Connecticut Health Insurance Exchange

Joint Advisory Committee Meeting

Qualified Health Plan Solicitation Process
Overview and Key Issues

November 20, 2012, 9 – 11 a.m.
Legislative Office Building, Room #1E

Agenda

1. Introductions
2. Meeting Objectives
3. Public Comment
4. Initial QHP Solicitation Process
5. Outstanding “Issues for Review”
6. “Managed Competition”: An Effective Purchasing Model in an Evolving Marketplace
7. Next Steps
8. Adjournment

Meeting Objectives

States are required to certify plans as "qualified" for inclusion on their Exchange.

Today, we will:

- Review the QHP Certification Process
- Obtain Committee approval for "Issues for Review" to take to the Board of Directors on November 29
- Review a continuum of potential QHP "purchasing" models for the Exchange

Sec. 1301 [of the Affordable Care Act]. Defines **a Qualified Health Plan (QHP)** as a plan that:

1) has in effect a certification (which may include a seal or other indication of approval) that it meets the Act's certification criteria issued or recognized by each Exchange through which such plan is offered;
2) provides the Essential Health Benefits package; and
3) is offered by a health insurance carrier that:
   a) is licensed and in good standing to offer coverage in each state in which the carrier offers coverage under this title;
   b) agrees to offer at least one QHP in the silver level and at least one plan in the gold level in each such Exchange;
   c) agrees to charge the same premium rate for each QHP of the carrier without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the carrier or through an agent; and
4) complies with the regulations developed by the Secretary and such other requirements as an applicable Exchange may establish.

Public Comment

Principles of QHP Certification

Consumer Focused:

Engage carriers which provide value to its clients—consumers and small employers. Sustainability of the Exchange depends upon it certifying QHPs and offering services that are valued by its clients.

Choice and Quality:

Ensure consumers have a range of choice between current and new carriers on the Exchange. Ensure those carriers which serve Connecticut best with choice, network and value see the Exchange as their premier avenue to the people of Connecticut.

Transparency:

Facilitate informed choice of health plans and providers by consumers and small employers. Ensure carriers provide the clinical, quality, network and cost metrics needed for consumers to make an informed choice.

Continuous Improvement:

Engage carriers that are committed to reducing health disparities and fostering health equity in Connecticut by evolving to serve consumers as the market and consumer needs change. Provide an effective forum for carrier to promote wellness and prevention through innovate plan design and delivery systems and for consumers to make their evolving needs known to carriers. Be a catalyst for delivery system reform while being mindful of the Exchange's impact on and role in the broader health care delivery system.

General Reforms Impacting the Market

General ACA reforms include:

- No medical underwriting
- No denial of coverage due to a pre-existing condition
- Strict limits on out-of-pocket expenditures
- Minimum medical loss ratio ("MLR") established
- Quality rating standards and enrollee information
- Minimum coverage requirements:
  - "Essential Health Benefits"
  - Extensive preventative services provided at no cost
  - Standardizes coverage levels based on actuarial value (i.e. metal tier)
- New rating factor standards reduce risk selection:
  - Elimination of industry rating
  - Elimination of gender rating
  - Rates must be set for entire benefit or policy year
  - Exchanges must receive rate increase justification prior to rate increase implementation
  - Compressed age band ratio – 5:1 to 3:1

Minimum QHP Certification Requirements

Minimum QHP certification requirements include:

- Annual information concerning rates, covered benefits, and cost sharing requirements
- Consideration of justification for rate increases
- Carrier must provide coverage information to the Exchange, including:
  - Claims payment and practices
  - Enrollment and disenrollment data
  - Data on denied claims and rating practices
  - Cost-sharing information and out-of-network coverage and payments
- *Accreditation (i.e.* NCQA or URAC): Carrier must be accredited on basis of local performance
- Carrier must comply with quality improvement standards. For example:
  - Improving patient safety
  - Lowering hospital readmissions
  - Reducing health disparities
  - Creating ACOs and funding of electronic medical records
  - Promoting of patient-centered medical homes
- Carrier must (i) disclose and report quality and outcome measures and (ii) meet required member satisfaction standards:
- Carrier must comply with carrier risk adjustment program
- *Network adequacy standards*: QHP must include “essential community providers” and meet minimum network standards

Connecticut QHP Certification Requirements

Recommended Connecticut-specific QHP certification requirements include:

- No substituting Essential Health Benefits with actuarially equivalent benefit
- Allowing wellness incentives
- Consideration of QHPs with less than statewide coverage

Greater Consumer Transparency

- For each QHP, the "Summary of Benefits and Coverage," including each of the coverage examples, defined by HHS, and;
- For each carrier:
  - "Certificate of Coverage"
  - Most recent CAPHS data and NCQA star ranking
  - Most recent MLR and projected MLR for 2014, for non-group and/or small group markets
  - Criteria for establishing medical necessity
- Exchange will use requested quality and performance information to develop a quality rating system that relates quality to price (to be implemented in later years)
- Publication of justification for rate increases

“Issues for Review”

Outstanding Issues for Review:

Certification Period and “Lock Out”

Mix and Number of Plans

Stand-Alone Dental

Rating Factors

Network Adequacy

Issue 1.a. Certification Period and "Lock Out"

Multi-Year QHP Certification

Should failure by a QHP carrier to participate in Exchange in 2014 inhibit participation by the carrier until (at least) 2016? An exception to such a "lock-out" period would be considered for existing and newly licensed carriers.

