As Approved by the Board of Directors on May 20, 2021

Connecticut Health Insurance Exchange
Board of Directors Regular Meeting

Remote Meeting

Thursday, April 15, 2021
Meeting Minutes

Members Present:
Charles H. Klippel (Chair); Paul Philpott (Interim Vice-Chair); Cecelia Woods; Steven Hernandez; Grant Ritter; Adam Prizio on behalf of Theodore Doolittle, Office of the Healthcare Advocate (OHA); 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); Commissioner Deidre Gifford, Department of Social Services (DSS) and Acting Commissioner of the Department of Public Health (DPH); Victoria Veltri; Matthew Brokman; Thomas McNeill; Gregory Messner, on behalf of Secretary Melissa McCaw, Office of Policy and Management

Other Participants:
Access Health CT (AHCT) Staff: James Michel; Anthony Crowe; Susan Rich-Bye; Robert Blundo; 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.

Charles Klippel called the meeting to order at 9:00 a.m. Mr. Klippel offered his words of sincerest appreciation to the Interim Vice-Chair, Paul Philpott for taking the role of leading the Board of Directors at the time where no chair was chosen.
Attendance roll call was taken.

B. Public Comment

No public comment.

C. Swearing-In New Board Members

Susan Rich-Bye, Director of Legal and Governmental Affairs, administered an oath to the newly appointed Board Member, Charles H. Klippel.

D. Votes

Chair Charles Klippel requested a motion to approve the February 18, 2021 Regular Meeting Minutes. Motion was made by Paul Philpott and seconded by Thomas McNeill. Roll call vote was ordered. **Motion passed.** Deidre Gifford abstained.

Mr. Klippel requested a motion to approve the March 1, 2021 Special Meeting Minutes. Motion was made by Paul Philpott and seconded by Thomas McNeill. **Motion passed**. Deidre Gifford abstained.

E. CEO Report

James Michel, Chief Executive Officer, provided the CEO Report. Mr. Michel noted that Mr. Klippel has been appointed by Governor Ned Lamont to the Access Health CT (AHCT) Board of Directors to serve a Chair of the Board. Mr. Michel welcomed Mr. Klippel to the Board and AHCT. Mr. Michel also provided a brief summary of Mr. Klippel's professional experience. Mr. Michel expressed his hope that given Mr. Klippel's extensive expertise in the field, it will be utilized to enhance operations of the organization. Mr. Michel also thanked Mr. Paul Philpott for stepping-in to the role of the Interim Vice-Chair over the last two years as well as for his extensive guidance and leadership that continues to benefit AHCT and the residents of Connecticut. Mr. Michel noted that Mr. Philpott will remain as the vice-chair of the Board.

Mr. Michel stated that the American Rescue Plan (ARP) was signed into law on March 11, 2021 by President Biden and has a significant impact on both the uninsured and current AHCT customers. Mr. Michel added that the implementation of this law will make health insurance coverage more affordable to many Connecticut residents as it will eliminate or vastly reduce monthly premium payments and more financial assistance (FA) will be available to consumers with higher incomes. Mr. Michel emphasized that AHCT will officially open the Special Enrollment Period (SEP) for the American Rescue Plan (ARP) on May 1 and it will run through August 15. He reminded the Board that part of AHCT's mission is to reduce the number of uninsured Connecticut residents and ARP will help in this ongoing effort. Mr. Michel indicated that the savings to consumers will be significant due to the implementation of ARP and provided that an average savings per household per year would amount to $1400.

Mr. Michel emphasized that those families with incomes that are currently above the 400 percent Federal Poverty Level (FPL) threshold, will be able, on average, to save $6200 a year. Mr. Michel added that the number of households who will pay close to no premium will double to nearly 33,000 households. Mr. Michel added that AHCT conducted its own SEP which ends on April 15 and during this two-month period, over 5,800 consumers enrolled in healthcare coverage. Mr. Michel added that in 2020, AHCT opened an SEP for the uninsured as well and 4,200 consumers signed up for coverage at that time.

Chair Charles Klippel commented that the ARP is a much-needed resource for this year and beyond for the Exchange and its customers.

F. Finance

Daryl Jones, Director of Finance, provided the Finance Update. Mr. Jones stated that the Fiscal Year 2021 Adjusted Budget, Fiscal Year 2022 Proposed Budget as well the use of the Exchange's Reserves to fund initiatives for ARP need to be acted on by the Board. Mr. Jones noted that the Finance Committee approved all of these items unanimously.

