As Approved by the Board of Directors on June 15, 2017

STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

Connecticut Historical Society
1 Elizabeth Street
Hartford

Thursday, May 18, 2017
**Meeting Minutes**

**Members Present:**
Lt. Governor Nancy Wyman (Chair); Robert Tessier (Vice-Chair); Victoria Veltri; Grant Ritter; Commissioner Miriam Delphin-Rittmon, Department of Mental and Health Addiction Services (DHMAS); Commissioner Katharine Wade, Connecticut Insurance Department (CID); Commissioner Roderick Bremby, Department of Social Services (DSS); Theodore Doolittle, Office of the Healthcare Advocate (OHA); Cecelia Woods; Secretary Benjamin Barnes, Office of Policy and Management (OPM); Paul Philpott

**Members Participating Remotely:**
Robert Scalettar, MD

**Members Absent:**
Maura Carley; Commissioner Robert Pino, Department of Public Health (DPH)

**Other Participants:**
Connecticut Insurance Department (CID): Mary Ellen Breault
Access Health CT (AHCT) Staff: James R. Wadleigh, Jr.; Shan Jeffreys; Robert Blundo; Tricia Brunton; Ann Lopes

**The Regular 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 Nancy Wyman called the meeting to order at 9:00 a.m.

## II. Public Comment

Lynn Ide, Director of Program and Policy at the Universal Healthcare Foundation of Connecticut provided a public comment.

Deb Polun, Director of Government Affairs at the Community Health Center Association of Connecticut provided a public comment.

## III. Votes:

Lt. Governor Wyman requested a motion to approve the April 20, 2017 Board of Directors Regular Meeting Minutes. Motion was made by Victoria Veltri and seconded by Robert Tessier. ***Motion passed unanimously.***

## IV. CEO Report

James Wadleigh, CEO, updated the Board on AHCT activities. Mr. Wadleigh indicated that recent developments in Washington, in particular, the passage of the American Health Care Act (AHCA) by the United States House of Representatives on May 4, affect the work of the Exchange. This legislation aims at repealing and replacing the Affordable Care Act (ACA). It has the potential to significantly change the way in which Access Health CT (AHCT) provides its services. AHCT is currently working on the crosswalk document that would compare both the ACA and the AHCA. When completed, it will be shared with the Board. This document will also be posted on the Agency's website. The United States Senate will now be deliberating on its version of the healthcare proposal. Mr. Wadleigh reminded the Board that the ACA is still the law of the land, and requires all Connecticut residents to maintain healthcare coverage.

Mr. Wadleigh provided the Board with an update on his trip to Washington, where he met with Centers for Medicare and Medicaid Services (CMS) administrators. The new healthcare legislation was the main topic of the conversation. Mr. Wadleigh indicated that flexibility for individual states was discussed.

**Commissioner Roderick Bremby arrived at 9:08 a.m.**

Mr. Wadleigh stated that on May 1, carriers in Connecticut submitted rates to the Connecticut Insurance Department (CID). While AHCT is disappointed at the requests for premium increases, the Exchange understands the driving factors behind these actions. The uncertainty around the continuation of the Cost Sharing Reduction (CSRs) payments is a major contributing factor behind these requests. AHCT, along with the carriers, should advocate to the Connecticut Congressional Delegation for the continuance of the CSR payments. If the CSRs are not authorized, a viable risk remains that the two carriers, which service AHCT customers, may depart from the Exchange. Both carriers indicated that would like to stay on the Exchange, and asked for assistance at the time of uncertainty surrounding the CSR payments. Mr. Wadleigh stated that ConnectiCare has filed rates for plans to be offered through the Exchange's small group market.

## V. Plan Management – Modifications in Standard Plan Designs (Vote)

Shan Jeffreys, Director of Marketplace Strategies, provided the Board with an update on plan designs. Carriers that are participating in the ACA must meet certain standards to be compliant. Two of the most important standards are meeting the Actuarial Value (AV) requirements for metal tiers and Mental Health Parity. One of the carriers failed the Mental Health Parity Test. CID has been working with two carriers to assist them in meeting these compliance guidelines.

