STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

Legislative Office Building, Room 1D

Thursday, February 18, 2016
DRAFT Meeting Minutes

Members Present:
Lt. Governor Nancy Wyman (Chair); Victoria Veltri, Vice-Chair, Office of Healthcare Advocate (OHA); Secretary Benjamin Barnes, Office of Policy and Management (OPM); Robert Tessier; Grant Ritter; Paul Philpott; Michael Michaud, Designee for Commissioner Miriam Delphin-Rittmon, Department of Mental Health and Addiction Services (DMHAS); Cecelia Woods; Robert Scalettar, MD; Commissioner Katharine Wade, Connecticut Insurance Department (CID); Maura Carley

Members Absent:
Commissioner Roderick Bremby, Department of Social Services (DSS); Commissioner Raul Pino, Department of Public Health (DPH)

Other Participants:
Access Health CT (AHCT) Staff: James Wadleigh, James Michel, Steven Sigal; Susan Rich-Bye; Andrea Ravitz; Tamim Ahmed; Ron Choquette; Shan Jeffreys; Robert Blundo

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

I. Call to Order

Lt. Governor Wyman called the meeting to order at 9:00 a.m.

II. Public Comment

None

III. Votes

Lt. Governor Wyman requested a motion to approve the January 21, 2016 Regular Meeting minutes. Motion was made by Robert Scalettar, MD and seconded by Victoria Veltri. Dr. Scalettar proposed an amendment to the minutes in order to reflect his thanks to the Department of Social Services staff for their presentation, and his request for a future presentation on the upcoming integration of the new DSS Impact system into the current Integrated Eligibility System. ***Motion to approve the minutes as amended passed unanimously.***

IV. CEO Report

James Wadleigh, CEO, provided an update on AHCT activities. AHCT has closed out the most successful open enrollment period to date, with over 116,000 Qualified Health Plan (QHP) enrollees, over 20,000 of whom were new to AHCT this year. The immediate focus is the completion of the enrollment process. To date, over 18,000 customers have 90 days to send in their verification documents, which verify income and citizenship. AHCT is also sending reminders to consumers through various media channels that the enrollment process is not completed until the first premium payment is made to the carriers.

Benjamin Barnes arrived at 9:05 a.m.

The plan management team has readied the 2017 standard plan designs. Plan changes are necessary to stay within the mandated actuarial values. In the early summer, the team will be working with the advisory committees to begin the discussions for the 2018 plan year, in order to prepare more significant changes to the standard plan designs.

Andrea Ravitz, Director of Marketing, has worked with the United States Citizenship and Immigration Service to allow Access Health CT to participate at the monthly citizenship swearing-in ceremonies, at which staff will hand out enrollment information. Connecticut is the first state to leverage this process.

Over the next month, AHCT will hold meetings with all participating carriers to discuss best practices for open enrollment, as well as opportunities to improve customer service. Carriers have ideas on improving collaboration in the future.

AHCT has been working with the federal government, as well as with carriers, to discuss improvements to the special enrollment process. Changes include improving guidelines on documentation, and educating consumers about eligibility for special enrollments. The biggest impact for the customer has been terminations for nonpayment after the exhaustion of the 90 day payment grace period allowed for consumers receiving advance payments of the premium tax credit (APTCs). Consumers receiving APTCs are given 90 days to pay any premiums due before a carrier may terminate their coverage for nonpayment. Termination of a plan due to nonpayment of premium does not allow a consumer to qualify for a special enrollment.

As AHCT prepares for 2017, more information will be shared on outreach programs and customer improvements.

V. Operations Update

James Michel, Director of Operations, provided an update on open enrollment. As of February 1, 2016 there were approximately 20,000 new QHP customers who enrolled through AHCT. Call center and enrollment partner performance was provided. There were no significant increases from prior years.

Mr. Michel reviewed the circumstances under which consumers can enroll outside of open enrollment, which include eligibility for Medicaid; American Indian or Alaska Native status; or a qualifying life event such as marriage, having a child, moving, experiencing an income change or losing health coverage, all of which would allow for a special enrollment. Consumers will be required to provide the proper documentation showing that they qualify for special enrollment. This process is being monitored.

