

VERBATIM PROCEEDINGS

STATE OF CONNECTICUT

PUBLIC FORUM

RE: HEALTH INSURANCE EXCHANGE

BOARD OF DIRECTORS MEETING

JANUARY 24, 2013

1 ELIZABETH STREET  
HARTFORD, CONNECTICUT

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 . . . Verbatim proceedings of a Public  
2 Forum on Health Insurance Exchange held on January 24,  
3 2013 at 8:36 a.m., at the 1 Elizabeth Street, Hartford,  
4 Connecticut . . .

5  
6  
7 CHAIRPERSON NANCY WYMAN: First of all,  
8 what I first wanted to do was welcome back Bob Tessier.  
9 Thank you, it's so good to see you again. You're looking  
10 dapper with your new goatee.

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

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

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

21 CHAIRPERSON WYMAN: Well, we don't have any  
22 -- right, five voting members. We need seven. So we  
23 might not be voting on anything, we might just be talking  
24 a lot today. You know, so that everybody knows, we don't

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 have any public comment so I'm going to skip over it  
2 anyway and explain that I have two letters of resignation  
3 from Board members so I would like to read them.

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

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

17 Michael did call and I believe most of you  
18 already had known about Mickey Herbert and, "The purpose  
19 of this letter is to tend my resignation immediately from  
20 the Board of Directors of the Connecticut Health Exchange.

21 It was a pleasure and honor to serve on the Exchange  
22 Board for the past 15 months. I am proud to have played a  
23 small part in the continuing effort to provide assessable,  
24 affordable, high-quality healthcare to all Connecticut

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 citizens.

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

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

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

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

18                   CHAIRPERSON WYMAN: -- okay. Mary's here?  
19 So I'm skipping over the review of the minutes and I  
20 request approval of the minutes of December 20th? May I  
21 have a motion?

22                   A MALE VOICE: So moved.

23                   A FEMALE VOICE: Second.

24                   CHAIRPERSON WYMAN: So moved and seconded.

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 All in favor?

2 VOICES: Aye.

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

7 MR. KEVIN COUNIHAN: Thank you Lieutenant  
8 Governor. And happy new year to everyone. The Exchange  
9 staff as, I think everyone can imagine, remains very busy.  
10 We've had a couple of interesting updates that I would  
11 just like to inform the Board of. The first is that we  
12 have received a third best practice recognition from  
13 CCIIO. This relates to the new relationship that we've  
14 developed with OHA that will oversee our navigator  
15 program. We are in the process of working with OHA with  
16 respect to establishing the training and the management of  
17 that and the details of it, but the concept of working  
18 with that agency is something that CCIIO thought it was  
19 something that should be considered or perhaps replicated  
20 by other states as a best practice with respect to the  
21 navigator program. So a special thanks to Vicky and Jason  
22 and our team for both initiating this and implementing it.  
23 I think we pretty much know nationally that  
24 we've got 18 states that will be adopting state-based

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 exchanges. That includes the includes the District of  
2 Columbia. There are two that have been approved for  
3 partnership exchanges, that being Arkansas and Delaware.  
4 And there may be some others, although the deadline for  
5 that is running out really within the next week. That  
6 would mean that there would be probably about 30 states,  
7 if not, a couple more that may be defaulting to the  
8 federal exchange. So we will be watching this stuff  
9 obviously very, very closely.

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

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

22 Five senior staff are attending a two-day  
23 seminar with CMS and CCIIO in Baltimore beginning Monday.

24 The core functional areas involved are IT, operations and

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 outreach, policy, and there's a separate session for CEOs,  
2 which may act more as a group therapy session as much as  
3 anything.

4 (Laughter)

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

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

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

22 Last week I was in Colorado to meet with  
23 the All Pair Claim Database folks as well as their  
24 exchange management team and learned a great deal about

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 the promise that the APCD can provide as a decision  
2 support tool for both consumers, small businesses, policy  
3 makers, legislators, and others. And I look forward to  
4 sharing more of those with you. Colorado has a series of  
5 reports already that are available online. They show such  
6 things as primary care visit rates, inpatient utilization,  
7 variations in care access and utilization, evidence of  
8 adverse selection, and preventable hospitalization for  
9 chronic illnesses. So that type of data is something that  
10 we're very much looking forward to being a part of serving  
11 our residents and small businesses and providers and  
12 health plans.

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

22 A fundamental tenant of health reform is  
23 the concept of shared responsibility and collaboration.  
24 One of the risks I think that we all face in implementing

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 health reform is a concern that if something isn't perfect  
2 the first time that it means that it's fundamentally  
3 flawed. And if we're expecting perfection out of health  
4 reform or out of an exchange or out of the website or out  
5 of the plan design we're all going to be disappointed. It  
6 has to be part of a broader commitment to the concept and  
7 the values that we owe insurance coverage as a fundamental  
8 right to our citizens in making this as affordable and  
9 comprehensive as possible. And I believe, and I think as  
10 a staff, we believe, that the collaborative atmosphere  
11 that we've experienced over the past three weeks to get us  
12 where we are in plan standardization is a great symbol for  
13 that type of sense of shared responsibility. So the staff  
14 and I personally are extremely grateful and thankful to  
15 that team.

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

20 MR. COUNIHAN: For the healthy chats?

21 CHAIRPERSON WYMAN: -- healthy chats.

22 Okay? You don't have to give them to us now, just make  
23 sure that the Board members, for those that want to  
24 attend, can.

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 MR. COUNIHAN: Okay.

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

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

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

17 VOICES: Aye.

18 CHAIRPERSON WYMAN: No, I'm just kidding.  
19 Congratulations.

20 MS. VICKI VELTRI: Thank you.

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

23 MS. VELTRI: Thank you.

24 CHAIRPERSON WYMAN: Thanks for taking it

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 on. We do appreciate it. Okay. And at this time I'm  
2 going to go up to the finance updates. Steve, do you want  
3 to?

4 MR. STEVE SIGAL: Thank you Lieutenant  
5 Governor. I'm Steve Sigal, the Chief Financial Officer of  
6 the Exchange and I wanted to take this opportunity --

7 CHAIRPERSON WYMAN: Steve, can you talk a  
8 little bit closer into your mic? Thank you.

9 MR. SIGAL: -- is it on?

10 CHAIRPERSON WYMAN: Yes, it is.

11 MR. SIGAL: Okay. Sorry.

12 CHAIRPERSON WYMAN: No problem.

13 MR. SIEGAL: I wanted to take this  
14 opportunity to update the Board on the Exchange continuing  
15 interaction with a variety of departments in the Health  
16 and Human Services Agency. Since the e-mail I shared with  
17 the Board on January 4th regarding the status of the  
18 grantee change to the Exchange from the Office of Policy  
19 and Management and access to the grant award funds much  
20 has occurred. This resulted from the significant delays  
21 the Exchange encountered.

