As Approved by the Board of Directors on March 23, 2017

STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Special Meeting

Connecticut Historical Society
Auditorium

Thursday, February 28, 2017
Meeting Minutes

Members Present:
Lt. Governor Nancy Wyman (Chair); Robert Tessier (Vice-Chair); Victoria Veltri; Maura Carley; Paul Philpott; Grant Ritter; Commissioner Miriam Delphin-Rittmon, Department of Mental and Health Addiction Services (DHMAS); Paul Lombardo on behalf of Commissioner Katharine Wade, Connecticut Insurance Department (CID); Theodore Doolittle, Office of the Healthcare Advocate (OHA); Robert Scalettar, MD; Cecelia Woods

Other Participants:
Access Health CT (AHCT) Staff: James R. Wadleigh, Jr.; Shan Jeffreys; Ann Lopes; John Carbone
Wakely Consulting: Julie Andrews; Brittany Phillips

Members Absent:
Commissioner Roderick Bremby, Department of Social Services (DSS); Commissioner Raul Pino, Department of Public Health (DPH); Secretary Benjamin Barnes, Office of Policy and Management (OPM)

The Special Meeting of the Connecticut Health Insurance Exchange Board of Directors was called to order at 10:00 a.m.

I. **Call to Order**

Vice-Chair Robert Tessier called the meeting to order at 10:00 a.m.

II. Public Comment

No public comment

III. CEO Report

James Wadleigh, CEO, indicated that Shan Jeffreys, Director of Marketplace Strategies, would provide a thorough review of all of the plan management initiatives.

IV. Standardized Plans for 2018

Shan Jeffreys provided an overview of the need to review and approve standardized plans, as well as the certification requirements for 2018. Mr. Jeffreys noted that in contrast to the previous years, changes in the methodology such as formulary, network adequacy, Essential Community Providers (ECPs), are being brought to the Board for consideration. Mr. Jeffreys indicated that AHCT wanted the Board to discuss the tobacco surcharge as one of the possible options. Robert Scalettar, MD, commented that the Affordable Care Act (ACA) is still the law, and AHCT's and the Board's initiatives have nothing to do with the discussions in Washington surrounding the future of the ACA. Mr. Jeffreys quoted the Mission and Vision of the Exchange as it was adopted by the Board of Directors in 2012, reiterating that one of the most important missions is to increase the number of insured individuals in the State of Connecticut. The strategy to achieve this goal is to provide access to quality insurance choices for individuals and small groups, improving quality of plan designs, transparency, as well as reducing disparities in healthcare.

In the past, the Centers for Medicare and Medicaid Services (CMS) used nationwide data in order to calculate the Actuarial Value Calculator (AV), whereas this year, data from individual exchanges are incorporated into it. Paul Philpott inquired as to what extent carriers on the individual side are allowed to offer non-standardized plans. Mr. Philpott also asked about innovations that may help the carriers. Mr. Jeffreys noted that carriers have the ability to offer non-standardized plans. In the individual market, eight standard and eleven non-standard plans are currently offered. On the Small Business Health Options Program (SHOP) side, there are six standard and two non-standard plans. The innovation from the carriers comes in the form of plan designs and plan orientations. This gives the carriers more flexibility in the market to be more competitive and reduces some regulatory barriers. Mr. Wadleigh indicated that the Silver plan drives the calculation of Advanced Premium Tax Credits (APTC) for AHCT customers. AHCT needs to be very cautious when possibly instituting changes to this plan. The other metal tiers allow much more noticeable creativity in the non-standard plan designs. Mr. Jeffreys added that the lowest-cost silver plan has to be a standardized plan design. Mr. Wadleigh noted that AHCT does not want to have a non-standard silver plan to be significantly lower than the standard silver plan. The current law would significantly reduce purchasing powers by lowering the APTCs.

Dr. Scalettar inquired about the timeline for putting new health plans in place for 2018. Mr. Jeffreys indicated that initial steps for the 2018 health plans were already undertaken at the end of November. The Health Plan Benefits and Qualifications Advisory Committee (HPBQ AC) met three times in January and February to discuss and approve plan designs. Plan designs and plan certification requirements had to be discussed and approved by the HPBQ AC. Political and regulatory changes that followed influenced some of the plan design activities. Wakely Consulting Group was also engaged in the plan design planning. Mr. Jeffreys noted that the release of the solicitation to the carriers has to occur by March 1st. Mr. Jeffreys added that the future meeting of the HPBQ AC will discuss the non-standard plan designs for the SHOP program. The Committee will also look at what other states are doing pertaining to SHOP's second lowest cost silver plan being a benchmark. Ann Lopes, Carrier Product Manager, added that after the solicitations go out on March 1st, the carriers need to have enough time to file with the Connecticut Insurance Department (CID). The solicitations will also include the certification guide. Following that, the carriers will be able to evaluate, assess, put the rate filings together, and submit them to CID.

