As Approved by the Board of Directors on March 20, 2018

STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

Hilton Hartford
Hartford Commons Room

Thursday, February 15, 2018
Meeting Minutes

Members Present:
Lt. Governor Nancy Wyman, Chair; Paul Philpott; Secretary Benjamin Barnes, Office and Policy and Management (OPM); 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 Navarretta on behalf of Commissioner Miriam Delphin-Rittmon, Department of Mental Health and Addiction Services (DHMAS); Cecelia Woods

Members Participating Remotely:
Robert Tessier (Vice-Chair); Victoria Veltri; Robert Scalettar, MD

Members Absent:
Commissioner Raul Pino, MD, Department of Public Health (DPH)

Other Participants:
Access Health CT (AHCT) Staff: James R. Wadleigh; Shan Jeffreys; Susan Rich-Bye; Ann Lopes; Andrea Ravitz; Anthony Crowe
Wakely Consulting: Julie Andrews

The Regular Meeting of the Connecticut Health Insurance Exchange Board of Directors was called to order at 9:02 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 January 18, 2018 Board of Directors Regular Meeting Minutes. Motion was made by Grant Ritter and seconded by Cecelia Woods. ***Motion passed unanimously.***

Lt. Governor Wyman requested a motion to appoint Paul Philpott to the SHOP Advisory Committee. Motion was made by Grant Ritter and seconded by Cecelia Woods. ***Motion passed unanimously.***

Lt. Governor Wyman requested a motion to alter the Agenda to include a vote to go into the Executive Session to discuss a matter exempt from disclosure pursuant to CGS § 1-200(6)(A). Motion was made by Grant Ritter and seconded by Cecelia Woods. ***Motion passed unanimously.***

IV. CEO Report

James Wadleigh, CEO, updated the Board on Access Health CT (AHCT) activities. Mr. Wadleigh thanked the Board and the media for their continuous assistance. Mr. Wadleigh stressed that the number of customers who need to submit their verification documents, in order to have their insurance coverage continue unaffected, has been reduced significantly over the last month. Mr. Wadleigh stated that some customers still have not made their first premium payments. AHCT wants to make sure that customers do not experience a lapse in their medical insurance coverage. The Plan Management Team is continuously working on the 2019 plan designs. Mr. Wadleigh thanked the Connecticut Insurance Department (CID) for the added time that was given to the Health Plan Benefits and Qualifications Advisory Committee (HPBQ AC) to discuss the 2019 plan designs, in order to make sure that the best possible health plan options are developed.

Benjamin Barnes arrived at 9:05 p.m.

V. Plan Management Update

Ann Lopes, Carrier Product Manager, provided the Board with an update on the plan certification requirements and the work of the HPBQ AC.

Theodore Doolittle arrived at 9:06 a.m.

Ms. Lopes indicated that the HPBQ AC had a discussion on the topics listed in the certification review schedule, and has completed a review of several of them. Ms. Lopes provided an overview of the Certification Review Schedule, stating that it identifies topics that the Health Plan

Benefits and Qualifications Advisory Committee (HPBQ AC) has reviewed over the last several months in their effort to assess all the policies and criteria pertaining to QHP Certification that have been developed over the past 5 years. This review was recommended during the August 2017 Board of Directors (BOD) meeting. The Committee has discussed each topic listed, and has completed its review of several of them.

During last month's Board meeting, there was discussion that the Connecticut Insurance Department (CID) 2019 plan year rate and form filing due date, which had been conveyed during a meeting held by the CID for health insurers in December 2017, could be moved to a later time. The CID released a Bulletin dated January 31, 2018, stating that all filings for plans to be offered in the individual and small group markets for 2019 are to be submitted no later than July 16, 2018.

This results in some additional time to complete the review of the remaining items. Additional meetings are being considered to complete discussions on all topics. The HPBQ AC has had some robust conversations during the last two Committee meetings since the last meeting of the Board on January 18.

