As Approved by the Board of Directors on February 15, 2018

STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

Legislative Office Building
Room 1D

Thursday, January 18, 2018
Meeting Minutes

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

Members Participating Remotely: Commissioner Raul Pino, Department of Public Health (DPH)

Other Participants:
Access Health CT (AHCT) Staff: James R. Wadleigh; Shan Jeffreys; Ann Lopes; Andrea Ravitz; Anthony Crowe; James Michel; Susan Rich-Bye; Robert Blundo
Connecticut Insurance Department (CID): Paul Lombardo

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

No public comment.

III. Votes:

Lt. Governor Wyman requested a motion to approve the November 16, 2017 Board of Directors Regular Meeting Minutes. Motion was made by Cecelia Woods and seconded by Victoria Veltri. ***Motion passed unanimously.***

Lt. Governor Wyman introduced Susan Rich-Bye, Director of Legal and Governmental Affairs, who requested that the Board consider adding Theodore Doolittle, the Connecticut Healthcare Advocate to the Health Plan Benefits and Qualifications (HPBQ) Advisory Committee. Ms. Rich-Bye explained the important role that the HPBQ Advisory Committee plays in assisting both staff members and the Board with recommendations on standard plan designs, and other factors that are included in the annual plan certification process. Mr. Doolittle's role as the Healthcare Advocate, and his knowledge and experience can aid the committee with its work.

Lt. Governor Wyman requested a motion to appoint Theodore Doolittle to the Health Plan Benefits and Qualifications Advisory Committee. Motion was made by Paul Philpott and seconded by Victoria Veltri. ***Theodore Doolittle abstained. Motion passed.***

The Exchange By-laws require the election of a Vice-Chair yearly in January. Lt. Governor Wyman requested a motion to re-elect Robert Tessier as vice chair of the Board. Motion was made by Victoria Veltri and seconded by Cecelia Woods. ***Motion passed unanimously.***

Lt. Governor Wyman expressed her appreciation to the AHCT staff for their work to make the 2018 Open Enrollment successful. Lt. Governor Wyman also expressed her gratitude to the participating carriers and healthcare providers.

IV. CEO Report

James Wadleigh, CEO, updated the Board on Access Health CT (AHCT) activities. Mr. Wadleigh emphasized that every Open Enrollment (OE) brings a new set of challenges as well as opportunities. AHCT is only six years old, but it may have encountered more changes in its existence than many other organizations have in their entire lifespan. All of those challenges have taught AHCT to appreciate each year for its uniqueness, and to adapt to those sometimes-unexpected changes in the best possible manner. Mr. Wadleigh emphasized that the 2018 OE was the most challenging one on record. Mr. Wadleigh enumerated numerous obstacles that AHCT had to endure during its first OE, mostly due to the issues that the federal exchange had experienced. Despite that, AHCT's efforts in mitigating those effects turned the Connecticut Exchange into a state-based model for other areas of the country to emulate. During the last OE, a new set of challenges emerged, including, but not limited to the new Administration, shortened enrollment period, and harder to reach population, on top of political confusion originating in Washington, D.C.

Mr. Wadleigh stated that despite the completion of this OE, AHCT has been preparing for the OE 2019 since August of last year. The Plan Management Team works with the HPBQ Advisory Committee on those very important issues. The Board is encouraged at this meeting to discuss possible ways that plan designs can be influenced to lower premiums, as well as to simplify and enhance platforms to improve customer experience. Mr. Wadleigh stated that today's

presentation by Robert Blundo, Director of Technical Operations and Analytics, will provide an in-depth analysis of data trends, customer purchase behavior, and shifts in the composition of AHCT's membership. Presentations by Ann Lopes, Product Carrier Manager, and Shan Jeffreys, Chief Operations Officer, on the 2019 Plan Certification Requirements; as well as James Michel, Finance Director on the 2nd Quarter Budget Report, will provide the Board with an overview of the work that AHCT staff is continuously performing to better assist Exchange's customers. Mr. Wadleigh emphasized that OE ended on December 22, 2017. At this point, individuals can only enroll if they experienced a qualifying life event. If a customer qualifies for Medicaid, she/he can enroll year-round.