AHCT has mailed IRS 1095-A forms to 2015 QHP enrollees on January 31, 2016. Some consumers have questions regarding the APTC and premium amounts, or dates of coverage reflected on the forms. Some consumers have received more than one 1095-A, because they changed their plan enrollment during the year.

Mr. Tessier expressed concern about the call center, particularly regarding the approximate 24% call abandonment rate during the last week of open enrollment, and asked whether AHCT had a plan to address this issue in the future. Mr. Michel replied AHCT is not happy that consumers are not getting high quality service from the call center, and that AHCT is addressing this issue. AHCT has issued a Request for Proposals (RFP) for call center services, and the procurement process for a call center vendor is currently underway. Mr. Wadleigh added that all prospective vendors will also be evaluated with the same due diligence, including the current vendor. Prospective vendors will be asked to provide plans to improve call center quality and decrease costs. Mr. Tessier added that on the Friday before the open enrollment deadline, 40% of people abandoned their calls because of an almost 13 minute wait time.

VI. All-Payer Claims Database

Susan Rich-Bye, Director of Legal Affairs and Policy, introduced the All-Payer Claims Database Privacy Policies and Procedures. The public comment period on the draft policies and procedures closed on November 27, 2015. A few public comments were received, but none of them merited any changes to the policy. The APCD Advisory Group discussed and approved the policies and procedures at their meeting on February 11, 2016 and agreed that they should be presented to the Board for adoption.

Lt. Governor Wyman requested a motion to adopt the All-Payer Claims Database Privacy Policies and Procedures as presented by Exchange staff. Motion was made by Victoria Veltri and seconded by Robert Scalettar, MD. ***Motion passed unanimously.***

Tamim Ahmed, APCD Executive Director, provided an update on APCD implementation. Data collection began in mid-November 2015, following the successful completion of the Phase I security audit. The APCD data vendor has begun accepting commercial plan data, beginning with test data. There are four phases of data collection – test data, historical data, year-to-date data, and ongoing monthly data submission. It is taking more time than expected to collect data. The data vendor has stated that their experience in other states is similar. It is anticipated that the Phase II Security Audit will be completed by the beginning of March. Despite challenges, the implementation timeline has not changed.

Dr. Ahmed presented a table depicting carriers' data submission status. Carriers have multiple systems and submitting units. If any carrier did not conform to the strict encryption guidelines, data submission was rejected. Member counts in the table do not include Anthem or United Healthcare.

Benjamin Barnes asked what the blank space represented in the data submission table. Dr. Ahmed replied that the blank area signified that the carrier has not yet submitted their data. Anthem and United Healthcare will begin the submission process at the end of this week or next week. Mr. Barnes asked further about the anticipated member counts. Dr. Ahmed explained that the United States Supreme Court is currently considering the case of *Gobeille v. Liberty Mutual*, in which Liberty Mutual has argued that the Employee Retirement Income Security Act (ERISA) pre-empts Vermont's requirement that self-insured employers submit data to its APCD. Connecticut is subject to the ruling of the Second Circuit Court of Appeals, which struck down the requirement for self-insured employers to submit data. As a result, some submitters such as Anthem and United Healthcare have decided not to submit self-insured plan data, but Aetna is submitting such data. Mr. Barnes asked about Cigna self-funded plan data. Dr. Ahmed replied that Cigna had agreed to submit data from its relatively small number of self-insured plans. Ms. Veltri added that she believed that Cigna has large ASO accounts. She argued that despite the pending court case, this data should be gathered, whether it is self-funded or not. Ms. Veltri asked about the timeline for data validation for Quarter 2, further adding that there is currently no data from Healthy CT. Dr. Ahmed replied that Healthy CT does not have a lot of data, and intends to meet the submission deadline. Historical data should be collected by the end of April, and AHCT is urging the carriers to submit data. Mr. Barnes asked whether Anthem or United Healthcare were submitting data related to the State of Connecticut employee plan. Dr. Ahmed replied that state employee health plan data is being submitted. Ms. Veltri clarified that she was not suggesting that any carriers were not submitting data, only that data should be collected.

