Board of Directors
Special Meeting

February 28, 2017

access health CT

Agenda

A. Call to Order and Introductions

B. Public Comment

C. CEO Report

D. Standardized Plans for 2018 – Vote

E. Certification Requirements for 2018 – Vote

F. Next Steps

G. Adjournment

Meeting Objectives

A. Review and approval of Standardized Plans for 2018

B. Review and approval of specified AHCT certification requirements for 2018

- Formulary
- Network Adequacy
- Essential Community Providers

C. Consider inclusion of tobacco surcharge in the Individual Market

➢*Standardized Plans for 2018*

Standard Plan Design Development Incorporates AHCT…

Vision

- The CT Health Exchange supports health reform efforts at the state and national level that provide CT residents with better health, and an enhanced and more coordinated health care experience at a reasonable, predictable cost.

Mission

- To increase the number of insured residents, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and provider that give them the best value.

Strategic Goals

- Focus on providing access to quality insurance choices for individuals and small businesses, delivering a positive customer experience, improving quality, cost transparency and reducing disparities in health care; which will result in healthier people, healthier communities and a healthier Connecticut.

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Overview: Standardized Plans

- Purpose
  - Promotes transparency, ease, and simplicity for comparison shopping
    - Cost-sharing for a key set of benefits is specified, including deductible, co-payment and/or co-insurance cost sharing for in-network and out-of-network coverage
- AHCT Individual Market Current Standardized Plan - Issuer Requirements
  - Platinum is optional
  - Gold, Silver, Bronze, Bronze HSA are required
  - Plan variants are also required in support of Cost Sharing Reduction options
- AHCT Small Group Market Current Standardized Plan - Issuer Requirements
  - Platinum, Gold, Silver, Silver HSA, Bronze, Bronze HSA are required

2017 Standardized/Non-Standard Plan Submissions

Number of QHPs for Submission by Issuers: Standardized & Non-Standard

Current guidelines, as approved by AHCT BOD, are outlined in the table below:

Number of Plans Permitted per Issuer				
	Individual Market*		Small Group Market	
	Standardized	Non-Standard	Standardized	Non-Standard
Platinum	1 (Optional)	2	1	2
Gold	1	3	1	3
Silver	1	3	2	3
Bronze	2	3	2	3
Catastrophic	N/A	1	N/A	N/A
Total	4 Required / 1 Optional	12 Optional	6 Required	11 Optional
Maximum	17		17	

2017 Available Plan Offerings

19 in Individual market (two issuers):

- 8 standardized plans (no Platinum)
- Non-standard plans: 2 Gold, 5 Silver, 2 Bronze and 2 Catastrophic

8 in Small Group market (one issuer):

- 6 standardized plans
- Non-standard plans: 1 Gold, 1 Bronze

**Additionally, plan variants are required for submission in the Individual Market*

Wakely

Access Health CT

2018 Standard Plan Designs

February 28, 2017

PRESENTED BY

Julie Andrews, FSA, MAAA – Sr. Consulting Actuary

Brittney Phillips, ASA, MAAA – Consulting Actuary

Agenda

1. Regulatory Changes
2. Federal AVC Changes
3. Notes and Caveats
4. Maximum Copays
5. Summary of Proposed Changes
6. Proposed Plan Designs

Regulation Changes for 2018

- Annual limitation on cost sharing was increased to $7,350 (from $7,150 in 2017)
  - Note: This limit does not apply to HSA qualified High Deductible Health Plans (HDHPs). That limit is released by the IRS in the spring.
  - The Cost Sharing Reduction (CSR) plan variations have a different set of limits:
    - 94% CSR (100-150% FPL): $2,450
    - 87% CSR (151-200% FPL): $2,450
    - 73% CSR (201-250% FPL): $5,850

Regulation Changes for 2018, Cont'd

- Expanded bronze "de minimis" range was finalized, which allows bronze plans with certain designs to have an AV between 58% and 65% (compared to 58% and 62% in prior years).
  - Applicable plans include HDHP plans, or plans that cover at least one major service, other than preventive, prior to the deductible.
  - Based on the 2017 plan designs, the CT standard bronze plan designs qualify for this expanded range.
  - Should CT choose to select a higher AV for the Bronze plans, this would likely translate to higher premiums for the members.
  - There would also be less distinction between the Bronze and Silver Plans, as the Silver plan AV is still limited to 72%.
- CMS released a proposed rule in mid-February that would allow plans a wider AV range of -4% to +2% (or -4% to +5% for Bronze plans described above), compared to the current range of -2% to +2%.

Changes to the Federal AVC for 2018

- Data underlying the calculator was updated
  - New data is based on 2015 individual and small group claims from a national database.
    - This is the first time underlying data has been updated since the original calculator used for the 2014 plan year.
    - Prior versions were based on 2010 claims data from a national database with small and large group experience.
  - Updated annual trend factors to project 2015 claims to 2018 using 3.25% for medical claims and 11.5% for pharmacy claims.
    - The prior calculators applied a 6.5% annual trend to both medical and pharmacy claims.
    - As a result, the average allowed amount of medical claims decreased and pharmacy increased in the calculator.
- Additionally, there were several functionality changes made, primarily to the calculation of the impact of the Maximum Out-of-Pocket (MOOP).

Notes and Caveats

- Federal HDHP minimum deductible and MOOP limits are not yet released for 2018.
  - The 2017 minimum single deductible and MOOP are $1,300 and $6,550, respectively.
  - The proposed plan designs do not make changes to either the HDHP deductible or MOOP.
    - The minimum deductible typically increases $50 every two to three years and the last increase was for the 2015 plan year.
    - The MOOP increases about $100 each year, though it did not increase from 2016-2017.
- The cost sharing shown on the following slides represents costs for in-network services, unless specified.
- The deductible and MOOP limits shown are for individuals. The family limits are 2x the individual limit for all plans.
- Preventive care is covered at no cost to the member for all plans.
- Mental Health cost sharing is the same as Primary Care for all plans.

Notes and Caveats, Cont'd

- The premium changes shown are meant to illustrate the trade-off between premium increases and cost sharing increases. The actual premium change will be based on each carriers' model and experience and may differ significantly from what is shown.
  - The premium change is based on the Wakely benefit model. The actuarial values were based on high level estimates of allowed PMPMs and adjusted for each metal level by the federal induced utilization factors. These estimates should be used as a high level estimate and an additional reference point, but not as the actual expected premium changes.

Enrollment by Metal Level

Metal Level	Percent Enrollment in AHCT Standard Plans – IND Market
Platinum	0.00%
Gold	7.63%
Silver	54.30%
Silver Standard	16.20%
Silver 73%	8.50%
Silver 87%	15.50%
Silver 94%	14.10%
Bronze	7.50%
Bronze HSA	14.10%

- Enrollment as of January 10, 2017
- Total enrollment was approximately 105,000 and 83.5% of enrollment in the individual market was in an AHCT standard plan.

Maximum Copays

- CID Bulletin HC-109 specified maximum benefit copays.

Service Category	Maximum Copay
Durable Medical Equipment	$25
Home Health Care	$25
Ambulance	$225
Laboratory	$10
Routine Radiology Services	$40
PCP Office Visit	$40
Specialist Office Visit	$50
Urgent Care	$75
Emergency Room	$200
Inpatient Admission	$500/day up to $2,000
Outpatient Surgery/Services	$500
Generic Drug	$5
Brand Drug	$60
Physical Therapy*	$30

- On the following slides, copays at these maximums are shown with an asterisk (*)

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* Sec. 38a-511a & 38a-550a limit physical therapy copays to $30.

