Approved as amended by the Board of Directors on February 18, 2016

STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

Legislative Office Building, Room 1D

Thursday, January 21, 2016
Meeting Minutes

Members Present:
Lt. Governor Nancy Wyman (Chair); Victoria Veltri, Vice-Chair, Office of Healthcare Advocate (OHA); Commissioner Roderick Bremby, Department of Social Services (DSS); 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; Robert Tessier

Members Absent: Secretary Benjamin Barnes, Office of Policy and Management (OPM); Acting Commissioner Raul Pino, Department of Public Health (DPH)

Other Participants:
Access Health CT (AHCT) Staff: James Wadleigh, James Michel, Steven Sigal; Shan Jeffreys
Department of Social Services: Kate McEvoy, Esq. - Director, Division of Health Services; Robert Zavoski, MD, MPH – Medical; and, Director Marc Shok – Director, Eligibility Policy and Economic Security
Wakely Consulting Group: Chris Bach; Julia Lambert

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 November 19, 2015 Regular Meeting minutes. Motion was made by Robert Scalettar, MD and seconded by Victoria Veltri. ***Motion passed unanimously.***

Lt. Governor Wyman requested a motion to elect Victoria Veltri as vice-chair of the Board. Motion was made by Paul Philpott and seconded by Robert Scalettar, MD. Victoria Veltri abstained. ***Motion passed.***

IV. CEO Report

James Wadleigh, CEO, provided an update on AHCT activities. Ten days remain until the end of Open Enrollment on January 31, 2016.

Katharine Wade and Michael Michaud arrived at 9:03.

As of January 20, 2016, approximately 109,000 Connecticut residents have enrolled in qualified health plans (QHP) for the 2016 plan year. Mr. Wadleigh provided an update on national trends that could have an impact on Access Health CT. Due diligence is needed to push the Affordable Care Act over the next hurdle. Mr. Wadleigh stated that the dismantling of the Kentucky health insurance exchange is an example of potential risks for state-based marketplaces. Some carriers have announced that they are losing money in the individual markets. Carriers are operating medical loss ratios of well over 90%, indicating future challenges for the carriers, and the possibility that rates will increase. There will be a need for collaboration with carriers to help lower costs of operations and creative services in order to lower rates. One recent national trend is the carriers' elimination of broker commissions. In 2016, Access Health CT will be pursuing initiatives to improve on customer service, including self-service. AHCT has established staff committees to drive customer service improvements through analysis of internal and external factors. Consumer websites need to be improved, leading to a better customer experience, and decreasing the need for consumers to contact the call center for help. Initiatives will also include a 100% first call resolution in the call center, which will lower costs for all organizations, and improve the customers' experience. Work will continue with carriers, advocates and state organizations to drive the importance of health education and literacy, and the overall role that Access Health CT can play in their lives.

V. DSS Overview

Three officials from the Department of Social Services provided an overview of the Connecticut Medicaid program. Kate McEvoy, Esq., Director of the DSS Division of Health Services, spoke about the current status of the Medicaid program, including major reform initiatives, as well as the means of covering services, including federal requirements and funding. Robert Zavoski, MD, MPH, DSS Medical Director, discussed the core concepts of Medicaid coverage, including the Medicaid State Plan, and the differences between Medicaid and Medicare, as well as Connecticut Medicaid's use of Administrative Services Organizations (ASO). Marc Shok, DSS Director of Eligibility Policy and Economic Security, spoke about Medicaid eligibility for each coverage group. (Presentation)

Robert Scalettar, M.D. thanked the Department of Social Services staff for the presentation and asked for a future presentation on the upcoming integration of the new DSS Impact system into the current Integrated Eligibility System.

VI. 2016 Open Enrollment Update

Shan Jeffreys, Director of Marketplace Strategies, provided an update on 2016 Open Enrollment, initiatives, communication plans and system performance. Planning is underway for 2017 Open Enrollment. Advisory Committee meetings will be taking place in February to review 2017 standard plan designs. Dental plan membership as of January 13, 2016 included 1,317 members, with 689 new dental enrollments from November 11 to January 13.

Ms. Veltri asked whether dental carriers have reported on utilization for the benefits currently offered. Mr. Jeffreys replied that a questionnaire on this topic had been sent to the carriers, and more information is expected prior to the first advisory committee meeting. Mr. Wadleigh added a caveat that the utilization will be low because of the plan exclusions and waiting periods. AHCT will be working to change the dental plans that are currently offered.

VII. Operations Update

James Michel, Director of Operations, provided an operations update. As of January 19, 2016, there were 15,214 new QHP enrollees for 2016, as well as 34,590 new Medicaid determinations in the system.

