STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

Connecticut Historical Society
One Elizabeth Street
Hartford, CT 06015

Thursday, April 18, 2013
DRAFT Meeting Minutes

Members Present:
Lieutenant Governor Nancy Wyman (Chair); Grant Ritter; Dr. Robert Scalettar; Robert Tessier; Vicki Veltri, Office of the Healthcare Advocate (Vice Chair); Secretary Benjamin Barnes, Office of Policy and Management (OPM), Deputy Commissioner Anne Melissa Dowling, Connecticut Insurance Department (CID); Commissioner Roderick L. Bremby, Department of Social Services (DSS), and Cecilia Woods, Vice Chair, Permanent Commission on the Status of Women.

Members Absent: Mary Fox; Paul Philpott; Commissioner Jewel Mullen, Department of Public Health (DPH).

Members Participating by Telephone: None.

Other Participants:
Health Insurance Exchange (HIX) Staff: Kevin Counihan, Julie Lyons, Grant Porter, James Wadleigh, Steve Sigal, Peter Van Loon and Virginia Lamb; Julia Lambert, Wakeley Consulting Group, Inc. ; Maura Carley.

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

A. Call to Order, Introductions and Announcements
Lt. Governor Wyman opened the meeting at 9:00 a.m.

Lt. Governor Wyman acknowledged a new member at the table and welcomed Maura Carley. Ms. Carley provided a brief background.

Benjamin Barnes arrived at 9:01 a.m.

B. **Public Comment**

There was no public comment

C. **Review and Approval of Minutes**

Lt. Governor Wyman requested a motion to approve the minutes from the March 14, 2013 meeting. Motion was made by Vicki Veltri and seconded by Robert Tessier. ***Motion passed unanimously.***

Approval of the April 1, 2013 Special Meeting minutes have been tabled until the May meeting.

D. **CEO Report**

Kevin Counihan, CEO. reported that steady progress continues. The focus now is on coding and preparing for System Integration Testing. Wave 1 testing with the Federal Data Hub is complete and the Exchange is moving forward with Wave 3. A successful final detailed design review meeting with CMS took place at the end of March. Releases 1 and 2 are on track for June 4 and October 1 respectively. Mr. Counihan thanked Peter Van Loon, Jim Wadleigh and the combined Access Health CT, Deloitte and KPMG teams for their efforts.

A contract has been signed with HealthPass New York as the Exchange's new SHOP vendor. Representatives from HealthPass were introduced. Julie Lyons, Director of Plan Management and Steve Sigal, Chief Financial Officer, and their teams continue to work hard supporting the health plans with enrollment eligibility and reporting formats.

The second round of Healthy Chats has concluded and preparation has begun for the third round. Navigator applications and grant funding is in process. Vicki Veltri and the Office of the Healthcare Advocate were thanked for their support. Ms. Veltri recently returned from a meeting in Washington D.C. and provided a brief summary on a consumer assistance programs roundtable with the Kaiser Family Foundation where discussions focused on the status of the navigator program. Most of the questions were directed to Connecticut and Oregon beause they are ahead of the pack in navigator and IPA program design. Mr. Counihan stated that there have been encouraging meetings with financial and retail firms to provide in-store signage for Access Health CT during Open Enrollment.

Work continues on developing the All Payers Claim Database (APCD). Five candidates have been identified for the role of Executive Director. Further, a draft data submission guide is due this week; an RFP for the data warehouse vendor is in process; and, there is a meeting of the APCD Advisory Group scheduled for later in April.

Mr. Counihan thanked Lieutenant Governor Nancy Wyman, Commissioner Roderick Bremby and the DSS team for their attendance at the detailed design review meeting in Baltimore and their constant support. He also thanked the entire Access Health CT team for their consistently high quality of work.

Lastly, Mr. Counihan discussed his testimony in Washington at a Senate committee hearing on the impact of the ACA market reforms on premium rates.

Dr. Scalettar asked about the plans for the APCD, public access to information regarding its evolution and the process to obtain further information. Mr. Counihan reported that additional information will be put on the website. The immediate implementation plan includes hiring an executive director, other staffing and a database management vendor. It is expected that reports will begin to be generated in the summer of 2014. Dr. Scalettar asked if the data submission guide specs have been developed yet? Mr. Counihan responded that the initial cut of a standard set of data guidelines that are currently being used by other states was taken to the APCD council for their review as well as to the public.