Access Health CT
2018 Standard Plan Designs
Individual Market

Individual - Summary of AV Changes

Individual Market	Platinum	Gold	Silver	Bronze	Bronze HSA
Permissible AV Range[2]	88.0%-92.0%	78.0%-82.0%	68.0%-72.0%	58.0%-65.0% [1]	58.0%-65.0% [1]
2017 AV	89.18%	81.05%	71.98%	61.98%	62.00%
2018 AV	90.15%	**84.11%**	**76.18%**	61.93%	61.20%

[1] Bronze plan designs are eligible for new expanded "de minimis" range

[2] CMS released proposed regulations that would expand the lower end of these ranges to -4%, compared to -2% in shown here. Since the regulation is not finalized, the ranges above do not reflect this change.

Individual Market - CSR Plan Variations	73% AV CSR	87% AV CSR	94% AV CSR
Permissible AV Range	72.0%-74.0% [3]	86.0%-88.0%	93.0%-95.0%
2017 AV	73.98%	87.87%	94.97%
2018 AV	**78.07%**	**88.98%**	93.95%

[3] 73.0% CSR Silver must be have a differential of 2.0%+ with Standard Silver

2018 - Individual Market Platinum Plan, 90% AV

Advisory Committee chose Option 1 as their recommendation

	2017 Platinum & 2018 Option 1
Combined Medical & Rx Deductible	$150 (INN)/$2,000 (OON)
Coinsurance	20%
Out-of-pocket Maximum	$2,000 (INN)/$4,000 (OON)
Primary Care	$15
Specialist Care	$30
Urgent Care	$50
Emergency Room	$100
Inpatient Hospital	$300 per day (after ded., $600 max. per admission)
Outpatient Hospital	$300 (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75
Non-Advanced Radiology (X-ray, Diagnostic)	$30
Laboratory Services	$10 *
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$15
Chiropractic Care 20 visit calendar maximum	$30
All Other Medical	20%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $15 / $30 / 20% (spec. after ded., $100 max per spec. script)
2017 AVC Results	**89.18%**
2018 AVC Results	**90.15%**
Difference	0.98%
Estimated Premium Impact	0.32%

Changes from the 2017 plan design are shown in red font and boxes.

*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2018 - Individual Market Gold Plan, 80% AV

Advisory Committee chose Option 3 as their recommendation

	2017 Gold	2018 Gold Option 1	2018 Gold Option 2	2018 Gold Option 3
Medical Deductible	$1,550 (INN)/$3,000 (OON)	**$2,250 (INN)/$4,500 (OON)**	**$1,750 (INN)/$3,500 (OON)**	**$2,250 (INN)/$4,500 (OON)**
Rx Deductible	$25 (INN)/$350 (OON)	**$50 (INN)/$350 (OON)**	**$50 (INN)/$350 (OON)**	**$50 (INN)/$350 (OON)**
Coinsurance	30%	30%	30%	30%
Out-of-pocket Maximum	$3,500 (INN)/$6,000 (OON)	**$4,400 (INN)/$8,800 (OON)**	**$4,000 (INN)/$8,000 (OON)**	**$4,400 (INN)/$8,800 (OON)**
Primary Care	$20	$20	**$25**	$20
Specialist Care	$40	$40	**$45**	$40
Urgent Care	$50	$50	$50	$50
Emergency Room	$100	**$100 (after ded.)**	**$150 (after ded.)**	**$200**
Inpatient Hospital	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)
Outpatient Hospital	$500 * (after ded.)	$500 * (after ded.)	$500 * (after ded.)	$500 * (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$65	$65	**$75**	$65
Non-Advanced Radiology (X-ray, Diagnostic)	$40 *	$40 *	$40 *	$40 *
Laboratory Services	$10 *	$10 *	$10 *	$10 *
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$20	$20	**$25**	$20
Chiropractic Care 20 visit calendar maximum	$40	$40	$40	$40
All Other Medical	30%	30%	30%	30%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $25 / $50 / 20% (spec. after ded., $100 max per spec. script)	$5 * / $25 / $50 / 20% (spec. after ded., $100 max per spec. script)	$5 * / $25 / $50 / 20% (spec. after ded., $100 max per spec. script)	$5 * / $25 / $50 / 20% (spec. after ded., $100 max per spec. script)
2017 AVC Results	**81.05%**	N/A	N/A	N/A
2018 AVC Results	**84.11%**	**80.21%**	**81.20%**	**81.69%**
Difference	3.06%	-0.84%	0.15%	0.64%
Estimated Premium Impact	N/A	-0.35%	0.24%	0.67%

Changes from the 2017 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2018 - Individual Market Silver Plan, 70% AV

Advisory Committee chose Option 1 as their recommendation

	2017 Silver	2018 Silver Option 1	2018 Silver Option 2	2018 Silver Option 3	2018 Silver Option 4
Medical Deductible	$4,000 (INN)/ $6,000 (OON)	**$5,000 (INN)/ $10,000 (OON)**	**$4,500 (INN)/ $9,000 (OON)**	**$4,400 (INN)/ $8,800 (OON)**	**$4,700 (INN)/ $9,400 (OON)**
Rx Deductible	$150 (INN)/ $350 (OON)	**$250 (INN)/ $500 (OON)**	**$200 (INN)/ $400 (OON)**	**$200 (INN)/ $400 (OON)**	**$200 (INN)/ $400 (OON)**
Coinsurance	40%	40%	40%	40%	40%
Out-of-pocket Maximum	$7,150 (INN)/ $12,500 (OON)	**$7,350 (INN)/ $14,700 (OON)**	**$7,350 (INN)/ $14,700 (OON)**	**$7,350 (INN)/ $14,700 (OON)**	**$7,350 (INN)/ $14,700 (OON)**
Primary Care	$35	**$40 ***	$35	$35	$35
Specialist Care	$50 *	$50 *	$50 *	$50 *	$50 *
Urgent Care	$75 *	$75 *	$75 *	$75 *	$75 *
Emergency Room	$200 *	**$200 * (after ded.)**	**$200 * (after ded.)**	**$200 * (after ded.)**	**$200 * (after ded.)**
Inpatient Hospital	$500 per day (after ded., $2,000 max. per admission) *	$500 per day (after ded., $2,000 max. per admission) *	$500 per day (after ded., $2,000 max. per admission) *	$500 per day (after ded., $2,000 max. per admission) *	$500 per day (after ded., $2,000 max. per admission) *
Outpatient Hospital	$500 * (after ded.)	$500 * (after ded.)	$500 * (after ded.)	$500 * (after ded.)	$500 * (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75	$75	**$75 (after ded.)**	**$75 (after ded.)**	**$75 (after ded.)**
Non-Advanced Radiology (X-ray, Diagnostic)	$40 *	$40 *	$40 *	$40 *	$40 *
Laboratory Services	$10 *	$10 *	$10 *	$10 *	$10 *
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	30 *	30 *	30 *	30 *	$30 *
Chiropractic Care 20 visit calendar maximum	$50	$50	$50	$50	$50
All Other Medical	40%	40%	40%	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $35 / $60 * / 20% (spec. after ded., $200 max per spec. script)	**$5 * / $35 / $60 * / 20% (all but generic after ded., $200 max per spec. script)**	**$5 * / $35 / $60 * / 20% (all but generic after ded., $200 max per spec. script)**	**$5 * / $35 / $60 * / 20% (all but generic after ded., $200 max per spec. script)**	**$5 * / $35 / $60 * / 20% (non-preferred brand and spec. after ded., $200 max per spec. script)**
2017 AVC Results	**71.98%**	**N/A**	**N/A**	**N/A**	**N/A**
2018 AVC Results	**76.18%**	**71.95%**	**71.88%**	**71.99%**	**71.92%**
Difference	4.20%	-0.03%	-0.10%	0.01%	-0.06%
Estimated Premium Impact	N/A	0.80%	-0.33%	-0.26%	-0.53%