Pros (for Two Year Certification and Lock Out):

- Prohibiting carriers from participating in succeeding years if they fail to participate in year one, may motivate more carriers to participate initially. Carriers do not want to risk being unable to compete in a new marketplace.
- Carriers that participate in initial year will have the benefits of securing a larger market share in the Exchange than those that have to wait until 2016; this will build consumer relationships and trust with the carrier and may provide a competitive advantage to carriers who do participate in Initial Solicitation.
- Reduces the administrative burden for 2015.
- Allows the next Certification process, in mid-2015, to be informed by a fully-lagged 12 month claims experience and customer satisfaction.
- Offers continuity in QHP benefit design.

Cons (for Two Year Certification and Lock Out):

- Prohibiting new carriers to enter the market could lead to a more limited number of carriers for two years
- Limiting carriers may compromise choice for consumers wishing to enroll through the Exchange
- A two year certification may be imprudent given magnitude of reforms being implemented in 2014 and potential for unintended consequences
- A two year certification could delay implementation of further reforms

Multi-Year QHP Certification

Staff Recommendation:

Length of QHP certification for Initial Solicitation and “Lock Out” Period
Staff recommends that the Exchange’s initial QHP solicitation be for a two-year QHP certification. (However, forms and rates will need to be approved annually by CID according to state regulation.) The Exchange would solicit applications for QHP certification again for plan year 2016, but reserves the right to admit existing or newly licensed plans in 2015. This would provide carriers with both a level of predictability and incentive to participate in the Initial Solicitation.

Carrier “Lock Out” Period

If a QHP carrier ceases participation in the Exchange, should the carrier be prevented from rejoining for two (or three) years?

Pros:

- Encourages prolonged participation by the carrier in the Exchange market.
- May preclude “gaming” by carrier who may opt-out temporarily due to a perceived competitive advantage.
- Minimizes consumer confusion regarding carrier options.

Cons

- If Exchange participation is low, and a carrier drops coverage due to financial insolvency or other technical issues, the Exchange should want to reintroduce that carrier as soon as they are deemed solvent or the deficiency is adequately addressed.
- May discourage initial carrier participation

Carrier “Lock Out” Period

Staff Recommendation:

Lock-out period after QHP ceases participation in Exchange
Staff recommends that if a certified QHP carrier ceases participation in the Exchange in 2015, the carrier be denied re-entry for a minimum two (2) years.* The Exchange will consider appeals to this general exclusion during the next solicitation after conducting a thorough review of the Issuer’s new application. *For example, if the QHP Solicitation for 2016 was for a one-year QHP certification, the Issuer’s lock-out would total two years as they could apply to participate again for plan year 2017; however, if the Solicitation for 2016 was, like the Initial Solicitation, for a two-year QHP certification, then the Issuer’s lock-out period would total 3 years—unless the Exchange grants the carrier an exception)

Number and Mix of QHPs

How many health plans should a carrier be required and/or allowed to offer through the Exchange?	
Pros (to limiting mix/number of products/plans):	**Cons (to limiting mix/number of products/plans)**
• Allowing too many products from each plan could be confusing to consumers • While distinguishing product factors are necessary to create the "meaningful" choice sought by consumers, too much choice is unhelpful	• If Exchange limits plan offerings, it could limit innovation among QHPs. • Limitation to number of plan designs could put Exchange at a competitive disadvantage to outside market, if offered plans are not among most popular. • Limiting the number of QHPs could lower choice among products with meaningful distinctions (e.g. Gatekeeper model, Preferred Provider Organization, Health Maintenance Organization, Point-of-Service, Accountable Care Organization, Tiered Networks)

Number and Mix of QHPs

Staff Recommendation:

Staff recommends that for both the Individual Exchange and SHOP Exchange (although a carrier does not need to participate in both exchanges), a QHP carrier must submit the following mix* of plans:

- One (1) Gold Plan
- Two (2) Silver Plans
- Two (2) Bronze Plans

For the Individual Exchange ONLY, a QHP carrier must submit:

- Three (3) required actuarial value ("AV") variations for **at least** one (1) Silver Plan^
- One (1) Catastrophic Coverage Plan
- One (1) child-only QHP for each metal tier for which a carrier submits a plan

An Issuer's proposed QHP offerings must exhibit **meaningful differences after controlling for plan's metal level*

^The AV alternatives reflect the "Cost Sharing Reductions" available to eligible individuals/families with household income below 250% of FPL. If these alternative Silver plans are offered for only one (1) Silver plan, it must be for the Issuer's lowest-costing Silver

Reference to Issue 2.a

Examples of Meaningful Plan Design Differences

- Plan design has a different payment structure (co-payment versus co-insurance versus deductible versus high-deductible health plan (HDHP)
- Deductible and maximum out-of-pocket (OOP) differences:
  - Medical deductible difference
  - Pharmacy deductible difference of $50 or more
  - Maximum OOP difference greater than $1000
- Changes in Cost Sharing for key service categories:
  - Inpatient/Outpatient Visit: at least 10% difference or if applicability of deductible is changed
  - PCP/Specialist Visit: at least $10 or 10% difference or if applicability of deductible is changed
  - Generic Drugs: at least a $5 average difference or if applicability of deductible is changed
  - Brand Drugs: at least a $10 average difference or if applicability of deductible is changed
- Change from Coinsurance to Copay on Inpatient/Outpatient/PCP/Specialist Visits
- Different care management (e.g. gatekeeper model; patient centered medical home; community health teams; wellness programs)
- Plan design features payment reform (e.g. pay-for-performance, tiered networks)

Allowance for Platinum QHPs

Should carriers be required, prevented, or given the option of offering Platinum QHPs?

