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

Connecticut Historical Society

Wednesday, October 25, 2017
Meeting Minutes

Members Present:
Grant Ritter (Chair); Neil Kelsey; Tu Nguyen; Ellen Skinner

Participants by Phone: Mary Ellen Breault; Paul Lombardo; Kimberly Martone; Wakely Consulting Group: Brittney Phillips; Julie Andrews

Other Participants:
Access Health CT (AHCT) Staff: Shan Jeffreys; Susan Rich-Bye; Ellen Kelleher; Ann Lopes; Charmaine Lawson

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

A. Call to Order and Introductions

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

B. Public Comment

No public comment

C. Vote: September 20, 2017 Meeting Minutes

Grant Ritter requested a motion to approve the September 20, 2017 Health Plan Benefits and Qualifications Advisory Committee Meeting Minutes. Motion was made by Neil Kelsey and seconded by Tu Nguyen. ***Motion passed unanimously.***

Mary Ellen Breault and Paul Lombardo joined the meeting at 4:03 p.m.

D. Certification Requirements

Ellen Kelleher reviewed the Advisory Committee goals. There was a discussion at the last meeting regarding the goals of the Health Plan Benefits and Qualification Advisory Committee. A refresher was provided by Ms. Kelleher, which summarized the certification, recertification and decertification of qualified health plans. Access Health CT's (AHCT) vision, mission and strategic goals were summarized as well.

Follow-ups from the previous meetings were reviewed including the future meeting schedule; the location of the 2018 standardized plans on the AHCT agency website; the requirements of standardized plans in other states; consumer feedback on plan designs and value based insurance design. Ms. Kelleher added that additional meetings might be added to discuss 2019 plan design approval.

Ann Lopes went into detail on the state standardized plans requirements for 2017 for the Federally-Facilitated Marketplace (FFM); State Partnership Marketplace (SPM); State-Based Marketplace using the Federal Platform (SBM-FP); and, (State-Based Marketplace (SBM). There is more detail in the Appendix. Ms. Kelleher added there is a trend in seeing more of an appetite for standardized plans.

Ellen Skinner arrived at 4:07 p.m.

Ms. Lopes continued. Another item from last month's meeting is to review information on consumer preference for plan selection. In a recent AHCT "Leaver" Study from November 2016, it was found that the important factors for plan selection are: keeping the monthly premiums low; having a low deductible; and, keeping co-pays low. Ms. Skinner added that it would be interesting to see the results by age. Ms. Kelleher stated that health literacy can come into play for consumers selecting plans.

Value-Based Insurance Design (VBID) was summarized. Ellen Skinner forwarded the State Innovation Model template but it was specific to small groups that are fully insured. There is no template for the individual market as of yet. The VBID approach is to improve health care quality, reduce costs often through incentives to consumers. Another approach is to reduce out-of-pocket costs for "high clinical value" services and discourage utilization of services that may not be necessary. Ms. Skinner added that the SIM program has an 80% enrollment goal for the state for self-insured and employee insured. Ms. Lopes added that it would be worth looking at in relation to looking at benefit designs. The VBID approach must comply with non-discrimination and mental health parity requirements.

Ms. Kelleher summarized the certification requirements and provided a refresher of topics reviewed previously by AHCT's Board of Directors. These will be used for 2019 plan development. The lowest cost Silver plan in the individual market will be discussed further today along with plan mix (how many non-standard and standard and allowed and which type) and moving forward with standardized plan design. These are foundations for what needs to happen going forward for 2019. Some decisions will have to be made in the next month.

Ms. Kelleher summarized the discussion points for today's meeting. Ms. Skinner inquired about whether AHCT should eliminate the requirement that the lowest cost Exchange Silver plan in the individual market be the AHCT standardized plan. Can carriers that are not on the Exchange have products priced lower than this plan? Ms. Rich-Bye stated yes. Mr. Ritter referred to the Silver

plans lower than the lowest cost one on the Exchange, which was presented at the last board meeting. Ms. Lopes added that there are a total of 16 Silver plans available on and off the Exchange for 2018. Ms. Lopes also referred to the last two pages of the Appendix, which included a high-level summary of plan information for Silver plans that were submitted in the carrier plan filings to the Connecticut Insurance Department (CID).

Mr. Ritter asked if the off-Exchange plans are considered qualified health plans and Ms. Lopes responded no. Ms. Lopes added that qualified health plans must be certified and AHCT will only certify on-Exchange plans, which must also be available off-Exchange. Mr. Kelsey added that when the Risk Corridor program was in place, he believes that only plans that were considered to be QHPs could be eligible for the program.

