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

Holiday Inn, Junior Ballroom
East Hartford

Wednesday, January 29, 2020
Meeting Minutes

Members Present: Grant Ritter (Chair); Theodore Doolittle; Neil Kelsey, Tu Nguyen; Jill Zorn; Ellen Skinner (on the phone); Paul Lombardo

Other Participants: Access Health CT (AHCT) Staff: James Michel; Anthony Crowe; Ann Lopes; Charmaine Lawson; Susan Rich-Bye; Robert Blundo
Wakely Consulting: Julie Andrews; Brad Heywood (on the phone).

A. Call to Order and Introductions

Chair Grant Ritter called the meeting to order at 4:00 p.m.

B. Public Comment

No public comment

C. Vote

Chair Ritter requested a motion to approve the December 18, 2019 Health Plan Benefits and Qualifications Advisory Committee Special Meeting Minutes. Motion was made by Jill Zorn and seconded by Tu Nguyen. ***Motion passed unanimously.***

D. AHCT Vision, Mission and Values

Ann Lopes, Product Carrier Manager, presented the Access Health CT (AHCT) Vision, Mission and Values description. Ms. Lopes noted that in order for AHCT to certify a health plan as a Qualified Health Plan (QHP) so it can be offered through the Exchange, carriers must comply with the minimum requirements established by the Affordable Care Act (ACA) and any additional requirements approved by the AHCT Board of Directors. Ms. Lopes stressed the important role

that the Health Plan Benefits and Qualifications Advisory Committee (HPBQ AC) has in reviewing existing certification requirements each year and determining whether any changes are necessary for the upcoming plan year. Ms. Lopes pointed out that some of those requirements were discussed during the Committee's meeting in December. Ms. Lopes elaborated that at a minimum each year, this Committee reviews, as one of the certification requirements, the standardized plans that are developed within this Committee and submitted by carriers as a condition for participation with AHCT in the Individual market. Ms. Lopes went on to say that this is needed every year because plans must adhere to Centers for Medicare and Medicaid Services (CMS) actuarial value (AV) requirements - a tool developed by CMS is used to determine whether a plan's actuarial value continues to comply with the requirements.

Ms. Lopes stated that changes to any of the certification requirements must adhere to the AHCT Vision and Mission and read both statements. James Michel, CEO, stated that anything this Committee does must be in support of the Vision and Mission and added that these were developed back in 2012 and are still relevant. There are parts of the Mission that we will focus on going forward as there has not been as much success with some.

Ellen Skinner inquired about the Mission and whether each of the bullets could be addressed in terms of public interest to see what has been done well and where there are challenges. Mr. Michel stated that the area of low-cost insurance continues to be an issue for Connecticut. Health care disparity is also an important issue that needs to be addressed on an ongoing basis. Ms. Skinner added that looking to improve healthcare quality and reduce disparities is something that everyone is concerned about.

Ms. Lopes stated that AHCT focuses on a set of values and associated behaviors that were established to remind the organization of the responsibility to its customers. Those values and behaviors were established to assist the organization in achieving its goals.

E. Follow-Ups from Prior Meeting

Ms. Lopes summarized take-aways from the prior meeting of the Committee, including but not limited to the data that was included in the Appendix as well as the discussion about the VBID-X report released by a group of public and private stakeholders last year. Ms. Lopes indicated that the URL was provided to the members of the Committee on January 8 so they could access the report and read it in advance of today's discussion.

F. 2020 Connecticut Individual Market Landscape

Ms. Lopes provided the Committee with the 2020 Individual Market Landscape. Ms. Lopes stated that Anthem submits their off-Exchange and on-Exchange plans together in a combined filing, while ConnectiCare has 3 different licensed companies with separate filings and their 'On-Exchange' plans are submitted by ConnectiCare Benefits Inc, or CBI.

Ms. Lopes added that as noted, 50% of the filed plans are offered through AHCT. It is possible that an 'off-exchange' plan, was filed but is not marketed. Ms. Lopes added that over 40% of the filed plans were at the Bronze metal level.

Ms. Lopes also summarized how the plans offered through AHCT compare, in terms of premium, for the various metal levels to those filed 'off-exchange' only. Ms. Lopes conveyed that at the Bronze level, AHCT has 2 plans that are lower in premium compared to any of the other 12 plans filed in the Individual market.