Pros (of offering Platinum):

- If Platinum benefits are common in the external market then not offering them in the Exchange will disadvantage the Exchange in attracting employers and unsubsidized individual enrollment
- Proportion of plans sold by five major carriers with an "AV" of 90% or greater, according to study by *Gorman Actuarial, LLC*:
  - 0.5% of plans sold in Individual market
  - 25% of plans sold in small group market

Cons (of offering Platinum):

- Platinum level coverage will take additional administrative effort by the carrier and by the Exchange, and may not attract a high level of enrollment.
- Offering Platinum will increase potential for "market adverse selection" impact (i.e. raising premiums across the carrier's book of business), especially in SHOP.
- Maximum out-of-pocket limits (for In-Network essential health benefits) reduces utility of higher AV plans

Allowance for Platinum QHPs

Staff Recommendation:

Allowance for Platinum QHPs
Staff recommends the Exchange not offer Platinum level coverage in the SHOP Exchange or the Individual Exchange.

Standardize Plan Design

Should QHP carriers be required to submit one or more standardized plan designs for one or more metal tiers as a part of their application to participate in the Exchange?

Pros (of requiring Standard Plan Design(s)):

- Makes it easier and faster for consumers to compare like products and make better-informed purchasing decisions.
- Give consumers confidence that they can choose a lower-priced or less well-known plan, opening market to greater competition.
- Limits carriers ability to attract healthy individuals and discourage high-risk individuals. Narrows the opportunity for insurers to compete mainly on risk selection.

Cons (of requiring Standard Plan Design(s)):

- Plans must already cover the same benefits and so QHPs will be comparable
- May discourage carrier participation
- May discourage innovation by the carriers and limit their efforts to implement value-based benefit design and provider tiering strategies to contain costs.
- Exchange could be put at a competitive disadvantage if carriers can sell innovative new benefit designs outside the Exchange
- Carriers need variability and flexibility in meeting the ACAs product requirements and would like to avoid further standardization.
- Developing one or more standard benefit designs will take time and could delay Solicitation process.

Standardize Plan Design

Staff Recommendation:

Standardizing benefit plan design
All health benefit plans offered must provide coverage for all Essential Health Benefits and meet the actuarial value requirements for the Gold, Silver, or Bronze metal tiers. While these requirements ensure minimum coverage and a certain level of equivalent coverage, they allow for a wide range of potential variation in plan designs. To increase comparability of carriers, staff recommends that a QHP carrier submit standard plans for each the Silver and Bronze tiers. These standard plans will count toward their required mix and number of plans. Consumers will be able to filter by these standard plans designs. The Exchange will define one (1) standard plan design for each the Silver and Bronze tiers that includes the deductible, co-payment and coinsurance mix, subject to adjustment after release of federal actuarial value calculator. The standard plan designs will be based upon the most popular plans sold in the small group market in 2012. For Preferred Provider Only plans, the Exchange will eliminate standards for out-of-network benefits (so long as they meeting CID regulations). The Exchange will require consumer transparency and disclosure of QHP coverage for non-emergent out-of-network care at both the plan and provider level.

Pricing Pediatric Dental

Should pediatric dental services be priced separately? (Alternative is to allow QHP carriers to bundle services.)

Pros (of separately pricing pediatric services):

- Only enrollees selecting a Child-only or Family plan would need to select a stand-alone pediatric dental plan. Adults without any children will not be subsidizing the cost of pediatric dental
- Increases transparency of premium pricing
- Increases viability of stand-alone dental plan offerings participating in the Exchange
- Dental is not currently provided as part of major medical policies
- May increase likelihood that enrollees purchase stand-alone dental for adults

Cons (of separately pricing pediatric services):

- Adults without any children will not be subsidizing the cost of pediatric dental/vision. Therefore, the cost associated with pediatric-only services will not be as widely distributed across the market, thereby increasing PMPM cost of pediatric dental for families and/or child-only QHPs
- Increases the number of choices required of enrollee.
- Embedding dental benefits (with medical) offers administrative ease and simplicity for the consumer and the Exchange.
- Would allow for clinical integration between medical and dental benefits.

Pricing Pediatric Dental

Staff Recommendation:

Separately pricing pediatric dental benefits
Staff recommends that the Exchange require QHP carriers to separately rate their pediatric dental benefit. If a QHP includes pediatric dental services, potential enrollees will be automatically assigned to the Issuer's dental benefit, but the enrollee will retain the option of selecting another Issuer's dental plan if desired.

AV Requirement for Stand-Alone Dental

For stand-alone dental plans, should carriers be required to offer plans across all, any, or specific metal tiers?