Changes from the 2017 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2018 - Individual Market Silver Plan, 73% AV CSR

Advisory Committee chose Option 1 as their recommendation

	2017 Silver 73% CSR	2018 Silver 73% CSR - Option 1 (Corresponds with Silver Option 1)	2018 Silver 73% CSR - Option 2 (Corresponds with Silver Option 2 or 3)	2018 Silver 73% CSR - Option 3 (Corresponds with Silver Option 4)
Medical Deductible	$3,400	**$4,700**	**$4,150**	**$4,300**
Rx Deductible	$100	**$250**	**$150**	**$150**
Coinsurance	40%	40%	40%	40%
Out-of-pocket Maximum	$5,700	**$5,850**	**$5,850**	**$5,850**
Primary Care	$35	**$40 ***	$35	$35
Specialist Care	$50 *	$50 *	$50 *	$50 *
Urgent Care	$75 *	$75 *	$75 *	$75 *
Emergency Room	$200 *	**$200 * (after ded.)**	**$200 * (after ded.)**	**$200 * (after ded.)**
Inpatient Hospital	$500 per day (after ded., $2,000 max. per admission) *	$500 per day (after ded., $2,000 max. per admission) *	$500 per day (after ded., $2,000 max. per admission) *	$500 per day (after ded., $2,000 max. per admission) *
Outpatient Hospital	$500 * (after ded.)	$500 * (after ded.)	$500 * (after ded.)	$500 * (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75	$75	**$75 (after ded.)**	**$75 (after ded.)**
Non-Advanced Radiology (X-ray, Diagnostic)	$40 *	$40 *	$40 *	$40 *
Laboratory Services	$10 *	$10 *	$10 *	$10 *
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30 *	$30 *	$30 *	$30 *
Chiropractic Care 20 visit calendar maximum	$50	$50	$50	$50
All Other Medical	40%	40%	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $35 / $60 * / 20% (spec. after ded., $100 max per spec. script)	**$5 * / $35 / $60 * / 20% (all but generic after ded., $100 max per spec. script)**	**$5 * / $35 / $60 * / 20% (all but generic after ded., $100 max per spec. script)**	**$5 * / $35 / $60 * / 20% (non-preferred brand and spec. after ded., $100 max per spec. script)**
2017 AVC Results	**73.98%**	**N/A**	**N/A**	**N/A**
2018 AVC Results	**78.07%**	**73.99%**	**73.99%**	**73.97%**
Difference	4.09%	0.01%	0.01%	-0.01%

Out of Network Cost Sharing will match the Standard Silver
Changes from the 2017 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2018 - Individual Market Silver Plan, 87% AV CSR

Advisory Committee chose Option 1 as their recommendation

	2017 Silver 87% CSR	2018 Silver 87% CSR - Option 1
Medical Deductible	$700	**$750**
Rx Deductible	$50	$50
Coinsurance	40%	40%
Out-of-pocket Maximum	$1,800	**$2,000**
Primary Care	$20	$20
Specialist Care	$35	$35
Urgent Care	$35	$35
Emergency Room	$75	**$75 (after ded.)**
Inpatient Hospital	$100 per day (after ded., $400 max. per admission)	$100 per day (after ded., $400 max. per admission)
Outpatient Hospital	$100 (after ded.)	$100 (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$60	$60
Non-Advanced Radiology (X-ray, Diagnostic)	$30	$30
Laboratory Services	$10 *	$10 *
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$20	$20
Chiropractic Care 20 visit calendar maximum	$35	$35
All Other Medical	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $20 / $35 / 20% (spec. after ded., $60 max per spec. script)	**$5 * / $20 / $35 / 20% (non-preferred brand and spec. after ded., $60 max per spec. script)**
2017 AVC Results	**87.87%**	**N/A**
2018 AVC Results	**88.98%**	**87.94%**
Difference	1.11%	0.08%

Out of Network Cost Sharing will match the Standard Silver
Changes from the 2017 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2018 - Individual Market Silver Plan, 94% AV CSR

Advisory Committee chose Option 2 as their recommendation

	2017 Silver 94% CSR & 2018 Option 1	2018 Silver 94% CSR - Option 2
Medical Deductible	$0	$0
Rx Deductible	$0	$0
Coinsurance	40%	40%
Out-of-pocket Maximum	$1,000	**$750**
Primary Care	$10	$10
Specialist Care	$30	$30
Urgent Care	$25	$25
Emergency Room	$50	$50
Inpatient Hospital	$75 per day ($300 max. per admission)	$75 per day ($300 max. per admission)
Outpatient Hospital	$75	$75
Advanced Radiology (CT/PET Scan, MRI)	$50	$50
Non-Advanced Radiology (X-ray, Diagnostic)	$25	$25
Laboratory Services	$10 *	$10 *
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$20	$20
Chiropractic Care 20 visit calendar maximum	$30	$30
All Other Medical	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $10 / $30 / 20% ($60 max per spec. script)	$5 * / $10 / $30 / 20% ($60 max per spec. script)
2017 AVC Results	**94.97%**	**N/A**
2018 AVC Results	**93.95%**	**94.86%**
Difference	-1.02%	-0.11%

Out of Network Cost Sharing will match the Standard Silver
Changes from the 2017 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2018 - Individual Market Bronze Non-HSA Plan, 60% AV

Advisory Committee chose Option 3 as their recommendation

	2017 Bronze Non-HSA & 2018 Option 1	2018 Bronze Non-HSA Option 2	2018 Bronze Non-HSA Option 3
Combined Medical & Rx Deductible	$6,000 (INN)/$10,000 (OON)	$6,000 (INN)/**$12,000 (OON)**	$6,000 (INN)/**$12,000 (OON)**
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	$7,150 (INN)/$13,200 (OON)	**$7,350 (INN)/$14,700 (OON)**	**$7,350 (INN)/$14,700 (OON)**
Primary Care	$40 *	$40 *	$40 *
Specialist Care	$50 * (after ded.)	$50 * (after ded.)	$50 * (after ded.)
Urgent Care	$75 *	$75 *	$75 *
Emergency Room	$200 * (after ded.)	$200 * (after ded.)	$200 * (after ded.)
Inpatient Hospital	$500 (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)
Outpatient Hospital	$500 * (after ded.)	$500 * (after ded.)	$500 * (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75 (after ded.)	$75 (after ded.)	$75 (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	$40 * (after ded.)	$40 * (after ded.)	$40 * (after ded.)
Laboratory Services	$10 * (after ded.)	$10 * (after ded.)	$10 * (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30 * (after ded.)	$30 * (after ded.)	$30 * (after ded.)
Chiropractic Care 20 visit calendar maximum	$50 (after ded.)	$50 (after ded.)	$50 (after ded.)
All Other Medical	40% (after ded.)	40% (after ded.)	40% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / 50% / 50% / 50% (all after ded., $500 max per spec. script)	$5 * / 50% / 50% / 50% (all after ded., $500 max per spec. script)	**$5 * / 50% / 50% / 50% (all but generic after ded., $500 max per spec. script)**
2017 AVC Results	**61.98%**	**N/A**	**N/A**
2018 AVC Results	**61.93%**	**61.62%**	**63.92%**
Difference	-0.05%	-0.36%	1.94%
Estimated Premium Impact	1.40%	-0.77%	1.80%

Changes from the 2017 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2018 - Individual Market Bronze HSA Plan, 60% AV

