Access Health Connecticut

Health Plan Benefits & Qualifications Advisory Committee (HPBQ AC) Meeting
December 13, 2018

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Agenda

- Call to Order and Introductions
- Public Comment
- Votes: Meeting Minutes (March 28, 2018 & April 11, 2018)
- Health Plan Benefits and Qualifications Advisory Committee (HPBQ AC) Requirements Overview
  - Roles, Responsibilities, Mission and Goals
- 2019 Plan Year: Certification Review
- Looking Ahead to Plan Year 2020 / Considerations
  - Key Deliverables
- 2020 Strategic Direction / Standardized Plan Design Development
  - Regulations & Guidance
    - Connecticut Insurance Department (CID)
    - Centers for Medicare and Medicaid Services
- Next Steps
  - Proposed schedule of meetings

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HPBQ AC Requirements Overview

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.

AHCT 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.

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Our Values in Action

At Access Health CT, it is with our customers and our employees in mind that we seek to promote these collective values and to live by these behaviors. Our culture of acceptance welcomes and values everyone. We challenge the status quo to find new ways to grow and improve our community, our company and ourselves. Our people take pride in the service we provide, and in the spirit of the common good that we share.

Authenticity	Integrity	Excellence	Ownership	One Team	Passion
Act with sincerity, credibility and self-awareness.	Commit to doing the right thing with genuine intention.	Aim high and challenge the status quo.	Take responsibility and initiative.	Collaborate to succeed.	Dedication to creating opportunities for greater health and well-being.

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HPBQ AC Requirements Overview

Co-Chair and AHCT Senior Leadership Team (SLT) Roles	Identify key emerging opportunities and market trends for research and review by HPBQ AC and AHCT Staff, when resulting in the potential for a change in standardized plans or certification policy/procedure, and determine if Committee discussion and review is appropriate.
Co-Chair and SLT Responsibilities	Co-Chairs: To be a resource and provide guidance (which is in line with AHCT strategic direction) pertaining to standardized plan benefit designs and plan certification criteria. SLT Responsibilities: Provide support and guidance to the committee. SLT designee will be responsible for securing the venue, selecting the dates, sending invitations, creating agenda with Chairs and documentation of meeting (i.e., minutes, etc.).

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HPBQ AC Requirements Overview

Mission / Focus	Develop ACA compliant benefit plan strategy and policy specific to Qualified Health Plans (QHP) and Stand-Alone Dental Plans (SADP) by creating standardized plan options and criteria for recommendation to the AHCT Board of Directors.
Guiding Principles	• Maintain consumer focus to align with AHCT overarching Vision and Mission • Minimize plan design changes year over year to mitigate consumer confusion and potential market disruption • Strive to make available an array of plan options that are easy to understand and use
Goals	• Support tasks necessary to meet ACA and AHCT Certification requirements to obtain board approval • Examine, educate, and review regulations impacting QHP/SADP • Identify and recommend AHCT certification requirements for QHP/SADP • Examine innovative product and plan offerings on and off exchange nationally to determine viability for inclusion in AHCT standardized plans • Determine carrier product flexibility, quality initiatives, and reporting mandates • Maintain transparency through regularly schedule public meetings

HPBQ AC Requirements Overview

Committee Composition per AHCT Bylaws	At least five (5) members with: • at least two (2) members who are not ex officio members of the Board • at least one (1) member who is an ex officio member of the Board. *No more than two (2) members of the committee shall be non-voting members of the Board*
Health Insurance Industry	• Actuarial / Underwriting Experience • Health Insurance representative with health product knowledge and experience in consumer buying practices of healthcare coverage
Healthcare Products	• Healthcare Product Development Experience
Provider / Pharmacological	• Connecticut resident that has front line clinical experience with treating patients
Advocate Community Representative	• Active advocate within Medicaid space

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HPBQ AC Requirements Overview

