Connecticut Health Insurance Exchange
Health Plan Benefits and Qualifications Advisory Committee
Special Meeting

Hartford Hilton
Hartford Commons Room

Tuesday, August 15, 2017
Meeting Minutes

Members Present:
Grant Ritter (Chair); Robert Tessier; Ellen Skinner

Members Participating by Phone:
Paul Lombardo; Tu Nguyen; Neil Kelsey

Other Participants:
Access Health CT (AHCT) Staff: James Wadleigh; Shan Jeffreys; Ann Lopes; Ellen Kelleher; Charmaine Lawson; Alexandra Dowe
Wakely Consulting (by phone): Julie Andrews; Julie Pepper; Suzanna-Grace Sayre

The Special Meeting of the Health Plan Benefits and Qualifications Advisory Committee was called to order at 4:00 p.m.

I. Call to Order and Introductions

Chair Grant Ritter called the meeting to order at 4:00 p.m.

II. Public Comment

No public comment

III. Vote

Grant Ritter requested a motion to approve the February 16, 2017 Health Plan Benefits and Qualifications Advisory Committee Special Meeting Minutes. Motion was made by Robert Tessier and seconded by Ellen Skinner. ***Motion passed unanimously.***

IV. Health Plan Benefits and Qualifications Advisory Committee Engagement

Shan Jeffreys, Chief Operating Officer, indicated that this is the first meeting of the Health Plan Benefits and Qualifications Advisory Committee (HPBQ AC) in six months. AHCT would like to start having the HPBQ AC meetings more frequently. Mr. Jeffreys pointed out that AHCT's strategy and mission would always be at the forefront of any decisions regarding plan designs. Wakely Consulting has been contracted to review plan design options to make sure that they comply with the metal tier requirements of the Affordable Care Act (ACA). AHCT seeks to maintain high value and quality for the plans offered on the Exchange. Due to various market conditions, changes are sometimes required. All of the plan designs for the 2019 plan year must be approved by the Board of Directors before March of 2018.

Alexandra Dowe, Policy Analyst at AHCT, indicated that in light of uncertainty that has the potential of destabilizing the market from the strategic and solution standpoints, AHCT is trying to be proactive in this area. AHCT has been working closely with Wakely to prepare a report that highlights possible scenarios that may be considered in the future.

V. Wakely Consulting Research

Julie Andrews, Senior Consulting Actuary at Wakely, indicated that her team's research and analysis included such topics as goals of market stabilization, high risk pools, reinsurance, merged market approaches, and 1332 waiver activity of other states. Ms. Andrews reviewed each of these topics in more detail, as outlined in the Wakely presentation.

Ellen Skinner inquired about the need for insurers to keep the administrative costs on the lower side, under a 'condition-based' reinsurance program. Ms. Skinner asked whether special enrollment forms are needed to find out what conditions people acquire. Special tracking may be needed to make sure that the primary insurer continues to cover them through that period. Ms. Andrews agreed that a certain level of complexity exists in terms of determining the eligibility. Ms. Skinner stressed that AHCT needs to be considerate of the administrative costs for a longer term. Ms. Skinner added that a comparison of the high risk pools, the condition-based reinsurance and the parameter-based reinsurance should be made side-by-side.

Dr. Ritter asked whether the condition-based reinsurance has been tried in other states. Ms. Andrews responded that Alaska was approved to have the 1332 waiver implemented. Dr. Ritter inquired about the conditions that are covered under the condition-based reinsurance program, and whether they are designed for more popular conditions, such as cancer. Ms. Andrews stated that 33 conditions are aligned, such as HIV/AIDS, brain cancers, sickle-cell anemia, and others. Ms. Skinner indicated that it would be difficult to predict costs of care in terms of lengths of stay, since some of them will not spend a considerable amount of time in a hospital setting, while others will have extended stays. Ms. Skinner stressed that condition-based reinsurance adds complexity that is not needed.

Robert Tessier inquired about the number of insurers in the individual market. Neil Kelsey, Vice-President, Actuarial Services at ConnectiCare, Inc. & Affiliates, indicated that the

company has three separate legal entities, including an HMO, an indemnity company, and ConnectiCare Benefits, Inc., which is an on-Exchange only license.

Mr. Kelsey inquired whether, in the event that the individual and small group markets are merged into a single risk pool, every carrier would be required to participate in the individual and small group markets. Ms. Andrews indicated that a single risk pool would not necessarily require every carrier to participate in both the individual and small group markets. It would be up to the state to decide whether to impose this requirement.

Mr. Tessier asked about the length of time the merged-market initiatives have been in place in those states that implemented them. Mr. Tessier also asked whether there is anything to be learned from these states' experiences with the merged insurance markets. Ms. Andrews indicated that Massachusetts has had 10 insurers participating in the individual market until last year. Ms. Andrews also mentioned Vermont and the District of Columbia. In terms of rate changes, Massachusetts had a 1% decrease, Vermont had about a 5% increase, and the District of Columbia had a 22% increase in rates. Ms. Andrews added that Alaska has been approved for their 1332 waiver. Minnesota has submitted an application for a waiver.