Advisory Committee chose Option 1 as their recommendation

	2017 Bronze HSA & 2018 Option 1	2018 Bronze HSA Option 2	2018 Bronze HSA Option 3
Combined Medical & Rx Deductible	$5,685 (INN)/$9,200 (OON)	**$4,500 (INN)**/$9,200 (OON)	**$5,000 (INN)/$10,000 (OON)**
Coinsurance	10%	10%	**20%**
Out-of-pocket Maximum	$6,550 (INN)/$12,900 (OON)	$6,550 (INN)/**$13,100 (OON)**	$6,550 (INN)/**$13,100 (OON)**
Primary Care	10% (after ded.)	10% (after ded.)	**20% (after ded.)**
Specialist Care	10% (after ded.)	10% (after ded.)	**20% (after ded.)**
Urgent Care	10% (after ded.)	10% (after ded.)	**20% (after ded.)**
Emergency Room	10% (after ded.)	10% (after ded.)	**20% (after ded.)**
Inpatient Hospital	10% (after ded.)	10% (after ded.)	**20% (after ded.)**
Outpatient Hospital	10% (after ded.)	10% (after ded.)	**20% (after ded.)**
Advanced Radiology (CT/PET Scan, MRI)	10% (after ded.)	10% (after ded.)	**20% (after ded.)**
Non-Advanced Radiology (X-ray, Diagnostic)	10% (after ded.)	10% (after ded.)	**20% (after ded.)**
Laboratory Services	10% (after ded.)	10% (after ded.)	**20% (after ded.)**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	10% (after ded.)	10% (after ded.)	**20% (after ded.)**
Chiropractic Care 20 visit calendar maximum	10% (after ded.)	10% (after ded.)	**20% (after ded.)**
All Other Medical	10% (after ded.)	10% (after ded.)	**20% (after ded.)**
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	10% / 15% / 25% / 30% (all after ded., $500 max per spec. script)	10% / 15% / 25% / 30% (all after ded., $500 max per spec. script)	10% / 15% / 25% / 30% (all after ded., $500 max per spec. script)
2017 AVC Results	**62.00%**	**N/A**	**N/A**
2018 AVC Results	**61.20%**	**63.65%**	**61.94%**
Difference	-0.80%	1.65%	-0.05%
Estimated Premium Impact	1.40%	3.97%	1.89%

Changes from the 2017 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

Access Health CT
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SHOP - Summary of AV Changes

Small Group Market	Platinum	Gold	Silver	Silver HSA	Bronze	Bronze HSA
Permissible AV Range[2]	88.0%-92.0%	78.0%-82.0%	68.0%-72.0%	68.0%-72.0%	58.0%-65.0% [1]	58.0%-65.0% [1]
2017 AV	90.49%	80.80%	71.43%	70.93%	61.98%	61.56%
2018 AV	89.97%	**82.64%**	**76.07%**	71.16%	61.93%	60.83%

[1] Bronze plan designs are eligible for new expanded "de minimis" range

[2] CMS released proposed regulations that would expand the lower end of these ranges to -4%, compared to -2% in shown here. Since the regulation is not finalized, the ranges above do not reflect this change.

2018 – SHOP Market Platinum Plan, 90% AV

Advisory Committee chose Option 1 as their recommendation

	2017 Platinum & 2018 Option 1
Combined Medical & Rx Deductible	$100 (INN)/$2,000 (OON)
Coinsurance	20%
Out-of-pocket Maximum	$2,000 (INN)/$4,000 (OON)
Primary Care	$15
Specialist Care	$35
Urgent Care	$50
Emergency Room	$100
Inpatient Hospital	$300 per day (after ded., $600 max. per admission)
Outpatient Hospital	$300 (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75
Non-Advanced Radiology (X-ray, Diagnostic)	$40 *
Laboratory Services	$10 *
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$15
Chiropractic Care 20 visit calendar maximum	$30
All Other Medical	20%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $25 / $40 / 20% ($100 max per spec. script)
2017 AVC Results	**90.49%**
2018 AVC Results	**89.97%**
Difference	-0.51%

Changes from the 2017 plan design are shown in red font and boxes.

*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2018 – SHOP Market Gold Plan, 80% AV

Advisory Committee chose Option 1 as their recommendation

	2017 Gold	2018 Gold Option 1	2018 Gold Option 2
Medical Deductible	$1,200 (INN)/$3,000 (OON)	**$1,300 (INN)**/$3,000 (OON)	**$2,000 (INN)/$4,000 (OON)**
Rx Deductible	$50 (INN)/$350 (OON)	$50 (INN)/$350 (OON)	$50 (INN)/$350 (OON)
Coinsurance	30%	30%	30%
Out-of-pocket Maximum	$4,000 (INN)/$6,000 (OON)	**$4,400 (INN)/$8,800 (OON)**	$4,000 (INN)/**$8,000 (OON)**
Primary Care	$25	$25	$25
Specialist Care	$45	$45	$45
Urgent Care	$75 *	$75 *	$75 *
Emergency Room	$200 *	$200 *	**$200 * (after ded.)**
Inpatient Hospital	$500 per day (after ded., $1,500 max. per admission)	$500 per day (after ded., $1,500 max. per admission)	$500 per day (after ded., $1,500 max. per admission)
Outpatient Hospital	$500 * (after ded.)	$500 * (after ded.)	$500 * (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75	$75	$75
Non-Advanced Radiology (X-ray, Diagnostic)	$40 *	$40 *	$40 *
Laboratory Services	$10 *	$10 *	$10 *
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30 *	$30 *	$30 *
Chiropractic Care 20 visit calendar maximum	$45	$45	$45
All Other Medical	30%	30%	30%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $30 / $50 / 20% (spec. after ded., $150 max per spec. script)	$5 * / $30 / $50 / 20% (spec. after ded., $150 max per spec. script)	$5 * / $30 / $50 / 20% (spec. after ded., **$200 max per spec. script**)
2017 AVC Results	**80.80%**	N/A	N/A
2018 AVC Results	**82.64%**	**81.96%**	**80.61%**
Difference	1.84%	1.16%	-0.19%
Estimated Premium Impact	N/A	1.33%	1.24%

Changes from the 2017 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2018 – SHOP Market Silver Non-HSA Plan, 70% AV

Advisory Committee chose Option 2 as their recommendation

	2017 Silver Non-HSA	2018 Silver Non-HSA Option 1	2018 Silver Non-HSA Option 2
Medical Deductible	$4,400 (INN)/$6,000 (OON)	**$4,600 (INN)/$9,200 (OON)**	**$4,600 (INN)/$9,200 (OON)**
Rx Deductible	$150 (INN)/$350 (OON)	**$200 (INN)/$400 (OON)**	**$200 (INN)/$400 (OON)**
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	$7,150 (INN)/$12,500 (OON)	**$7,350 (INN)/$14,700 (OON)**	**$7,350 (INN)/$14,700 (OON)**
Primary Care	$30	**$40 ***	$30
Specialist Care	$50 *	$50 *	$50 *
Urgent Care	$75 *	$75 *	$75 *
Emergency Room	$200 *	**$200 * (after ded.)**	**$200 * (after ded.)**
Inpatient Hospital	$500 per day (after ded., $2,000 max. per admission) *	$500 per day (after ded., $2,000 max. per admission) *	$500 per day (after ded., $2,000 max. per admission) *
Outpatient Hospital	$500 * (after ded.)	$500 * (after ded.)	$500 * (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75	**$75 (after ded.)**	**$75 (after ded.)**
Non-Advanced Radiology (X-ray, Diagnostic)	$40 *	$40 *	$40 *
Laboratory Services	$10 *	$10 *	$10 *
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30 *	$30 *	$30 *
Chiropractic Care 20 visit calendar maximum	$50	$50	$50
All Other Medical	40%	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $35 / $60 * / 20% (spec. after ded., $200 max per spec. script)	**$5 * / $35 / $60 * / 20% (all but generic after ded., $200 max per spec. script)**	**$5 * / $50 / $60 * / 20% (non-preferred brand and spec. after ded., $200 max per spec. script)**
2017 AVC Results	**71.43%**	**N/A**	**N/A**
2018 AVC Results	**76.07%**	**71.58%**	**71.97%**
Difference	4.63%	0.15%	0.54%
Estimated Premium Impact	N/A	0.34%	0.42%

