

MINUTES
Eastern Connecticut Health and Medical Cooperative
Board Meeting – April 18, 2024
2:00 - 3:30 pm

Members Present (in-person): Jeff Wihbey, Ben Whittaker, Kate Ericson, Mike Belden, Ian Neviaser, Holly McCalla, Christa Bauchman, Pamela Listorti, Kristina Martineau, John Hall, William Merrill, Troy Hopkins.

Members Present (via zoom): No Members

Others present (in-person): Thomas Kowalchik (USI), Lynn Iannuzzi-DiBene (USI), Joanne Lund.

Others present (via zoom): Salvatore Menzo, Superintendent Goodwin Schools.

Meeting called to order at 2:01 PM

Standing Agenda Items: Discussion and Possible Action

1. Approve minutes of March 28, 2024:

*Motion to approve March 28, 2024, meeting minutes made by Kristina M., seconded by John H.
Approved Unanimously.*

2. Financial Status Update

- a. Joanne Lund presented the March financial activity. The March net position of \$3.39M decreased \$250K for the month due to excess claims over revenues. Large claims over \$50K = 87; and large claims over the stop loss of \$150k= 32. YTD claims over revenues = \$2,098K. See financial reports for further details.

3. Marketing – new members:

- a. Ian N. and Tom K. provided updates with various communication: Spoke to East Haddam but we have not received any commitment yet as Anthem was late in getting East Haddam requested information; NFA – requested information from NFA with no response at this time; Norwich is still expressing an interest in the ECHMC.

4. Communication

- a. Received a request and sent the 6/28/23 minutes to the RSD # 17 Board of Education.

5. Reserve Fund Policy:

- a. The reserve fund policy was briefly discussed. A copy of the Policy is attached. As the ECHMC has grown from 742 members in FY 22/23 to 1,167 members in FY 23/24, a review of the policy will be discussed at a future meeting.

6. Update from Vendors/Anthem Update

- a. Tom K recommended that the vote on Term Life insurance be moved to the May meeting.

- b. Tom K. provided a summary of the claims analysis and stated that most of the claim exposure has continued to be driven by large claimants. Tom discussed the preliminary rate discussions and emphasized these results are one month in arrears. After reviewing all the data in detail, preliminary results show a projected percentage increase based on a rolling twelve-month cycle of approximately 8% -9%. Each member of the ECHMC can use this preliminary rate to assist with their own budget for the FY 24-25. Each \$290,000 in claims is approximately a 1.0% change.

Vote on FY 24-25 insurance rates:

Discussion concerning rate increases for next fiscal year.

Motion made by Holly M. to increase the Medical and Dental allocation rates for FY 2024-2025 by 8.0%. Motion seconded by Pam L.

Vote: 10 Approve; 1 Against, 1 abstention

- c. Lynn Iannuzzi-DiBene provided an update on the Medical Plan changes (see the attached Anthem documents for additional detail).

Medical Plan Changes

Item # 1: Increase to Deductible as a result of IRS Limit

Each member is already at or above the \$1,600 Single / \$3,200 Family limits.

Item # 2: Human Organ and Tissue Transplant

Motion made by Holly M. to not accept this change; seconded by Mike B.; Vote:

Unanimous

Item # 3: Virtual Visits for Primary Care and Behavior Health Services

Motion to keep medical plan as is made by Pam L. and seconded by Jeff W. Motion approved Unanimously.

Item # 4: Pharmacy Changes / Carelon Rx

No Vote was needed. CarelonRx Pharmacy will become the exclusive home delivery provider for all members in 2024.

Item # 5: Wellbeing Solutions Changes – ASO Enhanced and Anthem Health Guide.

No vote needed. See Detail on Anthem pages attached.

Legislative Updates:

HB6941: See Attached Detail

Motion to Not accept Section 231 of this bill made by Kate E.; seconded by Mike B., Motion passed Unanimously.

Motion to Not accept Sections 235 and 236 (step therapy) made by Holly M.; seconded by Kate E.; Motion approved unanimously.

Motion to accept this bill as it relates to schizophrenia, major depressive disorder, or bipolar disorder made by Kristina M, seconded by Christa B.

Motion passes: 11 for; 1 against.

Motion to accept sections 233 and 234 (see detail attached) made by Holly M, seconded by Kate E.; motion approved unanimously.

