The Commonwealth of Massachusetts
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza
Boston, MA 02108

CHARLES BAKER
Governor

KARYN POLITO
Lieutenant Governor

MARYLOU SUDDERS
Board Chair

LOUIS GUTIERREZ
Executive Director

Board of the Commonwealth Health Insurance Connector Authority

Minutes

Thursday, July 14, 2016
2:00 PM to 4:00 PM

One Ashburton Place
Boston, MA 02108
21st Floor Conference Room

Attendees: Louis Gutierrez, Marylou Sudders, Celia Wcislo, Mark Gaunya, Daniel Judson, Louis Malzone, Dimitry Petion, Nancy Turnbull, Michael Chernew, Roberta Herman. Lauren Peters attended as the representative of Kristen Lepore.

The meeting was called to order at 2:02 PM.

Secretary Sudders began by welcoming Dr. Roberta Herman, the new Executive Director of the Group Insurance Commission, to the Health Connector Board of Directors.

I. **Minutes:** The minutes of the June 9, 2016 meeting were approved by all but Roberta Herman, who abstained because she was not in attendance since she had not yet joined the Board of Directors.

II. **Executive Director's Report:** Mr. Gutierrez began the meeting by welcoming Dr. Herman, expressing his excitement that she has joined the Health Connector Board of Directors. He then apologized for last-minute content adjustments to matters coming before the Board. Next, Mr. Gutierrez summarized recent enrollment trends, stating that enrollment has remained stable despite terminations due to ongoing verifications processing. He then provided updates on recent Health Connector developments. He stated that, at the end of June, an error related to electronic payments impacted approximately 7,500 Health Connector subscribers. He stated that the issue was

remediated and that the Health Connector offered to pay any overdraft fees resulting from the error. He added that the Health Connector communicated to Dell senior management that the mistake was unacceptable. He then discussed risk adjustment, stating that risk adjustment was completed on June 30th and that more than $85 million is being transferred among issuers. He added that July 31st is the deadline for risk adjustment payments and that timely payment is required to remain in good standing to participate in selling products through the Exchange. He noted that, after Plan Year 2016, administration of the risk adjustment program will be transferred to the federal government. Mr. Gutierrez then provided an update on the status of the Small Group platform. He stated that the Health Connector conducted a second procurement for a Small Business Health Options Program (SHOP) vendor but that it did not yield any acceptable proposals. He stated that one proposal was risky as it would entail building an entirely new system and that the other two proposals were unsustainably expensive. Therefore, he stated, the Health Connector canceled the procurement and is considering other affordable solutions, including exploring whether the Rhode Island, Connecticut or Washington, DC Exchanges offer a compatible model for small businesses in Massachusetts. He added that he will continue to update the Board on SHOP developments. Lastly, he stated that preparations for the upcoming Open Enrollment period are ongoing, including continued investment in the Health Insurance Exchange/Integrated Eligibility System (HIX/IES). He then introduced Patricia Wada and stated that she will provide a brief update on the next major HIX/IES release, scheduled for August.

Ms. Wada began by stating that she last provided a HIX/IES update to the Board in May following Release 8.0, which delivered key functionality for MassHealth redeterminations. She added that Release 8.1 was deployed on schedule and that the next major release is Release 9.0, scheduled for August, which will contain functionality allowing for the preliminary and final eligibility processes. She stated that the second of three testing cycles for Release 9.0 has begun and that the first phase of pre-production like testing for preliminary eligibility and notices is complete. She stated that full-volume testing was executed prior to renewals last year and that the testing process will run again this year. In response to a question from Ms. Turnbull, Mr. Gutierrez replied that while he cannot address system changes for MassHealth Accountable Care Organizations (ACOs) specifically, current HIX/IES planning extends through 2017. Secretary Sudders noted that MassHealth will soon announce six ACO pilot programs. In response to a question from Ms. Turnbull, Mr. Gutierrez replied that SHOP is one of the elements legally available for the Section 1332 waiver process but that indications suggest waiver is a difficult path. Mr. Chernew asked whether alternative functionality would need to be proposed rather than simply ending SHOP as ending the program could affect individuals' access to care. Ms. Hague confirmed that any changes cannot affect individuals' access to insurance or tax credits. Ms. Wcislo commented that SHOP is not a wise use of funding.

