



STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

**Connecticut Health Insurance Exchange
Board of Directors Regular Meeting**

Legislative Office Building
300 Capitol Avenue, Room 1D, Hartford, CT

Thursday, July 26, 2012

Meeting Minutes

Members Present:

Lieutenant Governor Nancy Wyman (Chair); Jeannette DeJesus (Vice-Chair), Office of Health Reform & Innovation; Secretary Benjamin Barnes, Office of Policy and Management (OPM); Vicki Veltri, Office of the Healthcare Advocate; Deputy Commissioner Anne Melissa Dowling, CT Insurance Department (CID); Commissioner Roderick L. Bremby, Department of Social Services (DSS); Mickey Herbert; Grant Ritter; Dr. Robert Scalettar; Mary Fox and Cee Cee Woods; Commissioner Jewel Mullen, Department of Public Health (DPH); Robert Tessier; Michael Devine

Members by Telephone:

None

Other Participants:

Health Insurance Exchange (HIX) Staff: Kevin Counihan, Jason Madrak, Virginia Lamb; Julie Lyons, Grant Porter; Mintz & Hoke: Kathy Morelli and Andrew Wood; Mary Ellen Breault, Connecticut Department of Insurance

Members Absent:

None

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

I. Call to Order and Introductions

Lt. Governor Wyman opened the meeting at 9:01 a.m.

II. Public comment

Mary Anne O'Neil provided public comment.

III. Review and Approval of Minutes

Lt. Governor Wyman made a motion to approve the minutes from the June 21, 2012 meeting. Commissioner Bremby requested that a typographical error in the minutes be corrected on page 4 to reflect that that the dollar amount of the Level II Grant is \$108,631,635. The motion to approve the minutes as amended was seconded. **Motion passed unanimously.**

IV. CEO Report

Kevin Counihan, CEO of the Connecticut Health Exchange updated the Board on progress with staffing, funding, CCIIO relationships, procurement and the need for additional office space. James Wadleigh started as Chief Information Officer on July 9. A CFO will be named on July 27 and a COO will be named by the end of August. A favorable decision is expected on the Level I supplemental grant in the next two weeks in the amount of approximately \$1.67 million. A budget discussion is scheduled with CCIIO on Monday for the Level II grant. Given costs (over \$100 million), the process for approval for the Level II grant is more complicated but very much on the right path. A decision is also being finalized on the procurement process for the System Integrator. With the Systems Integrator on Board, the Exchange will require approximately 8,000 to 10,000 additional square feet of space to accommodate Exchange staff, Systems Integrator staff and KPMG staff. Visible community outreach has included interviews with *The Wall Street Journal*, *Hartford Courant*, *The Hartford Business Journal*, a presentation to the Greater Hartford Alliance and an interview on health care matters on WTIC.

V. Policies and Procedures

Virginia Lamb, general counsel for the Exchange, provided a summary of three proposed policies and procedures, two of which are in direct response to changes made in the Exchange's enabling legislation by the most recent special session of the legislation, PA 12-1.

The Exchange's Ethics Policy was revised to incorporate the changes made by PA 12-1. These changes include an added restriction that no Exchange employee can be a consultant to a trade association of any insurer, insurance producer, or broker, health care provider, health care facility or health or medical clinic. The same consulting restriction applies to Board members. New legislation also extended the time for an Exchange employee to get an insurance producer license. Ms. Lamb recommended that the Exchange's general counsel serve as the Exchange's compliance officer and this was incorporated in the policy.

The Exchange's Bylaws were also revised to incorporate the changes of PA 12-1. PA 12-1 designated the Healthcare Advocate as a voting member of the Board. As a result the number of ex-officio voting members increased to 4 and the number of ex-officio non-voting members decreased to 2. The quorum of the board also increased to 7 voting members. PA 12-1 also extended the term of office of the House Majority Leader's appointee from 1 year to 2 years. In addition, the Exchange's specific ethics restrictions were applied to all board members including the ex officio board members. Additional restrictions were also added prohibiting board members from being a consultant to or an employee of a trade association of insurers, insurance producers or brokers, health care providers or health care facilities or health or medical clinics while serving on the board of the Exchange.