Grant Ritter, HPBQ AC Chair, added that the committee is active in discussing and developing 2019 plans. Mr. Ritter stated that the attention of the committee has been focused on the Bronze Plans. The discussion in the committee centered on whether a third standard Bronze plan should be offered. The conversation included changing the design for the higher-priced standard Bronze plan, since information indicates that consumers' number one issue for their health care coverage is the plan's premium. Carriers have stated that reducing the actuarial value of a plan may not always mean that it could have a very different premium. The Committee has been encouraged to move the standard plan downward in premium. The Committee pointed out that lower cost Bronze plans exist, and AHCT is competitive at this metal level with the standardized HSA-compatible plan and a non-standard HMO plan. Some people do seem to pick a plan based on the benefit design. The deductible would have to be increased, or the plan would need to have a narrow provider network, to get a lower premium. Approximately 35% of Bronze plan enrollees have bought the standardized Bronze plan, which has the highest price in most areas. It may be better to give people a choice of different plans. It may not make a difference if the plan is called 'Standard'. The current standardized plans are like bookends, one low-priced and one high-priced, and that may be the way to keep it. There was also discussion on tiered benefit designs.

Mr. Ritter stated that even with the same Actuarial Value (AV), premiums can differ based on plan designs. In order to change another Bronze plan and make it less expensive, the possibilities of raising the deductible and/or narrowing the network exist, which may end up being unattractive to consumers. Mr. Ritter stated that it would possibly be more beneficial to keep

the other standard plan with a higher price and a richer plan design. Every year, new designs are developed. Mr. Ritter encouraged the carriers to come up with innovative ideas in order to affect the premiums.

Ms. Lopes provided a brief overview of some of the key deliverable dates that are taken into account as part of the annual Plan Management Life Cycle, noting that the Department of Health and Human Services (HHS) final Payment Notice for 2019 has not yet been released. That regulation will specify whether the maximum out-of-pocket thresholds, outlined in the proposed Payment Notice released at the end of October, are finalized as proposed for medical and stand-alone dental plans. We continue to expect the final regulation to be released at any time, and hope to have it available in advance of the March 20 Board meeting in order to incorporate any information necessary into the certification requirements.

Subsequent to the Board meeting of March 20, AHCT would expect to release the annual QHP & Stand Alone Dental Plan (SADP) Solicitation in April, as these specify certification requirements for the next plan year. Carriers would need these to assess the impact on premium rates, prepare documentation for the rate, and form filings.

VI. Adverse Selection Study

Susan Rich-Bye, Director of Legal and Governmental Affairs, introduced Julie Andrews from Wakely Consulting to present the 2017 Adverse Selection Study. Wakely was retained by AHCT to perform this study. AHCT is required by its enabling legislation to report annually on the impact of adverse selection on the Exchange, provide recommendations to address any negative impact reported, and provide recommendations to ensure the sustainability of the exchange. This study is based on 2017 data. Data for the study have been collected from various sources. Carriers' perspective was added through the survey responses. Risk factor profiles were presented. The nature of adverse selection, areas of potential adverse selection, and the study methodology were reviewed. Studies indicate that less healthy individuals are enrolling on the Exchange. Ms. Andrews accentuated that the risk adjustment program indicates that funds are transferred from off-exchange carriers to the on-Exchange insurance carriers.

Ms. Andrews provided a summary of various regulatory changes either being introduced or contemplated by the administration. Ms. Andrews also enumerated proposals in other states that may potentially try to undermine the medical insurance market, by creating insurance entities that may not be obliged to follow the Affordable Care Act (ACA) requirements. Ms. Andrews added that the carriers indicated that preventative measures that were adopted last year helped to mitigate the negative effects of some people abusing the system. Ms. Andrews added that carriers, based on responses, encouraged AHCT to monitor this area in order to improve on it further.

