.

So now I just wanted to go through what the working group recommended. Concentration with carriers, with staff, with the Connecticut Insurance Department the group felt that the plans that I’ll present offer the best value for the consumers given the realities of the
requirements imposed by the silver plan by having a 70 percent actuarial value. And so I’m going to -- and I’ve also included in your packets and appendices -- appendix with three different -- appendices one that goes through summary of the metal tiers, the bronze through platinum. The second one looks at the silver plan, it’s the same silver plan in relationship to the cost-sharing reduction plans. And then the final one looks at some of the other benefits that were not included in the AV calculator, and yet still need to be defined in order for the carriers to know how to construct their products for us.

So if we look at the silver plan, and the reason why I’m emphasizing the silver plan is because it’s the silver plan that will determine the advanced premium tax credits, how much subsidies will be available to the consumers purchasing through the Exchange. So we expect that most people will purchase that silver plan and they’ll be able to -- those tax credits will be pegged to the silver plan. The consumer will have the option of buying up or buying down. They could use those dollars to buy the bronze plan, those premium tax credits will go much further, but they’ll be getting a much less comprehensive plan. Or it’ll be as comprehensive, it covers the same benefits, the essential benefits, but
it’ll have a higher deductible and higher co-pays. Or they can spend more out of their own pocket each month in terms of premiums and buy up into the gold or the platinum plan, but -- and they can expect lower co-payments if they are in need of care.

So with the silver plan it has a $2,500 deductible medical expenses, a separate $200 deductible for prescription drugs. For office visits, for primary care and office visits is a 30/$45 plan, so $30 for primary and mental health, $45 for any type of specialist care. It has a $500 co-pay on hospitals, hospital stays up to four days. And it should be noted that the deductible, the 2,500 deductible only applies to hospital services, inpatient and outpatient hospital services. So if you need to go to a primary care doctor, a specialist, any noninstitutional setting, that deductible is waived. So although it’s high, it only applies to hospital services.

Any questions on the silver plan?

MR. TESSIER: Thank you Grant. Let me preface my question by saying, after two months away from the Exchange and all of our activities, the amount of work that’s been done is pretty staggering for someone kind of stepping back into things. And I want to express my
appreciation for staff and Board members and Advisory Committee members who have participated in all of this process with you to get us to where we are.

But I’m a little, I guess, I’m a little bit confused naturally. You said earlier that the numbers are based on national averages, so there’s no Connecticut data involved. So I guess my question is, if healthcare in Connecticut costs more than it does in some other parts of the country how comfortable or confident are we that the deductibles and co-pays that are listed will in fact equate to 30 percent of the cost, or 70 percent covered by the carrier?

MR. PORTER: Right. That’s a very good question. And we understand that the AV calculator is imperfect. If anything, it probably inflates the value of these plans, so healthcare is more expensive in Connecticut than elsewhere at 71.2 percent actuarial value as calculated here, may really be higher in Connecticut given these co-pays. That said, there are some known issues with the AV calculator that seem to overstate it, so there is an issue with how rehabilitative services are computed in the AV calculator. There was also an issue about how generic drugs are computed in the AV calculator. And so these are offsetting, we believe, and so it’s a
reasonable approximation for what we can expect and is fair.

MR. VAN LOON: If I can add to that? One of the parameters of the team and the disciplines was in fact in using the calculator as it is we got the imperfections or the challenges with it are minimal and I say that based on some of the input we got from the carriers. We know that in several months that we’re going to get a new one when they put the final rules out, but we have to make our decisions now to meet the timeframes that the carriers and the consumers need. And I thank the team who we worked with because we all understood that.

And it’s very interesting though talking to Dr. Scalettar’s point about engaging our friends in D.C. this was one of those aspects and we brought it right back to them just about these issues and they know about them. We’re not the only state, we may have been one of the first, but we’re not the only state now saying, we are using this to set our plans now and we really want to make certain that we continue with -- we don’t have to revamp seven months down the road when they come up with a new actuarial value calculator. The Feds know that and as a result, we’re moving forward with what we’ve got.

Through that, we did -- you’ll notice on
the allowance -- we did take one allowance on the bronze plan, we’re supposed to get within two points of 60 percent and we’re a little bit north of that right now. We on the team felt, and actually talking to the Feds, is we can use the concept of reasonableness as they said, is the law was put out a couple of years ago, they have to embrace the reality of what’s going on right today, and we’re going with deductibles that are over what the law might have stated, but we’re being reasonable given what actual costs are. So the Feds are allowing us that latitude.

So with the bronze plan we let it stay where it is with the idea that with what the Feds have told us about what we can expect in the next calculator that bronze plan might come down south of 62.0. But again, it’s a discipline. We weren’t slave to the tool, we were a slave to the values and the assumptions of the actuarial science behind it.