Mr. Wadleigh reminded the Board that those who enrolled in private health insurance through AHCT will need to make their first premium payment in order for their health insurance to become effective. Mr. Wadleigh stated that approximately 10,000 households received a letter asking them to verify details in their applications. These individuals need to submit required documentation in order not to risk becoming disenrolled. The future elimination of the health insurance mandate penalty has created a lot of confusion. Mr. Wadleigh reminded the Board that elimination of the health insurance mandate penalty is not effective until 2019; therefore, anyone who does not have healthcare coverage in 2018 still faces a possible tax penalty. Mr. Wadleigh thanked the Governor, the Lieutenant Governor, the Board of Directors, the Certified Application Counselors (CACs), brokers, enrollment centers, community business partners, the Department of Social Services (DSS), participating carriers, the media, and the AHCT staff. Mr. Wadleigh thanked AHCT customers for trusting the Exchange with their healthcare coverage needs.

Roderick Bremby praised the good cooperation between DSS and AHCT. DSS is current on its retrospective payments at the rate that was agreed upon by both agencies. Mr. Bremby indicated that with the last OE, a tremendous improvement was made in the technological aspect pertaining to seamless data transitions. The auto-renewals are very high on both systems. Mr. Bremby indicated that this technological improvement in the state of Connecticut may be one of the best in the nation in terms of that interface. Mr. Bremby inquired about the next steps that DSS needs to take regarding the MOA. Mr. Jeffreys indicated that both AHCT and DSS have been continuously working on the cost allocation and other agreements. More meetings will be held to discuss other matters.

Paul Philpott inquired whether brokers receive verification notices for their customers who are required to submit additional documentation to support their applications. Mr. Wadleigh indicated that AHCT is working on resolving this issue, due to privacy concerns that may arise if such action is undertaken. AHCT is working with the brokers to generate some reports unrelated to this issue. Ms. Rich-Bye added that if a broker or anybody else were listed as an authorized representative on a consumer's account, they would receive the copy of that notice. Victoria Veltri encouraged the CAC partners to obtain the copies of those notices as well.

Cecelia Woods inquired about the breakdown of individuals who called in terms of eligibility for Medicaid or Qualified Health Plans (QHP). Mr. Wadleigh pointed out that about 87 percent of customers were auto-enrolled for QHPs. Some individuals were ineligible for auto-enrollment.

All of those customers received correspondence from AHCT. Despite all of those efforts, some people did not enroll. After the December 22 deadline, AHCT received letters from consumers seeking to enroll in coverage because someone in their family is sick and needs health insurance. Mr. Wadleigh stressed that these individuals cannot enroll unless they qualify for a Special Enrollment period. Mr. Wadleigh emphasized that these types of situations are very unfortunate. He added that participating carriers have indicated in the past that some individuals would sign-up for medical insurance in order to get treatment, and following its completion, would stop paying premiums.

Mr. Bremby stated that the Integrated Eligibility System (IES) determines eligibility for Modified Adjusted Gross Income (MAGI) Medicaid, Husky A and D, but if individuals are not eligible for these programs, they are directed back to the DSS screen that provides them with more program options to consider with DSS.

V. 2018 Open Enrollment Overview

Robert Blundo, Director of Technical Operations and Analytics, provided the 2018 OE Overview. Mr. Blundo indicated that a full 2018 OE Report, which provides more in-depth analysis, is available on the agency's website. Mr. Blundo emphasized that the last OE saw a net increase in total enrollment of 2.3 percent, which amounted to 2,592 more QHP customers enrolling than during the 2017 OE. Over 80,000 enrollees renewed their policies for this plan year, which is the highest amount ever registered by AHCT, amounting to 87 percent. Close to 34,000 new QHP enrollees were added, and of those, 13,400 were first-time customers. Mr. Blundo indicated that 55,492 individuals completed applications or redeterminations processed through the IES. Broker commissions were reinstituted for 2018 enrollments. Thirty five percent of customers received broker assistance, versus 25 percent who did so a year prior. The call center performed better and more efficiently as compared to the 2017 OE.

