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

Connecticut Historical Society, Auditorium
Hartford

Thursday, February 21, 2019
Meeting Minutes

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

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

A. Call to Order and Introductions

Chair Grant Ritter called the meeting to order at 11:15 a.m.

B. Public Comment

No public comment

C. Vote

Chair Ritter requested a motion to approve the January 31, 2019 Health Plan Benefits and Qualifications Advisory Committee Special Meeting Minutes. Motion was made by Robert Tessier and seconded by Theodore Doolittle. ***Motion passed unanimously.***

D. Follow-Ups from Prior Meeting

Anthony Crowe, Chief Operating Officer, summarized activities at the prior meeting of the Committee that are also topics of conversation at this meeting.

E. AHCT Consumer and Buying Patterns

Robert Blundo, Director of Technical Operations and Analytics, provided the Committee with a summary of AHCT Consumer Buying patterns as well as an analysis of trends. He focused on consumer plan selection preferences, how eligibility for premium tax credits plays a role in product selection and how long-term customers have transitioned. Over the last six years, there have been a significant shift in customer enrollment toward lower cost metal tiers.

Mr. Blundo stated that plan premium is the most important assessment factor in the plan selection process for AHCT customers. In 2018, premium tax credits (PTCs) increased due to Silver-loading while in 2019, the reduction in PTC was a result of the introduction of the lower cost silver plans, which changed pricing dynamics. Mr. Blundo pointed out that there has been a growing increase in Bronze plans as well as a decrease in demand for richer plans. Mr. Blundo went on to summarize migration of consumers between plans based on selected criteria, such as for those who are eligible for PTCs and cost sharing reduction (CSR) plans.

Mr. Blundo reviewed the plan selections for enrollees eligible for Silver CSRs, indicating that the majority are picking a Silver plan, taking full advantage of the richer benefits. The number of people eligible for the 73% CSR level has dropped over the past three years, but it's difficult to know whether it is a good economic decision for these enrollees to choose a Bronze plan instead. For these individuals, there is not a large amount of difference in the cost sharing between the 73% CSR plan and the Silver plans. He provided an example of the premium cost difference for someone electing the Silver Choice Alternative plan versus the Choice Bronze Standard. A 30-year old with an annual income of $30,000 per year would save $850 per year in premium costs by taking the Bronze plan but would increase risk exposure in terms of deductible by about two and a half thousand dollars. Some people may benefit from this selection. Robert Tessier inquired about the number of individuals who qualified for the 94 percent CSR plan but purchased a Gold plan. Mr. Blundo indicated that there were 120 consumers in that category. Mr. Tessier stated that there may be some counties where a Gold plan is lower in premium compared to some of the Silver plans, and perhaps these consumers chose that Gold plan. Mr. Blundo stated that this could be broken out to get a better understanding. He reviewed the five plans that were the most popular for the last three years. Consumers continue to be price-conscious, with subsidized enrollees selecting the lowest cost Silver plan option. The unsubsidized group has favored Bronze plans. Mr. Blundo also provided an overview of the population, limiting it to include only repeat customers over a three-year period, outlining the percentage of the population that stayed enrolled continuously in a specific metal level for all three years.

Theodore Doolittle stated that cost is not the same as premium and encouraged examination of the actual cost experience for customers and making sure that they are provided with the right information to determine the "all-in" cost of health care. Chair Grant Ritter expressed his concern that some customers who were eligible for 94% CSRs in the Silver tier chose at the Bronze plan level. Dr. Ritter inquired about possible options to convince these customers to pick a CSR plan,

which are richer and may be less costly when factoring all aspects of the healthcare cost. Susan Rich-Bye pointed out that legally, AHCT cannot restrict consumers to choose a plan. Ms. Rich-Bye added that more outreach to these customers may have to take place. Consumers with incomes that qualify for CSRs may think the Bronze plan is more affordable premium-wise. Mr. Blundo provided an example of a 28-year old, their lowest cost Silver plan would be $330 unsubsidized versus $270 for the lowest cost bronze. Even with the APTCs incorporated, there is still a possibility of substantial premium cost difference between the plans.

James Michel, Chief Executive Officer, pointed out that brokers are essential in providing customers with assistance when picking plans. Mr. Tessier inquired whether the AHCT can sit down with the brokers and talk to them about their experience with certain consumers who are choosing Bronze plans while they are eligible for Silver CSR plans. Mr. Tessier posed a second question whether AHCT has means to identify the anomalies that are visible in the customers' plan selection process. Mr. Michel noted that AHCT knows who these customers are. Surveys can be conducted to inform the approach for next year's open enrollment. Ellen Kelleher, Carrier Product Manager, stated that when a consumer enters their income on the shopping portal, they are shown plans they eligible to purchase. The CSR plans would be brought up first. Mr. Blundo noted that approximately 30 percent of the population that is picking a non-silver plan is associated with a broker, and the hope is that consumers are being educated on the value of the plan. We are working on providing an improvement in a consumer's simulated experience for the next open enrollment.

