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

Holiday Inn, Salon A
East Hartford

Wednesday, February 7, 2018
Meeting Minutes

Members Present: Grant Ritter (Chair); Robert Tessier; Theodore Doolittle; Paul Lombardo

Participants by Phone: Neil Kelsey, Ellen Skinner; Tu Nguyen; Mary Ellen Breault

Other Participants:
Access Health CT (AHCT) Staff: James R. Wadleigh Jr.; Shan Jeffreys; Ann Lopes; Charmaine Lawson; Ellen Kelleher; Gary D'Orsi; Susan Rich-Bye (by phone); Alexandra Dowe (by phone)
Wakely Consulting: Julie Andrews (by phone)
Cecelia Woods (by phone)

A. Call to Order and Introductions

Chair Grant Ritter called the meeting to order at 4:01 p.m.

B. Public Comment

No public comment.

C. Vote: January 10, 2018 Meeting Minutes

Chair Ritter requested a motion to approve the January 10, 2018 Health Plan Benefits and Qualifications Advisory Committee (HPBQ AC) Special Meeting Minutes. Motion was made by Robert Tessier and seconded by Grant Ritter. ***Motion passed unanimously.***

D. Certification Requirements

- Ann Lopes, Product Carrier Manager provided the Committee with a brief summary of the Certification Review Schedule as outlined in the presentation. Ms. Lopes added that additional meetings of the committee might be needed.

- Connecticut Insurance Department (CID) issued a bulletin, which extended the filing deadline to July 16, 2018 for plans to be offered in both, individual and small group markets for 2019. The aim is to have all of the work of this committee finalized ahead of the March 20, 2018 Board of Directors Meeting.
    - Ms. Lopes provided a recap of the previous HPBQ AC Meeting. During the previous meeting, information on the current enrollment and plan rates for all the 2018 'On-Exchange' Bronze plans was reviewed, along with an illustration that outlined rates for an alternative Bronze plan available at a level of 15% less than the current standardized Bronze plans offered by each carrier.
    - The illustration assumed that the estimated rate impact would apply if one of the alternative plans was offered alongside the existing standardized Bronze plans, but during the discussion, there was feedback that indicated that the rating assumption would change if the alternative Bronze plans did not replace the existing standardized Bronze plan.
    - There was discussion about whether there was a need to require an additional Bronze plan be submitted in order to meet the certification requirements, and the consensus seemed to be 'no'. There was a suggestion to reflect on the discussion, consider other alternatives and to bring forth any new ideas to this meeting, and to spend a little time reviewing the options for Bronze, which are:
        - retaining the existing plan design but tweaking it to comply with the AV requirements;
        - replacing the plan with one that is expected to have a premium that is 10-15% lower than the current standard plans;
        - consider a different plan design that is somewhere between these approaches.
- Dr. Ritter noted that one of the standardized Bronze plans is HSA-compatible and the other is not. The current standard HSA premium is approximately 10 percent lower, and this seems to meet the goal of including a low priced standardized Bronze plan. Mr. Tessier indicated that CBI has 45 percent of Bronze HSA enrollment and Anthem has 6 percent. Fifty-one percent of Bronze enrollees are in the standardized Bronze HSA-plan. Mr. Tessier indicated that he is comfortable with the progress made in the committee. Paul Lombardo inquired whether any information was provided for consumers in the Bronze plans who are meeting the Out of Pocket (OOP) maximums and deductibles. Mr. Lombardo added that with the double-digit increases, one of the goals is to try to help to mitigate these increase by looking at less expensive alternative options for the base Bronze standard plan, the non-HSA standard plan.
- Julie Andrews from Wakely indicated that based on the survey response, 5.2 percent of enrollees in the standard bronze plan reached their deductible. In addition, approximately 2.5 percent reached their maximum out of pocket on their bronze plans.
- Theodore Doolittle indicated that designing cost-effective plans for consumers who do not receive Financial Assistance (FA) is an important element. Mr. Doolittle inquired whether there is any willingness to design a product around community health centers or walk-in clinics with the gatekeeper option to the specialist. Ms. Lopes indicated that to a certain extent, the HMO-style plan could employ a gatekeeper- arrangement. Currently, for the AHCT standardized plans, that is not permitted. This Committee could review that requirement. Ms. Lopes added that the Essential Community Provider (ECP) contracting requirements are in place, and carriers have