Victoria Veltri inquired whether the 87% auto-renewal also incorporates individuals who came back to the system and continued shopping for another plan. Mr. Blundo stated that over 80,000 enrollees were eligible for automatic renewal, and this number does not indicate whether individuals came back and shopped for another plan. Mr. Blundo pointed out that AHCT reports the Medicaid and QHP figures differently. The over 55,000 individuals who enrolled in Medicaid during this time period does not reflect automatic renewals. These are the repeat and new customers who were determined eligible during that period. Mr. Wadleigh added that the CACs enrolled approximately 2,000 Medicaid customers. AHCT is working on obtaining more conclusive data from the CACs and Brokers, who also enroll Medicaid customers. A higher number of consumers enrolled in the first two weeks of OE. Some of them shopped and picked plans before AHCT auto-renewed them.

Lt. Governor Wyman inquired whether information exists pertaining to those consumers who were auto-enrolled, and who also submitted their first premium payment. Mr. Blundo stated that AHCT has some indicators based on its current data from participating carriers. Preliminary indications reveal that 9 out of 10 consumers submitted their first monthly premium. Mr. Wadleigh added that this number is an improvement compared to previous years. Across

different segments of consumers who are qualifying for Financial Assistance (FA), which includes Advanced Premium Tax Credits (APTCs), APTC and Cost Sharing Reductions (CSRs) and no FA, an approximate 20 percent increase was reported. ConnectiCare Benefits Inc. (CBI) saw a 28.4% increase in business, while Anthem recorded a 4.2% increase. The 20 percent increase is shown in comparison to previous OE periods, not the whole year.

Benjamin Barnes commented on the larger role of providing more healthcare coverage for Connecticut residents. There are 15,000 individuals who were previously AHCT's customers, and whose healthcare needs may be of concern to the state. Mr. Barnes inquired whether AHCT could identify this group, and encourage them to obtain healthcare coverage. Mr. Blundo emphasized that one slide contains this information. Attrition, reacquisition, and outreach are part of this analysis. CBI accounts for nearly three quarters of enrollments during OE, while Anthem accounts for the remainder. AHCT consumers are price-sensitive. Approximately 10% of QHP customers have at least one dependent who is enrolled in a HUSKY program. Over 4,500 customers were enrolled by 10 enrollment centers and call center brokers.

Mr. Blundo provided a summary of AHCT's customer FA profile. Non-subsidized enrollees tend to be younger and have larger covered households. About 15 percent of the APTC plus CSR population were Medicaid recipients at some point in 2017. Thirty-two percent of enrollees receiving an APTC without CSR have been enrolled since 2015. Twenty-three percent of AHCT's enrollment consists of 18-34-year-olds. The 55-64-year-olds are the largest group of enrollees, accounting for 32% of the population. In addition, 1.5% of customers are over the age of 65, and of this particular segment, over 300 enrollees are 75 and older. Mr. Blundo emphasized that the last group most likely would be high utilizers of medical services, based on their age. Mr. Blundo added that a larger number of individuals under 19 years old signed up for coverage through the Exchange. In addition, more 55-64-years-olds signed up as well. The Exchange's customers are highly concentrated in urban areas. Mr. Blundo added that 18.2% of AHCT's customers were between 151% and 200% of Federal Poverty Level (FPL) and 26.7% were over 400% FPL.

Mr. Philpott commented on a full five-year differential in average age between non-subsidized and subsidized consumers. It will be very important going forward that AHCT does all it can to assist individuals who do not receive FA. If that cohort is diminished, it will put upward pressure on rates, in addition to other factors. The non-FA individuals are lowering the average age of the entire group.

