As Approved by the Board of Directors on February 18, 2021

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

Remote Meeting

Thursday, January 21, 2021
Meeting Minutes

Members Present:
Paul Philpott (Interim Vice-Chair); Cecelia Woods, Thomas McNeill; Steven Hernandez; Grant Ritter; Theodore Doolittle; Office of the Healthcare Advocate (OHA); Heather Aaron, Department of Public Health Acting Commissioner Designee; Paul Lombardo on behalf of Commissioner Andrew Mais, Connecticut Insurance Department (CID); Yvonne Addo on behalf of Commissioner Miriam Delphin-Rittmon, Department of Mental and Health Addiction Services (DHMAS); Gregory Messner on behalf of Secretary Melissa McCaw, Office of Policy and Management Secretary (OPM); Commissioner Deidre Gifford, Department of Social Services (DSS); Victoria Veltri; Matthew Brokman

Other Participants:
Access Health CT (AHCT) Staff: James Michel; Anthony Crowe; Susan Rich-Bye; Robert Blundo; Andrea Ravitz; Daniel Maloney; Daryl Jones; John Carbone; Glenn Jurgen; Marcin Olechowski
Wakely Consulting: Julie Andrews

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.
Vice-Chair Paul Philpott called the meeting to order at 9:00 a.m. Attendance roll call was taken.

B. Public Comment

No public comment.

C. Votes

Vote 1: Review and Approval of Minutes

Vice-Chair Paul Philpott requested a motion to approve the November 19, 2020 Regular Meeting Minutes. Motion was made by Victoria Veltri and seconded by Grant Ritter. Roll call vote was ordered. **Motion passed.** Deidre Gifford abstained.

Vote 2: Election of Vice-Chair

James Michel, Chief Executive Officer, explained that the Exchange's by-laws require the annual election of a vice-chair in January. Motion was requested to elect Paul Philpott as Vice-Chair of the Board. Motion was made by Victoria Veltri and seconded by Thomas McNeill. Roll call vote was ordered. **Motion passed**. Paul Philpott abstained.

Susan Rich-Bye, Director of Legal and Governmental Affairs, addressed votes related to Committee membership. Ms. Rich-Bye addressed the appointment of Matthew Brokman to the Health Plan Benefits and Qualifications Advisory and Audit Committees. Next, Ms. Rich-Bye addressed the appointment of Mark Schaefer to the Health Plan Benefits Qualifications Advisory Committee. Finally, Ms. Rich-Bye addressed a vote needed to remove members from the Health Plan Benefits and Qualifications Advisory Committee who have provided their resignations.

Vote 3: Appoint Matthew Brokman to the Health Plan Benefits and Qualifications Advisory and Audit Committees

Vice-Chair requested a motion to appoint Matthew Brokman to the Health Plan Benefits and Qualifications Advisory and Audit Committees. Motion was made by Victoria Veltri and seconded by Grant Ritter. Roll call vote was ordered. **Motion passed.** Matthew Brokman abstained.

Vote 4: Appoint Mark Schaefer to the Health Plan Benefits and Qualifications Advisory Committee

Vice-Chair requested a motion to appoint Mark Schaefer to the Health Plan Benefits and Qualifications Advisory Committee. Motion was made by Victoria Veltri and seconded by Grant Ritter. Roll call vote was ordered. **Motion passed unanimously.**

Vote 5: Remove Members from the Health Plan Benefits and Qualifications Advisory Committee

Vice-Chair requested a motion to remove the following members from the Health Plan Benefits and Qualifications Advisory Committee: Bonnie Roswig, Kevin Galvin, Kimberly Martone, Mark

Espinosa, Robert McClean and Stephen Frayne. Motion was made by Victoria Veltri and seconded by Grant Ritter. Roll call vote was ordered. **Motion passed unanimously.**

D. CEO Report

James Michel, Chief Executive Officer, provided the CEO Report. Mr. Michel thanked the members of the Board for their continued support through the Open Enrollment (OE) period that ended in a week prior to the meeting. Mr. Michel also expressed his great appreciation to all of AHCT's partners, the Connecticut Insurance Department (CID), Department of Social Services (DSS), brokers, two participating carriers, the Board of Directors and most importantly, the Exchange's employees for doing an amazing job during this unprecedented OE. Mr. Michel stressed that following the OE, AHCT is reviewing its messaging, evaluating its outreach efforts and making adjustments as needed to communicate to the residents of Connecticut the critical importance of taking care of one's health, especially during the health crisis that our country is experiencing.

