MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION
Minutes of the Board of Directors
November 19, 2018

A work session of the Board of Directors of the Maine Guaranteed Access Reinsurance Association ("MGARA" or the "Association") was held via teleconference at 3:00 p.m. Attendance is reflected in the record of attendance set forth below:

Jennifer Juke	Edward J. Kane
Katherine Pelletreau	David Howes
William M. Whitmore	Jolan F. Ippolito, Chair
Joel Allumbaugh (joined late)	Dana Kempton (absent)
Kevin Lewis	James Koelbl (absent)
Bruce Nicholson	Jim Lyon (joined late)

Also in attendance were Chris Howard and Emily Cooke of Pierce Atwood LLP, counsel to the Association, and Laren Walker, Administrator.

The purpose of the work session was to review and discuss the most recent round of revisions to MGARA's draft Amended and Restated Plan of Operation (the "Plan"), which incorporated comments received from Maine Association of Health Plans (Katherine Pelletreau) and Community Health Options (Kevin Lewis). Those comments are summarized in the matrix attached as Exhibit A hereto, which also reflects the Board's ultimate conclusion on the various items following discussion at the work session.

The Board discussion focused on the four areas of input that had not been fully accommodated in the revised Plan, as summarized below.

1) *Voluntary ceding window: 90 versus requested 120 days*

   The Board discussed the advantages and disadvantages of a shorter versus longer window – namely, balancing a reasonable amount of data on which to make voluntary ceding determinations versus risk to MGARA's financial model. It was acknowledged that the Board had previously concluded that a 90-day window was appropriate. There was a general consensus that in no event should the window be longer than 120 days, but varying views as to where to set the outside date. Following further discussion, it was agreed to extend the window to 120 days.

2) *ICD-10 codes*

   Commenters had recommended using a more limited or scrubbed list of ICD-10 codes as the basis for mandatory ceding, as further set forth in the attached matrix. Mr. Howard stated that no responsive change had been made to this provision, out of concern for the integrity of the program's underlying actuarial analysis, which was based on the ICD-10 codes without any further scrubbing or filtering. A

discussion ensued. Some participants raised the concern that use of the ICD-10 codes would cast too broad a net, identifying too many policies for mandatory ceding. Others opined that the ICD-9 codes that formed the basis for mandatory ceding under the original (pre-suspension) program would have had the same effect. Ultimately, the ICD-10 codes remained in the Plan without change.

3) *Mandatory review of preceding year's codes and national drug codes*

Following a lengthy discussion as to whether the proposed obligation to review the preceding year's ICD codes and national drug codes would have a disparate impact on some carriers versus others, in which participants expressed diverse views, a general consensus was reached to remove this proposed requirement to avoid the risk of a potential disparate impact.

4) *Authorization to inspect*

With respect to the provisions of Sec. 9.10(f) of the Plan relating to MGARA's ability to inspect Member Insurer records, Mr. Walker offered further context for the provision, noting in particular that it is principally required to facilitate third-party audits. No further comments were offered by participants.

As a next step, it was agreed that those with specific additional comments should provide them to Mr. Howard, with a goal of holding a vote on the draft Plan at the next scheduled Board meeting on November 26.

There being no further business to come before the Board, the meeting was adjourned.

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Duly Authorized Officer

Exhibit A

Matrix of Comments and Outcomes

Matrix for Board Discussion
Of
Comments from MeAHP and CHO on Draft MGARA Plan of Operations

Board Approved 11/26/18

Comment Received	Plan Section	Recommendation	Board Decision
Voluntary ceding window – more time needed to make voluntary ceding decisions. Requesting 120 days.	9.4(a)	Board decided 90 days at its 11/5/18 meeting. Note concept of "Designation Eligibility Date" was added to extend ceding window to policy inception in ACA environment	Ceding window enlarged to 120 days
MCS Enrollment Reconciliation Process – the Plan should allow for a "true-up" on premium to account for APTC adjustments.	9.5	New Section 9.5(viii) added to provide for a true-up to actual APTC and premium received for APTC-eligible members.	Approved Recommendation
Regarding the move from ICD-9 to ICD-10 codes, there are many more codes because ICD-10 accounts for "intensity" and includes codes for billable treatments and for remission for example. Moreover, preliminary analysis from at least one Plan suggests there are many codes on MGARA's current list that will not	4.1 and 9.4	The actuarial analysis underlying MGARA's financial model is based on the conditions listed in the ICD-10 Mapping provided by Milliman. Deviating from including those conditions could seriously undermine the MGARA financial model. From inception MGARA's plan	Approved Recommendation

