



STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

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

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

Thursday, November 29, 2012

Meeting Minutes

Members Present:

Lieutenant Governor Nancy Wyman (Chair); Jeannette DeJesús (Vice-Chair) Office of Health Reform & Innovation; Grant Ritter; Dr. Robert Scalettar; Mary Fox, Cee Cee Woods; Vicki Veltri, Office of the Healthcare Advocate; Secretary Benjamin Barnes, Office of Policy and Management (OPM); Commissioner Roderick L. Bremby, Department of Social Services (DSS);

Members by Telephone: Deputy Commissioner Anne Melissa Dowling, CT Insurance Department (CID)

Members Absent:

Jewel Mullen, Mickey Herbert, Michael Devine, Robert Tessier

Other Participants:

Health Insurance Exchange (HIX) Staff: Kevin Counihan, Jason Madrak, Julie Lyons, Grant Porter, Jim Wadleigh, Steve Sigal, Peter Van Loon, Virginia Lamb

The meeting of the Health Insurance Exchange Board of Directors was called to order at 9:03 a.m.

I. Call to Order and Introductions

Lt. Governor Wyman opened the meeting at 9:03 a.m.

II. Public Comment

There was no public comment.

III. Review and Approval of Minutes

Lt. Governor Wyman requested a motion to approve the minutes from the October 18, 2012 meeting. Motion was seconded by Cee Cee Woods. ***Motion passed unanimously.***

Announcement -- Lt. Governor Wyman thanked that staff and all those who arranged for the first Healthy Chat event held the previous evening that she attended and noted that a Healthy Chat will be held in Waterbury this evening and encouraged attendance.

IV. CEO Report

Kevin Counihan, CEO, reported that 400 pages of new guidance and proposed regulations were released by HHS approximately one week ago. Topics covered included the Essential Health Benefit (EHB) and wellness, actuarial values, the actuarial value calculator, and coordination of the Exchange with the Medicaid program, as well as rate review guidance and the proposed rules for the transitional reinsurance and risk adjustment programs. Summaries will be posted to the Exchange website. The Health Plan Benefits and Qualifications Committee (HPB&Q) and the Consumer Experience and Outreach (CE&O) Committees reviewed the draft RFP for solicitation of Qualified Health Plans (QHPs); met jointly and provided the staff excellent feedback on the proposed criteria working through many issues on a tight time frame. Wakely Consulting was officially hired and also provided guidance. Design, development and implementation remains on track to the open enrollment date. Healthy Chats are currently being held. Several new staff members were introduced. Commissioner Bremby and his staff at DSS were thanked for their continued support and the advisory committees were thanked for all their work.

V. Operations Update

Peter Van Loon, COO, reported that the Exchange is hiring based on long term needs with strong consideration given to financial sustainability. Call Center finalist presentations have concluded. The Center for Consumer Information and Insurance Oversight (CCIIO) has provided comments to the Exchange's draft RFP for the Small Employer Health Options (SHOP) Exchange. These comments will be reviewed with the SHOP Committee. Work progresses on systems integration. Mr. Van Loon explained that the Exchange's technology solution and the integrity of its processes will need to be independently validated. This validation is critical to final Exchange approval from the Centers for Medicare and Medicaid Studies (CMS). An RFP for the independent contractor to perform this work is currently being developed. The Exchange is awaiting notice of its conditional approval from CMS. Connecticut's Blueprint was submitted in October and is currently at the White House for review. The Exchange is in the process of transitioning from planning to operations. Mr. Van Loon reviewed the Integrated Eligibility Project Management (IE PMO) Dashboard as of November 29, 2012 including the assessment of project risks. The next design review with CCIIO and CMS is scheduled for January. The solicitation letter for QHPs is expected to go out in early December.

Money to fund the navigator program is still being sought as well as funds for the in-person assistor program. CMS feedback on submission of a grant application for this program has been received. Resubmission will take place in February.

Lt. Governor Wyman asked how much money was being sought for the navigator program and where the funds were being sought from. Jason Madrak replied that every state is struggling, because the law failed to provide funding to pay for navigators. In response to this challenge, CMS has introduced an in-person assister program. This program is similar to the navigator program, but funds are available through the Level I grant application. There is confidence that this program will be up and running and that only modest funding will be needed for the navigator program as a vast majority of work can be done through the in-person assister program. There is still a statutory requirement to set up a “navigator program”, so funds must be located and secured. Cee Cee Woods asked about the grant level for in-person assisters. Mr. Madrak responded that there will be numerous small grants to 300 or so organizations throughout the state in the \$5,000 to \$6,000 range.

