



STATE OF CONNECTICUT  
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange  
Board of Directors Special Meeting

Connecticut Historical Society  
One Elizabeth Street  
Hartford, CT 06015

Thursday, March 14, 2013  
**DRAFT Meeting Minutes**

**Members Present:**

Lieutenant Governor Nancy Wyman (Chair); Grant Ritter; Mary Fox; Robert Tessier; Vicki Veltri, Office of the Healthcare Advocate; Secretary Benjamin Barnes, Office of Policy and Management; Deputy Commissioner Anne Melissa Dowling, CT Insurance Department (CID); Commissioner Roderick L. Bremby, Department of Social Services (DSS), Cecilia Woods, Vice Chair Permanent Commission on Women; and Paul Philpott.

**Members Absent:** Dr. Jewel Mullen, Commissioner, Department of Public Health.

**Members Participating by Telephone:** Dr. Robert Scalettar

**Other Participants:**

Health Insurance Exchange (HIX) Staff: Kevin Counihan, Julie Lyons, Grant Porter, James Wadleigh, Steve Sigal, Peter Van Loon; Virginia Lamb; Paul Hencoski, KPMG.

**The Meeting of the Connecticut Health Insurance Exchange Board of Directors was called to order at 9:00 a.m.**

**I. Call to Order, Introductions and Announcements**

Lt. Governor Wyman opened the meeting at 9:00 a.m.

Lt. Governor welcomed and swore Paul Philpott in as a new board member. Mr. Philpott was appointed by Senator McKinney.

II. **Public Comment**

Mario Roman provided a public comment.  
Mary Moran Boudreau provided a public comment.  
Sheldon Toubman provided a public comment.

**Amendments to Agenda**

Lt. Governor Wyman requested a motion to alter the agenda to remove Essential Community Providers. Motion was made by Roderick Bremby and seconded by Vicki Veltri. ***Motion passed unanimously.***

III. **Review and Approval of Minutes**

Lt. Governor Wyman requested a motion to approve the minutes from the February 21, 2013 meeting. Motion was made by Robert Tessier and seconded by Vicki Veltri. Cecilia Woods asked that the reference in the minutes to Jennifer Jaffe be corrected to reflect that during the rate review process, Ms. Jaffe had provided substantive feedback to the Connecticut Insurance Department on rates.

***Motion as corrected passed unanimously.***

IV. **CEO Report**

Kevin Counihan, CEO, provided a report on Access Health CT's activities. Mr. Counihan clarified information in a recent article regarding the Exchange in ***The Hill***. Mr. Counihan had given an interview to the AP regarding implementation of the ACA and the Exchange's recent decision to defer any implementation of new laws, regulations, policies, etc. coming out of HHS and CMS until later so that the Exchange could be ready on October 1, 2013 for open enrollment. CCIIO was very supportive and understanding and were surprised more states hadn't requested the same accommodation. ***The Hill*** had suggested that Connecticut refused the implementation of new guidance, which was inaccurate.

The Exchange continues to make steady progress. The complexity of the project is not changing. There will be periods of yellows, reds, and greens and we are working through the challenges of completing a 3 year implementation in 10 months. CMS conducted an unexpected evaluation of Connecticut and all state-based exchanges, and Connecticut passed with flying colors. Wave I Testing of the Federal Data Hub will begin on March 20. CMS security team will be on-site from March 19-21 for further testing. The Exchange is on track for Release 1 implementation on June 4, and is also on track for Release 2 implementation on October 1.

Operations

- The Exchange continues to integrate new vendors in its operations, and has begun the contracting process with a new SHOP vendor. For State Run and Federally Facilitated

Exchanges, HHS has deferred SHOP employee choice requirements to January 1, 2015. Connecticut will be fully functional with its SHOP Exchange on January 1, 2014.

- We are hiring an actuary to better understand proposed rates by the carriers.
- The Exchange met with the basic health plan work group last week regarding collection of information and potential BHP enrollees.
- The Exchange is now finishing up the second round of Healthy Chats. The Exchange thanks our Board members, Jill Zorn and others for their assistance serving on the panels.
- Navigator grant funding is in progress and Vicki Veltri was thanked for her assistance.
- The Exchange has had encouraging meetings with several financial and retail firms for in-store signage during the open enrollment period.
- APCD – The search for executive director for the APCD is underway. The RFP for data warehousing is in process, and the APCD Advisory Council meeting will be scheduled for April.
- The Exchange thanked the Connecticut Insurance Department, specifically Anne Melissa Dowling, John Arsenault, Beth Cook, Mary Ellen Breault and Paul Lombardo, for their continued assistance as well as their detailed and informative presentation on the rate approval process at the February Board meeting.
- The Exchange also thanked DSS, specifically Commissioner Bremby, Lou Polzella, Vance Dean, Kristin Dowty and Julia Lentini-Marquis, for all of their ongoing support help.
- Mark Raymond and Eric Lindquist of BEST were thanked for their work.
- Joint Team Work Group was also thanked.
- Finally, the Lieutenant Governor was thanked for her consistent support and most recently, for her willingness to join the Exchange team at an important Design Review meeting at CMS in two weeks.

