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

Remote Meeting

Tuesday, January 11, 2022
Meeting Minutes

Members Present: Grant Ritter (Chair); Theodore Doolittle; Commissioner Manisha Juthani, Department of Public Health (DPH); Matthew Brokman; Jill Zorn; Mark Schaefer; Tu Nguyen; Neil Kelsey; Paul Lombardo (Subject Matter Expert – SME); Ellen Skinner

Other Participants: Access Health CT (AHCT) Staff: James Michel; Charmaine Lawson; Susan Rich-Bye; Kelly Gavigan-Cote; Marcin Olechowski
Wakely Consulting: Julie Andrews; Brad Heywood
Cecelia Woods

A. Call to Order

Chair Grant Ritter called the meeting to order at 2:00 p.m.

Roll call for attendance was taken.

B. Introductions

-Committee Membership and Staff

Susan Rich-Bye, Director of Legal and Governmental Affairs, introduced a new member of the Committee, Dr. Manisha Juthani, Commissioner of the Connecticut Department of Public Health (DPH), who also serves as an ex-officio member of the Access Health CT (AHCT) Board of Directors. Ms. Rich-Bye provided a brief background of Dr. Juthani who is an infectious diseases physician who previously worked at the Yale School of Medicine.

Ms. Rich-Bye explained the membership composition to the Committee and pointed out that it includes several board members who have different areas of expertise. Ms. Rich-Bye added that representatives from the three carriers that offer plans through the Exchange also sit on the Committee with one member representing two carriers. Ms. Rich-Bye emphasized that the rest

of the Committee is comprised of many stakeholders with varying areas of expertise. Ms. Rich-Bye also introduced a new Plan Management (PM) member, Kelly Cote, Product Carrier Manager.

C. Purpose of the Committee

Ms. Rich-Bye stated that the HPBQ AC makes recommendations to the Board of Directors for the Qualified Health Plan (QHP) certification requirements, which include the annual standard plan designs. Ms. Rich-Bye added that the Affordable Care Act (ACA) requires the Exchange to establish the requirements for certification, recertification and decertification of QHPs. Ms. Rich-Bye commented that this Committee does very important work making recommendations to the Board in this area.

D. Public Comment

No public comment was submitted.

E. Vote

Chair Ritter requested a motion to approve the May 14, 2021, Health Plan Benefits and Qualifications Advisory Committee Special Meeting Minutes. Motion was made by Theodore Doolittle and seconded by Jill Zorn. Roll call vote was taken. ***Motion passed unanimously.***

F. AHCT Mission, Vision and Values

Susan Rich-Bye, Director of Legal and Governmental Affairs, briefly outlined AHCT's Mission and Vision Statements. Ms. Rich-Bye stated that they were originally adopted by the Board of Directors in 2012. Ms. Rich-Bye added that it was a decade ago and the organization as well as the environment that the Exchange operates in have changed over this course of time.

A review is underway now to allow the Board to make adjustments to reflect AHCT's growth and development as well as future plans if necessary. Ms. Rich-Bye informed the members that the Strategy Committee and the Board of Directors are currently considering those changes.

Charmaine Lawson, Product Carrier Manager, summarized AHCT's Vision, Mission and Values. Ms. Lawson stated that the Values were recently incorporated into employee performance reviews.

Ms. Lawson provided the Plan Management Certification Life Cycle. Ms. Lawson stated that 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 (OE) commences. Ms. Lawson reviewed the details of the current landscape of the individual market and described the plans that are offered on and off-Exchange by metal level.

Ms. Lawson described details of each product offered, which include the EPO, HMO, POS and PPO medical insurance plans. She provided an overview of the suite of products offered through

AHCT and highlighted the differences in plan networks, out-of-network coverage and specific plan requirements which impact the overall cost of each product offering.

