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

Holiday Inn, Junior Ballroom
East Hartford

Thursday, January 31, 2019
Draft Meeting Minutes

Members Present: Grant Ritter (Chair); Robert Tessier; Theodore Doolittle; Neil Kelsey, Tu Nguyen; Jill Zorn; Paul Lombardo

Other Participants: Access Health CT (AHCT) Staff: James Michel; Anthony Crowe; Ann Lopes; Charmaine Lawson; Ellen Kelleher; Susan Rich-Bye
Wakely Consulting: Julie Andrews; Brad Haywood (by phone)
Cecelia Woods

A. Call to Order and Introductions

Chair Grant Ritter called the meeting to order at 4:01 p.m. Dr. Ritter welcomed Jill Zorn to the Committee.

B. Public Comment

No public comment

C. Vote

Chair Ritter requested a motion to approve the December 13, 2018 Health Plan Benefits and Qualifications Advisory Committee Special Meeting Minutes. Motion was made by Neil Kelsey and seconded by Robert Tessier. ***Motion passed unanimously.***

D. Standardized Plans Overview

Ellen Kelleher, Carrier Product Manager, refreshed the Committee with the AHCT Vision and Mission statements. AHCT Values in Action, which include authenticity, integrity, excellence, ownership, one team, and passion were described. Ann Lopes, Carrier Product Manager,

provided a recap of what standardized plans are – these are defined as uniform cost sharing across certain plans. Cost sharing includes the plan deductible, maximum out-of-pocket, copays and coinsurance. Customers are able to compare these plans side-by-side and assess the unique differences in these plans across carriers, including premium and network. Ms. Lopes provided an overview of cost-sharing and uniform cost-sharing. AHCT does not prescribe inclusion of certain items in standardized plans including the Non-Essential Health Benefits (EHBs), such as adult vision, or mail order drug coverage and programs such as wellness, disease management, centers of excellence and discounts. Ms. Lopes summarized that all insurers who participate with AHCT in the Individual Market must submit the required number and type of standardized plans each year in order to be certified. Currently, AHCT requires that carriers submit five standardized plans only for the Individual market: one Gold, two Silver and two Bronze. The "plan mix" can always be brought into the discussion of certification requirements each year.

E. Wakely Consulting Presentation: 2020 Standardized Plan Designs

Julie Andrews, Senior Consulting Actuary from Wakely provided an overview of the 2020 Individual Market Standard Plan Designs. Ms. Andrews summarized proposed federal regulation changes for 2020 plans released on January 24th with the comment period ending February 19th and final regulations released subsequent to that. They include the proposed annual limitation on cost-sharing to be increased to $8200. This limit does not apply to High Deductible Health Plans (HDHPs), as the IRS sets that separately, usually in the spring. With a Board of Directors (BOD) meeting to review and approve certification requirements for 2020 in April, this is something to be cognizant of as it could be possible that an adjustment after that would be needed for the HSA-eligible Bronze plan. There were no proposed changes to the Actuarial Value (AV) ranges, and the AV Calculator (AVC) data was not 're-based' this year, although it was trended forward. Ms. Andrews stated that the proposed rule did not indicate that there would be changes to the guidelines pertaining to Silver loading for 2020. Ms. Andrews reviewed a list of covered services that are not included in the AVC, but that AHCT specifies cost sharing for within the standardized plans.

Brad Haywood from Wakely joined at 4:14 p.m.

Ms. Andrews indicated that the Connecticut Insurance Department (CID) specified that the maximum benefit copays have been withdrawn. Statutory maximums, such as physical therapies remain. A summary of the results of the draft 2020 AV ranges for the 2019 standardized plans were provided. Cost sharing for the Gold, Silver copay and Bronze non-HSA plans will need to be modified in order to be compliant with the AV requirements, as well as most of the Silver cost sharing reduction (CSR) plans. While the Bronze HSA plan does remain compliant with the AV, it has not been revised since 2017 and is therefore becoming richer. Ms. Andrews itemized the traditional and non-traditional levers that could affect the AV Calculator (AVC). The traditional and non-traditional levers include copay, coinsurance, deductibles or the Maximum out of Pocket (MOOP), but there is more opportunity to adjust since, per CID guidance, the copay maximum requirements have been eliminated. Other non-traditional levers include an inside MOOP or a

combination of coinsurance to a copay maximum and value-based insurance designs. These last items would focus on a chronic condition, such as asthma or diabetes, where some of the services associated with these conditions, like office visits or prescription drugs, might be less than the costs when not specific to treating these conditions. The non-traditional levers would aim at incentivizing certain behaviors. The cons of these types of programs is that they do not fall well within the AVC, and, for standard plans, carriers would need to manage these unique benefits for the defined population, and how would this work with Mental Health Parity (MHP) testing when treating these medical conditions differently. Also, individuals would need to understand what they are purchasing and how these benefits would apply to them.