Lt. Governor Wyman requested a motion to approve the revised Ethics Policy for publication in the *Connecticut Law Journal* and on the Connecticut Health Insurance Exchange website for the 30 day public comment period. The motion was made by Vicki Veltri and seconded. **Motion passed unanimously.**

Lt. Governor Wyman requested a motion to approve the revised bylaws. The motion was made by Vicki Veltri and seconded. **Motion passed unanimously.**

Ms. Lamb also reviewed the proposed policy for developing Essential Health Benefits Benchmark Plan Policy. This is the process the board is using to reach a recommendation for an EHB Benchmark plan. The Board appointed a Health Plan Benefits & Qualifications (HPBQ) Advisory Committee and a Consumer Experience and Outreach Advisory Committees. The Health Plan Benefits and Qualifications Advisory Committee was charged with making recommendations to the Board on selection of the plan. The Consumer Experience Outreach and Advisory Committee made recommendations to the HPBQ Committee for their consideration. The Committee followed all Freedom of Information requirements including public meetings and notice, minutes and reported votes on the Exchange's website. The Committee was tasked with including the 10 statutory categories of Essential Health Benefits under the Affordable Care Act as well as the state's health care mandates and was required to balance affordability and the diverse needs of Connecticut residents and businesses. The Board will need to approve the process so that it can be noticed in the *Connecticut Law Journal* and on the Exchange website for 30 days of public comment. Following adoption of the policy by the Board, the Board can then act on any recommendations coming to the Board from the HPBQ Committee.

Lt. Governor Wyman requested a motion to approve the Essential Health Benefits Benchmark Plan Policy for publication in the *Connecticut Law Journal* and on the Connecticut Health Insurance Exchange website for the 30 day public comment period. The motion was made by Robert Tessier and seconded by Mary Fox. **Motion passed unanimously.**

Dr. Robert Scalettar joined the meeting at 9:24 a.m.

VI. Essential Health Benefits Overview

Anne Melissa Dowling provided a status report and overview of the work done by the Health Plan Benefits & Qualifications Advisory Committee and introduced co-Chair Mark Espinosa as well. Ms. Dowling provided a summary regarding the provision of the health care law which requires that all individuals and families are guaranteed a minimal level of coverage for certain healthcare services considered essential regardless of whatever health plan they choose. Discretion as to the essential health benefits was turned to the states by the Secretary of HHS at the end of December 2011. All insurers operating in the individual and small group markets both inside and outside of the exchange must cover this standard of benefits starting in 2014. If the selected Connecticut benchmark plan did not cover one of the 10 categories of services in the essential health benefits that are required under the Act, the State of Connecticut would be required to supplement its essential health benefits package with the additional required benefits from one or the other essential benchmark options. HHS provided additional guidance on how States were to provide additional services not traditionally provided in health plans today which the Committee followed. Connecticut had to make sure that what was chosen was a balance of comprehensiveness. Specific guidance was provided that no benefit designated as essential could be subject to an annual or lifetime dollar limit.

After three months of extensive analysis and review, the Health Plan Benefits & Qualifications Committee offered to the Board as its recommendation to the Board that the State of Connecticut's essential health benefits benchmark plan be defined by the benefits package included in the Plan D benchmark option supplemented by the prescription drug option included in Plan C, and the dental care benefits included in the Connecticut Children's Health Insurance program, Husky B. The vision benefits included in the Federal plan with the largest national enrollment was chosen for the pediatric vision requirement. Ms. Dowling thanked the members of the committee for their voluntary service. Carriers and the office of the Comptroller were thanked as well. Technical assistance was provided by Scott Anderson, Mary Ellen Breault, Tim Lyons and Beth Cooke as well as Bob Carey.

Commissioner Benjamin Barnes joined the meeting at 9:28 a.m.

Discussion turned to Julie Lyons and Grant Porter from the Exchange to provide broader understanding of the recommend benchmark plan.