22 What you have up there is a slide that  
23 reviews the chronology that you have seen parts of before.  
24 The headline here is that the grantee change took 63 days

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 when the Exchange was told to expect 30 to 45 days. And  
2 access to the funds to 27 days when the Exchange was told  
3 to expect 10 days. Further difficulties were experienced  
4 from the de-obligation of OPM's award before granting the  
5 new award to the Exchange.

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

16 CHAIRPERSON WYMAN: I'm so glad that we're  
17 here to teach them.

18 (Laughter)

19 MR. SIGAL: Yeah. Next slide? So there  
20 were unintended consequences, as I shared in the January  
21 4th e-mail, the unanticipated delays led to the Exchange  
22 borrowing \$5,000,000 from the State. It was allowed under  
23 part of our enabling legislation when we were first  
24 authorized.

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1                   The good news is that we actually received  
2                   our first drawdown of funds yesterday and repaid the State  
3                   yesterday off of our books and it should show up in the  
4                   State's bank account today.

5                   CHAIRPERSON WYMAN: We appreciate that  
6                   tremendously. Thank you. It showed up yesterday, not  
7                   that we're counting.

8                   (Laughter)

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

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

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

24                  Our work has not been without challenges.

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 In the Board package that you got last week you can see  
2 that. We did not meet our design confirmation due dates  
3 of the end of December, we think for extremely valid  
4 reasons. As a result we put ourselves as red and behind  
5 on our development. That was a week or so ago. Since the  
6 end of December we've been working with Noggin Surrea  
7 (phonetic) of Deloitte and our good colleagues there to  
8 adjust and adapt. Jim is going to go into a little bit  
9 more detail because in the interest we think we are back  
10 red, but again -- excuse me. I mean back green. Thanks  
11 Jim. It's good to have Jim around.

12 (Laughter)

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

19 What I'd like to go through today is just a  
20 distilled version of the dashboard. Now, I have slides  
21 for the dashboard, and our risks. You have the updated  
22 copies in the packets that we gave, but I'd like to just  
23 give you the update right here. But let me go back,  
24 Grant.

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1                   Update for that dashboard, and that  
2 dashboard that we do have up here is the distilled  
3 version. The main things in operations right now, our  
4 call-center contract is being negotiated. We look to have  
5 our vendor up and running officially by the 1st of March  
6 and unofficially working with our IT folks sooner than  
7 that. The small employer health options program, the  
8 contract was put out for bid last month. Just two days  
9 ago or -- two days ago we got three people that put in  
10 proposals. We're evaluating those proposals and at this  
11 juncture we can't share the names of those, but we will be  
12 working with different -- the shop AC and others to  
13 evaluate those.

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

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

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 will give you an update on that.

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

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

15                   CHAIRPERSON WYMAN: Jim? Thank you.

16                   MR. JIM WADLEIGH: Good morning. My name  
17 is Jim Wadleigh, I'm the Chief Information Officer for the  
18 Exchange. I want to give you this month's technology  
19 update.

20                   All of the teams continue to make  
21 significant progress. What we see here is -- continues to  
22 be our systems development lifecycle with all of our key  
23 dates. We are still on track for our two releases with a  
24 June and October implementation.

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1                   What have we accomplished over the last  
2 month? We've continued our design sessions. We will  
3 complete tomorrow our design confirmation for the Exchange  
4 and I'll talk a little bit in a minute about what that is.

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

15                   The Department of Social Service  
16 integration design confirmation is on track to be  
17 completed in mid-March. And our go live date of October  
18 1st, stays unchanged.

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

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 want to re-explain it.

2 (Laughter)

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

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

18 So what are some of the things that  
19 extended our deliverable and why did we do that? As we've  
20 communicated over the last couple of months we've had more  
21 stakeholder participation in our design sessions. So our  
22 Advisory Committee members, some of them that are sitting  
23 around the room, have participated in those design  
24 sessions. They have contributed in a positive way for a

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 better product. As a result of that, the out-of-the-box  
2 screen design and user interface we asked Deloitte to go  
3 back to the drawing board and make some significant  
4 modifications, all for the betterment of our customer  
5 experience. We will begin to see those and share those  
6 with our Advisory Committees, we'll begin to see those  
7 tomorrow. We'll begin to set up meetings over the month  
8 of February and share those and I'm very excited, because  
9 I've started to see some very positive changes in the  
10 design.

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

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

21 MS. MARY FOX: May I ask a question?

22 CHAIRPERSON WYMAN: Sure.

23 MR. WADLEIGH: Yes Mary, you may.

24 CHAIRPERSON WYMAN: Mary, can you talk into

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 the black mic?

2 MS. FOX: This one?

3 CHAIRPERSON WYMAN: Yes.

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

20 MR. WADLEIGH: First, thank you for the  
21 question. So right now the design is planned to have up  
22 to 20 different sort selections. As of right now I am not  
23 aware that one of our sorts will be -- begin with our  
24 carriers by provider. What we will have right next to

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 each carrier will be a link out to the provider  
2 directories that will allow our consumers to go out to  
3 those provider directories and do that search to find out,  
4 do they have all of the carriers -- providers that they  
5 are looking for with that carrier network?

6 MS. FOX: Before they select?

7 MR. WADLEIGH: Before they select.

8 MS. FOX: So can you imagine, you know, if  
9 we have some innovative solutions around ACOs available in  
10 October that that would come up in the course of events  
11 early on in the various screens?

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

15 MS. FOX: Excellent. Thank you.

16 CHAIRPERSON WYMAN: Bob?

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

23 MR. WADLEIGH: Great question Bob. Yes.  
24 And so, working with CCIIO and as jumping around on our

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 bullet here, you'll see that we're going down -- I leave  
2 on Sunday to go down with the rest of our team to meet  
3 with CCIIO. We've been in negotiations with CCIIO around  
4 the process of what functionality do we feel that we can  
5 defer post-October 1st that would not impact our consumer  
6 experience, or our integrated eligibility. And where we  
7 have ended up over the last couple of weeks is somewhere  
8 in the ballpark of about 30 percent of the functionality  
9 that we have defined in our requirements document we feel  
10 can be deferred.