result in the claims threshold for reimbursement being reached. Carriers will be forced to pay premium for policies that will not trigger payments from MGARA. We suggest that the selected ICD-10 codes be more carefully "scrubbed" and analyzed to better understand these issues and potentially change the list.		recognizes that there will be ceded policies that will not result ion claims. The Mandatory Ceding Conditions were originally designed to balance this effect. Recommend no change All ICD-10 subcodes will be included in the crosswalk.	
The current Operations Plan requires carriers to review the immediately preceding year's ICD-10 codes and NDC. This approach disadvantages carriers who sold on-Exchange last year and have that information. Plans that were not offered on the Exchange last year do not have the preceding year's information and therefore are not required to review it.	10.2(b)	The reason for this review is the experience in Idaho with late ceding of a very high volume of policies. Without at least using this available information, late ceding and retroactive premium and claims adjustments are highly burdensome. Regarding disparate impact on incumbent carriers – each carrier is required to perform this review to the extent the information is available. New market entrants are required to perform the review, but will likely have limited if any relevant information. However, after year 1, this disparate impact begins to quickly equalize. One might argue there are advantages and disadvantages to being the incumbent.	Deleted prior year review requirement due to disparate impact on incumbent carriers
Section 9.4(b)-Delete	9.4(b)	Change made in previous	Approved

reference to HealthInfoNet		version of Plan	Recommendation
Prevention of cross-walking members to substitute policies or policy numbers	9.4(i)	New subsection 9.4(i)(v) has been added addressing this concern. It prohibits any fraudulent, intentional or programmatic avoidance of the effect out the Freeze Out Period rules, an strengthens enforcement.	Approved Recommendation
Proration of Premium	9.5(d)(3)	Plan revised to provide that with respect to the initial and final calendar month of a policy's effectiveness, the premium shall be pro rated for any partial month based on the underlying Health Plan premium.	Approved Recommendation
Assurance that Deficit Assessments be prospective only	6.3	Section amended to reference Section 3957(5) of the Enabling Act.	Approved Recommendation
Section 9.4(c) and 10. 2- For Mandatory Ceding it references "history of." How should members who have gone into remission be handled?		We have added a provision to each of Section 9.4(c) and 10.2(b) - In the event a Covered Person's medical history demonstrates that the Covered Person is no longer subject to a Mandatory Ceding Condition evidenced in the Covered Person's medical history, then the Covered Person shall not be subject to Mandatory Ceding.	Approved Recommendation
Current language (section 9.4) indicates that the identification of Eligible	9.4(d)	Change made to close loophole	Approved Recommendation

Health Plan ties to each plan ID, including each CSR variant, (e.g., AV levels 73, 87, 94, for each marketplace based silver plan). Every variant is a separate Eligible Health Plan. In practice, people move amongst these variant plans on the basis of changes in their income on a routine basis throughout the year, and certainly from year to year. The existing language of the Plan indicates that when such changes from one plan ID to another occur, the carrier gets another opportunity to voluntarily cede the person to MGARA. This loophole would seemingly upend the actuarial basis of MGARA.			
Section 9.4(f)-References Section 9.4(h) in the last sentence. I think this should be Section 9.4(i).	9.4(f)	Correction made	Approved Recommendation
Section 9.4(i)(ii)-the last sentence should read "'Passive Non-Renewal' means the non-renewal of <u>a health plan that is effectuated by non-payment of premium that continues for the duration of the applicable grace period</u>."	9.4(i)(ii)	Change made	Approved Recommendation
Section 9.6(a)(ii)-References Section 9.4(h)(ii). There is no	9.6(a)(ii)	Reference corrected to 9.4(i),	Approved Recommendation