III. Update to Bylaws (VOTE): The PowerPoint presentation "Update to Bylaws (VOTE)" was presented by Edward DeAngelo and Ashley Hague. Before the presentation began, Secretary Sudders reiterated that Board materials must be distributed to Board members forty-eight hours in advance of the meeting, except in emergency cases. Mr. DeAngelo provided background on the bylaws, stating that the bylaws were first enacted in 2006 and

have not been updated since. He stated that changes were reviewed with the Administration and Finance Subcommittee of the Board, as well as by the Attorney General's Office. He stated that the proposed changes to the bylaws fall into three categories: updates to statutory changes, updates to reflect current practice, and changes to simplify administration. He provided examples of each, stating that, for example, the changes allow Health Connector staff to provide notice to Board members by e-mail, reflecting current practice. Mr. DeAngelo then reviewed changes relating to Board approval of contracts. He stated that the proposed changes clarify the definition of contracts brought before the Board for a vote such that, under the proposed amendment, the Board would continue to vote on all contracts over $250,000, but extensions, amendments and work orders for existing contracts that cost less than twenty-five percent of the original contract amount would not require Board vote as long as the cost is otherwise within the most recent fiscal year budget approved by the Board. He added that this recognizes that the Board considered the contract when it was initially voted on and approved before signing, and that the Board considered the expense within the administrative budget brought before the Board each fiscal year. The second proposed change related to contract approvals, he stated, is the increase in the threshold of contracts requiring Board notification from $5,000 to $15,000. He added that contracts under $15,000 are minor and generally administrative and that any contract not requiring a vote will continue to be subject to the five day advance notice rule. Lastly, he noted that these changes do not affect the Health Connector's competitive procurement process in any way. The Board voted unanimously to adopt the updated Health Connector Board of Directors bylaws as outlined in the presentation.

IV. Conditional Award of 2017 Seal of Approval (VOTE): The PowerPoint presentation "Conditional Award of the 2017 Seal of Approval (VOTE)" was presented by Ashley Hague, Brian Schuetz and Edith Boucher Calvao. Ms. Hague began by stating that the conditional Seal of Approval (SOA) is the mid-point of SOA presentations to the Board, informing the public of the responses received to the SOA Request for Responses (RFR). She then introduced Edith Boucher Calvao, who recently joined the Health Connector as Chief Actuary. She stated that Ms. Calvao will help the Health Connector analyze 2017 rates once they are filed in advance of the final SOA presentation in September. Ms. Hague then provided an overview of the 2017 SOA, stating that a primary goal this year is to support apples-to-apples comparison of products. She stated that the 2017 SOA proposes only one standardized plan design on each shelf and added that the Bronze tier is being standardized again this year. She noted that the same structure is imposed on the dental shelf. She stated that the Health Connector is using the SOA to inform planning for future years, including the incorporation of Value-Based Insurance Design (VBID) and measures of dental quality. Next, Ms. Hague reviewed the key certification criteria for the SOA, highlighting ways in which the SOA certification process is shared with the Division of Insurance (DOI). Mr. Schuetz noted that while the conditional SOA focuses on plan design, a key component – cost – is not yet available because rates have not yet been filed. He added that rates are critical for the selection of ConnectorCare plans as selection is based on price competitiveness on the Silver tier. Mr. Schuetz then reviewed the Qualified Health Plan (QHP) recommendation. He stated that in 2017, the Health Connector will offer a total of 62 QHPs from 10 medical issuers. He stated that all issuers met the baseline