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

19 A MALE VOICE: We're even.

20 MR. WADLEIGH: -- yeah, we're even. As you  
21 can tell, we're working on a lot of stuff. We do not need  
22 functionality to decertify a plan, October 1st. We also  
23 do not feel we need functionality to recertify a plan come  
24 October 1st. There are other things around financial

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 management that we feel that we can perform manually in  
2 the timeframe of October to some point at a later date.  
3 There's also reporting. A significant amount of our  
4 requirements is around reporting, that we feel that we can  
5 do manually and not need to integrate immediately by  
6 October 1st. So those are just a few of the things in  
7 discussion with CCIIO that we feel that we can -- that we  
8 can discuss with them.

9 One further note is we met with them a  
10 couple of weeks ago and as of that meeting we were the  
11 first state to come to them and say, we feel that we  
12 should be deferring some functionality. We have worked  
13 through what that functionality is and we want to come and  
14 talk to you. They were very happy to hear that and so  
15 much so that they have been shocked that other states have  
16 not come knocking on their door to discuss what is all the  
17 critical functionality that is needed just for October  
18 1st.

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

23 MR. WADLEIGH: At this point in time Bob  
24 there are no financial implications. I would say, at this

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 point in time, because we still need to work through our  
2 official change control process, which would go through  
3 our Steering Committee, clearly if we thought that there  
4 were we would bring that back to the Board and share it  
5 with them. But at this point in time through our  
6 conversations we are not expecting financial implications.  
7 The Deloitte contract is a set amount of functionality  
8 that we have asked to be delivered and moving that out not  
9 only helps us, but it helps them reach their goals as  
10 well.

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

24 CHAIRPERSON WYMAN: I agree. Very good.

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 All right. Jim?

2 MR. WADLEIGH: So in summary --

3 (Laughter)

4 MR. WADLEIGH: -- I want to continue to  
5 allay any fears. June 4th is our plan management  
6 implementation date. October 1st continues to be our core  
7 HIX functionality implementation date. Any changes in  
8 that would be communicated in the future.

9 CHAIRPERSON WYMAN: Any other questions for  
10 Jim? Anybody? Jim, thank you. Thank you all very much.

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

12 MS. JULIE LYONS: Thank you Lieutenant  
13 Governor. My name is Julie Lyons and today I'm going to  
14 provide you with information on plan management, including  
15 the definition. I'll outline the key responsibilities  
16 included in the scope of plan management and update you on  
17 some primary activities the team has been driving since  
18 our last Board meeting. Lastly, I'll inform you of some -  
19 - of the major tasks we will face in the next few months  
20 as we move closer to the rollout of the Exchange.

21 I look at plan management is a partnership  
22 between the Exchange and one of our key stakeholders, the  
23 issuers of benefits that will be offered on the Exchange.

24 In order for the Exchange to succeed in providing an

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 array of consumer options we need to engage the carriers  
2 to ensure that we have a mutual understanding of what must  
3 be supported according to federal regulations and  
4 guidance, as well as Connecticut state law. We need to  
5 make sure that we have the technology -- technical  
6 information needed to program their systems recognizing  
7 that we don't have all of the final guidance from our  
8 federal counterparts.

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

19 The QHP application must be drafted and  
20 incorporate requirements outlined in the regulatory  
21 guidance in the QHP solicitation. The application will  
22 include a series of attestations to which carriers will  
23 need to agree in order to become certified on the  
24 Exchange. As an example, the ACA requires reporting of

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 certain performance information, such as enrollment and  
2 disenrollment data, as well as the number of claims  
3 denied.

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

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

21 In support of the primary plan management  
22 functions of developing an effective relationship with the  
23 carriers we held an operational kickoff meeting earlier  
24 this month and we held in eligibility and enrollment

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 webinar yesterday to review the end to end process flow,  
2 outline expected timelines for enrollment, processing, and  
3 discuss various enrollment scenarios. Our goal at this  
4 meeting was to educate the carriers on how we expect our  
5 systems to work and support the enrollment process as well  
6 as obtain their important feedback. We expect to hold  
7 weekly webinar sessions for the carriers with future  
8 topics including technical data interchange and with  
9 regard to the attestations that are required as part of  
10 the certification process.

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

19 We also had an opportunity to meet with the  
20 Surf (phonetic) staff, along with representation --  
21 representatives from the Insurance Department to discuss  
22 the standard templates being developed for carriers to  
23 submit their benefits -- excuse me, administrative  
24 formulary network and rate information to us. The Surf

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 team will be establishing weekly conference calls with us  
2 so that we can review the progress of the templates --  
3 template development and discuss any concerns.

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

10 CHAIRPERSON WYMAN: You have a question?

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

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

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

24 MS. LYONS: Actually, we did receive some

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 questions that we're researching responses for from two of  
2 the issuers and it really goes hand-in-hand with all of  
3 the technology. So it's likely we will be publishing the  
4 questions and the answers on our web, so you know,  
5 complete transparent disclosure.

6 MS. VELTRI: Yeah. Exactly.

7 CHAIRPERSON WYMAN: Are you ready Bob?

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

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

23 MR. GRANT PORTER: March.

24 MS. LYONS: March? And the March date is

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 consistent with the policy form filings and rate filings  
2 be submitted to the Department of Insurance. So it's kind  
3 of a large coordination effort. We're targeting for the  
4 end of March.

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

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

17 By way of background, as we worked through  
18 the advisory committees and brought recommendations, got  
19 advice from them and brought recommendations to the Board,  
20 it was defined that the Board directed us to develop a  
21 standard plan design for one option coming from the  
22 carriers, with allowing the carriers -- encouraging the  
23 carriers to give also a non-standard option. So we spent  
24 our time working on the standard options.

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1                   Why standard option? Desire to allow the  
2 consumers to compare and contrast plans based on quality,  
3 network, and price, while holding the benefits and the  
4 cost-sharing constant.

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

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

16                  MR. BARNES: Okay. Thank you.

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

21                  Consumer focus. The idea is that the  
22 consumers require appropriate care and value for the money  
23 that they're spending, both in terms of premium dollars  
24 and cost sharing aspects, deductibles, coinsurance, and

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 co-pays. The team also emphasis to primary care, the idea  
2 being that we want people and incent people to get and  
3 maintain -- get care and maintain their health.