Meeting Protocol	• Committee members are expected to attend all meetings
	  ▪ In person attendance is preferred to dialing in to the conference call line
	• For purposes of accurate record keeping, speakers should state their name prior to any statement or question
	• Should the discussion veer from the published agenda, the committee chair/co-chair will redirect the conversation
	• Meeting timeslot is expected to remain from 4-6 PM, although occasional flexibility may be necessary
	• Meeting agenda / presentation materials and minutes are posted to: https://agency.accesshealthct.com/meetings
	  ▪ Select “Advisory Committees” and then “Health Plan Benefits & Qualifications Committee”

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HPBQ AC Requirements Overview

Meeting Protocol, continued	• Committee members are encouraged to submit agenda items that align with AHCT Mission, Vision and Committee Goals for Qualified Health Plans (QHPs) / Stand-alone Dental Plans (SADPs)
	  ▪ Agenda items should be provided in advance of the upcoming meeting
	  ▪ Committee members should speak to their submitted topic(s)
	  ▪ Proposed agenda items that need additional research can be deferred beyond the next meeting
	• In the event a member misses multiple meetings, the Chair will contact the member to confirm interest in continuing

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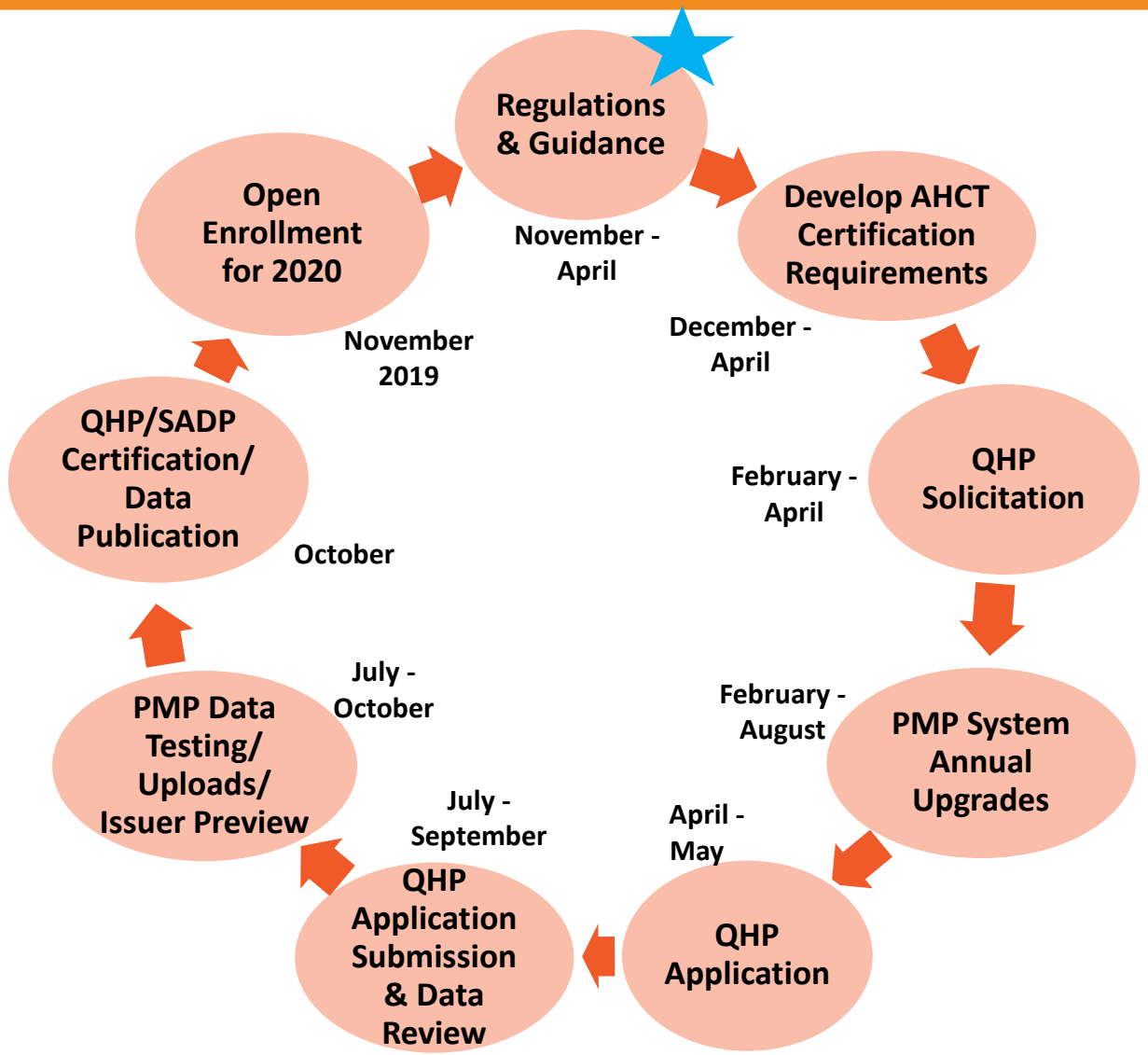
2019 Plan Year: Certification Review