Ms. Lawson emphasized that with the addition of ConnectiCare Insurance Company Inc. (CICI) for the first time, the Exchange is offering an EPO product as well as a PPO. This plan offers in, and out-of-network coverage and doctors out-of-network are covered at higher copay or co-insurance amounts. Ms. Lawson provided a comparison of all individual plans that were filed with the Connecticut Insurance Department of Plan Year 2022. Ms. Lawson noted that AHCT currently has a Platinum Plan on-Exchange, and no Platinum Plans are currently offered off-Exchange.

I. Certification Requirements

Susan Rich-Bye, Director of Legal and Governmental Affairs, presented the Certification Requirements.

Ms. Rich Bye provided a list of certification requirements. Ms. Rich-Bye stated that the Essential Health Benefits (EHB) Benchmark Plan is determined by the Connecticut Insurance Department (CID). Ms. Rich-Bye noted that in the past, the HPBQ AC has reviewed prescription drug formulary review responsibilities, tobacco use premium surcharges, broker compensation, network adequacy standards, ECP contracting standards, pediatric dental coverage within medical plans, and requirements regarding the lowest cost silver plan in the market.

Ms. Rich-Bye listed other certification requirements which include the Plan Mix for the Individual Market Medical and Stand-Alone Dental Plans (SADP), SHOP Medical and SADPs, Standardized Plan Development for the Individual Market Medical plans as well as Standardized Plan Development for SADP. Ms. Rich-Bye added that AHCT does not require carriers to offer standardized plans in the small group market.

Ms. Rich-Bye emphasized that AHCT uses standard plan designs for ease of comparison and shopping for consumers. For plan year 2022, that was the only area in which the Committee made changes. Ms. Rich-Bye stated that this is the proposal for 2023. Jill Zorn inquired about the number of plan choices available to consumers. Ms. Rich-Bye noted that with CICI joining the Exchange, it increased the number of choices, and the new carrier is also required to offer the standard plan offerings. Ms. Zorn discussed examining this issue again.

J. 2023 Individual Market Standard Plan Designs

Julie Andrews, Wakely Consultant Senior Consulting Actuary, presented the 2023 Individual Market Standard Plan Designs. Ms. Andrews provided information on the regulation changes for 2023. There are three items that are impactful to the design of the standard plans:

The first is the proposed increase to the annual out-of-pocket maximums from 8,700 to $9,100, Ms. Andrews reminded the group that for PY 2021, the original proposal was to increase the annual out-of-pocket maximums to $9,100. However, after the new Administration came into

office, changes were made in the calculations resulting in a lower out-of-pocket maximum than initial proposed $9,100.

Ms. Andrews added that the second constraint that exists is the release of Maximum Out-of-Pocket (MOOP) limits by the Internal Revenue Service (IRS). Ms. Andrews noted that the MOOP limits for the coming year will not be released until May 2022. The third regulatory constraint is complying with Mental Health Parity (MHP) requirements.

Ms. Andrews noted that additional regulatory and statutory elements will be important aspects in 2023. Ms. Andrews indicated that the financial assistance expanded under the American Rescue Plan Act (ARPA) is set to expire at the end of 2022 noting that extension of this provision is pending.

Ms. Andrews also discussed the Covered Connecticut program that was established in July of 2021. Ms. Andrews stated that for eligible consumers, the State of Connecticut pays the consumer portion of premium and consumer portion for cost sharing while the individual is enrolled in the Silver CSR plan. Ms. Andrews noted that it is not known whether the Covered Connecticut program will be extended into 2023.

Ms. Andrews provided information on the proposed changes to the Federal Actuarial Value Calculator (AVC) for PY 2023. Ms. Andrews stated that the 2022 Federal AVC had no update, whereas the 2023 Draft Federal AVC has updates, however, they have not been finalized. Ms. Andrews also indicated that the underlying data is being updated to reflect the 2018 experience by metal level and updated trend numbers will be applied as applicable. Ms. Andrews added that demographic weights were adjusted to reflect the 2023 anticipated population as well as the proposed changes to metal level de minimis ranges.