MR. TESSIER: Thank you. Excuse me. I guess the question that remains for me, I’m wondering if certainly not for this year, but Kevin, you’ve talked about this being an iterative process in a number of different ways. I’m wondering if as we go forward will we have access to Connecticut-specific data that we’re
comfortable with and that we’ll be able to verify the accuracy of the targets and those kinds of things?

M. V. LOON: Yes sir. It’s an option and of course, we will make certain that we have the right data working with our various partners, public and private, and of course as we adjust to use the data we’ll be coming back to the Board with any approvals that we need from you. But the law specifically states that we have the option in 2015 of using Connecticut specific data.

M. TESSIER: Thank you.

C. WYMAN: Ben?

M. BARNES: Just so I understand what that -- thank you for the question, it was helpful, but it also raised another question for me. Ultimately though, as I understand it, the metal tiers are intended to provide sort of benchmarks or points of comparability for consumers to compare different plans and regardless of its imperfections or its use of national or statewide data ultimately the two bronze plans are going to be similar in terms of their value to a customer and to the extent that a bronze plan actually isn’t at 60 percent under the Connecticut marquee conditions, it’s more like whatever, 72 percent or something like that, because Connecticut is
a higher cost environment, that’s going to be built into
the pricing by the insurance companies, but the plans, the
two bronze plans will be similar in terms of value to
customers. So even while I appreciate that we may want to
have it better targeted to Connecticut’s marketplace in
the future for a lot of policy reasons in terms of its
function for consumers that’s not a concern in the short
run. Am I correct in that?

MR. PORTER: Yeah, that’s correct. And
that’s one of the reasons why you want to use the federal
AV calculator and have the plans use that so that they are
all using the same assumptions.

MR. BARNES: Okay.

MR. PORTER: So, you’re right, they could
all be inflated or deflated relative to the number
computed here, but it’ll be across the board.

MR. BARNES: Right. And to the person
shopping they’re going to look at, oh, 62.50 out-of-
pocket, I mean, my goodness, I have to pay $250 with the
prescription drugs every year, do I want to pay more
premium to get a lower deductible in an area that I think
I’ll use? So customers will probably not be embracing the
actuarial value concept other than as a way to kind of
keep score maybe.
MR. PORTER: And it’s useful to note that the premiums that will be available, the premium credits available from the federal government will be pegged to these plans, and so it could increase the value of those premiums for Connecticut residents relative to the lower cost states.

MR. BARNES: Oh, that’s an interesting point. So we might get higher levels of premium for richer plans given the bias created by a high-cost environment?

MR. PORTER: Correct. Because the assumption is that --

MR. BARNES: That’s favorable. I can live with that.

CHAIRPERSON WYMAN: Yes.

MR. VAN LOON: If I may? As we work through these the concept affordability came up again and again in the fact that some of these deductibles that we have up here we got from people on the team and from people in the public that it’s still unaffordable and it’s very difficult for a lot of the people that they represent to meet some of these deductibles. And we have the chance, and I don’t think that -- we don’t have an
absolute answer, but there was a process in the ACA to try
to accommodate or to mitigate some of the out-of-pocket
maximums and the out-of-pocket costs for individuals on
the lower end of the income scale and that was a cost-
sharing reductions around the silver plans. And if it’s
all right by the Board, if we can move to that and explain
how that impacts, I’ll turn it over to Grant and he’ll go
through the different aspects of the cost-sharing
reductions.

MR. PORTER: Sure. As Peter mentioned,
there’s great concern over that deductible and we did look
at -- just before moving into the silver alternatives, we
did look at alternative designs for the silver baseline,
that benchmark. For example, you could lower the
deductible from $2,500 to $1,500, but everything would be
subject to that deductible. So if you needed to go see a
primary care doctor for anything other than preventative
care you’d be paying that entire bill until you reach that
$1,500 deductible. And so we -- there was a preference
for increasing the deductible, but making it only
applicable to hospital services. So that was a decision
point made early on and then it was -- you’ll see how that
follows through in each of the silver alternatives.

So the ACA allows, and the federal
government will be financing these cost-sharing reduction plans, so the premium has been set by the silver plan. That has a 70 percent actuarial value and that’s going to be supported by the advanced premium tax credits.

There’s additional subsidies available for individuals between 100 and 250 percent of poverty to lower their out-of-pocket costs. They’ll still have the same responsibilities towards the premium, but they’re going to be getting a much more generous plan, a richer benefit, than the silver baseline. So what that allows us to do is you’ll see progressively lower the deductible and progressively lower the co-pays for the different services.

So for someone earning between 200 and 250 percent of the poverty line the actuarial value of this plan increases from 71.2 to 74 percent, so a marginal increase. But your out-of-pocket maximum reduces by about $1,000 and the deductible for their hospital care reduces from 2,500 to 2,250 and for prescription drugs it would reduce it from $200 to $150. We also lowered the co-pays on primary care and mental health.