Mr. Blundo reiterated that 84% of customers who enrolled in a 2017 plan prior to OE were renewed or retained in a 2018 plan. Thirty percent of QHP customers with a 2018 plan were newly acquired during this OE period. The newly acquired QHP customers are on average four years younger than the retained customers. Nearly 50% of new acquisition customers from the 2018 OE do not receive FA, compared to only 28% in the 2017 OE. Re-acquired customers are more likely to receive financial help for premiums, and nearly one-third transitioned from HUSKY.

Ms. Veltri commented that if someone's income were below 250% of the FPL, this person would qualify for a medical plan that includes both APTCs and CSRs. Ms. Veltri inquired why some of these customers are enrolling in bronze plans, which do not provide CSRs. Mr. Blundo admitted

that it is an ongoing challenge that the Exchange is facing. Generally, the population is more conscious about their monthly premium cost, and not so much about their out of pocket exposure. Mr. Blundo pointed out that if a customer shops through AHCT's web portal and is eligible for CSRs, only the silver plans appear by default. In addition, the outreach strategy focused on the different CSR plans. For the 73% AV CSR plan cost sharing savings are less substantial than the other CSR plans. AHCT only targeted those customers who were eligible for the higher AV CSR plans. Ms. Veltri commented that this was a great approach. Ms. Veltri also made a suggestion regarding an informational box on the shopping portal, to warn customers about the implications of their decision selecting a plan without CSRs.

Andrea Ravitz, Director of Marketing and Sales, stated that 17,000 people used the cost comparison tool. There is room for improvement from an educational perspective at the point of purchase. Ms. Ravitz emphasized that the outreach efforts concentrated on the message that consumers should not only consider the price of the premiums when making their decisions, but also encouraged individuals to consider other aspects, such as medications, expected utilization of services, among other items. There are creative ways to help educate consumers throughout the year, not just during the OE season.

Mr. Barnes inquired about consumers who receive no FA, and whether their decision to purchase plans through the Exchange might have been caused by relative pricing outside and inside of the marketplace. Mr. Blundo confirmed that this is probably the main cause for these consumers to purchase medical coverage through the Exchange. Mr. Blundo added that three carriers off Exchange no longer offer plans in the individual market in Connecticut. This might have also been a contributing factor.

Mr. Tessier inquired about individuals who do not receive FA and purchase plans on the Exchange. Plan comparison is easier for the on-Exchange plans versus those off-Exchange. The ability to compare plans online is an important factor. Paul Lombardo indicated that there are two carriers on the Exchange, CBI and Anthem. The off-Exchange market contains two carriers, ConnectiCare and Anthem. CBI is a separate legal subsidiary of ConnectiCare. Anthem offers plans both on and off-Exchange. The premium increases off-Exchange were significant, higher than increases for plans on the Exchange. Mr. Barnes emphasized that consumers who receive no FA and purchase plans through the Exchange is a positive sign.

Lt. Governor Wyman inquired about senior citizens who signed up for medical coverage though AHCT, and how they found out about it. Ms. Ravitz pointed out that market research had been performed for the past four years to understand age brackets. The main targets were the young invincibles. Ms. Ravitz reiterated that social media platforms are also utilized by older consumers. Many individuals utilize various social media platforms to keep in touch with their families. AHCT has used this opportunity to reach out to different age groups. The marketing campaign during this shortened OE period was very intense. It was a combination of the amount and frequency of advertising, the fact that the marketing campaign was started earlier, and AHCT's improved understanding of targeted groups and their motivation to enroll. Many of them saw AHCT as an ally.