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

17 We had carriers on board also. The actuary  
18 from Aetna, Bruce Campbell, Jan Bacher (phonetic) an  
19 Anthem actuary, and Alex Hutchinson from Health ACT, the  
20 new co-op. And there was some concern about that, but in  
21 the words of our advisory team members who actually  
22 requested that the carriers be on board, they provided a  
23 great service to us and in support of the team working.  
24 We got some free actuarial advice, which we appreciated,

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 and also a chance to vet out what made sense in the market  
2 and what did not.

3 The meetings were extremely collaborative.

4 When I say that, we had brokers discussing the impact of  
5 benefit plans that maybe a consumer advocate would  
6 appreciate, and there was honest and frank discussions  
7 about how that could work. And the best part I liked is  
8 that folks learned from each other as we moved forward.  
9 We got into a lot of detail. A Dr. McLean (phonetic) was  
10 one of the team members and would broach some various  
11 clinical aspects that the team appreciated. The consumer  
12 advocates continued to bring up, as everyone did, the  
13 concept of affordability across the board and the  
14 recognition that even as we set standard plan designs  
15 that's not addressing the whole totality of affordability,  
16 but it was an interesting group.

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

20 What were the parameters under which the  
21 team worked? First and foremost -- I shouldn't say, first  
22 and foremost, our friends in D.C. might take exception.  
23 Anything we came up with had to work -- had to work  
24 underneath Connecticut state law and regulations. We had

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 some ideas about some co-pays that we didn't have to -- we  
2 were quickly adjusted to reality by the Insurance  
3 Department and we changed those.

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

14 ACA is very strident about the fact that  
15 preventive services are free and to be encouraged and it  
16 also limits some out-of-pocket maximums. And all of these  
17 things we had to take into account. One of the primary  
18 disciplines that we had to follow was actuarial science  
19 and that was embodied in a tool that we had to practice  
20 actuarial science and that was the actuarial value  
21 calculator. And the fact that that was the tool by which  
22 we were able to meet the requirements of actuarial value  
23 for each metal tier for the basic bronze, silver, gold and  
24 platinum plans that also the silver plans that deal with

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 cost-sharing subsidies to folks that are under the 250  
2 percent of the federal poverty level.

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

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

21 So first, what is actuarial value? You can  
22 think of it as the total percentage -- the percentage of  
23 total healthcare that is paid for by your premium dollars.

24 So a 70 percent actuarial value plan means that your

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 premiums are paying for 70 percent of your healthcare  
2 costs on average for a typical population. That also  
3 means that 30 percent of those costs are being borne by  
4 the member through their out-of-pocket expenditures.  
5 Again, this is based on averages and using a typical  
6 population.

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

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

23 Before I go forward, is there any question  
24 sort of on the -- sort of the idea of actuarial value?

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1                   CHAIRPERSON WYMAN: I just want to know,  
2 who's typical?

3                   (Laughter)

4                   MR. PORTER: There's really -- there's  
5 really no typical individual because health care costs are  
6 so skewed and that you have this sort of 80/20 rule where  
7 20 percent of the population might be using 80 percent of  
8 the care, so the median and the mean are very much  
9 different. But actuarial value assumes those averages and  
10 those means.

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

19                   As Peter mentioned, we're allowed a two  
20 percent variation amongst those -- across those ranges, so  
21 a 60 percent bronze could really be -- fall between 58 and  
22 62 percent. In addition to those metal tiers there are  
23 additional subsidies that will be offered to consumers at  
24 certain income levels and these are cost-sharing

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 reductions that reduce the out-of-pocket expenditures. So  
2 with the silver plan instead of expecting to pay 30  
3 percent out-of-pocket to the average consumer it will be  
4 significantly less. And so there are three different  
5 levels for cost-sharing in these cost-sharing reduction  
6 plans for silver alternatives, which we'll go into greater  
7 detail when we look at each of the different plans.

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

18 It was released to us in late November as  
19 part of some of the proposed regulations. It's not  
20 finalized, it's a draft, or a proposed calculator. But  
21 it's reasonable, it gives us a good estimate of what we  
22 can expect these actuarial values to ultimately be with  
23 respect to the essential health benefits and in network  
24 services.

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1           A point to note is that it uses nationwide  
2 data, not Connecticut specific data. So every state will  
3 be using the same data. We'll have the option of using  
4 our own data in 2015, but for now we're using nationwide  
5 data.

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

18           So in developing the standard plans and  
19 using this actuarial value calculator and the science  
20 behind it, the process that we followed was first, as  
21 Peter mentioned, public input and what we got from them  
22 and from the Advisory Committee, public comments that we  
23 received through the phone or e-mail was that  
24 affordability was key. They wanted reasonable out-of-

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 pocket costs and premiums. There was a desire for  
2 separate deductibles, so a deductible for medical  
3 expenditures and a separate deductible for prescription  
4 drugs. They wanted simple and transparent cost-sharing  
5 requirements and we'll demonstrate how this was used in  
6 the development of our plans.

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

18 There was also a preference for care  
19 outside of institutions, and this will be demonstrated in  
20 both the bronze and silver plans, where the deductible is  
21 waived for primary care services and then more -- it's  
22 waived for more types of services in the silver plan as we  
23 move up in the actuarial value and move up in the  
24 generosity of the plan, so how much is being paid through

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 your premiums, we were able to waive the deductible for  
2 more services. As I mentioned, there was a preference for  
3 co-payments as opposed to a coinsurance. Consumer  
4 advocates and others felt that it makes healthcare more --  
5 health expenditures more predictable for the consumer. If  
6 you don't know how much a primary care visit costs, if  
7 you're not sure how much going to a specialist would cost,  
8 there's no way to calculate what 30 percent of that final  
9 bill will be. But you'll know that with a co-payment of  
10 \$30 or \$45, exactly what your bill will be and what that  
11 expense will be leaving you -- the doctor's office or the  
12 hospital. Finally, as I mentioned, the separate  
13 deductibles.

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

20 So now I just wanted to go through what the  
21 working group recommended. Concentration with carriers,  
22 with staff, with the Connecticut Insurance Department the  
23 group felt that the plans that I'll present offer the best  
24 value for the consumers given the realities of the

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 requirements imposed by the silver plan by having a 70  
2 percent actuarial value. And so I'm going to -- and I've  
3 also included in your packets and appendices -- appendix  
4 with three different -- appendices one that goes through  
5 summary of the metal tiers, the bronze through platinum.  
6 The second one looks at the silver plan, it's the same  
7 silver plan in relationship to the cost-sharing reduction  
8 plans. And then the final one looks at some of the other  
9 benefits that were not included in the AV calculator, and  
10 yet still need to be defined in order for the carriers to  
11 know how to construct their products for us.