VI. Policies and Procedures for Adoption

Steve Sigal, CFO, reviewed the four policies and procedures for adoption. They include the Exchange’s Investment Policy, Small Employer Health Options (SHOP) Policy, the Policy Establishing Requirements for Certification, Recertification and Decertification of Qualified Health Plans and the Navigator Grant Program Policy. These policies were approved for publication by the Board at its September meeting. Notice was given in the *Connecticut Law Journal* on October 9, 2012 for a 30 day comment period expiring on November 9, 2012. The policies are now ready to be adopted. No changes are proposed except a formative change to the Investment Policy. The Investment Policy originally referenced a 401K plan. This reference needs to be changed to a 401A plan because under the IRS code, political subdivisions can no longer offer 401K plans. They can, however, offer 401A plans.

Mary Fox recommended excluding tobacco stocks from the Exchange’s portfolio. Secretary Barnes stated that he endorsed the policy for the Exchange’s portfolio, but not if it restricted employee investment options. Mr. Sigal assured him that the way the policy was constructed, the proposed restriction would not impact the employees’ investments. Ms. Veltri asked whether there had been any public comments on any of the four policies. Mr. Sigal responded that there were no comments on any policies. Virginia Lamb, General Counsel, clarified that the motion was for adoption of the investment policy as revised to reference the 401A plan and the exclusion of any Exchange investment in tobacco stocks.

Lt. Governor Wyman requested a motion to adopt the investment policy as revised. Motion made by Dr. Scalettar and seconded by Mary Fox. ***Motion passed unanimously.***

Lt. Governor Wyman requested a motion to adopt the Small Employer Health Options Program (SHOP) Policy and the Navigator Grant Program Policy and the Policy Establishing the Requirements for the Certification, Recertification and Decertification of Qualified Health Plans. Motion made by Dr. Scalettar and seconded by Vicki Veltri. ***Motion passed unanimously.***

VII. Advisory Committee Updates

Consumer Experience and Outreach Advisory Committee Update: Mr. Van Loon introduced Vicki Veltri who provided an update of the activities of the Consumer Experience and Outreach Advisory

Committee (CE&O). The committee recently held its own meeting as well as two joint meetings with the Health Plan Benefits and Qualifications (HPB &Q) Committee to discuss the criteria for qualifying health plans for the Exchange. At the CE&O Committee meeting, navigator program recommendations were discussed and a recommendation was made to move forward with the in-person assistor program. Portal design issues were also addressed and there was also a brief discussion about the upcoming joint committee meeting as well as the new name for the Exchange. The staff was thanked for including advisory committee members in the design review.

Update on the Joint Meeting of the Consumer Experience and Outreach Advisory Committee and the Health Plan Benefits and Qualifications Advisory Committee: Deputy Commissioner Dowling joined Ms. Veltri to provide this update. Commissioner Dowling stated that she felt the best compromise possible was reached with the caveat of being able to move forward given the timeframe. Ms. Veltri provided additional comments. QHP recommendations were requested of staff. A robust discussion followed the staff presentation with different viewpoints and perspectives being shared by the committee members. Since a decision was not reached within the allotted time, another meeting was scheduled. That meeting was held by the two committees by phone on November 26. Prior to that meeting, staff was charged with making revisions to the recommendations based on comments from the first meeting and asked to get these revisions to the committee members, so they could be reviewed before the phone conference. On the 26th there was a good display of cooperation among the committee members, but complete agreement on the recommendations was still not reached by the end of the meeting. Recognizing the need to send recommendations to the Board for its November 29 meeting, committee members agreed that a smaller sub-committee of diverse stakeholders from the two committees should be set up to draft recommendations on the remaining outstanding issues concerning the criteria. These compromise recommendations would be put to an E-mail vote by the full membership of the two committees.

Small Employer Health Options (SHOP) Program Advisory Committee Update: Mr. Van Loon provided this update noting that SHOP is a business process that will be outsourced for administration with ultimate accountability retained by the Exchange. The SHOP Exchange will allow employers to not only shop for health insurance for their employees but when appropriate, secure tax credits. Late input from CCIIO will need to be incorporated into the SHOP RFP. The RFP will then be turned back to the SHOP Committee for review and comment. Lt. Governor Wyman asked how other states were handling SHOP and what response they had gotten to their RFPs? Mr. Counihan reported that California was having finalist presentations and expected to select its SHOP vendors in a week.

Strategy Committee Update: Mary Fox provided an update on the Strategy Committee. The Committee had its first meeting and set the overarching framework for tactical decisions to implement the Exchange's vision and mission. Input will also be taken from the Healthy Chats. Expected deliverables include a report identifying priority items and a short list of implementable ideas.

VIII. Navigator and In-Person Assistance Program

Lt. Governor Wyman introduced Jason Madrak who presented an overview of the Final Recommendation for the Navigator Program. Mr. Madrak explained that the document represents the skeleton for how the program should be rolled out. Additional questions and issues are

expected to occur later during execution and items will continue to be reviewed with the Brokers, Agents and Navigators (BAN) Committee and the Consumer Experience and Outreach Committee.