Mr. Blundo stated that AHCT was able to retain 90% of customers who were eligible for APTCs, and 85% of consumers who were not eligible for financial assistance. Overall, the OE 2018 retention rate was 88.4%. The retention rate during OE 2017 was 78.1%. Mr. Blundo provided an in-depth analysis of the 2018 OE attrition rates. Mr. Blundo described AHCT customers' metal tier preferences, where 55% of QHP customers selected a plan in the Silver metal tier. In addition, 55% of customers 19 years old and younger purchased a plan in the Bronze metal tier. Bronze plans are the most popular option for non-FA customers, which stands at 68%, in comparison to 60% in the prior OE. A continuous trend of people deferring to bronze plans over other metal tiers is visible. It indicates that customers are price conscious. Mr. Blundo pointed out that out of 3,100 customers who switched carriers, 81% chose CBI. In addition, 78% of new acquisition customers selected a plan from CBI. Mr. Blundo stated that for customers between 55 and 64 years of age, who account for 32% of all QHP customers, their average monthly premium after APTC ranges from $115 to $867, depending on the level of financial assistance.

Approximately 60% of enrollees are paying less than $200 per month for their policy, which includes APTCs. For enrollees who retained similar financial help between 2017 and 2018, the average monthly premium increase after APTC was less than $5 for FA customers and $116 for non-FA consumers. About 9 in 10 Anthem customers made their first premium payment with the effectuation status of January 10. CBI's data was not available at the time of the Board meeting. Customers have 90 days to close any open verifications from the date they were determined eligible. As of this Board meeting, approximately 22,600 households currently have open verification issues. About 31% of open verifications have a due date of February 25, 2018.

Anthony Crowe, Director of Operations, provided a summary of Outstanding Verifications (VCL). Mr. Crowe indicated that the amount of open VCLs is about 30% less than AHCT had last year at the same time. AHCT is reaching out to those individuals ahead of the 90-day deadline for them to submit documentation. The Operations team is very being proactive on this front. The Marketing team is also assisting in reaching out to the customers with outstanding VCLs. Mr. Crowe indicated that individuals who are 75 days into their time period to submit documentation will receive daily e-mail reminders. Direct mail campaigns will also take place to reach those customers. AHCT is also looking to get brokers and CACs involved in reaching out to their customers who have outstanding VCLs.

VI. Plan Certification Requirements

Ann Lopes, Carrier Product Manager, provided the Board with an update on the plan certification requirements and the work of the HPBQ Advisory Committee. Ms. Lopes indicated that the committee, per the Board's decision, is reviewing all of the policies and criteria pertaining to QHP certification that have been developed during the past five years. The committee has completed a review of many items, most of which were the certification requirements that had been reviewed last year and modified for the 2018 plan year. Ms. Lopes stated that the committee reviewed the following: the requirement to submit standardized plan designs; the plan mix for standard and non-standard plan offerings; the EHB Benchmark Plan; prescription drug formulary standards; network adequacy standards; ECP contracting standards; broker compensation; and, the SHOP plan mix. Other items are pending additional review. One item is outstanding.

Ms. Lopes provided current guidelines in terms of number of plans permitted per Issuer. Twenty plans have been submitted by the two participating carriers in the individual market for 2018, eight of them being standardized plans, with no Platinum plans. In the non-standard category, AHCT offers one Gold, five Silver, four Bronze, and two Catastrophic. In the Small Business market, the two participating carriers offer non-standard plans only, which include one Platinum, three Gold, five Silver, and five Bronze. One issue that is pending further discussion is whether AHCT should continue to permit submission of non-standard Silver plans for the individual market. The 2018 Individual Market Standardized Plans at the Gold, Silver, and Bronze metal levels would no longer comply with the Actuarial Value (AV) de minimis range for 2019, based on the results of the AV calculator tool. A number of options were discussed, which included making minimum changes to the plan design in terms of the cost sharing elements. The second option discussed included a significant change in the cost sharing. The third option included a significant change in the cost sharing structure as well as the product type. The last two options could produce significant savings in the range of 20 to 25 percent for the gold and silver plans, and 10 to 15 percent for the bronze plans. These options were presented by the Connecticut Insurance Department (CID).