Pros (of requiring specific tiers for dental):

- Offering a stand-alone plan along the same tier as the most popular comprehensive QHP may attract consumer to the plan.

Cons (of requiring specific tiers for dental):

- There is no regulation requiring that stand-alone dental plans be offered on separate tiers.
- Cost-sharing in a stand-alone dental plan is already high, it may not be practical to expect different levels of cost-sharing or different tiers of stand-alone dental plans. Changing cost-sharing in order to meet the AV standards of various metal tiers may be difficult to accomplish with a stand-alone dental plan

AV Requirement for Stand-Alone Dental

Staff Recommendation:

AV requirements for stand-alone dental
Staff recommends that actuarial certification to the metal tiers not apply to stand-alone dental visions, unless required by federal regulations.

Benefit Tiers for Stand-Alone Dental

For stand-alone dental plans, should the Exchange consider selling two benefit tiers of stand-alone dental plans: (1) preventive only; and (2) full benefits?

Pros (of offering preventative only plans):

- Allowing for two different benefit options may increase consumer choice, especially for those who are new to the insurance market, and may not be inclined to purchase a full benefits package that they feel they may not use.

Cons (of offering preventative only plans):

- Pediatric dental services must include full benefits as required in Essential Health Benefits
- A preventive-only plan is of limited value and could cause confusion among consumers who believe they are may be fully insured
- Because stand-alone dental plans must comply with QHP certification standards, allowing for two separate levels of benefit may increase the administrative burden of the Exchange

Benefit Tiers for Stand-Alone Dental

Staff Recommendation:

Benefit offerings for Stand-Alone Dental
All stand-alone dental plans must provide coverage for the full dental benefits, as included in the "essential health benefits" for pediatric dental services. Instead of offering a limited preventative-only dental plan, the Exchange will explore value of offering access-only dental plans. An "access-only plan" offers membership to a network of dentists that have agreed to a maximum payment schedule for services. These plans are not insurance and would not be subject to QHP certification requirements.

Tobacco Rating

Should the Exchange make tobacco-use a required rating factor in the Individual Exchange?

Pros (of requiring tobacco rating):

- Similar to a tobacco tax, higher premiums for tobacco users provide an additional incentive to stop
- Tobacco use increases an individual's expected health care costs that are borne by all enrollees
- Promotes health and well-being

Cons (of requiring specific tiers):

- Tobacco rating is cumbersome to administer and susceptible to gaming by carriers for purposes of risk selection
- A higher than average percentage of lower income individuals use tobacco and would be required to pay the surcharge
- The premium tax credit is calculated based on premiums before any tobacco-use adjustments are applied. This means that subsidized enrollees must pay the entire cost of any tobacco use surcharges regardless of their income.
- Tobacco is addicting, and it is not clear that a premium surcharge would be an effective incentive to stop using tobacco
- Though allowed in the non-group market, tobacco rating is not currently used by carriers and so the Exchange would need to reach consensus for the complicated calculations

Tobacco Rating

Staff Recommendation:

Tobacco Rating
Staff recommends that the Exchange require QHP carriers to include tobacco use as a rating factor in the Individual Exchange.* *Connecticut General Statute 38a -567 excludes tobacco use as a rating factor for small groups.

Standardizing Rating Factors

Should the Exchange require carriers to agree to standardized rating factors (for geography, age, household size, and, if applicable to the non-group market, tobacco use) across all QHPs sold through the Exchange?

Pros (of standardized rating factors):

- ACA reduces the number of rating factors in the SHOP and Individual Exchanges
- Limits the ability of plan to select based upon risk

Cons (of standardized rating factors):

- Unnecessary to standardize rating factors beyond limits
- The state does not currently have standardized rating factors and so the Exchange would need to reach consensus for the complicated calculations
- Carriers may be able to react more quickly and nimbly to market changes, utilization patterns and actual costs than the Exchange
- Carriers have different cost structures by area (with different provider networks and rates). Standardized ratios may not be actuarially sound or fairly represent costs. This could lead to market withdrawals and other undesirable outcomes.
- The law already has caps/floors for many of these. Given the 3-to-1 limit on age-based rate variation, potential variation of age factors across carriers is significantly reduced

Standardizing Rating Factors

Staff Recommendation:

Standardize Rating Factors
Family. It is possible that federal rules may standardize both family composition tiers and tier ratios across the market. If this is the case, the Exchange may not need any additional options related to this issue. If the federal government does not act, staff recommends that the Exchange standardize family composition structure, but allow carriers to determine tier ratios. **Age.** Per ACA reforms QHPs will be subject to a 3:1 age factor rating. Staff recommends that the Exchange allow carriers to determine tier ratios. **Geography**. Staff recommends that the Exchange follow industry standards and allow carriers to determine tier ratios. The Exchange's QHP offerings will comply with all CID regulations.

Network Adequacy Requirements

What should the Exchange's network adequacy standard be as it relates to Essential Community Providers?