Mr. Herbert asked if the Exchange had to accept a benchmark plan that covers all mandates and Ms. Dowling noted that it does. Mr. Herbert further asked if the whole package had been costed out. Mr. Counihan noted that based on a rough sample size of population there is a good sense of the cost. Mr. Herbert further asked whether the information was provided to the Committees. Mary Fox noted that tables with various costs had been made available. Ms. Dowling indicated that there is a relative understanding of base level costs that were further built upon. Mr. Tessier noted that the cost sharing provisions of those plans were all different making it very difficult to determine how to compare the premiums.

Julie Lyons thanked the Health Plan Benefits & Qualifications Committee and the Consumer Experience and Outreach Committee for their dedication and commitment to the project.

Ms. Lyons and Mr. Porter presented an overview of the essential health benefits elements; a summary of the Institute of Medicine recommendations; and, the guidance provided by CCIIO as well as the approach the advisory committees used to make a recommendation for the essential health benefits. The Health Plan Benefits and Qualifications Committee after much debate surrounding the medical necessity of therapy visits in certain situations adopted Plan D as the medical portion of the essential health care benefits. The stakeholders concluded that the slightly more generous limits in Plan D provided greater security to anyone who would suffer catastrophic injury or illness and would require more intensive rehabilitation. Both the Health Plan and the Consumer Outreach Committees accepted the options in Plan D as their recommendation.

Ms. Lyons continued with process for selecting coverage for prescription drugs, habilitative services and pediatric dental and vision services. Both advisory committees recommended Plan C for the prescription portion of the essential health benefits. Ms. Lyons noted that habilitative services are not a commonly covered category or described set of benefits within an insurance evidence of coverage. For that reason, the advisory committees were not able to make a choice. This choice will remain with the insurance carrier. The benefit can be treated as outpatient rehabilitation or the carrier can determine on its own what services would qualify as habilitative service benefits and then report that to the Department of Health and Human Services. The Advisory committee recommended the CHIP (Husky B) program to supplement the pediatric dental portion of the essential health benefits package and the federal pediatric vision plan for vision care. This was the only option available to choose from.

Mickey Devine arrived at 9:50.

Lt. Governor Wyman opened up discussions to questions. Mickey Herbert referred back to his two previous questions. Mr. Herbert believes that Board should have the cost of the entire package in advance of the next board meeting. Mr. Counihan responded that calculations of base rate were provided and will be provided to the Board.

Mr. Herbert asked where state mandates fit into the ACA and the state's enabling legislation or CClIO guidance. Mr. Porter responded that if the Committee selected the Federal employee health plan, given Connecticut's state mandates, the state might be required to pick up the cost of those mandates after the 2 year transitional period. Mr. Counihan clarified that it was not anticipated that when the ACA was written that states were going to be given this two year period. All mandated states are being given a chance to define their own benefits for two years and will be faced with absorbing the costs of keeping their mandates, if the federal government ends the subsidy after the transitional two years. Commissioner Mullen indicated the need for a work group to look into whether state mandates really need to remain state mandates.

Vicki Veltri responded that the Connecticut Insurance Department is mandated by state law to do a study on new mandates proposed and potential cost on a per enrollee per month basis. Ms. Veltri further indicated that the federal government punted the decision to us and gave us a choice of 4 or 5 plans. Every one of those plans except the federal plan covers the state mandates. Mandates are law. It would require an act of legislation to repeal them. Ms. Dowling also indicated that the Act requires that we follow state law. Dr. Scalettar indicated that most states in the process of health reform are revisiting all mandates to see relevance and evidence based on cost. Bob Tessier asked for further clarification on Mr. Herbert's question on cost and also inquired about the cost of the pediatric vision and dental benefit. Mr. Herbert confirmed that he was inquiring about premium information and expressed concerns that the carriers need to know what this is going to cost and the viability of the product.

Ms. Dowling invited Mary Ellen Breault from the Department of Insurance to discuss layering and costing and whether costing out can be expected by the next Board meeting. Ms. Breault clarified that the essential health benefit determination based on federal guidance must be made without regard to cost sharing. It is also very difficult to come up with cost estimates. Exchange plans do have to meet actuarial values and there may be a diverse change in networks (as the carriers are exploring a shift to smaller networks). The benchmark plans considered were all based on existing populations and negotiated rates and setups. Based on discussion with carriers in Connecticut and across the country through the NAIC, there will be a shift in large networks to smaller networks and a lot of dynamics that will change the cost. This process is dictated by Federal guidance and still waiting for final regulations. Connecticut is just choosing the categories of services that need to be covered. The cost part of it will be defined with actuarial value and cost sharing and will be a decision within the Exchange. The Exchange's goal is make the plan the most affordable plan possible. Mr. Ritter inquired as to the cost difference estimates between Plan B and Plan D? Mr. Porter responded that differences between Benchmarks are very narrow.