VI. Recap: 2018 Standardized Plan Design Development

-Modifications Approved by Board of Directors

Ann Lopes, Carrier Product Manager, described recommendations that were presented to the Board of Directors during the February 28, 2017 Special Meeting. Ms. Lopes stated that once rate filings were submitted to the Connecticut Insurance Department (CID), it was determined that certain elements were not compliant with the requirements of the ACA. Therefore, plans needed to be revised. The mental health parity testing was a significant component that led to those plans' revisions. Mental health parity regulations prevent insurers from providing less favorable mental health and substance abuse benefits, when compared with medical and surgical benefits. In plans that provide coverage for medical/surgical benefits and mental health/substance use disorder benefits, plan deductibles and co-payments cannot be more restrictive for mental health and substance use disorders, when compared to predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. One of the key elements of mental health parity testing is that the carriers have to use their own claims experience. Based on carrier submissions to CID, it was determined that the carriers could not meet the mental health parity testing requirements for several of the standardized plans. Ms. Lopes indicated that the mental health parity standards could not be met for the AHCT Gold and the Silver standardized plans, which included the 70% Actuarial Value (AV), as well as the plan variants at the 73% AV and 87% AV levels. Additionally, the carriers were not able to meet the AV calculator thresholds for these same 2018 plans/variants when taking into account uniform methodology for off-exchange plans. The carriers, CID, and AHCT reviewed the issue, and worked to modify the plans so that the result would allow the carriers to meet the federal requirements. Ms. Lopes added that there were four different cost-sharing areas that were adjusted for the gold and silver plans, including the variants. Ms. Lopes stated that the text in blue font on the slide represents the changes that were subsequently presented to the Board and approved in May 2017.

As the development of standardized plans for 2019 moves along, we will need to add time to account for testing for mental health parity, prior to going to the Board on recommendations on the plans. Ms. Lopes indicated that testing would have to be done by the carriers. It would be an additional step in the process. AHCT has utilized Wakely to determine the AV calculations of each of the plans. Mr. Kelsey added that clear definitions of plan designs are needed when presented to the carriers. Mr. Kelsey indicated that potential new carriers on the Exchange would have to go through the mental health parity testing and actuarial value testing, and they will not be a part of the discussion that is underway in this Committee. Ms. Lopes thanked Mr. Kelsey for his input. Mr. Tessier thanked AHCT for the presentation and for choosing to bring the issue back to the Committee. Mr. Tessier encouraged engaged entities to educate the Committee, as well as the Board, in terms of the plan design development, and the impact that any potential changes to those plans may have on coverage and affordability.

Mr. Tessier indicated that he did not have a full understanding of why the carriers did not meet the Mental Health Parity and Substantially All Test requirements. Mr. Tessier expressed his concern that non-advanced radiology and laboratory services will be subject to the deductible for 2018 in those plans. Mr. Tessier communicated his support for adjusting plan designs for 2019, in which these services will not be subject to the deductible. Mr. Tessier reiterated that these are basic benefits that people need. Mr. Tessier stressed that these are the benefits for which health insurers are able to obtain good discounts from in-network providers. Given that they are relatively low-cost items, AHCT should do everything that can be done to make them more accessible to people by not requiring them to pay deductibles.

Mr. Lombardo indicated that it is necessary to make sure that these plans, prior to being recommended to the Board, meet the mental health parity and the AV Calculator requirements based on each carrier's own data. Mr. Lombardo added that any plan proposed by AHCT and Wakely should be presented to the carriers to determine whether the carriers will be able to meet the mental health parity and the AV calculator requirements, before any decisions are made by the Committee, and eventually the Board. Ms. Lopes added that the Committee may want to contemplate co-insurance for the standardized plans in the future. If it means lowering deductibles to make it more manageable, the Committee may consider recommending instituting co-insurance all across the board. It may be worth debating and considering. Many factors are dependent on the developments in Washington, DC.

Robert Tessier left at 5:26 p.m.

VII. 2019 Certification Requirements & Plan Design Considerations

Ms. Dowe stated that AHCT was charged by its Board with reviewing topics pertaining to plan certification that were considered by the Board in the past, in an effort to determine whether any changes should be considered for the future. These are outlined in the presentation, and can be used by this group as a platform moving forward to determine whether changes in certification requirements may be necessary.

Ms. Lopes described Essential Health Benefits (EHB). Ms. Lopes indicated that all non-grandfathered plans in the Individual and Small Group markets have to follow the EHB base-benchmark plan. In the past, the timeline to modify the EHB benchmark plan was two years before the beginning of a new plan year. The Department of Health and Human Services is responsible for evaluating the effectiveness of the EHB benchmark plan. AHCT is following regulations and guidance provided by the Centers for Medicare and Medicaid Services (CMS) for EHB requirements. Earlier this year, CMS requested a meeting with representatives of

AHCT and CID, as part of an effort to collect information from all states regarding the EHB benchmark plan selection process, and obtain feedback on adapting the EHB benchmark plan over time, as well as gauge interest from the State regarding flexibility on the EHB benchmark plan. There has been no additional new guidance from CMS on modifying the current EHB benchmark plan; therefore, there may not be an opportunity to explore this further for 2019. AHCT will keep abreast of CMS guidance on this item.