And then, so as you move further down amongst the federal poverty line you’ll see a further reduction in the deductible and you get a significant jump
once you move below 200 percent of poverty. So between 150 to 200 percent of poverty enrollees are eligible for this 87 percent actuarial value plan. Again, they are paying a premium associated with a 70 percent silver, but they’re getting a much more richer benefit. For this plan the deductible for medical benefits is just 500 and it’s waived for prescription drugs. The co-pays would go from a 30/45 plan to a 15/30 plan for primary care and specialist visits and the inpatient admissions for hospitals and outpatient surgeries and skilled nursing homes reduces from $500-$250 for a max of two days.

Finally, between 100 and 150 percent of poverty, it won’t be many people, because most of these people will be enrolled through Medicaid, but for those who are ineligible for Medicaid, or above 138 percent of poverty the plan has no deductible and a maximum out-of-pocket of 2,250, which given the co-pays is unlikely to be reached because there’s a $5 co-pay for primary care and mental health, $15 for specialists, and the hospital care is only 250 -- not only, but it’s at $250 per day for a maximum of two days per admission.

MR. VAN LOON: We went through this with some of our constituents and stakeholders and I’d be remiss in saying that one of the -- a couple of the people
on the consumer advocacy panel came up with the explicit
direction that they appreciated the fact that the cost-
sharing reductions in the silver plans attempt to mitigate
the out-of-pocket costs, but they made the comment that
even people between 100 and 150 percent it’s still a huge
burden for people to bear. But they also recognize that
we were working under, and subject to, the actuarial
science that brought us to this plan design.

   MS. VELTRI: Thank you. Just maybe a
question or comment. Obviously, the AV calculator is a
math exercise, right? I mean, fundamentally that’s what
it is. And we don’t really have that much control over
what we can do about it. And it has nothing to do with
the premium other than -- I mean, the AV amount, we have
no idea what the premiums will be yet, right? Am I right?

   MR. PORTER: Correct.

   MS. VELTRI: Okay. I mean, so just going
back to what Ben had said earlier, I think it may be
important to note that, I mean, if premiums are higher the
subsidies are higher, but the premiums are higher and
that’s an issue because 30 percent of the people that
we’re trying to reach are above the subsidy level. And
even those who I think are at the subsidy level, like
Peter just said, may be struggling a little. So I just
think we have to keep that in mind as we’re going. It has nothing to do with this and I think everybody understood that and that’s why it was such an effective process, everybody really understood what the AV calculator and what we are required to do in terms of plan design.

But I do think -- and I think all of us around the table recognize the issue that this is not the premium, this is just the AV -- the cost-sharing. So in our strategy group meeting we are going to have later I think this will obviously be one of the topics that we do still need to take on, the affordability issues, which are somewhat out of the control of the Board itself. I do think we need to address it.

MR. COUNIHAN: And the Exchange.

MS. VELTRI: And the Exchange, yes.

CHAIRPERSON WYMAN: Anne Melissa?

MS. ANNE MELISSA DOWLING: Hi. One other thing to remind us though is that this is one option that you guys have worked so hard, so hard to come to, but we also are permitting carriers to submit one other plan of their own design and, you know, early feedback is that matches some of this, but it has the potential to be quite a bit more affordable. More targeted, narrower, all of that. The question I have, and I’m sorry to bring it, but
can I just get reminded why we limited it to one? Is it really just because the system is so new we just probably couldn’t handle multiple other inputs from the carriers in year one? Or -- I just could not remember why we limited them to one alternative. And that would be a fair answer, if it was we could only handle, you know, one additional design.

MR. VAN LOON: The -- I’m channeling back to our Board meeting of the end of November and I remember the concept of, we’re starting new, let’s keep it basic, and there was a -- we ended up using what the advisory committees came up with and it was just offering one standard with one non -- excuse me, nonstandard option with the idea that as we get started let’s keep it as simple as we can with the idea that going forward we can in the second year certainly increase.

MS. DOWLING: That’s fair. So if it’s really just how much you can handle all at once, if that’s the answer, that’s fine.

MR. COUNIHAN: Actually, Anne Melissa, it’s a good question. I believe what the Board had decided is that for the initial period we’re going to go one and one for metal tier, but moving into the second year we were going to go one plus two. So it was really too, as Peter
said, it was just -- if we get five health plans, which we are very hopeful that we can to participate, that’s 40 options for folks. And we thought that for this initial period, I think the Board believed that it made sense just to get people acquainted with how that would work and make it as easy and simple as possible. And then in the next second year provide the chair with two options per metal tier.

MS. DOWLING: The good news is I think there’s some energy from the carriers to offer more. So that’s good news.