12 So if we look at the silver plan, and the  
13 reason why I'm emphasizing the silver plan is because it's  
14 the silver plan that will determine the advanced premium  
15 tax credits, how much subsidies will be available to the  
16 consumers purchasing through the Exchange. So we expect  
17 that most people will purchase that silver plan and  
18 they'll be able to -- those tax credits will be pegged to  
19 the silver plan. The consumer will have the option of  
20 buying up or buying down. They could use those dollars to  
21 buy the bronze plan, those premium tax credits will go  
22 much further, but they'll be getting a much less  
23 comprehensive plan. Or it'll be as comprehensive, it  
24 covers the same benefits, the essential benefits, but

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 it'll have a higher deductible and higher co-pays. Or  
2 they can spend more out of their own pocket each month in  
3 terms of premiums and buy up into the gold or the platinum  
4 plan, but -- and they can expect lower co-payments if they  
5 are in need of care.

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

19 Any questions on the silver plan?

20 MR. TESSIER: Thank you Grant. Let me  
21 preface my question by saying, after two months away from  
22 the Exchange and all of our activities, the amount of work  
23 that's been done is pretty staggering for someone kind of  
24 stepping back into things. And I want to express my

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 appreciation for staff and Board members and Advisory  
2 Committee members who have participated in all of this  
3 process with you to get us to where we are.

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

13 MR. PORTER: Right. That's a very good  
14 question. And we understand that the AV calculator is  
15 imperfect. If anything, it probably inflates the value of  
16 these plans, so healthcare is more expensive in  
17 Connecticut than elsewhere at 71.2 percent actuarial value  
18 as calculated here, may really be higher in Connecticut  
19 given these co-pays. That said, there are some known  
20 issues with the AV calculator that seem to overstate it,  
21 so there is an issue with how rehabilitative services are  
22 computed in the AV calculator. There was also an issue  
23 about how generic drugs are computed in the AV calculator.  
24 And so these are offsetting, we believe, and so it's a

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 reasonable approximation for what we can expect and is  
2 fair.

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

13 And it's very interesting though talking to  
14 Dr. Scalettar's point about engaging our friends in D.C.  
15 this was one of those aspects and we brought it right back  
16 to them just about these issues and they know about them.

17 We're not the only state, we may have been one of the  
18 first, but we're not the only state now saying, we are  
19 using this to set our plans now and we really want to make  
20 certain that we continue with -- we don't have to revamp  
21 seven months down the road when they come up with a new  
22 actuarial value calculator. The Feds know that and as a  
23 result, we're moving forward with what we've got.

24 Through that, we did -- you'll notice on

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

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

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

19 MR. TESSIER: Thank you. Excuse me. I  
20 guess the question that remains for me, I'm wondering if  
21 certainly not for this year, but Kevin, you've talked  
22 about this being an iterative process in a number of  
23 different ways. I'm wondering if as we go forward will we  
24 have access to Connecticut-specific data that we're

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 comfortable with and that we'll be able to verify the  
2 accuracy of the targets and those kinds of things?

3 MR. VAN LOON: Yes sir. It's an option and  
4 of course, we will make certain that we have the right  
5 data working with our various partners, public and  
6 private, and of course as we adjust to use the data we'll  
7 be coming back to the Board with any approvals that we  
8 need from you. But the law specifically states that we  
9 have the option in 2015 of using Connecticut specific  
10 data.

11 MR. TESSIER: Thank you.

12 CHAIRPERSON WYMAN: Ben?

13 MR. BARNES: Just so I understand what that  
14 -- thank you for the question, it was helpful, but it also  
15 raised another question for me. Ultimately though, as I  
16 understand it, the metal tiers are intended to provide  
17 sort of benchmarks or points of comparability for  
18 consumers to compare different plans and regardless of its  
19 imperfections or its use of national or statewide data  
20 ultimately the two bronze plans are going to be similar in  
21 terms of their value to a customer and to the extent that  
22 a bronze plan actually isn't at 60 percent under the  
23 Connecticut marquee conditions, it's more like whatever,  
24 72 percent or something like that, because Connecticut is

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 a higher cost environment, that's going to be built into  
2 the pricing by the insurance companies, but the plans, the  
3 two bronze plans will be similar in terms of value to  
4 customers. So even while I appreciate that we may want to  
5 have it better targeted to Connecticut's marketplace in  
6 the future for a lot of policy reasons in terms of its  
7 function for consumers that's not a concern in the short  
8 run. Am I correct in that?

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

13 MR. BARNES: Okay.

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

17 MR. BARNES: Right. And to the person  
18 shopping they're going to look at, oh, 62.50 out-of-  
19 pocket, I mean, my goodness, I have to pay \$250 with the  
20 prescription drugs every year, do I want to pay more  
21 premium to get a lower deductible in an area that I think  
22 I'll use? So customers will probably not be embracing the  
23 actuarial value concept other than as a way to kind of  
24 keep score maybe.

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 (Laughter)

2 MR. PORTER: And it's useful to note that  
3 the premiums that will be available, the premium credits  
4 available from the federal government will be pegged to  
5 these plans, and so it could increase the value of those  
6 premiums for Connecticut residents relative to the lower  
7 cost states.

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

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

14 MR. BARNES: That's favorable. I can live  
15 with that.

16 CHAIRPERSON WYMAN: Yes.

17 MR. VAN LOON: If I may? As we work  
18 through these the concept affordability came up again and  
19 again in the fact that some of these deductibles that we  
20 have up here we got from people on the team and from  
21 people in the public that it's still unaffordable and it's  
22 very difficult for a lot of the people that they represent  
23 to meet some of these deductibles. And we have the  
24 chance, and I don't think that -- we don't have an

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 absolute answer, but there was a process in the ACA to try  
2 to accommodate or to mitigate some of the out-of-pocket  
3 maximums and the out-of-pocket costs for individuals on  
4 the lower end of the income scale and that was a cost-  
5 sharing reductions around the silver plans. And if it's  
6 all right by the Board, if we can move to that and explain  
7 how that impacts, I'll turn it over to Grant and he'll go  
8 through the different aspects of the cost-sharing  
9 reductions.