The Navigator will combine the roles of educator and enroller and be responsible for providing assistance to all. There will be no SHOP-specific Navigator program per the recommendation of the BAN Committee and CMS guidance. The Navigator's role is to provide unbiased advice. Navigators will not provide specific recommendations about what carrier, plan or QHP to choose. That decision will be left to the consumer. Training and certification will be required of all Navigators and of all producers who enroll people through the Exchange. A draft curriculum is in the document. Seventy five percent (75%) of a grant will be issued in advance of activity and 25% issued upon successful completion. Per statute, Navigators will not be able to receive direct compensations from carriers. This effectively prohibits producers from becoming certified Navigators unless their current broker/agent appointments are severed.

Ms. Fox inquired if there was a place holder for education and training for the non-traditional products and how the Navigator would be able to convey all the products to the population. Ms. Fox also stated that hopefully products offered will be simpler than traditional products. Mr. Madrak indicated that numerous things will change between now and when the products hit the marketplace and that the Exchange will include all products in its training program. Secretary Barnes asked about costs. What is the difference in costs for enrollment with Navigator assistance versus through a broker? Mr. Madrak stated that the commission process for producers will remain the same. Navigators will have an ID not for commission purposes but for gauging their performance. There will also be a small service fee for all products sold through the Exchange to support the Exchange's self-sustainability post 2014 but no additional load or fees are contemplated to provide commissions for Navigators. The premium price will continue to include a commission load and the premium for a particular product will be the same inside and outside of the Exchange.

Mr. Barnes expressed hope that there would be a way to identify and eliminate the commission as it relates to the policies being sold on the Exchange through navigators. Lt. Governor Wyman stated that the goal is to make health care accessible and affordable. The Exchange needs to constantly look at the building of that base and what the benefit really is. Grant Ritter stated that a related issue is how the Exchange is going to be sustainable after 2016. Some portion of premium must be kept by the Exchange for its operations. Premiums will be the same inside and outside of the Exchange and this will have to eventually be addressed. Mr. Sigal stated that the Exchange currently is looking at all sources for revenue and not just those solely related to a service fee. The goal is to minimize the service fee wherever possible. Mr. Coughlin indicated that there may be either a regulatory or statutory requirement limiting Exchange flexibility for including or taking out commissions and cautioned that the role of brokers and navigators in enrollment success is complicated and should not be underestimated. Explaining advance premiums tax credits will not be a simple thing to do.

Mr. Madrak continued with an overview of the in-person assistor program. This program was developed by CMS to assist states with the funding challenges related to navigator grants. Exchange strategy is to use Level I funding to put forward a very robust in person assistor program and offer a more modest navigator program that meets requirements of the law. Dr. Scalettar inquired as to the absolute dollar amount for the Level I supplemental grant. Mr. Madrak stated it is roughly \$2.6 million. Feedback has been received from CMS on the Exchange's application with refilling scheduled for February.

Ms. Veltri requested a further description of the ground effort to reach out to the communities. Mr. Madrak replied that the in person assistor program will be the foundation for marketing outreach. The program begins with one on one interactions. Assistors are expected to be as equally diverse as Connecticut's population. The program is envisioned to roll out through several hundred smaller grants to get to the block level to make the biggest possible impact. Additional challenges include increased training following additional grants. Next year the Exchange needs to move forward along several parallel paths. These paths include: getting the RFP out for grant applications; training assistors and navigators; certification; and completing the Level I application process so that funding is secured to award grants and train people. Next Steps include the Board vote on overall program structure recommendations as well as the continued exploration of funding options; reapplication for the Level I In-Person Assistor grant; hiring an outreach manager; and, exploring and formalizing additional partnerships including a memorandum of understanding (MOU) with the Office of the Healthcare Advocate.

Lt Governor Wyman requested a motion to approve the Navigator and In-person Assistor Program as proposed. Vicki Veltri made the motion and Cee Cee Woods seconded. ***Motion passed unanimously.***

IX. IT Update

Jim Wadleigh, Chief Information Officer, provided the IT and Exchange relocation updates. Design review has begun with the Exchange's systems integrator. Consumer advocates from the CE&O Committee have been engaged in the process. The design is on track to be completed by the end of December for a scheduled January design review with the Centers for Medicare and Medicaid Services (CMS). Work continues with the Bureau of Enterprises and Systems Technology (BEST) to host Exchange operations. Technical requirements have been reviewed by BEST and signed off on. This will allow the RFP process to go forward for purchasing the hardware and software necessary to support the Exchange's technology needs. A lease has been signed for the Exchange's Offices at 280 Trumbull Street. An interim project manager is under contract to help manage the logistics of the build out and move. While the Exchange is responsible for payment, the BEST organization is being leveraged for network and telephony, and a DAS contract is being used for furniture purchases. The move is tentatively scheduled for beginning to middle of January. OPM was thanked by the Lt. Governor for housing the Exchange.