MR. COUNIHAN: That’s right.

MS. DOWLING: And it’s, you know, probably a bit frustrating that they’re going to have to wait, you know? But I understand, we’re bound by, you know, probably some just newness.

MR. COUNIHAN: Yeah. Right.

CHAIRPERSON WYMAN: Ben?

MR. BARNES: I just have -- I’m just trying to make sure I keep all of the moving pieces of how this is going to impact people so as we begin to see what some of the pricing information is, and I’d like to get -- if you could tell me sort of when we’re going to start to see some of the premium information becoming available. So in
addition to, if I’m a household between 150 and 200 percent of the federal poverty level I can buy a silver plan with a subsidy -- a subsidize premium, which is subsidized based on my income level, and then that subsidy will be sort of reinforced by additional subsidy paid through the Exchange to the insurer to provide a version of the silver plan that has lower out-of-pocket costs?

MR. PORTER: Correct.

MR. BARNES: So the subsidy comes in two ways, one of them is sort of direct on the premium, and one of them is related to the difference in cost between the base silver plan and the enhanced silver plan?

MR. PORTER: Right.

MR. VAN LOON: First of all, Jim hit me upside the head and wanted me to reiterate the fact that the system, our technology can handle any number of options, but the idea to be simple to the consumers and the administration is something that when we want to expand we’ll have a technology that will be able to do that. But that technology and that process that we’re putting together is to deem the eligibility for all these different options as people come in, you know, where are they on the income scale? Working with the Feds, reaching out to them through the federal data hub to validate what
people are telling us so that when we deem them eligible for a certain level of premium tax credit or a silver cost reduction, cost-sharing reduction plan, that we have facts to develop that eligibility.

But your point sir, I want to stress is, we get that information and people make the decision of what plan they’re going to choose. We take that electronic information and we ship it to the plan and to the Feds with the idea that the Feds and the Department of the Treasury, we use that information to ship the money to the respective plans. We on the Exchange are working to avoid having to handle all of that money and all of that cash.

MR. BARNES: But you’re sort of part of the direction of identifying where it should go?

MR. VAN LOON: Right. We are actually responsible for that, but just from an old control of cash flow perspective --

MR. BARNES: I understand that.

MR. VAN LOON: -- we’re more than happy to have the actual cash go between people that aren’t us.

MR. BARNES: Okay. Now, and then the last question is, these cost-sharing reduction options are only available for the silver plan. So if I am a low income person 150, 200 percent say, I could elect to buy a bronze
plan if I wanted, because I think I’m healthy and I’m never going to go to the doctor and I don’t care, but the incentives are set up to provide significantly -- significant incentives for me to buy the higher actuarial value plan because it comes with the cost-sharing reduction enhancement, which is not available for the other levels?

MR. PORTER: Correct. So, I mean, that’s a good question and states are grappling with what the solution to that is. Because as the Exchange, you could direct that individual to just purchase that plan, that silver plan, and make them have to jump through hoops to get to the bronze level. So you’re encouraging them to buy that silver cost-sharing reduction plan that is much more -- has a much richer benefit. But if they’re worried about, if they don’t want to pay the $75 monthly premium that they’d have to pay, and they prefer to pay $50 or $40, which they could do if they bought the bronze plan, but really they’re comparing now a 60 percent actuarial value plan to and 84 percent actuarial -- 87 percent actuarial plan.

MR. BARNES: And so -- and we’re taking steps to ensure why obviously that’s a choice that individuals may choose to make on either side of that
call, we’re taking steps to ensure that nobody would make the decision to buy a bronze plan based on a lower premium amount without fully understanding the value of the out-of-pocket cost reductions --

MR. PORTER: Correct.

MR. BARNES: -- okay. Thank you.

MR. VAN LOON: And sir, you introduced a concept that came up in a lot of our discussions is, the need to engage the consumer’s with education through our broker navigators and appropriate public relations in-person assisters. We can’t just develop the people and the process and the technology and expect it’s all going to work, we have to reach out to the people and educate and engage.

MR. COUNIHAN: And frankly Ben, you know, I could tell you based on past life, it’s very hard to do. I mean, it’s critical that we do it, and we’re committed to doing it, but it’s not easy.

MR. BARNES: Yeah. No, I’m glad I have employer provided insurance.

MR. COUNIHAN: Yeah. People just -- all of the stuff we take for granted, deductible, co-pay, network, coinsurance, the average consumer does not necessarily understand or is it really that interested in,
and it’s very, very hard. So we’re planning on actually just showing examples, because that’s actually the most effective way. So if someone breaks an arm how would that look under bronze? How would that look under silver? How would that look under gold? So just some -- we’re trying to make it as tangible as possible.

MR. BARNES: Yeah. I think that’s a very good approach.

