STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

Connecticut Historical Society
Auditorium

Thursday, April 19, 2018
Draft Meeting Minutes

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

Other Participants:
Access Health CT (AHCT) Staff: Shan Jeffreys; Gary D'Orsi, Ann Lopes; James Michel
Connecticut Insurance Department (CID): Paul Lombardo
Wakely Consulting: Julie Andrews

The Regular Meeting of the Connecticut Health Insurance Exchange Board of Directors was called to order at 9:01 a.m.

I. Call to Order and Introductions

Lt. Governor Nancy Wyman called the meeting to order at 9:01 a.m.

II. Public Comment

No public comment.

III. Vote

Lt. Governor Wyman requested a motion to approve the March 20, 2018 Board of Directors Special Meeting Minutes. Motion was made by Robert Tessier and seconded by Paul Philpott. ***Motion passed unanimously.***

IV. Discussion of Tobacco Surcharge Certification Requirement

Lt. Governor Wyman introduced Gary D'Orsi, Director of Product Development, to begin a discussion of the Tobacco Surcharge Certification Requirement following public comments made at March 20, 2018 Board of Directors Meeting. Mr. D'Orsi stated that last year, the Board of Directors (BOD) voted to include the tobacco surcharge on the individual market for the 2019 Plan Year. During last month's BOD meeting, a number of public comments were submitted opposing a decision made last year to permit carriers to include a tobacco surcharge in the rates of on-exchange Individual Market plans. The American Cancer Society submitted one of the comments. Back in October of 2017, three carriers offering plans 'off-exchange" in the individual market included tobacco surcharges on their plans. Currently, no carriers offering plans in the individual market in Connecticut have it. Mr. D'Orsi pointed out that Access Health CT (AHCT) did not implement the surcharge on its platform primarily due to the cost of the enhancement to the system.

Commissioner Katharine Wade arrived at 9:03 a.m.

Paul Lombardo arrived at 9:03 a.m.

Mr. D'Orsi stated that research of this issue indicates that consumers are not always truthful when being asked about smoking habits. More members would not purchase insurance, as opposed to admitting that they are smokers. Based on this information, AHCT suggests rescinding the Board vote from March 2017 that provided: "Effective for the 2018 plan year, allow inclusion of a tobacco surcharge in the premium rates for QHPs in the Individual Exchange market." Paul Philpott indicated that the idea of instituting a tobacco surcharge would work in the way that smokers would pay more for their monthly premiums, which would benefit non-smokers, who will see their rates reduced. No practical manner exists to check whether people smoke. Mr. D'Orsi stated that many smokers are not self-reporting. If AHCT implemented the tobacco surcharge on its platform, consumers would be required to complete attestations stating whether they are smokers or non-smokers.

Robert Scalettar, MD., arrived at 9:05 a.m.

Mr. Philpott inquired about members who qualify for Financial Assistance (FA). Mr. Philpott inquired whether the FA is based on the non-smoker premium. Mr. D'Orsi indicated that the surcharge would be added after the FA is applied to the base premium. Shan Jeffreys, Chief Operating Officer, indicated that if the surcharge existed, it would have been applied to the premiums for those consumers that attested to being a smoker. Mr. Jeffreys indicated that the smoker attestation is applied to the applicant. In addition, this attestation request would need

to be designed to filter down to other family members of legal smoking age. Mr. Jeffreys added that it would cost AHCT about $1 million to implement the changes necessary to the system. Mr. Philpott inquired whether, in the case of a family where one spouse uses tobacco and other does not, the surcharge would be applied to one person only or the entire family. Mr. Jeffreys added that the attested person's surcharge would be added to their individual premium, but it would not be added to the non-smoking family members.

Lt. Governor Nancy Wyman requested a motion that, effective for the 2019 plan year, the inclusion of a tobacco surcharge in the premium rates for QHPs in the Individual Exchange Market will not be permitted. Motion was made by Robert Tessier and seconded by Paul Philpott. ***Motion passed unanimously.***

V. Leadership Update

Shan Jeffreys provided the Board with the Leadership Update. Mr. Jeffreys stressed that various AHCT Teams have been working on prioritization of tasks and preparation for the upcoming Open Enrollment. AHCT has been working in close cooperation with the Department of Social Services (DSS) with regard to the Memorandum of Agreement (MOA) Addendum. It should be executed prior to the adoption of the AHCT budget in May. Several employees attended a meeting of all state-based marketplaces that took place in Denver, Colorado. The meeting was also attended by representatives from the Department of Health and Human Services (HHS), Centers for Medicaid and Medicare Services (CMS), among others. AHCT was able to share details of operational practices, marketing examples, as well as technology. All the states are looking at plan designs from different perspectives. The plan benefits' committees are discussing Advanced Premium Tax Credits (APTCs) and the impact they have on the population that is not receiving FA.