contracted with the Federally Qualified Health Centers (FQHCs). The current expectation is that the carriers would contract with at least 50 percent of the FQHCs. There needs to be consideration of the entire population, and whether an unsubsidized person might not consider the opportunity to go to an FQHC. Mr. Tessier stated that they are not available in every area of the state. Paul Lombardo questioned whether those who do not receive financial assistance would use the FQHCs, and whether it would it be convenient for them. With this approach, we would need to find out if the plan meets network adequacy requirements. Dr. Ritter questioned whether there would be savings with this type of network and gatekeeper requirement. Ms. Kelleher stated that ConnectiCare has plans that require a gatekeeper type of approach and Anthem HMO plans do not. Mr. Tessier stated that his understanding of the suggestion would result in a limited network, and there could be issues for unsubsidized enrollees and those without convenient access to one of these providers and that this may not be the way to go for standardized plans. Tu Nguyen stated that the carriers may have the same goal in mind but different ways in reaching it, and it might be a better approach to let this occur under a non-standard plan design. Neil Kelsey agreed with this statement. Mr. Doolittle questioned whether this approach would have a significant impact to the premium and whether network adequacy requirements could be waived. Mr. Lombardo stated that because Connecticut is a small state it is not too difficult to meet the network adequacy requirements, even for a narrow network situation. If there is not a provider that meets the guidelines for travel, time and distance for a consumer, carriers have to provide coverage for the out of network provider at the in-network costs.

- Mr. Tessier indicated that FQHCs are located in healthcare underserved communities. It would be interesting to see if AHCT or the carriers can find an innovative solution around that. Ellen Skinner stated that individuals who move from Medicaid to a QHP plan would most likely want to keep their current doctors. It would provide continuity of care if providers at FQHCs were in-network. Dr. Ritter pointed out that it would be great to obtain data on specialist referrals from FQHCs. Ms. Skinner stated that based on her experience, networks for specialists are self-limiting because many of them do not participate in Medicaid, so most of these consumers would be going to the academic medical centers, and these would likely be more costly than a contracted specialist would in a commercial health plan.

- The committee discussed whether a third standard Bronze plan should be offered. The conversation included changing the design for the higher-priced standard Bronze plan, since information indicates that consumers' number one issue for health care is the plan's premium. Carriers have stated that reducing the actuarial value of a plan may not always mean that it would have a lower premium. The Committee has been encouraged to move the standard plan downward in premium. The Committee pointed out that lower cost Bronze plans exist, and AHCT is competitive at this metal level with the standardized HSA-compatible plan and a non-standard HMO plan. Some people do seem to pick a plan based on the benefit design. The deductible would have to be raised, or the plan would need be limited to a narrow provider network, to get a lower premium. Approximately 35% of Bronze plan enrollees have bought the standardized Bronze plan, which has the highest price in most areas. It may be better to give people a choice of different plans. It may not make a difference if the plan is called 'Standard'.
- Robert Tessier made a motion to not make any significant changes to the standard bronze plans as they exist, but to make the changes that were reviewed and discussed at the December 13

HPBQ AC meeting to satisfy the AV calculator. This would be to modify the out-of-pocket maximum from $7,350 to $7,900. Theodore Doolittle seconded it. Discussion followed. Mr. Kelsey stated that CBI looked for lower cost standard plans and identified very low cost plans. There is a range of possibilities in between tweaking the current standard just to get under the maximum AV and to design a very low cost plan. We may want to consider a plan that is closer to the current standard Bronze plan but achieves a little cost savings, makes it more attractive in the market and gets away from the top of the AV range that would get more breathing room on the AV for next year. Since there is a little more time before the filing deadline, we may want to spend a couple of weeks looking at additional options. James Wadleigh inquired whether the committee wants to have the standard bronze plan designs to be at the top end of the metal AV tier or at the bottom end and let the non-standard plans be an opportunity for consumers to buy plans providing more coverage if they wanted to.