E. **Operations and IT Update**

Peter Van Loon, COO, provided an operations update. Releases are on schedule for June. All risks are monitored on a daily basis and steps are taken to mitigate. The three major risk groups -- schedule, quality and scope, their definition, remediation approach, resolution date and responsible party, were reviewed.

In the last month, standard plans designs were defined with the assistance with the advisory committees. Carriers have been engaged on a technical basis. The Qualified Health Plan (QHP) contract will be released shortly. Hiring continues, and the Exchange's latest addition, Controller Tricia Brunton, was introduced. There will be additional hiring in operations, plan management and communications.

Jim Wadleigh provided an IT update. The Exchange continues to make progress. A well-attended consumer website wireframe demonstration was held at Middlesex Community College on March 20. Many good questions were asked about tax credits, Medicaid integration and a few other key areas. This input will be incorporated in the focus group study. A video replay is available on http://www.accesshealthct.com.

On March 19th through the 21st, a federal onsite security team reviewed AHCT's hosting facility and operations. They looked at our controls to secure data including our physical site and our policies and procedures. The IRS is the predominant agency pushing for security within our application. Our data is designated as "secret" data and our controls must meet the requirements for this level. The security team will return in July to check that the requested modifications have been completed. Wave 1 testing began on March 28. Eight of the 11 services that the Exchange will require from the federal data hub were tested. Six state based markets and five federal markets were testing simultaneously and are working through identified challenges. Connecticut found seven defects in the federal services. Upon Wave 1 completion, Connecticut provided the most comprehensive testing of those services. Connecticut will also participate in Wave 3 testing where new releases will fix any defects found

by Connecticut and other states. A new code release will take place in May and unofficial testing has started in that environment.

Lieutenant Governor Wyman asked if every state does the wave testing in the same manner. Mr. Wadleigh responded that it depends on where a state is in the development process. In Connecticut, testing has begun earlier. Other states have not even begun. Ultimately, there is a milestone that all states must begin testing by the mid-May timeframe. The Lieutenant Governor asked if every state must be at the same level eventually. Mr. Wadleigh responded yes, but stated that not all states will be delivering the same functionality as Connecticut. Mr. Counihan asked if that was true of all the federal facilitated marketplace (FFM) states as well. Mr. Wadleigh responded that eventually they will all be the same, leveraging the same applications. All FFM states will be at same level. State based exchanges could be at different levels. Connecticut's Final Detailed Design Review in March was approved with comments. The infrastructure, architecture, testing, development and overall project plan were reviewed. A live presentation was presented which was very well received by the federal term. The Lieutenant Governor and Commissioner Bremby's attendance at the Review reinforced for the federal team Connecticut's commitment to its Exchange.

Ms. Veltri stated that there was a demonstration of the ConneCT portal by DSS at the Medical Assistance Oversight Council, and she asked how the portal will be facilitated with the Access Health CT portal vis-a-vis information sharing between the two. Some Exchange eligible customers may come through the ConneCT portal. Commissioner Bremby provided an explanation. There are currently two deployments through the ConneCT initiative – one to check if individuals are eligible for services and another for individuals to check their account status. Releases 6 and 7 are scheduled for the fall and will provide a more complete portal for individuals to get additional access to information from DSS. These releases will integrate the ConneCT portal with the Access Health CT portal. These releases may be pushed back to January so that the integration between the DSS and AHCT portals is tighter and seamless, and to assure that shared customers see the same portal. There will be more thought on this development process.

Ms. Veltri asked whether someone going into the ConneCT system could be brought from DSS to the Exchange portal. Commissioner Bremby replied that it will be brought up in design. The portal is currently designed strictly for DSS and for ConneCT access. Getting from one place to another will need to be made easier. Today, customers will only see DSS information. In the fall, it will be a more integrated process. Mr. Wadleigh stated that ConnectCT was started earlier than the Exchange portal. There have been a lot of conversations regarding operation model and integration points and some changes are being discussed. Commissioner Bremby further commented that it would be helpful to think of Medicaid and Access Health CT as a continuum of coverage opportunities for the people of Connecticut.

