As approved by the Board of Directors
with corrections on May 22, 2014

STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Connecticut Health Insurance Exchange
Board of Directors Special Meeting

Telephone Conference

Wednesday, April 30, 2014
Meeting Minutes

<u>Members Participating by Telephone</u>:
Lieutenant Governor Nancy Wyman (Chair); Vicki Veltri, Office of the Healthcare Advocate (Vice Chair); Deputy Commissioner Anne Melissa Dowling, Connecticut Insurance Department (CID), Commissioner Roderick Bremby, Department of Social Services (DSS), Robert Tessier; Paul Philpott; Maura Carley; Cecilia Woods; Dr. Robert Scalettar; Grant Ritter; Maura Carley

<u>Members Absent</u>: Commissioner Patricia Rehmer, Department of Mental Health and Addiction Services (DMHAS); Secretary Benjamin Barnes, Office of Policy and Management (OPM);

<u>Other Participants</u>:
Health Insurance Exchange (HIX) Staff: Kevin Counihan, Peter Van Loon, Julie Lyons, Virginia Lamb; Matt Salner;
The Meeting of the Connecticut Health Insurance Exchange Board of Directors was called to order at 9:00 a.m.

A. Call to Order and Introductions
Lt. Governor Wyman opened the meeting at 9:00 a.m. Board members and AHCT staff participating identified themselves.

B. Public Comment
Kris Hathaway, NADP's Director of Government Relations, provided a public comment.

C. Network Adequacy Requirements for 2015

Julie Lyons discussed the rational for revisiting certain elements of the Qualified Health Plan (QHP) criteria. While the issuer agreements specify a two year carrier certification, the Exchange reserved the right to re-evaluate the QHP criteria on an annual basis. The proposed changes to QHP criteria are the result of lessons learned over the past year, as well as feedback from consumers, advisory committees and stakeholders. Revisions to the standard plan designs result from changes in state and federal law. In order to remain competitive in the market, it was necessary for the Exchange to analyze and compare plan features such as deductibles, benefit cost sharing and pharmacy cost sharing to those individual products sold outside of the

Exchange. The primary goal for 2015 is to offer plans which are attractive to all consumers, whether or not they are eligible for subsidies.

The QHP solicitation, which outlines carrier and plan requirements for 2015, was released in mid-March. The proposed changes impacting QHP certification for the second year include: more stringent standards for network adequacy; expansion of the number of non-standard plan options allowed; an additional requirement addressing the prescription drug formulary; change to pediatric dental benefit; and the development of a consumer shopping portal for stand-alone dental plans.

The proposed network adequacy standards include reasonable access requirements for all plans (standard and non-standard) sold by an issuer on the AHCT marketplace. In addition, the requirement for substantial similarity for a provider network has been expanded for 2015 such that the network for the standard plans must include at least 85% of unique providers that are included in an issuer's network for its "benchmark" plan. The Exchange will monitor compliance with this requirement by periodically reviewing current network information for each carrier's standard and benchmark plans.

Anne Melissa Dowling asked about the current status of carrier compliance. Ms. Lyons replied that carriers would submit detailed analyses regarding the ECP and FQHC standards. United Health Care, ConnectiCare Benefits, Inc. and HealthyCT have the same provider networks for plans sold on and off of the Exchange, while Anthem does not. Anthem's network met the 80% substantial similarity standard for 2014 but will be increased to 85% for 2015. Ms. Lyons stated that carriers are working to meet the requirement, and confirmed that the reasonable network adequacy requirement applies to every plan, not just the standard plan, consistent with the Board's directive.
Lt. Governor Wyman requested a motion to require Qualified Health Plan (QHP) Issuers to develop and maintain provider networks for the standard plans offered for sale on the Exchange, which include at least 85% of those unique providers and entities that comprise the network of the most popular plan, of a similar type, actively sold by the Issuer or the Issuer's affiliate if such affiliate has a larger provider network. Motion was made by Vicki Veltri and seconded by Robert Tessier. ***Motion passed unanimously.***

D. Number of Nonstandard Plan Options

Ms. Lyons discussed the number of nonstandard plan options each carrier could offer on the Exchange. Based on feedback from consumers and the advisory committees, staff proposed expanding the number of nonstandard plan options for each carrier from two to three, as well as requiring carriers to offer a Health Savings Account (HSA) compatible Bronze standard plan. Under these revised rules, an issuer will be required to offer one standard Gold plan, one standard Silver plan, and two standard Bronze plans (one being an HSA-compatible plan). An issuer may also opt to offer a catastrophic plan, and three each of non-standard Gold, Silver and Bronze plans. If an issuer decides to offer a Platinum plan, its offerings must include one standard Platinum plan and up to two non-standard Platinum plans.