Ms. Fox indicated that there has been tremendous value in discussing component parts of the plans. There is a need in implementing the ACA to go beyond traditional thinking and look at innovative solutions to meet basic needs with evidence based medicine. There is a need to look at innovative solutions beyond the traditional plans.

Ben Barnes inquired whether there was any progress in looking at health coverage in non-traditional ways. Mr. Counihan noted that there are preliminary conversations with plans who are looking forward to new thoughts on how to make coverage more affordable and more effective. Commissioner Bremby suggested building a process map to see where this step lies in the overall step so as to not miss opportunities to weigh in on changing the system and to see where this rests with other components of the process.

VII. Mintz & Hoke Update

Jason Madrak provided a marketing and communications updated reviewing the 6 major steps in cycle of complete marketing and communications campaign. Research is wrapping up. A comprehensive stakeholder research report reflecting conversations with board members, members of the public, advocates, insurers, providers and other individuals will be provided. Consumer and small business research is also being completed and a formal report will be issued. An analysis of key findings of the Thomson Reuters study was provided. Data analysis next steps were also reviewed.

Ms. Veltri inquired as to how disability data was obtained. Ms. Veltri further indicated that the Permanent Commission on Status of Women commissioned a self-sufficiency study on the cost to live in Connecticut including cost of insurance and asked whether this information could somehow be helpful or integrated in some way. Mr. Madrak will provide the specific survey questions relating to the disability metric. While the formal parts of the research process is being wrapped up, the investigation and learning will never cease. The Permanent Commission on the Status of Women information will be looked into.

Commissioner Barnes asked whether the Thomson Reuters data showed significant overlap at the household level with respect to uninsured people living with people covered by Medicaid. Mr. Madrak responded that the data did not point specifically to the household level although the data did suggest a high likelihood of large overlap. Mr. Herbert inquired as to undocumented individuals. He also expressed concerns as to a substantial enrollment in order for the Exchange to be viable. Mr. Madrak replied that there will be other populations that enrollment will be drawn from.

Mintz & Hoke was introduced by Jason Madrak. Kathy Morelli reviewed the status of market exploration, strategic development and bridging communications. Andrew Wood provided a summary as to where research is going to be in the future. The Thomson Reuters data will define how individuals will be reached and to develop right messages to the right people to the right places. Strategic development and the next steps were reviewed. Finally, Mr. Madrak reviewed bridge communications. Ms. Fox inquired as to whether takeaways will be provided from all consumers and small group meetings at the next Board meeting. Mr. Madrak replied that the two formal reports will be released and a summary will be provided to the Board. Commissioner Mullen inquired as to whether the website is assessable in Spanish. Mr. Madrak indicated that it is in English and there are numerous technical fixes to toggle between languages and will take this as a take away.

VIII. Public comment

Dr. Jeanne Hosinski provided a public comment.

IX. Executive Session – Vendor Procurement

Lt. Governor Wyman requested a motion to move the Board to Executive Session to discuss procurement issues under CGS 1-200(6)(e) . Motion was made by Benjamin Barnes and seconded by Grant Ritter. **Motion passed unanimously.**

Attendees Include:

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CTHIX: Kevin Counihan, Jim Wadleigh, Virginia Lamb;
Lt Governor's Office: Mary Jo Pakulis;
KPMG: Paul Hencoski and Roger Albritton.

X. Adjournment

Lt. Governor Wyman requested a motion to adjourn the Board meeting. Motion was made by Vicki Veltri and seconded by Dr. Scalettar. **Motion passed unanimously.** The meeting adjourned at 11:50 a.m.

Resources:

[Agenda](#)

[Minutes from previous meeting](#)

[July 26, 2012 Board Presentation](#)

[Mintz & Hoke Presentation](#)