Ms. Andrews stated that the Centers for Medicare and Medicaid Services (CMS) is hoping that by narrowing the range for the silver plan, it will increase the generosity of the second lowest cost silver plans that may be currently offered at the lower end of the de minimis range. CMS continues to anticipate and promote the expanded bronze plans at the top of the range. Ms. Andrews noted that this constraint will likely have no impact on the Connecticut standard plans since the plans were generally offered at the higher end of the de minimis range and the constraining is at the lower end. Ms. Andrews cautioned the Committee that at this point, AHCT is unaware of any legislation that may be introduced at the 2022 Connecticut General Assembly Legislative Session that may impact the plan design process for 2023. Ms. Andrews pointed out that existing copay maximums remain unchanged.

Brad Heywood, Wakely Actuary, provided the Summary of 2023 Proposed AV Changes. Mr. Heywood noted that the AVC's overall purpose is to estimate the portion of medical claims that would be paid by the carrier. Mr. Heywood noted that it is portioned and there are different targets, depending on the metal level of the plan. The 2023 Proposed AV ranges are as follows: for the Gold Plan 78%-82%, for Silver 70%-72%, for Bronze and Bronze HSA 58%-65%. The proposed AV ranges for the 73% CSR are 73%-74%, for the 87% CSR 87%-88% and for the 94%

CSR 94%-95%... Mr. Heywood noted that the silver plans will need more changes than the other metal levels in order to fall into the permissible AV range.

Mr. Heywood provided a history of benefit changes that were made in prior years which included changes to deductibles, MOOP, copays that were subject to deductibles and others. Mr. Heywood added that when consideration is made of any benefit changes to the standardized plans, especially within the AVC, it is important to understand that certain benefits such as a PCP copay or specialist copays are going to be more impactful to AVC than other changes. Mr. Heywood stated that in 2021, new legislation was added to change the age for the Dependent Dental from 19 to 26. Mr. Heywood added that this change has no impact on the AV as pediatric dental above age 19 is a non-essential health benefit.

Julie Andrews briefly described the 2022 Plan Design Overview. Mr. Heywood mentioned other services that are not included in the AVC, but cost sharing is specified for each standardized plan. Mr. Heywood noted that among those services are mammography, ultrasound, ambulance services or urgent care center or facility to mention a few. Mr. Heywood provided a summary of the 2022 Gold, Silver, Silver CSR variations as well as Bronze Plans.

Ms. Andrews noted that when AHCT receives feedback from the carriers regarding their 2023 valuations, the Gold Plan may still be compliant, or it may require minor changes. Ms. Andrews noted that in the past, AHCT focused on the medical deductible or the MOOP as the lever used to bring those plans into compliance. Ms. Andrews stated that plan testing would be required, and, if necessary, plan modification may follow to bring them into compliance for 2023. Chair Ritter noted that he would suggest raising the Out-of-Pocket Maximum as little as possible to get it below the 82 percent AV for the Gold plan.

Mr. Heywood provided the Committee with the Silver Plan Avs using the current standard plan designs in the proposed 2023 AVC, including the CSR Variations. Chair Ritter noted that the biggest changes would be expected in the 70% AV plan and suggested to increase the MOOP to a higher amount, which currently stands at $8600, with the maximum allowable being $9100. Theodore Doolittle stressed that when the MOOP is raised those dollars are exclusively going to be coming from families that are hit with a big sickness or a big disability. Therefore, this negative perspective of increasing must be kept in mind. Mr. Doolittle encouraged the Committee to explore other options at the same time but not negating the Chair's opinion about increasing the MOOP.

Ms. Andrews noted that those individuals with income under 250% of the Federal Poverty Level (FPL) are eligible for CSRs so there are some protections for those individuals who are at the lower income levels. Mr. Doolittle noted that while the AVC is a useful tool utilized by the insurance companies, it is relatively meaningless for the consumer. Mr. Doolittle encouraged reviewing the impact for the 25th percentile consumer.