Dr. Scalettar inquired whether work on the plan designs did not start too late in comparison to previous years. Ms. Lopes responded that plan design work for 2018 actually started earlier than in previous years. The proposed guidance from CMS, the 2018 payment notice, as well as the AV Calculator were released two months earlier than in previous years. Also, the final rule was approved at the end of December. It all affected the planning work. Ms. Lopes noted that AHCT did not come to the Board with the draft information as it has in the past. Victoria Veltri inquired about the proposed changes in the AV regulations, which propose a wider AV range for metal tiers. Ms. Veltri also asked whether there are any plan designs that may be affected by the potential changes in those regulations. Ms. Lopes stated that for the standard silver plan in the individual market, closeness to the top of the AV range is apparent.

Lt. Governor Nancy Wyman arrived at 10:28 a.m.

Ms. Veltri asked that, given the CID's deadlines for submissions, and potential changes in the regulation, the Board be provided an opportunity to see those potential changes with the assumption that this regulation goes into effect. Mr. Lombardo responded that given the information that is currently available, if those changes in regulations are adopted, every plan that will be shown would satisfy that change. Mr. Jeffreys added that there were two outstanding items discussed in the HPBQ AC: removing the standardized silver from being a benchmark for

the Silver plan and APTC, and removing standard and offering only non-standard plans on the SHOP platform.

Grant Ritter asked whether the non-standard plans still have to meet the network adequacy and essential community provider requirements that apply to the standard plans. Mr. Ritter commented that limited networks for the non-standard plans is not the optimal solution. Mr. Ritter disagreed with the notion that elimination of the standard plans is necessary, since the second lowest silver plan is required to be a standard plan. If AHCT starts offering more non-standard plans, they will be less expensive, but also subsidies offsetting the cost of premiums will be smaller. Mr. Ritter added that he did not like some features of the plans that were approved by the HPBQ AC, however, it was impossible to meet the actuarial values of those plans without them being in place. Last year's silver plan qualifies as this year's gold plan.

Julie Andrews and Brittany Phillips discussed the standardized plan designs for 2018. Ms. Phillips reviewed the changes to the Actuarial Value (AV) Calculator. Ms. Phillips indicated that the annual limitation on cost sharing was increased from $7,150 to $7,350. However, this limit does not apply to HSA-qualified High Deductible Plans. Ms. Phillips added that the Bronze plan range was finalized, allowing certain designs to have an AV between 58% and 65%. Functionality changes were also made. Preventative care is covered at no cost to the consumer. Ms. Veltri commented that the Cost Sharing Reduction (CSR) limits are set by the federal, not the state government. Changes were also made to the Federal AV calculator. It is the first time since 2014 that the underlying data were updated. Significant changes to the risk adjustment formula will take place. The 2018 calculator is based on 2014 data. The annual trend factors were also updated. The Maximum Out-Of-Pocket (MOOP) was affected by the functionality changes. Ms. Phillips also reviewed regulatory changes. Mr. Lombardo added that the cost structure in Connecticut is higher than the nationwide data. The rate filings can be found online and are publicly available. Theodore Doolittle added that with the current rate of growth, the system is not sustainable. Ms. Phillips reviewed enrollment numbers in the metal tiers. The majority of individuals enrolled in the silver plan are receiving financial assistance with their premium payments. The majority of members who are not eligible for the tax credits are in the bronze plans.

Ms. Phillips provided a brief summary of the maximum co-pays allowed in accordance to CID's bulletin. Ms. Tessier inquired whether the maximum co-pays are governed by the statute. Mr. Lombardo responded that they are set by the CID bulletin and are not based on any statute or regulation. Ms. Phillips presented the plan recommendations of the HPBQ Advisory Committee.