The major goal in examining different options is to find a plan design that will result in significant premium savings. Ms. Lopes noted that estimates do not incorporate other factors that could impact premiums, such as claim trend and adjustments resulting from changes in network, among other issues. Ms. Lopes enumerated next steps for the upcoming two meetings of the HPBQ Advisory Committee.

Shan Jeffreys, Chief Operating Officer, indicated that the new AV calculator was published at the end of 2017, and AHCT reviewed the bench line AV for its current standard plans. Modifications will need to be made to those plan designs for the 2019 plan year. All metal levels, with the exception of the Bronze HSA, will be affected. Mr. Jeffreys emphasized that modifications to each existing standard plan design, would need to be made, such as altering deductible amounts in order to meet the AV ranges for 2019. Small changes to those plans may be required. The maximum co-pays set by the CID limit AHCT's ability to affect the AV calculator in this area. AHCT has been working with the carriers and CID on areas that can impact the AV for a particular plan.

One of the options under consideration is moving from the current plan designs to options that are more reliant on co-insurance with a different co-pay structure, and have a combined medical and prescription deductible. Mr. Jeffreys stated that by looking at different plan options, as well as to the AV of the plans, an estimated 20 to 25% reduction in premiums may take place. Mr. Jeffreys indicated that the HPBQ Advisory Committee asked for the Board members' opinions pertaining to the plan design development. Health insurance literacy also plays an important role in the whole process to provide improved transparency. AHCT's Bronze metal tiers do have combined medical and prescription deductibles. Many consumers are gravitating toward those plans, because they are price-conscious. Mr. Jeffreys stated AHCT needs to look at both the non-FA and FA markets.

Mr. Philpott thanked the AHCT staff for providing a great report. Mr. Philpott commented that on average, the non-FA customers are five years younger than those who are receiving FA. If these two groups are separated and grouped differently, the non-FA people would be paying lower premiums and the FA customers would be paying higher premiums. In reality, an additional subsidy is received from non-FA individuals. Mr. Philpott indicated that there appears to be a safe harbor in the Bronze plans for the non-FA customers. Mr. Philpott suggested reaching out to actual consumers and brokers, asking them for their opinions and encouraging greater sensitivity to the Exchange's responsibility for offering affordable health insurance.

Mr. Bremby inquired about the HPBQ Advisory Committee's approach in terms of size and narrow networks. Mr. Jeffreys indicated that one of the ideas discussed by the committee would be to have a plan with a narrower network, and no out-of-network coverage, similar to an HMO-style plan. Higher co-insurance and combined deductibles would be a part of the plan. Ms. Wade commented that some consumers assume that co-payment would be less expensive than co-insurance. In reality, in many cases the co-insurance would be less expensive than a co-pay. Mr. Lombardo added that any plan that is considered by the Board would need to meet a threshold for the AV calculator. The cost sharing mechanism would have to be within the de minimis range. The low end of the Silver plan de minimis range dropped to 66%. Mr. Lombardo added that some significant flexibility exists with various options. The co-insurance plan generated an AV of 72%. In addition, a co-pay plan that generates an AV of 66% can also be developed. The AV calculator shows that the co-insurance plan in itself is providing more coverage to the consumer than the 66% AV of a co-pay plan. There will be consumers on the co-insurance that will pay more for a service. Mr. Lombardo stated that for 90 to 95 percent of the claims, CID set the co-pay so that the individual gets at least 50% coverage. Mr. Lombardo added that for 90-95% of claims under the co-pay plan, people would still maintain the co-insurance value that will be equal to or less than the co-pay that is being generated for that particular service. The AV calculator is only based on in-network services.