Mr. Jeffreys pointed out that the Health Plan Benefits and Qualifications Advisory Committee (HPBQ AC) has been meeting frequently to come up with plan design solutions. AHCT is very proactive in this area, since the changes to the health insurance market as well as on the federal level occur frequently. The Connecticut Insurance Department (CID) and the participating carriers have been included in this process. One of the issues that was raised by the federal partners in Denver is that the focus on program integrity is increasing for the national landscape. It relates to APTCs, reconciliation and other carrier information. AHCT had already planned it.

VI. Finance Update

James Michel, Director of Finance, provided the Board with the Finance Update. Mr. Michel provided information on the Third Quarter Reforecast. Mr. Michel indicated that variances that are reported due to timing issues. AHCT is expected to spend its budget by June 30. Mr. Michel added that AHCT is in the process of procuring a new independent auditor. Eight firms have responded, and AHCT is reviewing the proposals. The final selection is planned to be presented to the Audit Committee, and later to the Board.

Mr. Philpott inquired whether the $0.5 million variance in the marketplace assessment is expected to increase. Mr. Michel stated that AHCT expects to collect an additional $7 million in

marketplace assessment fees by the end of the year. The carriers pay every quarter. AHCT bills on the estimated premium from two ago that is received from CMS and CID. The carriers have the ability to adjust their assessments based on the actual premium figures. Mr. Philpott asked whether there are any potential financial risks involved this Fiscal Year (FY). Mr. Michel indicated that no financial risks for this FY exist. Mr. Michel provided fiscal projections for the end of FY 2018 FY. The shifting of the call center allocations between DSS and AHCT, from 80-20 to 70-30, are reflected in AHCT's projections. The additional $1.6 million in expenses related to that will be absorbed by the Exchange's reserves. Cost allocations between AHCT and DSS were discussed. Mr. Michel provided a summary of the FY18 Cash Flow Statement. The cash balance at the end of March 2018 was $18,628,728 while the projected reserves at the end of June are expected to amount to $20,503,190. Robert Scalettar, MD., inquired whether the reserves had even been used previously. Mr. Michel indicated that it represents the first time that AHCT had to use its reserves. Victoria Veltri complemented Robert Blundo, Director of Technical Operations and Analytics, for all the work performed to reduce the expenditures on the APCD line.

Lt. Governor Nancy Wyman requested a motion to approve the Third Quarter Reforecast as presented by Exchange staff. Motion was made by Robert Tessier and seconded by Paul Philpott. **Motion passed unanimously.**

VII. Certification Requirements for 2019

Gary D'Orsi presented the Certification Requirements for 2019 as recommended by the HPBQ AC. AHCT is looking for the Board's approval of technical changes, technical adjustments to the Stand-Alone Dental Plans, the number of standardized plans required and optional non-standard plans permitted in the individual market, as well as modifications to cost-sharing for standardized plans to comply with the federal guidance. Mr. D'Orsi expressed his words of gratitute to the HPBQ AC, the carriers, Plan Management Team, CID, and Wakely for their hard work over the past several months in preperation for the recommendations that are being presented to the Board. The HHS Notice of Benefit and Payments Parameters was released, and changes were anticipated due to its publication. The only change prescribed by HHS was to remove the Actuarial Value (AV) requirement from pediatric dental coverage. The new dental plan mix includes one standard and three non-standard plans for the maximum number of four to be permitted.