Mr. Jones added that the Operating and Capital Improvement budgets are discussion items. Mr. Jones stated that in order to implement the required changes for ARP, additional funding is needed for marketing, operations, and technology for the remaining of this Fiscal Year (FY) and 1st quarter of FY 2022. Mr. Jones added that the costs are not to exceed $2.51 million and technology costs are anticipated to be reimbursed through a grant from the Centers for Medicare and Medicaid Services (CMS) as part of ARP and any reimbursements will be deposited back into AHCT reserves. Mr. Jones provided additional information pertaining to the efforts that will be undertaken in the marketing and outreach operations as well as technology to implement the ARP initiatives. Paul Philpott inquired whether the hiring of additional brokers to assist in enrollment in the individual market will be salaried. Mr. Michel answered that those brokers will be salaried, and they will be hired by the Exchange's call center. Expenses for that will be reimbursed to the call center.

Chair Klippel requested a motion to approve the FY 2021, FY 2022 American Rescue Plan Use of Reserve Funds as presented by Exchange staff. Motion was made by Paul Philpott and seconded by Victoria Veltri. **Motion passed unanimously.**

Mr. Jones presented the FY 2021 Projected Reserve Fund Balance. Mr. Jones noted that the net reserve as of June 30, 2020 was $22,747,069 which amounted to 7.8 months of operating funding. Mr. Jones added that after subtracting reserve funded projects which were approved in FY2019 and ARP Costs, the projected reserve on June 30, 2021 is $19,728,904 which constitutes 6.7 months of operating funding.

Mr. Jones provided an updated on the Calendar Year 2021 Assessments. Mr. Jones stated that carrier assessments fund AHCT's operations and are collected on a Calendar Year (CY) basis at the rate of 1.65 percent and pointed out that in CY 2021 Assessment revenue decreased by $3.7 million compared to CY2020 which impacted half of FY2021 by $1.85 million. It will impact the first 6 months of FY2022 by the same amount. Mr. Jones added that the decrease in assessment revenue is due to lower premiums assessed in both the individual and small group markets in 2019.

Mr. Jones emphasized that AHCT adjusted its fiscal budget and developed the FY2022 Budget using expected lower assessment revenues. Mr. Jones went on to provide the FY2021 Budget Summary Update. Mr. Jones summarized the Operating Budget – 3rd Fiscal Quarter Year-to-Date. Mr. Jones indicated that the Actuals for AHCT were $22,570,508 with a variance of $1,820,103 and DSS Shared Cost Actuals were $13,749,177 with a Variance of $396,694. Mr. Jones emphasized that the total Actuals were $36,319,685 versus the adopted Budget of $38,536,481 which showed a Variance of $2,216,797.

Mr. Jones described the FY2021 Adopted and FY2021 Adjusted Budget. Mr. Jones indicated that the total FY Adjusted Budget is $53,266,486 which includes $19,990,688 of the DSS Shared Costs, showing a variance of $1,866,190, while the FY2021 Adopted Budget was $55,132,676. Mr. Jones continued with an in-depth summary of the 3rd Quarter Budget Report which provided the line-by-line budget, actuals, and variances.

Mr. Klippel requested a motion to approve the FY2021 Q3 Operating Budget Report as presented by Exchange staff. Motion was made by Paul Philpott and seconded by Thomas McNeill. Roll call vote was ordered. **Motion passed unanimously.**

Mr. Jones provided an analysis of the FY2022 Proposed Budget. Mr. Jones stated that the FY2022 Proposed Budget is $53,119,241 and within that amount, $21,174,273 are the costs shared with DSS. Total operating expenses will be $31,944,968. The total operating expenses are decreased when compared to FY2021 by $3,197,020 which is a result of lower assessments. Mr. Jones noted that because of the lower assessment revenue, AHCT will not undertake any new IT-enhancements but will continue upgrades to its system.

Mr. Jones stated that reductions have been introduced in contractual, equipment and maintenance among others. Mr. Jones added that the DSS shared costs increased by $1,183,585 due to call center costs resulting from increased Medicaid enrollment. Mr. Jones noted that total reduction in expenses when compared to FY2021 amount to $2,013,435. Mr. Michel reassured the Board that despite those fiscal challenges, AHCT is meeting all its obligations from an IT security perspective. Commissioner Deidre Gifford inquired whether the ARP has any funding available for Exchange operations. Mr. Michel stated that some funds are set aside for the IT-enhancements to support the implementation of the ARP and AHCT is waiting for details regarding its distribution to the states.