Mr. Wadleigh reported on his and Peter Nichol's visit to Deloitte's facility for development, system testing preparation, and system integration testing in Harrisburg, Pennsylvania. He will be returning to Harrisburg the first week of May for a final demonstration with the Deloitte team and will present that report at the May board meeting. First Data has been on boarded as the Independent Validation and Verification (IV&V) vendor providing monthly third-party reports on the Exchange's status to CMS. Their feedback indicates that the Exchange is making good progress. Their first report will be shared with the Board. On April 12th, the first release

code development was completed. Connecticut is the first state that will have a release on June 4 delivering the plan management functionality. Systems integration testing of that functionality has begun this week. Defects are being corrected and the development team continues to move forward at a rapid pace and make great progress. Pappas McDonnell has also been working with Deloitte to set up a demonstration for customers. Focus group testing will be videotaped and the feedback on consumer response to screen flow will be shared with the Board. Ms. Veltri suggested speaking to Kate Gervais and getting volunteers for testing so that a full range of the customer base will be covered. Mr. Wadleigh agreed.

Dr. Scalettar thanked Mr. Wadleigh for his presentation and inquired about the look and feel of the website as it continues to roll out. The look and feel of the screens was shared at Middlesex Community College. There will be opportunities to improve them. Based on prior experience, Mr. Wadleigh believes this application will continue to be updated over three years based on constant feedback from the customer base. The Exchange's first priority now is to get feedback from the entire spectrum of the customer base.

Ms. Veltri reiterated that there is a difference between marketing and understanding the customers on the ground and urged that the Exchange use the Consumer Advisory Committee for this purpose. The testing phase should include a combination of marketing knowledge and feedback from consumers.

Commissioner Bremby commented that the software is pre-formed and uses bundled sets of code. Programmers working with multiple organizations and design teams are bringing a vanilla version of the software package. There will be pre-information which can be modified and edited around the edges going forward to make it unique to Connecticut but there is no need to start from scratch. Mr. Wadleigh stated that Jason Madrak, Chief Marketing Officer, is working with all the Advisory Committees and the list of outreach groups will be sent to Ms. Veltri. Special recognition was given by Mr. Counihan to Mr. Wadleigh and his team noting that the CMS team had applauded Access Health CT afterward.

Mr. Wadleigh introduced James Michel, Operations Manager who updated the Board on the Exchange's collaboration with DSS and presented a very high level process schematic showing the connection with DSS. Access Health CT and DSS are working together in the following areas: integrated eligibility and enrollment system; in person assister (IPAs) and navigators; web portals and interactive voice response (IVR); call center operations; appeals; printing of notices to applicants; vendor management and operations implementation. In addition, DSS web portal will have a link to the Access Health CT website.

Lieutenant Governor Nancy Wyman asked whether someone truly not able to use a computer will have a way to obtain assistance, and whether someone who is visually impaired will have a way to apply without use of the web portal. Mr. Van Loon responded yes, by working with IPAs and navigators as well as brokers. Numerous agencies want to understand the system and have volunteered to serve those special populations. Lieutenant Governor Wyman asked about a voice activated entry point. Mr. Van Loon responded that options will be provided. Ms. Veltri confirmed that is there a provision to access the call center for the visually impaired.

Mr. Van Loon updated the Board on the standard plan designs. The standard plan designs were presented at the March Board meeting and the Board requested clarification surrounding the discussion on preventive and prenatal care services.

Mr. Van Loon reviewed key parts of the ACA guidelines which define prenatal care as preventive and require that it be covered at no cost sharing to the enrollee. This aspect of the ACA has been in place for several years. Guidance was sought from the Connecticut State Medical Society as well as several physicians to determine how prenatal services are handled today. The Exchanged learned that physicians already treat prenatal care as preventive. This is accomplished by either global billing or by coding individual services as preventive. Exchange staff reported back to the Board on April 1 with information received from Dr. Steven Fleischman, Associate Chief of Obstetrics and Gynecology at Yale New Haven who verified that prenatal care is covered as preventive care and services are coded as either global billing for the entire pregnancy or as individual preventive services. The Center for Consumer Information and Insurance Oversight (CCIIO) also stated their expectation that prenatal services are preventative services. In summary, any plan designs approved for Access Health CT will require that preventive care of any type, prenatal, pediatric etc. be covered as the law directs – at no cost to enrollees.