Lt. Governor Nancy Wyman requested a motion to approve, effective for the 2019 Plan Year, the requirement that Stand-Alone Dental Plan Issuers offer one Standardized Plan and allow up to three Non-Standard Plans for the Individual and SHOP Exchange. Motion was made by Robert Tessier and was seconded by Victoria Veltri. ***Motion passed unanimously.***

Lt. Governor Nancy Wyman requested a motion to approve, effective for the 2019 Plan Year, the existing Standard Stand-Alone Dental Plan for the Individual and SHOP Exchange with in-network coverage only, with an option to include out-of-network coverage at the choice of the carrier subject to form filing approval by the Connecticut Insurance Department. Motion was made by Grant Ritter and was seconded by Robert Tessier. ***Motion passed unanimously.***

VIII. Qualified Health Plans

Mr. D'Orsi stated that over the last few months, the HPBQ AC worked diligently on coming up with recommendations. Mr. D'Orsi pointed out that many different silver options were discussed at the committee meeting. Two standard options were presented, and both carriers indicated that they could met the Actuarial Value (AV) for these options. Ultimately, no agreement has been reached. The recommendation of the committee for the silver plan options is to keep the current standard plans in place and make an adjustment to the AV, as well as ensuring that both carriers can meet the mental health parity requirements. Mr. Jeffreys added that AHCT has worked very closely with the Connecticut Insurance Department (CID) and the participating carriers. The Committee was concentrating on the silver plan options, since a majority of the Exchange's enrollees use those plans. In addition, a large cohort of these customers do not receive FA. Mr. Jeffreys stressed that various options were discussed. At the last committee meeting, an option existed to make the minimum changes to the current plan design. Another option consisted of a compromise plan by having two standard plans in silver. The additional standard plan would have been at the lower AV range. Mr. Jeffreys stated that nationally, there is consideration of the risk of Congress removing APTCs, and an increased focus on the premiums for on silver plans, especially the extra premium loads to cover the cost of the Cost Sharing Reductions (CSRs).

Grant Ritter pointed out that when the federal government ceased making the CSR payments, the carriers were given permission to add an extra 17 percent to the silver plan premiums only. It has been referred to as "silver-loading." In Connecticut, it was a very successful way to mitigate the impact for the population that is receiving FA. However, those who are not the recipients of FA are forced to pay more for their premiums on the silver level. Mr. Ritter stressed that those plans are simply too expensive. Mr. Ritter reported that the committee discussed ideas to try to lower the premiums. Mr. Ritter, however, offered a different approach by stating that offering non-standard Gold and Bronze plans may be a better option. The Silver plans are almost as expensive as the Gold plans. AHCT should educate the non-subsidized purchasers of the Silver plans that better options do exist.

Katharine Wade respectfully disagreed with Mr. Ritter. Keeping the status quo is not in the best interest of consumers. Premiums and the cost of medical insurance on the Exchange is expensive. Ms. Wade added that uncertainty around silver-loading for the upcoming plan year adds to the market's volatility. The rule requires the standard silver plan to be the issuer's lowest priced plan. It limits flexibility and innovation on non-standard plans in silver, which could offer significant premium savings for consumers in the state. Paul Lombardo added that the more constraints that are placed on silver plans, the more constraints are placed on the participating carriers. It does not make the Exchange carrier-friendly for other carriers possibly considering joining AHCT. Mr. Lombardo added that there was serious consideration on the part of the HPBQ AC members of the idea of having two standard silver plans, one less expensive than the other, allowing some flexibility without significantly changing the APTC level for an individual in that market. The lower Silver plan would have coinsurance. The consumers would have more options,

and it would provide more opportunities for those who are not the recipients of FA within the silver plan.

Ms. Veltri stated that she would feel uncomfortable with the status quo. Ms. Veltri added that the compromise that the committee discussed was a step in a right direction. Mr. Ritter indicated that the committee liked the compromise. However, since the meeting occurred, the compromise appears not to be acceptable to one of the carriers. Mr. Ritter pointed out that since one of the carriers was not supportive of this initiative, the committee did not feel that this plan should be recommended to the Board. Mr. Lombardo added that the carriers were not asked if they were in support of the status quo. Mr. Lombardo added that if the Exchange is looking for unanimity among the carriers, it is very uncertain that it will be achievable. Mr. Tessier added that neither of the carriers would have been happy with the existing status quo with the modest changes that are required to meet the AV and mental health parity standards. Mr. Philpott expressed his concerns about individuals who are not receiving FA, and are paying seventeen percent in additional premium for the cost sharing reduction benefit that they are not receiving. Mr. Philpott expressed that there has to be a safe harbor option for these consumers. There needs to be a plan to migrate them to a more appropriate plan. Most of them should not be auto-renewed into their existing plan. Mr. Philpott added that it is, in his opinion, the biggest issue. Ms. Wade reiterated that the Exchange's requirement that the standard silver plan has to be the lowest cost plan eliminates other options for consumers in the marketplace. Ms. Wade added that a compromise is a step in the right direction, but it is not far enough in terms of affordability for consumers, particularly the non-subsidized.