A discussion ensued regarding the decision to require a Bronze HSA standard plan. Ms. Lyons stated that various stakeholders suggested the inclusion of such plans, which are offered currently as nonstandard plans on the Exchange. Kevin Counihan added that consumer research and discussions with brokers indicated demand for HSA plans. Ms. Veltri expressed the need for consumer education regarding HSAs. Mr. Counihan agreed, indicating that education will be necessary on all plans, based on consumer research recently completed. Robert Tessier stated that HSA plans are mostly offered by employers, who have educated their employees. Mr. Tessier felt that these were substantially different than HSAs in the individual markets. Mr. Counihan reminded the Board that carriers currently offer nonstandard Bronze HSA plans on the Exchange. Lt. Governor Wyman added that she is uncomfortable with an HSA and asked if plan designs would be revisited annually, and Mr. Counihan

confirmed. Ms. Dowling asked whether an HSA plan could be a nonstandard option, and Ms. Lyons replied that HSA plans are currently offered as nonstandard plans on both the individual and SHOP Exchanges. Mr. Tessier asked why it is necessary to require a standard Bronze HSA plan, as opposed to continuing to allow such plans as nonstandard options. Ms. Lyons replied that nonstandard plans do not have the same protections as standard plans, including the substantial similarity requirement for provider networks. Ms. Veltri added that there has to be discussion surrounding a curriculum for educating consumers about HSAs. Ms. Dowling expressed concern about affordability and the size of provider networks, and suggested further discussion on this issue. Maura Carley expressed support for the requirement of a Bronze HSA standard plan. She argued that once consumers understand HSAs, they may see them as a useful tool to pay for significant medical expenses. Paul Philpott predicted that there would be a growing population of consumers migrating from corporate-funded HSAs to Exchange plans, and said that a standard Bronze HSA plan would be attractive to this group.

Lt. Governor Wyman again expressed concerns regarding HSA plans and argued for ongoing evaluation of these plans throughout the year. She asked that the motion before the Board include requirements for education and working with the carriers to monitor consumer utilization. Ms. Veltri recommended analysis of the cost and quality of HSA plans. Lt. Governor Wyman asked whether the Exchange could track consumer utilization. Mr. Counihan replied that the Exchange does not have utilization data but may be able to obtain national data. Lt. Governor Wyman asked if the carriers could help to provide such data. Ms. Carley added that some people would view these products as more flexible, depending on the extent to which the HSA is funded. Ms. Lyons stated that the Exchange has no control over nonstandard plan education. Mr. Counihan added that the Exchange needs to respond to demand in the market. Mr. Tessier added that this is the first time the Board is being asked to approve HSA standard plans, and because of the concerns raised, the Board should revisit these issues next year.

Lt. Governor Wyman requested a motion to increase from two to three the number of non-standard plans that issuers may offer in 2015 for the Bronze, Silver and Gold Metal tiers and develop a consumer education program on appropriate use of the Bronze HSA standard plan, monitor the plan and re-evaluate as an offering prior to plan year 2016. Motion was made by Lt. Governor Wyman and seconded by Mr. Tessier. ***Motion passed unanimously.***

E. Prescription Drug Formulary Requirements for 2015

Ms. Lyons presented the 2015 prescription drug formulary requirements for the standard plans. The proposal is to require a QHP issuer to provide a prescription drug formulary that offers the highest benefit level whether it meets the requirements of the federal regulation (either one drug in every United States Pharmacopeia category or class, or the same number of prescription drugs in each category and class as the EHB benchmark plan), or is equal in number and type to the formulary in the plan with the highest enrollment representing a similar product sold outside the Exchange. The goal of the pharmacy drug formulary revision is to increase consumer access to clinically appropriate prescription drugs.