#### V. **Operations and Information Technology Update**

Peter Van Loon, COO provided the operations up date. The Exchange continues to recruit and hire the staff necessary to stand-up the Exchange. New staff members include Kathleen Tallarita, Kate Gervais, Jeff DiGirolamo, Matt Salner and James Michel. Currently, Exchange staff is managing over 4,000 lines of various interdependencies and tasks on a daily basis. Dashboards are updated weekly and senior leadership team meetings are held weekly to coordinate activities. PMO meetings are also held weekly. Feedback from the Board has been reviewed and incorporated into project plans. Risks are categorized as being either: a scope; resource; quality; or schedule risk and are addressed on an on-going basis. The Exchange is on track for the October 1, 2013 “Go-live” date.

Jim Wadleigh, CIO provided the IT update. IT risks change from day to day and are common for projects of this size, complexity and aggressive timeline. Currently a key risk is completing all documents necessary for the Design Detail Review scheduled with the Federal team at the end of the month. A second risk is the need to meet the newly released absolute minimum

benchmark dates set by the Federal team for all states. To comply, 70% of IT development must be completed by the end of May. The Exchange team is also working with CMS and CCIIO to determine the exact definition of completion for each benchmark task. The Exchange Team communicates with the Federal team on almost a daily basis to clarify expectations. The Exchange uses the waterfall approach for project management. This means that when one project is completed, the Exchange moves on to the next. Other states are using an agile approach, which means that each workgroup goes through requirements, design, development and testing simultaneously.

The Exchange is currently behind schedule on contracting with an Independent Validation and Verification (IV&V) vendor. This vendor will provide independent monthly status reports (audits) to CMS on the Exchange's IT progress. This is a requirement of the Level II grant that will continue on through the gate process. The Department of Social Services (DSS) plans to leverage one of its existing contracts with a vendor who meets all qualifications for IV&V. DSS has submitted its approach to CMS for review. Since this vendor is already knowledgeable about DSS, IT, there should be a quick catch up. The next risk is securing access to Department of Labor (DOL) and Department of Motor Vehicles (DMV) data for eligibility verification. Primary eligibility verification will be through the Federal Data Services HUB. The ability to access secondary data sources is being built into the project as a contingency to assist Exchange customers when, and if, the Federal Data Services HUB is unavailable or does not have the most recent data. Department of Corrections (incarceration), Department of Public Health (death certificates), DMV (state residency) and DOL (employment and income) data is needed to verify eligibility on as close to real time basis as possible. Memorandums of Understandings (MOUs) to access the required data should be finalized in May.

The Exchange has some IT quality risks. Corrections are required to design deliverables. These document corrections are being made by the Systems Integrator (SI). They do not impact the project date as design deliverables normally go through multiple iterations throughout the life of the project. Changes also need to be made when new legislation passes and as additional pieces of the project are identified. The Exchange is working closely with the Systems Integrator (SI) on drafts documents. Design confirmation requirements have been developed. As the Exchange proceeds with implementation, questions that need to be answered are listed as risks. There is a process in place to identify those risks and obtain answers through Deloitte and KPMG.

There are also scope risks. The division of labor is being developed with DSS to find the right balance of automated and manual systems. Another issue is an inconsistency in how information is gathered for the screen used by power users and staff, and the screen used by regular users. This is important because information needs to be consistent.

The Exchange is following a "no-wrong door" approach, working with consumers via the web, telephone, in person, and by paper. The Exchange is working with DSS to coordinate this approach. The Call Center contract with Maximus has been signed. Negotiations continue with the Small Employer Health Options Program (SHOP) contract. The Standard Plan designs have been redefined to incorporate new federal regulations.

Mr. Wadleigh reported that overall the Exchange is making great progress. March is an important month from a design perspective. Connecticut is one of five states, asked to

participate in the Wave I testing process. As part of Wave I, Connecticut will be providing User Acceptance Testing for the Federal Data Services Hub. This testing will begin on March 20, 2013. It provides the Exchange early entry into the development process, and allows the Exchange to learn of any issues. The Consumer Website presentation is scheduled for March 20 for all four of the Advisory Committees. This will include a walk-through demonstration of the screen shots. A Federal onsite security team review is planned for March 19 through March 21. This is the next step as preparation continues on the detailed design Gating process with the Federal government. The Federal team will walk through the BEST hosting facilities as well as the Exchange's facilities looking at such items as; whether there are security guards in the building; are security swipe cards required for access; how are the servers locked; how is personal equipment being treated; etc. CMS takes these matters very seriously. This review feeds into the detailed two day design review that will take place in Baltimore where the Exchange team will explain and share with the Federal teams and all their support groups, including the IRS, the Exchange's progress to date. This is a two day review covering designs, security and application. This review is a critical milestone in the Gate process. Mr. Coughlin underscored for the Board the importance of the March 27, 2013 meeting in Baltimore and noted that Commissioner Bremby and Lt. Governor Wyman will be participating in the first day of sessions.