Mr. Klippel requested a motion to approve the FY2022 Operating Budget as presented. Motion was made by Paul Philpott and seconded by Cecelia Woods. Roll call vote was ordered. **Motion passed unanimously.**

G. Qualified Health Plan Certification Requirements for 2022 Plan Year

Ann Lopes, Carrier Product Manager and Julie Andrews, Actuary from Wakely Consulting, presented the Qualified Health Plan Certification Requirements for the 2022 Plan Year. Ms. Lopes stated that back in January, the Plan Management Team (PMT) and Wakely Consulting provided the Board with an overview of the Plan Management Certification Life Cycle and work that the Health Plan Benefits and Qualifications Advisory Committee (HPBQ) is involved in each year. Ms. Lopes stated that at that time, it was noted that finalization of the review of certification requirements for Plan Year 2022 was targeted for completion by April.

Ms. Lopes stressed that insurance carriers are advised of AHCT certification requirements through a Solicitation each year, and then determine whether they want to offer plans through the Exchange based on that guidance. Ms. Lopes added that this document also includes information needed to create the rate and form filings that are due to be submitted to the Insurance Department on July 2 for the 2022 plan year. In order for the insurance carriers to have sufficient time to prepare those filings, AHCT targets the release of the Solicitation for April.

Ms. Lopes added that the PMT is seeking Board approval of the standardized plans for the Individual market for plan year 2022 and at this time, federal guidance pertaining to the maximum out-of-pocket (MOOP) and Actuarial Value Calculator (AVC) have not been finalized. Ms. Lopes pointed out that, given the desire to move forward with ample time for the carriers to prepare rate and form filings and also submit the Application to AHCT based on what is currently known, and if necessary, the adjustment will be made once the final guidance is available. Ms. Lopes emphasized that once it is known, this could result in the need to bring the standardized plans back for review again with this Board in the near future.

Ms. Lopes went on to describe the ‘plan mix’ for Individual and Small Group medical plans offered through the Exchange and added that it shows, at each metal level, the number of plans carriers are required to submit, as well as the number of optional plans they can submit. For the Individual market, AHCT requires that each carrier submit four standardized plans, but allows for each carrier to submit an additional nine non-standard plans. Ms. Lopes pointed out that for SHOP, rather than requiring standardized plans, carriers must submit a minimum number of plans that include certain parameters, such as inclusion of both in- and out-of-network coverage to be able to offer plans through AHCT, and for this market segment, carriers have the ability to submit 15 additional plans each. Ms. Lopes stated that the HPBQ Advisory Committee has not recommended any changes to the plan mix for PY2022.

Ms. Lopes described the activities related to standardized plan development that took place this year. Ms. Lopes indicated that back in January, there was an expectation that a major focus for the Committee was to determine how the current standardized plans would need to be modified to incorporate the state legislation pertaining to coverage for certain medications and equipment used in treating diabetes. Ms. Lopes affirmed that the legislation was passed last year and is outlined in Public Act 20-4.

Ms. Lopes stated that the items from this legislation impacting cost sharing under the standardized plans have an effective date of January 1, 2022, and require that an enrollee's coinsurance, copayments, deductibles, and other out-of-pocket expenses may not exceed:

- $25 for each thirty-day supply of medically necessary covered insulin drugs
- $25 for each thirty-day supply of medically necessary covered non-insulin drugs
- $100 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 stated that the legislation indicates that it would apply to High Deductible Health Plans (HDHPs) to the maximum extent permitted by federal law and, does not disqualify an enrollee that has an associated Health Savings Account from tax deductions allowed for that account per the IRC.

Ms. Lopes pointed out that the review of the impact of this legislation included assistance from the Connecticut Insurance Department, and a Bulletin dated April 7 posted to the Insurance Department website which outlined that the $100 cap for diabetes devices or ketoacidosis devices is to be applied as a thirty-day supply cumulative cap for all such devices. Ms. Lopes added that during the last HPBQ Advisory Committee meeting, Paul Lombardo clarified that the caps would apply only for in-network coverage, and that inclusion of these cost sharing maximums for HDHPs once the plan deductible is met would be a carrier decision; AHCT could choose to include this coverage in its standardized Bronze HSA plan or not between the deductible and MOOP.