Dr. Scalettar stated that while he appreciated the efforts to encourage Anthem and United Healthcare to submit data, they are already voluntarily submitting data to APCDs in other states. Additionally, he believes that Anthem submits claims data to the Health Care Cost Institute (HCCI), which is a large non-profit database, and a leader in recognizing the value of pooling data across carriers. Dr. Scalettar urged the APCD to step up the activity to stay with the timeline.

Mr. Tessier stated that he works with self-insured employers, and said that ERISA attorneys have advised their clients that self-insured claims data should not be submitted to the APCD unless and until the US Supreme Court rules that ERISA plans have to comply with state laws requiring data submission. He said that if that data is submitted voluntarily, plans could be in violation of HIPAA, and the penalties can be severe. Ms. Veltri asked how other state APCDs were handling this issue, and whether there were other sources of self-insured data. Dr. Ahmed stated that other data sources are not being explored, and that AHCT is awaiting the Supreme Court decision. Dr. Ahmed stated that Anthem and United Healthcare are submitting the data, and are awaiting a waiver to address issues related to coding and infrastructure.

Lt. Governor Wyman added that she thought there was little hope for a Supreme Court decision in June. She suggested that Board members could send a letter to carriers, requesting that they submit data to the APCD.

Mr. Wadleigh stated that the data submission dates have changed a number of times. Dr. Ahmed will be sending out monthly updates, and Mr. Wadleigh has full confidence that carriers will submit data, and feels that this is a normal part of the process. Ms. Veltri requested that AHCT research other state APCDs' collection of self-insured data.

Dr. Ahmed continued with a summary of cost transparency reports which will be designed for the consumers' benefit. Besides reports to assist consumers, there are various types of reports, including those for state policy makers and researchers. Dr. Ahmed summarized the characteristics of the cost transparency reports.

Dr. Ahmed summarized the data from Google on the Consumer Decision Support Tool for the period from November 1, 2015 through January 31, 2016.

VII. Finance

Steven Sigal, Chief Financial Officer, provided an update on Finance activities. The assessment process continues without issues. AHCT collected approximately $28 million in assessments in 2015. For 2016, over $34 million in assessments is expected, with over $1 million received to date. Three audits have been finalized, and were discussed with the audit committee at its meeting on February 8, 2016. There was a clean Financial Statement Audit report. The Programmatic Audit has been completed, and there were no major issues with regard to eligibility and enrollment. One item, however, was identified but has been resolved. CMS requested a 2014 Reinsurance Audit, and there were no issues identified.

Dr. Scalettar asked if there were any 2015 market assessments outstanding. Mr. Sigal replied that there is a relatively small amount outstanding, and these payments are being pursued. There is approximately a six month cash reserve. Further assessments are due quarterly, and the first is due March 31.

Lt. Governor requested a motion to accept the Fiscal Year 2015 Audited Financial Statements. Motion was made by Benjamin Barnes and seconded by Victoria Veltri. ***Motion passed unanimously.***

Lt. Governor requested a motion to accept the Fiscal Year 2015 CMS Programmatic Audit. Motion was made by Victoria Veltri and seconded by Cecelia Woods. ***Motion passed unanimously.***

Lt. Governor requested a motion to accept the Report of 2014 Transitional Reinsurance Payments. Motion was made by Victoria Veltri and seconded by Benjamin Barnes. ***Motion passed unanimously.***

Four regulatory reports were completed and filed. The enterprise resource planning tool is moving forward.