Mr. Ritter asked if carriers were expecting that co-pays were not going to be made by lower income consumers. Mr. Kelsey said that all someone will see in a CSR is the plan design and the co-pay for that plan. Ms. Lopes stated that in the AHCT standardized Silver plan for 2018 with no CSR, there is a $3700 medical deductible and a $250 prescription drug deductible, but a person in the 94% CSR plan will have a zero deductible. In the past, the federal government funded this, but now, it will be funded by an increase in the premium. If the federal payments return, there will be some flexibility and restrictions set by CMS noted Mr. Kelsey.

EHBs are the same both on and off the Exchange. Ms. Lopes added that prescription drug coverage is a good example of the difference between QHPs and off exchange individual plans. Earlier this year, AHCT's Board removed the requirement regarding formulary compliance with AHCT guidelines. AHCT is deferring to Connecticut Insurance Department (CID) for prescription drug formulary review for on Exchange plans, as well as for network adequacy. Previously, AHCT had an additional standard for these elements that carriers had to meet in order to meet QHP certification requirements. AHCT will be circling back in the future to determine whether to continue with this change. . Dr. Ritter inquired about the difference between plans that are considered to be QHPs and those that are not. Mary Ellen Breault stated that all plans both on and off the Exchange are reviewed for compliance with all of the same requirements. The only difference is that to be certified for on Exchange, a plan must also meet certain on Exchange requirements. Ms. Lopes clarified that QHPs must meet AHCT certification requirements, and gave an example of a difference between minimum requirements of the ACA for a carrier to be certified to offer plans on Exchange and those of AHCT. She outlined the situation where, in the federal marketplace, a carrier must submit a Gold and a Silver plan to be considered for certification. AHCT's requirement regarding number of plans is that carriers must submit, at a minimum, each of the standardized plans in the Individual market. Ms. Kelleher indicated this is a 'layered' approach that includes Federal, State and AHCT requirements.

Mr. Jeffreys asked whether certain plan components can affect the AV of a plan, and could change its metal level. He also asked whether any of the carriers requested a data call and if so, would CID have enough time to solicit that information prior to plan design development for 2019. Ms. Breault replied that no carriers have yet made a request and it needs to happen very soon. It would be a review to see if the maximum co-pays can be increased. Mr. Jeffreys added that he hears a lot of discussion regarding the generic drug copay maximum. Ms. Breault responded that it is currently $5 and could go down based on data. Ms. Breault added that there are other options, such as coinsurance or coinsurance with a maximum. Mr. Jeffreys indicated that it would be necessary to ensure consumers understood those types of benefits.

Ms. Lopes whether AHCT should remove the certification requirement for carriers to submit standardized plans in the individual market. Reasons to retain and eliminated were summarized. The appendix includes updated enrollment data showing consumers in the standard plans versus

non-standard plans. There is very high participation in AHCT standard plans at all metal tiers. If standard plans are removed, the mapping for purposes of renewing the enrollee may see some disruption. Mr. Jeffreys asked whether instead of removing standardized plans, AHCT removes the requirement for the lowest cost Silver to be a standard plan, would allow AHCT to continue offering standardized plans and effectively lower premiums. Ms. Lopes stated that the committee needs to first decide if AHCT should continue to require standardized plans for the individual market. Mr. Jeffreys stated that if AHCT keeps standardized plans, but removes the requirement for the standard Silver plan to be the lowest cost Silver plan submitted by a carrier, a non-standard plan could be the lowest cost, but AHCT could still ensure there were innovative plans from a standardization viewpoint. Mr. Ritter added that many consumers do not understand the plan benefits and are choosing the lowest premium, so we are making the decision for the consumer and providing a decent plan option at the lowest possible cost. If removed, the lower cost plans may not be appropriate for consumers. Ms. Rich-Bye stated that the result would also reduce the amount for premium subsidies, because it would be based on a lower cost plan. Mr. Nguyen added that premium subsidies must be considered in this analysis. You want consumers to get premium subsidies high enough so they can afford to buy the plan. If you decide to go with a standard plan for Silver, may want to ask if we want to eliminate the non-standard plan so that the calculation is always based on the second lowest cost Silver standardized plan. Mr. Ritter suggested that at least one of two standard plans is available at the lowest cost. Ms. Lopes added that for 2018, consumers will start looking at the Bronze plans closely because Silver plan premium increases resulted in increased premium tax credits, and Bronze plans will look more attractive from a premium perspective.