Lieutenant Governor Wyman thanked staff for the clarification indicated her satisfaction with the response.

F. **Finance Update**

Steve Sigal, CFO, provided the finance update. Procurement of all employee benefits was been completed with the matching salary deferral and the flexible spending account; the first financial and Federal Single Audits for fiscal year 2012 have also been completed; Tricia Brunton has been hired as the controller; the procedure for developing "Acquiring Operating Funding" is in process; and, work continues on enhancing existing finance processes and procedures including the development of financial metrics.

The March 2013 YTD budget snapshot was presented. The Level I grant has been completely expended. Staffing has been slower than originally anticipated. Year to date personnel cost – budget vs. actual—was presented. The Deloitte DDI is slightly behind. The project expense narrative was presented showing the marketing campaign expenditures slightly above expected levels and the Level 2 Grant development ramp-up slower than projected. The full year budget snapshot for July 2012 to June 2013 was also presented. This is all Level II money that can be rolled over into the next fiscal year.

Secretary Barnes asked whether the delay in securing benefits resulted in any harm to employees? Ms. Sigal replied no. The 401a was put into place with a catch up. Grant Ritter commented on the burn rate not reflecting work actually completed by Deloitte because the full deliverable was deferred. Mr. Ritter inquired whether there was a way to track progress compared to where Deloitte should have been. Mr. Wadleigh stated he reviews Deloitte's progress vis-à-vis deliverables on a weekly basis. It is expected that by the end of May a lot of tasks will be caught up. Mr. Sigal added that this will generate a large cash expenditure.

Mr. Sigal reviewed the audited financial statements. It was a clean audit and is what is referred to in the accounting world as an unqualified opinion. Secretary Barnes commented that it is has been an interesting year for Access Health CT. April was somewhat late for an audit with a June 30 year end, but he recognized the issues surrounding the start up. Mr. Sigal reported that an extension was filed for this year's audit and planning of the next audit has already begun.

Lieutenant Governor Wyman requested a motion to approve, as presented by Whittlesey & Hadley, P.C., the FY 2012 Audited Financial Statements. Motion was made by Dr. Robert Scalettar and seconded by Secretary Ben Barnes. ***Motion passed unanimously.***

Commissioner Roderick Bremby left at 10:13 a.m.

G. **Rate Review and Analysis**

Steve Sigal presented the rate review and analysis for the Board. Rates for Qualified Health Plans (QHPs) have a far reaching impact, particularly in 2014, which is the first year of implementation of the Affordable Care Act (ACA). Rates are central to the affordability of health coverage through the Exchange. For those carriers offering QHPs on the Exchange, the rates being filed establish the cost of plans both inside and outside the Exchange impacting the entire Connecticut markets for individuals and small groups.

Anne Melissa Dowling, CID Deputy Commissioner, provided a recap of CID's earlier presentation on rate filings and review for QHPs. Connecticut is a model state in state based exchange creation and rate review. CID has conducted insurance rate reviews for the past 46 years. Connecticut was one of first states designated as an effective review state by the U.S. Department of Health and Human Services, and received a federal grant in 2010 to invest in its rate review process. As of today, there are only 7 states that have not achieved this designation. If the designation is lost, the federal government will take over this rate review process. Connecticut's process is very rigorous. The federal medical loss ratio (MLR) in effect in recent years is an additional check on premium spending. A minimum of 80% of premium must be spent on policy owner care in the individual and small group markets and 85% in the large group markets. When the filings for potential QHPs are received, all rate review and correspondence between the carriers and CID are available on-line from the moment of rate filing to final disposition, along with any comments from any individuals, carriers, and actuarial firms filed within 30 days. At the end of the disposition, a consumer friendly plain language summary will be made available. Ms. Dowling further commented that the ACA will help provide coverage to previously uninsured people and will remove limits to coverage that existed previously, reducing the number of uninsured citizens in the United States.