Ms. Veltri stated that education of customers, pertaining to the choices that are available, is crucial. Ms. Veltri encouraged exploring possible network options, including value-based insurance designs. Robert Scalettar, M.D., commented that when discussing coverage and affordability, they should not be confused with the total cost of care. All of the design issues are tricky and complicated. It seems unreasonable to combine medical and prescription deductibles without recognizing its impact on how people get care, as the issue of adherence to medication has been difficult. Dr. Scalettar indicated that carriers are incentivizing their customers to take their medications, as opposed to not having any access to them until the full combined deductible is met. Dr. Scalettar strongly urged the committee not to combine medical and prescription deductibles without recognizing its true impact. In some states, all individual medical insurance plans are sold through their respective state-based exchanges. Dr. Scalettar stressed that exchanges bring more benefits to consumers, such as comparison shopping, simplicity, efficiency, and the value that they bring to the market. Dr. Scalettar indicated his support for requiring all of the individual plans to be sold on the Exchange. Administrative cost savings may also follow. Dr. Scalettar indicated that there is still work to be done in the area of attracting more people to the insurance pool.

Mr. Tessier, as member of the HPBQ Advisory Committee, provided the Board with his view of the important mission that this committee undertakes. Mr. Tessier expressed words of appreciation to Mr. Lombardo and Mary Ellen Breault from CID, who have been serving as subject matter experts on the committee. Mr. Tessier also thanked the staff for their continuous work on plan designs. Mr. Tessier stated that both the committee and the Board are considering making dramatic changes to the structure of plan designs in order to reduce premium costs for consumers. Mr. Tessier emphasized that these discussions are very important due to rising healthcare costs, despite all of the efforts that had been undertaken by the staff, the carriers, stakeholders, and advocates. Some successes were achieved, but consumers are still facing difficult choices and problems with affordability. Mr. Tessier expressed his concern with the fact that a decision affecting thousands of AHCT's customers will have to be made within a short period of time. The HPBQ AC started meeting in August of 2017. The meetings have been held monthly and bimonthly. Mr. Tessier expressed his support for not making any significant decisions on the 2019 plan designs, and delaying those decisions until the following year. Mr. Tessier encouraged the Board to spend the next year examining the 2020 plan designs, with a focus on value-based plan designs, and work with the carriers.

Mr. Barnes stated that premium cost is the most important element when people decide whether to purchase medical insurance coverage. It is the main determining factor. Mr. Barnes stated that while he understands the complexity and time it takes to develop plan designs, the price of the premium is the detrimental factor, which in many cases deters people from signing up for coverage. It puts people at risk for catastrophic financial situations. The uninsured individuals do not get the negotiated price while being provided medical care; they pay the highest cost. Mr. Barnes expressed his support for enrolling as many people as possible, with possibly greater cost participation for them, but with lower premiums, which would attract them to get coverage. Mr. Barnes expressed his support for having a large number of people insured, even with imperfect medical insurance, than having coverage that is more robust but more costly, which would make some people not purchase it.

Mr. Philpott echoed Mr. Barnes' approach. Typically, the people who choose to go without coverage are younger and healthier. It is in everyone's interest to enroll as many of these individuals as possible. Retaining them is also an important role. The premium pricing tipping point may be reached. In this scenario, those individuals may stop signing up for coverage, which would create upward pressure on premium prices, since these customers tend to be younger and healthier. In this instance, a new cohort of uninsured individuals would be created.

Ms. Wade indicated that the plans CID brought for a potential review to the HPBQ Advisory Committee do not represent the view of CID, but were prepared to provide examples of how those plan designs can be modified in order to reduce the cost of premiums. Ms. Wade encouraged the Board not to wait another year to consider these options, since the premium pricing may be reaching a tipping point for many customers.