Mr. Ritter asked whether the non-standard plans have to meet the mental health parity requirements as well. Ms. Lopes replied yes. Mr. Kelsey added that there needs to be additional communication on what the standard plan design is beyond what is on a piece of paper. Ms. Kelleher added that dialogue is starting sooner to prevent going down a path where it is too late to change course in meeting items such as mental health parity. The input from carriers is welcomed and valuable. By eliminating standardized plans, administratively, from a timing perspective, that needs to be closely aligned with what carriers are considering from a system perspective to make sure the consumer portal can display plan information as clearly as possible to help consumers understand. Mr. Kelsey added that the Board and the Committee need to be aware that they will lose control of the plan offerings on the Exchange if the requirement regarding standardized plans is removed. Other carriers can come up with products on the Exchange and the Committee or the Exchange may not approve of the product offerings. Standard plans are a good idea and they need to be refreshed and consistent with what is in the market. Mr. Ritter added that Board will not have an appetite for removing standardized plans. It is better for the consumer in a very complicated situation to have it be the lowest plan. Mr. Ritter is not opposed to offering other plans even on the Silver tier and should be debated further. Mr. Nguyen stated that if a decision is made to continue with only standard Silver plans on the Exchange, it does not mean that other non-standard plans at other tiers are not allowed because subsidies would then be based on the second lowest cost standard Silver plan. Ms. Skinner agreed we should have standardized plans. Ms. Kelleher added that the focus going forward should be the plan mix. Ms. Lopes asked whether a board vote is needed if there is no change. Ms. Rich-Bye stated that there would not be a vote but suggested an update to the Board on the thought process as to the decisions.

Ms. Lopes continued with the next question as to whether AHCT should continue to permit carriers to submit non-standard plans in the individual market. Reasons to continue and eliminate were summarized. Ms. Skinner asked if AHCT has data regarding renewal choices made by consumers enrolled in non-standardized plans. Mr. Jeffreys stated that this information could be shared with the group if available. Ms. Kelleher added that the goal for auto-renewal for 2017-2018 is 85%. Mr.

Jeffreys added that AHCT is aware of those non-subsidized enrollees in Silver plans impacted by the premium increases for 2018 and AHCT is providing outreach to make sure they are aware to consider their options off Exchange or perhaps a bronze plan on Exchange. This group is approximately 4,000 households. Mr. Kelsey is in favor of continuing to allow non-standard plans and table the discussion about allowing them at specific metal levels later in the discussion. It may encourage carrier participation and innovation adding that 15% of the population enrolls in non-standard plans and are there for a reason. The Committee is in agreement but there needs to be further discussion on the plan mix. Kim Martone agrees that the more options there are for consumers, the better.

Ms. Lopes continued with whether AHCT should continue to prescribe the maximum number of plans that carriers can offer on the Exchange. The current number of plans permitted per issuer was discussed. It is not necessary to have a cap on the number of plans. Is there any thought as to whether AHCT should eliminate the current maximum requirement? It allows for a broad array of choices. Having the caps allows AHCT to ensure that an excessive number of plans are not offered through the Exchange, because it could make plan selection more challenging for the consumer. Ms. Skinner noted that it is difficult for carriers to manage a large number of plans. Mr. Nguyen stated that limits make sense and in the past years, Anthem started to simplify its portfolio. Keeping limits make sense to him. Mr. Kelsey added that ConnectiCare is not currently offering the maximum. Mr. Nguyen stated that in the end the key is to provide options so that consumers can shop, while being mindful of premium subsidies. Mr. Kelsey added that the committee and board also need to consider the interests of potential new carrier participants as well. The group agreed to maintain the current maximum number of plans.

Next, Ms. Lopes reviewed the plan mix and ways AHCT could structure requirements for the number of plans that could be submitted. In both the on and off Exchange marketplaces, carriers are moving away from offering rich plans, but AHCT still prescribes a standardized Platinum plan. Perhaps there should be consideration of eliminating the standardized Platinum plan since no carrier is currently submitting one. Especially as it is optional, and two non-standard Platinum plans can be offered. Should a standard optional Platinum continue to be a developed? Mr. Kelsey stated that this requirement creates work that appears unnecessary. Eliminating this would have to be voted on both by the Committee as a recommendation and to the Board for a vote. This will be on the agenda for the next Committee meeting.

The next item for consideration is reducing the number of Gold plans. There are a total of five Gold plans that were filed with the CID for 2018 for both on and off Exchange. Anthem offers two on Exchange, and CBI offers one on Exchange. AHCT requires one and allows up to three non-standard. Is there an appetite to reduce the three non-standard? This is a cap but is there any reason to change. Committee advised no.