Pros (of extensive network standards):

- Prevents carriers from profiling networks as a way to mitigate risk selection

Cons (of extensive network standards):

- May discourage innovation by carriers to construct tiered and narrow networks
- Lowers carriers bargaining power vis-à-vis providers and hospitals.
- Could disadvantage academic hospitals by seeing these higher-cost facilities residing in tiers with highest deductible and co-payments or being excluded from narrow networks.
- Risks undermining patient-physician relationships

NOTE: *The ACA minimum is that "A QHP carrier must have a sufficient number and geographic distribution of [Essential Community Providers]." The definition of "sufficient" is left to Connecticut.*

Network Adequacy Requirements

Staff Recommendation:

Network Adequacy Requirement
A QHP carrier must ensure that the provider network of each of its QHPs meets these standards: 1) Include essential community providers in accordance with ACA (Examples next slide for comment) 2) Maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay. 3) Is consistent with the network adequacy provisions of section 2702(c) of the PHSA. Staff recommends that the Exchange consider proposals for tiered networks for a non-standard QHPs. The Exchange will need to develop separate standards for tiered networks. However, selective contracting decisions should be based on professional competency, quality of care, and the appropriateness by which medical services are provided and not on a single criterion. Staff recommends that the Exchange not certify an Issuer's narrow network plan offerings in its Initial Solicitation

Network Adequacy Requirements

Staff Recommendation:

Staff recommends that sufficiency of ECP will be defined as carriers having contracts with:

1) At least 50% of the essential community providers across Connecticut; and,
2) At least 75% of the ECPs located in any city or town that contains one or more of the 20 zip codes with the greatest number of uninsured individuals in Connecticut; and,
3) At least 66% of the federally qualified health centers (FQHC) or “look-alike” health center in Connecticut.

Short of meeting such standards, staff recommends that carrier be allowed to evidence a good faith effort to contract with ECPs by, for example, providing contract terms accepted by some providers, and offered to, but rejected by, ECPs.

Managed Competition

An Effective Purchasing Model in an Evolving Marketplace

"Active Purchasing" v. "Any Willing Carrier"

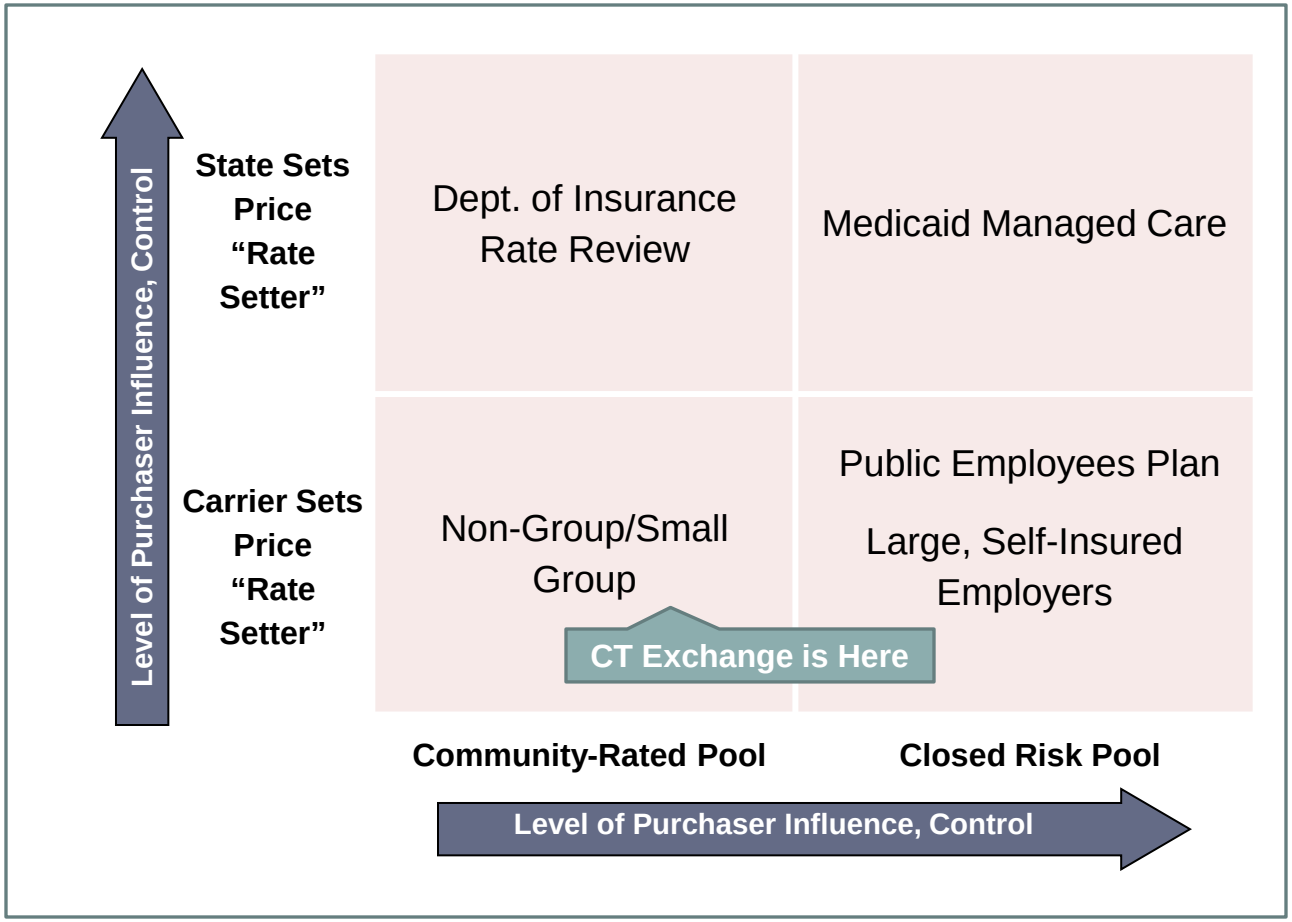
- **It's not an "either-or" choice.** States seeking to establish their own exchanges do not need to, nor will they be able to, choose either an "Active Purchasing" model or a "Any Willing Carrier" model. The Exchange will have features of both models.
- Creating an efficient and transparent market will force carriers to compete on price and value.
- Policymakers must consider exchanges' interactions with broader insurance market.
- Exchanges should offer "right" products and service to attract consumers
- Exchange should "partner" with health plans to attract and serve consumers
- Exchanges can be effective market innovators. Success in managing program costs will depend on the capacity of Exchange and carriers to foster new, innovative coverage models.
- **Health reform is iterative.** The Exchange's position relative to carriers, consumers, providers and the general market must evolve in 2015 and 2016, based on strategic objectives and experience