Changes from the 2017 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2018 – SHOP Market Silver HSA Plan, 70% AV

Advisory Committee chose Option 2 as their recommendation

	2017 Silver HSA & 2018 Option 1	2018 Silver HSA - Option 2	2018 Silver HSA - Option 3
Combined Medical & Rx Deductible	$3,200 (INN)/$6,000 (OON)	$3,200 (INN)/$6,000 (OON)	**$3,000 (INN)**/$6,000 (OON)
Rx Deductible	N/A	N/A	N/A
Coinsurance	10%	**20%**	**0%**
Out-of-pocket Maximum	$4,200 (INN)/$12,500 (OON)	$4,200 (INN)/$12,500 (OON)	**$5,000 (INN)**/$12,500 (OON)
Primary Care	10% (after ded.)	**20% (after ded.)**	**0% (after ded.)**
Specialist Care	10% (after ded.)	**20% (after ded.)**	**0% (after ded.)**
Urgent Care	10% (after ded.)	**20% (after ded.)**	**0% (after ded.)**
Emergency Room	10% (after ded.)	**20% (after ded.)**	**0% (after ded.)**
Inpatient Hospital	10% (after ded.)	**20% (after ded.)**	**0% (after ded.)**
Outpatient Hospital	10% (after ded.)	**20% (after ded.)**	**0% (after ded.)**
Advanced Radiology (CT/PET Scan, MRI)	10% (after ded.)	**20% (after ded.)**	**0% (after ded.)**
Non-Advanced Radiology (X-ray, Diagnostic)	10% (after ded.)	**20% (after ded.)**	**0% (after ded.)**
Laboratory Services	10% (after ded.)	**20% (after ded.)**	**0% (after ded.)**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	10% (after ded.)	**20% (after ded.)**	**0% (after ded.)**
Chiropractic Care 20 visit calendar maximum	10% (after ded.)	**20% (after ded.)**	**0% (after ded.)**
All Other Medical	10% (after ded.)	**20% (after ded.)**	**0% (after ded.)**
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	10% / 10% / 10% / 10% (all after ded., $200 max per spec. script)	10% / 10% / 10% / 10% (all after ded., $200 max. per spec. script)	**$5 / $50 / 50% / 50% (all after ded.)**
2017 AVC Results	**70.93%**	**N/A**	**N/A**
2018 AVC Results	**71.16%**	**70.62%**	**71.59%**
Difference	0.23%	-0.32%	0.65%
Estimated Premium Impact	1.09%	0.27%	1.66%

Changes from the 2017 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2018 – SHOP Market Bronze Non-HSA Plan, 60% AV

Advisory Committee chose Option 2 as their recommendation

	2017 Bronze Non-HSA & 2018 Option 1	2018 Bronze Non-HSA Option 2	2018 Bronze Non-HSA Option 3
Combined Medical & Rx Deductible	$6,000 (INN)/$10,000 (OON)	$6,000 (INN)/ **$12,000(OON)**	$6,000 (INN)/ **$12,000(OON)**
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	$7,150 (INN)/$13,200 (OON)	**$7,350 (INN)/$14,700 (OON)**	**$7,350 (INN)/$14,700 (OON)**
Primary Care	$40 *	$40 *	$40 *
Specialist Care	$50 * (after ded.)	$50 * (after ded.)	$50 * (after ded.)
Urgent Care	$75 *	$75 *	$75 *
Emergency Room	$200 * (after ded.)	$200 * (after ded.)	$200 * (after ded.)
Inpatient Hospital	$500 (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)
Outpatient Hospital	$500 * (after ded.)	$500 * (after ded.)	$500 * (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75 (after ded.)	$75 (after ded.)	$75 (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	$40 * (after ded.)	$40 * (after ded.)	$40 * (after ded.)
Laboratory Services	$10 * (after ded.)	$10 * (after ded.)	$10 * (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30 * (after ded.)	$30 * (after ded.)	$30 * (after ded.)
Chiropractic Care 20 visit calendar maximum	$50 (after ded.)	$50 (after ded.)	$50 (after ded.)
All Other Medical	40% (after ded.)	40% (after ded.)	40% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / 50% / 50% / 50% (all after ded., $500 max per spec. script)	$5 * / 50% / 50% / 50% (all after ded., $500 max per spec. script)	**$5 * / 50% / 50% / 50% (all but generic after ded., $500 max per spec. script)**
2017 AVC Results	**61.98%**	**N/A**	**N/A**
2018 AVC Results	**61.93%**	**61.62%**	**63.92%**
Difference	-0.05%	-0.36%	1.94%
Estimated Premium Impact	1.40%	-0.77%	1.80%

Changes from the 2017 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2018 – SHOP Market Bronze HSA Plan, 60% AV

Advisory Committee chose Option 2 as their recommendation

	2017 Bronze HSA & 2018 Option 1	2018 Bronze HSA Option 2	2018 Bronze HSA Option 3
Combined Medical & Rx Deductible	$6,000 (INN)/$9,200 (OON)	$6,000 (INN)/**$12,000 (OON)**	**$5,500 (INN)/$11,000 (OON)**
Coinsurance	10%	**20%**	**20%**
Out-of-pocket Maximum	$6,550 (INN)/$12,900 (OON)	$6,550 (INN)/**$13,100 (OON)**	$6,550 (INN)/**$13,100 (OON)**
Primary Care	10% (after ded.)	**20% (after ded.)**	**20% (after ded.)**
Specialist Care	10% (after ded.)	**20% (after ded.)**	**20% (after ded.)**
Urgent Care	10% (after ded.)	**20% (after ded.)**	**20% (after ded.)**
Emergency Room	10% (after ded.)	**20% (after ded.)**	**20% (after ded.)**
Inpatient Hospital	10% (after ded.)	**20% (after ded.)**	**20% (after ded.)**
Outpatient Hospital	10% (after ded.)	**20% (after ded.)**	**20% (after ded.)**
Advanced Radiology (CT/PET Scan, MRI)	10% (after ded.)	**20% (after ded.)**	**20% (after ded.)**
Non-Advanced Radiology (X-ray, Diagnostic)	10% (after ded.)	**20% (after ded.)**	**20% (after ded.)**
Laboratory Services	10% (after ded.)	**20% (after ded.)**	**20% (after ded.)**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	10% (after ded.)	**20% (after ded.)**	**20% (after ded.)**
Chiropractic Care 20 visit calendar maximum	10% (after ded.)	**20% (after ded.)**	**20% (after ded.)**
All Other Medical	10% (after ded.)	**20% (after ded.)**	**20% (after ded.)**
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	10% / 15% / 25% / 30% (all after ded., $500 max per spec. script)	10% / 15% / 25% / 30% (all after ded., $500 max per spec. script)	**$5* / $50 / 50% / 50% (all after ded.)**
2017 AVC Results	**61.56%**	**N/A**	**N/A**
2018 AVC Results	**60.83%**	**60.70%**	**61.14%**
Difference	-0.73%	-1.30%	-0.86%
Estimated Premium Impact	1.46%	1.23%	1.63%