F. Wakely Consulting Presentation: 2020 Standardized Plan Designs

Julie Andrews from Wakely Consulting provided the Committee with the 2020 Standardized Plan Designs options. Ms. Andrews summarized the results of the draft 2020 Actuarial Value (AV) Calculator on AHCT standardized plans, stating that the focus is on those that need alterations in order to fall within AV compliance. Ms. Andrews noted that subsequent to the last meeting, she provided a brief survey to the participating carriers requesting feedback on the direction to take on modifications to cost sharing for certain benefits, such as Durable Medical Equipment (DME) and X-Ray and Lab not subject to the deductible. Ms. Andrews stated there were nine plans provided to carriers to analyze for AV and Mental Health Parity (MHP) compliance. Adjustments were made to these, resulting in twelve plans going back to the carriers. The plans that were found to be compliant by both carriers for AV and MHP are being presented today. Ms. Andrews noted that as the 2020 benefit payment parameters is still in the proposed status, a question remains how CMS will trend forward the maximum out-of-pocket (MOOP) and a back-up plan is being considered, in the event the MOOP limit is not finalized as $8200. Ms. Andrews enumerated various possible changes that may be incorporated for those plans to be compliant with the AV Calculator. Carriers have not had an opportunity to respond to the suggested ideas under the back-up plan. Discussion ensued around potential adjustments to cost-sharing for various services under the Gold, Silver and Bronze plans. Ms. Andrews stated that, on average, to change the DME cost sharing from 40% coinsurance to 30% coinsurance that there would be

a savings of between $13 to $30 for members, so given the minimal impact, this change has not been proposed. The options discussed will need to be reviewed by the carriers for compliance with AV and MHP.

Ms. Skinner commented that the outpatient hospital is more expensive than ambulatory outpatient and inquired whether there is any rationale of examining them independently. Neil Kelsey indicated that could be examined by trying to encourage consumers to use the most cost-effective services. Ms. Skinner asked about laboratory services, and whether there was a review to determine if they had to be subject to the plan deductible. Ms. Andrews acknowledged that this issue was examined with two plan options, one having lab or x-ray before deductible and another plan that had both, but these fell out of compliance in either AV or MHP. However, we could look to see if there was a way to get this through. Ms. Skinner stated she would suggest lab be prioritized over x-ray, under the approach to improve overall wellness. Jill Zorn pointed out that prescription and medical deductible were combined last year in the Bronze plan and stated a person in the plan would have to first spend $6,000 in order to obtain prescription coverage. Ms. Andrews clarified that the deductible does not apply to generic drugs. Ms. Andrews stated that the Bronze plan is at a high AV level right now, and it would be difficult to come into compliance with AV if the deductible did not apply to prescription drugs.

Dr. Grant Ritter left at 12:06 p.m.

Tu Nguyen arrived at 12:07 p.m.

Ms. Andrews went on to explain the estimated impact of a simplified VBID plan, outlining that there are some complications to implementing this type of design in a standard plan, especially in terms of the Mental Health Parity. Ms. Andrews stated that she selected two of the medical conditions included in the state employee health plan to examine and to determine impact on AV when cost sharing for prescription drug coverage related to the conditions would not be a subject to the deductible. Ms. Andrews outlined the steps that were taken to evaluate the impact and estimated that the AV impact would be an increase of 0.1% and 0.3% for the two conditions considered, and that would need to be made up with higher cost sharing on other services. Mr. Tessier inquired whether information from other state-based exchanges or the Federally Facilitated Marketplace (FFM) was reviewed. Ms. Andrews stated that they were looked at from the analytical perspective. Mr. Michel stated that some information from Massachusetts would be presented. Ms. Skinner asked if it is known that non-compliance with drug utilization is a reason that could help control costs for the conditions used, stating that it would be helpful to understand whether, if this type of program was implemented, if there are potential future savings to look for. Discussion ensued around differences between the State of Connecticut Health Enhancement Program (HEP) and a Value Based Insurance Design (VBID)like approach that could be implemented for the Individual market, as it may not be able to incorporate some incentives that can be included in a group plan, and without a broader program, it may not be as meaningful. The participating carriers were encouraged to share data on the chronic disease prevalence with Wakely and the Plan Management Team, and they agreed to explore doing that.