"Managed Competition"

Features of Exchange's managed competition model:

- Increase competition on price and quality by aligning benefits and cost-sharing across QHPs
- Increase competition by attracting new health plans
- Improve access, quality & service, by:
  - Requiring QHPs to contract with essential community providers and to report routinely on access issues
  - Rigorous standards for measurable quality improvement over time
  - Score and prominently display an index of carriers' claims payment, dispute resolution, MLRs, and other public data
  - Using Navigators and requiring carriers to add customer service resources specially trained to deal with new enrollees
- Promote delivery system and payment reform by encouraging unique product designs from carriers
- Promote cost containment by rigorously reviewing the justification for QHP rate increases that exceed overall medical inflation indexes, or some other trigger point below HHS' 10% trigger

Potential Types of Purchasers



Source: WAKELY CONSULTING GROUP

Reference: Purchasing Models for the Exchange

Characteristics of Markets and Purchasers

Closed Risk Pool v. Community Rating

Closed Risk Pool

- Large volume, ability to analyze population risk allow carriers to price more aggressively
- Greater scale and ability to directly negotiate provides greater opportunity to impact quality and price
- Examples: Public and Municipal Employee Plan, Large Employers, Medicaid Managed Care

Community Rating

- Small group size leads to uncertainty and more conservative pricing practices
- Pricing adjustments set by law and must be consistent inside and outside the Exchange
- Individual groups have limited ability to affect price and quality
- Example: Small and Non Group Markets

"Rate Setter" v. "Rate Taker"

Rate Setter

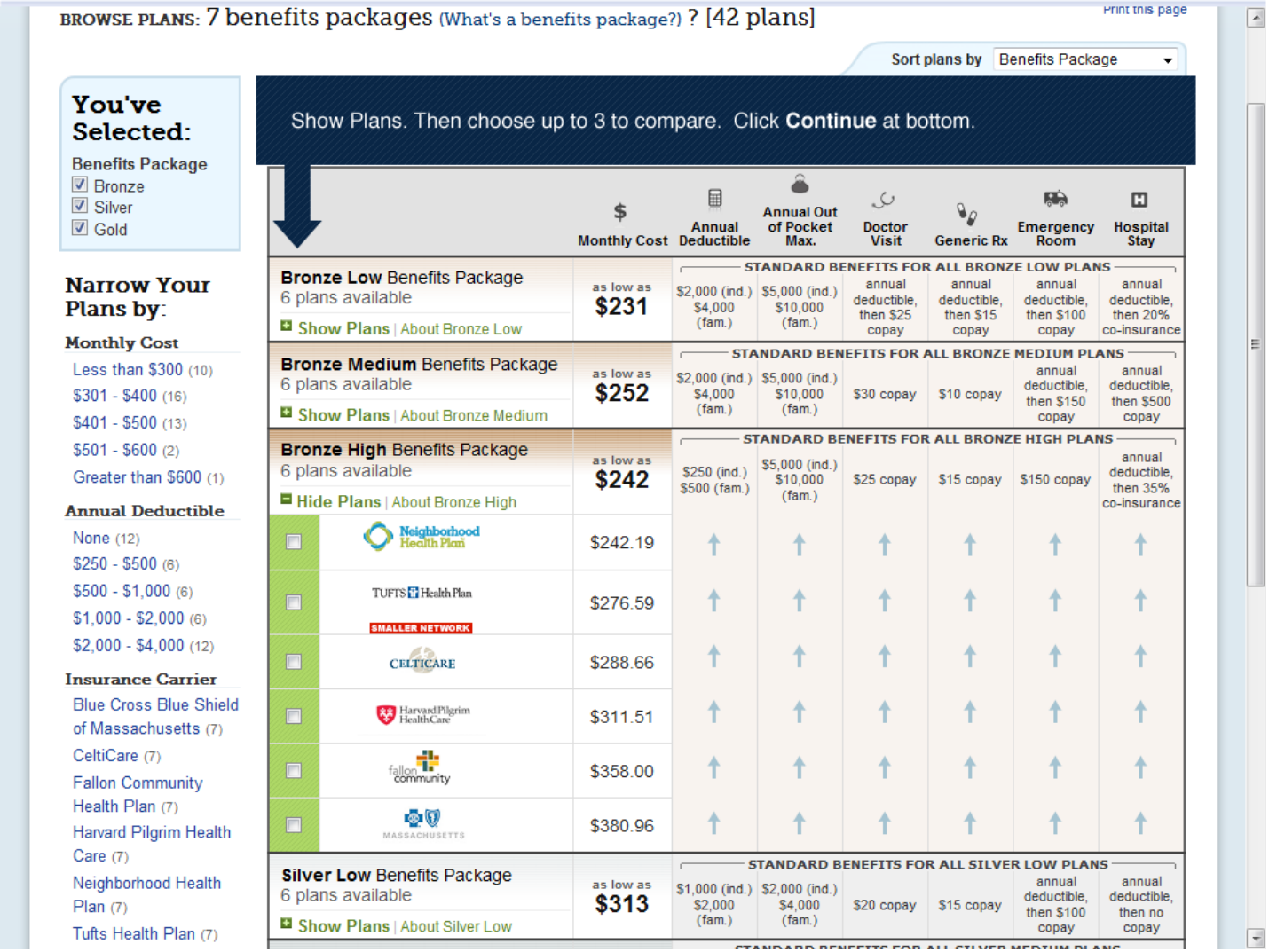
- The purchaser establishes the premium rate and carriers compete to meet this price
- Provides greater control to the purchaser in managing price
- Purchaser can influence price, but also other elements it deems important (networks, quality, etc)
- Examples: DOI Rate Review, Medicaid Managed Care