Mr. Ritter inquired whether the risk adjustment program, in the case of medical insurance carriers who participate both on and off-Exchange, is the best approach since it may transfer funds from an off-Exchange carrier to its on-Exchange affiliate. Ms. Andrews indicated that it creates equality in premiums. If the transfer of funds did not occur, premium increases for the on-Exchange plans would have been more significant. Ms. Andrews stated that indicators exist that more people are reporting that they are in self-funded plans, but the validation of those data is not available. The overall marketplace for small group plans is shrinking.

Paul Philpott commented that this is one of the reasons why the revenues from the marketplace assessments are diminishing. Mr. Philpott added that many practitioners and insurance brokers indicate that significant movement exists in the small group market from fully insured plans to at least partially self-insured plans. Mr. Philpott inquired whether the re-insurance carriers are regulated by CID. Katharine Wade stated that the stop-loss component is regulated by CID. Ms. Wade inquired whether these data include the defunct HealthyCT. Ms. Andrews pointed out that it was statewide data reported through the supplemental healthcare exhibit, and the HealthyCT filing was included in this data analysis.

Benjamin Barnes asked whether a specific approach could be taken to determine where the currently uninsured reside, and whether they are not covered, or if they have moved to a different part of the marketplace. Ms. Wade accentuated that it is challenging to obtain these data, and CID would need regulatory authority to collect it.

Mr. Philpott commented that due to the risk adjustment formula, many cooperatives such as HealthyCT in Connecticut and Minuteman in Massachusetts had to cease their operations. Mr. Philpott commented that Minuteman created high efficiency networks. All of these accomplishments were undone by the risk adjustment program. One of the unintended outcomes of the risk adjustment program were disincentives for the creation of innovative and efficient networks to control costs. Ms. Wade stated that the risk adjustment methodology is flawed, and CID had long been advocating to change it. HealthyCT should have received money if the program worked effectively. CID continues to try to make changes to the program. Mr. Ritter added that HealthyCT and Minuteman were signing up people who might have been relatively healthy, and the fact that they had lower cost healthcare might have been counterproductive in this regard. Since they were signing up healthier individuals and other insurance carriers had sicker populations, they had to pay money to those carriers who experienced higher-than-usual enrollment of sicker individuals. Ms. Wade added that those cooperatives might not have had as strong an infrastructure as other carriers to make the risk score.

Ms. Wade noted that there are no regulatory differences between on-Exchange and off-Exchange in the small group and individual markets and how CID reviews them.

VII. Operations Update

Antony Crowe, Director of Operations, provided the Board with the Operations Update. Mr. Crowe state that approximately 95 percent of all AHCT customers have been effectuated. As of February 12, the QHP enrollment stood at 108,447 individuals. Since the end of the last Open Enrollment (OE), 1,070 people had enrolled using the Special Enrollment Procedure (SEP) for those with qualifying life events. Mr. Crowe pointed out that in January, 6,929 people had open verification requirements. This number has been reduced to 3,504. Mr. Crowe stated that when compared to the same period last year, AHCT is experiencing approximately 40 percent fewer open verifications. Mr. Crowe stated that the Operations Department initiated a pilot program in which a team of five employees calls customers whose verification documents are due in the next 60 to 90days. The list is updated three times a week. AHCT is also targeting customers based on their projected termination dates. In addition to the Operation Department efforts, the Marketing Department has been working to reach out to those audiences proactively. Weekly e-mails are sent to customers with outstanding verifications. Weekly social media posts remind customers to pay premiums and submit documents, if necessary. AHCT finds this program to be successful. A higher percentage of individuals whose documents are due within 60-90 days are sending in their documents, and a higher percentage of consumers are providing correct documents.

VIII. Executive Session

Lt. Governor Wyman requested motion to go into the Executive Session to discuss matters exempt from disclosure under C.G.S. §1-200(6)(A). Motion was made by Grant Ritter and seconded by Cecelia Woods

IX. Adjournment

Lt. Governor Wyman requested a motion to adjourn. Motion was made by Grant Ritter and seconded by Cecelia Woods. **Meeting adjourned at 10:05 a.m.**