requirements for submission and that 28 non-standard plans were submitted. He added that Fallon Health submitted four of its 2016 non-standard plans as "frozen" plans for 2017 and that all issuers submitted Catastrophic plans as required, with six requesting to waive their Catastrophic plan offering. In response to a question from Ms. Wcislo, Mr. Schuetz replied that 576 members are currently enrolled in Catastrophic plans. Mr. Schuetz stated that issuers elected to close 29 plans, representing approximately 25 percent of the unsubsidized and Advance Premium Tax Credit (APTC)-only population. He noted that the majority of the closures are due to UnitedHealthcare leaving the Exchange and the removal of the requirement of the second Gold plan design. He added that Health Connector staff are considering the best ways to map these members to 2017 plans, and communicate these changes, to facilitate a smooth member transition. Mr. Schuetz then displayed a graph of the percentage and member count of individuals who will be able to renew into their same plan in 2017. In response to a question from Ms. Turnbull, Mr. Schuetz stated that the Health Connector does not have much visibility into why an issuer closes a plan on the Health Connector shelf but continues to offer it outside of the Exchange, but added that it could be related to the Health Connector's requirements. Ms. Hague added that, as part of the Health Connector's renewal process, members will be notified if their plan is available off of the Exchange. In response to a question from Mr. Chernew, Mr. Schuetz stated that the Health Connector is conducting a uniqueness analysis to inform whether non-standard plans add sufficient value. Mr. Schuetz then compared the number of plans offered in 2016 to the proposed number of offerings in 2017 by metallic tier and standardization. He noted that the 62 plans proposed for 2017 represent a 25 percent reduction from 2016. Next, Mr. Schuetz reviewed the 2017 QHP product shelf goals: standardization, choice, value and administrative simplification. He first discussed standardization, stating that the Bronze tier is being re-standardized for 2017. Mr. Gaunya remarked that he received a lot of feedback from issuers regarding Health Savings Account (HSA)-compatible plans and wondered what was the reason that issuers did not select this option. Ms. Hague stated that not all issuers elected to offer Bronze plans and the ones that did elected the copay version. In response to a question from Mr. Gaunya, Ms. Hague replied that she does not think the reason for the choice is related to risk adjustment. Ms. Calvao noted that she was also surprised that no issuers opted for the HSA-compatible option. Mr. Gaunya expressed his disappointment that the option was created yet issuers did not elect to use it. Mr. Schuetz continued to discuss standardization, stating that the number of standardized benefits will increase from 14 in 2016 to 21 in 2017. He added that "standard" will be included in the plan name in the shopping experience and that all issuers are able to meet these new requirements. Ms. Wcislo inquired about continued confusion regarding Tufts Direct and Tufts Premier. Mr. Schuetz replied that flags were adding to the Health Connector's shopping pages to help consumers identify tiered or limited networks and Ms. Hague noted that while the Health Connector attempts to mitigate confusion, it cannot control issuer naming. Ms. Turnbull echoed Ms. Wcislo's concerns and stated that after seeing a provider, individuals discover the provider is not in their network and receive a bill they are not able to pay. Ms. Herman noted that, with so many standardized features, the primary element differentiating plans is often the network. Mr. Chernew commented that consumers need to be offered better ways to compare network variation between plans. Ms. Hague noted that the Health Connector has a provider search tool but stated that it is outside of the shopping experience. In response to a question from Mr. Chernew, Mr.

Schuetz replied that the Health Connector operations team monitors calls received by the call center regarding network confusion. Ms. Hague stated that, anecdotally, this issue was especially challenging last year and that the Health Connector will continue to monitor the issue this year. In response to a question from Ms. Herman, Mr. Schuetz answered that the Health Connector encourages consumers to check whether their provider is covered by their plan in its consumer education materials. He added that the provider search tool will be expanded to include additional provider types and that other decision support tools are also under consideration. Mr. Petion remarked that it is important that carriers are forthright and open when consumers call to ask whether their provider is included in a plan's network. Mr. Gaunya commented that while carriers have to play a role in mitigating consumer confusion, providers are responsible as well as the contract between provider and carrier dictates network. Ms. Turnbull remarked that Tufts Direct has a narrow mental health network. Secretary Sudders stated that, while the issue will not be resolved immediately, it is important that educational materials direct Health Connector members to check whether their provider is covered in their plan. In response to a question from Ms. Peters, Ms. Hague stated that the Health Connector's annual survey asks questions regarding why an individual started an application but did not finish and why an individual left Health Connector coverage. In response to a question from Mr. Malzone, Mr. Schuetz replied that Tufts Direct is the most popular Health Connector carrier and noted that it is the least expensive.

