As Approved by the Health Plan Benefits and Qualifications Advisory Committee on January 10, 2018

Connecticut Health Insurance Exchange
Health Plan Benefits and Qualifications Advisory Committee (HPBQ AC) Special Meeting

Connecticut Historical Society

Wednesday, December 13, 2017

Meeting Minutes

Members Present:
Grant Ritter (Chair); Neil Kelsey; Tu Nguyen; Robert Tessier; Mary Ellen Breault; Paul Lombardo

Participants by Phone: Mehul Dalal on behalf of Kimberly Martone; Dr. Maria Diaz

Other Participants:
Access Health CT (AHCT) Staff: James R. Wadleigh Jr.; Shan Jeffreys (on the phone); Susan Rich-Bye; Ellen Kelleher; Ann Lopes; Charmaine Lawson; Alexandra Dowe; Gary D'Orsi

Wakely Consulting Group: Julie Andrews

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: November 29, 2017 Meeting Minutes

Chair Ritter requested a motion to approve the November 29, 2017 Health Plan Benefits and Qualifications Advisory Committee Special Meeting Minutes. Motion was made by Robert Tessier and seconded by Tu Nguyen. ***Motion passed unanimously.***

D. Certification Requirements

Charmaine Lawson, Carrier Product Manager, provided the Committee with a brief overview of the certification review schedule as outlined in the presentation. Ms. Lawson also outlined matters discussed at previous meetings.

- Policies and criteria utilized were reviewed.
- Julie Andrews of the Wakely Consulting Group provided an overview of 2018 plan designs available in the federally-facilitated marketplace (FFM) focusing on cost-sharing for 14 specific benefits.
- Robert Tessier inquired whether a large percentage of plans across the country have the co-insurance after the deductible cost-sharing feature. Ms. Andrews indicated that it is the case. Mr. Tessier expressed his concern that a co-insurance payment in addition to a deductible makes the medical insurance coverage unaffordable for many consumers, and AHCT has tried to avoid this for the past five years. The trade-off is lower premiums, but there would be less coverage. Mary Ellen Breault explained that even in Silver plans, substantial deductibles exist and preventative is the only benefit with zero cost sharing to consumers.
- Dr. Ritter expressed his concern about deductible levels along with costs associated with co-insurance. Ms. Andrews described prescription drug costs. James Wadleigh stated that last year we ran a $10 co-pay for generic medications in the AV Calculator and it reduced the AV by 3 points on just that one change. Dr. Ritter added that the AV Calculator is very sensitive to the pricing of generic medications, and that there are many popular generics that are very expensive now. Mr. Nguyen added that it might be caused by the volume of the generic drugs used. Ms. Breault stated that a maximum copay of $5 or coinsurance of 50% for generic drugs is currently permitted in Connecticut. Discussion ensued around the AV calculator ranges and the utilization of services as well as unaffordability of plans with deductibles and coinsurance vs. copays.
- Mr. Wadleigh stated that there may be a need to have a conversation about the goals of this Committee and plan designs. Is it to influence premium, lower the size of the deductible, have benefits with co-payments? Do we want to change some of the fundamental premises that were established 4-5 years ago. Neil Kelsey inquired whether the committee should develop goals and objectives for the Board's consideration or it should be the other way around. Mr. Tessier stated that the Board has received recommendations from the Committee and broadly, the Board believes the Committee members are close to the issues, and does not believe the Board is looking to weigh in with recommendations. Mr. Tessier expressed his concern about costs of medical insurance, which includes high premiums, deductibles and co-insurance. People expect to pay a copay for most services, and those who have difficulty paying the premium for a plan will at least be able to obtain value from the plan by paying lower costs for the services covered by the plan. Mr. Wadleigh indicated that the HPBQ Advisory Committee is extremely important in issuing recommendations that ultimately affect many Connecticut residents.

Dr. Maria Diaz joined by phone at 4:34 p.m.

- Ms. Breault summarized the need for mental health parity testing to be confirmed prior to plan designs being submitted to the Board for approval. Ms. Lopes described initiatives taken up by the Plan Management Team pertaining to the mental health parity testing aspect to ensure that carriers would be able to meet this requirement, as well as actuarial value testing, for the proposed standardized plans prior to presentation to the HPBQ AC and Board.

  Paul Lombardo arrived at 4:40 p.m.