- As recommended by the AHCT Board of Directors, all policies and criteria pertaining to plan certification requirements that were developed for prior years were reviewed by the HPBQ AC for the 2019 plan year
  - Focus was to determine if existing requirements resulted in higher premium plans or increased uncertainty for carriers, and whether any modifications were warranted
- Results of review included:
  - Addition of a standardized Silver plan based on coinsurance designed to be stabilize year over year plan design and premium rates
  - Minimal changes to cost sharing for standardized Gold, Silver and Bronze plans, providing plan alternatives not otherwise available in the Individual market
  - Modification to the number of non-standard plans available for the Silver metal level, encouraging the introduction of lower cost, more innovative plan designs

Looking Ahead to Plan Year 2020 / Considerations



Plan Management Certification Life Cycle

Each plan year, the cycle begins with the release of regulations and guidance, including the Actuarial Value Calculator (AVC) tool used to develop standardized plans, and ends once Open Enrollment commences

Note: timeframes subject to change

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2020 Strategic Direction / Standardized Plan Design Development

- Regulations and Guidance
  - Connecticut Insurance Department
    - Bulletin HC-124 issued October 24, 2018 eliminates maximum copayment amounts for specific categories of benefits for health insurance plans
      - Rescinds CID Bulletin HC-109 issued February 5, 2016
      - Allows for additional flexibility in developing ACA compliant plan designs
      - Cost sharing maximums set by statute are not impacted by HC-124
    - Additional cost sharing options
  - Centers for Medicare and Medicaid Services
    - Proposed regulation (i.e., '2020 Payment Notice') not yet released
    - CMS Letter to Issuers in the Federally Facilitated Marketplace for 2020 not yet released
    - Draft Actuarial Value Calculator (AVC) Tool for 2020 not yet released
      - The only major change to the 2019 AVC was to project claims data forward an additional year

Next Steps

Proposed Meeting Agendas *(subject to change)*	Target Dates *(subject to change)*
Preliminary 2020 Standardized Plan Design Modeling/Draft AVC/Regulations	January 2019
Secondary 2020 Standardized Plan Design Modeling Research/Results	January 2019
2020 Standardized Plan Design Modeling/Final AVC/Regulatory Considerations	February 2019
Final 2020 Standard Plan Design Modeling/Recommendations	February 2019
Board of Directors Meeting/Present 2020 Plan Design Recommendations for Approval	March 2019

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Appendix

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APPENDIX:
CID Bulletin HC-109 Issued 2/5/2016

Maximum cost sharing* thresholds listed as follows:

Benefit / Service	Maximum Copay
PCP Office Visit	$40
Specialist Office Visit	$50
Urgent Care	$75
Emergency Room	$200
Outpatient Surgery / Services	$500
Durable Medical Equipment	$25
Inpatient Admission	$500/day up to $2000
Generic Drug	$5
Brand Drug	$60
Home Health Care	$25
Ambulance	$225
Laboratory	$10
Routine Radiology Services	$40
Any service subject to coinsurance:	Cannot exceed 50% (applies to In-Network and Out-of-Network)

**Unless otherwise specified in state regulation, such as Sec. 38a-511a, which limits physical therapy copays to $30*

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