MS. FOX: I have one comment and one question. My comment is just that I think we really need to continue to think about sustainability, because all of these questions that we’re asking are around, you know, the first year or so until we maybe don’t have this level of subsidy and we have to be able to have a financial model for the Exchange that is durable. So I don’t want to get ahead of ourselves, we’ve made good progress, but that is a very big question for me and for us I think.

The other question I have is, you know, the innovative designs that the carriers seem anxious to put forward, do we know how we’re going to categorize they come through the metal tiers? I mean, how innovative are they and how different will they look and how do we categorize so that they come up for review for some of the options? That’s, you know, part A of the question about
he innovation and the design. And then secondly, we may have some designs that really do get at cost. Maybe not first year, but I suspect there will be a few. We will have a track record after the first year and see how the lower-cost plans actually get picked up by consumers and how they work. How are we going -- are we thinking about accommodating all of that?

MR. WADLEIGH: Thanks Mary. One of the things that I was quickly jotting notes to Peter over here was exactly around that. So there have been a lot of conversations. As interested as our advisory committees are, the carriers for different reasons are just as interested about how our sort and selection criteria will be based into our system. Right now, what we are expecting is we are going to default to the silver plans because those plans will allow our customers that fall into the federal poverty levels the premium tax credits. That’ll be the first selection criteria.

We expect that premium will be that next sort and from there we continue to work through some of the remaining items on how -- whether it’s quality, if we have that information when we start, but a myriad of things. The carriers are also asking the same question, I would presume, actually, I’m not even going to presume,
but they are asking the same question from their point of view as well.

MS. FOX: Thank you.

CHAIRPERSON WYMAN: Thank you. Are there any other questions? Okay.

A FEMALE VOICE: We’ll distribute a test.

CHAIRPERSON WYMAN: Yeah. No.

(Laughter)

MR. PORTER: I’ll quickly go through the prescription drug benefit for each of the metal tiers because it’s sort of comparable across the different levels. We stuck for the most part with a three tier prescription drug benefit with a separate specialty drug tier. There is a 10/25/40 breakdown with a 50 percent coinsurance on specialty drugs. Again, in the bronze plan it had a $250 deductible, silver had a $200 deductible, gold $150 deductible, and the platinum zero. I just want to make sure I’m correct with those numbers. Yes. And for all of them we waived the co-pay -- we waived the deductible for the generic drugs. That was important to the group.

And with respect to the cost-sharing reduction plans for the first tier, the 73 percent AV with a 10/25/50 50 percent, 10/25/40 50 percent breakdown, so
the same as the silver with a lower deductible. And then
as you move down in poverty and up in the AV for the other
silvers -- silver alternatives it was a 5/15/30 and
instead of a coinsurance on that specialty drug it was a
flat co-pay of $40.

So any questions on the prescription drug
benefits?

CHAIRPERSON WYMAN: I gather the way you’re
planning that is the carriers that are delivering the
health care benefits are going to be delivering the drug
plans?

MR. PORTER: Yeah. At this stage the
essential health plan is inclusive of prescription drugs.
The only exception is the standalone dental so that it’s
the expectation that the base medical plan will have
incorporated the prescription drug benefit.

CHAIRPERSON WYMAN: And I know the carriers
in the room are not going to be happy with what I’m
saying, but it has proven for the health care plan for the
State at some point that we did split that and there was a
major cost savings. So I’m hoping that in the future
we’re going to see some kind of changes in that.

MR. PORTER: Yeah, that’s certainly
something that we would like to explore. It would require
a federal waiver I would presume. The Exchange certainly does not allow for that currently.

CHAIRPERSON WYMAN: Maybe something I think we should be exploring with the federal government to give us a little bit more leeway.

MR. TESSIER: I would agree with you Governor especially in light of this specialty drug co-pay at 50 percent. The number of drugs being added to specialty pharmacy, both currently and the projections for the future are enormous, and those costs are going to be just unaffordable for lots and lots of people at 50 percent. And in the same way that negotiating, or a separate program with standalone PBM’s, the same applies with specialty pharmacies as well. It’s a real opportunity for savings.

MR. PORTER: Certainly.

CHAIRPERSON WYMAN: I would want to take -- I just don’t want to take that off the table for us. And, you know, in discussions with Washington that I think should be, you know, put on the table for them also. Any other questions on the drugs? Okay.

MR. PORTER: So finally, in sort of the 11th hour of our working group team meetings we tackled some of the other benefits. So these are benefits that
were not directly addressed by the AV calculator. For the most part, the AV calculator probably reflects well over 95 percent of medical expenditures. So these are somewhat ancillary. Some are included in the AV calculator, we just wanted to draw them out so that specific limits could be imposed on them. For example, the emergency room is included in the AV calculator, but we included it on the other benefits just to put it in comparison with urgent care and walk-in centers and ambulance transportation.