Mr. Nguyen indicated that this type of program may have an initial cost, but there could be long term cost benefits, and he would determine if there was information on benefit design that could be shared.

G. AHCT QHP/SADP Certification Requirements & Submission: Plan Year 2020 Timeline

Anthony Crowe provided the Committee with the Plan Year 2020 Timeline and submission deadlines that must be met. It is expected that items will need to be firmed up during the next meeting.

H. Certification Requirements: Discussion Topics

Ann Lopes, Carrier Product Manager, summarized certification requirement topics reviewed by the Committee for the 2019 plan year. They included the requirement for carriers to submit standardized plan designs.

Ms. Lopes summarized the results of outreach to obtain additional information on VBID concepts in other exchanges. AHCT had a discussion with the Massachusetts Health Connector. AHCT was advised that a national workgroup was formed within the past year to determine the feasibility of a VBID approach that could apply to Individual Market plans offered through Health Insurance Exchanges. Ms. Lopes pointed out that the workgroup identified high and low value services, and reviewed multiple disease states to determine appropriate areas upon which to focus. A consultant was charged with developing a report that would summarize the results of the findings. Ms. Lopes indicated that the Massachusetts Health Connector permits optional VBID offerings, within the framework of their standardized plans as long as it does not impact premium or cost sharing.

Mr. Tessier inquired whether the PM Team was able to assess the outlines of the Massachusetts Health Connector voluntary program and possibly what effect it may have on the participating carriers on the Exchange. Ms. Lopes added that these conversations can take place with the carriers. The information that was received from Massachusetts is that there has not been a significant uptick in this. Also, there are some additional challenges with implementing this type of a program. As an example, the federal data templates used by carriers to submit plan data are not designed to include indicators for a VBID program or to capture differences in cost sharing for conditions that are included in the program, so it would be virtually impossible for an Exchange to obtain this type of data and post to its consumer portal. Since there was CMS representation on the workgroup, this issue was identified. There is also the potential for adverse selection to occur, in the event a program is included in a plan offered through the Exchange but not also outside the Exchange. Massachusetts stated it is difficult to identify the medical condition to use. Additionally, carriers may have different results for the same program in terms of AV and MHP compliance. Ms. Zorn stated the rules to the AV Calculator would need to be altered, as it would be difficult to implement this program because the prices would need to be

raised somewhere else. Ms. Andrews pointed out that a potential exists that CMS might add additional functionality to the AV Calculator. It would be a significant project for CMS. Further discussion touched upon prevalence of certain chronic conditions and possible ways to mitigate costs in treating them. Ms. Skinner inquired whether chronic conditions may be managed better under a VBID approach. Mr. Tessier asked the carriers if it would be helpful to determine if the chronic conditions used in the example provided have a high prevalence of enrollees being treated for those illnesses. Ms. Skinner stated that in the lower economic strata that there could be a higher prevalence of some of these diseases, and if that is true, with the population enrolled, can care be managed better by looking at some VBIDs, and how could it be structured given existing constraints. Mr. Kelsey pointed out that one of the ways to determine that would be using the Wakely simulation project. All carriers on the market provide information to that study. It provides information with the disease prevalence relative to the overall market. Ms. Andrews stated that she used that dataset for the Northeast region, as she is prohibited from using Connecticut only data, for the protection of carriers that submit information. It is reflective of a subsidized population. Mr. Nguyen stated that it would take some time to determine if they can pull this data, but it would be necessary for both carriers to respond.

Ms. Andrews stated that there was a suggestion in a previous meeting to allow only one standardized silver plan. It is a directionally different path than the Committee strove to go in 2018. Last year the Committee decided to add more plans to ensure affordability, keep plan options vibrant by adding innovative features. Ms. Andrews added that while going to one standard plan may positively impact the levels of APTCs, there may be individuals that have selected certain plans that would be negatively impacted. Mr. Tessier stated that a significant interest exists in going back to one standard Silver plan based on the decreased level of APTCs being available to enrollees for 2019. The increase of premiums in the Bronze plans were significant and enrollees were additionally burdened with more financial obligations. Mr. Michel noted that one of the carriers submitted data to support one standardized Silver plan. Ms. Andrews indicated that one carrier undertook sample modeling in terms of what it would look like if plan options were reduced to one standard plan and how it would impact APTCs. The increase of APTC would result depending on the Federal Poverty Level (FPL). An additional scenario was returning to multiple Silver plans with the standard plan being the lowest cost option. Under that scenario, the APTCs would also be increased. However, some individuals will also be negatively impacted. Mr. Tessier stated that when the Silver-loading was implemented for 2018 and had a significant increase in premiums in the standard Silver plan, the APTC increase for most people more than made up for the premium increases. The premiums increased substantially, but APTCs insulated enrollees from those increases. Ms. Andrews stated those individuals who may have chosen to go into the lowest cost Silver plan would experience an increase on the post APTC basis due the fact that the standard plan would become the only plan. In addition, all the unsubsidized individuals would see increases in their premiums.