Ms. Veltri asked whether the Board is expected to provide guidance to the HPBQ Advisory Committee. Mr. Jeffreys stated that the Board should provide some direction to the committee before final recommendations on plan designs are voted on during the committee's February 7 meeting. Mr. Wadleigh added that it is possible that the filing deadline will be moved. The committee seeks guidance from the Board members in order to get additional ideas. Ms. Veltri encouraged the committee to use the APCD data to track the experience of the people who are selecting plans, in terms of what services consumers are using. Mr. Wadleigh stated that this was a great recommendation. Mr. Wadleigh emphasized that AHCT also needs to listen to its participating carriers, since they are the ones who are providing the products. The non-standard plans are providing a level of innovation for the carriers, and some of them are successful. Mr. Wadleigh pointed out that carrier participation in the HPBQ Advisory Committee is important, because committee members can learn about their strategic approach in the healthcare coverage industry. Mr. Wadleigh emphasized his support for the carriers to sit at the table.

Grant Ritter noted that there was willingness to make the 2019 silver plan very similar to the current plan, which may result in an increase in premiums. Mr. Ritter noted that standard bronze plans might be adjusted in significant ways, or carriers may be allowed to create non-standard bronze plans. Many ideas are being considered. Since premium assistance amounts are based on the second lowest cost silver plan, Mr. Ritter indicated that it may make sense to have just two standard plans in the silver tier, and allow APTCs to be based on the higher cost silver plan. Mr. Ritter supported the idea of modifying bronze plans in order to make them less costly. Mr. Jeffreys stated that about 42% population in the Gold tier do not receive FA. In the Silver metal tier, about 4,700 people receive no FA. Mr. Ritter added that it is up to the carriers to decide on the designs of the non-standard plans, and he hoped that they will come back with innovative ideas.

Cecelia Woods thanked the committee and AHCT staff for all of their hard work. Mr. Bremby indicated that value-based designs are essential for the future. In addition, the non-standard plan designs with narrower networks are also an encouraging option that can be put before the public.

V. Finance Update

James Michel, Director of Finance, provided a Finance Update. Mr. Michel indicated that following the recent Finance and Audit Committee meetings, the Board is being asked to vote on four different items. Mr. Michel stated that AHCT had to adjust its budget to reflect the change in allocations pertaining to the call center between DSS and AHCT, from an 80-20 to an approximately 70-30 ratio. AHCT absorbed another 10 percent of the costs. Because of that, AHCT's budget will be reduced by $1.6 million. DSS's share of overall costs between AHCT and DSS will be reduced by $2.4 million. This amount also includes various IT adjustments. The first six months of FY 2018 show a surplus of $539,373, due to the previously planned expenditures that will be undertaken later. The actual cash reserves were over $8.7 million as of December 31, 2017, which amounted to four months of the organization's operations. Mr. Michel stated that due to the payments received from assessments and DSS reimbursements, current AHCT reserves equal to approximately eight months of operations.

Lt. Governor Wyman requested a motion to approve the Fiscal Year 2018 2nd Quarter Budget Report. Motion was made by Benjamin Barnes and seconded by Robert Scalettar. ***Motion passed unanimously.***

Lt. Governor Wyman requested a motion to approve the 2017 AHCT Audited Financial Statements. Motion was made by Benjamin Barnes and seconded by Victoria Veltri. ***Motion passed unanimously.***

Lt. Governor Wyman requested a motion to approve the 2017 Programmatic Audit Report. Motion was made by Victoria Veltri and seconded by Benjamin Barnes. ***Motion passed unanimously.***

Lt. Governor Wyman requested a motion to approve the Transitional Reinsurance Report. Motion was made by Victoria Veltri and seconded by Cecelia Woods. Mr. Barnes, as a chair of the Finance Committee, expressed his appreciation for the work of the staff for producing timely clean audits and financial reports. Mr. Barnes also thanked the auditors, who have completed a statutorily limited engagement with AHCT, for their work. ***Motion passed unanimously.***

VIII. Adjournment

Lt. Governor Wyman requested a motion to adjourn the meeting. Motion was made by Roderick Bremby and seconded by Victoria Veltri. ***Motion passed unanimously.*** Meeting adjourned at 11:53 a.m.