So these are again, the co-pays typically get lower as you move across the metal tiers and they’re reflective of what we saw in the market today. So we didn’t want to -- because they’re not all tied into the AV calculator we didn’t want to -- we couldn’t afford to have zero co-pays on all of these because that could really impact what the overall AV of the plans would be. And they’re still supposed to be in that -- those specific metal tiers. So these are reflective of what’s in the market today and seemed reasonable to staff in the working group.

And again, in the bronze plan the deductible applies to most of the items there. We excluded it from the diabetes education because that’s sort of a primary care service. But with the silver plan
it’s only the inpatient services which the deductible applies to, all of the outpatient services it doesn’t have the deductible. Likewise on the gold and platinum.

CHAIRPERSON WYMAN: Can I ask you just a quick question? Maybe this is kind of going backwards a little bit maybe, but you have that the outpatient surgery is the same kind of price as the inpatient surgery. And done in outpatient centers rather than in hospitals. Everything we’ve seen the cost of outpatient or in surgical centers rather than hospitals are less expensive, but we have the same co-pay on that. Have we thought of that as -- we want to gear more patients to more -- rather than the hospitals and not anything against the hospitals, but we know the cost is higher in the hospitals.

MR. PORTER: Correct. If we were to do a coinsurance model that would be reflected in the coinsurance, but because we have a co-payment that has a maximum co-pay of $500 that’s a reasonable co-pay for both inpatient and outpatient services. So whether it’s -- if it’s a hospital visit it will run several thousand dollars per day, and outpatient surgery will also run several thousand dollars, not as many thousands, but -- so in both cases you’re getting a significant benefit with that $500 co-pay. It’s more, it’s greater with the inpatient
hospital services, but given the limitations of what the
maximum co-pay can be it seemed reasonable.

CHAIRPERSON WYMAN: The whole thing is just
trying to keep costs down and so to me it’s, you know, we
go just as long as it’s good care to someplace that’s
going to deliver service at a less cost. And I think as
we go forward I would like to -- for you all to kind of
look at, you know, steering people to getting great
treatment but where we can have a lower cost and that it
shows on here.

MR. VAN LOON: Lieutenant Governor, you
just in miniature you just replicated so many of our
discussions over the last couple of weeks as far as
working with the trade-offs that we have to experience.
And what we reiterate again that even as we come up with
the standard plan designs we’re going to adjust and adapt
based on the reality and the input, not just from the
Board, but also from the public.

If I may, just -- we’ve gone through the
plans, I’d like to just go back a little bit on the
process that we followed. As I said, we worked with that
team, they were delegated by their advisory committees to
help develop the advice for the staff. As we walked
through I called and asked for votes on all of these from
the team and we didn’t get any negative votes on any of
the plans that you see. We’ve got people that said, you
know, we understand this is a compromise and we’re voting
yes with the idea that we continue to stress the need for
affordability going forward.

But everybody was positive, no negative
votes. Doctor -- I was going to say, Dr. McLean was not
at those meetings the last night, but he did review what
we put out and he approved it. So the official vote that
we had on Tuesday night, but he was definitely in favor.
With that, the team asked us to inform the advisory
committees of their decisions and their advice to us and
the staff and we did that last night over a couple of
hours. It was a purely informational session. We got a
lot of good questions, some were the same here, and we
appreciated that to get, you know, even more input. And
the affordability kept coming through.

But I don’t know, Virginia, exactly what
the right format is, but we wanted to -- before we got
into the lessons learned and our next steps ask the Board
to approve the standard plan designs as brought up and
recommended to the staff by the team that we put together.
I’d also like to say that what we’re advocating is
exactly what the team gave us as far as advice.
CHAIRPERSON WYMAN: Peter, I’m going to ask for a motion from the Board to do that. I just wanted to make sure everybody had their questions. And please, don’t take my question incorrectly, I just think that as we go forward we’re going to have to look at other things. I think what you all presented today is great, and I’d, you know, but of course there’s going to be a lot more questions when we see what the actual costs are, you know? And Grant, you have --

MR. PORTER: Yeah. I could respond a little bit to that last point. In many situations where we thought that the consumer was actually the one that made the choice and we tried to direct them towards the cheaper or the, you know, better care, that was represented by the E.R. versus the urgent care, sort of like lower co-pay as you move down from an E.R. to an urgent care to a walk-in clinic to the primary care providers, you know, doctor’s office, I’m not sure that the consumer is the one that decides whether the surgery is going to be done out patient or hospital. Certainly in my experience you go to the surgeon and they tell you, it will be done, and they will tell you where it’s going to be done. So I’m not sure that the consumer can push back and say, well, you know, I get a lower co-pay if you do it
over at the ambulatory care. There are so many factors that determine for the physician whether they do it in a hospital versus the ambulatory care center, I think they are the one that really makes that decision.