. Mr. Tessier inquired whether the value-based plans in the state-based or Federally Facilitated Marketplaces (FFM) have been mandated as standard plan designs and if there are any data on the savings achieved from this approach. Ms. Andrews stated that this information could be gathered and presented.

Mr. Tessier stated that implementing these in standard plans would impact the majority of the enrollment and outlined the example of the state-employees' health enhancement program and its requirements and mandates such as annual physicals aim at keeping the costs down for the carriers and keeping the consumers more aware of their health status. One of the most important elements of this program contains no co-pays for medicines treating chronic conditions. Mr. Tessier indicated that the latter part is consumer-friendly and would result in people becoming compliant with their medications.

Mr. Tessier asked how much we will have to make up in changes to plan designs for the upcoming plan year as compared with previous years in order to meet the AVC. The question is related to how much benefits would have to be reduced for a consumer. Ms. Andrews reviewed the alternative plan designs, with changes to cost sharing, for the standardized Gold plan to come into compliance. It was noted that these plan options have not yet been reviewed by the carriers for compliance with AVC or MHP. Discussion ensued around the 2020 Individual Market Gold Plan options. Various ideas were considered such as, increasing the copays, and elimination of a deductible for laboratory services and non-advanced radiology. All of those changes, however, may cause the plan to fall outside of the acceptable AV range. Usage of urgent care centers as an alternative to emergency rooms and the relationship of this to primary care) and specialist care was discussed. Mr. Kelsey stated that reimbursement of PCP and urgent care is not the same.

Ms. Zorn asked for clarification on mental health parity and the impact to cost sharing for radiology services. Ms. Lopes stated that a few years back, there was a need to adjust the plan designs after they were filed with the CID. After some review, it was determined that to minimize changes in the plan designs, that the laboratory and x-ray benefits for some of the standardized plans were adjusted so that they would be subject to the plan deductible in order for the plan to meet MHP testing requirements. Mr. Lombardo stated that there are two tests for MHP, and they are company specific, based on each carrier's own claim data; therefore, Wakely cannot test plans for this. The easiest way to think about MHP testing is, if mental health services have the

lowest cost sharing vs all others, then MHP would be met. But, to the extent that other services have potentially lower overall cost sharing, that could result in not meeting the MHP requirement. Mr. Lombardo noted that CID has shared with the legislature AV and MHP requirements and that there may be unintended consequences of initiatives to reduce cost sharing for certain benefits.

Ms. Kelleher stated that this whole initial effort in modeling the plans is to get a better sense of what areas can be reviewed so we know what levers to consider. Mr. Lombardo noted that the cost for outpatient hospital services can be very high, so may want to look at the cost share for outpatient hospital to see if it should be increased. Carriers may be able to review this. Ms. Lopes stated that a large portion of the 2019 enrollment is in the silver tier, with a significant increase in non-standard plans.

Ms. Andrews went on to summarize the options for cost sharing changes for the 2020 Individual Market Silver copay plan at the 70 percent AV level. She asked for feedback on the generic drug copay changes outlined. Dr. Ritter stated that this could result in an enrollee paying the entire cost of these drugs. Mr. Nguyen recommended adjusting the brand drug copays, rather than the generic, as they are more costly. Mr. Lombardo mentioned that the proposed federal regulation includes information about modifications in drug coverage, with the potential of a consumer choosing a brand name medicine when a generic is also on the formulary, that the amount the consumer pays beyond the cost of the generic would not be counted toward meeting MOOP and the deductible. Another concern is whether it is a subject to the state law or if it will pre-empt any law that will be put in place and the brand-name drug would not be a considered an EHB and it would be outside of the premium tax credit (PTC) as well. Mr. Lombardo mentioned there are legislative proposals that would affect the carrier's ability to change their formulary throughout the year, resulting in carriers not being able to remove a brand drug from the formulary when a generic drug is introduced. Mr. Doolittle stated that a lower generic drug copay is value-based insurance design (VBID) and expressed his support for encouraging consumers to use generic drugs since it would represent a savings to the system, and therefore to the consumer. Mr. Tessier pointed out that any changes should be consumer-friendly and suggested avoiding an increase to the prescription drug deductible. Other options that should be considered are increasing the emergency room the outpatient hospital copays.