Ms. Phillips indicated that the Platinum, Bronze and Bronze HSA still fall within the permissible AV calculator, whereas the Gold and Silver Plans were outside of the range. On the CSR variations in the Silver Plan, the 73% and 87% fall outside of the range, and the 94% plan was still within the AV range. The approach was to try to make minimum changes and limit the negative impact for the consumer. The recommendation for the Platinum plan was not to incorporate any changes. Ms. Lopes added that no carrier submitted Platinum tier level plans for 2017. Mr. Jeffreys indicated that at the end of 2016, AHCT had 1,500 individuals enrolled in the Platinum plan. Ms. Phillips indicated that in the Individual Market Gold Plan 80% AV, Option 3 was chosen by the HPBQ AC, which makes numerous changes in order to meet the AV calculator requirements. Medical and pharmacy deductibles were increased as well as the Maximum Out of Pocket. The copay for the Emergency Room (ER) visit was also increased. The Board recommended Option 3.

In the 2018 Individual Market Silver Plan, 70% AV, the HPBQ AC chose Option 1, which makes numerous changes in order to make up the 4% difference in the AV calculator. Ms. Phillips indicated that this plan was the most difficult one to bring back into compliance with the AV range. Medical and prescription deductibles were increased. Preferred and non-preferred prescription brands will also be subject to the deductible. Out of pocket maximums, primary care and ER copays were increased. Mr. Philpott commented that the Board is faced with very difficult decisions, in some cases the deductible will rise by 25%. Mr. Philpott asked about the difference in the pricing this year versus the projected premium increase. Ms. Andrews indicated that there is uncertainty in the marketplace about risk adjustment payments, as well as the moratorium on the health insurance provider fee that may be expiring this year. Mr. Lombardo indicated that some large carriers submitted updates to their rate filings. The noticeable trend is that their experience adjustments are in the vicinity of 9%. Then specific items that may impact a particular carrier are added. Carriers are asked to price their products for 2018 without knowing the impact of the risk adjustment.

Mr. Philpott expressed his skepticism about the affordability and sustainability. Mr. Lombardo noted neither AHCT nor the State has any control over the AV calculator. Mr. Lombardo added that the health insurance fee that was waived for 2017 is coming back. Mr. Ritter asked what is built into the estimated premium impact. Ms. Andrews indicated that two different data sets are taken into consideration when considering the price estimate. It is an estimate of changing the services, and taking into consideration leveraging different services based on trend. Mr. Ritter asked whether there is a possibility of using co-insurance instead of co-pays in the AV calculator. Mr. Ritter stated that AHCT may have to consider incorporating more co-insurance in

order to meet the requirements of the AV calculator. Ms. Veltri asked about the $200 maximum for specialty scripts. Ms. Phillips indicated that the specialty script maximum is $200 per given prescription. Ms. Veltri indicated that it is a major impact to the consumer. Ms. Veltri inquired whether the HPBQ AC considered increasing the advanced radiology co-pay instead of making it subject to the deductible. Mr. Ritter responded that difficult choices had to be made. Mr. Ritter added that every attempt was made to avoid placing a deductible burden on the consumer, but it was unavoidable. Ms. Lopes added that Connecticut statute limits the MRI from $75 to $375 maximum per year. Mr. Lombardo indicated that CID evaluated the co-pay maximums. There was no analysis this past year. The actual data and the benchmark is that 90% of the claims obtain at least 50% of insurance coverage. Mr. Lombardo assumed that if the laboratory doubles the maximums that are set, 90% of the claims will receive no insurance coverage.

Dr. Scalettar inquired about the difference between Option 1 and Option 2. Mr. Ritter responded that it comes down to tradeoffs between hurting a few consumers and larger groups. Mr. Ritter commented on the difficulties in meeting the AV calculator ranges by raising the deductibles, or making some services subject to deductible. The one item that could really move the percentage down was to make ER visits subject to a deductible; nothing else could move the dial by 4% that much. Nothing else seemed to have the same magnitude effect. Mr. Wadleigh added that one change such as changing the co-pay from $5 to $15 had an almost 1% impact on the AV calculator. Mr. Wadleigh added that there are levers that are being constrained. Mr. Philpott commented that co-payments were never designed to pay for services such as radiology that cost thousands of dollars. Mr. Ritter agreed and added that co-insurance should be considered to keep the co-pays on the lower side.

The Board recommended Option 1 for the Silver 73% CSR, which increases the maximum out of pocket with the separate limitation on cost-sharing. It makes the ER visit subject to the deductible. It also increases the primary care co-pay by $5.