CHAIRPERSON WYMAN: That’s very true. And I don’t disagree with you on that, but I think that there are -- especially on one-day surgeries, there are --

MR. PORTER: Oh, they are much cheaper.

CHAIRPERSON WYMAN: -- they are much cheaper. And that surgeons, if you’re going to that doctor anyway, the doctor is going to choose whichever one is best that they can get into at that time, and I understand that. But I’m just saying, if we can give a push -- I think earlier we talked about -- Kevin said something about fractured arms and how you can -- as a former x-ray technician it’s easier to do it -- it’s just as -- if it’s a minor fracture compared to where you’re going to have to do surgery on it you’re going to take that person out of the doctor’s office. But if you can set that arm in the doctor’s office it’s going to be a lot cheaper if it’s a minor fracture. You know, I’m just saying we should be looking at what could be out there.

Jewel, Commissioner?

COMMISSIONER JEWEL MULLEN: I wanted to
remind us that there is more than one side to this
equation in terms of consumer choice. And I appreciate
that not only do the different tiers enable people to
actually, you know, have a chance to choose what might be
best for them, since they fall within that -- under the
bell curve of individual patient there’s a lot of
variability. But the other side of directing consumers to
sites of care requires adequate information provided at
the time. And anybody who found out that their co-pay was
going to be more after they went to a certain place for a
procedure to be done, but the doctor’s office didn’t
inform them, knows that there’s this other piece of
obligation on the side of the provider so that the
consumer can make the best choice.

So that might not be the work that we do
specifically, but it’s important work to be done with the
hospitals and provider groups.

CHAIRPERSON WYMAN: All right.

MR. VAN LOON: If I may Lieutenant
Governor? Just to finish up with some of the lessons
learned and what we’re doing, because we’re not quite done
yet. Lessons learned, trade-offs. The team understands
this is a series of compromises. You can’t get everything
that you want and we appreciated that collaborative
We also recognize that setting the standard plan design based on actuarial value is not the same thing as setting a premium, but to Secretary Barnes’ standpoint, part of the reason that we’ve been under this time pressure to do that, to set the standard plan designs is so that we can get those standard plan designs to the carriers so they can have time to develop their plans, come up with the rates, and then submit them to the CID for their approval or review. Affordability keeps coming up and everybody on the team recognized, and I daresay, I think we started to get across the point to some of the deeper membership of the advisory committee that we’re subject to actuarial science.

And the other part of this process was we got a lot of people thinking about other aspects that we have to work on as far as the Exchange outside of the standard plan designs. And we talked about some of that today, the education, the consumer shopping experience. Another one, particularly, our relationship with the Department of Social Services and ensure that our operating model is dovetailed with the folks that administer Medicaid.

In the short term we got a lot of
questions, we are developing those questions to get them up on the website. But we look to continue this process of collaboration going forward. We’ve got next steps. In February, one part of the other benefits that we could not get a decision on was the out of network, deductibles and coinsurances there. The staff has worked for the team as far as actuarial input on the premium impact of the best deductible coinsurance options and what we can do and cannot do with the out-of-pocket maximums.

We also have a standalone dental plan that we have to lock down. We believe that these two aspects, you know, we need to get them done quickly, but with what we’ve done in the last month, and hopefully what we get approved by the Board today, we’ll get the carriers what they need to get going on their rate filings and plan design.

Next steps looking forward, we understand that anything that we do today, tomorrow, the next day is still going to have to adjust to the emerging rules that come from CCIIO. And we also recognize that with the new legislative that there could be potentially new Connecticut state laws and regulations that we’re going to have to adjust and adapt to. So we’re definitely open to that, but I just want the Board to know that as we work to
set this, if not in stone, but in concrete so that we can work through this next year. We recognize that there are forces at work that we’re going to have to subordinate our work to going forward and we will. And with that, Lieutenant Governor, I’ll turn it back to you.

CHAIRPERSON WYMAN: Does anybody have any questions before I ask for a motion? Go ahead.

MS. VELTRI: So my suggestion would be, I mean, independent of -- excuse me, the vote that we’re about to take, is that, you know, as Anne Melissa said earlier, you know, the carriers are talking about maybe more flexible plan designs than what were offering. The sooner that gets in front of people for people to understand what those flexible -- to the degree of flexibility we have with, you know, one additional option right now, that people know about that and potential options that they might see, for instance, I mean, maybe one of the plan -- carriers plan designs, I don’t know this, but you know, one of them may have differing co-pays for outpatient surgical versus hospital day surgery or something. I mean, things like that. It would be good for I think everybody to know as we go along rather than kind of wait and down the road after the rate filings are done. And those are publicly available. CID has them on
their website, people can see them. But I think the sooner the information becomes available and people see it the better.