X. Marketing and Outreach Update

Mr. Madrak provided a marketing and communications update. The final major research initiative will be concluded next week; consumer outreach efforts (Healthy Chats) are underway; and, the marketing RFP process has concluded. Name development research is also formally wrapped up. Names were evaluated for effectiveness across multiple categories. Ten unique names were tested across two rounds of research. Stringent legal and trademark use vetting was also done to make sure these names can be used. Through the vetting process some names were taken off the table.

Jeannette DeJesús the left room at 10:23 a.m.

Final results indicated that Access Health was the best option. This name is a soft launch. Mr. Madrak also reviewed event dates and locations for future Healthy Chats. Healthy Chats are being

broadcast on CT-N. Coverage has also been provided by Channel 30. The Lt. Governor requested that a Healthy Chat event be scheduled for the northeast corner and suggested Eastern Connecticut State University as a possible location. Chats will continue well into next year as they move across the State. The marketing RFP selection process has been concluded. Eight agencies responded. Three agencies were selected for finalist presentations the week of October 22. Pappas Macdonnell was selected as the marketing services provider. Members of the Pappas Macdonnell team introduced themselves and following inquiry by Ms. Fox a brief summary of the firm's experience with underserved communities was provided.

Jeannette DeJesús returned 10:38 a.m.

XI. Finance Update

Steve Sigal, CFO, provided a finance update. The Exchange is in the process of changing the Grantee from OPM to the Exchange. This process is expected to take place in early December following CMS approval; business credit cards were issued for tighter control of expense reporting; the Exchange joined the state's 457B salary deferral plan in late October; Exchange financial statements and department expense budgets have been developed. Mr. Sigal also provided an update of Finance staffing and reviewed the Exchange's Financial Statements and department expense budgets as of October 2012. Next steps include a mock audit; the fiscal 2012 financial and federal single audit by an independent accountant; institution of various new business processes following the change of grantee; operationalizing financial information and metrics; and, developing a sustainability model for the Exchange. Secretary Barnes thanked Mr. Sigal for his efforts to expedite the grantee name change.

XII. QHP Solicitation Requirements

A: Review of Draft Solicitation

Mr. Van Loon recognized the efforts, collaboration, responsiveness and sense of urgency demonstrated by the two advisory committees in helping the Exchange design its products for the individual and small group markets. On November 12, 2012, the Exchange published on its web site a draft RFP for solicitation of qualified health plans as well as policy questions that required input from the advisory committees. Mr. Van Loon outlined the principles of QHP certification. Plans will need to meet the Accountable Care Act's (ACA) definition of a QHP including offering the required Essential Health Benefits (EHB). The Exchange will look to engage carriers that are consumer focused; offer choice and quality; are transparent in their results both clinical and financial; are supportive of continuous quality improvement and efforts to improve the health of consumers through wellness and prevention; deliver value to the consumer; and, are willing to be a catalyst for delivery system reform. Mr. Van Loon also reviewed the ACA reforms impacting the market including: guaranteed issue, no lifetime cap on expenditures, strict limitations on out of pocket expenses, mandatory medical loss ratio and the elimination of many rating factors. In addition, he reviewed the recommended Connecticut-specific QHP certification requirements. Issues for review today include: the certification period; a lock out for those plans choosing not to participate in the first year; the mix and number of plans that must be offered by carriers; accreditation and ranking criteria; network adequacy; essential community providers; the purchasing model that will be used by the Exchange; and, offering a stand alone dental program.

B. Review of Public Comments

Grant Porter, Senior Analyst, was introduced. Mr. Porter noted that while the Exchange staff's recommendations do not align 100% with those of the advisory committees, the committees' input was carefully listened to as were public comments to the draft certification requirements. Mr. Porter summarized the public's comments noting where comments were incorporated into the Exchange staff's recommendations.

The Exchange received feedback from carriers, brokers, advocates and accreditation bodies. There was a consistent theme among the carriers in opposition to any type of lockout period. Carriers noted the problem of system readiness in meeting plan requirements the first year. Carriers also wanted full flexibility beyond minimum ACA requirements on the mix and number plans. Carriers argued that limiting the number of plans could prohibit innovation, limit consumer choice and put the Exchange at a disadvantage to the outside market. Carriers were in favor of allowing but not requiring platinum plans. Plan standardization was opposed. With respect to accreditation and ranking comments, the National Center for Quality Assurance (NCQA) provided feedback clarifying star rankings and when data will need to be submitted. This feedback will be incorporated in the RFP. The QHP solicitation will not be looking at standalone vision but will be looking at standalone dental. One carrier recommended against pricing dental benefits separately arguing that it would increase the cost of pediatric dental services. One carrier was in favor of allowing standalone dental benefits for adults, children only or both. Carriers asked for clarification of the tiered dental benefit plan and the definition of preventative only services versus full benefit coverage. Based on comments, the tiered dental benefit plan was stricken and any dental plan offered must provide a full range of pediatric services. Advocate comments recommended that the standard for network adequacy be the standard set out in the Connecticut Medicaid Managed Care contract. Another commenter provided data that indicated that network adequacy required inclusion of 100% of all the Federally Qualified Health Centers. Several comments addressed the need for the Exchange to negotiate rates directly with carriers. The Massachusetts experience was cited as the model. Mr. Porter noted that it was earlier explained at one of the Joint Advisory Committee meetings, by the former head of the Mass Connector, that the Connector was only any active purchaser for its ComCare product. It did not actively purchase for the unsubsidized broader ComChoice Exchange, and instead relied on market dynamics for premium reduction.