E. 2021 Open Enrollment Update

Robert Blundo, Director of Technical Operations and Analytics presented the 2021 Open Enrollment Update. Mr. Blundo provided the most important statistical data for the OE period. Mr. Blundo noted that the enrollment website experienced an increased volume of visitors with 313,000 unique visits which is 37 percent higher when compared to the prior OE. Mr. Blundo added that the call center handled 258,000 calls, which is slightly lower than the prior OE's data. Mr. Blundo informed the Board that at the start of the OE period, AHCT had almost 99,000 enrollees and at the end of the OE period, close to 105,000 people enrolled in a Qualified Health Plan (QHP) with 28 percent being eligible for the Advanced Premium Tax Credits (APTC) only and 42 percent of them qualified for both APTCs and Cost Sharing Reductions (CSR). In addition, 34,000 were determined eligible and completed their applications for Medicaid during the OE period.

Mr. Blundo went on to provide detailed analysis of the Public Health Emergency (PHE) efforts and the impact on Connecticut residents as well as the institutions, including AHCT, that assist them. The PHE has been extended by the U.S. Department of Health and Human Services through April 20, 2021, maintaining coverage for current HUSKY members through April 30, 2021. Mr. Blundo added that coverage for over 123,000 individuals with HUSKY was extended since the start of the PHE and added that verification requirements for enrollees continue for the duration of this special period. Mr. Blundo reiterated that AHCT continuously monitors and adjusts its systems as well as operational approaches as necessary to any PHE developments.

Mr. Blundo provided the Board with an in-depth analysis of customer acquisition and churn as well as demographics along with plan selections and premiums. Mr. Blundo noted one of the

most significant information that came up is that the retention rate stands at 92.7 percent which is slightly higher when compared to the prior year. In addition, 44.2 percent of enrollees were associated with a broker and 46.8 percent selected a silver plan, which is 0.5 percent higher when compared to OE 2020. Mr. Blundo also enumerated improvements that have been made to enhance the customer experience.

Mr. Blundo made the Board aware of the upcoming operational dates and deadlines. Theodore Doolittle praised Mr. Blundo and his team for the report with very valuable information and inquired about the reasons why customers who are coming off HUSKY tend to use brokers at a higher rate. Mr. Blundo indicated that more research would need to be done on this topic. Mr. Philpott inquired about possible detrimental plan selections by customers and asked if AHCT advises enrollees that better plans exist for their individual needs. Mr. Blundo noted that in certain instances, individuals who are eligible for 94 and 87 percent CSR plans may choose a bronze plan instead, potentially forfeiting benefits offered by such plans. Mr. Blundo indicated that brokers from the call center make outbound calls to those individuals that do not have a broker associated with them already and offer their assistance in the plan selection process. Mr. Blundo stressed that in case those enrollees do have a broker already, AHCT sends a communication to their broker that their client's selection might have been detrimental. Mr. Blundo added that AHCT's Customer Service Representatives cannot by law advise enrollees on their plan selection process; this duty falls on brokers who are properly licensed.

Andrea Ravitz, Director of Marketing, provided the Marketing Update. Ms. Ravitz reiterated that it was one of the most challenging open enrollments in many respects to assist as many people as possible due to the COVID-19 pandemic, at the time when healthcare coverage is crucial. Ms. Ravitz provided a timeline of marketing efforts that included opening a Special Enrollment Period (SEP) in March when the pandemic was taking hold of the state.

Ms. Ravitz added that the SEP brought in approximately 30,000 new enrollees either to HUSKY or to a QHP. Ms. Ravitz informed the Board that this year's campaign was driven by many factors, including extensive research, conducting focus groups and other elements; it was a multi-platform campaign that was driven by frequency. Ms. Ravitz stressed that AHCT's messaging was competing with a lot of information by different sources and the market was saturated with election campaign advertisements. Ms. Ravitz provided statistical data on the number of times advertisements and public service announcements (PSAs) were shown and aired on numerous platforms and indicated that advertisements were also published in ethnic newspapers throughout Connecticut. Ms. Ravitz discussed the success of the social media outreach as well.

Ms. Ravitz stressed that Special Enrollment continues to be a priority for the organization and provided an overview of the Exchange's outreach and educational campaign efforts outside of the OE period. Ms. Ravitz provided the Board with an update of the ongoing and future efforts including continuation of strategic partnerships, enrollment, and post-enrollment messaging

among other aspects. Mr. Michel reemphasized the idea of AHCT being more active and engaged especially with vulnerable populations in Connecticut at a time when education about the COVID-19 vaccine is so important and emphasized that AHCT will be working with its strategic partners to achieve this goal. Deidre Gifford, Department of Social Services Commissioner and Acting Department of Public Health Commissioner, added that DSS and DPH are trying to leverage the work that has been done in other areas to be able to access hard to reach communities regarding vaccinations.