10 MR. PORTER: Sure. As Peter mentioned,  
11 there's great concern over that deductible and we did look  
12 at -- just before moving into the silver alternatives, we  
13 did look at alternative designs for the silver baseline,  
14 that benchmark. For example, you could lower the  
15 deductible from \$2,500 to \$1,500, but everything would be  
16 subject to that deductible. So if you needed to go see a  
17 primary care doctor for anything other than preventative  
18 care you'd be paying that entire bill until you reach that  
19 \$1,500 deductible. And so we -- there was a preference  
20 for increasing the deductible, but making it only  
21 applicable to hospital services. So that was a decision  
22 point made early on and then it was -- you'll see how that  
23 follows through in each of the silver alternatives.

24 So the ACA allows, and the federal

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 government will be financing these cost-sharing reduction  
2 plans, so the premium has been set by the silver plan.  
3 That has a 70 percent actuarial value and that's going to  
4 be supported by the advanced premium tax credits.

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

14 So for someone earning between 200 and 250  
15 percent of the poverty line the actuarial value of this  
16 plan increases from 71.2 to 74 percent, so a marginal  
17 increase. But your out-of-pocket maximum reduces by about  
18 \$1,000 and the deductible for their hospital care reduces  
19 from 2,500 to 2,250 and for prescription drugs it would  
20 reduce it from \$200 to \$150. We also lowered the co-pays  
21 on primary care and mental health.

22 And then, so as you move further down  
23 amongst the federal poverty line you'll see a further  
24 reduction in the deductible and you get a significant jump

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1       once you move below 200 percent of poverty. So between  
2       150 to 200 percent of poverty enrollees are eligible for  
3       this 87 percent actuarial value plan. Again, they are  
4       paying a premium associated with a 70 percent silver, but  
5       they're getting a much more richer benefit. For this plan  
6       the deductible for medical benefits is just 500 and it's  
7       waived for prescription drugs. The co-pays would go from  
8       a 30/45 plan to a 15/30 plan for primary care and  
9       specialist visits and the inpatient admissions for  
10      hospitals and outpatient surgeries and skilled nursing  
11      homes reduces from \$500-\$250 for a max of two days.

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

22                       MR. VAN LOON: We went through this with  
23      some of our constituents and stakeholders and I'd be  
24      remiss in saying that one of the -- a couple of the people

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 on the consumer advocacy panel came up with the explicit  
2 direction that they appreciated the fact that the cost-  
3 sharing reductions in the silver plans attempt to mitigate  
4 the out-of-pocket costs, but they made the comment that  
5 even people between 100 and 150 percent it's still a huge  
6 burden for people to bear. But they also recognize that  
7 we were working under, and subject to, the actuarial  
8 science that brought us to this plan design.

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

16 MR. PORTER: Correct.

17 MS. VELTRI: Okay. I mean, so just going  
18 back to what Ben had said earlier, I think it may be  
19 important to note that, I mean, if premiums are higher the  
20 subsidies are higher, but the premiums are higher and  
21 that's an issue because 30 percent of the people that  
22 we're trying to reach are above the subsidy level. And  
23 even those who I think are at the subsidy level, like  
24 Peter just said, may be struggling a little. So I just

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 think we have to keep that in mind as we're going. It has  
2 nothing to do with this and I think everybody understood  
3 that and that's why it was such an effective process,  
4 everybody really understood what the AV calculator and  
5 what we are required to do in terms of plan design.

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

14 MR. COUNIHAN: And the Exchange.

15 MS. VELTRI: And the Exchange, yes.

16 CHAIRPERSON WYMAN: Anne Melissa?

17 MS. ANNE MELISSA DOWLING: Hi. One other  
18 thing to remind us though is that this is one option that  
19 you guys have worked so hard, so hard to come to, but we  
20 also are permitting carriers to submit one other plan of  
21 their own design and, you know, early feedback is that  
22 matches some of this, but it has the potential to be quite  
23 a bit more affordable. More targeted, narrower, all of  
24 that. The question I have, and I'm sorry to bring it, but

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 can I just get reminded why we limited it to one? Is it  
2 really just because the system is so new we just probably  
3 couldn't handle multiple other inputs from the carriers in  
4 year one? Or -- I just could not remember why we limited  
5 them to one alternative. And that would be a fair answer,  
6 if it was we could only handle, you know, one additional  
7 design.

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

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

20 MR. COUNIHAN: Actually, Anne Melissa, it's  
21 a good question. I believe what the Board had decided is  
22 that for the initial period we're going to go one and one  
23 for metal tier, but moving into the second year we were  
24 going to go one plus two. So it was really too, as Peter

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 said, it was just -- if we get five health plans, which we  
2 are very hopeful that we can to participate, that's 40  
3 options for folks. And we thought that for this initial  
4 period, I think the Board believed that it made sense just  
5 to get people acquainted with how that would work and make  
6 it as easy and simple as possible. And then in the next  
7 second year provide the chair with two options per metal  
8 tier.

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

12 MR. COUNIHAN: That's right.

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

17 MR. COUNIHAN: Yeah. Right.

18 CHAIRPERSON WYMAN: Ben?

19 MR. BARNES: I just have -- I'm just trying  
20 to make sure I keep all of the moving pieces of how this  
21 is going to impact people so as we begin to see what some  
22 of the pricing information is, and I'd like to get -- if  
23 you could tell me sort of when we're going to start to see  
24 some of the premium information becoming available. So in

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 addition to, if I'm a household between 150 and 200  
2 percent of the federal poverty level I can buy a silver  
3 plan with a subsidy -- a subsidize premium, which is  
4 subsidized based on my income level, and then that subsidy  
5 will be sort of reinforced by additional subsidy paid  
6 through the Exchange to the insurer to provide a version  
7 of the silver plan that has lower out-of-pocket costs?

8 MR. PORTER: Correct.

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

13 MR. PORTER: Right.

14 MR. VAN LOON: First of all, Jim hit me  
15 upside the head and wanted me to reiterate the fact that  
16 the system, our technology can handle any number of  
17 options, but the idea to be simple to the consumers and  
18 the administration is something that when we want to  
19 expand we'll have a technology that will be able to do  
20 that. But that technology and that process that we're  
21 putting together is to deem the eligibility for all these  
22 different options as people come in, you know, where are  
23 they on the income scale? Working with the Feds, reaching  
24 out to them through the federal data hub to validate what

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 people are telling us so that when we deem them eligible  
2 for a certain level of premium tax credit or a silver cost  
3 reduction, cost-sharing reduction plan, that we have facts  
4 to develop that eligibility.

5 But your point sir, I want to stress is, we  
6 get that information and people make the decision of what  
7 plan they're going to choose. We take that electronic  
8 information and we ship it to the plan and to the Fed's  
9 with the idea that the Fed's and the Department of the  
10 Treasury, we use that information to ship the money to the  
11 respective plans. We on the Exchange are working to avoid  
12 having to handle all of that money and all of that cash.