Benjamin Barnes inquired about the compromise solution, and how it addresses the requirement that the lowest cost plan is the standard silver plan. Mr. Lombardo indicated that at this point, one standard silver plan exists, and both carriers have to price any optional non-standard plans higher than that level. Mr. Lombardo added that with two silver standard silver plans, the requirement as it stands now, is to require that any non-standard silver plans be priced higher than the highest option that they offer. There is no flexibility with regard to the non-standard silver plans. At the last HPBQ AC meeting, one of the carriers brought up the idea of allowing the non-standard silver plans, and the benchmark for that to be the low standard silver option, rather than the high standard option. The non-standard silver plans would have to be priced higher than the lowest silver standard plan. The committee did not vote on this proposal. Instead, the committee voted on a proposal that they had to be higher than the highest standard option. Mr. Lombardo added that the other carrier offered reservations that offered the compromise. They raised concerns about offering a non-standard silver plan to be priced higher than the lowest silver plan. Mr. Barnes added that if the non-standard plans are allowed to come in twenty five percent less expensive than standardized plans, the APTC would go down, but people would be able to apply that against the less expensive plan. Mr. Tessier echoed Mr. Barnes concerns.

Mr. Ritter stated that the safe harbor would be a high end Bronze plan. Mr. Jeffreys added that AHCT has been working on increasing consumer education around plan designs. AHCT cooperates with brokers, and an increased marketing effort targeted for the population that is using Silver CSR plans has been implemented. Consumers that belong to the 73% CSR, 87% CSR

and 94% Silver CSR amount to approximately 43,000 individuals. The APTC-only group is about 14,000 people. The unsubsidized population in Silver is 4,700. They did not have enough funds to jump up to the Gold plan, but they did not want to have the high deductible of the Bronze. They saw value in Silver, even though there is a Silver-load on the premium. There will be a continuous marketing effort targeting this population. Mr. Lombardo added that the carriers did present some plans with additional significant savings, but it was related to network savings. One carrier had a certain structure for their network, which is becoming more common, tier networking, and the other carrier had a more traditional narrow network concept. Building those options into the standard plan design would have been very difficult, and it would have been impossible to build or incorporate it into two different network mechanisms. Mr. Lombardo pointed out that there could be additional savings in the non-standard plans. There could be an additional five to eight percent savings on the premium for introducing different types of networks.

Theodore Doolittle commented on the concept of affordability. Mr. Doolittle thanked the carriers for participating. Both sides have a lot of merit to them. One of the items that the administration in Washington is proposing is to try to make premiums more affordable. However, it does not mean that healthcare insurance will become more affordable. If the entire focus is just on lowering the premiums, it is intended only for healthy individuals. The out-of-pocket expenses are another side of the story. Everyone gets a chance to experience the unbelievably high out of pocket costs. Ms. Wade expressed her concern that pushing people to high deductible plans is not the best approach. Mr. Ritter added that the difference in deductible between Silver and Bronze plans is nowhere near where it used to be. Mr. Ritter encouraged discussion in case the Administration disallows Silver loading. Ms. Wade indicated that it will be addressed in the rate-review process. Ms. Wade added that a contingency plan exists in case this happens. Mr. Lombardo clarified that coming up with new plan designs in September in case the Silver loading is disallowed would be impossible to achieve.

Mr. Tessier recommended that the Board adopt the compromise recommendation that had broad support at the committee level but lacked sufficient support from both carriers. It appears that no resolution will be acceptable to both carriers. At least the compromise that was discussed has the benefit of moving in the right direction, maybe not enough for one carrier. The compromised approach would include minor modifications to the existing standard plan design in Silver, adoption of a second, lower AV standard plan design in Silver, and reduce the number of possible non-standard plans offered by carriers from three to one, but maintaining the requirement that the latter one be at the higher price than either of the standard plans.