C. Exchange Staff Recommendations

1. Certification and Lock out Period: The staff and Joint Advisory Committee recommended an initial two year QHP certification. If a certified QHP leaves in 2015 the carrier will be denied re-entry for a minimum of two years. Appeals would be considered. The purpose is to minimize consumer confusion and get carriers on board for an extended period of time. The negative is that it can discourage carriers from initially getting on the Exchange. The value of two year certification is predictability for the carrier. It incentivizes participation in a risky environment and gives consumers predictability on the purchasing end. If there are not enough carriers; if there is a new market entrant; or if a carrier's systems were not ready in time, a carrier could apply to participate in the next open enrollment (2014), but they would receive only a one year certification.

Secretary Barnes asked about the enrollment process and expressed concern that people may not be aware of the program and may miss the enrollment cut-off. Mr. Coughlin responded that it is an annual open enrollment period, but because this is a new product and people need time to become familiar with the product, the first open enrollment period will be for six months. It will be a three month enrollment period thereafter. The period is set by law. Small groups can enter at any time. Certain life qualifying events, (e.g., marriage, adoption, etc.) also allow individuals to enroll at any time. Ms. Veltri clarified that these enrollment periods are the same as those in the

individual and small employer marketplace today. Mr. Counihan noted that the Exchange's mission is to make sure people know of the enrollment period. Mr. Madrak indicated that the Exchange can match projections to how enrollments are trending by geographies and direct more outreach resources to lagging areas. The Lt. Governor stressed the need for the Exchange to develop a contingency plan ahead of time.

2. Standardization of Plan Design. Both the staff and joint Advisory Committee recommended that a QHP offer one standard plan for gold, silver and bronze tiers with deductibles, co-payment and co-insurance that meet the required actuarial value for the tier, but no more than two gold, silver or bronze plans and one platinum plan. The purpose is to make it easier for consumers to compare plans. However, Exchange staff recommended allowing the carriers the option of offering two platinum plans. This would give carriers an opportunity to be more diverse in their product offerings out of the box. Staff further recommended that for plan year 2015, the Exchange allow the carriers to offer a third silver, bronze or gold plan. The Exchange recommends postponing this additional offering to the second year to reduce potential confusion in the selection process for the first year. The Exchange staff and joint Advisory Committee also both recommended that for the individual Exchange, a QHP carrier must submit three actuarial value variations for at least the standard silver plan, one child-only QHP for each metal tier for which a carrier submits a plan, and may submit one catastrophic coverage plan.

Ms. Veltri stated that it was her impression, as well as that of others, that the joint recommendations from the advisory committees would not include any alterations and recommended that because of significant alterations to the Joint Committee recommendations that the Board separately vote on the criteria. Her concern is that having too many plans on the Exchange will confuse the consumer. Secretary Barnes asked whether there was any reason to make the decision now to offer additional plans in the 2015 plan year? Mr. Porter explained that the addition of the second platinum plan (actuarial value of 90%) was based on the results of market research by Gorman Actuarial. The Gorman study showed that there were a significant number of platinum plans sold in the small group market today. The Exchange would be putting itself at a disadvantage were it not to at least offer a variety of platinum plans. It is expected that these plans will be purchased by a fairly sophisticated shopper or through the SHOP Exchange. With respect to the addition of the third plan to the bronze, silver and gold tiers, there is a need for innovation. This provides that flexibility. A carrier can offer an innovative plan, without risking its business. Allowing a third plan offering in 2015 provides additional room for innovation, while limiting first year confusion. Jeannette DeJesus stated that while there may be too many plans from the perspective of consumers, it is also important to keep in mind the overall goals of health reform. Innovation will be key and this is one of the few mechanisms to allow innovation by the carriers.