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

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

18 MR. BARNES: I understand that.

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

21 MR. BARNES: Okay. Now, and then the last  
22 question is, these cost-sharing reduction options are only  
23 available for the silver plan. So if I am a low income  
24 person 150, 200 percent say, I could elect to buy a bronze

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 plan if I wanted, because I think I'm healthy and I'm  
2 never going to go to the doctor and I don't care, but the  
3 incentives are set up to provide significantly --  
4 significant incentives for me to buy the higher actuarial  
5 value plan because it comes with the cost-sharing  
6 reduction enhancement, which is not available for the  
7 other levels?

8 MR. PORTER: Correct. So, I mean, that's a  
9 good question and states are grappling with what the  
10 solution to that is. Because as the Exchange, you could  
11 direct that individual to just purchase that plan, that  
12 silver plan, and make them have to jump through hoops to  
13 get to the bronze level. So you're encouraging them to  
14 buy that silver cost-sharing reduction plan that is much  
15 more -- has a much richer benefit. But if they're worried  
16 about, if they don't want to pay the \$75 monthly premium  
17 that they'd have to pay, and they prefer to pay \$50 or  
18 \$40, which they could do if they bought the bronze plan,  
19 but really they're comparing now a 60 percent actuarial  
20 value plan to and 84 percent actuarial -- 87 percent  
21 actuarial plan.

22 MR. BARNES: And so -- and we're taking  
23 steps to ensure why obviously that's a choice that  
24 individuals may choose to make on either side of that

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 call, we're taking steps to ensure that nobody would make  
2 the decision to buy a bronze plan based on a lower premium  
3 amount without fully understanding the value of the out-  
4 of-pocket cost reductions --

5 MR. PORTER: Correct.

6 MR. BARNES: -- okay. Thank you.

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

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

19 MR. BARNES: Yeah. No, I'm glad I have  
20 employer provided insurance.

21 MR. COUNIHAN: Yeah. People just -- all of  
22 the stuff we take for granted, deductible, co-pay,  
23 network, coinsurance, the average consumer does not  
24 necessarily understand or is it really that interested in,

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 and it's very, very hard. So we're planning on actually  
2 just showing examples, because that's actually the most  
3 effective way. So if someone breaks an arm how would that  
4 look under bronze? How would that look under silver? How  
5 would that look under gold? So just some -- we're trying  
6 to make it as tangible as possible.

7 MR. BARNES: Yeah. I think that's a very  
8 good approach.

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

18 The other question I have is, you know, the  
19 innovative designs that the carriers seem anxious to put  
20 forward, do we know how we're going to categorize they  
21 come through the metal tiers? I mean, how innovative are  
22 they and how different will they look and how do we  
23 categorize so that they come up for review for some of the  
24 options? That's, you know, part A of the question about

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 he innovation and the design. And then secondly, we may  
2 have some designs that really do get at cost. Maybe not  
3 first year, but I suspect there will be a few. We will  
4 have a track record after the first year and see how the  
5 lower-cost plans actually get picked up by consumers and  
6 how they work. How are we going -- are we thinking about  
7 accommodating all of that?

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

19 We expect that premium will be that next  
20 sort and from there we continue to work through some of  
21 the remaining items on how -- whether it's quality, if we  
22 have that information when we start, but a myriad of  
23 things. The carriers are also asking the same question, I  
24 would presume, actually, I'm not even going to presume,

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 but they are asking the same question from their point of  
2 view as well.

3 MS. FOX: Thank you.

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

6 A FEMALE VOICE: We'll distribute a test.

7 CHAIRPERSON WYMAN: Yeah. No.

8 (Laughter)

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

22 And with respect to the cost-sharing  
23 reduction plans for the first tier, the 73 percent AV with  
24 a 10/25/50 50 percent, 10/25/40 50 percent breakdown, so

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 the same as the silver with a lower deductible. And then  
2 as you move down in poverty and up in the AV for the other  
3 silvers -- silver alternatives it was a 5/15/30 and  
4 instead of a coinsurance on that specialty drug it was a  
5 flat co-pay of \$40.

6 So any questions on the prescription drug  
7 benefits?

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

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

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

23 MR. PORTER: Yeah, that's certainly  
24 something that we would like to explore. It would require

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 a federal waiver I would presume. The Exchange certainly  
2 does not allow for that currently.

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

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

16 MR. PORTER: Certainly.

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

22 MR. PORTER: So finally, in sort of the  
23 11th hour of our working group team meetings we tackled  
24 some of the other benefits. So these are benefits that

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 were not directly addressed by the AV calculator. For the  
2 most part, the AV calculator probably reflects well over  
3 95 percent of medical expenditures. So these are somewhat  
4 ancillary. Some are included in the AV calculator, we  
5 just wanted to draw them out so that specific limits could  
6 be imposed on them. For example, the emergency room is  
7 included in the AV calculator, but we included it on the  
8 other benefits just to put it in comparison with urgent  
9 care and walk-in centers and ambulance transportation.

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

21 And again, in the bronze plan the  
22 deductible applies to most of the items there. We  
23 excluded it from the diabetes education because that's  
24 sort of a primary care service. But with the silver plan

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 it's only the inpatient services which the deductible  
2 applies to, all of the outpatient services it doesn't have  
3 the deductible. Likewise on the gold and platinum.

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

15 MR. PORTER: Correct. If we were to do a  
16 coinsurance model that would be reflected in the  
17 coinsurance, but because we have a co-payment that has a  
18 maximum co-pay of \$500 that's a reasonable co-pay for both  
19 inpatient and outpatient services. So whether it's -- if  
20 it's a hospital visit it will run several thousand dollars  
21 per day, and outpatient surgery will also run several  
22 thousand dollars, not as many thousands, but -- so in both  
23 cases you're getting a significant benefit with that \$500  
24 co-pay. It's more, it's greater with the inpatient

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 hospital services, but given the limitations of what the  
2 maximum co-pay can be it seemed reasonable.

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

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

19 If I may, just -- we've gone through the  
20 plans, I'd like to just go back a little bit on the  
21 process that we followed. As I said, we worked with that  
22 team, they were delegated by their advisory committees to  
23 help develop the advice for the staff. As we walked  
24 through I called and asked for votes on all of these from

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 the team and we didn't get any negative votes on any of  
2 the plans that you see. We've got people that said, you  
3 know, we understand this is a compromise and we're voting  
4 yes with the idea that we continue to stress the need for  
5 affordability going forward.