Lt. Governor Wyman requested a motion to require a QHP Issuer for the Standard Plan designs to provide a prescription drug formulary that offers the highest benefit level, whether it meets one of the standards set forth in 45 C.F.R. 156.122 or is equal in number and type to the formulary in the plan with the highest enrollment (representing a similar product) offered outside of the Exchange. Motion was made by Robert Scalettar and seconded by Mr. Tessier. **Motion passed unanimously.**

Grant Ritter left at 10:00 a.m.

F. Dental Compliance

Virginia Lamb, General Counsel, reported on Pediatric Dental Compliance. The National Association of Dental Plans (NADP) believes that the Exchange needs to do three things: 1) allow stand-alone dental plans on the Exchange; 2) allow the stand-alone plans to be offered on a stand-alone basis or purchased in conjunction with a QHP; and, 3) eliminate the requirement that the pediatric benefit be embedded in QHPs. AHCT agrees fully with positions 1 and 2, and agrees partially with position 3. AHCT firmly believes that it has the authority to require that the pediatric dental benefit be embedded in its standard plan designs. The NADP is interpreting the ACA and state law too broadly on this point. Federal regulations require the Exchange to act in the best interests of the consumer and employer. Federal regulations also state that the Exchange should not deny a medical carrier solely because they do not offer the pediatric dental benefit. Connecticut state law requires the Exchange to offer the most comprehensive health benefit plans offering high quality benefits at the most affordable price. The decision to require embedding in the standard plan designs is based upon the already demonstrated desire to have a full comparative shopping experience, and without embedding, there would not be one. It is in the best interest of the consumer. AHCT's actuary estimates that this embedded benefit would cost approximately $5 to $6 of the premium, versus $25 to $35 dollars on a stand-alone basis. This will enable the consumer to purchase the product in one simple transaction, reducing confusion and allowing for an Advanced Premium Tax Credit. Ms. Lamb added that embedded pediatric dental services are not required to be part of any other QHP – only the standard plan designs.

Lt. Governor Wyman asked if carriers can offer nonstandard plans without embedded pediatric dental coverage. Ms. Lamb replied that carriers may choose whether to embed this coverage in non-standard plans.

Ms. Veltri added that AHCT made a public policy decision to provide children with access to dental care. Ms. Dowling added that if this benefit was separately priced, it could be cost 5 to 10 times more than the embedded benefit. Mr. Philpott suggested that it is cheaper because it is amortized over the entire population. Ms. Dowling agreed.

Lt. Governor Wyman asked for a motion to require embedded pediatric dental benefits in Access Health CT's Standard Plan designs and to recognize the Qualified Health Plan (QHP) Issuers' choice whether to embed or not embed the pediatric dental benefit in the Non-Standard Plans. **Motion was made by Vicki Veltri and seconded by Robert Scalettar.** ***Motion passed unanimously.***

G. Dental Compliance and Stand-Alone Plans Options

Matt Salner, Policy Analyst, reviewed the stand-alone dental plan options for the 2015 plan year. For the 2014 plan year, dental carriers have had the ability to offer plans through links on the AHCT website. For 2015, there will be a separate stand-alone dental shopping experience through the Exchange. Two standard plan designs ("high" and "low") were approved by the Board for 2014. New federal regulations this year made changes to required cost-sharing amounts for stand-alone dental plans, which made it difficult for AHCT to develop a standard low plan. The Department of Health and Human Services (HHS) and AHCT actuaries confirmed this difficulty as well. AHCT recommends that the Board approve one standard stand-alone dental plan which conforms to the high plan actuarial value. The recommended standard high plan has some minor changes from the 2014 standard plan in order to meet the actuarial value – individual deductible increased from $50 to $60; and, out-of-pocket maximum increased from $300 for one child and $600 for two or more children to $350 for one child and $700 for two or more children. Additionally, AHCT staff recommends that stand-alone dental carriers be allowed to offer up to three non-standard plans, an increase from the 2014 limit of two non-standard plans.

Ms. Veltri added that there should be an education piece for consumers to assist in choosing a dental plan.