In the first year, the CID will allow carriers to provide estimates or projections of the relative risk of new entrants. There is guaranteed issue. It will be reviewed after one year of experience, but relative risk assumption will not be permitted. In the rate filings, medical underwriting, industry distinctions, case size adjustments and gender distinctions will be eliminated. However, there will be the addition of regulatory fees and cost-sharing. In addition, compression of the age ratio to 3 to 1 from Connecticut's 6 to 1 is expected to significantly impact rates. The ACA provides for a single statewide pool for the individual market and another for the small group market. Federal regulation would have required that Connecticut use five geographic or rating areas, even though the state has eight counties. HHA agreed to

Connecticut's request for an exception to use the eight counties to avoid market disruption. In February, HHS published fairly prescriptive final rules on rate review. States must use a single risk pool for all plans inside and outside of the Exchange. Carriers must establish a single index rate for the individual market across the state annually. There can be no distinction between rates inside or outside of the Exchange. Index rates must be based on the carriers' own specific claims' experience and expectations and not projections. For policy years beginning after 2014, a health insurance issuer may vary its premium rates for a particular plan from its market wide index on the following actuarially justified plan specific factors: the actuarial value, the cost sharing design of the plan, the providers network delivery system characteristics and utilization management practices, administrative costs excluding Exchange user fees. There has been a lot of speculation on rate impact in blogs, consultant papers and from actuaries but these comments will not be considered by the CID. No filings have been received to date by the CID from any Qualified Health Plans (QHPs). CCIIO has set a firm deadline of July 31 for rates for all QHPs.

Julia Lambert of the Wakely Consulting Group was introduced to discuss the federal programs created by the ACA to ameliorate risk in these new marketplaces. Though Wakely has been assisting the Exchange in other areas, the Wakely actuarial arm has not done a lot of work in Connecticut with either health plans or the Exchange. Ms. Lambert provided a summary of work done by Wakely Actuarial in other areas.

The concept of the 3Rs (risk adjustment, transitional reinsurance and risk corridors) were introduced with regard to rate setting. Ms. Lambert provided a summary as to how the 3Rs apply inside and outside of the Exchange in both the small group and individual markets, as well as who administers the programs. Ms. Lambert emphasized that in the risk corridor program non-grandfathered individual and small group plans outside of the Exchange will be deemed substantially similar to plans inside the exchange, and will also qualify for risk corridor protection. Many carriers outside of the Exchange may want to take advantage of the risk corridor program as the plans will be substantially similar, but HHS has not completely defined what this means yet.

Ms. Lambert also discussed the administration of the programs. HHS will be administering the risk adjustment as well as the risk corridor program, and Connecticut will be administering its own transitional re-insurance program. Ms. Lambert provided examples of how risk adjustment levels the playing field so that carriers won't feel it necessary to compete for healthier individuals. The ACA's risk adjustment program includes an evaluation of each carriers' risk after the first year. Carriers who insure healthier individuals will transfer some of their premium dollars to the federal government. The federal government will in turn evaluate and send some of those premium dollars to the carriers who attracted the worst risk. A premium rate must be based on an average risk individual of 1.0.

Secretary Barnes inquired whether this assumption of the average 1.0 risk individual will be applied uniformly by all carriers in the state? Ms. Lambert stated that she did not know Connecticut's thinking about this issue. Mary Ellen Breault replied that because this is a retrospective look the first year, it is unknown because the federal government will be assessing each carrier's risk within their population. It is thought because of guaranteed availability, CID would not allow the carriers in first year to estimate what the carriers risk adjustment may be.

In subsequent years when the information on the actual experience is available and the federal government sets those rates, it would be reviewed for an estimated migration. Carriers with lower risks will actually be required to increase their rates and those with higher risks will be required to lower their premiums which appears to be counterintuitive. This will be necessary so that the carriers with low risk will have premium dollars to pay into the risk adjustment program in order for the carriers with high risk to receive payments from the program. Secretary Barnes clarified that the carriers with better risk will use the claims savings to pay the risk adjustment. Ms. Breault replied that it depends on how it is priced. The first year will be priced on the average risk.