Deputy Commissioner Dowling agreed with Ms. Veltri that there was no understanding that there would be a balancing proposal from the Exchange staff from work done by the Joint Advisory Committee. It was assumed that there was a three way compromise. There is a need to determine the operating model going forward. On the technical side, consumers, carriers and research indicated that choice cannot be overwhelming. By law silver plans need to be offered. The expectation is that most people will be buying bronze plans that will be more expensive than the most popular plans offered in the state today. Inviting carriers to offer gold and platinum plans makes sense, but requiring them to do so does not. The best diversity would be in silver and bronze. Asking carriers to provide several of each does not spread risk well. Every recommendation that has been made by the Joint Advisory Committee comes with a caveat that it

is the best that can be done for initiation of the Exchange. A lot of work, monitoring, correction and improvement will need to occur during the first year based on research and experience.

Mr. Ritter asked about the three different tiers-- with different co-pays and deductible levels and commented that basically it looks like, one plan with three different actuarial values. To go to two plans per tier would seem to indicate an HMO and PPO as a choice. Mr. Counihan commented that the Connector first offered 23 plans. This was overwhelming to consumers eventually leading to discussions of standardization which resulted in offering high, medium and low options. There is a need to provide clarity and choice. Enrollment increased at the Connector following standardization in large part because people felt they understood their choices. But carriers felt it was too rigid. They needed the option to innovate. The Exchange is trying to phase in promoting innovation and experimentation. The Lt. Governor requested a clarification on the standards for gold, silver and bronze plans. Mr. Counihan replied that one standard gold, one standard silver and one standard bronze plan would be required of each QHP. There would also be an option for carrier innovation within the confines of actuarial value for the metal tiers allowing carriers to come up with new ideas.

Mr. Barnes stated that he felt the staff did a fine job clearly articulating recommendations different from those of the committees and noted that there needed to be a mechanism for the plans to have permission to offer additional plans based on demonstrated innovation. Ms. Veltri stated that discussions at the Joint Committee had not gotten as far as discussion about additional options. Ms. Fox suggested that it be required that when carriers submit their plans they also submit a narrative addressing health reform issues. The mix and number of plans looks very standard. If a carrier is looking to present innovation, the RFP does not encourage it at this point. The requested carrier narrative about health reform and innovation should be put front and center as opposed to in footnote to help clarify what is being sought.

Jeannette DeJesús left at 11:44 a.m.

Dr. Scalettar stated that he felt the staff recommendations encompassed simplicity and "threading the needle" with choice. Two of the staff's recommendations were not previously considered by the committees. The staff provided a compelling reason why it might be valuable to competitively have two platinum plans so as to not lose business by offering this choice. The staff recommendations keep it simple at the outset but look towards innovation in 2015. "Will consider" gives that flexibility after the initial launch. Ms. Veltri stated that she would have liked the benefit of her committee's view on that issue. Mary Fox inquired as to those newly insured who are having their first experience with insurance and recommended having an innovative plan which is simpler and more beneficial to them from the get go.

Ms. Veltri asked how the plans will appear to the consumers on the portal. If the QHP chooses to offer the maximum number of plans, how can it be reflected on the portal so that consumers are not seeing too many options to choose from? Mr. Van Loon stated that the general sense is that people can deal with three choices. Consumers will be able to screen by benefits and price. Three options will be presented at a time. These three options can be changed. The Lt. Governor requested additional information about the platinum plans. Mr. Porter stated that the preliminary survey research by Gorman Actuarial found that 20-25% of small businesses between one and 50 employees offer coverage at the Platinum level.

3. Pediatric and Stand Alone Dental: Mr. Van Loon reported that both the Joint Advisory Committee and staff recommended that QHP carriers separately rate their pediatric dental benefit. If a QHP offers a pediatric dental plan enrollees in that QHP will be automatically enrolled in the dental plan but may opt-out for another carrier's plan. Both the staff and Joint Advisory Committee also recommended that the actuarial value certification to the metal tiers not apply to stand-alone dental plans. All stand alone dental plans must provide full dental coverage benefits as indicated in the essential health benefits for pediatric dental services.

4. Standardizing Rating Factors: All offerings will comply with Connecticut Insurance Department (CID) regulations. Both the Exchange Staff and Joint Advisory Committee agreed that tobacco use will not be allowed as a rating factor in the individual market. It is already prohibited as a rating factor in the small group market. While the ACA sets a maximum 3 to 1 age factor rating, both staff and the Joint Advisory Committee recommend that carriers be allowed to determine the tier ratios. Both agreed that the Exchange will establish geographic regions following industry standards but allow carriers to determine tier ratios between the regions. And both staff and the Joint Advisory Committee agreed that absent federal guidance, the Exchange will also standardize family composition structure based on current industry standards, but allow carriers to determine tier ration. Ms. Fox commented that the Exchange's intention is to support wellness programs, such as smoking cessation, but there also needs to be a signal that individuals will be accountable for life style choices.