The Board recommended Option 1 for the 87% AV CSR. Ms. Phillips indicated that it follows the 70% and 73% plans, the deductible and maximum out of pocket maximum; ER is subject to the deductible. Also, generic and preferred brand drugs are not subject to the deductible. The non-preferred and specialty drugs are subject to the deductible.

Ms. Phillips indicated that the 94% AV CSR Plan meets the requirements of the AV Calculator. The maximum out of pocket expense was dropped to $750. The Board recommended Option 1.

For the 60% Bronze Non-HSA Plan, the Board chose Option 3. The combined medical and prescription deductibles were increased as well as the out of pocket maximum. Except for generic drugs, prescriptions will become subject to the deductible.

Ms. Phillips then described the 60% Bronze HSA Plan. This plan meets the de minimis range. The decision has been reached to keep the plan's current structure as a recommendation. Mr. Philpott inquired whether there is any positive selection built into these plans. Mr. Lombardo responded that a person who is healthier most likely will choose a plan with a higher cost-sharing. Ms. Veltri indicated that some people are not aware that when choosing a less expensive plan that they would be faced with a higher deductible. Mr. Wadleigh indicated that in some instances, consumers need more information to make a final decision regarding choosing their insurance plan. Some consumers are not aware of the implications of picking a less expensive plan. Mr. Doolittle commented that the healthcare costs are too high in the state and across the nation. Mr. Tessier noted that Option 1 in the Bronze 60% HSA Plan was chosen by the Board in consensus.

Mr. Tessier requested a motion to approve the 2018 Standard Plan Benefit Designs for the Individual Exchange as recommended by the Advisory Committee and proposed by Exchange Staff. Motion was made by Grant Ritter and seconded by Paul Philpott. ***Motion passed unanimously.***

Ms. Phillips reviewed the SHOP Plan designs. The SHOP Gold and Silver plan designs fall outside the de minimis range requirements using the 2018 calculator. The Platinum plan needed no changes from the 2017 plan year. The Silver HSA, Bronze and Bronze HSA fall within the AV range requirements, therefore no changes are needed. For the Platinum Plan, the Board agreed to follow the HPBQ AC's recommendation of keeping Option 1. Ms. Phillips indicated that the Committee recommended Option 1 for the SHOP Gold Plan, which increases the medical deductible by $100 and the out of pocket maximum by $400. Mr. Wadleigh asked if standard plan designs for SHOP are recommended.

Miriam Delphin-Rittmon left at 11:39 a.m.

John Carbone, SHOP Sales Manager, indicated that standard plan designs for SHOP had been a deterrent for the program to grow. By creating rich plans, employers are reluctant to purchase them. Not enough options are provided. Eliminating the standard plan designs for SHOP, and introducing non-standard plan designs, will give employers more options. It will allow SHOP to bring carriers from the outside. By continuing to offer the standard plans through the SHOP platform, not enough options are there to make these plans attractive to employers. Mr. Philpott commented that it is very important to entice more carriers to join the program by letting them offer their standard plans, which are already being sold in their marketplace. Mr. Philpott indicated that AHCT needs to create some incentive for the carriers to participate in SHOP, since the tax credits from the early days of the ACA are gone.

Lt. Governor Wyman commented that at this point, SHOP is not attractive to businesses. Mr. Ritter expressed his skepticism about eliminating the standard plans and offering non-standard plans only on the SHOP platform. Mr. Carbone stated that the small group market is highly concentrated with brokers. Mr. Wadleigh added that competitors have a number of items that AHCT does not have at its disposal, which puts this organization at a disadvantage. Technology is a limiting factor for AHCT. AHCT is looking at a new technological solution to work with the carriers as well as consumers. Mr. Wadleigh added that waiting a year is not in the best interest of the SHOP program. Ms. Lopes stated that current guidance to the carriers was voted on by the Board. It contains the idea of horizontal versus vertical choices. If there are multiple carriers on the exchange, the employees can choose a metal level. In the last case scenario, the employees can choose a plan from any of the carriers participating. Mr. Philpott commented that the employer sets the number of choices that the employee would have.