Ms. Lopes said that Wakely Consulting worked with the two insurance companies offering plans through AHCT to review the standardized plans to determine whether including these new caps on medication and devices used in the treatment of diabetes would result in the need for offsetting modifications in cost sharing due to the increased benefit of these caps and the actuarial value of the plan designs. Additionally, the carriers assessed whether the plans would continue to meet Mental Health Parity (MHP) requirements when the caps were included. Ms. Lopes added that the assessment of AV and MHP compliance can differ amongst carriers for the standardized plans based on each insurance company's own methodology and claim data.

Ms. Lopes indicated that the Committee requested further review of the standardized plan designs to determine if Laboratory Services could be incorporated so that the benefit would be subject only to a copay and not the annual deductible; like the review for the addition of the maximum cost sharing for medication and devices used in the treatment of diabetes, the Committee needed to consider increasing other elements of the cost sharing in the plans to offset the increased benefit of waiver of the deductible and the carriers needed to perform the evaluation for AV and MHP compliance. Ms. Lopes added that waiver of the deductible is not permitted for non-preventive services in an HSA-compatible plan, so this feature could not be incorporated into the standardized HSA-Bronze plan pre-deductible.

Ms. Lopes informed the Board that the Committee was also interested in exploring whether IRS guidance released in 2019 that allowed for certain services to be considered "preventive" when used to treat specific conditions such that the deductible could be waived for the service under the HSA-compatible standardized Bronze plan. Ms. Lopes described that the IRS guidance allowed for 14 different services associated with the treatment of conditions including diabetes, different types of heart disease, asthma, osteoporosis, depression and liver and bleeding diseases.

Ms. Lopes informed the Board that there was discussion on whether the 6 services out of the 14 pertaining to diabetes could be included under the plan in the spirit of the state legislation on diabetes and in the end, there were 2 possible services that may have been possible to include (A1c testing and retinopathy screening) where the plan could continue to be compliant with the AVC and MHP per evaluation by both carriers. Ms. Lopes pointed out that after further review, it was determined not to recommend inclusion of these 2 items in the HSA compliant standardized Bronze plan and there was consideration on the potential challenges for members to understand the differential between this provision and the state legislation, particularly since the state legislation regarding copay maximums would not apply pre-deductible and have the plan still meet IRS definition for a HDHP. Ms. Lopes added that there was also a consideration of administrative complexity on the carrier side and the Insurance Department raised the potential issue of general compliance with IRS rules related to HDHPs.

Ms. Lopes said that one other element related to plan designs that was reviewed by the Committee was for the standardized stand-alone dental plan; CMS guidance has indicated that the pediatric dental maximum out-of-pocket could increase by $25 due to adjustments in the Consumer Price Index specific to dental services for Plan Year 2022. Ms. Lopes stated that, however, the Committee has not recommended any changes to the current standardized SADP required for both the Individual and SHOP markets, where the MOOP for pediatric services is $350 for one child in a family and $700 for 2 or more children.

Commissioner Gifford inquired about the difference between standardized and non-standardized plans. Ms. Lopes stated that the purpose of the standardized plans from the AHCT's

perspective is to allow for transparency for an enrollee when they are looking for a plan. Ms. Lopes stated that the cost sharing is uniform across any carrier that offers plans through the Exchange and a consumer would be able to explore other plan features such as network provider access, plan premiums and formulary among others. Ms. Lopes added that in the non-standard plans, AHCT does not dictate what the cost sharing is for those plans, however they must meet the requirements of the state and federal guidance and CID has to approve them. Ms. Rich-Bye added that diabetes caps do not go into effect until January 1, 2022.

Ms. Lopes went on to provide a preview of the HPBQ Advisory Committee recommended changes to the standardized plans for 2022. Ms. Lopes stated that each of the 4 required standardized plans in the Individual market are listed in the first column of the slide including a break-out of the Silver cost sharing reduction plans that are available in the Individual market to consumers with household income between 138% & 250% of the federal poverty level who select a Silver plan.

Ms. Lopes added that in the second column, a summary of the cost sharing changes that are an outcome of the state legislation regarding maximum cost sharing for medications and devices used to treat diabetes are provided.

Ms. Lopes described that in the last column, the cost sharing changes resulting from incorporating lab services not subject to the deductible, where it was possible to do and still maintain compliance with AVC and MHP, is outlined.