Mr. Tessier noted, that the chair of the Committee indicated during the Board meeting that the Exchange's future strategy should include maximizing the APTCs. In addition, those who are not

receiving financial assistance in paying for their premiums, should be offered lower cost, innovative plans at the Bronze and Gold levels. Mr. Nguyen noted that given the expanded range of the AVs now, the lines between Silver and Bronze are blurred.

Mr. Kelsey encouraged the Committee not to reverse course so the current structure could remain in place for one more open enrollment cycle to explore the results. A significant population was moved into a co-insurance plan. There are no results available in terms of their reaction to their plans. Mr. Kelsey stressed that it will not be fully determined until the next open enrollment cycle begins. Mr. Kelsey expressed his support for leaving the status-quo in place and make very modest changes. Ms. Kelsey noted that next year, the Committee will have some data that could be very valuable to determine which course of action should be taken. Ms. Zorn indicated that she does not understand how, from the consumer-perspective, coinsurance plans can be a positive plan for people. After a year, results would be based on who got sick versus who did not, and it's not just about premium. It's about all the money that people will have to spend Ms. Zorn added that the Universal Healthcare Foundation performed a survey and about 50 percent of respondents indicated that they did not know what coinsurance is, and too much choice may not necessarily a good thing. Ms. Zorn added that the concept of two standard plans is confusing. Ms. Zorn expressed her support for Mr. Tessier's approach. Mr. Tessier stated that he understands Mr. Kelsey's comments, however, and would rather not revisit what was discussed last year. However, seeing the result of the reduction in APTCs may be one of the reasons why this issue would need to be revisited. Mr. Tessier added that 75 percent of the Exchange's customers are the ones who use financial assistance to help them pay their premiums and those enrollees saw reduction in that help. Mr. Tessier expressed his appreciation that in the Silver tier, newer, less expensive plans were made available. Mr. Tessier added that currently the Exchange has two standard Silver plans. Consideration may be made in going with just one standard Silver plan and no non-standard plans or have one standard Silver plan along with allowing non-standard Silver plans but requiring that the standard Silver plan be the lowest cost plan which would ensure that the second lowest cost is the standard plan and that would maximize the APTCs. Mr. Michel pointed out that the AHCT's Leadership Team serves at the pleasure of the Board and serving the customers is the most important element. Mr. Michel emphasized that whatever is decided, the Exchange will implement those decisions, and. stated that changes that were instituted for the last OE were very confusing to customers. Access Health CT did their very best to mitigate confusion. Mr. Michel added that reverting to the previous plan designs would cause confusion, however, reiterated that if such decision is made in the best interest of customers, AHCT will implement it. Mr. Michel suggested the Committee consider transitioning changes to minimize the negative impact on consumers. Ms. Lopes referred to an exhibit on slide 45 that depicts that approximately 28% of the enrollment is in a non-standard Silver plan, showing there was a lot of movement to these, and communication and auto-enrollment plans would need to be factored in. Ms. Zorn asked for this chart to be broken down by subsidized and non-subsidized enrollment.

Items I and J. Future Items for Discussion and Action Items

Anthony Crowe provided the Committee members with possible items for future discussion. Mr. Crowe pointed out that there exists a need to determine why certain enrollees who chose the Gold plans, it when it may have been more advantageous for them to pick the Silver CSR plan. Additional analysis is needed to determine why certain enrollees who qualified for the 94% Silver CSR ended up choosing the Bronze plan. AHCT will also be reaching out to the State Comptroller's Office for information pertaining to prevalence of the chronic conditions included on state plans. Mr. Nguyen will research to determine if there is any information available on existing VBID plans regarding whether reducing copays results in increased prescription drug compliance. Also, Ms. Andrews will review prevalence data included in the Wakely simulation project. Several modifications to standardized plan options will be reviewed by Wakely and the carriers for compliance with AV and MHP, including possible trade-offs that would be required to implement certain features. Wakely will review the potential impact on consumers for moving to a single standard Silver plan. Ms. Lopes stated the next scheduled meeting is March 14th.

K. Adjournment

Robert Tessier requested a motion to adjourn. Motion was made by Theodore Doolittle and seconded by Ellen Skinner. Motion passed unanimously. **Meeting adjourned at 1:15 p.m.**