Lt. Governor Wyman asked for a motion to require Stand-Alone Dental Plan (SADP) Issuers to offer one Standard High Option Plan and allow up to three Non-Standard Low and/or High Option Plans. **Motion was made by Vicki Veltri and seconded by Robert Tessier. *Motion passed unanimously.***

H. Standard Plan Designs by Metal Level, Actuarial Value and H.S.A. Bronze Plan

Mr. Salner presented the proposed standard plan designs for 2015. In response to consumer research and input from stakeholders and the market, AHCT recommends some changes to the 2014 standard plan designs. At the suggestion of Board members, research was conducted utilizing focus groups of consumers who purchased plans through Access Health CT. The Exchange learned that consumers, when comparing plans, considered the size of the deductible, but did not examine plans to determine which services were or were not subject to the deductible. This information was used to revise the standard plans to make them more competitive in the market. Additionally, some changes in the plan designs were required in order to be in compliance with new federal and state regulations. Among these were the Connecticut Insurance Department's (CID) new requirements with regard to cost sharing for prescription drugs. Wakely Consulting Group assisted in the validation of the proposed changes to the standard plans. Wakely further provided an estimate of the pricing impact of these changes. These recommended plan designs have been reviewed and approved by all four advisory committees.

AHCT staff recommends maintaining the 2014 Platinum standard plan design with no changes for 2015.

Recommended changes to the 2015 Gold standard plan design are as follows: the prescription deductible has been eliminated, so consumers purchasing this plan will have first dollar coverage on all prescription drugs; the copay for generic drugs was lowered from $10 to $5 to comply with CID guidelines; cost sharing for specialty drugs was changed from 30% coinsurance to a $60 copay, likely resulting in significant savings and predictability for consumers; and, most medical services on this plan are not subject to the deductible. Wakely actuaries project a price increase of seven tenths of one percent for this revised plan.

For the 2015 Silver standard plan, it was recommended that: the medical deductible be decreased from $3,000 to $2,600; the prescription drug deductible be reduced from $400 to $25; the prescription drug copays be adjusted to comply with CID guidelines and the specialty drugs would be subject to a $60 copay instead of 30% coinsurance; and, copays for specialist visits and laboratory services be increased slightly in order to conform to AV requirements. Wakely actuaries project that these changes will result in a 2.7% price increase for this plan.

For the 2015 standard Bronze Plan, it was recommend that: the deductible be increased from $3,250 to $5,000 (there is no separate prescription drug deductible in either plan); the copay for primary care visits be increased to $40, with the first three primary care visits (and the first three mental health office visits) not subject to the deductible; and, the prescription drug cost sharing amounts are consistent with CID guidelines. Other cost sharing amounts are 40% coinsurance, which is the same as in the 2014 Bronze plan. Wakely projects that these changes will result in a 2.9% decrease in price.

An additional Bronze standard plan for 2015 is being recommended which would be paired with a Health Savings Account (H.S.A.). This plan has a $4,600 deductible, and consumers would use their HSA to pay for services up to the $4,600 deductible. After the deductible has been reached, all medical services are covered at

100% without cost sharing for the consumer. The prescription drug cost sharing is compliant with CID guidelines. This is also compliant with the IRS guidelines for H.S.A. plans.

Robert Tessier moved that the Board require Issuers to offer the Standard Plan Designs as recommended by the Exchange Staff; Vicki Veltri seconded. Discussion continued with Robert Tessier congratulating the staff for the consumer friendly changes and collaborative efforts of the Advisory Committees and AHCT staff. ***Motion passed unanimously.***

Dr. Scalettar asked about the rating factors for tobacco use on the QHP solicitation and if there have been any discussion to revisit this rating factor for individuals. Ms. Lamb responded that staff discussed this topic and there are no proposed changes. Carriers will be asked to work with the Exchange to study this issue. There is a very severe penalty for a smoker in the premium, and AHCT did not want to drop people from Exchange until the carriers had an opportunity to work with these consumers.
Mr. Tessier asked whether non-tobacco users would see a substantial decrease in premium costs if tobacco rating were allowed on the Exchange. Ms. Lamb responded that the actuaries were not asked to quantify this. There would be a sizable increase for tobacco users, and another concern is that consumers in this category may actually have mental health issues.

I. Adjournment

Motion to adjourn the board meeting was made by Mr. Tessier and seconded by Ms. Veltri. ***Motion passed unanimously.*** The meeting adjourned at 11:22 a.m.