As Approved by the Board of Directors on September 19, 2019

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

Legislative Office Building, Room 1D
300 Capitol Avenue, Hartford

Thursday, June 20, 2019
Meeting Minutes

Members Present: Victoria Veltri; Cecelia Woods; Grant Ritter; Robert Scalettar, MD.; Theodore Doolittle, Office of the Healthcare Advocate (OHA); Paul Philpott; Yvonne Addo on behalf of Commissioner Miriam Delphin-Rittmon, Department of Mental and Health Addiction Services (DHMAS); Paul Lombardo on behalf of Commissioner Andrew Mais, Connecticut Insurance Department (CID); Deputy Commissioner Heather Aaron on behalf of Commissioner Renee Coleman-Mitchell Department of Public Health (DPH); Anne Foley on behalf of Secretary Melissa McCaw, Office of Policy and Management (OPM); Deputy Commissioner Janel Simpson on behalf of the Department of Social Services (DSS) Commissioner, Roderick Bremby

Members Absent: Robert Tessier (Vice-Chair)

Other Participants: Access Health CT (AHCT) Staff: James Michel; Anthony Crowe; Rajiv Chawla; Susan Rich-Bye; Andrea Ravitz; Glenn Jurgen; Robert Blundo; Margo Lachowicz

A. Call to Order and Introductions

The Regular Meeting of the Connecticut Health Insurance Exchange Board of Directors was called to order at 9:00 a.m.
Victoria Veltri called the meeting to order at 9:00 a.m.

B. Public Comment

No public comment.

C. Votes

A motion was requested to appoint Victoria Veltri to act as Presiding Officer at the June 20, 2019 meeting in the absence of the Chair and Vice-Chair. Motion was made by Grant Ritter and seconded by Anne Foley. **Motion passed.**

Presiding Officer Victoria Veltri requested a motion to approve the May 16, 2019 Board of Directors Regular Meeting Minutes. Robert Scalettar, MD, requested the April 18, 2019 Board of Directors Meeting Minutes to be amended due to a typographical error on the bottom of page 7, to change the reference from Medicare Part B to Medicare Part D. Motion to approve the Meeting Minutes as amended was made by Cecelia Woods and seconded by Grant Ritter. Anne Foley abstained. ***Motion passed.***

D. CEO Report

James Michel, Chief Executive Officer, provided the CEO Report. Mr. Michel indicated that Connecticut has been ranked number three in the Nation for healthcare by U.S. News and World Report. The same report named Connecticut as a national leader in access to healthcare. According to the official rankings, important factors bear heavily on the well-being of any state resident as the overall quality of health. Mr. Michel pointed out that while the organization has matured over the years, it is not at the point at which it can be considered a full success. A large number of Connecticut residents still do not have a health insurance, which means that they do not have access to healthcare.

Mr. Michel outlined the main objectives of this Board meeting, with presentations by the Marketing and Legal Teams. Mr. Michel noted that AHCT has been continually preparing for the upcoming fiscal year audit. It is anticipated that it will be concluded by the beginning of November. Mr. Michel added that a successful off-site session was held with the Senior Leadership Team (SLT) with the purpose of better understanding AHCT's strengths, weaknesses, opportunities, and threats. This information is used to develop a strategic focus to enhance the organization's performance.

Mr. Michel commented that AHCT SHOP initiative, to officially launch and grow the small business offering, is off to a great start. Mr. Michel expressed his words of appreciation to all members of AHCT's advisory committees, who always provide the necessary guidance to the organization. AHCT held a vendors' summit with the aim of providing them with the 2020 Open Enrollment preparations. The summit was held at the call center in Bristol. It was well attended and received. AHCT is also conducting an uninsured survey in order to find out who they are, and how AHCT can help them overcome barriers, concerns, and challenges that prevented them from obtaining health insurance.