Ms. Veltri thanked the staff for having the consumer website demonstration and inquired if there would be a follow-up where the live website could be demonstrated. Mr. Wadleigh responded that the goal is to have a live demonstration, but the date is uncertain, since staff needs to complete the user acceptance testing. IT will work with marketing to do focus group testing. That feedback will be incorporated into the website. The application will not be completely finished until September. Ms. Veltri suggested working with Kate Gervais and perhaps the IPAs as testers for the system.

Mr. Van Loon provided the Access Health CT critical dates including releases, milestones with carriers, design review, requirements, etc.

Paul Hencoski from KPMG provided a national context for Connecticut's project status. Categorizing certain activities as yellow (cautionary) naturally raised questions. But yellow status is not unusual. There are inherent risks in any software development lifecycle. All projects have this concept of inherent risk at some level. These risks -- scope, schedule, and quality -- exist for all Exchange projects nationwide including the Federal Exchange. The ACA has set an extraordinarily ambitious schedule for the Exchanges. Work which normally takes seven years or longer is being done in less than three years. Dealing with evolving scope is comparable to building an airplane while in flight. Many states have been frightened off in trying to attempt what Connecticut is currently doing very effectively. With respect to quality, the Exchange is attempting to build something that has never been built before. This is in and of itself inherently risky. Connecticut has the benefit of having a transfer solution from Washington, but that solution is only about a month or two ahead of Connecticut in the design development lifecycle. Software development normally goes through a deliberative process. But Connecticut, like most states, is taking chunks of functionality and fast tracking certain pieces to get them up and running. Lots of activities are happening in parallel and that introduces risk to the project. The quality bar for this project has been set artificially high to meet the schedule. Implementation dates cannot be changed because they were codified in the law.

Finally, regarding the national scope, there are only 18 states who requested the opportunity to implement a State Based Exchange. The vast majority of states will be Federally Facilitated. A few will be Partnership Exchanges. Connecticut is in the minority. Of the 17 states plus the District that remain, a good number of them will have their conditional approvals revoked in the next few months, as it becomes clear that they will not be ready by October 1. CCIIO asked Connecticut to be part of Wave I testing. This puts Connecticut in the small minority likely to meet the October 1<sup>st</sup> deadline. Mr. Hencoski expects this project to be “yellow” all the way through. This project status does not put Connecticut in any worse position than any other state, and is actually better than most.

Mary Fox thanked Mr. Hencoski for the presentation. She asked whether there is a standard definition and/or criteria across the nation for red, yellow and green levels. Mr. Hencoski replied that CCIIO is the ultimate arbiter of the levels of risk. Connecticut has put in place conservative definitions of red, yellow and green. He is not familiar with other states. The Gate review process serves as a good read because the Federal review team is looking at things uniformly across the country.

## **VI. Plan Management Update**

Lt. Governor Wyman introduced Julie Lyons, Director Plan Management. Ms. Lyons provided the Plan Management update reviewing the functions that must be completed for certification. Her review focused on the groundwork required to receive data from carriers including benefit and rate data, network information and pharmacy formulary information. The process will be both automated and manual. The data relates heavily into the certification, application and model contract. The plan management timeline for March and April was reviewed. Mr. Van Loon added that her team holds weekly meetings with carriers and that carrier comments have been favorable.

## **VII. Marketing Update**

Jason Madrak, CMO, provided a marketing update. The second round of Healthy Chats is concluding. Questions are now becoming more specific. A Web Site demonstration will take place on March 20 at Middlesex Community College from 5 p.m. to 7 p.m. and will be videotaped. The process of launching broker continuing education classes has begun, as well as working with the brokers to provide them with important information for the open enrollment period. The focus will be three-fold: getting the broker community up to speed around the ACA basics to effectively service their clients; and the development of a module specific to the small group component and the individual component.

The continuing outreach plan was reviewed. There will be smaller and even more targeted Healthy Chats. The Exchange is in the process of putting the final touches on a full year marketing plan and is looking to build its outreach on a foundation of direct consumer engagement including physical meetings, direct mail or phone calls and mobile applications to make consumers aware of what is coming. In addition, a robust and sophisticated navigator and IPA program will be implemented to help consumers enroll in the Exchange. Lastly, there will be

an overall marketing and advertising program so that all constituents are aware of what is happening on a local level.