- There was discussion regarding comparison shopping, and whether consumers are using the standardized plans to compare "apples to apples," or are buying standardized plans because they have the features that they want, such as fixed co-pays. It is easier to look at the standardized plans to compare different carriers.
- Ms. Skinner inquired whether there had been any focus groups of people who have purchased standard plans, and if AHCT had any feedback from the consumers. Mr. Wadleigh pointed out that AHCT had conducted focus groups and had received consumer feedback. Consumers want to have plans with lower premiums. Dr. Ritter commented that if consumers are buying plans based on the cost of premiums, then they would choose a standard HSA plan that is the lowest cost plan. Mary Ellen Breault commented that carriers are required to verify if consumers have an HSA account. Dr. Ritter stated that since so many have chosen the standard non-HSA Bronze plan, they are buying it because they think the plan might deliver something to them. Mr. Nguyen noted that noted that carriers have the same benefit designs for standard plans, but different premiums, which would help consumers determine what to purchase. Networks could also be one of the determining factors. Mr. Kelsey noted that the study by the Urban Institute and Robert Wood Johnson Foundation for 2017 stated that 67 percent of respondents answered that premium was either very or extremely important, followed by the deductible level and then network. Mr. Tessier stated that the Committee should consider alternative plans as suggested. With the standardized non-HSA Bronze plan at a 65.2% AV needing to be reduced slightly to comply with the de minimis range versus a reversal of philosophy to go to a low AV such as 58%, it seems like it would be a plan with a dramatically higher deductible, and it is unclear whether anyone wants that type of plan. Mr. Ritter provided an historical perspective on the Bronze plan development since the inception of the Exchange, where it was difficult to get agreement to vote for plans even when they were at the highest possible AV level. Ms. Lopes stated that the Committee may want to consider some guiding principles for the carriers to develop options, such as whether the plans should or should not have services such as PCP or generic drugs subject to a deductible or coinsurance-based. Dr. Ritter encouraged the carriers to examine tiered networks and coinsurance instead of co-pays, but indicated that including a deductible on PCP visits or generic drugs might not be a cost effective approach. Mr. Lombardo encouraged the carriers to come up with plan designs with equivalent AVs to the current standard Bronze plan with the combination of coinsurance and co-pays with premium savings. Mr. Kelsey agreed with the direction of the discussion and expressed his concern pertaining to dedicating resources and the fact that only

two carriers are participating on the Exchange. He suggested that Wakely quantify the goals of the Committee and have the carriers work through them. Paul Lombardo asked what the minimum level of premium differential was desired without changing the benefits significantly. Mr. Nguyen suggested cost sharing be defined for the preferred network tier and provide more flexibility across carriers for the non-preferred network tier.

- Mr. Wadleigh stated that rate increases receive a lot of media attention every year. AHCT continues to focus on the challenge of lowering the uninsured rate in the state, and needs to do more to attract additional people to sign up for medical insurance coverage through the Exchange. Mr. Ritter noted that to weaken the plan design due to ever-increasing cost of health care seems to be a temporary solution.

- Ms. Skinner suggested looking at a 'base model' plan design that could be a lower price. Ms. Lopes noted that one of the alternate plans for Bronze presented at the December 13 meeting was at 58.58 AV, but it was the plan with 50 percent coinsurance for everything in-network, a $7000 deductible and all of the services were subject to it with the exception of the preventative care. It might be the base model plan. Ms. Lopes pointed out that there was not a lot of interest in this. Mr. Tessier stated that if this plan is appealing to a consumer, it would be offered as a non-standard plan. Mr. Tessier pointed out that in Fairfield County only a $10 difference per month exists on premium between the CBI HSA compatible plan and the next two plans that are offered. Mr. Wadleigh noted that last year AHCT lifted a number of restrictions on the carriers. However, the carriers did not have enough time to adjust to the changes due to their plan development cycle.
- Mr. Tessier withdrew the motion to not make significant changes for the standard bronze plan right now, and spend some time reviewing other options. Theodore Doolittle withdrew his second. The vote on the Bronze plans is deferred to a future meeting of the committee. ***Motion was withdrawn***. Mr. Ritter noted that the carriers are encouraged to provide any new ideas and concepts on plans. Mr. Wadleigh indicated that AHCT will work with the Insurance Department and the carriers, and will meet with Mr. Lombardo shortly to develop an e-mail to the carriers for their assistance, and have Ms. Andrews from Wakely help to coordinate this request.
- Ms. Lopes provided details on the 2018 "On Exchange" Gold Plan and Enrollment by the county. At the last meeting, the Plan Management team recommended making minimal cost sharing changes to the standardized Gold plan design in order to become compliant with the AV for 2019. This was because the two standardized plans have high percentage of the enrollment, and one of the carriers already offered a plan that was approximately 24% lower in cost. The Committee may want to consider reviewing other options, per the discussion for the Bronze plans. Mr. Kelsey stated that people who buy Gold plans can afford them and there is a different buying decision in this range. He stated there is not a need to drive to a lower cost plan for Gold. Mr. Nguyen agreed with this.
- Robert Tessier made a motion to recommend to the Board that only the minimal changes as presented by Exchange Staff be made to the current Gold plan design to meet the AV requirement for 2019. Theodore Doolittle seconded the motion. ***Motion passed unanimously.***
- Ms. Lopes outlined the Stand-Alone Dental Plan (SADP) Mix and Standardized Plan, and reviewed the items that were briefly discussed at the January 10 Committee meeting. Ms. Lopes provided a summary of current regulations and guidance pertaining to the SADP. The pediatric portion of