Mary Ellen Breault, Director of the Life and Health Division at CID, provided the Board with an update on the requirements of the Mental Health Parity Test. The test has to be done not only for each plan, but also for each set of the cost-sharing requirements within that plan. The test is performed for the deductible, the copay as well as for the co-insurance. The carriers are required to use their own claims experience. They also have to test it for classification of benefit types. Ms. Breault indicated that the problem was found within the outpatient services. One of the Exchange's carriers failed that test. CID, as the insurance industry regulator, has to make sure that carriers comply with this requirement. CID has worked with the carriers and AHCT in order for both carriers to meet the AV and Mental Health Parity requirements.

**Secretary Benjamin Barnes arrived at 9:15 a.m.**

Robert Tessier inquired whether formal notification by the carrier was provided to CID pertaining to the carrier's inability to meet the requirements of standard plan designs adopted at the February 28th Board of Directors Special meeting. Ms. Breault indicated that notification to the Exchange was provided. Until the carrier makes the formal filing, it would be part of it. This action was not taken until May 1. Ms. Breault indicated that both carriers provided demonstration on two specific plans. They did fail in the Substantially All Tests. ConnectiCare Benefits, Inc., (CBI) performed it using a wrong benefit design, and they also would have failed the test. Katharine Wade indicated that CID does not have a formal letter from the carriers, but CID has reviewed all of the calculations, and came to the conclusion that adjustments to plan designs needed to be made. Ms. Wade added that formal notification to the Exchange was provided. Mr. Tessier expressed his concern that as member of the Health Plan Benefits and Qualifications Advisory Committee, he was not aware of such communication. Mr. Jeffreys indicated that Anthem did reply to the Exchange, indicating they would not be able to meet the Mental Health Parity Test. The Exchange asked to obtain more information. One of their suggestions encouraged a substantial change to one of the plan designs. The Exchange did not feel that it was an appropriate step to take. At that point, the Exchange decided to progress with the currently approved plan designs to allow the other carrier to submit rate filings.

Grant Ritter inquired how a change in plan design would have negative consequences for the other carrier. Mr. Jeffreys indicated that one of the changes requested by the carrier would have included all services being a subject to a deductible. Ann Lopes, Carrier Product Manager, indicated that the other change would have split the cost sharing to two different service locations for both laboratory services and x-rays. Ms. Lopes added that if a consumer went to a freestanding facility, the co-pay would be applied. If a consumer went to an outpatient facility

associated with a hospital, the deductible would be applied. The Exchange felt that such a scenario would have created an unnecessary confusion for consumers. Ms. Breault added that due to the carriers failing the Substantially All Test, two-thirds of the medical and surgical benefits did not apply to the deductible.

Theodore Doolittle inquired about the practical effect on a family or on a consumer that has high mental health costs. Ms. Breault indicated that design changes do not affect mental health benefits. Mr. Doolittle indicated that based on the documents received, changes exist in the mental health services from having a $500 co-pay to having the deductible in addition to a co-pay. Mr. Doolittle asked whether outreach to the mental health community was conducted during the decision-making process. Ms. Lopes indicated that changes in the plan benefits design affected laboratory and x-ray benefits. The changes to plan designs adopted at the February 28th Board of Directors Special meeting aimed at minimizing negative impact for consumers. The revisions to the individual Gold plan design include x-rays and laboratory services being subject to the deductible. Also, the In-Network (INN) medical deductible was reduced from $2250 to $1250 per member.

Mr. Doolittle asked for a theoretical example of a family who utilizes mental health services. Mr. Doolittle inquired about this family's financial obligations to obtain those services. Ms. Lopes indicated that $4440 is the Maximum Out of Pocket Expense (MOOP) for an individual utilizing the INN providers. This amount increases to $8800 for a family of two. In addition, this amount stays at $8800 if a family is composed of more members. The 94% CSR plan has a much lower MOOP, which equals to $750 per member. Ms. Lopes described revisions to the 70% Silver plan which is not eligible for CRSs. In order for the carriers to comply with the Mental Health Parity Test, x-ray and laboratory services will be subject to the deductible. Also, the INN deductible was reduced from $5000 to $3700 per member. The Out-Of-Network (OON) medical deductible was also reduced accordingly.