Mr. Tessier asked if the intention of AHCT is to not approve standard plan designs. Mr. Carbone confirmed this intention, and added that SHOP would offer non-standard plan designs. Mr. Jeffreys noted that it would contain two parts, the first one being to offer the non-standard plans in SHOP. Another part would be to set up parameters which would be sent out in solicitations. Mr. Tessier asked for materials to be available which summarize the matter in question. Lt. Governor Wyman noted that the vote would only be to allow AHCT to offer non-standard plan designs on the SHOP program. The design of those plans would be up to them. Mr. Jeffreys added that it would not be a plan structure that is normally seen. At this point, standardized plans are being considered for approval. From the non-standard plan, it would be just the approval standpoint, it would not be a design. Mr. Jeffreys added that a minimum needed to be set so that the carrier participating would be doing it in that metal level. Mr. Carbone noted that the current book of business for SHOP has 51% of those enrolled using the Silver plan, 28% in

Gold, and 14% in Bronze. Mr. Ritter added that every carrier should offer at least one plan in each metal tier. Mr. Wadleigh added that the Board does not need to vote on the non-standard plans. It is just allowing AHCT to offer non-standard plans. Mr. Tessier asked for a motion to eliminate the requirement for standardized plans in SHOP. Motion was made by Grant Ritter and seconded by Paul Philpott. ***Motion passed unanimously.***

Mr. Wadleigh indicated that AHCT will define what the parameters for the non-standard plan designs for SHOP will be. This information will be sent out to the Board. Mr. Doolittle inquired whether other states went in a similar direction in terms of the SHOP program. Mr. Wadleigh responded that other states never went in this direction. There are states that allow 170 plan designs in small group. Small enrollment numbers are experienced around the country.

Mr. Jeffreys described the Stand-Alone-Dental Plan (SADP) options. No changes are proposed in the design. Currently, one carrier on the Exchange provides a dental plan. AHCT would like to relax some of the requirements to entice more carriers to join, allowing them to offer only in-network services. The majority of consumers who are buying dental plans on the Exchange then obtain coverage outside of the Exchange. AHCT's plan is very rich. Mr. Jeffreys presented the Board with three options. Option 1 would maintain the status quo by retaining the standardized plan only, thereby requiring carriers to cover benefits in network as well as well as out-of-network. Option 2 would add offering out-of-network coverage and add another standardized SADP that includes only the prescribed in-network cost-sharing. Option 3 would revise the existing standardized plan to reflect in-network coverage only, with an option to include Out-of-Network (OON) coverage. Mr. Jeffreys stated that AHCT's recommendation is Option 3. Mr. Wadleigh added that the legislature approved single purpose dental health centers. This would encourage dental HMOs to join the Exchange. Mr. Tessier asked for a motion to approve the High Option, 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 Lt. Governor Nancy Wyman and seconded by Paul Philpott. ***Motion passed unanimously.***

Mr. Wadleigh stressed that all of the actions that AHCT is undertaking are aimed at offsetting the potential rate increases for 2018. Mr. Tessier inquired whether documentation to support this statement exists. Mr. Lombardo noted that CID's conversations with carriers and experiences around the country have indicated that these are achievable savings. If the carriers would not prove that these savings are achievable, CID would not be recommending implementation. Ms. Veltri added that criteria needs to be set in order to make sure that they are achieved. Mr. Wadleigh noted that the potential rate impact of allowing formulary differences could potentially change rates by 3% to 5%. Network adequacy changes would also amount to potentially changing rates from 2% to 5%. Other potential saving lies in the study on the Essential Community

Providers requirement and lowering the standard. Research is still being conducted on that issue. The same can be said for smoking rates. Mr. Lombardo described the tobacco use factor in determining rates. In the individual off-exchange market, three carriers are using a tobacco use factor. Aetna has a 10% tobacco use load while Cigna has a 25% and Golden Rule uses a grading process. From age 21 to 34, they have a 5% load. From age 35 to 49, they have a 10% load and from age 50 and above they have a 20% load. On the Exchange, a combined, tobacco and non-tobacco rate exists. To split it out, everybody's rates would change. The smokers' rates would go up and the non-smokers' rates would go down. Carriers would have to generate this type of information. Carriers assume that 10% of their enrollees are smokers. Mr. Philpott asked whether the tobacco use on the medical insurance application is self-reported. Mr. Lombardo confirmed that consumers must self-report tobacco use.