Mr. Michel described his positive experiences of the listening tour. Mr. Michel noted that all of those communities' leaders are committed to serving their respective populations. Healthcare is one of their top three concerns. One of the most important issues raised was the access to healthcare for undocumented people across the country. All of those leaders expressed their words of appreciation to AHCT for the outreach efforts in their communities, in particular, to people of color.

Mr. Michel announced to the Board that he has received a Board resignation letter from Dr. Robert Scalettar. Mr. Michel commended and thanked Dr. Scalettar for many years of service to the Exchange and Connecticut residents, who, thanks to his efforts, can have access to affordable medical insurance. Dr. Scalettar has been a member of the Board of Directors from the inception of the Exchange. Dr. Scalettar's leadership, guidance, and expertise in the delivery of healthcare has been instrumental to the success of AHCT. Mr. Michel thanked Dr. Scalettar on behalf of the organization, the Board, as well as Connecticut residents who can now enjoy better access to healthcare.

Dr. Scalettar thanked the staff, the Board and community for their continuous support. It is always a team effort. Dr. Scalettar pointed out that healthcare and health is more than access to healthcare. Dr. Scalettar emphasized that it has been a pleasure to serve on the Board throughout his tenure. Ms. Veltri expressed her words of appreciation to Dr. Scalettar on her own behalf, as well as on behalf of the former Chair of the Board and the current Vice-Chair, not only for being a member of the Board, but a member of the AHCT subcommittees.

E. Marketing Update

Andrea Ravitz, Director of Marketing, provided the Marketing Update. Mrs. Ravitz stated that AHCT has been very active since the conclusion of the last Open Enrollment (OE) through its media, outreach, and very robust public relations strategy. Mrs. Ravitz pointed out that this update provides a brief overview of the concluding Fiscal Year (FY) activities of the Marketing Department, and the focus for the next few months as the organization prepares for the next OE, which starts on November 1. Mrs. Ravitz described the current Marketing campaign, called "Choose, Use, and Be Well." This campaign contains many important elements that contribute to the success of this effort. As the current FY is nearing its end, the Marketing Department conducted close to 100 community events during that time. In the upcoming FY, AHCT is planning on having approximately 150 such events. AHCT is committed to being part of smaller community events, as well as the larger ones throughout Connecticut.

Mrs. Ravitz stated that AHCT is close to finishing research studies that will help the organization build the foundation for the upcoming OE. The uninsured study, as well as the psychographic research, are part of the approach. Five regional planning meetings with the Certified Application Counselors (CACs) and community partners have been concluded. Mrs. Ravitz elaborated that the evaluation committee will be presenting a final recommendation to AHCT about applicants for the Navigator Program. Mrs. Ravitz added that community outreach events are a great way of providing Connecticut residents with information on how AHCT can help them obtain affordable health insurance, since many of them are not aware that the Exchange can help them do that. AHCT will be testing what the organization calls "home events," which will be gatherings in respective communities with their key influencers.

The "Choose, Use, and Be Well" campaign is an off-season campaign about preventative healthcare. Mrs. Ravitz noted that it has been a successful campaign. This effort was launched in mid-May, and within a month, close to 16,000 unique visitors utilized its webpage. AHCT is working on providing additional tools once people come to the website.

Mrs. Ravitz told the Board that the Marketing Department is very proactive in its preparations for the upcoming OE. The OE7 Readiness plan includes another research study, a community conference, and healthy chats. The Community Conference is expected to have about 250 community partners and CACs. The in-person help strategy will be altered to better meet the needs of Connecticut residents. The number of fairs will be increased during OE7. AHCT expects to host up to 40 fairs. Mrs. Ravitz reminded the Board that OE7 starts on November 1, but the Marketing Department's main outreach efforts will commence on October 1.