Mr. Ritter inquired whether the Substantially All test applies to each category of service. Ms. Breault pointed that federal regulations define classifications. Ms. Breault indicated that inpatient, outpatient, and office visits are distinct classifications which are defined by the federal government. Mr. Ritter commented that it means that the Substantially All test is defined as two-thirds of all outpatient services. Paul Philpott inquired if a single insured reaches the MOOP for the individual member, whether she/he still would be required to pay for her/his family's annual deductible for the services to be fully covered. Ms. Lopes stated that if an individual reaches her/his MOOP, she/he would not have to contribute to the family's annual deductible. Roderick Bremby inquired about the differences in MOOP for the INN and OON utilization of services. Ms. Lopes stated that generally, the OON MOOP is twice the amount of the INN MOOP. Benjamin Barnes commented that the Silver 70% Plan is set-up in a way that minimizes reaching the MOOP for an individual. It would be difficult to reach MOOP without multiple hospitalizations and medical services.

Ms. Lopes described the 73% Silver CSR Plan. The revisions to the previously adopted plan include introducing deductibles to laboratory and non-advanced radiology services. The revisions also

include reducing the INN and OON individual deductibles to $3350 and $7400. The 87% CSR Silver plan follows the same pattern. It also reduces the INN and OON individual deductibles to $600 and $7400 respectively. The 94% Silver CSR Plan's only revision involves reducing the OON medical deductible from $10,000 to $7,400. Mr. Ritter thanked AHCT staff for their outstanding work in revising plans. Mr. Ritter indicated that much effort was placed into making sure that these revisions are mitigated for consumers. Ms. Lopes followed with providing the Board with theoretical examples of medical services and the costs for consumers associated with them.

Mr. Philpott thanked CID and Exchange staff for working on plan revisions. Mr. Philpott asked whether one of the options might be to provide states with some flexibility in being able to come up with plan designs. Mr. Wadleigh indicated that discussions around this topic are taking place. Ms. Veltri added that the Mental Health Parity and Addiction Equity Act is a separate from the ACA law. Mr. Philpott stated that in addition to the increase in financial obligations to consumers, the complexity of the law is also an issue. Mr. Wadleigh indicated that state waivers from certain requirements are a topic of numerous discussions that are taking place. Mr. Wadleigh added that by introducing waivers, the reduction in benefits would most likely follow. Mr. Wadleigh stated that main reasons for the increasing costs for healthcare coverage is due to costs for medical services, which are not appropriately discussed on a national level. Extremely high costs, including deductibles, counted in thousands of dollars at a time when an average person has $100 in a savings account, should be addressed.

Mr. Barnes indicated that reducing the deductible is supremely valuable. It is a consumer-friendly approach. Mr. Barnes encouraged AHCT and the Board to consider plans with an emphasis on lowering deductibles. Mr. Doolittle expressed support for this concept. Mr. Doolittle asked if an option existed to enrich the mental health benefit to meet the Mental Health Parity. Ms. Breault responded that most of the services in the mental health benefit design are covered. Mr. Barnes indicated that they could have been enriched by lowering or eliminating the deductible. However, it would have put the AV percentage for the plan out of the range. Mr. Ritter disagreed that lowering the deductible would have had a significant impact on the Substantially All test results. It would have caused the AV percentage go down even further. Mr. Barnes added that more than two-thirds of the services covered in the mental health category were covered by the deductible, but less than two-thirds were covered in a medical or surgical category. Mr. Ritter indicated that less than two-thirds were covered in the outpatient category. No breakdown between the mental health and other categories exists. It applies to all outpatient services. Two-thirds of those services need to be subject to the deductible.