Lt. Governor Wyman requested a motion to approve, effective for the 2019 Plan Year, the Standard Plan Benefit Designs for the Individual Market with the two Standardized Silver Plans, and permitting one non-standard Silver Plan that must be priced higher than both of the carrier's Standardized Silver Plans as presented by Exchange Staff, including the elimination of the Standardized Platinum Plan. Additionally one of the carrier's standard silver plan must be at the lowest cost silver plan. Motion was made by Robert Tessier and was seconded by Grant Ritter. Discussion followed.

Lt. Governor Wyman requested a motion to adjust the policy proposed by allowing that a non-standard silver plan must be priced higher than the lowest cost standard silver plan instead of the prior policy, which was must be more expensive than both standard silver plans. Motion was made by Benjamin Barnes and seconded by Grant Ritter. Discussion followed.

Mr. Lombardo added that when the non-standard silver plan discussion took place at the committee level, one of the carriers identified that they would prefer having the option to offer a non-standard silver plan priced below the highest option standard plan, but would be fine with it being above the lowest standard plan. The threshold would be the low standard silver versus the high standard silver. When it went above the highest standard silver, the other carrier agreed with that. They had opposite feelings on both situations.

Mr. Tessier added that the compromise presented was in fact a compromise, not only between committee members, but also between the carriers. In the end, one of the carriers disagreed with this approach. Mr. Jeffreys added that one of the carriers on the committee abstained from voting at that time on this proposed solution, and was going to perform due diligence. Ms. Veltri inquired whether the issues discussed present a tipping point in terms of carrier participation on the Exchange. Mr. Lombardo indicated that during the discussions with the two participating carriers, no proposal discussed was identified as a tipping point.

Mr. D'Orsi indicated that the Board needs to review the proposed plans before it can take action. The HPBQ AC recommended eliminating standard Platinum plan.

Julie Andrews of Wakely Consulting Group discussed the standardized plan designs for 2019 and changes that are required from the AV Calculator perspective. Ms. Andrews reviewed the regulatory changes. Mr. Philpott commented that from the safe harbor perspective, having the richest Bronze plan available is one of the best options. It seems like AHCT has already done it. Ms. Andrews reviewed proposed plan changes in the Gold, Silver and Bronze metal levels on the individual market, including the Silver CSR variations. Ms. Andrews presented the 2019 Alternative Standard Silver Plan Design.

Ms. Veltri inquired whether the $5 co-pay for generic medicines will still be in effect for the 2019 plan year. Mr. Lombardo indicated that CID asked the carriers whether they have compelling data which would warrant increasing the generic drug co-pay, and to submit it to the Department. None of the carriers submitted any data; therefore, the generic drug co-pays will remain at a $5 maximum. Lt. Governor Wyman inquired whether the $2600 deductible pertains to one individual in a family, in case of the 73% AV CSR Alternative Silver Plan Design, and if that individual accrued medical charges of $5200 or more, would she/he have fulfilled family's maximum annual deductible. Ms. Andrews stated that once one family member reached the $2600 deductible, she/he would have met the individual deductible. Another family member or the combination of the other members' deductible amounts would have to reach another $2600 in order to meet the $5200 family deductible. Mr. Philpott inquired whether in the family of four, where no one has reached a $2600 individual deductible, but they have reached in aggregate

$5200 in expenses, if that will suffice in meeting the family deductible. Ms. Lopes confirmed that the family deductible would have been met.

Mr. Tessier asked for clarification whether the major difference between the alternative standard silver plan design and other individual market standard silver plan is that the first one relies heavily on co-insurance for cost-sharing versus co-pays. Ms. Andrews confirmed that it is the case. The biggest driver of the change is that essentially that the structure would be moving from the co-pay to the co-insurance after the deductible has been met. Coverage for the primary care visits and generic drugs would be provided before the deductible. The approach was not just to drive savings from cost-sharing shifting, but the committee was looking for additional savings on top of that. Ms. Andrews provided a summary of the Bronze plans. Mr. Barnes expressed his willingness to withdraw his amendment in order to be able to vote on Mr. Tessier's underlying motion. Mr. Barnes indicated that if Mr. Tessier's motion fails, his motion would supersede his. If Mr. Barnes' proposal fails, Mr. Tessier's motion would prevail.