Changes from the 2017 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

➢2018 Optional Small Group Plan Offering

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AHCT SHOP: Optional Platinum Standardized Plan

	2017/2018 Standardized Platinum	2018 Additional Platinum Option
Combined Medical & Rx Deductible	$100	$0
Coinsurance	20%	0%
Out-of-pocket Maximum	$2,000	$2,600
Primary Care	$15	$30
Specialist Care	$35	$50 *
Urgent Care	$50	$75
Emergency Room	$100	$200
Inpatient Hospital	$300 per day (after ded., $600 max. per admission)	$500 per day ($1,500 max. per admission)
Outpatient Hospital	$300 (after ded.)	$300
Advanced Radiology (CT/PET Scan, MRI)	$75	$75
Non-Advanced Radiology (X-ray, Diagnostic)	$40 *	$0
Laboratory Services	$10 *	$0
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum	$15	$30 *
Chiropractic Care 20 visit calendar maximum	$30	$50
All Other Medical	20%	0%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $25 / $40 / 20% ($100 max per spec. script)	$5 / $50 / 50% / 50% ($500 max. per non-preferred brand or spec. script)
2017 AVC Results	**90.49%**	**N/A**
2018 AVC Results	**89.97%**	**88.15%**
Difference	-0.51%	-2.34%
Estimated Premium Impact	0.33%	-0.04%

Actuarial Value Calculator (AVC) results provided by Wakely Consulting Group

Represents In-Network Cost Sharing;
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

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AHCT SHOP: Optional Platinum Standardized Plan

	CURRENT PLATINUM PLAN		ADDITIONAL PLATINUM PLAN	
Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Plan Deductible				
Individual	**$100**	**$2,000**	**$0**	**$2,000**
Family	**$200**	**$4,000**	**$0**	**$4,000**
Out-of-Pocket Maximum*				
Individual	**$2,000**	**$4,000**	**$2,600**	**$5,200**
Family	**$4,000**	**$8,000**	**$5,200**	**$10,400**
*Includes deductible, copayments and coinsurance				
Provider Office Visits				
Adult Preventive Visit	**$0 copay per visit**	**20% coinsurance per visit**	**$0 copay per visit**	**30% coinsurance per visit after OON plan deductible is met**
Infant / Pediatric Preventive Visit	**$0 copay per visit**	**20% coinsurance per visit**	**$0 copay per visit**	**30% coinsurance per visit after OON plan deductible is met**
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	**$15 copayment per visit**	**20% coinsurance per visit after OON plan deductible is met**	**$30 copayment per visit**	**30% coinsurance per visit after OON plan deductible is met**
Specialist Office Visits	**$35 copayment per visit**	**20% coinsurance per visit after OON plan deductible is met**	**$50 copayment per visit**	**30% coinsurance per visit after OON plan deductible is met**
Mental Health and Substance Abuse Office Visit	**$15 copayment per visit**	**20% coinsurance per visit after OON plan deductible is met**	**$30 copayment per visit**	**30% coinsurance per visit after OON plan deductible is met**

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AHCT SHOP: Optional Platinum Standardized Plan, cont'd

	CURRENT PLATINUM PLAN		ADDITIONAL PLATINUM PLAN	
Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Diagnostic Services				
Advanced Radiology (CT/PET Scan, MRI)	$75 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	20% coinsurance per service after OON plan deductible is met	$75 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	30% coinsurance per service after OON plan deductible is met
Laboratory Services	$10 copayment per service	20% coinsurance per service after OON plan deductible is met	$0 copayment per service	30% coinsurance per service after OON plan deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service	20% coinsurance per service after OON plan deductible is met	$0 copayment per service	30% coinsurance per service after OON plan deductible is met
Mammography Ultrasound	$20 copayment per service	20% coinsurance per service after OON plan deductible is met	$20 copayment per service	30% coinsurance per service after OON plan deductible is met
Prescription Drugs - Retail Pharmacy (30 day supply per prescription)				
Tier 1	$5 copayment per prescription	20% coinsurance per prescription after OON plan deductible is met	$5 copayment per prescription	50% coinsurance per prescription
Tier 2	$25 copayment per prescription	20% coinsurance per prescription after OON plan deductible is met	$50 copayment per prescription	50% coinsurance per prescription
Tier 3	$40 copayment per prescription	20% coinsurance per prescription after OON plan deductible is met	50% coinsurance up to a maximum of $500 per prescription	50% coinsurance per prescription
Tier 4	20% coinsurance up to a maximum of $100 per prescription	20% coinsurance per prescription after OON plan deductible is met	50% coinsurance up to a maximum of $500 per prescription	50% coinsurance per prescription

AHCT SHOP: Optional Platinum Standardized Plan, cont'd

	CURRENT PLATINUM PLAN		ADDITIONAL PLATINUM PLAN	
Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Outpatient Rehabilitative and Habilitative Services				
Speech Therapy *(40 visits per plan year limit combined for Rehabilitative PT/OT/ST; separate 40 visitsper plan year combined for Habilitative PT/OT/ST)*	$15 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$30 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy *(40 visits per plan year limit combined for Rehabilitative PT/OT/ST; separate 40 visitsper plan year combined for Habilitative PT/OT/ST)*	$15 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$30 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Other Services				
Chiropractic Services *(up to 20 visits per plan year)*	$35 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$50 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies	20% coinsurance per equipment/supply	20% coinsurance per equipment/supply after OON plan deductible is met	50% coinsurance per equipment/supply	50% coinsurance per visit after OON plan deductible is met
Durable Medical Equipment (DME)	20% coinsurance per equipment/supply	20% coinsurance per equipment/supply after OON plan deductible is met	50% coinsurance per equipment/supply	50% coinsurance per visit after OON plan deductible is met
Home Health Care Services *(up to 100 visits per plan year)*	$0 copay per visit	20% coinsurance per visit after $50 deductible is met	$25 copay per visit	25% coinsurance per visit after $50 deductible is met
Outpatient Services (in a hospital or ambulatory facility)	$300 copayment after INET plan deductible is met	20% coinsurance per visit after OON plan deductible is met	$200 copayment per visit	30% coinsurance per visit after OON plan deductible is met

AHCT SHOP: Optional Platinum Standardized Plan, cont'd

	CURRENT PLATINUM PLAN		ADDITIONAL PLATINUM PLAN	
Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Inpatient Hospital Services				
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) **(skilled nursing facility stay is limited to 90 days per plan year)*	$300 copayment per day to a maximum of $600 per admission after INET plan deductible is met	20% coinsurance per visit after OON plan deductible is met	$500 copayment per day to a maximum of $1,500 per admission	30% coinsurance per visit after OON plan deductible is met
Emergency and Urgent Care				
Ambulance Services	$0 copay	$0 copay	$0 copay	$0 copay
Emergency Room	$100 copayment per visit	$100 copayment per visit	$200 copayment per visit	$200 copayment per visit
Urgent Care Centers	$50 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$75 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Pediatric Dental Care (for children under age 19)				
Diagnostic & Preventive	$0 copay per visit	50% coinsurance per visit after OON plan deductible is met	$0 copay per visit	50% coinsurance per visit after OON plan deductible is met
Basic Services	20% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met	40% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Major Services	40% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services *(medically necessary only)*	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Pediatric Vision Care (for children under age 19)				
Prescription Eye Glasses *(one pair of frames and lenses or contact lens per plan year)*	$0 copay for Lenses; $0 copay for Collection frame; Non–collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered	$0 copay for Lenses; $0 copay for Collection frame; Non–collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist *(one exam per plan year)*	$35 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$50 copayment per visit	30% coinsurance per visit after OON plan deductible is met

➢2018 Plan Offerings: Stand-Alone Dental Plan (SADP)