Discussion ensued around factors that contributed to the historical changes to the plans over the years as well as the possible options to comply with the AVC without negatively affecting those

who on the lower income levels. Topics also included sensitivity of the AVC pertaining to adjusting for various services. Chair Ritter inquired about the limits that Connecticut has for different kind of medical services and added that they have been raised but asked if the amounts mentioned are below the state maximum. Paul Lombardo from CID stated that Connecticut did away with the maximum copays a few years ago and the only maximum copays that Wakely went over that are statutory maximums that are caps.

Mark Schaefer from the Connecticut Hospital Association inquired whether any data exists about the extent to which the avoidable use of wrong services is driving the premium. Ms. Zorn commented on the challenges of the AVC and the use of value-based plan designs. Ms. Rich-Bye added that in addition to having to work with the parameters of the AV calculator, AHCT and the carriers have to work within the MHP requirements, so the plans have to be able to pass both the AVC and the MHP.

Mr. Heywood continued with the Summary of the Bronze Non-HSA Plan AV and the Bronze HSA Plan AV using the 2023 draft AVC.

K. 2023 Plan Year Timeline

Susan Rich-Bye, Director of Legal and Governmental Affairs, presented the 2023 Plan Year Timeline. Neil Kelsey asked about the release of information pertaining to the just concluded OE. Ms. Rich-Bye noted that it will be presented at the next Committee meeting. Ms. Rich-Bye added that it will also be presented to the Board of Directors as well. Ms. Zorn inquired whether differences in the non-standard plans are meaningful in ways that add value. Mr. Kelsey noted that the silver plans have silver-loading in the premium. Ms. Rich-Bye added that in the proposed rule, the de minimis range would be changed at several metal tiers. Ms. Zorn encouraged when plans are listed, to also include the AVC for each of those plans. Ms. Zorn also encouraged, when listing plans, to differentiate them by category such as whether they are a standard or non-standard plans. Ms. Rich-Bye and Ms. Lawson confirmed that standard plans are required to include “Standard” in the plan name.

Ms. Rich-Bye emphasized that the plan is for this Committee to complete its work and be able to make recommendations to the Board for the April Board meeting. Ms. Rich-Bye noted that the timeline allows AHCT to issue its solicitation in late April so that the carriers have enough time to complete their benefit and rate and filings, as they are due to CID and AHCT in early July.

Committee members discussed the current certification requirement of only allowing carriers to offer the standard silver plan and not allowing any non-standard silver plan offerings, and APTC impact. Ms. Rich-Bye stated that ConnectiCare Benefits Inc. (CBI) and CICI are separate carrier entities and any carrier offering plans on the Exchange must comply with the standard plan offering requirements, accordingly the number of standard silver plans offered may change from year to year depending upon the number of carriers offering plans on-Exchange.

Mr. Lombardo stated that the rate filings are separate and independent for each of the companies, and CICI's base rate is developed on CICI's experience, while CBIs base rate is based upon CBI experience. Mr. Lombardo emphasized that there is no co-mingling of experience, and they are treated independently of each other. All the assumptions are analyzed actuarily. Mr. Lombardo stressed that CID does not allow for shadow-pricing, and they are completely independent having separate experience data.

Mr. Lombardo also noted that in the Benefit Payment and Parameter Notice for 2023, there is a potential requirement that each carrier participating on a Federally Facilitated Marketplace (FFM) or an exchange that uses the federal facility would be required to offer a standard plan. Brief discussion ensued around comparing the number of issuers and plan choices in other states. Ms. Rich-Bye stated that if changes are made to the number of non-standard plan options permitted, this could be a disruption for consumers with possible discontinuation of their current plan.

Agenda Item L HPBQ AC Meeting Schedule was bypassed.

M. Next Steps

Ms. Rich-Bye enumerated the next steps.

L. Adjournment

Chair Grant Ritter requested a motion to adjourn. Motion was made by Theodore Doolittle and seconded by Jill Zorn. Roll call vote was ordered. **Motion passed unanimously**. Meeting adjourned at 3:52 p.m.