Ms. Lambert continued, and stated that the program will be revenue neutral. Examples of risk adjustment at a member level were reviewed and illustrated how the risk adjustment will be developed. There are separate weights based on demographic components. Ms. Veltri inquired if this will be done for every member level and then aggregated? Ms. Lambert replied yes. Risk adjustment facts were reviewed. The Risk Adjustment program is permanent while the other Rs are temporary or transitional. The program is based on historical data, comparing average risk scores for plans. Where there was a large deviation, there were significant revenue transfers. Carriers are working on coding and adequate claim capturing.

Dr. Scalettar asked what this will mean for new Access Health CT entrants with no claims experience? Ms. Lambert responded that you look at publicly available information, such as the Lewin Study, to try and determine what the average risk is for market and it is challenging. You are always looking for the 1.0 risk rate. There is a small user fee paid to HHS for doing the risk adjustment. The actual transfer of money will take place in 2015 based on information gathered in 2014.

The transitional reinsurance program was reviewed and Ms. Lambert explained that it will be used to temporarily stabilize the individual marketplace. Information will be sent to the administrator calculating what recovery will be earned based on total claims that are experienced by the member. The recovery attachment point will be $60,000 on a paid basis. Carriers will be able to send data to the administrator to get recovery which is 80% of all amounts between $60,000 and $250,000. Payments will be on a broad basis. In working with individual carriers with strong underwriting, few carriers will see this threshold. The assessment of $5.25 PMPM is on a national basis. The premium impact of the transitional reinsurance program was reviewed. The program transitions over time

Grant Ritter stated that the reinsurance program has gotten bad press and is talked of as a new tax because of the ACA because it is not deductible. The $5.25 PMPM will reflect a 1% premium increase across the board resulting in the carriers increasing their premiums by 1.5%, putting more pressure on premiums across the country. Ms. Lambert responded that the benefits will be available to carriers who are offering individual coverage. The insurance premium will be reduced. Everyone else is increasing and when averaged out the intent is that it will be budget neutral. Mr. Ritter asked if the $5.25 PMP was subject to the MLR or was it part of overhead? Ms. Lambert replied that she is of the understanding that the $5.25 is off the record.

The Risk Corridor program was also reviewed. The federal government will share in any extreme profits/losses of QHPs offered on and off the Exchange. This is a protection mechanism. It is retrospective and will coincide with the MLR timing. It is at the QHP level calculation, and is not

expected to be budget neutral. It is not known whether the federal government will make money from this program, or whether the money will be needed to help carriers with their losses. Ms. Lambert further explained how the risk corridor program will work. There are two concepts – a target and an actual. The target loss ratio is set by the rule that HHS expects 80% of premiums to be spent on medical expense. If a plan's loss ratio is more than 3% above or below the expected loss ratio, the federal government will share in the profits or the losses of the program after the reinsurance and risk adjustment monies are transferred. On the actuarial side, the rules are explicit and the other two Rs are incorporated in those costs.

Secretary Barnes asked whether these programs are well understood by the carriers and if it seems that carriers will get premiums right? Ms. Lambert stated that, in general, there is a lot of information that carriers are getting up to speed on and she is not familiar with the Connecticut market. Lt. Governor Wyman asked about other states that Julia has had dealings with, and whether she has insight into the carriers' thoughts? Ms. Lambert stated that she has heard that some strategies are to be potentially aggressive because the federal government will help. Ms. Lambert continued with a high level illustrative rate setting methodology and showed where the 3Rs come into play. Ms. Veltri asked over what period is the PMPM? Ms. Lambert replied that it is based on a calendar year beginning with any quarter but it is a one year period of actual experience. Ms. Breault noted that no pre-existing condition exclusions will be permitted. Ms. Lambert reviewed the 3 Rs timeline for the 2014 plan year.

Ms. Veltri requested an explanation regarding Ms. Lambert's role and how she is working with the Exchange. Ms. Lambert replied that her role is to educate on the 3Rs and the 12 implications on rate setting. Mr. Sigal explained that the Exchange was trying to provide very useful information to share with the Board. The intention is to provide information that is easily understood by everyone. Lt. Governor Wyman asked about Wakely's role after this meeting.? Mr. Sigal stated that it would be at the desire of the Board. Secretary Barnes stated that he appreciated the presentation and added that the idea for the presentation came from conversations about the desire to impact rates, and to find a way for everyone to better understand the programs and the process. He is hopeful that following these discussions, detailed recommendations can be made about rates. Mr. Counihan stated that the Exchange is totally in line with Mr. Barnes' statement.