AHCT 2017 Standardized SADP Plan Design

Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible *(Does not apply to Preventive & Diagnostic Services for In-Network Services)*	$60 per member, up to 3 family members	$60 per member, up to 3 family members
Out-of-Pocket Maximum *for children under age 19 only* For one child Two or more children	 $350 $700	Not Applicable
Diagnostic & Preventive Services		
Oral Exams / X-Rays / Cleanings	$0	20% after OON deductible is met
Basic Services		
Filings / Simple Extractions	20% after INET deductible is met	40% after OON deductible is met
Major Services		
Surgical Extractions, Endodontic Therapy, Periodontal Therapy, Crowns, Prosthodontics	40% after INET deductible is met	50% after OON deductible is met
Other Services *(for children under age 19)*		
Medically-Necessary Orthodontic Services	50% after INET deductible is met	50% after OON deductible is met
Waiting Periods and Plan Maximums (*for adults aged 19 and older only)*		
Applicable Waiting Period for Benefit		
Diagnostic and Preventive Services	no waiting period	
Basic Services	6 months	
Major Services	12 months	
Plan Maximum	$2,000 per adult member age 19 and over (combined In-Network and Out-of-Network Services)	

Actuarial Value (AV): "High" (85%) Pertains to Pediatric Benefits *only*

No CMS prescribed AV Calculator for SADPs

Maximum Out-of-Pocket: $350/$700

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Stand-Alone Dental Plan (SADP) Standardized Plan

- Health Plan Benefits & Qualifications (HPBQ) Committee Discussion & Considerations included:
  1. No change to existing approach
     - Retain the existing standardized plan only, thereby requiring SADP carriers to cover benefits in-network as well as out-of-network
  2. Retain existing standardized plan for SADP carriers that offer both in-network and out-of-network coverage, AND add another standardized SADP that includes ONLY the prescribed in-network cost sharing
     - Carrier would submit the applicable plan based on license (e.g., single purpose dental health care center would submit plan with In-Network (INN) coverage only)
  3. Revise the existing standardized plan to reflect in-network coverage only, with an option to include Out-of-Network (OON) coverage
     - Licensed single purpose dental health care center would not include OON coverage
     - Other carriers can submit non-prescribed OON cost sharing to the Connecticut Insurance Department (CID) for review, potentially resulting in different OON cost sharing amongst participating carriers

➢Certification Requirements for 2018

AHCT Certification Standard: Formulary

Overview	AHCT Standard	Recommendation
Federal regulations require health plans to provide Essential Health Benefits (EHBs), including a specified minimum number of prescription drugs in a plan's formulary • Applies to QHPs "On" or "Off" Exchange • Formulary drug list must be submitted to the Exchange, State or federal Office of Personnel Management • Effective 1/1/17, health plan is required to use a pharmacy and therapeutics (P&T) committee for clinical evaluation of formulary CID Bulletin issued in June 2016 requires carriers "to file their prescription drug formularies for all plans, whether or not such plans are subject to the ACA, to ensure consistency and transparency in the marketplace."	As approved by AHCT BOD in April 2014, the current certification standard pertaining to formulary review is: "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 Marketplace."	Rely on CID analysis and review of sufficiency of formulary and compliance with federal regulations in place of current standard Results in consistent evaluation for "On" & "Off" Exchange plans Does not include comparison of submissions across carrier licenses AHCT will review inconsistencies in submissions and research complaints as required

AHCT Certification Standard: Network Adequacy

Overview	AHCT Standard	Recommendation
Federal regulations require: • **That each QHP issuer using a provider network must ensure that in-network providers are made available to all enrollees and essential community providers (ECPs) are included;** • **The QHP issuer maintains a network that is sufficient in number & types of providers, including mental health and substance abuse providers, to assure that all services will be accessible without unreasonable delay** **Connecticut Public Act 16-205 was effective 1/1/17, requiring carriers to maintain a network of providers consistent with health plan accrediting entity standards** **CID Bulletin issued in 2016 outlined its requirements for health plan network adequacy review**	**AHCT's current requirement to assess network adequacy, as approved by AHCT BOD in April 2014 is: "To require Qualified Health Plan (QHP) Issuers to develop and maintain provider networks for the standard plan designs offered for sale in the Marketplace that include at least 85% of those unique providers and unique 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."**	**Rely on CID analysis and review of network adequacy in place of current standard** **Results in consistent evaluation for "On" & "Off" Exchange plans,** **Does not include comparison of submissions across carrier licenses** **AHCT reserves the right to request carrier network data for various purposes (e.g., assess network breadth, research complaints, etc.)**

AHCT Certification Standard: ECPs

Overview	AHCT Standard	Recommendation
Federal regulations require that a QHP issuer using a provider network include a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area **AHCT supplies Issuers with an ECP list as a source to use in ECP contracting efforts C** **High level ECP contracting requirement in FFMs:** • **Medical: Issuers must contract with at least 30 percent of available ECPs in each QHP's service area** • **Dental: Issuers must offer a contract to at least 30 percent of available ECPs in each plan's service**	**AHCT's current standard for ECP contracting approved by the AHCT BOD in November 2012 & updated/approved in June 2013, requiring QHPs to have contracts with at least 90% of FQHCs or "look alike" health centers in CT, and by 1/1/2015, 75% of all other designated ECPs, with consideration given for issuers demonstrating a good faith effort to accomplish these standards** **Requirement has been applied to both QHPs and SADPs**	**Revise the current standards, using a requirement for contracting at a level of 50% for both types of ECPs**

AHCT Certification Standard: Tobacco Surcharge

Overview	AHCT Standard	Recommendation
Federal regulations: • **Allow for application of a tobacco surcharge to premium rates (up to 1.5:1 compared to premium rates for non-smokers) for those who may legally use tobacco under federal and state law** • **Defines tobacco use as consumption of tobacco on average four or more times per week (within no longer than the past 6 months) & includes all tobacco products, except religious/ceremonial use** • **State that the premium tax credit amount may not include any adjustments for tobacco use** **Per Connecticut General Statute, tobacco use is not an allowed case characteristic for the small employer market in Connecticut**	**AHCT does not currently permit a tobacco surcharge adjustment to premium rates in the Individual Market**	**Obtain feedback from AHCT BOD with regard to permitting inclusion of tobacco surcharge in premium rates for Individual Market Exchange plans**

AHCT Certification Standard: Broker Commissions

Overview	AHCT Standard
Under Marketplace regulations at 45 C.F.R. 156.200(f), a QHP issuer must pay the same agent or broker compensation for QHPs offered through a Federally Facilitated Marketplace (FFM) that it pays for similar health plans offered in the State outside an FFM **CMS stated the following in its '2018 Letter to Issuers in the Federally-facilitated Marketplaces': "We remind issuers that compliance with this rule is a required participation standard for QHP issuers offering coverage in the FFMs, including both the individual market and SHOP. We note that in determining whether a health plan offered in the State outside of the Marketplace is similar to a QHP offered through the FFMs, we would consider whether the plan has a similar cost sharing and benefit structure, covers a majority of the same service area, and covers a majority of the same provider network as compared to the QHP. A compensation arrangement in which an issuer pays no commission for sale of a QHP through an FFM, but does pay commission for sale of a similar plan outside of the FFM, would violate this FFM standard for agent and broker compensation."**	**AHCT BOD approved the following during the meeting held on January 26, 2017:** **"To require any health carrier offering a health insurance plan through the Exchange to pay a commission to an insurance producer or broker who assists an individual or small employer in enrolling in a health insurance plan through the Exchange."** **"To require that the amount of commission a carrier pays to a producer or broker who assists an individual or small employer enrolling in a health insurance plan through the Exchange be the same as the amount of commission the carrier pays to producers or brokers who assist individuals or small employers in enrolling in health plans outside of the Exchange."**