Mr. Wadleigh asked whether the EHB benchmark plans are rich. Mr. Lombardo confirmed that in comparison with other states, the Connecticut EHBs are rich. Mr. Lombardo added that Connecticut has one of the richest EHB benchmark plans in the country. Mr. Wadleigh asked the Plan Management Team for a summary that details this plan and an outline of the differences from the guidelines that CMS recommends. Dr. Ritter inquired whether it is safe to say that some of the elements in the richer plans are not included in the AV calculator, and do not affect the actuarial value calculation, but they do increase the premiums. Mr. Lombardo indicated that the EHB represents base benefits, and is the same for each plan. The difference between the metal tiers is the cost sharing structure, which is entered into the AV calculator.

Mr. Wadleigh encouraged the Committee to review as much information as possible, and take into consideration items that are driving rates beyond what is seen in other states. Some of those items may include mandates and other potential obstacles that are influencing the rates in a negative way. Mr. Wadleigh encouraged having an open dialogue between AHCT, the participating carriers, and CID. It is crucially important to help find creative ways to lower the cost of healthcare coverage. Mr. Wadleigh indicated that hopefully formularies could be influenced to be made less expensive. Ms. Skinner asked for confirmation that benefits that are above and beyond could be identified, and Mr. Wadleigh confirmed this would be done.

Ms. Lopes indicated that the Second Lowest Cost Silver Plan (SLCSP) is used in determining premium tax credits (PTCs) for qualified enrollees. In 2013, The Board of Directors voted that the AHCT Standardized Silver Plan must be the carrier's lowest cost silver plan in the individual market. The intent of this was to guarantee affordability of the Silver plan. The standardized plan was developed to ensure that a large number of benefits would not be subject to the plan deductible. This results in a probable higher cost plan compared to other possible options, where more benefits are subject to the deductible, but also results in a higher amount of the PTC. A large difference exists in rate filings from one carrier versus another for the Silver standardized plan. Ms. Lopes indicated that as a result of that, one carrier has both the lowest cost silver plan (the AHCT standardized Silver plan), and the second lowest cost silver plan, which is one of the non-standard plans, but consumers who are eligible for PTCs can select either of these plans at the lowest possible cost. Going forward, there can be more discussion on continuing to require standardized plans, the plan mix, and possibly no standardized plans.

Ellen Kelleher, Carrier Product Manager, indicated that a balance of various factors is needed when developing standardized plans, such as premium and cost sharing on one side, weighted against regulations on the other side, that govern items such as maximum out of pocket limits and deductibles. This is about making sure that AHCT do everything in its power to assist its consumers through consideration of innovative plans that fit with the AHCT Strategic Goals, Mission and Vision. Mr. Kelsey suggested including mental health parity as one of the elements of "Regulations & Guidance" in the graphic. Ms. Kelleher reiterated that it is crucially important to work cohesively with all stakeholders in the process of developing standardized plans. Ms. Kelleher reviewed the cost sharing maximums for certain benefits

that must be considered as part of development of standardized plans. She advised that once the draft AV Calculator is released, the 2018 approved standardized plans can be run through to determine if they meet federal requirements. In addition, AHCT can look at alternatives. Mr. Jeffreys discussed the concept of a data call by CID in response to a carrier request. This would be to ascertain whether the copay maximums continue to represent the appropriate threshold, based on more recent claims data.

VIII. Next Steps

Charmaine Lawson, Carrier Product Manager, asked the Committee for input regarding future meeting topics, as well as the frequency of the meetings. Mr. Wadleigh stressed that proper attendance to the HPBQ AC meetings is critical. Ms. Skinner inquired whether there are any other lessons to be learned from AHCT, or the carriers themselves, regarding benefits or administration. Mr. Wadleigh stated that one of the best approaches is to ask the carriers to come to the HPBQ AC meeting and make recommendations on what changes would improve the customer experience, and/or outline the "give and take" and drivers for cost savings, so that options can be weighed. Mr. Jeffreys obtained confirmation that the group is comfortable meeting monthly going forward. Dr. Ritter suggested that the Committee review the requirement regarding the standardized Silver plan being the lowest cost Silver plan in the Individual market at the next meeting, along with the more general topic of requiring standardized plans. He expressed interest in understanding what other states are doing regarding standardized plans.

IX. Adjournment

Grant Ritter asked for a motion to adjourn. Motion was made by Ellen Skinner and was seconded by Neil Kelsey. **Motion passed unanimously.** Meeting adjourned at 5:57 p.m.