Lt. Governor Wyman re-read the motion. Effective for the 2019 Plan Year, to approve the Standard Plan Benefit Designs for the Individual Market with the two Standardized Silver Plans and permitting one non-standard Silver Plan that must be priced higher than both of the carrier's Standardized Silver Plans as presented by Exchange Staff, including the elimination of the Standardized Platinum Plan. Additionally one of the carrier's standard silver plans must be the lowest cost silver plan. ***Motion passed unanimously.***

Mr. Barnes requested a motion to adjust the policy enacted by allowing that a carrier's non-standard silver plan must be priced higher than the carrier's lowest cost standard silver plan instead of the prior policy which required that it be priced higher than both of the carrier's standard silver plans. Motion was made by Benjamin Barnes and seconded by Grant Ritter. Discussion followed.

Mr. Ritter indicated that this proposal was appealing to one of the carriers and unappealing to the other. It does build protections into the plan requirements that the lowest cost silver plan from each carrier is a standard plan. It is a bigger change that may bring lower premiums. Ms. Veltri stated that she is not against this proposal, but expressed her concern about voting on this proposal at this time due to the insufficient data available on the effects of the implementation of this recommendation. Ms. Veltri added that hearing from the carriers would help in determining their positions and whether the compromise could be reached. Ms. Veltri expressed her reservations and stated that for the purposes of this vote, she will oppose it. Mr. Tessier also indicated his uneasiness about passage of this amendment. Mr. Tessier reiterated Mr. Lombardo's view about the last meeting of the HPBQ AC, during which the committee members felt that a compromise was very near until one of the carriers expressed objections. Mr. Tessier stated that the proposal by Mr. Barnes is a significant step back from that compromise. Mr. Tessier added that he will not support this measure. Mr. Barnes added that the rationale behind proposing this motion is to allow slightly greater latitude in allowable pricing for the non-standard plans without interfering with the basic structure of the APTC benchmarking. Mr. Barnes added that it could be a great way for greater market flexibility.

Ms. Lopes added that one of the difficulties in modelling other scenarios is trying to determine where other plans would fall. Ms. Lopes added that allowing more flexibility on the non-standard plans to be priced more appropriately relative to the standard plans, would likely result in a lower premium for that silver plan which would most likely result in lower APTC in some of the rating areas and counties in the state. The individuals eligible for the 87% and 94% CSR are in some way insulated because the premium is the same, but their cost sharing is at much reduced rate compared to people who are receiving benefits at the standard 70% and 73% silver level. Mr. Barnes added that potentially the second lowest cost silver plan could be a non-standard plan. Ms. Lopes added that the second lowest cost silver plan is currently a non-standard plan. Mr. Ritter added that currently the second lowest cost silver plan is a non-standard plan from the same carrier that is producing the standard plan. Ms. Lopes stated that currently it is, but in theory, the pricing could be very similar in a particular rating area for the standard plans that they could be priced very closely with one another. Different rating areas have to be taken into account as well as varying subsidy levels. Mr. Barnes inquired about the possible variation of premiums between high and low standard silver plans under the plan currently adopted. Ms. Lopes indicated that it would be between two and eight percent difference specific to the carrier.

Lt. Governor Wyman requested a roll call to adjust the policy enacted by allowing that a carrier's non-standard silver plan must be priced higher than the carrier's lowest cost standard silver plan instead of the prior policy enacted which required that it be priced higher than both of the carrier's standard silver plans. Robert Tessier and Victoria Veltri opposed. Michael Gilbert and Cecelia Woods abstained. The remaining voting members voted in favor of the motion. **Motion passed**.

Mr. Tessier acknowledged and thanked the Plan Management Team, the Connecticut Insurance Department, both carriers for participating, members of the HPBQ Advisory Committee. Mr. Tessier thanked Mr. Ritter for the leadership on the committee, and Mr. Jeffreys. Mr. Tessier added that it was a lot of work for many months. Mr. Ritter echoes Mr. Tessier's comments.

IX. Adjournment

Lt. Governor Wyman requested a motion to adjourn the meeting. Motion was made by Robert Tessier and was seconded by Victoria Veltri. **Meeting adjourned at 11:19 a.m.**