F. Plan Certification Update

Ann Lopes, Product Carrier Manager, provided the Plan Certification Update. Ms. Lopes stated that while many employees at AHCT are working on items pertaining to the OE period for Plan Year 2021 or are preparing to work to assist customers with questions on Form 1095 for tax filings for 2020, the Plan Management (PM) team is moving forward to Plan Year 2022.

Ms. Lopes emphasized that a key responsibility of the PM Team is certification of Qualified Health Plans to be offered through the Exchange and pointed out that the target date for certification is October. At that point, AHCT will have verified that the plans submitted by carriers interested in offering plans through AHCT meet the requirements established by this organization and the federal government and AHCT will have completed review of carrier data submission to assure accuracy of cost sharing and premium rate information to be displayed in the Consumer Portal.

Ms. Lopes pointed out that one of the certification requirements AHCT has for carriers participating in the Individual Market is offering standardized plans, meaning that AHCT has prescribed the cost sharing, such as deductible, copays and coinsurance, for specified plans and these must be offered to consumers through the Exchange as a condition of the carrier's participation.

Ms. Lopes added that the federal government releases a regulation each year known as the Notice of Benefit and Payment Parameters (NBPP) as well as an Actuarial Value Calculator. Ms. Lopes went on to describe the proposed Payment Notice regulation for Plan Year 2022.

Ms. Lopes stated that on January 14, a partial final rule was released addressing some of the policies and regulatory revisions outlined in the proposed rule. The document indicated that HHS is continuing to review comments to the proposed 2022 Payment Notice and expects to address remaining provisions in future rulemaking.

Ms. Lopes reemphasized that this guidance is critical for AHCT to determine whether existing standardized plans for the Individual market are going to be in compliance with 2022 guidelines and pointed out that one key element included in the Payment Notice that is considered when developing standardized plans is the maximum out-of-pocket threshold, or MOOP. This value is

the most a consumer would pay for covered in-network Essential Health Benefits in a plan year when enrolled in a health insurance plan subject to the Affordable Care Act (ACA). After reaching this amount on deductibles, copayments, and coinsurance, the insurance company would pay 100% of those covered claim costs. Ms. Lopes indicated that for Plan Year 2022, that value has been proposed as $9100 for a single enrollee for other than the Silver CSR plans. This value has not yet been finalized for Plan Year 2022, as information on this was not included in the partial final rule released January 14. Ms. Lopes also described the role of the AHCT Health Plan Benefits and Qualifications (HPBQ) Advisory Committee that reviews certification requirements each year.

Ms. Lopes pointed out that insurance carriers are advised of AHCT requirements through the annual Solicitation, and then determine whether they want to offer plans through the Exchange based on that guidance. Ms. Lopes provided a brief summary of topics to be discussed at the kick-off meeting of the HPBQ Advisory Committee and added that a major focus for the Committee is expected to be determining whether the standardized plans will need to be modified to incorporate the state legislation pertaining to coverage for certain medications and equipment used in treating diabetes. The legislation was passed last year and has an effective date of January 1, 2022. It requires that an enrollee's coinsurance, copayments, deductibles and other out-of-pocket expenses may not exceed:

- Twenty-five dollars for each thirty-day supply of a medically necessary covered insulin drug
- Twenty-five dollars for each thirty-day supply of a medically necessary covered non-insulin drug
- One hundred dollars for a thirty-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices that are included in an insured's diabetes treatment plan

Ms. Lopes noted that legislation outlines that it would apply to High Deductible Health Plans to the maximum extent permitted by federal law. Ms. Lopes added that the review of the impact of this legislation on the actuarial value of these standardized plans is currently underway with AHCT's actuarial consultant, Wakely Consulting, and the carriers. Mr. Doolittle inquired whether the new requirement on diabetic medicine and supplies will have a specific impact on the cost of premiums. Ms. Lopes answered indicating that an inquiry will be made with the carriers to obtain this information. Discussion ensued around changes to specific plans over the years. Mr. Philpott commented that unlike other Exchanges, approximately 30 percent of the enrollees do not qualify for the APTCs or CSRs.