Ms. Lopes added that all the plans and variants in the first 6 rows with the lighter orange shading have the maximum cost sharing for diabetes medications and devices incorporated, and all but the Gold plan and the 94% Silver CSR plan have a recommended change to incorporate the lab services not subject to the deductible. Ms. Lopes stated that for the Gold plan, at least one of the carriers was unable to arrive at a design that would meet both AVC and MHP. Ms. Lopes indicated that in each of the other rows, the deductible for lab services was eliminated but to maintain AV compliance, the maximum out of pocket had to be increased as an offset, as well as the copay for the Silver 70%, 73% & Bronze plans.

Ms. Lopes stated that for the standardized HSA-compliant Bronze plan, based on guidance outlined by Paul Lombardo of the Insurance Department, there were two options related to the state legislation on diabetes maximum cost sharing; the Committee could recommend that the caps be included once the plan deductible was met or had the option not to include the caps under the plan at all. The Committee chose to include those maximums after the deductible was met, however, in order to do so, the MOOP needed to increase from $6900 to $7000. Ms. Lopes stated that the plan could not be revised to include lab services not subject to the deductible as this would not be compliant with the definition of a HDHP per IRS guidance.

Ms. Lopes pointed out that as mentioned earlier, the PMT currently awaits final federal guidance for the AVC and the maximum out of pocket limits and if there are changes, these scenarios would result in reconvening the HPBQ Advisory Committee to review options and determine what should be recommended to this Board, as well as presenting those recommendations at a future meeting of this Board.

Ms. Lopes expressed the appreciation for the support of both the Insurance Department and the insurance carriers during this cycle to establish the certification requirements and the standardized plan.

Adam Prizio from the OHA inquired pertaining to the bronze HSA plan which was mentioned. The two options that were put to consideration were either applying the state diabetes treatment caps, post-deductible or not applying them at all. Mr. Prizio asked if that was done to meet the AVC there or was it another reason why it was not considered to include those caps pre-deductible. Ms. Lopes answered that the IRS would not allow those caps to be included pre-deductible and in order to qualify for a HDHP and an enrollee with an HSA, the only services that can be offered though HDHP that are not subject to deductible are preventative services, including those limited services listed in the 2019 guidance.

Julie Andrews from Wakely Consulting provided an analysis of the 2022 Individual Market Standard Plan Designs. Ms. Andrews first enumerated regulation changes for 2022 that include proposed annual limitation on cost sharing that was increased to $9100. Ms. Andrews pointed out that the Federal High Deductible Health Plans minimum deductible and MOOP limits have not yet been released for 2022.

Ms. Andrews described the proposed changes to the Federal AVC for 2022 and added that the Federal AVC has not yet been finalized and changes to the final model may impact results. Ms. Andrews added that no underlying changes were made to the draft 2022 Federal AVC and existing copays maximums remain unchanged. The statutory changes for 2022 plans, that include diabetic drugs and emergency insulin, were briefly summarized.

Ms. Andrews informed the Board of the summary of the 2022 AV changes with the incorporation of the statutory changes pertaining to the diabetes legislation. Ms. Andrews described the permissible AV range for Gold, Silver, Bronze and Bronze HSA plans with the 2021 AV Final and 2022 AV-Preliminary results. Ms. Andrews went on to provide the same analysis for the CSR Variations in the Silver metal category with 73% AV CSR, 87% AV CSR and 94% AV CSR.

Ms. Andrews provided a summary of the 2022 Gold Plan AV and proposed 2022 benefit changes. Ms. Andrews noted that two changes are incorporated in this plan design for 2022 and they include $25 for each 30-day supply of a covered, prescribed, medically necessary insulin or non-

insulin drug. Also included is a $100 for 30-day supply of all covered, medically necessary diabetic devices or diabetic ketoacidosis devices.

Chair Klippel requested a motion to approve the Standard Gold Plan as the Standard Plan for the Plan Year 2022 as recommended by the Health Plan Benefits and Qualifications Advisory Committee. Motion was made by Paul Philpott and seconded by Thomas McNeill. Roll call vote was ordered. **Motion passed unanimously.**

Ms. Andrews went on to provide a summary of the 2022 Silver Plan 70% AV and indicated that the HPBQ Advisory Committee recommended 2022 Individual Standard Silver Plan Alternative 2 Option to be approved by the Board. Ms. Andrews added that changes, which include the diabetes bill caps, also include changes to the Individual Out-of-Pocket Maximum and Laboratory Services co-pay.