F. Reinsurance Study

Susan Rich-Bye, Director of Legal and Governmental Affairs, provided an update on the reinsurance study. Ms. Rich-Bye stated that the reinsurance program is a market stabilization effort, designed to lower premiums in the individual health insurance market and increase the number of insured residents. Ms. Rich-Bye explained that an insurer is reimbursed for some of the claims it would have been responsible for previously, resulting in lower premium charged for the insurance. Governor Ned Lamont and the Connecticut General Assembly considered a reinsurance program in Connecticut during this past legislative session. AHCT has decided to engage Wakely Consulting to perform an analysis, with the purpose of providing state stakeholders with information about the potential premium savings and costs.

Ms. Rich-Bye provided information on the federal 1332 State Innovation Waiver program to pursue ways to provide residents with access to high quality, affordable health insurance, while retaining basic protections of the ACA. Reinsurance programs reduce premiums, resulting in premium tax credit (PTC) savings for the federal government. The 1332 waiver requests that the federal government "pass through" some of these savings to the state, which the state can use to fund part of the reinsurance program. The program is funded partially by both the state and federal funds.

Ms. Rich-Bye pointed out that the Wakely analysis included information on how a potential reinsurance program would impact premiums in 2020. It included an analysis of a potential pass-through if the state pursues a reinsurance -based 1332 waiver. It also took into consideration the potential state funding that would be needed, as well as the potential reinsurance payment parameters for select funding scenarios. Ms. Rich-Bye provided information on the potential premium savings, needed state funding, and federal pass-through percentage for three scenarios that included 5 percent, 10 percent, and 20 percent premium reductions. In order to achieve a bigger premium reduction, the federal pass-through and needed state funding would increase. The numbers presented do not include administrative costs. Ms. Rich-Bye added the state has the infrastructure to operate the reinsurance program because AHCT operated the transitional

reinsurance program with Health Reinsurance Association (HRA) in the past. AHCT was the only exchange in the country to have done it.

Ms. Rich-Bye provided the Board with information about the potential funding levels for the program based on three enrollment scenarios: low, neutral, and increased. As the enrollment increases, so does the cost. Ms. Rich-Bye added that Wakely conducted an analysis for a "claims-based" reinsurance program. Two types of reinsurance programs exist, claims-based and conditional. Wakely recommended using the claims-based approach. The claims-based reinsurance program reimburses issuers for a portion of their costs, which is the coinsurance amount above a set threshold (called the attachment point) and up to a maximum amount, which is a cap. Ms. Rich-Bye provided historical figures about the transitional reinsurance program. When it expired in 2017, it resulted in approximately 8-10 percent premium increases.

Ms. Veltri commented that a reinsurance programs has been debated on the state level, given that it could provide potential premium savings for on-Exchange and off-Exchange customers. It was not implemented this year. Ms. Veltri added that the reinsurance program would have to be modeled out for more years, since this research was based only on one year. Dr. Scalettar commented about the fact that the State of Connecticut did not implement the program and inquired about what the federal Government has approved for federal pass-through funds for 1332 waivers on reinsurance programs historically. Ms. Rich-Bye responded that currently, 7 states have 1332 waivers for reinsurance programs, and premiums savings vary. Ms. Rich-Bye added that this was one of the main reasons why the reinsurance study was specifically done for Connecticut. The markets across the nation are very different, and the premium savings in some states is greater than others. Ms. Rich-Bye added that the state funding line is not tied to an assessment. It is just identifying how much funding would be needed.

Paul Lombardo commented that Minnesota was expecting a significant amount of the federal pass-through funds and received approximately half of what they were expecting. It is not certain that any given state will receive the amount of money that they are expecting based on the federal government's analysis. Theodore Doolittle inquired whether Wakely analyzed the distribution of the benefits amongst the communities, in terms of the income distribution and geographical location. Ms. Rich-Bye pointed out that Wakely looked for savings on premiums and did not analyze the mentioned aspects. They used premium information from the carriers from the past few years. Mr. Doolittle added that the Office of the Healthcare Access (OHA) has supported reinsurance in the past, but noted that it is not his first choice, since the benefits mostly flow to the individuals with higher incomes. If the state is in the position to invest money into the AHCT community, something else should be considered, but the OHA supports the reinsurance program if it is offered.