Mr. Tessier expressed his concern that if the Board does not approve those revisions, both carriers currently participating on the Exchange will not be compliant with the Mental Health Parity. As a result, they would need to cease their participation in the individual market on the Exchange. Mr. Tessier added that these revisions are not consumer-friendly. Mr. Tessier also conveyed his gratitude toward AHCT staff on working with the Wakely Consulting Group to mitigate the consumers' impact by reducing the deductibles. In 2013 and 2014, both, AHCT and CID staff, in a concerted effort, attempted to make many services not subject to the deductible, with an aim for people to utilize their medical services effectively.

Lt. Governor Wyman requested a motion to approve the revised 2018 Standardized Plan Designs for the Silver, Silver CSR Variants and Gold plans for the Individual Plans as presented by Exchange staff. Motion was made by Grant Ritter and seconded by Paul Philpott. **Motion passed unanimously.**

## VI. Enrollment Update

Robert Blundo, Director of Technical Operations and Analytics, provided the Board with an enrollment update. Since the last meeting update, the 90-day period passed that followed the Open Enrollment (OE). The active Qualified Health Plan enrollment stands at 99,846. It is down 10.5% from the peak of the OE. Since the end of the OE, the attrition stood at 17,693 individuals. Also, 6,270 gained QHP coverage. The CSR group is the largest in both attrition and acquisition categories. In comparing the retention rate to the previous OE, it is slightly better this year. Seventy-two percent of enrolled customers did not have to provide any post-enrollment verification documents. In addition, 3.9% of enrolled customers have an outstanding verification to complete. Ms. Veltri inquired if the CSR population was predominant in the outstanding verification category. Mr. Blundo indicated that while he does not have the up-to-date data pertaining to this inquiry, it is close to 75%. Approximately 11% of open verifications have a due date in the week of July 30. Ms. Veltri inquired if AHCT is performing a follow-up with those customers. Mr. Blundo indicated that numerous forms of communication are utilized to inform those individuals about open their verification issues. Mr. Blundo added that 96% of all enrolled customers have made their first monthly premium payment. Mr. Wadleigh added that AHCT has been manually processing Special Enrollments (SE) verifications outside of the system throughout the year. The Exchange recently implemented an automated system to process SEs. Mr. Blundo added that it provides consumers with the ability to better manage their SE verification process.

## VII. APCD Update

Mr. Blundo provided an update on the All Payer Claims Database (APCD). The APCD project is designed to collect all administrative claims data from all the carriers in the state. The first main objective is to make this data accessible to the community and stakeholders to support research, as well as displaying and reporting this information to improve health and transparency. The second main objective includes creating consumer tools, with the aim of better understanding of the cost-drivers behind medical services.

Mr. Blundo stated that a variety of important topics were discussed at the May 11th APCD Advisory Group meeting, including the goals and objectives. The mission, vision and the strategy of the APCD project were deliberated at that meeting. Goals and strategies were assigned to each objective with the description of how AHCT plans to fulfill them. One of the most meaningful ideas that was taken up included tools to educate consumers how to use the available data to shop for medical services. The group also discussed how the limited resources available at the APCD's disposal could be utilized as effectively and efficiently as possible.

The APCD is also concentrating on the quality of data received. Mr. Blundo added that the APCD is currently working on the development of the data release committee. In addition, the APCD is coordinating its work with the Connecticut SIM project. The APCD is close in obtaining Medicare data.

In addition, AHCT is actively working with the University of Connecticut Health Disparities Institute. At the last Board of Directors meeting, Dr. Victor Villagra, the Associate Director of the University of Connecticut Health Disparities Institute, provided an overview of the Health Literacy Survey Findings. Mr. Blundo indicated that most of the data used in that research was provided by the AHCT analytics team. Also, AHCT is actively engaged with Yale University to help support more research initiatives.

Mr. Blundo added that the APCD was able to collect all of the data up to the end of 2016. The ongoing data collection process is underway. The APCD provided the first preliminary report to the Connecticut State Healthcare Cabinet. It focused on pharmaceutical costs. An evaluation of existing consumer tools is taking place. Lt. Governor Wyman and Cecelia Woods thanked Mr. Blundo for his work and presentation.