Ms. Zorn asked what the coinsurance for 'All Other Medical' applies to. Ms. Andrews pointed out that it applies to services such as durable medical equipment. Ms. Zorn stated that the cost sharing of 40% for diabetic supplies and equipment is a perfect example of not aligning with value-based benefit design and inquired whether it may be possible to lessen the cost sharing. Mr. Lombardo noted that potential savings may not show up immediately, so it may take time to materialize.

The Committee discussed possible options of coverage for chronic conditions, and whether there may be some that should be targeted when considering VBID. There was discussion about the conditions included in the State plan. Ms. Zorn also asked about the cost sharing for

mammography ultrasound coverage. Ms. Lopes stated there is a maximum copay per statute, and it can be brought back as a follow up at the next meeting. Mr. Doolittle inquired whether any interest exists in introducing multi-year plans. Mr. Lombardo elaborated that in the large group market it exists, but in terms of the compliance with the ACA, a lot of exceptions would need to be made in the individual and small group markets. Mr. Tessier stated that, in the individual market, there is greater risk to the insurance company, and a three-year policy would be a more than three separate year policies. Mr. Nguyen noted that, given the ACA regulations, members can shop and move regularly versus in the large group market programs can be implemented consistently and the employer would be more likely to stay with the carrier, so it would be difficult to institute multi-year plans on the individual market. Also, plans would have to fit into the AV for each year. Mr. Kelsey concurred and indicated that a lot of exceptions would need to be instituted. Ms. Zorn asked if there was a lot of movement of enrollees year over year. Mr. Michel stated that on average, 18 percent of the AHCT customers changed plans but for this plan year about forty-nine percent of the Exchange's customers changed their plans. AHCT played a critical role in providing consumers with all of the necessary information and tools that allowed them to make educated decisions.

Ms. Andrews went on to explain the CSR variations for the 2020 Individual Market Silver copay plan, which would be revised to align with the 70% AV plan and moved to the 2020 Silver Standard coinsurance plan. Ms. Zorn stated that the Universal Healthcare Foundation conducted a survey and 50% of those surveyed indicated that they did not know what coinsurance was. Ms. Zorn asked if the assumption is that there would be two standard Silver plans next year. Mr. Kelsey pointed out that coinsurance plans may be confusing to consumers, but it is where the market is going and one of the goals for last year was to introduce lower cost more flexible and innovative plans, and it was decided to have two standard Silver plans. Dr. Ritter suggested that different options might be considered, such as moving the coinsurance plan down to Bronze or have only one standard Silver copay plan and no non-standard Silver plans.

Mr. Tessier expressed his concern that one of the trends that is happening has to do with the fact that health insurance is becoming more unaffordable for many people. While the premium rates were lowered, so were the premium tax credits that people use in order to help them in paying for their coverage. Mr. Kelsey indicated that by introducing the non-standard silver plan, with the price below the standard coinsurance plan, numerous consumers are paying lower premiums for the coverage. Mr. Kelsey stated that many of them also are not utilizing their benefits. Mr. Doolittle inquired whether it would be possible to find out the financial impact on the consumer of coinsurance versus the co-pay plan for the future. There was recognition that this could take up to one and a half years for data to be available. Mr. Kelsey stated that Silver plan premiums were dramatically reduced for 2019, and using the AV as a measure, the plan coverage was approximately a 2% reduction. Given changes in affordability, choice and innovation that are now available, he stated he would not advocate moving back. Mr. Lombardo added that consumers need to be educated on what coinsurance is, and the movement to this approach is to reconnect people with what the cost of services are, as opposed to copay plans that do not.