Ms. Rich-Bye emphasized that reinsurance is a temporary measure, and for more stable premium relief, other options on the state level would need to be considered to drive down healthcare costs. Mr. Michel added that more clarity about Mr. Doolittle's inquiry could be provided once the uninsured study is completed. Mr. Doolittle added that while he supports the reinsurance program, and everyone benefits from that, most of the benefits would flow to the higher income

individuals. Mr. Doolittle urged that if Connecticut decides to implement the program, it should be designed in a way that would be more effective than others. Ms. Veltri stated that the APCD data can be utilized to possibly design such a program.

G. Legal Update

Ms. Rich-Bye provided a legal update. Ms. Rich-Bye described the Health Reimbursement Arrangement (HRA) Final Rule that has been released by the federal government. This rule is a big departure from the direction that the federal government has taken over the last few years.

This rule was a part of the three-part effort by the Administration, following President Trump's Executive Order providing people with more options and lowering costs. Ms. Rich-Bye pointed out that, according to this rule, employers of any size may offer "individual coverage HRA's" to employees for individual health plans on or off of the Exchange. Funds would come from the employer only. An HRA may be used to pay for individual plan premiums, cost-sharing, or other medical expenses, and the employer may limit it. Ms. Rich-Bye added that an employer may offer an HRA or a group health plan, but not a choice between the two to the individual employee. Employers can offer HRAs or group health plans to separate classes of employees.

The Final Rule states that there will be no minimum or maximum contribution amount. However, in order to use an HRA to satisfy the Minimum Essential Coverage (MEC) requirement for larger employers, the amount must be enough to make coverage "affordable" by the ACA definition. If the offered HRA makes coverage "affordable," the employee will not be eligible for Premium Tax Credits (PTCs). Ms. Rich-Bye pointed out that for plans beginning January 1, 2020, exchanges must ask potential qualified health plan enrollees whether their employer offered them an HRA for "affordable" coverage for PTC determination. The employers are required to provide a very detailed notice to the employees with the HRA offer. The HRA has to be tied to a health insurance plan. The employee has to show the employer that they have enrolled in an individual health insurance plan. Ms. Rich-Bye explained that the employee must be enrolled in a health insurance plan to access HRA funds. If the plan terminates, she/he must notify the employer, and HRA funds would be no longer available from the date of termination. Employees offered HRA's will be eligible for a Special Enrollment Period (SEP) to enroll in an individual plan if it is outside of the annual open enrollment period.

Ms. Veltri thanked Ms. Rich-Bye for a very good summary of a rule that is very complicated and is close to 500 pages-long. Ms. Rich-Bye added that some of the commenters to the then-proposed rule were very concerned about adverse selection, due to the possibility that an employer could used an HRA to put sicker, higher cost enrollees into the HRA, and not in the group plan, to keep the premiums low. The federal government feels that their rule addresses this problem, but not everyone agrees with that. Cecelia Woods inquired about what the federal government considers classes of employees. Ms. Rich-Bye stated that they are part-time, full-

time, seasonal employees, employees that are in a unit that is part of the collective bargaining group, employees who have not yet satisfied a waiting period, those who have not yet reached the age of 25 prior to the beginning of the plan year, employees who are non-resident immigrants without U.S.-based income, and employees whose primary site of employment is within the same rating area as where they live. The last two groups are a combination of any of these classes. Ms. Veltri stated that this rule is effective for the 2020 Plan Year, which can potentially increase premiums. The second issue with the ruling involves potential loss of PTCs.

Ms. Rich-Bye added that if an HRA is offered and it meets the MEC requirement, a person would not be eligible for PTCs, which could be troublesome for many customers. Mr. Michel indicated that a meeting with CMS was held and guidance is expected from them, specifically a tool to help individuals and businesses determine their course of action. AHCT is working to mitigate the risk and confusion to its customers. Mr. Michel added that one of the possible options that the Exchange may pursue is to add technological features to help customers maneuver through this new rule. If it is achievable and the cost would be outside of the IT development budget, AHCT will return to the Board to approve the funding for it. AHCT is also looking to address this issue collaboratively with Exchanges across the country.