HB 1039: See Attached Detail

Sections 11 and 12 of this bill update the requirements regarding the diagnosis and treatment of infertility.

Motion to reject this made by Holly M., seconded by Ben W.; Motion passes: 11 for; 1 against.

HB 1075: See Attached Detail

An act concerning Hospice and Palliative Care

Motion to accept this (we are already currently doing this) made by Holly M; seconded by Kate E.; motion approved unanimously.

7. Old Business:

a. Bylaw rate adjustment review – Article 9.1.5

The subcommittee distributed the recommended new by-laws language for the allocation rate adjustment process (see attached).

Motion made by Mike B. to accept the by-law as stated in Article 9.1.5; seconded by Holly M.; Motion passes: 11 for; 1 against.

8. New Business - Agenda Setting for May 23, 2024 meeting:

a. Term Life Insurance Vote – Presented by Tom K.

b. Tom K. to provide new allocation rates for all members

c. Add a subcommittee to the marketing section to discuss the profile of a new member and the process for being accepted as a new member of the ECHMC group (summer work).

Motion to adjourn meeting made by Kate E. seconded by Holly M., motion passes unanimously. Meeting adjourned at 3:25pm. Unanimously approved.

Next Meeting – March 28, 2024, at 2:00 PM.

Zoom information will be provided in a calendar invite if needed.

Respectfully Submitted,
Mike Belden



Article

9.

9. Payment and Collection of Monthly Premiums.

9.1. Payment of Monthly Premiums

9.1.1. The Directors shall determine the monthly premium to be paid by each Member.

9.1.2. Each Member shall make prompt monthly payments to the Cooperative in such premium amount and under such terms as specified by the Directors.

9.1.3. Monthly premiums shall be paid by each Member to such depository or depositories and in the manner specified by the Directors.

9.1.4. In setting the premium rate for each Member, the Directors shall use their discretion consistent with the law, these Bylaws, and the Cooperative's policies, based upon the relevant information available to them.

9.1.5. Consistent with this discretion as set forth in Section 9.1.4, above, a Member may be eligible for a one-time rate adjustment. In order for any such Member to be eligible for such an adjustment, the Cooperative's reserve fund balance must be at least seventy five percent (75%) of the reserve fund goal, consistent with these Bylaws and the Cooperative's policies. In order to be eligible for such an adjustment, a Member a) must have been a member of the Cooperative for a minimum of three full years prior to the request for a rate adjustment, b) must submit a request for such a rate adjustment on or before December 31st, with such an adjustment to be in effect for the year commencing on July 1st of the succeeding fiscal year, and c) must offer to its employees an insurance plan design that is comparable to at least one current member of the Cooperative. The decision to grant or deny a request for a such a rate adjustment, along with the amount of such an adjustment (and the application of the above listed criteria) shall be within the sole discretion of the Directors. If a Member is granted such a one-time rate adjustment, it will not again be eligible for a rate adjustment during the course of its participation and membership in the Cooperative.

9.1.6. If a rate adjustment for any member is approved in accordance with Section 9.1.5, above, the Directors shall then determine the allocation/renewal rates for all of the remaining Members, consistent with Section 9.1.4, above and in light of said rate adjustment amount (and any information acquired during the process of approving the same).

9.2. Collection of Monthly Premiums.

9.2.1. The payment of the premium by each Member shall be made by the 20th day of the month or at such other times as the Directors shall specify.

9.2.2. A Member that does not timely pay the monthly premium as provided in this Article 9, may be charged a penalty of ten (10%) percent of the outstanding monthly premium, prorated on a daily basis until the required payment is made,

as determined by the Directors.

- 9.2.3. In the event the Member has made the required payment in a timely manner as provided in this Article 9 for three (3) consecutive months, it will not be penalized for the first month that the required payment is not made in a timely manner. However, in the event that the Member does not make required payments in a timely manner as provided in this Article 9 for a second time in the next three (3) months, it may be charged the penalty provided in this subsection.
- 9.2.4. The Directors shall take such steps, including but not limited to the institution and prosecution of, or the intervention in, such legal or administrative proceedings as the Directors determine to be in the best interest of the Cooperative for the purpose of collecting any amounts owed to the Cooperative.

Large Group Benefit Changes for Connecticut

For ASO Public Sector Groups with 100+ contracts. Effective at renewal on or after January 1, 2024.