section (ii).			
Section 9.5(d)(i)(ii)- tight timing on monthly enrollment reporting	9.5(d)(ii)	Change made to reporting so that report relates to previous moth rather than the current month.	
Section 9.7(f)- embedded dental and vision should be covered claims		Clarification made - (f) Non-medical benefits, such as stand-alone dental, vision, disability, or other non-medical benefits or services; provided, however, that coverages embedded in the Health Plan, such as pediatric dental and vision or non-EHB adult vision are included in Eligible Claims.	Approved Recommendation
Should extend claims submission deadline to accommodate claims reporting under retroactively ceded policies whether Mandatory Ceding or Discretionary Ceding because both can be retroactively ceded	9.9	Change made to allow submission of claims with any properly retroactively ceded policy, whether mandatory or discretionary - The claims payment submission deadline will be extended to accommodate claims reporting under retroactively ceded policies ceded on a timely basis, in which case all existing claims under the policy shall be reported together with the Ceding Notice, and thereafter are subject to the reporting deadlines specified above.	Approved Recommendation
Section 9.10(f)-this section relates to MGARA inspecting records and Member Insurer providing records, data or other information. Concern expressed regarding what	9.10(f)	Change made to require Member Insurers shall exercise "reasonable efforts" to secure necessary authorization from Covered Person(s) for this purpose, such as	Approved Recommendation

constitutes necessary authorization and how it is obtained?		including MGARA or reinsurers generally, in any information disclosure authorizations.	
Clarify that duplicate reimbursement provision is not intended to apply to not payments under the federal risk adjustment program.	9.10(h)	Clarification made - (h) In the event that the Member Insurer is reimbursed by another party for claims previously reimbursed by MGARA, the Member Insurer shall reimburse MGARA for the amount of any duplicate reimbursement from sources such as co-ordination of benefits, excess loss reinsurance obtained by the carrier, and payments under the federal high cost risk pool, but specifically excluding payments under the federal risk adjustment program. The Member Insurer shall execute and deliver any instruments and otherwise undertake any actions necessary in order to preserve and secure its right to reimbursement from third parties, including any actions that may be required by MGARA	Approved Recommendation
Definition of Designation Eligibility Date – The current definition, while much improved to reflect issues surrounding the ACA grace period, still does not account for dependents who become covered upon a special enrollment event.	4.1	We believe this is already addressed under Section 9.4(d)(i) which allows Discretionary Ceding when a person is added to the plan.	Approved Recommendation

Because rates typically must be filed in early June, carriers must be provided with notice of any changes in the assessment earlier in the year, in order for it to be built into rates. July 31 is not only after the filing date, but it is also after the deadline for changes to the rates. We would suggest that carriers notified by January 1 and no later than April 1.	11.2	We made the following change in the previous version of the Plan – "MGARA will exercise commercially reasonable efforts to collaborate with the Member Insurers and the Bureau to determine and notify Member Insurers of any adjustments in assessment rates as early as reasonably possible in order to facilitate an orderly rate filing and determination process." This covers the specific concern but also allows for flexibility to address changes in dates.	Approved Recommendation
Notice for operations matters that would impact the value from a Plan perspective such as ceding conditions, attachment points, and process for voluntary ceding need to be know well in advance – perhaps mid-April to be included in rate development. Last year the Bureau required initial rates by June 4th and permitted revisions to July 25th.	Misc	New Article XIX added regarding providing advance notice of material Plan changes – "MGARA will exercise commercially reasonable efforts to collaborate with the Member Insurers and the Bureau to determine and notify Member Insurers of any material changes or adjustments in this Plan, its operations or its reinsurance program, such as, but not limited to, ceding conditions, attachment points, and process for ceding as early as reasonably possible in order to facilitate an orderly rate filing and determination process."	Approved Recommendation

Treatment of Student Health Plans for purposes of assessment or ceding	Art XI	Limited benefit student accident insurance is generally not considered medical insurance.	Approved Recommendation
What kind of agreement do Plans need to execute with River9 to allow sharing of PHI and other information? What is the process and timeline for getting these documents in place?	Misc	HHS has issued guidance and provides in the Preamble to the Privacy Rule that a reinsurer does not become the business associate of a health plan simply by selling a reinsurance policy to the health plan and paying claims under the policy, including reinsurers, stop-loss and excess of loss insurance. 65 Fed. Reg. 82609 (2000). Therefore no agreement is necessary.	Approved Recommendation
Section 14.5-references interest at 18% per annum. References to interest in other sections is 12% per annum.	14.5	Corrected in prior version of Plan	Approved Recommendation