G. Adverse Selection Report

Julie Andrews from Wakely Consulting presented the 2020 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. 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. Ms. Andrews provided a summary of various regulatory changes either being introduced or contemplated by the administration. Ms. Andrews pointed out that the past year has brought changes to the individual and small group markets that impact overall market selection, not just for the Exchange. Two of those important factors include the outbreak of the COVID-19 pandemic as well as the congressional and presidential elections.

Ms. Andrews pointed out that the new administration's approach toward the (ACA) will substantially differ from the one offered by the past administration. Ms. Andrews added that any new decisions by the Biden Administration will be in the shadow of the U.S. Supreme Court decision pertaining to the constitutionality of the individual mandate which is expected in the spring. Ms. Andrews enumerated various executive actions that may be undertaken to bolster the ACA.

Ms. Andrews enumerated data types that were utilized in the research. Ms. Andrews expressed her words of appreciation to both participating carriers in support of the study. Potential adverse selection of the grandfathered versus non-grandfathered plans in the individual marketplace was reviewed. On and off-Exchange adverse selection was summarized. Ms. Andrews explained the minimum loss ratio which requires the carriers to spend at least 80 percent of the premium dollars to be used on claims. Ms. Andrews presented conclusions for the individual market on vs. off Exchange. Ms. Andrews stated that higher off exchange risk scores continue to deteriorate as compared to 2018. The on-Exchange enrollees are of higher average age than off exchange plan enrollees in the individual market and pointed out that Loss Ratios after consideration of risk adjustment transfers indicates that on exchange enrollees are currently not financially disadvantaged.

Ms. Andrews continued with her analysis of the small group market on vs. off Exchange. Similarly to last year, small group on exchange enrollment is low and not fully credible by metal tier and Wakely cannot make any conclusions regarding adverse selection. Ms. Andrews noted that low enrollment should be monitored outside of adverse selection to ensure sustainability of the market. Ms. Andrews provided recommendations that include the following: monitor overall market enrollment, as the off-exchange market continues to shrink; review impact of shifting metal tier enrollments and explore mechanisms for stabilizing the individual and small group

markets. Discussion ensued around rate filings, stop-loss, risks adjustments, indemnity as well as self-funded ERISA plans.

H. Legal Update

Susan Rich-Bye, Director of Legal and Governmental Affairs, presented the Legal Update. Ms. Rich-Bye noted that the Centers for Medicare and Medicaid Services issued a Partial Final Rule for the Notice of Benefit and Payment Parameters for PY 2022 which includes reducing user fees for the Federally Facilitated Marketplaces (FFMs) and state-based marketplaces that use the FFMs platforms. The new Partial Rule, among other elements, contains changes related to Section 1332 State Innovations Waivers. Ms. Rich-Bye also enumerated provisions that need to be finalized, such as the Verifications of the Special Enrollment Period's (SEPs), SEP Eligibility for Decrease in Employer Contribution for COBRA among others.

Ms. Rich-Bye went on to describe potential congressional actions to strengthen the ACA. Ms. Rich-Bye added that they include making subsidies available to consumers in additional income brackets, making subsidies more generous, addressing the Family Glitch, providing funding for State-based reinsurance or subsidy programs. Ms. Rich-Bye noted that some of them would require Congressional approval in the U.S. Senate with at least 60 U.S. senators supporting it, which in the current configuration could be difficult to achieve. Ms. Rich-Bye went on to point out that one of the ways to potentially strengthen the ACA is to create a SEP for the FFMs and restoring funding for marketing and outreach for the FFMs.

Ms. Rich-Bye discussed the issue that is currently before the United States Supreme Court that deals with the constitutionality of the mandate in the *California vs. Texas* case. Ms. Rich-Bye emphasized that there are a few options that may cure the issue at stake. They include the following: saving the mandate by increasing the penalty above $0, severing the mandate from other portions of the ACA, or eliminating it from the ACA by Congressional action. Discussion ensued around waivers and direct enrollment rules. Mr. Doolittle noted that while he is against direct enrollment, he encouraged AHCT to discuss this possibility. Mr. Michel noted that research pertaining to this issue will be made and report to the Board will be prepared.

I. Future Agenda Items

Mr. Michel listed Future Agenda Items:

- 2022 Standard Plan Designs
- OE8 Update
- Health Disparities Study
- Subsidiary

J. Adjournment

Vice-Chair Paul Philpott requested a motion to adjourn. Motion was made by Thomas McNeill and seconded by Grant Ritter. Roll call vote was ordered. **Motion passed unanimously**. Meeting adjourned at 10:46 a.m.