In the past, the importance of data as it relates to marketing has been discussed. Data available today is greater than in the past. This information can be used in a very effective way to reach people at the right time with the right message. Also, through this process, a lot of information will be generated including phone calls, the website and interactions with navigators/IPAs. There will be a need to place and store this information which will allow the Exchange to see how the program is unfolding and allow it to make changes in real time. This data will help determine how the Exchange can improve the next open enrollment period. The Exchange is currently in the process of working with an organization to determine what this database should look like. Mr. Counihan stated that the Board will be shown more detail as to how this works in the future. Mr. Madrak stated that the work currently being done is what is separating Connecticut from other states. There is not a lot of work being done in the data asset area in other states. The Exchange is carving out a different path, and Mr. Madrak feels strongly that this is the correct path for Connecticut. Tactical components were reviewed. A broad array of tactics will be deployed. Everything will ladder up to a consistent message. The marketing project timeline was also presented and will be reviewed at a future Board meeting. At the highest possible level, there will be a lot of collateral training and media development.

#### VIII. **Finance – Sustainability Options**

Steve Sigal, CFO, provided an overview of the Exchange's sustainability options. The Finance Subcommittee reviewed this information on March 6 and approved it for action by the full Board. The ACA and Connecticut law require the Exchange to be self-sustaining by January 1, 2015. Mr. Sigal presented several scenarios to achieve that self-sustainability and noted that the scenarios included information that is now known, as well as a substantial amount of information that is not known, and can only be forecast. Operating expenses are estimated at between \$25 million and \$30 million per year. Based on discussions with other exchanges, these operating expenses are believed to be less than for similar exchanges. Membership was projected at three levels – high, moderate and low. The Exchange has three primary revenue sources: market assessments, user fees and Medicaid cost recovery. There are possible secondary revenue sources which are not included such as advertising revenues, but there are specific hurdles to try to realize them.

The Sustainability Policy enumerates three approaches: market assessments, user fees and a catch all. Market assessments and user fees have both been authorized by the ACA and the Connecticut enabling legislation for the Exchange. Connecticut's enabling legislation specifically broadens the base for market assessments and fees imposing them on health carriers that are "... capable of offering a qualified health plan through the exchange." With respect to a market assessment, as the Exchange moves forward, it would include the entire small group and individual market.

The specific provisions allowing the Exchange to charge assessments were reviewed, including the Connecticut enabling legislation and the ACA authority. This empowerment is consistent with what the Exchange proposes to accomplish. A new market is being created with commercial value, and that new market provides a large brand and marketing campaign. In the

individual market, there will be enrollment, call center services and eligibility services; and in SHOP, there will be all the previously mentioned services along with billing. The Exchange will offer substantial value, and there should be the right financial support from the marketplace.

Revenue requirement projections were reviewed based on both known and unknown costs. The \$25 million cost level may expand based on the hardening of some of those costs. The low, moderate and high differences are based on the membership projections and the change in the variable cost components. About a third of the expenses are variable and the rest are fixed moving around based on the level of membership. QHP premiums were projected, presenting a view of what the premiums may look like based on the membership. Mr. Sigal noted that the premium *per member per month* is a broad guess as rates are currently unknown.

Revenue options were reviewed. There is a placeholder for Medicaid cost recovery which could net to zero. But for this example, there is a positive result for the Exchange. Option 1 is based on the required revenue and a user fee that will range from about 4% and as the Exchange moves forward all the way over to 2.5%. Option 2 is a market assessment only and the percentages range from about 68 basis points down to about 57 basis points. Option 3 would be a combination of both market assessments and user fees: a 1% user fee and a market assessment ranging from 50 basis points down to about 34 basis points. This shows what the percentages may look like regardless of what the final premiums and cost structures may be, and the percentages are realistic.

The Exchange is presenting the “Policy: Acquiring Operating Funding” which includes the market assessment option together with Medicaid cost recovery and other opportunities that may arise. It provides a broad basis for the Exchange to achieve market sustainability. The market assessment is the preferable approach. It will have less of a cost impact on members; promotes shared responsibility; is consistent with the Exchange’s vision and mission; and provides an incentive for health plan carriers to participate on the Exchange. It will allow the Exchange to have strong pricing competitiveness. The market assessment will also provide a more predictable revenue stream as the Exchange is building its membership. It is a small price to pay to create a new market. The policy provides a toolbox of options for the Exchange to pursue as appropriate as it tries to achieve sustainability. The Policy will be noticed in the *Connecticut Law Journal* and published on the Access Health CT website for 30 days of public comment.