Chair Klippel requested a motion to approve the Individual Standard Silver Plan 70% AV Alternative 2 as the Standard Silver Plan for Plan Year 2022 as recommended by the Health Plan Benefits and Qualifications Advisory Committee. Motion was made by Paul Philpott and seconded by Thomas McNeill. Roll call vote was ordered. **Motion passed unanimously.**

Ms. Andrews informed the Board about the HPBQ Advisory Committee recommendation of pertaining to the 2022 Silver Plan 73% Cost Sharing Variations (CSR) AV. Ms. Andrews noted that the 2022 Individual Standard Silver Plan 73% AV Alternative 2 was recommended by the Committee. Ms. Andrews pointed out that similarly, to the Silver 70% AV, changes include the diabetes bill caps, also include changes to the Individual Out-of-Pocket Maximum and Laboratory Services co-pay.

Ms. Andrews told the Board that the HPBQ Advisory Committee recommended 2022 Silver Plan 87% AV Alternate 2. Ms. Andrews noted that as in all of the plans, the diabetes bill caps were included; in addition, the laboratory services co-pay was instituted at $10 not subject to the deductible.

Ms. Andrews then presented the 2022 Silver Plan 94% AV and the current plan is compliant with the AV therefore no changes were made to that plan from the prior PY.

Chair Klippel requested a motion to approve the 73% AV Alternative 2, 87% AV Alternative 1, and 94% Silver CSR Plan Variants as the Standard Plans for Plan Year 2022 as recommended by the Health Plan Benefits and Qualifications Advisory Committee. Motion was made by Paul Philpott and seconded by Thomas McNeill. Roll call vote was ordered. **Motion passed unanimously**.

Ms. Andrews then followed with the review of the Bronze Non-HSA Plan offered through AHCT. Ms. Andrews noted that the HPBQ Advisory Committee recommended Alternative Option 2 to

be approved by the Board. Ms. Andrews added that the major difference between this option and others being considered includes a change to the Laboratory Services co-payment of $20 which is not subject to a deductible as compared to PY 2021 when the $10 copayment was subject to a deductible. Ms. Andrews added that the Out-of-pocket maximum will increase from $8550 to $8800.

Chair Klippel requested a motion to approve the Bronze Non-HSA Plan Alternative 2 as the Standard Bronze Non-HSA Plan for Plan Year 2022 as recommended by the Health Plan Benefits and Qualifications Advisory Committee. Motion was made by Paul Philpott and seconded by Thomas McNeill. Roll call vote was ordered. **Motion passed unanimously.**

Ms. Andrews provided information on the HPBQ Advisory Committee recommendation on the Bronze HSA Plan AV. Ms. Andrews noted that several plan modifications were considered for incorporating statutory diabetic services changes in the Bronze HSA plan pursuant to IRS Guidance. Ms. Andrews noted that ensuring continued HSA/HDHP tax advantaged plan compliance was a primary consideration. Ms. Andrews indicated that the HPBQ Advisory Committee recommended Option 1 which incorporated the cost-sharing maximums after the deductible for the diabetic drugs and supplies applying the guidance from CID on the applicability of the device co-payment maximum over a 30-day period.

Chair Klippel requested a motion approve the Bronze HSA Plan Option 1 as the Standard HSA Bronze Plan for Plan Year 2022 as recommended by the Health Plan Benefits and Qualifications Advisory Committee. Motion was made by Paul Philpott and seconded by Thomas McNeill. Roll call vote was ordered. **Motion passed unanimously.**

Chair Klippel praised the work of the Health Plan Benefits and Qualifications Advisory Committee and their plan recommendations.

H. American Rescue Plan Update

Susan Rich-Bye, Director of Legal and Governmental Affairs, and Robert Blundo, Director of Technical Operations and Analytics provided the American Rescue Plan Update. Ms. Rich-Bye provided information on the Advanced Premium Tax Credits (APTCs), their structure as well as eligibility for individual and families. Ms. Rich-Bye stressed that to qualify for APTCs, a consumer must enroll in coverage through AHCT, cannot be eligible for other affordable coverage through their employer or government program and must be a Connecticut citizen, or lawful resident of the United States and cannot be serving in a penitentiary institution.