Thank you once again for offering your employees Anthem Blue Cross Blue Shield health care coverage. We would like to take this opportunity to let you know about some important changes affecting your plan(s).

Changes are effective upon your 2024 renewal date (unless otherwise noted). Ask your Sales Representative for full details on these features.

Medical Plan Changes

Medical Benefits	Product Type	2023 Benefit	2024 Renewing Benefit
Increase to deductible as a result of IRS limit increases	HSA Plans	Non-embedded HSAs: Deductible: \$1,500 Single/\$3,000 Family Embedded HSAs: Deductible \$3,000 Single/\$6,000 Family	Non-Embedded HSAs: Deductible increased to \$1,600 Single/\$3,200 Family Embedded HSAs: Deductible increased to \$3,200 Single/\$6,400 Family- Only applicable to Old Saybrook
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell / Cord Blood) Services, Cellular and Gene Therapy Services	All Plans	\$10,000 per Covered Procedure	\$10,000 per Benefit Period Leaving as is as per covered procedure is better
Virtual Visits for Primary Care and Behavioral Health Services from our	Various HMO & PPO Plans	Copay [\$] Deductible then Copay [\$] Deductible then Coinsurance [%]	Copay \$0 Deductible then Copay \$0 Deductible then Coinsurance 0%-keep as is for Old Say Brook and RSD#17

[anthem.com](https://www.anthem.com)

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Virtual Care-Only Providers			
-----------------------------	--	--	--

Pharmacy Changes

Program Name/Benefit	2023 Benefit	2024 Renewing Benefit
CarelonRx Pharmacy	Anthem Home Delivery Pharmacy	CarelonRx Pharmacy will become the exclusive home delivery provider for all members in 2024. -have to take

Wellbeing Solutions Changes

Program Name	2023 Benefit	2024 Renewing Benefit
ASO Enhanced + Anthem Health Guide	<p>10 AIM Clinical Review Programs</p> <p>Clinical Review Reminder: AIM has moved to Claim-Based costs for ASO</p>	<p>NEW</p> <ul style="list-style-type: none"> • My Health Check In (health assessment) – Retiring WebMD • Behavioral Health Advantage – includes increased access to address top BH concerns <p>Enhanced</p> <ul style="list-style-type: none"> • Medical Case Management - <u>Cancer Care Navigator (CCN)</u> offers disease centered care, increases access, reduces unnecessary utilization and improves outcomes • Will be included automatically

Legislative Updates

Connecticut's legislative session took place in early 2023. There is some legislation that could impact groups at their renewal effective January 1, 2024.

HB 6941 AN ACT CONCERNING THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2025, AND MAKING APPROPRIATIONS THEREFOR, AND PROVISIONS RELATED TO REVENUE AND OTHER ITEMS IMPLEMENTING THE STATE BUDGET.

There are many components within the State budget bill. Several sections include mandates related to health insurance benefit coverage. They are as follows:

- Section 231 prohibits health carriers from requiring prospective or concurrent reviews of a recurring drug being used to treat any autoimmune disorder, multiple sclerosis or cancer after the carrier has certified use of the drug through utilization review. This does not mean that a carrier is prohibited from excluding a prescription drug from the policy's covered benefits (i.e. formulary updates as applicable) or requiring use of a generic drug when one is available. Carriers are also not required to cover a prescription drug that was approved by a previous Carrier's plan. Not accepted-Keep as is for safety and cost control
- Sections 235 and 236 amend the requirements regarding step therapy. The updates reduce the amount of time a member is required to use step therapy for applicable prescription drugs from sixty to thirty days. Not Accept as Carelon does not apply day limits
- The bill also prohibits prescription drug step therapy from being applied between January 1, 2024 and January 1, 2027 when the condition being treated is schizophrenia, major depressive disorder, or bipolar disorder. Accept as these are serious conditions
- Sections 233 and 234 extend the time frame a member has to notify the insurance carrier of a member's newborn child and to add that child to the plan. Previously a member had to add the child within sixty-one days after birth. That time period has been extended to ninety-one days after birth. This also extend the time period that an insurer must cover the newborn, even if they are never added to the policy, from sixty-one days to ninety-one days. Accept

SB1039 AN ACT CONCERNING THE INSURANCE DEPARTMENT'S RECOMMENDATIONS REGARDING FINANCIAL REGULATION, LIFE INSURANCE AND INSURANCE LICENSING REQUIREMENTS AND TECHNICAL CORRECTIONS AND REVISIONS TO THE LIFE AND HEALTH INSURANCE STATUTES.