  Ms. Andrews outlined the CMS proposed regulation changes for 2019 and provided information on the changes to the 2019 Federal AV calculator. Data underlying the calculator was not updated from the prior year. In addition, the updated annual trend factors project 2015 claims to 2018 using 3.25% for medical claims and 11.5% for pharmacy claims. They also project 2018 claims to 2019 using 5.40% for medical claims and 11.5% for pharmacy claims. Ms. Andrews reviewed the maximum copays permitted in the State per regulations and CID guidance.

- Ms. Andrews indicated that the 2019 AV for all 2018 standardized plans (except for the Bronze HSA compatible plan) exceeded the de minimis range in part due to the trending of medical services benefits. Ms. Andrews summarized the proposed changes affecting the least number of levers, for the Gold, Silver and Bronze plans in the individual market.
  - Gold plan changes were to increase the medical deductible from $1250 to $1300 and increase the out-of-pocket maximum from $4400 to $5000;
  - Silver plan changes were to increase the medical deductible from $3700 to $4300 and increase the out-of-pocket maximum from $7350 to $7900;

- Mr. Nguyen added that the 70% silver plan would be less critical if the Cost Sharing Reductions (CSR) are not funded because members that don't receive subsidies are less likely to purchase this plan. Paul Lombardo added that it could also relate to the 73% silver plan. Mr. Wadleigh stated that the net number of unsubsidized customers is approximately 2500. Ms. Lopes indicated that approximately 86-87% of AHCT's auto-enrolled population were renewed into an equivalent plan for 2018. The majority of that population has not taken action to change to a different plan. Ms. Lopes added that for enrollees new to the Exchange, which is about 17,000 individuals, price sensitivity is a major driving factor in determining which plan to choose. Customer product migration evaluated from 2016 to 2017 found that approximately 20% of enrollees who were subsidy eligible moved to a lower metal level, and 36% of those not eligible for financial assistance moved to a lower metal level, and we are seeing comparable migration trends this year. Mr. Wadleigh added that there are less than 8,000 customers that were enrolled for 2017 but are not yet enrolled for 2018.

- Dr. Ritter inquired whether the AV calculator handles co-insurance for generic drugs. Ms. Andrews indicated that it does include that. Ms. Breault added that the maximum co-insurance for medications is 50 percent. Mr. Lombardo added that a combination of co-insurance and cap could be used. Ms. Andrews stated that the Bronze plan change was an increase of the out-of-pocket maximum from $7350 to $7900, and there were no changes needed for the HSA-compatible Bronze plan.

- Ms. Breault stated that CID asked the carriers to come up with alternative plan designs in order to avoid possibly facing obstacles with the mental health parity testing that will be lower cost plans that could result in substantial premium savings of as much as 20-25% for the Gold metal level.
- Two different alternative Gold plan designs were summarized which included the PPO/POS and in-network only types.
    - Gold plan changes included, for the first alternative, an increase in the deductible from $1250 for medical and $50 for prescription drug to a combined deductible of $2000 and an increase in the out-of-pocket maximum from $4400 to $6250; the PCP copay would increase from $20 to $30 and the Specialist copay would increase from $40 to $50; some services would be subject to coinsurance rather than a copay, and some would now be subject to a combined medical/prescription drug deductible as well, including some of the prescription drug tiers;
    - Gold plan changes included, for the second alternative, an increase in the deductible from $1250 for medical and $50 for prescription drug to a combined deductible of $1500 and an increase in the out-of-pocket maximum from $4400 to $7350; the PCP copay would increase from $20 to $40 and the Specialist copay would increase from $40 to $50; many services would be subject to coinsurance rather than a copay, with many subject to a combined medical/prescription drug deductible as well, including some of the prescription drug tiers; there would not be any out-of-network coverage available, except for emergency services;

- Mr. Lombardo added that when the co-pay maximum for the laboratory was set at $10, 96.3 percent of claims that came in for these services received from the data submitted to CID by the carriers would be covered at a $10 copay using 50% coinsurance. There would not be a significant change in the cost sharing to the individual consumer when moving from copay to coinsurance, for the vast majority of laboratory services.
- Ms. Breault indicated that they cannot promise the savings, because assumptions and networks could change when rates are filed next year. Dr. Ritter inquired about the reasoning behind the six percent savings in the AV, which would make a 20 percent savings in premium. Ms. Breault stated that it is because the AV is based on a small market basket of benefits, and does not take into account the value of out-of-network

benefits when available in the plan. It represents the portion of expected claims that would be paid by the plan vs the consumer.