Secretary Barnes stated that the Finance Subcommittee reviewed this policy. None of these alternatives is ideal insofar as they involve assessing fees that need to be as low as possible to ensure affordability of plans under the Exchange. But he and other members of the Finance Committee were very comfortable with the staff recommendation to use the market assessment. Staff arguments were quite compelling. Market assessment provides a predictable level of Exchange funding when there is significant enrollment uncertainty. In addition, market assessment does not create a disincentive to participate on the Exchange. Companies electing not to participate in the Exchange should not be rewarded.

**Lt. Governor Wyman requested a motion to approve the Policy for Acquiring Operating Funding for publication in the *Connecticut Law Journal* and 30 days of public comment. Motion was made by Mary Fox and seconded by Robert Tessier.**

Robert Tessier appreciated the broadening of the base and for all the reasons given, agrees with the policy. Mr. Tessier asked about the process once this is posted and public comments are received. Lt. Governor Wyman replied that there is a vote again after reviewing the public comments. Mr. Sigal further added that the policy would be noticed in the *Connecticut Law Journal* and published on the Exchange web-site and raised again at the April or May Board meeting for adoption. The Exchange will respond to all the comments during the comment period. After adoption, the Exchange will develop a procedure to implement the policy. That procedure would be brought back to the Board for approval and then noticed in the *Connecticut Law Journal* for comment. After public comment, the proposed procedure would be presented for Board adoption. The Exchange will also be finalizing its 2014 budget, and will present the budget to the Board for discussion and approval before making a recommendation for the assessment.

Grant Ritter inquired as to what option is being recommended. Mr. Sigal responded that the Exchange is not recommending any options at this point, and is merely looking for a recommendation to approve the policy. Further, the 2014 budget discussion will include the level of assessment and the type of combination.

Paul Philpott asked if the assessment would be similar to a high risk pool assessment used by the Connecticut Insurance Department used for small groups. Mr. Sigal stated that it would be similar. Mr. Philpott asked whether any thought has been given to precisely how it would be apportioned by various carriers. Mr. Sigal responded that all regulatory report sources will be reviewed for premiums, and the assessment will be based on a percentage of the book of business in the state. Mr. Philpott inquired whether it further assumed that carriers who are participating outside of the Exchange will continue to pay state premium tax. Mr. Sigal replied that there will be no lifting of premium taxes that he is aware of. Further, Mr. Sigal stated that the pricing inside and outside of Exchange has to be equivalent.

**Lt. Governor requested a vote. *Motion passed unanimously.***

#### **IX. Standardized Plan Design Recommendations**

Peter Van Loon presented the Standard Plan design recommendations. The Essential Health Benefits were set in the fall. In late November, the Federal government published a draft of its actuarial value (AV) calculator which by the ACA is required to be used by states to define a plan's cost sharing parameters. Using the AV calculator the Exchange worked with the Joint Team to set what was hoped to be the Exchange's standard plan designs. The process through January was impassioned and collaborative with a desire for affordable premiums and out of pocket expenses. In February, the Board approved out of network plans designs for the Exchange's standard plan designs. At the end of February, the Federal government released the final AV calculator. Based on this new AV calculator, the Exchange had to revise its standard plan designs. What is being presented today is a detailed review of the process and the recommendations for the Standard Plan Design. This information was previously presented to the Joint Team.

Grant Porter recapped the working group process. The Exchange has been working with eight members selected from each of the Advisory Committees to review proposed revisions based on the changes to the AV calculator. Mr. Porter thanked team members and the CID for their support. The group has been governed by principles set out at the beginning – the standard plans needed to be simple to understand, consumer focused, and have a primary care emphasis. Operational parameters include – Connecticut state law; ACA regulations and the AV calculator. The main concerns of the team were overall affordability and ensuring that primary care is accessible and promoted. An overview of the federal regulations as they relate to the actuarial values of the different metallic tiers was reviewed. The metal tiers specify the specific actuarial value that a plan must meet, which is the proportion of costs that are paid by the carrier out of premiums for medical care.

The Exchange defined the standard plans in November, and these plans were voted on by the Board in January based upon the draft AV calculator. All of the plans, except for the original Bronze plan that the Exchange recognized at that time would need to be changed, were validated against the draft AV calculator in January.

The final AV calculator incorporated some significant changes to the calculation of the plans' actuarial value. It more accurately reflected the true cost of skilled nursing facilities; rehabilitative services; generic drugs and the treatment of maximum out of pocket costs. However, the final AV calculator produced counter-intuitive results for the treatment of a separate prescription drug deductible.

When Connecticut's plan designs were tested against the final AV calculator, the actuarial values of the previously approved plan designs for certain plans changed. This caused some plan designs to fall outside the allowed range of their metal tier. After much work with the final AV calculator, Exchange staff concluded that the calculator cannot accurately approximate the AV of a plan that incorporates a separate prescription deductible. Many of the plans approved by the Board in January incorporate a separate prescription drug deductible.