Open enrollment ends on January 31, 2016 at midnight. A consumer may only enroll during the Open Enrollment period, unless he or she meets one of the following criteria: a qualifying life event which would allow a special enrollment period, Medicaid or CHIP eligibility, or American Indian or Alaska Native status. Loss of coverage due to non-payment of premium does not constitute a qualifying life event. Consumers will be required to provide the proper documentation proving qualification for a Special Enrollment period. Mr. Wadleigh stated that more communications regarding qualifying life events will be broadcast and sent to consumers. Lt. Governor Wyman requested that this message be conveyed to consumers. Robert Tessier asked whether there had been any communication from CMS regarding the abuse of special enrollment periods. Mr. Wadleigh replied that CMS and CCIIO provided updates on qualifying life events at the federal level, such as a system error or tax penalty. Carriers have begun reacting to issues resulting from the special enrollment process. AHCT is responding in order to support carriers and consumers alike.

AHCT consumers will be receiving 1095-A forms beginning next week. These forms will allow consumers to reconcile tax credits and provide evidence of health insurance coverage. Approximately 600,000 1095-Bs will be mailed to Medicaid customers. There will be coordination between DSS and AHCT to serve consumers who were enrolled through both AHCT and DSS, in order to ensure that there are no discrepancies in the forms. Ms. Veltri asked whether there had been communication to the community partners regarding 1095s. Mr. Michel replied that postcards with instructions have been mailed to all consumers, and that AHCT had discussed 1095s with community partners as well. Commissioner Bremby asked whether AHCT had considered designating one point of contact for all 1095 matters for both AHCT and DSS.

Michael Michaud left at 10:42 a.m.

Mr. Michel replied that, regardless of whether a consumer calls AHCT or DSS regarding a 1095, the call will be transferred to the appropriate agency. Mr. Bremby clarified his question, asking whether one entity should handle resolution of 1095 issues, as there may be a gap in information between agencies. Mr. Michel replied that AHCT does not have access to 1095-B information in the DSS EMS system. Mr. Bremby added that Xerox does have that information, and could serve as the single point of contact for 1095 issues next year.

Mr. Michel provided an update on the Husky A transition. Transitional Medical Assistance (TMA) will end on July 31, 2016 for approximately 18,500 Connecticut residents who are no longer eligible for Husky A. These individuals must enroll in coverage by July 31, 2016, for an effective date of August 1, 2016, in order to avoid any gap in coverage. AHCT and DSS have been jointly planning for this transition. Ms. Veltri added that it is important to engage the community partners, who will assist in making this transition a success. Dr. Scalettar asked for a summary of the previous transition during 2015, and what was learned from this experience. Mr. Michel replied that there was not enough time for meaningful planning and outreach. For the transition this year, there is more time to communicate the message. Dr. Scalettar asked what other states in similar situations experienced. Mr. Michel replied that, as Connecticut was planning for the previous transition, it was determined other states experienced similar results. Mr. Jeffreys added that there is a very detailed project plan for this year's transition, including more outreach, in light of last year's results.

VIII. Technical Operations & Analytics Update

Robert Blundo, Director of Technical Operations & Analytics, provided a technical operations and analytics update. He summarized brief enrollment counts, analysis of customer shopping decisions, and plan migration since last Open Enrollment. After the end of open enrollment, there will be a shift to utilize analytics to guide improvement of customer service. Metrics will continue to be tracked following the close of open enrollment.

Paul Philpott asked whether AHCT could calculate the cost of transactions, such as enrollment, disenrollment, and churn between QHP and Medicaid, based on data from previous experience. Mr. Wadleigh replied that, with the changes in the original rules for special enrollment periods, and fewer self-attestations, there would be a significant change in the enrollment process. It may take approximately one year for the customer to realize these changes. It may be difficult at this point to see any trends. There will be continued collaboration with the brokers to attract non-subsidized customers into the exchange.

Lt. Governor left at 11:08 a.m.

Ms. Veltri pointed out that messages and outreach to consumers should emphasize the importance of shopping for the most appropriate plan. Mr. Wadleigh stated that Mr. Blundo will analyze consumer plan selection behavior based on whether consumers have been assisted by brokers. For consumers who shop without a broker, AHCT must provide education on plan selection.

Mr. Blundo will also separate and analyze the populations according to age. There will be further analysis of consumer plan selection behavior through the annual customer census survey.

IX. Legislative Requirement – Adverse Selection Study

Steve Sigal summarized the annual requirement for AHCT to perform an adverse selection study. Chris Bach and Julia Lambert of Wakely Consulting provided a high level summary of the study. AHCT is required by its enabling legislation to report annually on the impact of adverse selection on the exchange, provide recommendations to address any negative impact reported, and provide recommendations to ensure the sustainability of the exchange. Adverse selection is defined as one segment of the market attracting enrollees with a higher health risk than another segment of the market. The nature of adverse selection, areas of potential adverse selection, and the study methodology were reviewed. Conclusions and recommendations were summarized for both the individual and small group markets.

Roderick Bremby left at 11:23 a.m.