5. Network Adequacy Requirements. Exchange staff agreed with all Joint Advisory Committee recommendations regarding the general requirements for determining network adequacy, except the requirement for contracting for an ongoing independent secret shopper review and an ongoing independent monitoring process. Ms. Veltri disagreed with this recommendation. The network for each plan must be URAC or NCAQ accredited. The network must also include a sufficient number and geographic distribution of essential community providers (ECPs) to ensure timely access to care, in the service area to the medically underserved. Providers must be sufficient both in number and type to ensure all services including mental health services will be accessible without unreasonable delay. The network must meet the adequacy provisions of the Public Health Services Act (PHSA) for standard plan offerings in the Exchange, and must be substantially the same as the network it offers in its largest plan outside the Exchange.

Considerable discussion followed about the pros and cons of requiring a secret shopper program. Mr. Porter stated that carriers already must meet adequacy standards by law and state regulations. There are professional accrediting bodies that have greater resources to assure that networks are adequate and there is transparency. A Secret shopper can always be instituted later and consideration needs to be given to budget and resources. Dr. Scalettar stated that the Exchange needed transparency in its criteria as well as the ability to track compliance with standards. Plans today are required to do this through self-reporting. There needs to be something between self-reporting and the audit process to use at the front end to see if there is a problem or not. Mr. Ritter asked whether there was a better way to address the issue. Could a statistical method be used to get at compliance with network adequacy requirements, such as through claims analysis? Ms. Veltri replied that claims only show those with appointments. The Lt. Governor asked whether anyone knew the cost for the program. The answer was no. Mr. Madrak stated that the Exchange plans to reach out to consumers for feedback on their experience with shopping, enrollment, and plan experience. Mr. Counihan suggested perhaps a quarterly or every 6 month survey of the membership would be more statistically valid. Secretary Barnes agreed that there is a need to understand the number of customers that are dissatisfied because they have health problems

which are not being addressed by their plans and suggested that the staff be tasked with developing a quality assurance program. The Lt. Governor Wyman asked Ms. Veltri if the staff can come back with recommendations on how this would be done outside the solicitation as long as it still addresses what issues are important? Ms. Veltri responded that from her daily work perspective, access is a core issue and she did not think the secret shopper program is expensive to do. Her office has been a part of one and conducted one, but she does not mean to suggest that it is the holy grail of independent monitoring. In her opinion, two core items that should be included are independent monitoring of the networks beyond the NCQA accreditation. Equally as important, is the need to put consumers and carriers on notice in the solicitation that they will be held accountable for network adequacy. Dr. Scalettar stated that he believes that everyone is in accord that accreditation alone does not ensure network adequacy and that the Exchange has a responsibility to monitor network adequacy, both availability and access. But there are perhaps other reporting mechanisms that could be used and one should not get stuck on the secret shopper technique.

Dr. Scalettar asked about the provider networks offered inside and outside the Exchange. Mr. Van Loon clarified that the language agreed upon is that a plan must offer substantially the same networks inside and outside the Exchange. Staff believes that since the EHB and pricing need to be the same in and outside the Exchange that would pretty much mean that the networks would be similar. Lt. Governor Wyman requested the Exchange develop a better definition of substantially the same. Mr. Van Loon stated that through the QHP solicitation process, the Exchange will be looking for what is similar inside and outside the Exchange.

6. Essential Community Providers: The staff's recommendation differed from that of the Joint Advisory Committee with respect to the percentage of essential community providers that needed to be part of the network. The Joint Advisory Committee's recommendation was to require the plans to contract with 75% of the ECPs located in each county in which the QHP operates and 100% of the federally qualified health centers (FQHC) or "look alike" health centers in each county in which the QHP operates. The staff's recommendation was to contract with 66% of the ECPs located in each county in which the QHP operates and at least 80% of the federally qualified health centers (FQHC) or "look alike" health centers in Connecticut. Ms. Veltri pointed out that FQHCs are essential to the success of the Exchange. The Thomson Reuters data showed that underserved people reside where these centers are located. Ms. Veltri also noted that the carriers can pay the Centers the Medicaid rate. Mr. Porter noted that the staff's requirements are minimum requirements. A carrier must pay a claim for a FQHC even if it is out of network. This is a stipulation of the ACA. The staff's recommendations would allow carriers the opportunity to contract more aggressively with providers. Mr. Barnes clarified that Medicaid rates paid to the Federally Qualified Health Center are not established by the same methodology as other Medicaid rates. They are essentially set by the FQHC itself based on its cost. This changes market dynamics. Ms. Veltri stated that school based centers (SBHCs) are ECPs and there is a state statute requiring carriers to contract with SBHCs.

7. Active Purchasing v. Managed Competition: This topic generated the most discussion over the past few weeks. However, several realities shaped the Joint Advisory Committee and the Exchange staff's belief that active purchasing was not feasible for the first year of Exchange operations. One of these realities is the time element. The other is that the Connecticut Insurance Department (CID) approves rates and has expressed its opinion that the Exchange cannot independently negotiate rates. There is also a belief that market forces put into place by the Accountable Care Act such as the required medical loss ratio, will help keep rates down.