Mr. Schuetz then discussed the next 2017 SOA goal: choice. He stated that the 2017 SOA eliminated the requirement for a second standard Gold plan but noted that carriers had the option to offer the other Gold plan as a non-standard or frozen plan. He stated that non-standard plans remain an important part of the QHP shelf. He discussed Catastrophic plans, stating this year, the Health Connector received a larger number of waivers for Catastrophic plans. Mr. Petion inquired about the number of zip codes limited to one Catastrophic offering in 2017, and Mr. Schuetz replied that Health Connector staff can provide this information. He then discussed new proposed non-standardized plan designs and noted that Minuteman's proposed Platinum plan includes VBID features. He reviewed the maximum number of plan offerings carriers could propose, stating that carriers generally use 52 percent of the maximum plans allowed. Ms. Hague noted that this provides some flexibility for carriers to innovate. Mr. Schuetz then discussed the goal of promoting value and health outcomes, beginning with opioid use. He stated that the Health Connector partnered with DOI to develop a joint opioid questionnaire for carriers and that at the September presentation to the Board, Health Connector staff will discuss implementation of opioid requirements as part of the ConnectorCare program. In response to a question from Ms. Wcislo, Mr. Schuetz stated that the opioid requirements include the availability of Narcan and that one therapy will be zero cost. He then discussed the inclusion of pediatric vision and pediatric dental essential health benefit (EHB) coverage. He stated that pediatric vision is required by federal law and that the inclusion of pediatric dental brings the Health Connector in parity with the off-exchange market. In response to a question from Ms. Turnbull, Mr. Schuetz answered that CeltiCare highlighted operational challenges of including pediatric dental EHB coverage related to how to structure the offering to their small number of beneficiaries. He summarized issuer responses to the RFR relating to VBID, stating that responses included comments on telemedicine,

telephonic outreach and a focus on chronic diseases. He added that one carrier offers a rewards-based approach for healthy behaviors. Mr. Malzone thanked Health Connector staff for their efforts and stated that he looks forward to discussing the 2018 SOA process. He added that the Tufts naming issue poses a significant problem for consumers. Mr. Chernew remarked that it will be important to continue the conversation about VBID as it relates to benefit design and Ms. Turnbull emphasized the importance of reviewing evidence regarding the effectiveness of VBID. Mr. Gaunya stated that it would be useful for the Board to learn more about VBID from experts in order to have a more informed conversation on the topic. Ms. Hague noted that Health Connector staff established an internal VBID workgroup and that the group is reviewing literature to determine what can be achieved and what is effective. Mr. Chernew remarked on the importance of involving carriers in VBID planning. Mr. Petion commended Health Connector staff for their work in developing the proposed 2017 plan shelf. He stated that it would be helpful to use data from the Center for Health Information and Analysis (CHIA) to try to determine whether our health plans are effective and affordable to individuals with chronic conditions. Ms. Wcislo emphasized the importance of consumer education and decision support tools, stating that, even for providers in an individual's network, an individual could pay as much as $150 to $200 per month in copays for specialist visits. She added that alerting consumers to costs in addition to their monthly premium is important. Ms. Herman noted that cost calculators are available to consumers. Mr. Schuetz summarized briefly the last goal of the 2017 SOA: administrative simplification. He stated that this year's SOA was streamlined to make the process more efficient for both issuer and Health Connector staff.

Next, Mr. Schuetz provided an overview of the 2017 SOA for Qualified Dental Plans (QDPs). He stated that the small group QDP shelf is mostly unchanged from 2016 but noted that Guardian has requested to submit for the 2017 SOA after all of the published deadlines. He added that MetLife, a small group QDP issuer, did not resubmit for the 2017 SOA. He stated that the QDP goals for the 2017 SOA are the same as the QHP shelf and began by discussing standardization. He stated that the 2017 QDP requirements align dental plans with the QHP shelf. He discussed the next goal, choice, and stated that non-standard plan options continue to allow carriers design flexibility. He reviewed the maximum and actual QDP plan offerings from carriers and stated that for 2017, carriers overall are offering 67 percent of the maximum number of plans allowed. He then summarized carrier comments related to the last goal: promoting value and health outcomes. He stated that many of the carrier responses related to measuring the quality of dental care focused on pediatric care as well as on process rather than on outcomes.

Mr. Schuetz then outlined next steps in the SOA process and stated that the final SOA recommendation in September will be based on rates and value and will include the ConnectorCare program design. In response to a question from Secretary Sudders, Ms. Hague replied that Health Connector staff plan to return to the Board in December to discuss the 2018 SOA. She added that since the 2018 SOA will be released in March, a December discussion with the Board would allow for feedback to be incorporated before the March presentation on the Qualified SOA. The Board voted unanimously to allow the 2017 Conditional Seal of Approval to enable consideration of all recommended standardized and non-standardized QHPs and QDPs proposed by the carriers listed in the

presentation. The Board also voted unanimously to allow staff to evaluate Guardian's request to submit for the 2017 Seal of Approval after the published deadlines. Mr. Gutierrez clarified that the Board vote addressed these two recommendations.