Mr. Lombardo commented that rates for both individual and small group markets have to be filed with the Connecticut Insurance Department (CID) by July 8. They will be posted and available to the public no later than July 12. CID has no way of knowing what the carriers' perceptions are at this time, and how they interpret this rule. CID will evaluate both, the individual and the small group market as well as the large group carriers, whose filings are later. Carriers can make filings on a quarterly basis in the large group market. Mr. Doolittle agreed with Mr. Lombardo, and added that as a former corporate healthcare attorney, the issue described is a very complicated one that has numerous exceptions. Mr. Doolittle added that complexity creates barriers for the consumer and favors the resource-rich organizations. He stated that it is going to be difficult for the employers to evaluate their course of action to determine the detriments and benefits in going that way in a timely fashion. Ms. Rich-Bye added that despite the federal government's assertion that such action will benefit the individual market, if adverse selection exists, it will not be the case.

Mr. Lombardo added that one of the options that employers may exercise is to stop offering a group health plan and increase their employees' salaries so they can purchase insurance on the individual market. This would be after-tax dollars. Ms. Rich-Bye pointed out that the employee that would use those pre-tax dollars cannot be used for the Exchange coverage due to the ACA restrictions, but could be used to pay for off-Exchange coverage.

Ms. Rich-Bye provided a summary on the State-based Marketplace Annual Reporting Tool (SMART). The ACA requires exchanges to keep accurate accounting of all activities and expenditures, and to monitor and report to HHS on Exchange-related activities, complete an

annual report, and engage an independent auditor to perform annual independent financial and programmatic audit to ensure compliance with regulations and standards. Ms. Rich-Bye noted that CMS developed an online reporting tool for Exchanges with all the SBM requirements. SMART was created in 2015, and it includes 4 specific sections: eligibility and enrollment, financial and programmatic audit, program integrity, and attestation of completion. Ms. Rich-Bye provided a timeline for all of those activities.

Ms. Rich-Bye then reviewed a recent case with Simple Health Plans, LLC., which was using deceptive sales practices, selling virtually worthless medical plans that did not comply with ACA rules and regulations. The Federal Trade Commission (FTC) sued them and obtained a preliminary injunction. The FTC has asked the court for permission to send notices to the affected individuals informing them of the suit, and the course of action that they may take, including the ability to enroll using the SEP to obtain an ACA-compliant plan. The Federally Facilitated Marketplace (FFM) as well as AHCT will be providing SEPs for these individuals if they want to enroll in coverage. Ms. Rich-Bye noted that approximately 460 Connecticut residents may have purchased those products.

Ms. Veltri added that the federal government is proposing another rule regarding the non-discrimination section of the ACA, section 1557, that would change protections against discrimination on the basis of sex and would reinterpret the existing statute to allow for discrimination on the basis of gender identity and expression, and not to protect individuals on the basis of the sexual orientation.

If that rule becomes final, it would have widespread ramifications. Ms. Rich-Bye added that it could impact AHCT as well. Mr. Doolittle pointed out that OHA will be commenting on the proposed rule. Mr. Doolittle emphasized that this proposed rule is detrimental to many of the protections that consumers currently enjoy. It would especially affect transgender-related services. Currently, the insurers are required to provide coverage for those services. Mr. Doolittle stressed that it is an outrageous proposal, and comments by the OHA will be submitted to reflect its opposition.

H. Future Agenda Items

Mr. Michel provided the Board with the list of possible future agenda items, which include the Board Training, the Final SHOP Study, the Uninsured Survey and Open Enrollment 7 Preparedness.

I. Adjournment

Presiding Officer Victoria Veltri requested a motion to adjourn. Motion was made by Robert Scalettar and seconded Cecelia Woods. **Motion passed unanimously**. Meeting adjourned at 10:08 a.m.