the plan must provide benefits in accordance with State's Essential Health Benefit (EHB) Benchmark plan. SADPs do not have metal levels, but are designated as either 'high', which would have an 85 percent AV or 'low' with a 70% AV, meaning that on average about 70 percent of the claims would be paid by the carrier for the pediatric portion of the plan. The plan must include a Maximum Out of Pocket (MOOP) for children under age 19 that does not exceed $350 for one child or $700 for two or more children. There is no prescribed tool for calculating AV, so carriers must develop their own methodology. Ms. Lopes indicated that the Centers for Medicare and Medicaid Services (CMS) released a proposed change in the regulation to remove the need to calculate the AV requirement for stand alone dental plans. There was no indication that the MOOP limit would change. AHCT currently requires only one standardized SADP. The plan is the same for both individual and small group. Three non-standard plans are allowed that can have either a high or a low AV. Last year, a modification to the standardized plan was approved where AHCT would no longer prescribe the out of network coverage. Ms. Lopes reviewed the features of the current standardized SADP. The discussion points to be considered include whether the plan mix is adequate, requiring one standardized plan and permitting up to three non-standard plans. If the CMS regulation is finalized as proposed, the plan mix would need to be adjusted to remove the reference to "high" and "low" plans. The Committee may also want to review the cost sharing of the standardized plan and the features such as the annual maximum for adults. Current total enrollment stands at around 810 individuals, but may change once we learn whether the first month's premiums were paid. Ms. Lopes added that the standard plan design for adults is close to the highest premium plan available in the Individual market when looking at those plans that are not ACA compliant. Two non-standard low option plans available through AHCT are more in line with many lower priced plans in the market. The lowest premium for an off-Exchange dental plan is about $12.69 per month for adults, but this is a fairly limited plan providing preventive care. The maximum is $84.99. The Exchange's plan premium for adults is $71.09 per month. Only one zip code was reviewed for pricing. A lot of variability exists in dental plan designs. Most of the plans have a $50 deductible, while the AHCT standardized SADP has a $60 deductible, however, ACA compliant plans have to meet the AV requirement, and we had to go a little higher on that in order to get to a compliant plan. Twenty-one percent of the enrollment is in the standardized plan. Mr. Tessier inquired whether dental plans have to be available statewide. Mr. Lombardo indicated that dental plans have to file with CID. Ms. Breault added that dental plans are excepted benefits so they are not a subject to the ACA. Mr. Doolittle inquired whether dental is a subject to the same Open Enrollment (OE). Ms. Lopes stated that for plans that are offered through the Exchange, they are limited to the normal Open Enrollment and Special Enrollment Plan requirements. Plans that are offered off-Exchange do not have the same requirement, even if a plan has been certified by the Exchange. Mr. Ritter inquired about the age scale on the dental market. Ms. Lopes answered that no age scale exists on the dental market, such as the 3:1 ratio required for ACA medical plans. For most plans researched off-exchange thus far, the child rate seems to be uniform for those under age 19, but there are some carriers that may have different rates for varying adult ages such as 55 or 60. One additional step that does need to be taken for SADP is to verify with the participating carrier that the standardized plan will continue to meet the AV requirement for a high plan for 2019. Should the regulation be finalized as proposed, there will no longer be a requirement that the plan meet an AV level. One item not discussed yet for

the standardized medical plans is regarding retaining pediatric dental coverage in each of those, and no changes have been proposed to that for 2019.

E. Next Steps

Gary D'Orsi, Director of Product Development, provided the committee with proposed meeting dates. The agenda topics would include outstanding certification requirements.

F. Adjournment

Chair Grant Ritter requested a motion to adjourn. Motion was made by Robert Tessier and seconded by Theodore Doolittle. ***Motion was carried.*** Meeting adjourned at 6:07 p.m.