- Ms. Breault provided information on the alternative Silver plans.
    - Silver plan changes included, for the first alternative, an increase in the deductible from $3700 for medical and $250 for prescription drug to a combined deductible of $5500; some services would be subject to coinsurance rather than a copay, and some would now be subject to a combined medical/prescription drug deductible as well, including some of the prescription drug tiers;
    - Silver plan changes included, for the second alternative, a revision in the deductible from $3700 for medical and $250 for prescription drug to a combined deductible of $3700; some services would now be subject to coinsurance rather than a copay, with many subject to a combined medical/prescription drug deductible, including some of the prescription drug tiers; there would not be any out-of-network coverage available, except for emergency services;
- Ms. Breault provided information on the alternative Bronze plans.
    - Bronze plan changes included, for the first alternative, an increase in the deductible from $6000 for combined medical and prescription drug to $7000; the majority of the services would be subject to coinsurance and the deductible, including PCP, Specialist and generic drugs;
    - Bronze plan changes included, for the second alternative, a revision in the out-of-pocket maximum from $7350 to $7900; more services would now be subject to coinsurance rather than a copay, including radiology and laboratory and inpatient hospital; there would not be any out-of-network coverage available, except for emergency services;

- Dr. Ritter encouraged the carriers to explore alternative plans in the bronze and gold metal levels. Dr. Ritter asked if it is wise to explore the HMO plan design for a silver standard plan. Potential of 25 percent premium savings exists, but with a much different coverage. Do we want to go to more coinsurance as in alternative one? These would be something for the entire Board to weigh in on. Mr. Kelsey stated that making these revisions for 2019 would likely result in less changes being required for the subsequent plan year, because the AV is at the lower end of the range. Dr. Ritter stated that one of the alternative Silver plans could be tweaked slightly to get it down to the range of a Bronze plan and offer it as a non-standard Bronze plan on the Exchange. Mr. Nguyen indicated that whenever the plan is designed, different populations need to be considered separately. There are non-subsidized and subsidized populations. Mr. Nguyen stated that the most important plans for subsidized are the Silver metal tier at the 87% CSR and 94% CSR. Ms. Breault emphasized that the alternate plans are not recommendations. They serve for illustrative purposes only. Dr. Ritter stated that the Silver plan could be

structured with a high cost with the assumption that only subsidized individuals will take it, resulting in the ability to obtain a Gold plan that is a little more costly or a Bronze plan at virtually no cost, resulting in maximizing the federal subsidy. Mr. Wadleigh added that a strategy needs to be defined before the decisions are made. Mr. Lombardo stated that the 87% and 94% CSR plans will continue to result in very reduced cost sharing for the population that qualifies for them. Mr. Kelsey added that a lot more flexibility exists in plan designs in the market outside of the Exchange. In that way, the unsubsidized population does not have to purchase medical insurance through AHCT, they can find alternative plans off-Exchange. Dr. Ritter stated that these individuals may not want to purchase the Silver plan on the Exchange, but they can choose a Bronze plan that is less expensive. Dr. Ritter indicated that some plans with co-insurance with the cap might be one of the possible options to consider. Mr. Wadleigh stated that AHCT wants to offer plans that are competitive or equal in value to those available off-Exchange plans.

- Ms. Kelleher stated that over the years, HSA and co-insurance-based plans have been introduced and we may be at a point of introducing more coinsurance-based plans that are not HSA compatible.
- Mr. Lombardo reviewed information on benefits that are included in the plans offered by both carriers, such as pediatric dental and vision services that may need to be evaluated for continued inclusion in the Essential Health Benefits benchmark plan, as well as consideration for reducing coverage limits.
- Ms. Lopes added that in the event that this is a path that we want to pursue, it would be up to the State to request a revision to the EHB benchmark plan and file with CMS/CCIIO to get approval needed for it to be changed. It would not be an Exchange item. The reason the current EHB benchmark plan includes a 90 day limit for skilled nursing is because the benchmark plan chosen for Connecticut included that level of benefit. It is not something that we can go ahead and do at this time under existing regulations. It would require a process to be in place to complete this.

E. Next Steps

- Ms. Kelleher reviewed the certification review timeline, advising the group that another meeting for January should be entertained in order to hold a discussion on the remaining topics, including those not covered today. Mr. Tessier suggested January 24th as the next meeting date. The group agreed that this date should be proposed.

F. Adjournment

Chair Grant Ritter requested a motion to adjourn the meeting. Motion was made by Robert Tessier and seconded by Tu Nguyen. ***Motion passed unanimously.*** Meeting adjourned at 6:07 p.m.