Mr. Michel expressed his concern about the rising rates for medical services by the providers as well as pharmaceutical companies. These issues need to be addressed on national and state levels. It is not something AHCT can impact. Mr. Lombardo noted that 80 cents of every dollar has to cover the claims. Mr. Nguyen noted that the goal is to offer choice and also maximize the premium subsidies. Dr. Ritter supports the idea of introducing a bronze plan with a coinsurance option. Mr. Kelsey would like to see statistics on how many unsubsidized people bought Silver plans. Ms. Zorn indicated that those with lower incomes end up as a greater proportion of those who are uninsured. Mr. Michel stated that an AHCT objective in the next nine months or so is to commission a survey to identify the uninsured in Connecticut, including geography and ethnicity. There are conversations occurring at the State level about items like waivers, and the only pool of federal funds is the amount of premium tax credits.

Ms. Andrews went on to review the 2020 Individual Market Bronze Non-HSA Plan, which can have up to a 65% AV when qualifying as an expanded Bronze. The Bronze HSA plan is within the expanded Bronze range, but it is moving up in the range, and there may be a desire to get this closer to a lower Bronze plan. It has not been touched in several years and continues to creep up. Mr. Tessier noted that premiums for the HSA plan for 2019 in some counties were higher than non-HSA plans. Ms. Lopes indicated that over time, the AV for that plan has increased because there were no changes to the cost sharing. The deductible has remained static but medical claims have trended upwards in the meantime, so people are paying a smaller share of overall claims. Ms. Andrews stated this is the 'leveraging effect'. Mr. Kelsey requested that we go back two years in looking at data for purchasing patterns and would like to know where people ended up with the change in PTC – did they stay in Bronze or move to Silver. Mr. Tessier suggested looking at more than the last two years. Mr. Kelsey indicated that if you go back more than two years, the pool would shrink due to lack of continuous enrollment.

Ms. Andrews outlined follow-up items, including more information about VBID and on different levers, and bringing plans into compliance with the AV ranges. She will work with the AHCT team and the carriers on additional samples. Mr. Lombardo stated that plan designs that go to the carriers for an initial review, may need to be transferred back again if any plans need to be tweaked to ensure that they continue to meet AV and MHP requirements.

F. Future Items for Discussion

Anthony Crowe, Chief Operating Officer, summarized future items for discussion. Mr. Tessier encouraged all committee members to bring forth ideas that they have not been considered that may potentially lower consumer costs for the Exchange's healthcare plans. Mr. Tessier expressed his concern about the constantly rising costs of those plans and the negative impact it has on the AHCT's customers. Discussion ensued about potential savings that can be achieved including negotiating with medical providers and adjusting drug formularies. Mr. Doolittle offered his support as the Healthcare Advocate to combat the high cost of medicines and medical services

as long as it is proper and properly administered. Mr. Lombardo added that there are a finite number of healthcare systems now that have much more negotiating power than they ever had. The percentage increases that are seen when disputes between the providers and carriers emerge are not small. They can be 35, 40 to 50 percent. Conversations are taking place to use Medicare as a benchmark for reimbursements. There are reasons why it has not happened yet. Mr. Lombardo mentioned how Massachusetts approaches this problem where certain cost controls are instituted, and consumers are able to find out how much a service will cost in one hospital versus another. Mr. Kelsey stated that profit margins for the carriers are much lower than the remaining 20 percent. They are usually 2 or 3 percent. Mr. Doolittle indicated that he is interested how the 80 percent of every dollar that has to cover claims by medical providers is spent by them. Mr. Doolittle mentioned that he is in support of the legislative proposal currently being considered at the State's General Assembly that would require affordability to be part of the rate review process. Mr. Lombardo stated that CID can only regulate the carriers. There is no regulatory body on the state level for hospitals.

G. and H. Actions Items and Meeting Schedule

Ms. Kelleher provided the proposed meeting schedule, some of which is a subject to change. Based on the discussion, it was decided to move the next meeting out by one week so that there will be sufficient time to incorporate elements of this discussion into plan options, as well as push the February 27th meeting out one week.

Ms. Rich-Bye enumerated different action items that will be taken up at the future meetings of the Committee. They include whether any other state-based or FFM exchange requires the use of VBID in standard plan designs, how this year's AV compliance compares to previous years and purchasing habits for the past three years.

I. Adjournment

Chair Grant Ritter requested a motion to adjourn. Motion was made by Robert Tessier and seconded by Theodore Doolittle. Motion passed unanimously. **Meeting adjourned at 6:05 p.m.**