Grant Porter presented an overview on how the ACA will work towards making healthcare affordable and an explanation of the Federal Poverty Level (FPL). The 2014 poverty level will be the same as the one used for 2013 and it is set by the Secretary of HHS. There are three distinct poverty levels- one for Alaska, one for Hawaii and one for the other 48 states, all based on household size divided by household income. Advanced premium tax credits (APTC) will be paid on a monthly basis directly to the carriers and will be available only through AHCT to subsidize the cost of a household's monthly premiums at the level of the second lowest costing silver plan. An applicant may use their APTC to "buy up" or "buy down" coverage- meaning they are not required to purchase a plan at the silver level, but the amount of their APTC will be determined based upon their household income and the cost of the second lowest costing silver plan. If an individual chooses to "buy up," they will be required to pay the difference in premium. The second type of subsidies available through the Exchange are cost sharing reductions (CSRs). These will be in addition to the APTCs for those with household incomes between 133% and 250% of the FPL, and also for those with income levels that would qualify them for Medicaid but who are not eligible because of Medicaid's five year residency

requirement. The CSRs reduce the cost of obtaining healthcare (e.g. co-payments) and are exclusive to the three alternative silver plans.

Secretary Barnes asked if the out of pocket maximum is per individual or per household. Mr. Porter responded that it is per individual and would be double per household. Secretary Barnes asked whether a consumer at the 145% of FPL who buys down to a bronze plan could realize a significant reduction in premium cost and also take advantage of the cost sharing reductions. Mr. Porter replied no, that CSRs are only available at the silver level. Navigators and IPAs will be educating consumers about the benefits but ultimately it will be the consumers' decision.

Mr. Porter provided an example of what the out of pocket costs would be for the premiums based on annual or monthly income. Hypothetical eligibility examples were provided. The first scenario was for a household with children who are not eligible for Medicaid/CHIP.

Mr. Counihan asked for an articulation from the Board regarding Wakely's services. The Lieutenant Governor asked if Wakely could work with the plans to look at the rates prior to their filing with CID? The Board feels that premiums need to be as low as possible, and is looking for a unified voice. Ms. Lambert stated that Wakely has in the past had meetings with carriers with regard to rating impact, but it may be difficult to talk about rates until they are available. Secretary Barnes stated that he shares in the concerns of the Lieutenant Governor. It is important for the Exchange's further engagement of Wakely, that there be a forum where any member of the public, including individuals and agencies, can provide comments on the rate setting process. To have someone formally representing the interests of Connecticut consumers in the rate setting process would be one piece of the engagement with Wakely. There may also be a way to see if some adjustments are warranted prior to submitting to CID. This would be an opportunity to influence the process through the Exchange for the benefit of Connecticut consumers. Dr. Scalettar referred to earlier conversations on active purchasing and the consideration of working with Wakely Consulting seems to be an active step to have as much openness and thoughtfulness as possible in the rate filing process.

The Lieutenant Governor asked if Wakely is ready for this work as it seems to have the capacity for this project? Ms. Lambert agreed they would be interested. Ms. Veltri agreed with Mr. Barnes' comments and stated that the Board is obligated to do everything it can to ensure that the rates are as low as possible especially in the first year. Ms. Lambert requested that the Exchange develop a scope of work document. Ms. Dowling reminded the Board that the deadline for rate submission to CID is April 30th. Mr. Sigal stated that while it would be beneficial to be able to do this before submission, but timing is tight. While CID is expecting rates by April 30th, there is a strong belief that rates will not be filed by that date. Mr. Sigal noted that there is no mechanism in place for carriers to pre-file with the Exchange. Lieutenant Governor Wyman suggested that perhaps a phone call would help. Ms. Veltri noted that the rate filings will be on the CID website and publicly available once they are filed anyway. The Lieutenant Governor stated her understanding is that the insurance companies are still waiting for additional information through CID from CCIIO and she questioned how rates can be filed by April 30?