I will say, since we’re going to be doing the independent assister program in partnership with the Exchange, I mean, we are committed to a ground game effort. And I’m talking really literally ground game, one-to-one with consumers in the communities explaining what’s available, what isn’t available, educating them about what the Exchange is and what it isn’t and what plans are available to them. I think that will also be helpful in getting people educated and understanding really what we’re trying to do here. I do think, I mean, there are certain realistic things we have to be able to explain to consumers about what we’re doing that the Exchange may or may not be able to achieve on its own that are just broader health reform issues. So I just wanted to bring all that out before we vote.

CHAIRPERSON WYMAN: Okay. So at this time I’m going to ask for a motion to approve what the staff has presented on as the four metal tier for the qualified health care plan. So I’m going to ask for a motion?

A MALE VOICE: So moved.

CHAIRPERSON WYMAN: So moved? And the
second?

A FEMALE VOICE: Second.

CHAIRPERSON WYMAN: Second. All in favor of the plans say aye?

VOICES: Aye.

CHAIRPERSON WYMAN: Opposed? Okay they have passed. That was easy.

MR. COUNIHAN: Lieutenant Governor?

CHAIRPERSON WYMAN: I think.

MR. COUNIHAN: Lieutenant Governor? I just quickly I just wanted to thank the Board for that vote. Thank the Committee once again for it’s work. Specifically thank some Board members, Grant and Melissa and Vicki for all of the time that they have spent helping us on this. To Maryellen Breault for all of the technical support that she provided. And from our team, Peter and Grant for all of their terrific work.

CHAIRPERSON WYMAN: Yes. I want to ditto that and for all of the advisory committee people that have been involved in this on the grass root level. I know there was a two hour discussion last night and I want to thank you for doing that because I gather it answered a lot of questions and people understood. So I do want to thank everybody for all the work. And Kevin, I thank you
for your leadership on this also.

So at this point I’m going to -- the next meeting is scheduled for February 21st. Are you saying something? Do you want to say something again?

MS. VELTRI: Yes. Well, this is really important.

CHAIRPERSON WYMAN: Who voted you for Vice Chairman?

MS. VELTRI: I know, yeah, she’s going to take it back. Actually, no, this is important. I wanted to do this. Jason isn’t here and we talked about this. Kevin I think already knows, he’s announced about the independent assister program. We are posting today the Exchange is going to be posting on its website, OHA is going to be posting on its website, four positions for the independent assister program that will be available. A manager’s position to oversee it, training coordinator, a recruiting coordinator, and an AA. So I wanted to make sure I made that announcement here so people would look at the websites and tell your friends, tell your families, about these openings.

CHAIRPERSON WYMAN: Great. Thank you.

Good idea. Yes?

DR. SCALETTRAR: So as long as you’ve opened
all of this up could you update us on a couple of things? I heard at the beginning that the navigator program was going to be under OHA. The last meeting the conversation was, so how do we fund the navigators? So an update on the funding of navigators. And then, the in-person assister, we were in the process of submitting a grant, and the status on the grant.

CHAIRPERSON WYMAN: Do you want -- Kevin, do you want to update?

MR. COUNIHAN: Sure. I’ll take some of this in reverse Bob. We actually have a phone call at 11:30 with CMS to talk about the grant or about the funding for the in-person assistance program. My colleague and late-night e-mail crime Vicki responded within a nanosecond to the questions that were raised by CMS. I guess that was Tuesday night or something, at 11:30. But we are talking to them this morning and so we should know -- we have to have our written responses in by the 30th, Bob. We’re tracking very well with respect to getting that money. What was the other --

CHAIRPERSON WYMAN: Funding the navigator.

MR. COUNIHAN: -- oh, was it --

CHAIRPERSON WYMAN: Navigator funding.

MR. COUNIHAN: -- oh, the funding, yes. So
we are continuing to work at options for that funding.
We’ve had some discussions with some foundations in the
state who have expressed interest in supporting us in that
and we’re making a presentation to one of them, I believe,
in February. So we’re making progress on that.

That’s one of the issues, excuse me, as an
aside, that apparently the CEOs are bringing up with CMS
on Monday.

CHAIRPERSON WYMAN: Okay. Good. And I
won’t cut this off, I really don’t want to, but are there
any other questions or concerns? Okay. Then I will cut
it off. Okay. So the next meeting is February 21st at
9:00 o’clock and it will be at the state capital in room
310. So at this time I need a request for adjourn -- a
motion for adjournment?

A MALE VOICE: So moved.
CHAIRPERSON WYMAN: So moved and seconded.
All in favor?
VOICES: Aye.
CHAIRPERSON WYMAN: Thank you all very,
very much. And again, thank you to everybody for all the
work you’ve put in.

(Whereupon, the meeting adjourned at 10:24
a.m.)