Maura Carley indicated that the membership in those three companies using the tobacco use rating factor outside of the Exchange is relatively small. Ms. Carley asked whether there is anything to be gained there. Mr. Lombardo commented that if the Exchange does not have the tobacco rating factor, it may be selected against. Mr. Wadleigh noted that the Board of Regents no longer requires health insurance as part of their admission process. Aetna has a contract for that. AHCT can now compete with that younger group of customers if AHCT plans are less expensive than the Aetna plans. Ms. Carley inquired whether the two on-exchange carriers in the individual market currently do not use tobacco use as a rating factor. Mr. Lombardo confirmed that these carriers do not use tobacco rating. The tax credit would also be based upon the non-smoker rate. Mr. Wadleigh added that AHCT does not have a recommendation. Also, the Exchange has a limited number of levers to influence rates. The tobacco use rating factor is one of them and it is also a controversial one. Mr. Wadleigh emphasized that the last thing that AHCT wants to do is to hurt its customers.

V. Certification Requirements for 2018

Mr. Jeffreys reviewed the Certification Requirements for 2018. Mr. Jeffreys indicated that AHCT would like CID to review formulary requirements. Ms. Veltri asked whether such action would reduce costs for AHCT. Mr. Tessier responded that it can potentially save 3% to 5% on premiums. Mr. Doolittle expressed concern that AHCT is allowing flexibility with an unknown result awaiting them. Mr. Tessier requested a motion, effective for the 2018 plan year, to suspend for two years the current AHCT standard pertaining to formulary review adopted by the Board of Directors in April 2014 and rely on the Connecticut Insurance Department analysis and review of formulary

for both standard and non-standard plans. Motion was made by Victoria Veltri and seconded by Lt. Governor Nancy Wyman. ***Motion passed unanimously.***

Ms. Lopes added that a CID review is based on the federal benchmark standard. Ms. Carley expressed concern regarding the two-year suspension. Mr. Lombardo indicated that it is a potential cost-savings, and creates an incentive for the carriers that are not on the Exchange to potentially join. Separate standards required by both CID and AHCT may be seen as prohibiting them from joining. By CID reviewing them, it creates an equal playing field for the carriers. Mr. Tessier reiterated Mr. Doolittle's comment that suspension for two years is being incorporated due to the potential negative outcomes for consumers.

Mr. Jeffreys reviewed the network adequacy requirement changes proposals. Mr. Jeffreys explained that the standards require Qualified Health Plan (QHP) issuers to develop and maintain provider networks for the standard plan designs offered in the Marketplace that include at least 85% of those unique providers and unique entities that comprise the network of the most popular plan, of a similar type, actively sold by the issuer or the issuer's affiliate if such affiliate has a larger provider network. Mr. Jeffreys explained that AHCT would like to rely on CID analysis and review for network adequacy, which is the same for on and off-Exchange. The aim would be to narrow the gap between both of those markets. Ms. Veltri inquired whether this proposal is not the same as the ECP option. Mr. Wadleigh stated that it would allow a smaller network size. Mr. Lombardo stated that at this point, carriers require complete networks. Carriers across the country offer multiple networks. They have narrow and broad networks. Mr. Lombardo provided a hypothetical example about two hospitals that are located within a few mile radius of each other. In this instance, the carrier will be able to choose one hospital in that area. The smaller network still has to be run through the network adequacy model that CID will be reviewing. It could potentially generate cost-savings between 5% and 10% on the premium side. The ACA allows for differentials for network pricing. This is another tool that could generate potential cost-savings. Mr. Lombardo noted that the network adequacy information will be submitted by May 1. Mr. Doolittle added that the true benefit for the consumers comes in the ability to create a price pressure on the providers. Lt. Governor Wyman requested a motion, effective for the 2018 plan year, to suspend for two years the current certification standard pertaining to network adequacy review adopted by the Board of Directors in April 2014 and rely on Connecticut Insurance Department analysis and review of network adequacy for both standard and non-standard plans. Motion was made by Robert Scalettar and seconded by Grant Ritter. ***Motion passed unanimously.***

Mr. Philpott stated that if AHCT has a standard above and beyond CID's going forward, AHCT is at a disadvantage compared with the off-exchange market, where carriers do not have that issue.

In that case, AHCT can be adversely selected. What may happen is that more of these narrow networks may proliferate outside of the exchange. Mr. Philpott added that people who are low utilizers will choose the narrow networks, while the high-utilizers will opt to choose the broader network.

VI. Adjournment

Robert Tessier requested a motion to adjourn the meeting. Motion was made by Victoria Veltri and seconded by Robert Scalettar. ***Motion passed unanimously.*** Meeting adjourned at 12:59 p.m.