At the Silver metal level, AHCT went in a different direction for Plan Year 2020, permitting carriers to offer only one plan through the Exchange, and that is the standardized plan. The AV range for this plan is greater than most of the Silver plans filed. A new Silver plan available through ConnectiCare Inc is at a premium level ranging from about 9% to 12% lower than the lowest AHCT Silver plan premium. It varies by county. Ms. Skinner asked how the carrier was able to achieve that price. Neil Kelsey stated that the cost structure for that company is different and there is a lot of flexibility for 'off-exchange' plans. Ms. Zorn added Silver loading applies for 'on-exchange' plans.

Ms. Lopes stated that at the Gold metal level, there were 7 plans filed, 5 of them available through AHCT. A non-standard Gold 'on-Exchange' plan is the lowest premium Gold plan. In addition, that plan is lower in premium than the lowest premium 'on-exchange' Silver plan in all counties (ranging from about 0.2% below in Hartford county to about 5% below in Litchfield, New London, Tolland & Windham counties). Ms. Lopes stated that the AHCT standard Gold plan offered by either carrier is within the top 3 highest premium plans filed in the marketplace. The AV range for this plan is over 81%, compared to the other Gold plans that were filed that are in the AV range of 76-77%.

G. Value-Based Insurance Design (VBID)

Ms. Lopes provided information on Value-Based Insurance Design (VBID) and the possibility about adding components of it into the standard plan designs. Ms. Lopes stated that a VBID principle is to reduce cost sharing for consumers for certain 'high value' services while increasing it for certain 'low value' ones with the goal of keeping premium and AV neutral. Ms. Lopes elaborated that last year, a group of public and private stakeholders, including representatives from the Massachusetts and California Exchanges, met to discuss the viability of establishing a template that could be used as a guideline for carriers and Exchanges in the Individual market to follow to build VBID into plans. Ms. Lopes summarized the report which essentially supported the idea that incorporating this approach on cost sharing changes for high and low value services could be done, but noted that depending on specifics of state regulations, that the plan design sample they devised would not be viable across the country. Additionally, the report outlined that implementing higher cost-sharing for the low value services identified was not sufficient to offset the lower cost-sharing for high value services, so they looked at categories of services instead. ACA compliant plans already incorporate an element of VBID with certain preventive

services at no cost sharing. Last year, this Committee recommended a modification to cost sharing for Outpatient Services to based on the site of the service for most of the standard plans, which could be considered a VBID principle. Ms. Zorn stated that the report outlined the concept of lowering barriers to high value care but to offset that by addressing low value care, and how hard it is to do the low value side. Paul Lombardo noted that whenever cost-sharing is altered, it squeezes the balloon in the AV calculator. It may also impact the mental health parity (MHP) calculation. Mr. Lombardo specified that it is highly dependent on the carriers' claim data. Different results may be encountered since carriers use their own claims data and it may have un-intended impact in requiring a shift in other cost sharing. Mr. Kelsey stated that the report did not address the issue of risk adjustment and adverse selection. If the introduction of VBID changes the morbidity of the overall impact of the risk pool, that would have an impact. Mr. Lombardo stated there are situations where reverse MHP might occur, such as dropping cost sharing for mental health and substance abuse services as it would be in conflict and a discriminatory feature. CID will be requiring a more rigorous mental health parity upfront for non-quantitative as part of the refiling submission for 2021. Non-quantitative is becoming a bigger issue at the federal level. Prior authorization and provider compensation methodology are examples of non-quantitative items to consider in reviewing MHP. Discussion ensued around network adequacy, the AV calculator and VBID implementation in plans in other states. Consideration of whether the cost sharing incentive is high enough to change behaviors as well as communication or navigation assistance to help the member make the change are important. Dr. Ritter stated that ramifications regarding parity must be thought through before implementing changes, and when business is taken away from hospitals, there may be a need to subsidize them more so they continue to serve their purpose. Ms. Zorn said that as other states figure this out, we can learn from them, and that there may be more that can be done on site of service. Mr. Nguyen recommends identifying services that include VBID components and determining how to help enrollees to go to the right setting for care.