Mary Ellen Breault, Director, Life and Health Division of CID, reported that while CID is awaiting additional clarification from CCIIO on some minor issues, rates should be pretty much developed by the carriers by now regardless of the information from CCIIO. Rates can be submitted now

and adjustments can be made after the deadline. CID has a concern if filings come in any later than end of April that the approval cannot happen in by the end of July.

Lt. Governor Wyman asked for a review of the process. Ms. Breault responded that the companies are required to submit documents to the federal system by July 31, working through the National Association of Insurance Commissioners (NAIC) and its electronic system. That is a federal deadline. To accommodate the Exchange having the rates in time for its system, the CID was trying to have rates filed by April 30. Julie Lyons noted that the Exchange is also tracking along with the CID schedule. The QHP certification process would extend through July to align with the federal deadline. The Lt. Governor inquired about the length of time needed for the rate filing review. Ms. Breault responded that review of any one given filing can take anywhere from a few days to a week or longer depending on how many issues are identified, and the correspondence back and forth with carrier requesting additional information. Carriers all file rates at the same time and a large volume is anticipated.

Ms. Dowling noted that there is also a 30 day public comment period. Ms. Dowling suggested that the public comment period be used for the Wakely review. If there are any issues, a carrier can withdraw and resubmit. CID would approve, deny or refine the rates. The process is fairly compressed but needs to allow time to go back and forth.

Secretary Barnes suggested that the Board authorize an expenditure from Access Health CT for Wakely Consulting to review the rate filings to help facilitate the goal of affordability noting that options are limited due to time constraints. Ms. Dowling provided a reminder that whatever is approved, the rate filings are for every product that the carriers offer in the Connecticut marketplace. Lt. Governor Wyman asked if Secretary Barnes' suggestion is agreeable to the Board and for a motion to authorize the Exchange, at Mr. Counihan's direction, to expend up to $100,000 to work with Wakely to conduct the market study and rate review assistance under the circumstances that the Board had discussed. Mr. Counihan provided that a statement of work will be created. ***Secretary Barnes made the motion and it was seconded by Vicki Veltri. Motion passed unanimously.***

Secretary Barnes provided comments with regard to other issues that do not necessarily fall directly under the purview of the Exchange. The first is a technical matter. Under current statutes, there is no CID jurisdiction over small group indemnity plans. This can cause a potential complication with adverse results for that segment of the population. Secretary Barnes stated that he felt the Exchange should take a position to support the department to include the small group indemnity plans. The other legislative matter is more significant. While the federal law requires a MLR of 80% for the individual and small group market, it does not limit the state from setting a higher MLR. One way to address costs is to increase the MLR from 80% to 85% by statute thereby making more of the premium dollar available for health care. Secretary Barnes noted that there may be some adverse consequences on carriers to sustain administrative costs and it would probably be opposed by the carriers.

Dr. Scalettar asked how this issue was being handled around the country? Ms. Breault responded that pursuant to the NAIC model, across the country many states are only using 55% in the individual market from a pricing perspective. Ms. Veltri stated that this is very aggressive, but it does send a good message which may be complicated in the beginning but will be consumer oriented.

Mr. Ritter stated that the 80% versus 85% distinction between individual/small group and large group is probably based on administrative cost. Since the Exchange will be providing substantial marketing, the difference may no longer be justifiable. He would like to hear from the carriers.

Lt. Governor Wyman noted there may be a legislative timing issue. The thought is that if this can be done legislatively, it will lower plan costs. Support from the Exchange would be helpful for the legislators to hear. A question was raised as to whether a motion should be requested. Ms. Veltri stated that a motion sends a strong message.

Ms. Veltri made a motion to recommend to the Connecticut General Assembly that the MLR for individual and small group insurance policies be increased to 85 percent and that all issuers of small group health insurance policies or certificates file their rates with the Commissioner of the Connecticut Insurance Department and those rates be approved by the Commissioner prior to becoming effective. **Secretary Barnes seconded the motion.** ***Motion passed unanimously.***

H. **Adjournment**

Lt. Governor Wyman requested a motion to adjourn the board meeting. ***Motion passed unanimously.*** The meeting adjourned at 12:05 p.m.

The next Board Meeting will take place on May 16, 2013 at 9:00 a.m.
at a location to be determined

Agenda
Presentation