Ms. Rich-Bye described changes impacting Connecticut's individual market that are a result of ARP. Ms. Rich-Bye emphasized that the ARP increases Financial Assistance (FA) at and below 400 percent of the Federal Poverty Level (FPL); in addition, it removes the 400 percent FPL subsidy

cliff. Ms. Rich-Bye added that ARP expands eligibility for people receiving Unemployment Insurance as well as it provides 100 percent premium payment for those with COBRA coverage from April 1, 2021 and September 30, 2021.

Ms. Rich-Bye provided an analysis of the required individual contribution rates prior to ARP and post-ARP and added that individuals who earn over 400 percent of FPL will be eligible for premium assistance for the first time since the Affordable Care Act was enacted and will only be responsible to contribute 8.5 percent of their income towards their premiums, and these changes are in effect for 2021 and 2022. Ms. Rich-Bye noted that for 2020, any excess premium tax credits that the consumers receive will not have to pay that back to the IRS.

Mr. Blundo provided theoretical examples of how the ARP impacts monthly premiums for Connecticut residents. Mr. Blundo noted that many factors are involved in terms of determining the actual premiums and expected monthly savings; they include elements such as household size, age, income, FPL percentage and the plan consumers end up selecting. Mr. Blundo emphasized that the largest expected savings would be for individuals with annual income just above 400% of the FPL. Mr. Blundo provided an example of a four-person family, ages 62, 63, 20 and 18; their income is $107,000, which is 408 percent of the FPL. Mr. Blundo stated that they are enrolled in the Bronze plan and prior to ARP, they did not receive any APTCs and their pre-ARP premium was $3,323. Mr. Blundo stated that because of the ARP implementation, their monthly net-premium will be $8, with the expected monthly savings of $3,315.

Mr. Blundo went on to provide an in-depth analysis of the estimated ARP Marketplace impact. Mr. Blundo's analysis was on a more conservative side; expanded subsidy for people receiving unemployment insurance was not considered and new on-exchange enrollment spurred by increased Financial Assistance (FA) was also not taken into account. Mr. Blundo noted that while those figures will fluctuate, approximately 16,700 households will not see additional savings since they already pay $0 in Essential Health Benefits (EHB) premium.

Mr. Blundo added that about 6,000 households will see over $200 savings per month in their current plan and 34,000 households will be enrolled in a $0 EHB premium plan, which is up 16,000 before ARP. Mr. Blundo emphasized that based on the analysis, an additional $7.1 million of extra premium tax credits dollars will be applied to the Connecticut marketplace, with a total annual savings of over $85 million making medical insurance more affordable. Mr. Blundo added that currently, over 10,000 individuals do to request FA when enrolling in the health insurance plan through AHCT; the organization has an outreach strategy to those consumers with the aim of informing them that FA is available to them through ARP.

Mr. Blundo added that close to 30 percent of currently enrolled households will not observe any savings while less than 1 percent of enrolled households will have savings in excess of $1,500 a

month. Mr. Blundo outlined key dates that are critical to the proper implementation of ARP on the Exchange.

Matthew Brokman inquired about the expected number of additional enrollees for the Special Enrollment Period commencing in May. Mr. Blundo stated that it is difficult to project. Other state-based marketplaces and the Federally Facilitated Marketplace (FFM) are being monitored for their enrollment numbers as well. Mr. Blundo added that based on the Census data, the number of uninsured individuals in Connecticut is about 200,000 and there are about 10,000 enrollees off-Exchange. Substantial volume increases are expected with the estimates ranging from 10 percent to 20 percent of the uninsured population acquiring medical insurance coverage through AHCT.

Mr. Philpott commented that changes that the ARP will bring to the Exchange impact consumers who for many years have been left out of any kind of FA even though their income was not significantly higher from those consumers who were receiving FA. Mr. Philpott inquired whether AHCT will be performing specific outreach to this cohort. Mr. Blundo stated that it is the case, and AHCT will be focusing on eight specific target groups in its outreach efforts.