Conclusions of the study were provided. The individual market on the exchange had a slightly higher overall risk score than the individual market off of the exchange. This may indicate potential adverse selection, but currently has a minimal impact in the market due to the protection of risk adjustment mechanisms. Small group enrollment on the exchange is low, and data are not fully credible in order to analyze by metal tier. Thus, no conclusions can be made regarding adverse selection in the small group market. The low enrollment should be monitored outside the context of adverse selection in order to ensure sustainability of the exchange. Individual grandfathered policies appear to experience favorable selection, and enrollees are minimal and declining, with a decreasing impact to the individual market. There was no analysis of adverse selection in small group grandfathered plans, since there was no enrollment in this market as of June 2015.

Connecticut data indicates an increase in the prevalence of self-funded small groups in recent years, but the data may not be credible. National data indicate no significant change in the prevalence of self-funded small groups in recent years, but it may not be appropriate to compare to Connecticut due to differences in small group regulations. There is a lack of credible or comparable data results with no clear conclusion as to whether there is adverse selection in the small group market. This needs to be closely monitored as more data become available, in order to ensure healthier small groups do not move to a self-funded basis, leading to significant adverse selection. In the survey, carriers stated that one of the most significant issues impacting adverse selection in their plans is the special enrollment period. Access Health CT and the Connecticut Insurance Department are aware of the special enrollment period issues, and are determining the next steps to minimize adverse selection of these enrollees.

Recommendations were summarized. Small group enrollment on the exchange should continue to be monitored to control adverse selection and to ensure sustainability. Further, it was recommended that AHCT collaborate with other states and carriers to advocate for improvements in the federal risk adjustment formula in order to improve its accuracy. There were no recommendations for changes to the grandfathered plans, due to the minimal impact

of adverse selection. Carriers will likely consider terminating the grandfathered plans in the near future due to low membership and economic inefficiency. It was recommended that the small group market be closely monitored to ensure that healthier small groups do not move to self-funded plans, potentially leading to adverse selection. Consideration should be given to implementing a stop-loss insurance regulation to limit adverse selection due to the migration of small groups to self-funded plans.

Other considerations to mitigate adverse selection include stricter documentation requirements for special enrollment periods, and termination of enrollment in the case of misrepresentation or fraud. Future considerations include studies with a more mature experience that may provide more definitive results. The current analysis indicates that there may be some adverse selection in the Connecticut health insurance market, but the limited experience makes it difficult to form a definitive opinion on the impact of adverse selection at this time.

Grant Ritter asked what triggers a payment under the risk adjustment program. Ms. Lambert replied that in Connecticut, funds are transferred between carriers both on and off the exchange. The carrier experience that Wakely reviewed indicated that plans on the exchange were generally a worse risk than those off the exchange. The risk adjustment mechanism provides funds to the on-exchange policies because the risk experience is worse. Risk scores are based on the concurrent year experience.

Dr. Scalettar asked Commissioner Wade when the small group maximum size will increase from 50 to 100 in Connecticut. Commissioner Wade replied that employers were surveyed, and they responded that the maximum small group size should remain at 50 because of cost. Dr. Scalettar asked about the carriers' reaction to the adverse selection study survey, and whether carriers were required to respond. Ms. Bach replied that the legislative requirement does not include any reporting requirement of the carriers. The survey was developed through AHCT and the carriers' responses were appreciated. As far as their outlook, the carriers feel that there is adverse selection occurring in plans on the exchange versus those off the exchange, as well as in grandfathered plans versus non-grandfathered plans.

Mr. Philpott asked Commissioner Wade whether state regulations set minimum attachment points for reinsurance of self-funded groups. Ms. Wade replied affirmatively. Mr. Philpott further inquired whether there were issues for self-funded plans in terms of having access to provider networks, and if there is truly any cost savings for self-insured employers. Mr. Tessier asked about the credibility of these responses, given the relatively dramatic trend to self-funding by employers of all sizes. Mr. Bach replied that she feels that there is a trend of smaller groups becoming self-funded. This has always been an adverse selection issue, and has always been prevalent, but it may be too early to tell whether this increase is a direct result of the ACA.

Ms. Veltri asked whether the risk of on-exchange products is expected to stabilize. Ms. Bach stated that theoretically, risk is expected to stabilize over time. However, the carriers do not feel that the current federal risk adjustment program is appropriately distributing the risk payment or covering costs. If that is the case, risk may not stabilize over time.

Co-Chair Veltri requested a motion to accept and submit the Connecticut Health Insurance Exchange Adverse Selection Study - Based on 2014 Data to the General Assembly as required

under C.G.S. §38a-1084(25). Motion was made by Grant Ritter and seconded by Robert Tessier. ***Motion passed unanimously.***

X. Adjournment

Co-Chair Victoria Veltri requested a motion to adjourn the meeting. Motion was made by Robert Scalettar, M.D. and seconded by Grant Ritter. ***Motion passed unanimously***. Meeting adjourned at 12:00 p.m.