Mr. Tessier asked if there is confidence in the AV calculator generally and have there been conversations with CCIIO about these issues? Are other states encountering these same problems? Mr. Porter responded that overall he had a fair amount confidence in the calculator. The draft AV calculator was changed because CCIIO thought that it underestimated the generosity of the plan designs. The tables used to build the AV calculator look at utilization, and have hundreds of thousands of data points and thousands of lines of code. But, when separate deductibles are introduced, things go awry. The Exchange had a series of meetings with CCIIO on this issue, but CCIIO deemed the final version of the calculator a final regulation that could not be changed, without new regulations. Mr. Van Loon noted because some states are using a combined deductible they have no problem with the new AV calculator. But, because of this problem, CCIIO is allowing the Exchange to supplement use of the AV calculator with an independent actuarial certification of the plan design's AV.

Exchange staff tried numerous ways to reach the required AVs, including the use of co-insurance. But given the desire for a co-payment-based plan and current co-payment limits in Connecticut, this did not work. Secretary Barnes stated that every consumer would feel the change in lowering the prescription deductible, and encouraged the Exchange to keep the

prescription co-pay as low as possible. Mr. Ritter stated he was on the working group looking at this.

Staff worked with its actuary consultants Gorman Actuarial, LLC to reach required AV targets. Carriers were also brought in. Staff wanted to make sure that this flexibility was clearly articulated to the carriers so that they would be encouraged to design their non-standard plans with a separate deductible.

Using the final AV calculator, the Silver plan as originally designed with a \$2,500 deductible for hospital care and a \$200 deductible for prescriptions, now has an AV of 74.5%. After considering this information, the team recommended a significant increase in the hospital deductible so that it could maintain a separate prescription drug deductible and keep the plan in compliance with the final AV calculator. The team recommended a \$3,000 hospital deductible with a \$400 deductible for prescriptions. But upon further review by Gorman Actuarial the AV for this design is 72.03% AV. Although almost there, there is no flexibility in the federal rule: the AV must be less than or equal to 72.0%. To compensate the Exchange's actuaries had suggested increasing the hospital deductible to \$3,000 and the prescription deductible to \$500 to fall more comfortably within the AV calculator range for the silver plan. Staff recommended this suggestion to get the design to the appropriate AV.

Lt. Governor Wyman asked if any other states had the same issues with the calculator. Mr. Porter responded that staff looked at the California and Vermont plans. Those states were able to offer a lower hospital deductible by using a co-insurance based plan with high co-pays on certain non-hospital based care. Mr. Counihan stated that through experience, explaining co-insurance is very challenging and it gets complicated with regards to cost-sharing.

Ms. Veltri questioned whether the AV calculator is a math exercise essentially, with some policy behind it, which does not address any public policy issues that the state would have to take into consideration. Mr. Porter agreed that it is a math exercise but noted that it reflects actuarial science. Policy still comes into play. The Exchange made a decision to not apply the deductible to primary care and intentionally kept primary care office visits at a very low co-pay. Secretary Barnes asked about the policy to leave emergency room services outside the deductible. Mr. Porter responded that there is a significant difference between the co-pay for an emergency room visit and a primary care visit. Mr. Porter stated that it should not incentivize use. Mr. Philpott asked with respect to hospital co-pay, what is exempt – for example, is out-patient surgery exempt or are there any procedures that are exempt? Mr. Porter responded that certain preventive services are exempt from the deductible and are covered 100% by the plan based on ACA requirements. Mr. Philpott further asked about out-patient surgery. Mr. Porter responded that out-patient surgery would be subject to the deductible, with the \$500 co-pay. Any services provided as part of an in-patient stay is captured by that \$500 co-pay so there is no separate billing.

Dr. Scalettar thanked those who worked on these issues. Further, he asked why not go to a \$2,750 hospital deductible with a \$500 prescription deductible as that would still be under 72.0%. Mr. Porter responded that could be done. Mr. Ritter stated that while he appreciated Mr. Porter's work, it was a \$400 deductible on prescription drugs that was discussed and recommended during the team meeting on Monday. He is not comfortable increasing the deductible to \$500. He asked if the generic drug co-pay could be raised to \$15, or could

something else be changed so that the AV would fall from 72.03% down to 72.0% with a \$400 prescription deductible?

Mr. Counihan asked whether, since the 72.03% AV rating is not pure science, a case could be made that 72.03% is close enough to 72%? Mr. Porter stated that it cannot be certified by the Exchange. If the Exchange is given the discretion, staff can go back to the actuaries and ask them for certain changes to the plan design that allows them to get the pharmacy deductible down to \$400. For example, an increase to the out of pocket max could put the AV of the plan I within that *de minimus* range. The actuaries would need to certify the adjustment.