H. Reinsurance Study Update

Susan Rich-Bye, Director of Legal and Governmental Affairs provided a brief summary of the reinsurance analysis that Wakely Consulting prepared, providing information to share with stakeholders at the state level about the potential pass-through of federal reimbursement amounts, the potential need for state funding and reinsurance parameters. Wakely outlined this information at three levels of premium reduction, 5%, 10% and 20%. None of the scenarios included a situation where the state funding source was through an assessment. Wakely Consulting has been engaged, with the Board's approval, to provide a new analysis this year that could lead to a 1332 waiver, that would ultimately turn into the economic analysis report that would need to be part of the 1332 waiver. Access Health CT is getting the information, but it would be the state that would make the decision to try to get a 1332 waiver, legislation would

have to be passed, and an application would have to be submitted. There are other requirements such as a series of public hearings and public impact. The legislative session starts next week, and it is not known yet whether this will be considered. However, it definitely would lower premium. Ms. Zorn asked if the reinsurance program could hurt subsidized enrollees, especially at the Bronze level. Julie Andrews of Wakely Consulting confirmed that reinsurance will impact all premiums, therefore lowering the premium for second lowest cost Silver plan, which drives the subsidy, and there would be less subsidy available for purchasing coverage, but the premiums would be lower. Mr. Lombardo added that the point is to waive a feature of the ACA that reduces the cost to the federal government and effectively impacting the premium. The state would get a percentage but would need to make up the difference of that reduction and create the reinsurance program that helps to lower premiums. Discussion followed about possible solutions of using state funds to lower premiums in case the reinsurance program is implemented. Ted Doolittle asked if the program could be designed so that some of the dollars are used to hold harmless or reduce the impact on the subsidized enrollees, such as add a new subsidy. Ms. Andrews said the state can come up with options, but that is probably outside the scope of this program since it would be outside the waiver process and the new subsidy would not involve the federal government. Ms. Zorn stated that California and Washington state have come up with money to add to subsidies and subsidize people above 400% of the federal poverty level (FPL). Ms. Skinner stated that California also improved quality, their enrollment is up, and they were able to subsidize more. Mr. Lombardo stated that if an assessment to fund the state's portion is levied on the industry, it would offset the premium savings outlined. Additionally, there is a possibility of having retaliatory taxes. The premium tax in Connecticut is 1.5 percent. Mr. Lombardo stressed that for the domestic health carriers from Connecticut that do business outside of the state, the premium tax that they have to pay on that business they write in that state is their premium tax or the premium from Connecticut, whichever is higher. Mr. Lombardo cited examples of how those taxes are incorporated into medical premium prices. Mr. Lombardo went on to explain more intricacies of the taxation imposed on the insurance carriers.

I. Certification Requirements

Ms. Lopes briefly outlined AHCT Certification requirements using the same chart that was reviewed at the Committee meeting in December. It contains the certification requirement topics that have been reviewed by this Committee in past years.

J. Individual Market Standard Plan Designs

Ms. Andrews reviewed regulation changes for 2021 and added that the 2021 Notice of Benefit and Payment Parameters (NBPP) has not yet been released. Due to the NBPP not being available, no Maximum Out of Pocket (MOOP) information is available. The federal AV calculator (AVC) also has not been finalized and the changes to the final model may impact the results. Some carriers and states have raised concerns about the most recent AVC changes, which has been based on new 2017 claim data that has been trended forward, had some changes in the underlying continuance tables and methodology, eliminating claims over one million to make it

more credible. The information on 2021 limits for high deductible health plans (HDHPs) will not be released until the spring, so in developing options for the standard Bronze HSA compatible plan, the 2020 limits were used. Silver loading will persist for 2021.