➢ *Next Steps*

➢ *Appendix*

AHCT Individual Enrollment: Standardized/Non-Standard Plans

	Enrollment as of:			
	3/11/2014	2/3/2015	2/2/2016	1/10/2017
Platinum Non-Standard	0	0	0	0
Platinum Standardized	0	840	1,561	0
TOTAL	0	840	1,561	0
Gold Non-Standard	2,734	4,354	4,670	2,108
Gold Standardized	10,492	11,413	9,340	8,001
TOTAL	13,226	15,767	14,010	10,109
Silver Non-Standard	7,132	9,990	9,052	10,325
Silver Standardized	29,121	47,732	62,299	56,941
TOTAL	36,253	57,722	71,351	67,266
Bronze Non-Standard	7,830	12,947	16,475	3,109
Bronze Standardized	2,027	6,635	10,564	22,651
TOTAL	9,857	19,582	27,039	25,760
Catastrophic Non-Standard	1,397	1,531	2,063	1,724
N/A	0	0	0	0
TOTAL	1,397	1,531	2,063	1,724
Combined Non-Standard	19,093	28,822	32,260	17,266
Combined Standardized	41,640	66,620	83,764	87,593
TOTAL	60,733	95,442	116,024	104,859

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Stand-Alone Dental Plan – Actuarial Value (AV) Overview

- ACA Compliant plans must conform with either a "High" or "Low" Actuarial Value
  - AV pertains ONLY to pediatric portion of plan, as adult dental is not considered an Essential Health Benefit per ACA regulations
  - High plan = 85% AV: consumer, on average, pays 15% of cost sharing for covered pediatric benefits
  - Low plan = 70% AV: consumer, on average, pays 30% of cost sharing for covered pediatric benefits
- No prescribed tool provided by CMS to perform analysis
  - Actuarial Certification is required
  - Plus/Minus 2 point 'de minimis' range is permitted
- AHCT standardized SADP is certified as a "High" AV plan
  - No cost sharing changes are required for 2018 to current SADP, as plan continues to meet High AV
  - CMS final 2018 Payment Notice confirms no change in maximum out-of-pocket (MOOP) for SADP
    - $350 for one child / $700 for two or more children in a family

Formulary Requirements: ACA Regulation/CID Guidance

Title 45: Public Welfare

45 C.F.R §156.122

- **Under Marketplace regulations a health plan does not provide essential health benefits unless it covers at least the greater of one drug in every United States Pharmacopeia (USP) category and class; or the same number of prescription drugs in each category and class as the EHB-benchmark plan; and**
- **Submits its formulary drug list to the Exchange, the State or the federal Office of Personnel Management, and**
- **Beginning on or after January 1, 2017, uses a pharmacy and therapeutics (P&T) committee that meets specified standards**

Connecticut Insurance Department (CID) Bulletin No. HC-113

- **Published June 22, 2016**
- **Carriers are required "to file their prescription drug formularies for all plans, whether or not such plans are subject to the ACA, to ensure consistency and transparency in the marketplace."**
- **CID will obtain information via a survey to perform an annual evaluation**

Network Adequacy Requirements: Regulations & Guidance

Title 45: Public Welfare **45 C.F.R §156.230**	• Each QHP issuer that uses a provider network must ensure that the network (consisting of in-network providers) made available to all enrollees: • Includes essential community providers; • Maintains a network that is sufficient in number & types of providers, including mental health and substance abuse providers, to assure that all services will be accessible without unreasonable delay; and, • Is consistent with the network adequacy provisions of section 2702(c) of the Public Health Services (PHS) Act.
Connecticut Public Act 16-205	• The Act specifies that, effective January 1, 2017, carriers are to maintain a network of providers consistent with the National Committee for Quality Assurance (NCQA) network adequacy requirements or URAC's provider network access/availability standards
CID Bulletin No. HC-117 (10/25/16)	• Outlines how the requirements of Public Act 16-205 are to be implemented • Requires health carriers to file each new network and access plan within 30 days prior to the date any new network will be offered, and complete the Network Adequacy Survey as its filing submission; Annual survey submissions for networks effective on and after January 1, 2018 to be included as part of the annual form filing process

Essential Community Providers (ECPs): ACA Regulation

Title 45: Public Welfare

45 C.F.R. §156.235

- **"A QHP issuer that uses a provider network must include in its provider network a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards."**

Essential Community Providers (ECPs) Defined

- Providers serving predominantly low-income, medically underserved individuals
- Providers described in section 340B of Public Health Service (PHS) Act & section 1927(c)(1)(D)(i)(IV) of Social Security Act
- Include not-for-profit / State-owned providers as described in section 340B of PHS Act *that don't participate in the 340B Program*
- Not-for-profit or governmental family planning service sites that don't receive a grant under Title X of the PHS Act
- Indian health care providers

Category	Types of Entities
HOSPITALS	**Disproportionate Share Hospitals (DSH) and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals**
FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)	**FQHCs and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations**
INDIAN HEALTH CARE PROVIDERS	**IHS providers, Indian Tribes, Tribal organizations, and urban Indian Organizations**
RYAN WHITE PROVIDERS	**Ryan White HIV/AIDS Program Providers**
FAMILY PLANNING PROVIDERS	**Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics**
OTHER ECPs	**STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals**

Tobacco Use Surcharge: ACA Regulations/CT Statute

Title 45: Public Welfare **45 C.F.R §147.102**	• **Tobacco surcharge permitted, but may not vary by more than 1.5:1 compared to premium rate for non-smokers; may only be applied for those who may legally use tobacco under federal and state law** • **Tobacco use is defined as consumption of tobacco on average four or more times per week (within no longer than the past 6 months) & includes all tobacco products, except religious/ceremonial use** • **Tobacco use must also be defined in terms of when a tobacco product was last used**
Title 26: Internal Revenue **26 C.F.R §1.36B-3(e)**	• **The premium tax credit amount may not include any adjustments for tobacco use**
Connecticut General Statute §38a-567	• **Tobacco use is not an allowed case characteristic & is therefore not applicable in the small employer market in Connecticut**

C.F.R. = Code of Federal Regulations

Tobacco Use Facts & Figures

- Per the Centers for Disease Control and Prevention website*
  - 36.5% of adults with any mental illness reported current use** of tobacco in 2013 compared to 25.3% of adults with no mental illness
  - People living below the poverty level and people having lower levels of educational attainment have higher rates of cigarette smoking than the general population
    - Among people having only a GED certificate, smoking prevalence is more than 40%
  - 29.8% of African American adults reported current use** of tobacco in 2013.
  - 20.9% of Hispanic/Latino adults reported current use** of tobacco in 2013.
- A Kaiser Health News article from May 2016 indicated that smokers may be avoiding the surcharge in states that include it by not reporting tobacco use status appropriately, citing the following:
  - Idaho: per federal survey, 17% of adults smoke regularly, but < 3% who bought coverage in 2016 on the state's insurance exchange paid the surcharge.
  - Kentucky: over 25% of adults smoke regularly, but 11% paid the tobacco surcharge.
  - Minnesota: 18% of adults smoke, but < 5% paid the tobacco surcharge.
- A Yale School of Public Health study released in July, 2016 stated that high tobacco surcharges resulted in lower enrollment rates for smokers for 2014, and did not increase smoking cessation.

* https://www.cdc.gov/tobacco/disparities/index.htm

*** "Current Use" per CDC website was defined as self-reported consumption of cigarettes, cigars, smokeless tobacco, and pipe tobacco in the past year and past month (at the time of survey)*