There are many components contained within this bill, but related to health insurance benefit coverage are sections 11 and 12 that revise current mandated coverage for infertility services.

- Sections 11 and 12 of this bill update the requirements regarding the diagnosis and treatment of infertility. The bill removes infertility diagnosis and treatment limits based on age, and also prohibits an insurer from requiring the person to have been active on the policy a minimum of 12 months before services for infertility diagnosis and treatment are covered. Effective 1/1/24 carriers are prohibited from discriminating against an individual seeking services for medically necessary diagnosis and treatment for infertility based on the person's gender identity or expression, sexual orientation, or age. However age can be considered a basis of medical necessity regarding infertility based on the professional guidelines

published by the American Society for Reproductive Medicine, its successor organization, or a comparable organization. Not accept currently have the federal mandate

SB1075 AN ACT CONCERNING HOSPICE AND PALLIATIVE CARE

This bill requires insurance policies to cover in-home hospice services provided by a hospice care program licensed by the Department of Public Health to the same extent they cover in-patient hospice services in a hospital. There are no prohibitions on an insurer conducting utilization review for in-home hospice, provided the utilization review is conducted in the same manner and uses the same criteria used for the same hospice services provided in a hospital. Not accept already in place

INFORMATIONAL ONLY:

HB 6669 AN ACT PROTECTING PATIENTS AND PROHIBITING UNNECESSARY HEALTH CARE COSTS.

The section applicable to health insurance benefit coverage is related to the electronic distribution of documents pertaining to coverage. Anthem will apply this mandate to all fully and self-insured members as appropriate to state and federal law; this includes electronic receipt of the Explanation of Benefits.

Section 21 of this bill requires insurers to allow any member who is covered under the policy and is legally capable of consenting to the provision of covered benefits under the policy, to specify in writing, that the insurer make all documents pertaining to coverage available by electronic means, as long as the electronic documentation meets all federal and state laws and regulations related to data security.

This summary is for notification of benefit modifications. All product offerings are subject to regulatory review and approval and therefore subject to change. We have also updated your plan benefits to reflect recent changes in applicable law. For more information, contact your broker or account representative.

Note: This benefit overview is for illustrative purposes and some content may be pending CT Insurance Department (CID) approval.



It is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract/Benefit Booklet and this description, the terms of the Group Contract/Benefit Booklet will prevail.

Eastern Connecticut Health and Medical Cooperative (ECHMC) Reserve Fund Balance Policy

Introduction

The purpose of this document is to establish a target range for the Eastern Connecticut Health and Medical Cooperative (ECHMC) reserve fund balance based on the year-end financial report. This policy is intended to assist the ECHMC in maintaining an adequate level of a reserve fund balance to mitigate current and future risks (e.g., unexpected high claim volumes, member departures) and to ensure stable medical and dental Insurance premium rates for the members. The ECHMC reserve fund balance has been accumulated to meet this purpose, to provide stability and flexibility to respond to unexpected adversity and/or opportunities.

Policy

ECHMC shall monitor the level of the net position balance and determine strategies to maintain a balance that is within the range recommended by the active voting members of the ECHMC. The total reserve fund goal is comprised of two parts, the reserve fund goal and the maximum exposure goal. Reserve funds are used for many purposes including, but not limited to, insurance claims, fees, marketing, or related expenditures incurred by the ECHMC. The reserve fund goal shall be set at 20% of the annual projected claims. The maximum exposure amount is determined by the insurance broker for the ECHMC and/or the insurance carrier for ECHMC utilizing an annual analysis of the service providers aggregate claim amounts.

The fund reserve goal amount plus the maximum exposure amount is the amount that is used to determine the ECHMC's goal for the total reserve amount. This figure represents an estimation of the ECHMC's total claim exposure liability. The ECHMC will maintain the total reserve fund at a range of 70% - 150% of this amount. The total fund balance reserve figure may change based on membership additions and withdrawals.

(Example: if the reserve goal is \$2.64 million (20% of projected annual claims of \$13.2 million) and the maximum exposure amount is \$2.64 million, the total reserve will be \$5.28 Million. The acceptable range is a minimum of 70% of the goal and a maximum of 150% of the goal or \$3.70 million to 7.92 million).