Rate Taker

- The carrier establishes the premium rate
- Larger scale provides greater opportunity to spur competition amongst carriers to reduce prices
- Examples: Small and Non Group Markets, Public and Municipal Employee Plan

Source: WAKELY CONSULTING GROUP

Price is King



BROWSE PLANS: 7 benefits packages (What's a benefits package?) ? [42 plans]

Print this page

Sort plans by Benefits Package

You've Selected:

Benefits Package
- ☑ Bronze
- ☑ Silver
- ☑ Gold

Narrow Your Plans by:

Monthly Cost
- Less than $300 (10)
- $301 - $400 (16)
- $401 - $500 (13)
- $501 - $600 (2)
- Greater than $600 (1)

Annual Deductible
- None (12)
- $250 - $500 (6)
- $500 - $1,000 (6)
- $1,000 - $2,000 (6)
- $2,000 - $4,000 (12)

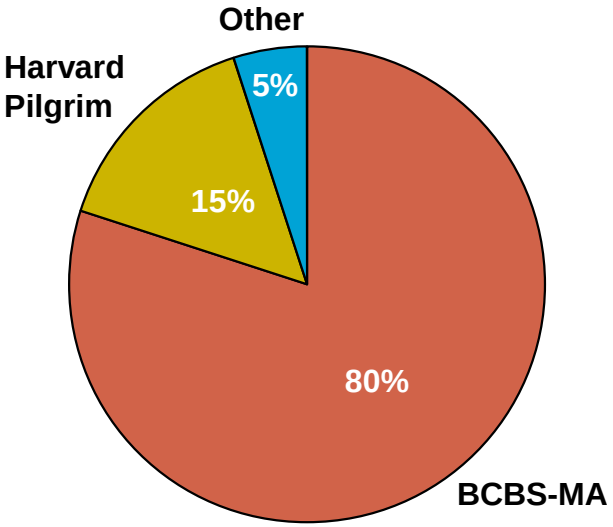
Insurance Carrier
- Blue Cross Blue Shield of Massachusetts (7)
- CeltiCare (7)
- Fallon Community Health Plan (7)
- Harvard Pilgrim Health Care (7)
- Neighborhood Health Plan (7)
- Tufts Health Plan (7)

Show Plans. Then choose up to 3 to compare. Click **Continue** at bottom.