Lt. Governor Wyman asked if the Board wants to give direction to the staff, and if it is agreed by the Board with the prescription deductible of \$400 and the numbers are reviewed by staff, would the Board be comfortable with those levels and staff getting back to the Board with the changes. Ms. Veltri added that it is important to see how it works in practice and see how it affects consumers before the Board makes the recommendation to change it. Lt. Governor Wyman stated that it would be a vote on the concept of what was presented with the idea of lowering the deductible. Virginia Lamb, General Counsel, stated that a special Board meeting could be called with a telephone vote so long as a 24 hour notice was provided to the Secretary of State.

Mr. Tessier commented that as he understood it, the staff is looking for approval today so that they can release the plans to the carriers on Monday. The difference is about 3/100 of 1%, which in his experience with health care actuaries, is well within their margin of error. He is comfortable with the numbers and proposes the Board approve the \$3,000 hospital deductible and \$400 pharmacy deductible discussed by Grant Ritter, further charging the Exchange staff, subject to Mr. Counihan's oversight and approval, to make the necessary changes to the balance of the coverage benefits. Ms. Veltri stated that her point is that before the Board votes, the staff needs to walk through the examples as to how it impacts people as her vote may depend on the impact.

Mr. Porter continued, stating that he was informed by Gorman Actuarial late yesterday that after re-running the numbers, they were more confident with the \$500 deductible than the \$400 deductible.

Mr. Porter presented some utilization scenarios depicting the out of pocket costs a member might pay when they encounter a typical health problem. The figures presented illustrate estimated costs with the Silver plan design that has a \$400 prescription drug deductible. . The other plans presented are the silver cost-sharing reduction plans for individuals with income under 250% of the FPL.

Ms. Veltri stated that she understands and appreciates the work done by the plan design team. However, she has grave concerns about the people with lower incomes. A recent Health Foundation report stated that even with the potential of out of pocket expenses of \$1,800 per month would put some consumers in this income bracket in peril. Mr. Porter stated that with the cost sharing reduction, the maximum annual out of pocket for low income individuals could be \$2,000 or \$2,250, depending on the plan. A member would only reach his level of cost sharing if they suffered multiple hospitalizations. Ms. Veltri corrected her earlier comment that it would be \$1,800 per year. Mr. Tessier commented that he agreed with Ms. Veltri's

comments. It is clear that there is a need to go forward on the issues of affordability. Mr. Tessier asked for further discussion after this vote. Cee Cee Woods requested an adjustment down even lower.

Mr. Porter continued with a discussion of revisions to the standard plans. Additional changes to “other” benefits were approved by the team in January but were never presented to the Board. The co-pay on hospice care has been eliminated, as well as the co-pay for home healthcare services because it was common in the market today. The co-pay for vision services has been included in the gold and platinum plans to be consistent across the tiers. Co-insurance on durable medical equipment, prosthetics and diabetic supplies has been increased from 50% to 10 points less than the actuarial value of the plan, which potentially will lower out of pocket costs for these individuals. The co-pay for maternity care visits was increased from the PCP co-pay to the specialist co-pay level, which is consistent with the market correcting an error. Specialist co-pay applies for an allergist visit. There were no changes to the standard out-of-network benefits.

Previously, the Board voted on a recommendation on the dental benefits that would be embedded with respect to the pediatric dental and also reflective of the design for the stand-alone dental plans. These are currently being validated by Wakely Consultants as the AV calculator is not applicable to stand alone dental plans. It is expected that there will be no changes. A dental wellness-only standard plan was reviewed by the team which would be a low cost alternative to the comprehensive dental benefit being offered but only for adults. This is an option for offering diagnostic, preventative care and basic restorative care only. Another valuable component of this plan would be access to the dental carrier’s network. The recommendation is to approve the benefits for the pediatric dental high and low plans. The low plan would be paired with the bronze and the silver. The high plan would be paired with the gold and platinum. There are no waiting periods or maximums allowed for the pediatric dental coverage pursuant to ACA regulations, and the deductible would apply per child but would be waived for those cost sharing reduction plans. The recommendation for the wellness only plan is to include that on the Exchange. Ms. Veltri asked what the co-pay is for pediatric dental? Mr. Porter responded that there is no co-pay for diagnostic and preventative care.

Mr. Porter continued with an adjustment to the QHP solicitation to allow for an additional standard bronze plan – a catastrophic plan look-alike. This was developed in consideration of premium cost. From a premium perspective, this bronze plan would be the most affordable plan that could possibly be developed for the Exchange. The deductible would equal the maximum out-of-pocket. Co-pays for three primary care visits per year would be waived with no other exceptions except for home health care, which is subject to a \$50 co-pay. It is for a healthy individual who may be eligible for tax credits.