Roderick Bremby left at 12:42 p.m.

The Exchange staff agreed with the Joint Advisory Committee's recommendation that the Exchange contract with any carrier that met the standards for QHP certification and that carriers be required to submit a narrative outlining how they will attempt to better coordinate care and control costs, etc. But the staff did not agree with the recommendation to develop a plan for active purchasing. Mr. Ritter stated that he felt the language "move along a continuum" was not as strong as the staff suggested and that he had no problem voting yes for this particular Advisory Committee recommendation. Dr. Scalettar shared Mr. Ritter's view. You are only an active purchaser if you negotiate with carriers. This is an iterative process and he is comfortable with the language crafted by the advisory committees. Ms. Veltri stated that she hopes that carriers who come in with innovative ideas will be rewarded. With regard to negotiating rates, there are complicating factors within the statutes. On one hand, the statute says any tool can be used to control costs but there still must be compliance with every regulation including rate review. There is a concern that the Exchange's hands are tied. They cannot negotiate rates particularly in year two. Secretary Barnes shared many of Ms. Veltri's concerns. There may be minor and major adjustments with the Insurance Department going forward. The value of negotiating rates is a lack of confidence in mechanics of the marketplace. The ACA/Exchange in combination significantly changed those mechanisms. Secretary Barnes is comfortable with the language because it leaves the issue of negotiation to review in the future.

Lt. Governor Wyman turned to Mr. Ritter for his suggested language. Mr. Ritter suggested changing the language from "any willing carrier" to "from the current situation" as it is boarder. Dr. Scalettar added or "to move along the continuum towards a more active purchaser". Mr. Ritter agreed and stated to remove "from any willing carrier". Lt. Governor stated that this would not be a separate vote.

Lt. Governor Wyman pointed out that there were two recommendations that did not have final answers which included the amount of plans and the FQHC recommendation and those issues would be taken up in separate votes.

Lt. Governor Wyman asked for a motion to accept the staff recommendations on the amount of plans to be implemented in the Exchange. Grant Ritter moved and was seconded by Benjamin Barnes. Vicki Veltri abstained. **Motion passed.**

Lt. Governor Wyman requested a motion to accept the staff's recommended language on the FQHC. The argument was to keep it at 80% or a mandate that it be at a 100%. Benjamin Barnes moved. There was no second. **Motion failed.**

Mr. Barnes made a second motion to accept the staff recommendation on network adequacy except that QHPs would be required to contract with at least 75% of the ECPs located in each county and at least 90% of the federally qualified health centers or "look-alike" centers in Connecticut. The Lt. Governor seconded. Vicki Veltri abstained. **Motion passed.**

Discussion resumed on the question of active purchasing and rate negotiation. Ms. Veltri inquired as to the meaning of "move along the continuum" and suggested adding "move to more active purchasing" starting with the next solicitation. Mr. Counihan expressed confusion on the active purchasing piece because it is very broad and suggested using rate negotiation. Ms. Veltri

suggested the Exchange develop a plan to pursue negotiation of rates with QHPs as part of the next solicitation.

Benjamin Barnes left at 1:02

Lt. Governor Wyman inquired if next year's rates are low will there still have to be rate negotiation?

Mr. Counihan suggested language such as subject to statutory approval. Ms. Veltri said the plan should include investigating statutory requirements. Lt. Governor Wyman inquired if active purchasing is the only way. Ms. Veltri replied that it is not, but it is one of the biggest tools in the toolbox to promote affordability. The Lt. Governor stated that "any willing carrier" will be taken out and different ways will be sought to make it easier to purchase healthcare. There is a need to find the best way to purchase healthcare. Ms. Veltri indicated that it is in the spirit of what she is suggesting but she wants to make sure not to take negotiating rates off the table.

Lt. Governor Wyman requested wording to reflect the need for the best plan to get the best cost for healthcare. Lt. Governor Wyman stated that there was no need to vote as everyone shook their heads in agreement. Mr. Counihan suggested language to the effect that the Exchange develop a plan which evaluates the most effective means to provide low cost or affordable health insurance and asked if that would work for the Board? Everyone agreed to that revision.

Benjamin Barnes returned 1:08 a.m.

Lt. Governor Wyman requested a motion to adopt the recommended requirements for certification of the Qualified Health Plans as presented by Exchange staff but amended by Board. Grant Ritter moved. Benjamin Barnes seconded. **Motion passed unanimously.**

XIII. Adjournment

Adjourned at 1:12 p.m.

Benjamin Barnes moved and seconded.

***The next Board Meeting will take place on December 20, 2012 at 9:00 a.m.
at the Legislative Office Building.***

[Agenda](#)
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