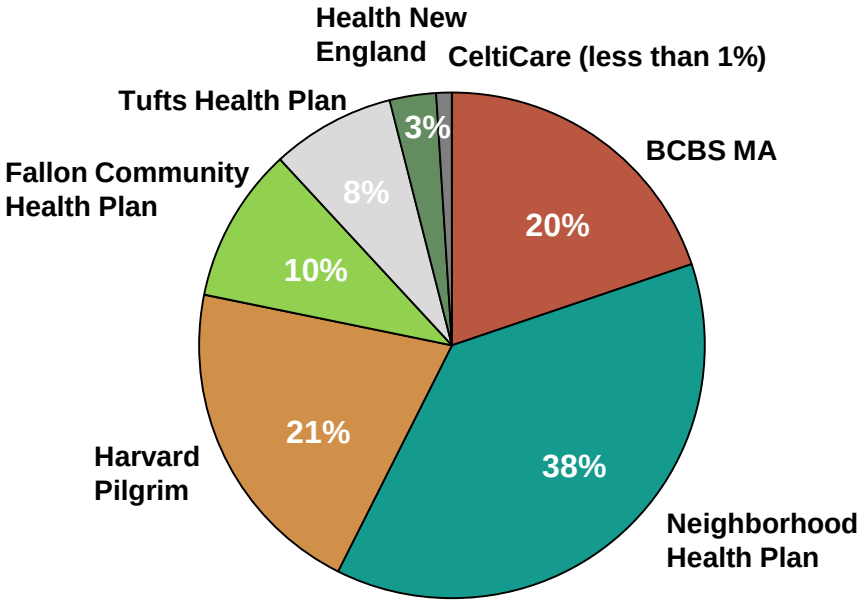
	Monthly Cost	Annual Deductible	Annual Out of Pocket Max.	Doctor Visit	Generic Rx	Emergency Room	Hospital Stay
Bronze Low Benefits Package 6 plans available Show Plans | About Bronze Low	as low as **$231**	STANDARD BENEFITS FOR ALL BRONZE LOW PLANS					
		$2,000 (ind.) $4,000 (fam.)	$5,000 (ind.) $10,000 (fam.)	annual deductible, then $25 copay	annual deductible, then $15 copay	annual deductible, then $100 copay	annual deductible, then 20% co-insurance
Bronze Medium Benefits Package 6 plans available Show Plans | About Bronze Medium	as low as **$252**	STANDARD BENEFITS FOR ALL BRONZE MEDIUM PLANS					
		$2,000 (ind.) $4,000 (fam.)	$5,000 (ind.) $10,000 (fam.)	$30 copay	$10 copay	annual deductible, then $150 copay	annual deductible, then $500 copay
Bronze High Benefits Package 6 plans available Hide Plans | About Bronze High	as low as **$242**	STANDARD BENEFITS FOR ALL BRONZE HIGH PLANS					
		$250 (ind.) $500 (fam.)	$5,000 (ind.) $10,000 (fam.)	$25 copay	$15 copay	$150 copay	annual deductible, then 35% co-insurance
☐ Neighborhood Health Plan	$242.19	↑	↑	↑	↑	↑	↑
☐ Tufts Health Plan (SMALLER NETWORK)	$276.59	↑	↑	↑	↑	↑	↑
☐ CeltiCare	$288.66	↑	↑	↑	↑	↑	↑
☐ Harvard Pilgrim HealthCare	$311.51	↑	↑	↑	↑	↑	↑
☐ fallon community	$358.00	↑	↑	↑	↑	↑	↑
☐ Blue Cross Blue Shield Massachusetts	$380.96	↑	↑	↑	↑	↑	↑
Silver Low Benefits Package 6 plans available Show Plans | About Silver Low	as low as **$313**	STANDARD BENEFITS FOR ALL SILVER LOW PLANS					
		$1,000 (ind.) $2,000 (fam.)	$2,000 (ind.) $4,000 (fam.)	$20 copay	$15 copay	annual deductible, then $100 copay	annual deductible, then no copay

Managed Competition in Action

Massachusetts Pre-Reform Non-Group Market Share
Based on 2005 Membership, 10 Players



Massachusetts Post-Reform Non-Group Market Share (Non-subsidized Exchange)
Based on 2011 Membership, 7 Players



- Neighborhood Health undercut BCBS-MA pricing on the order of approx. one-third, rapidly eroding share in a market of markedly increased transparency
  - Lower pricing driven by more narrow networks and the ability to operate without a broker network, resulting in administrative fees less than half of BCBS-MA

Source: http://www.marylandahu.com/downloads/mahu_exchange_study.pdf

Why Not Negotiate Rates for 2014

- **Exchange not well-positioned to set rates for 2014**
  - Rates have to be the same in and out of the Exchange, but the Exchange will have a relatively small market share (less than 5% of CT market in initial years)
  - Unlike the State Employee Plan or other large employer groups, the Exchange is not a direct purchaser that can promise many enrollees to one or two carriers
  - Connecticut is a prior approval state: all rates must be approved by the Connecticut Insurance Department
- **Carriers face huge challenges for 2014, even w/o the uncertainties of rate-setting**
  - Significant new financial risks to carriers for 2014 in the non-group market
  - Significant operational costs for carriers to participate in the Exchange.
- **Rates will be constrained by other mechanisms**
  - Reforms to Medical-Loss-Ratio already limit administrative overhead of carriers
  - The Exchange creates an efficient market that should help individuals and employers make value-based purchasing decisions
  - Subsidies are pegged to the second-lowest costing Silver plan, so carriers will compete for this extremely price-sensitive population

Recommended Purchasing Model

Staff Recommendation:

Managed Competition
1. The Exchange's purchasing model will reflect its principles for QHP certification. Staff recommends that the Exchange contract only with those carriers that meet the specific standards for QHP certification defined in its QHP Solicitation.
2. For its Initial Solicitation and to promote member choice and carrier competition, staff recommends that Exchange not deny any carrier QHP certification on the basis of its approved rates. The Connecticut Insurance Department must approve all form and rates.
3. However, staff recommends that the Exchange reserve the right to not offer for sale an otherwise certified QHP that is a drastic outliers with respect to submitted rates.

QHP Solicitation Process

Date	Activity
November 26	Extension for Public Comment
November 29	Board Approval of QHP Certification Requirements
December 7	Final Release QHP Solicitation
December 31	Deadline for Notice of Intent to Respond to Initial QHP Solicitation
Early January 2013	Begin QHP Carrier Support
Early January	Release of Standardized Plan Design
Mid January	Release of Model Contract

Adjournment