The final recommendation is to change the QHP solicitation to allow carriers to offer an additional non-standard plan. This is being addressed because there were continued concerns about affordability expressed by the team. The original solicitation allowed carriers to offer one standard plus two non-standard plans in year 2, but this accelerates the timeframe.

Secretary Barnes inquired as to the possibility of any additional affordability as a result of the submission under the provisions, and would it have any bearing on people below 250% of the FPL? Mr. Porter stated that there is another recommendation which would ensure that the

standard silver plan be the lowest plan offered by a carrier on the Exchange at the silver tier, which will protect the value of the premium tax credits.

Secretary Barnes wanted to confirm that if there is a premium tax credit at 150% of the FPL, those tax credits will be calculated irrespective of the premium or based on some calculation reflecting the premium and income together. Mr. Porter responded that it is calculated by a combination of income, household size and then a percentage based on that which is the associated with the second lowest cost Silver plan. Secretary Barnes asked if there is still the potential for price comparison shopping and allowing consumers to make decisions to increase the affordability of plans for people at very low income levels. Mr. Porter confirmed that these options did exist. This impacts anyone under 400% of FPL who is eligible for the tax credits which are determined relative to the second lowest costing silver plan.

Mary Fox asked how mental health co-pays or visits are being treated? Mr. Porter responded that there was a conscious decision to ensure that mental health visits had the same co-pay as a primary care visit. Ms. Fox further inquired as to maternity care which was moved from a lower co-pay to a higher co-pay as it was characterized as a specialist visit. She stated that this is a major decision and asked how it was made? Lt. Governor Wyman commented that for many women, their primary care doctor is their OB/GYN. She asked whether there would be an additional cost for women to see their OB/GYN as their primary care physician. Mr. Porter responded that it would only be for non-routine visits. Mr. Porter stated his understanding that maternity would not be treated as routine primary care visits. The insured would be charged the higher co-pay. Mr. Coughlin added that it is a coding issue on the claim form.

Commissioner Bremby commented that while an OB/GYN might be considered a specialist, prenatal visits are encouraged as preventive care, and a lower out of pocket cost would ensure that women obtained that care during the pregnancy and he would like to see it go back the other way. Ms. Veltri inquired as to what are the plans doing now and how is it being treated? There has to be access to OB/GYN as a primary care physician, but in terms of coding of the visits are there dual co-pays? Mr. Porter responded that he thinks it is treated at the level of the specialist co-pay.

Secretary Barnes inquired as to whether it is treated as one billing to cover the entire prenatal care, as a bundled service? If it is a single specialist co-pay, then it is not terribly unreasonable given that it is spread out over what could be quite a number of visits and not a particular onerous charge. If it is for every visit, it could be difficult if it is a complicated pregnancy. Mr. Porter responded that it would not be one co-pay, and prenatal care is limited to 10 visits. Maternity care is currently not covered in the individual market. This is one of the largest drivers for the upcoming rate bump.

Ms. Fox stated that that one of the issues the Exchange is working on concerns past gender discrimination in premium rate setting, and she asked if that was thought of with regard the premiums necessary to fund new maternity care benefits? Pursuant to the ACA, carriers will not be allowed to charge women higher premiums than men. Ms. Fox asked that the Exchange look for ways to promote the well-baby and well-mother visits when setting the co-pays for maternity care.

Ms. Veltri stated that the federal government regulations regarding the difference between preventive care, treatment and the physician codes is the deciding factor as to whether a service is deemed to be treatment or preventive care. Mr. Porter stated that certain maternity related services would be considered preventative. If there was a co-insurance based plan, the costs associated with those services would not be billed.

Lt. Governor Wyman requested clarification regarding whether there would be an additional cost if a regular physical was performed by an OB/GYN under this plan because the visit is with a specialist versus a PCP. Mary Ellen Breault, from the CID, responded that all preventive care, regardless of the provider, would be covered at 100% with no-copay.

Lt. Governor Wyman requested a motion to approve as presented by Exchange staff the revisions to the Standard Plan designs and to require that the Standard Silver plan be the carrier's lowest cost Silver plan in the individual Exchange to guarantee the affordability of the Standard Silver plan, but also, to have a \$400 pharmacy deductible for the plan. Grant Ritter made the motion and Vicki Veltri seconded. ***Motion passed unanimously.***

X. **State Innovation Model**

It will be reported at the April meeting

XI. **Adjournment**

Lt. Governor Wyman requested a motion to adjourn the board meeting. Motion was made by Grant Ritter and seconded by Robert Tessier. ***Motion passed unanimously.*** The meeting adjourned at 12:09 p.m.

**The next Board Meeting will take place on April 18, 2013 at 9:00 a.m.  
at the Connecticut Historical Society.**

[Agenda](#)  
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