The second quarter expense reforecast was provided. The total is down by approximately $1 million, and AHCT is unfavorable by $3.2 million. This is mainly due to expenses from the call center, which has exceeded the budget and AHCT has been unsuccessful in reducing costs down to the original budgeted amount. In addition, there was an unanticipated expense due to AHCT participation in Release 19 for the Integrated Eligibility System. Mr. Sigal summarized the Fiscal Year 2016 Contractual, second quarter Reforecast. There were two unanticipated variances in IT and the call center. Mr. Sigal noted that it is no longer in the IT allocable category. There is a new approach to working with the Department of Social Services (DSS), where DSS and AHCT will contract with vendors separately. Mr. Sigal reminded the Board that at end of the 1st quarter, AHCT was $1.5 million over budget because of the Husky A change release. This reforecast does not include a late December/early January participation with DSS

in its state bonding request. AHCT should be receiving approximately $1 million through DSS for the Husky A change. It is currently not reflected in the reforecast.

Mr. Barnes asked for clarification on the difference between the columns depicting the Q1 reforecast and Q2 reforecast in the FY 2016 Reforecast table. Mr. Sigal replied that the columns on the left side of the table represent the total reforecast, while those on the right side of the table show AHCT's re-forecasted share, after allocations have been made. Mr. Sigal also reviewed the 2016 Expense Results against the new Quarter 2 reforecast, which is actually $2 million favorable due to salary and fringe favorability, as well as contractual and temporary staffing favorability due to the timing of IT activity.

Dr. Scalettar complimented the team on the clean audit reports.

VIII. Plan Management Update

Shan Jeffreys, Director of Marketplace Strategies, provided an update on Plan Management activities. Advisory Committee meetings were held on February 17 to review and approve the 2017 standard plan designs. Each committee member brought his or her own perspective to these discussions. The advisory committees decided to evaluate the number of plans offered to consumers, as well as the long term strategy for understanding consumer preferences. There will be future meetings to discuss these topics.

Wakely Consulting assisted with the development and analysis of the plan designs, and responded to changes discussed during the meeting. The Connecticut Insurance Department responded to difficult and challenging questions.

Ron Choquette, Director of Small Business Sales & Operations, stated that the Broker and SHOP advisory committees assisted in the discussion of balancing co-payments and deductibles. Mr. Choquette added that there is a strong interest in moving the SHOP program forward.

Ms. Veltri added that the Health Plan and Consumer advisory committees raised the issues of affordability, non-standardized plans in particular metal tiers, and the impact of the reinsurance program ending. Ms. Veltri emphasized that the Board and other stakeholders should develop a strategy to mitigate the end of this program.

Mr. Sigal stated that there have been recent conversations on the possibility of a state level reinsurance program.

Mr. Tessier echoed Ms. Veltri's comments. In each of the last three years, CMS has released a new actuarial value (AV) calculator, which sometimes results in AHCT standard plan designs with more costly benefits in the various metal tiers. The plans become more expensive for consumers, who generally find co-pays to be more advantageous than co-insurance. Mr. Tessier agreed that Wakely was very helpful in this process, as were the participants from the Connecticut Insurance Department.

IX. Strategy Committee Update

Dr. Scalettar summarized recent Strategy Committee activities. Dialogue continues on the role of the Advisory Committees. The Strategy Committee has decided that the charge and composition of the Advisory Committees should change, and staff will be making

recommendations to that end. Additionally, articles were provided to the committee on different trends in health care, as well as local efforts concerning health literacy and quality/value issues. Mr. Wadleigh shared a document from Covered California during the meeting. The document was a work product from Covered California staff, noting efforts such as the QHP selection process and expectations. The committee discussed its contents in the context of AHCT's long term goals and strategies. The committee and staff hope to present some early draft of an AHCT equivalent at the April Board meeting. Mr. Wadleigh confirmed that there will be a presentation on an AHCT 3 to 5 year strategy, integrating such items such as SIM and HIT.

Mr. Wadleigh clarified that Anthem did submit their claims data to the APCD on January 29. They are working on some connectivity issues.

X. Adjournment

Lt. Governor Wyman requested a motion to adjourn the meeting. Motion was made by Victoria Veltri and seconded by Robert Tessier. ***Motion passed unanimously***. Meeting adjourned at 10:24 a.m.