Ms. Andrews outlined the in-network and out-of-network services that are not included in the AVC but will be specified cost sharing for each standardized plan. Ms. Andrews summarized the results of the 2021 draft AVC for the 2020 standard plans as run by the carriers and Wakely, with the cells shaded in yellow for those only out of compliance under the Wakely methodology. Following this short summary, Ms. Andrews elaborated on the possible changes in the cost-sharing structures for the services provided for standardized plans for each metal level. Some of the plans fell outside of the permissible AV range, therefore, they would need to be readjusted to meet the AV requirement. Dr. Ritter indicated that if the plan is compliant, there is no need to change it. Ms. Zorn inquired about the Gold plan that has lower premium than the standardized Silver plan. Ms. Lopes stated that it is an HMO plan with tiered in-network cost sharing, with a lot of services at tier one on a copay basis and at tier two on a coinsurance basis, and that if it would be helpful for Committee members, the non-standard plans could be added to the resource materials using a similar set-up as the standardized plans. Dr. Ritter stated he would like to understand the enrollment distribution for standard vs non-standard plans. Discussion centered on the medical services, their coinsurances and deductibles for standardized plans. Ms. Skinner asked if the rehabilitation and chiropractic care service have high utilization and whether it would be possible to increase cost sharing for those and lower the deductible. Ms. Andrews indicated that it would not be likely that this proposed change would result in a significant swing in the AV, but they could look at this if there was interest. Ms. Andrews provided an overview of the Bronze non-HSA plan, stating that it has included primary care and generic drug coverage not subject to the deductible, which results in it meeting the CMS requirement for the expanded Bronze AV range of up to 65 percent. She noted that the maximum out-of-pocket used for the sample plan was below that programmed into the AVC, but that since the draft NBPP for 2021 has not been released, this may have to be revised. Mr. Lombardo stated that Connecticut has a law that does not permit anyone to be charged a prescription drug cost share that would be higher than the cost of the drug, so those paying $3-$4 for a generic drug would not see an increase in their cost sharing. Ms. Andrews outlined other cost sharing options that can be considered, such as increasing the copay for primary care services. Ms. Lopes stated that urgent care cost sharing has not been looked at in some time, and while there is not a direct entry into the AVC for this, it may be of interest to explore a change here as it may impact plan premium. Ms. Andrews reviewed the cost sharing changes for the HSA-compatible standard Bronze plan, which is also eligible for the expanded Bronze AV of 65 percent since it is a high deductible health plan (HDHP), and the cost sharing had to be significantly changed. Ms. Zorn inquired about the change in IRS guidance for certain services that can be pre-deductible. Mr. Lombardo noted that in order to make this work and still be tax qualified, the fourteen items included in the IRS notice would need to be first dollar coverage but it would force the coinsurance to increase and the MOOP or deductibles might have to increase as well. Mr. Lombardo implied that it may affect

the mental health parity result as well. Ms. Andrews summarized the alternate AV levers that could be utilized to fall within the de minimis range for all metal tiers. Ms. Lopes stated that there are about three weeks between this meeting and the next, and it would be best to suggest alternate cost sharing ideas now as timing will be tight. Dr. Ritter noted that few changes make a big difference in the AV, other than deductible and out-of-pocket. Mr. Nguyen recommended making simple changes. Mr. Kelsey noted that for the fourteen items included in the IRS guidance, the reduced cost sharing option discussed earlier would apply only for individuals diagnosed with specific conditions. Ms. Andrews summarized costs and utilization of services based on the 2017 Federal AVC Individual and Small Group national data trended forward to 2021. Due to timing, the committee can review this more during the next meeting.

K. Meeting Schedule for 2021 Plan Year Certification Review and L. Next Steps

Ms. Lopes provided the Committee with the proposed meeting agendas that are subject to change. Timeline for the Committee to make determinations was presented. She stated that if any other changes in cost sharing or designs for any plans need to be modeled during the next meeting, we will need to know what those plan features are no later than end of day on Monday. Suggested changes can be submitted to either Susan, any of the Plan Management team or Marcin. Ms. Zorn stated that she is interested in knowing how the HSA-Bronze plan would be impacted by the IRS guidance on the fourteen items. Ms. Lopes stated that Wakely will provide cost sharing changes to the carriers for the HSA-compatible Bronze plan incorporating the IRS guidance, but if there are any other alternatives that Committee members want to review, submit them before end of day on Monday.

M. Adjournment

Chair Grant Ritter requested a motion to adjourn. Motion was made by Jill Zorn and seconded by Tu Nguyen. Motion passed unanimously. **Meeting adjourned at 6:03 p.m.**