## VIII. Finance Update

Tricia Brunton, Head of Financial Planning and Analysis, provided an overview of the AHCT 2018 budget. Ms. Brunton stated that the budget of $30.7 million is 14.5% less than the Quarter 2, 2017 forecast of $35.9 million. On a gross expense basis, including costs shared with the Department of Social Services (DSS), the total budget amounts to $54.6 million. It is 15% less than the Quarter 2 2017 forecast of $64.2 million. Ms. Brunton indicated that the decrease in the AHCT budget relates to the new call center and the per member per month billing structure, as well as the continued maturation of the Integrated Eligibility System (IES), resulting in less Information Technology (IT) development. Ms. Brunton added that the Marketing Department expenses were also reduced. The decrease in gross expense relates to a reduction in IT expenses and continuation of directly billing vendor charges to both AHCT and DSS for their respective shares.

Ms. Brunton added that 2018 will be the fifth year of the marketplace assessment. In 2015, the Board of Directors approved a marketplace assessment rate of 165 basis points for next two calendar years. Ms. Brunton added that for 2018, AHCT staff recommends maintaining the assessment at its current level. Ms. Brunton stated that AHCT transitioned its budget to financial statements. For 2018, AHCT expects the revenues to decline by approximately $2.8 million. It is mainly due to declining assessments caused by a reduction in premiums by about 1% and exhausting all of the remaining federal grants. AHCT expects operating expenses to drop by about $5.4 million. As a result, the operating expenses will amount to approximately $27.8 million. Ms. Brunton added that reconciliation involves operating expenses and expectation for IT development for a total operating budget of $30.7 million.

Mr. Philpott commented that the amount of fully insured premium is decreasing. Ms. Brunton responded that it is a mix. Individual premiums have gone up, while the decreases in the small group market are observed. Mr. Philpott added that the net effect will be a decrease. The last few years, premiums have been increasing dramatically. This still results in a net decrease in fully insured premiums for the state. Mr. Philpott inquired how it is possible. Mr. Wadleigh indicated that in the beginning of the Exchange's operations, the premium increases were in a single digit range. Recently, premium increases were larger. Next year's rates will be very important. At this point, AHCT's assessment is based on the premiums from 2016. AHCT is working with CID and analyzing reports from previous years in trying to forecast future years. Mr. Philpott added that it is an important issue that needs to be tracked. Mr. Barnes added that economic factors play a role in this issue. When prices rise, demand declines. Payers are buying less rich plans. Premium levels were reduced, and more of the healthcare spending was pushed to consumers' cost share for deductibles and out-of-pocket expenses as opposed to premiums. In addition, the conversion to self-funded plans in the small group market is also a factor.

Ms. Brunton explained the contractual, temporary staffing, as well as equipment and IT development, including allocable and non-allocable costs. Equipment and maintenance costs are ongoing. They are both allocable and non-allocable. For 2018, 2016 premiums will be used. Ms. Brunton added that AHCT expects to have a 7-month reserve. Ms. Brunton summarized the employment information at AHCT. As of April 2017, AHCT had 80 permanent and 15 durational employees. Repeal and replacement of the ACA, call center transition, as well as possible funding shortfalls constitute potential risks for AHCT. Opportunities include call center, continuous business process improvements as well as greater collaboration with marketplace carriers.

Lt. Governor Wyman requested a motion to adopt the FY2018 budget. Motion was made by Robert Tessier and seconded by Cecelia Woods. ***Motion passed unanimously.***

Lt. Governor Wyman requested a motion to approve for calendar year 2018, the Exchange's Market-Assessment Rate of 165 basis points. Motion was made by Robert Tessier and seconded by Victoria Veltri. ***Motion passed unanimously.***

## IX. Adjournment

Lt. Governor Wyman requested a motion to adjourn. Motion was made by Grant Ritter and seconded by Cecelia Woods. ***Motion passed unanimously.*** Meeting adjourned at 10:53 a.m.