The current net position as of the end of each fiscal year must be reviewed by the voting members of the ECHMC. The reserve goal plus the maximum exposure amount will also be calculated at each year end. The ECHMC must have a standing agenda item for each monthly meeting to discuss this balance. During such discussions a sufficient range in excess reserves will be set and maintained for the following year. If the reserve fund balance is either lower or higher than this range, strategies will be put in place to reach the desired range.

Procedures:

Each year, the reserve balance will be reviewed and discussed prior to setting the allocation rates for the following year.

Fiscal activities for the prior three (3) years will be reviewed and discussed prior to determining new allocation rates.

Surplus:

If it is determined that the total reserve fund balance is in excess of the desired goal (an amount in excess of the upper limit of the total reserve fund balance range); the following strategies will occur:

At the next annual allocation rate setting meeting, a minimum 5% allocation rate reduction will be made. Additional changes to the allocation rate may be considered using information including, but not limited to, detailed claim data, overall insurance market trends, and any carrier update information.

The ECHMC may vote to designate a specific amount of funds from the total reserve fund to cover for the following purposes:

- Fund unforeseen expenditure (e.g. legal costs) or unanticipated revenue fluctuations.

- Reduce or avoid unreserved fund balances by any member of the ECHMC. If there is a negative reserve fund balance in any member district position, the ECHMC may elect to use reserve fund balance funds to allow a member district to borrow from this fund balance to temporarily reduce the negative balance. A separate agreement will be made with any member district approved by the ECHMC.

Shortfall:

If it is determined there is a shortfall (an amount below the lower limit of the total reserve fund balance range), the fund balance is to be rebuilt through an appropriation and/or a minimum increase in allocation rates of 3.0% during the next annual allocation rate vote. In addition to this increase, the ECHMC's insurance broker will provide the ECHMC with a detailed analysis of the claims history so the ECHMC has additional data to set the new allocation rates for the following fiscal year.

If this is financially infeasible, a written plan shall be adopted by the ECHMC to restore the reserve fund balance to an amount within the range. Such plan must include a timeline to address the shortfall of no more than five (5) years from date of initial plan.

This plan may require a review of the benefit plan designs, increases in allocation rates, fees, or some combination thereof.

DEFINITIONS

- **Reserve Fund Balance**
 - Total ECHMC fund assets minus total ECHMC fund liabilities
- **Net Position:**
 - Total revenue received from all Members of the ECHMC minus total claims paid from all members.
- **Change in Net Position:**
 - Premiums paid less health insurance claims = operating gain/Loss plus rebates less administrative costs
- **Reserve Goal:**
 - This is the net position the ECHMC has agreed to as a reserve goal. This amount is determined as a percentage of projected annual claims plus an amount determined for maximum exposure risk..
- **Reserve Goal plus Maximum Exposure**
 - This represents a goal for the ECHMC to maintain in reserves to cover claims.
- **Projected Annual Claims**
 - The anticipated cost of total claims for the year.
- **Maximum Exposure**
 - 125% of the carrier's expected claims and total fixed costs plus any laser liability if applicable.
- **Year To date Income**
 - The amount members have paid in premium to the ECHMC year to date.
- **Claims**
 - This represents the total medical and dental claims submitted by the members insured in the ECHMC.
- **Large Claims**
 - Claims for each insured over \$50,000.
- **Stop Loss**
 - The maximum amount of claims paid by the ECHMC for any individual insured claim in a single year is \$150,000. All claim expenses over \$150,000 are covered by the carrier.
- **Operating Revenues**
 - This is the Premiums paid into the plan by each member of the ECHMC including employee and employer contributions.
- **Operating Expenses**
 - The medical and dental claims (expenses) paid by each member of the ECHMC.

- **-Fiscal Agent**
 - The entity contracted by the ECHMC to provide financial services including, but not limited to, financial statement preparation, collection of all premiums, reconciliation of all claim activity, wiring of money to/from bank(s), bank reconciliations, tallying census activity for each group, and email correspondence to member districts/towns.
- **Surplus / (Deficit)**
 - Premiums collected less claims paid.
- **Claims Payable - Incurred But Not Reported (IBNR)**
 - Incurred but not reported (IBNR) is a type of reserve account used in the insurance industry as the provision for claims and/or events that have transpired, but have not yet been reported to the carrier.