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

18 But I don't know, Virginia, exactly what  
19 the right format is, but we wanted to -- before we got  
20 into the lessons learned and our next steps ask the Board  
21 to approve the standard plan designs as brought up and  
22 recommended to the staff by the team that we put together.

23 I'd also like to say that what we're advocating is  
24 exactly what the team gave us as far as advice.

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1                   CHAIRPERSON WYMAN: Peter, I'm going to ask  
2 for a motion from the Board to do that. I just wanted to  
3 make sure everybody had their questions. And please,  
4 don't take my question incorrectly, I just think that as  
5 we go forward we're going to have to look at other things.

6 I think what you all presented today is great, and I'd,  
7 you know, but of course there's going to be a lot more  
8 questions when we see what the actual costs are, you know?  
9 And Grant, you have --

10                   MR. PORTER: Yeah. I could respond a  
11 little bit to that last point. In many situations where  
12 we thought that the consumer was actually the one that  
13 made the choice and we tried to direct them towards the  
14 cheaper or the, you know, better care, that was  
15 represented by the E.R. versus the urgent care, sort of  
16 like lower co-pay as you move down from an E.R. to an  
17 urgent care to a walk-in clinic to the primary care  
18 providers, you know, doctor's office, I'm not sure that  
19 the consumer is the one that decides whether the surgery  
20 is going to be done out patient or hospital. Certainly in  
21 my experience you go to the surgeon and they tell you, it  
22 will be done, and they will tell you where it's going to  
23 be done. So I'm not sure that the consumer can push back  
24 and say, well, you know, I get a lower co-pay if you do it

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 over at the ambulatory care. There are so many factors  
2 that determine for the physician whether they do it in a  
3 hospital versus the ambulatory care center, I think they  
4 are the one that really makes that decision.

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

8 MR. PORTER: Oh, they are much cheaper.

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

23 Jewel, Commissioner?

24 COMMISSIONER JEWEL MULLEN: I wanted to

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

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

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

18 CHAIRPERSON WYMAN: All right.

19 MR. VAN LOON: If I may Lieutenant  
20 Governor? Just to finish up with some of the lessons  
21 learned and what we're doing, because we're not quite done  
22 yet. Lessons learned, trade-offs. The team understands  
23 this is a series of compromises. You can't get everything  
24 that you want and we appreciated that collaborative

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 effort.

2 We also recognize that setting the standard  
3 plan design based on actuarial value is not the same thing  
4 as setting a premium, but to Secretary Barnes' standpoint,  
5 part of the reason that we've been under this time  
6 pressure to do that, to set the standard plan designs is  
7 so that we can get those standard plan designs to the  
8 carriers so they can have time to develop their plans,  
9 come up with the rates, and then submit them to the CID  
10 for their approval or review. Affordability keeps coming  
11 up and everybody on the team recognized, and I daresay, I  
12 think we started to get across the point to some of the  
13 deeper membership of the advisory committee that we're  
14 subject to actuarial science.

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

24 In the short term we got a lot of

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

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

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

17 Next steps looking forward, we understand  
18 that anything that we do today, tomorrow, the next day is  
19 still going to have to adjust to the emerging rules that  
20 come from CCIIO. And we also recognize that with the new  
21 legislative that there could be potentially new  
22 Connecticut state laws and regulations that we're going to  
23 have to adjust and adapt to. So we're definitely open to  
24 that, but I just want the Board to know that as we work to

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 set this, if not in stone, but in concrete so that we can  
2 work through this next year. We recognize that there are  
3 forces at work that we're going to have to subordinate our  
4 work to going forward and we will. And with that  
5 Lieutenant Governor, I'll turn it back to you.

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

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

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 their website, people can see them. But I think the  
2 sooner the information becomes available and people see it  
3 the better.

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

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

23 A MALE VOICE: So moved.

24 CHAIRPERSON WYMAN: So moved? And the

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 second?

2 A FEMALE VOICE: Second.

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

5 VOICES: Aye.

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

8 MR. COUNIHAN: Lieutenant Governor?

9 CHAIRPERSON WYMAN: I think.

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

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

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 for your leadership on this also.

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

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

7 CHAIRPERSON WYMAN: Who voted you for Vice  
8 Chairman?

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

22 CHAIRPERSON WYMAN: Great. Thank you.  
23 Good idea. Yes?

24 DR. SCALETTAR: So as long as you've opened

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 all of this up could you update us on a couple of things?

2 I heard at the beginning that the navigator program was  
3 going to be under OHA. The last meeting the conversation  
4 was, so how do we fund the navigators? So an update on  
5 the funding of navigators. And then, the in-person  
6 assister, we were in the process of submitting a grant,  
7 and the status on the grant.

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

10 MR. COUNIHAN: Sure. I'll take some of  
11 this in reverse Bob. We actually have a phone call at  
12 11:30 with CMS to talk about the grant or about the  
13 funding for the in-person assistance program. My  
14 colleague and late-night e-mail crime Vicki responded  
15 within a nanosecond to the questions that were raised by  
16 CMS. I guess that was Tuesday night or something, at  
17 11:30. But we are talking to them this morning and so we  
18 should know -- we have to have our written responses in by  
19 the 30th, Bob. We're tracking very well with respect to  
20 getting that money. What was the other --

21 CHAIRPERSON WYMAN: Funding the navigator.

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

23 CHAIRPERSON WYMAN: Navigator funding.

24 MR. COUNIHAN: -- oh, the funding, yes. So

HEARING RE: HEALTH INSURANCE EXCHANGE  
JANUARY 24, 2013

1 we are continuing to work at options for that funding.  
2 We've had some discussions with some foundations in the  
3 state who have expressed interest in supporting us in that  
4 and we're making a presentation to one of them, I believe,  
5 in February. So we're making progress on that.

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

9 CHAIRPERSON WYMAN: Okay. Good. And I  
10 won't cut this off, I really don't want to, but are there  
11 any other questions or concerns? Okay. Then I will cut  
12 it off. Okay. So the next meeting is February 21st at  
13 9:00 o'clock and it will be at the state capital in room  
14 310. So at this time I need a request for adjourn -- a  
15 motion for adjournment?

16 A MALE VOICE: So moved.

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

19 VOICES: Aye.

20 CHAIRPERSON WYMAN: Thank you all very,  
21 very much. And again, thank you to everybody for all the  
22 work you've put in.

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