V. Health Connector Fiscal Years 2016 & 2017 Administrative Finance (VOTE): The PowerPoint presentation "Health Connector Fiscal Years 2016 & 2017 Administrative Finance (VOTE)" was presented by Kari Miller and Nupur Gupta. Ms. Miller began by introducing Ms. Gupta, a financial analyst at the Health Connector. Ms. Miller provided an overview of the presentation, stating that the Fiscal Year (FY) 2016 and 2017 budgets are especially challenging as federal funding is no longer available to offset operating costs. She stated that the FY16 year-end projected loss is $13 million, an improvement over initial projections but still reflecting a reliance on reserves. She added that a $4.4 million loss is projected for FY17 and that while unfavorable, it indicates a path toward stabilization. Ms. Gupta discussed the FY16 year-end projection in greater detail, stating that the budget reflected investments in IT and operations, Affordable Care Act (ACA) transition costs, HIX/IES development, SHOP development, and the exhaustion of federal grant funding. She stated that FY16 revenue decreased by $14 million, mostly due to timing as federal revenue for HIX, SHOP and payment portal functionality anticipated in FY16 is being shifted to FY17. She added that other drivers of the change in revenue include lower-than-projected carrier administrative fees due to a modeling error, postponement of Risk Adjustment Data Validation (RADV) and additional Commonwealth Care Trust Fund (CCTF) revenue the Health Connector was fortunate to be able to access. She reviewed the FY16 administrative budget year-end expense, stating that FY16 total expense is $69.1 million, a decrease of $16.8 million compared to budget. She stated that this is due again in part to timing, as some IT development, payment portal and SHOP costs will be shifted to FY 17 and that the remaining decrease is due to decreased operating costs. In response to a question from Ms. Herman, Ms. Miller explained that the CCTF was established under Chapter 58 and that its primary revenue sources are the cigarette tax and the Employer Medical Assistance Contribution. She stated that CCTF funds are used for ConnectorCare subsidies. Ms. Herman inquired whether funding from the CCTF can be relied upon in the future and Ms. Miller responded that currently, revenue projected to go into the CCTF exceeds projected expenses, which is promising. In response to a question from Ms. Herman regarding efficient operating costs, Mr. Gutierrez stated that the Health Connector's Per Member Per Month (PMPM) cost currently is more expensive than in 2007. He stated that this is due, in part, to heavy system building and ACA requirements. He noted that the Center for Medicare & Medicaid Services (CMS) attempted to compare PMPMs across exchanges but noted that a comparison cannot be easily made because Massachusetts is the only state that performs functions such as risk adjustment and premium collection.

Next, Ms. Gupta discussed FY16 year-end enrollment. She stated that FY16 enrollment was higher than budgeted, particularly in the ConnectorCare program. She noted that the enrollment counts reflected in the chart do not match exactly to counts reported in the monthly Board enrollment report since the Board report is a point-in-time snapshot and the financial enrollment counts reflect retroactivity. She stated that enrollment growth due to MassHealth redeterminations and verifications was offset by Health Connector