Victoria Veltri inquired about shopping for existing customers between carriers in case they may obtain less expensive coverage. Mr. Michel pointed out that AHCT considered that option. Mr. Michel added that if a consumer is under 400 percent of the FPL, it would be allowed to shop and change plans within the same carrier. Mr. Michel pointed out that if a consumer's income is above 400 percent of the FPL, on or off-Exchange, consumers will be able to shop and compare any plans from any carrier since they will be the first time FA recipients. Ms. Veltri followed-up with an inquiry about the issue preventing individuals who are below 400 percent FPL to shop between the carriers. Mr. Michel emphasized that AHCT is trying to minimize the impact to both, consumers and the carriers. Ms. Rich-Bye added that being mindful of any accumulators that they may already have, consumers also need to consider the plan network and the prescription drug formulary. Mr. Michel added that the carriers were in approval of this notion, but the issue of minimizing the confusion for the consumers was the main driving factor.

I. Legal Update

Susan Rich-Bye, Director of Legal and Governmental Affairs, presented the Legal Update. Ms. Rich-Bye noted that AHCT presents legal updates at the Board meetings on any possible legal changes that may impact the marketplace in Connecticut. Ms. Rich-Bye enumerated various legal topics, including the *California, v Texas* Supreme Court case and ACA litigation matters on various topics, including the public charge.

Ms. Rich-Bye noted that depending on appeals before several appellate courts, at this point, the Court order is in place based on the Seventh Circuit decision, and this means that

everything will revert back to the 1999 interim field guidance on public charge and not the changes that had come into place during the Trump Administration.

Ms. Rich-Bye stated that for *California v Texas*, AHCT is still waiting for the Court's decision. Ms. Rich-Bye added that the Biden Administration in February informed the Court that it was changing its position from that of the prior Administration emphasizing that that the mandate is constitutional and even if it is found to be unconstitutional, that it indeed is severable.

Ms. Rich-Bye stated that for some of the ACA litigation matters that AHCT followed over the last years, the Department of Justice asked various courts to put many of these cases on hold to allow time to consult with new agency leadership. Ms. Rich-Bye stated that the cases are on hold and the parties file regular status reports, including cases on association health plans, the double billing rule for abortion coverage, provider conscience rules as well as Section 1557 of the ACA the non-discrimination provisions. Ms. Rich-Bye added that they also include the contraceptive mandate, the approval of the Georgia 1332 waiver and the data marketing partnership arrangement with the Department of Labor that was discussed last fall. Ms. Rich-Bye stated that those legal matters are all currently on hold.

Ms. Rich-Bye briefly discussed the Notice of Benefit and Payment Parameters for PY 2022. Ms. Rich-Bye noted that AHCT is waiting for certain provisions to be finalized and noted that one of those that concerns the plans is the Maximum Out of Pocket and noted that CMS issued the Partial Final Rule in January. Ms. Rich-Bye stated that the rule includes the following: reducing user fees for FFM, changes for acceptance of premium payments for HRAs, network adequacy standards for certain QHPs, new direct enrollment options as well as changes related to Section 1332 State Innovation Waivers.

J. Future Agenda Items

Mr. Michel enumerated future agenda items. They include:
- Subsidiary
- Health Disparities
- Strategic Initiatives
- 2020 Annual Financial and Programmatic Audits, Fiscal Year 2018 and 2019 State Audit, and State-Based Marketplace Annual Reporting Tool (SMART)

Deidre Gifford commented that as a supporter of the Exchange and a person who is trying to advocate for more coverage under the Exchange, she continues to struggle a bit to explain ARP to the stakeholders. Ms. Gifford added that with ARP and trying to get people to support the Exchange as a viable alternative for moderately low-income individuals, a simple explainer about the functions would be helpful. Ms. Gifford added that in this way, DSS and other state entities would be doing a better job as ambassadors and advocates of AHCT. Mr. Michel answered that such a document is in the works and will be distributed to the Board soon.

Commissioner Deidre Gifford let at 11:00 a.m.

Chair Klippel noted that he understands the Commissioner's concern and added once the system that incorporates the ARP is operational, a communication strategy to the public will follow. Mr. Klippel added that it is imperative to communicate additional FA available through AHCT due to the ARP implementation to the public.

Cecelia Woods welcomed Mr. Klippel as a Chair of the Board and added that it is one of the most rewarding and challenging endeavors that one can experience. Ms. Woods added that AHCT's CEO and the staff are very responsive, and the Board is very collaborative. Mr. Klippel stated that AHCT is a great organization and praised its work, along with his predecessors who served as Chairs of the Board.

K. Adjournment

Chair Charles Klippel requested a motion to adjourn. Motion as made by Paul Philpott and seconded by Victoria Veltri. Roll call vote was ordered. Motion passed unanimously. **Meeting adjourned at 11:03 a.m.**