The next consideration is eliminating the option for non-standard plans at the Silver metal level, as this falls within the Committee's ability to recommend to the Board. This will result in just two plans at this metal level, one from each carrier. We currently require one standard and up to three non-standard plans. To recap in terms of the number of Silver plans submitted for 2018, there are three from CBI and a total of four from Anthem. Ms. Skinner advised waiting for the data on the

standard and non-standard plans and wait to see what the market is doing. Mr. Nguyen added that data from 2017 will be completely different from the data for 2018 because of the premium increases and premium subsidy increases. The results from this year's Open Enrollment will provide the best information to help inform the decision. Mr. Ritter suggests tabling this until after open enrollment ends. Ms. Rich-Bye suggested looking at the 15% of the population enrolled in non-standard versus standard and whether they are subsidized or unsubsidized. Mr. Jeffreys said historical data could be pulled as well as analytics during open enrollment to see how consumers view value. Information will be shared with the Committee. Mr. Nguyen recommends for the next meeting to examine the calculation for the premium subsidy if the non-standard plan continues as well as the premium subsidy calculation without non-standardized plans at different subsidy levels. Ms. Lopes stated that for last week's board meeting there was a static comparison in different counties between 2017 and 2018 for the standard Silver plans for a 46-year old. The findings for Silver is that other than for non-subsidized consumers, the net cost was going down slightly at every level. This information was posted to the AHCT website, and it did not factor in the change in age slope. Mr. Nguyen asked if the calculation could be examined if the non-standard plans are eliminated at the Silver tier. Ms. Lopes said yes, and this could be a helpful decision point. For Bronze and Catastrophic, AHCT recommends no modifications.

Discussion turned to eliminating the requirement that the lowest cost Silver plan in the individual market be the AHCT standardized Silver plan and reasons to continue or eliminate were summarized. Ms. Lopes stressed that if this requirement is eliminated it will likely result in consumers migrating to other plans because this plan may no longer be deemed to be affordable, particularly if AHCT continues to design it in the same way as has been done in the past by including fixed dollar copays. If the goal of the Exchange is having low cost plan options, this requirement can be eliminated resulting in competitively priced Silver plans to be offset by benefit reductions. During the meeting last month, scenarios were presented using all Silver plans filed and approved in the Individual market on and off Exchange in determining the second lowest cost Silver plan for 2017. In some counties, there was little or no change in the amount of the premium tax credit calculation, but the amount decreased by about 8% for some areas. This same exercise could not be used for 2018 because of the increases in premium for on Exchange Silver plans, caused by the assumption that federal CSR payments would cease. Ms. Skinner asked if it is possible to get more people enrolled because of increased competition. Mr. Ritter stated he did not think so because Bronze plans are a cheaper option. The de minimis actuarial value range for Silver plans is 66% – 72%. Ms. Kelleher stated that there is also an expanded de minimis range for the actuarial value for Bronze plans that now goes up to 65%. A change to the requirement could result in a lower premium benchmark. Lower premium benchmark for everybody would result in reduced tax credits. Mr. Kelsey stated this would be the down side, as people would be eligible for smaller premium subsidies. Mr. Ritter stated that AHCT's Silver standard plan is a 72% actuarial plan, which maximizes the amount of money from the federal government for premium subsidies. Another comment was that it also results in lower out of pocket costs for consumers. Mr. Nguyen added that those eligible for a 73% CSR are more likely to buy Bronze because of the difference in premium for a small benefit in reduced cost sharing. Mr. Jeffreys added that this should be tabled as well as this OE will show a change in consumer behavior. Mr. Ritter stated that this puts the subsidized and unsubsidized groups directly against each other. For subsidized, it would be better to keep this requirement, and for unsubsidized, it would be better to eliminate it. He said that he believes the Board would lean towards the lower income group.

Mr. Jeffreys asked about consideration of Copper plans. Ms. Lopes stated that an Actuarial Value Calculator tool is not available for these plans at this time. Underlying claim data in the current tool may not support utilization of someone at a Copper level but until there is direction from CMS to determine cost sharing for these, it does not appear to be an option for consideration. It was agreed that it is not currently permitted. Ms. Rich-Bye stated that Catastrophic plans are similar to Bronze plans.

Mr. Jeffreys stated that analysis will be provided from this OE at end of December and from a timing perspective asked if this will meet the plan management's deadline for board approval. This should work, as there are three more Committee meetings between now and when we believe the January Board meeting will be held. Historic information will be shared as well as scenarios. There will be some information available for the next AC meeting. Auto-renewals will be completed by then as well.

Charmaine Lawson reviewed next steps. Silver plans will be revisited as well as reviewing OE data. Future agenda items will be revisited. Discussion about pediatric dental will be included during the plan design development sessions. Mr. Ritter asked that the Board be updated on the Committee's discussions.

Ms. Lawson reviewed the benefit cost sharing categories that need to be considered with the AV Calculator tool and what may be adjusted going forward. Ms. Kelleher stated this is predicated on our current knowledge of the AV Calculator with the landscape as of today, keeping in mind that it could change.

E. Adjournment

Grant Ritter requested a motion to adjourn the meeting. Motion was made by Tu Nguyen and seconded by Neil Kelsey. **Motion passed unanimously.** Meeting adjourned at 6:00 p.m.