verifications and redeterminations, as well as terminations for non-payment of premium. In response to a question from Ms. Wcislo, Ms. Miller answered that under Commonwealth Care, the administrative fee was paid by the CCTF but it is now paid by the carriers. Ms. Gupta then summarized the FY16 administrative budget year-end net position, stating that the FY16 year-end $13 million projected loss is favorable to budget but still reflects reliance on Health Connector reserves. Ms. Turnbull inquired as to why the FY16 year-end carrier fee revenue is lower than budgeted if enrollment increased. Ms. Miller stated that about three-quarters of the difference is due to a formula problem in a model that was developed before the ACA. She added that the remaining quarter is due to lower ConnectorCare premiums, which is favorable for members but results in a lower administrative fee as the fee is based on premiums. Mr. Gaunya commended the Health Connector financial team on its work and requested a future conversation regarding how the Health Connector can be more efficient. He agreed that SHOP is not a good use of funding. Mr. Gutierrez noted that Ms. Miller was recently promoted from Director of Finance to Chief Financial Officer. Ms. Miller then reviewed the FY17 administrative budget. She stated that the FY17 budget continues to be impacted by ACA transition requirements. She outlined four key assumptions in the FY17 budget: increased financial support from the CCTF, Dell contract renewal terms, the exhaustion of federal funding to support eligible operating costs, and higher expenses for HIX operations costs allocated to the Health Connector, primarily due to timing. She stated that the cost of operating an ACA-compliant exchange is substantial and requires support from carriers and the CCTF. She stated that the Health Connector will request to use $38.2 million in dedicated CCTF revenue in FY17. In response to a question from Ms. Peters, Ms. Miller replied that the increases from FY16 to FY17 are driven by HIX operations and maintenance costs, the Dell customer service contract, and one-time costs moving from FY16 to FY17. Ms. Miller added that in FY16, CMS approved the use of additional establishment grant funds to support continued outreach activities targeting the remaining uninsured. In response to a question from Mr. Chernew, Ms. Miller stated that in determining the amount of funding to request from the CCTF, the Health Connector first considers the expected amount of carrier fee revenue, and then projected expenses, before submitting a CCTF request. Ms. Peters noted that the CCTF also makes an annual payment to the Health Safety Net (HSN). Secretary Sudders added that the CCTF has several purposes and is dependent upon available revenue. She acknowledged the importance of supporting the Health Connector as well as the HSN. She stated that the Executive Office of Administration and Finance (ANF) acknowledges the importance of the CCTF as a source of revenue but noted that it is not a singular source. Ms. Peters stated that ANF allocates the expected contribution to the CCTF in development of the House budget. In response to a question from Ms. Herman, Mr. Gutierrez stated that the Health Connector tries its best to stay within the budget set in January. Secretary Sudders stated that the administration is attempting to be as lean, efficient and effective as possible and that she appreciates the Health Connector's acknowledgement of these goals. Ms. Wcislo commented that the $19 million in reserves is the remainder of the original $25 million the legislature allocated to the Health Connector when it was established ten years ago. Ms. Turnbull noted that, in state government, resources are scarce. She stated that it would be useful to review the cost structures of other state-based marketplaces and Mr. Gutierrez noted that CMS is conducting a cross-exchange survey related to that topic. Mr. Chernew stated that the Health Connector should

aim to develop a three-year budget and Mr. Gutierrez acknowledged the request. Ms. Miller noted that the Health Connector's budget model extends to 2021. Ms. Miller then discussed the Dell contract in the FY17 budget, stating that the contract will avoid significant disruption for Health Connector members. She stated that the contract reflects a commitment between the Health Connector and Dell to improve the customer experience and reduce call volume. She added that the new Customer Relationship Management (CRM) system was implemented in June. In response to a question from Ms. Herman, Ms. Miller stated that the Dell contract is a four-year contract and that the monthly cost per member is based on a per policy amount. Ms. Miller stated that the Health Connector will no longer have access to federal grant funds for operating costs in FY17 but stated that federal funds to support remaining one-time ACA transition costs are available through the end of calendar year 2016. She then discussed HIX operations and maintenance costs in FY17. She stated that governance of the HIX system is shared between the Health Connector, MassHealth and MassIT. She stated that the Health Connector's estimated $7.2 million contribution is a conservative estimate for 18 months of operations payments allocated to the exchange. She discussed projected FY17 enrollment, which is projected to be 25 percent higher, on average, than FY16 enrollment. She reviewed the FY17 proposed budget breakdown, with $69.2 million in projected operations costs and $10.9 million in projected ACA transition costs funded by federal grants. She added that, of the $69.2 million in operations costs, approximately $40 million is projected for the call center and premium processing activities. She discussed sustainability and the use of reserves, stating that, at the end of FY17, approximately $15.5 million is estimated in remaining reserves funding. She noted that this is troubling because it equates to three months of operating costs and auditors recommend maintaining six months of operating costs. She added that the Health Connector is divesting the risk adjustment program, transitioning the program to the federal government. In response to a question from Ms. Peters, Mr. Gutierrez stated that consulting costs decreased as reliance on consultants decreased and internal personnel were added. He noted that the Health Connector plans to hire a compliance officer and a director of reporting. Ms. Wcislo noted that the Health Connector also hired an actuary. Ms. Herman acknowledged the strong year the Health Connector experienced. The Board voted unanimously to approve the FY17 administrative budget recommendation.

The meeting was adjourned at 4:04 PM.

Respectfully submitted,
Maria H. Joy