As part of its QHP certification requirements approved by the Board on November 29 and incorporated into the QHP Solicitation issued on December 14, carriers interested in participating on the Exchange will be required to submit one standard plan for each of the Bronze, Silver and Gold tiers. Carriers are allowed to offer a standard plan design for the Platinum tier.

Carriers are encouraged to submit a non-standard plan for each tier.

The Exchange is focusing initially benefit designs for the Individual and Family segments, and use that information to inform the process with which we address plan designs for the Small Employer Health Options (SHOP) program. The following standards apply only to qualified health plans offered by on a carriers’ indemnity license.1

Appendix A and Appendix B present the Exchange’s preliminary drafts of general cost sharing parameters for the standard plan designs. The Exchange looks forward to receiving comment from interested stakeholders on the attractiveness and affordability of the standard plans.

The actuarial value (“AV”) of each metal tier must adhere to the following levels:

- Bronze: 60%
- Silver: 70%
- Gold: 80%
- Platinum: 90%

The actual AV of the plans must be within +/- 2 percent of the defined AV.

In addition to the above AV levels, for each standard Silver plan, carriers participating in the Individual Exchange must provide three Silver alternative plans that reflect cost sharing reductions. These plans will only be offered to individuals and families with a certain level of household income. Based on the household’s income in relationship to the Federal Poverty Level (“FPL”) the AV of these plans are:

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1 The Connecticut Insurance Department requires non-indemnity health care center plans (i.e. HMOs) to have a minimum deductible of $1,500 (only exemptions to the deductible are certain preventative services required to be covered with no cost sharing). Further, in Connecticut an HMO plan cannot combine copayments and co-insurance.

Using the proposed AV Calculator, Exchange staff could not define a Platinum plan with $1,500 deductible. More significantly, staff could only define a limited number of Gold plans and could not design two of the three Silver alternative plans with actuarial values of 87 percent and 94 percent. Because carriers are required by the ACA to offer at minimum a Gold plan and these Silver alternative plans to participate in the individual Exchange, HMO plans may be excluded from the Individual Exchange.

Staff will consider exemptions to the requirements of the standard plans for HMOs wanting to participate in the Small Employer Health Options Program (SHOP) Exchange.
200-250% of FPL: 94%
150-200% of FPL: 87%
100-150% of FPL: 73%

The actual AV of the Silver alternative plans must be within +/- 1 percent of the defined AV.

In defining each of the standard plans, the Exchange and Connecticut’s carriers must conform to federal and state regulations. These plans will need to meet the appropriate metal tier AV defined and be in full compliance of all federal and state regulations pertaining to maximum out-of-pocket limits, copayments, and co-insurance.

For example, in Connecticut an HMO plan cannot combine copayments and co-insurance. While the proposed standard plan designs refer only to plans offered on a carrier’s indemnity license they all rely strictly upon a copayment schedule. In accordance with State law the following limits on copayments are reflected in the proposed Standard plan designs:

- Non-preventative Primary Care Visit: $40
- Specialist Office Visit: $45
- Urgent Care Visit: $75
- Emergency Room Visit: $150 (assumes ER copayment is waived if admitted)
- Outpatient Surgery: $500
- Inpatient: $500/day (up to $2,000 per admission)

High Cost Diagnostic Tests (e.g. CAT, MRI, PET): $200

We will continue to work with the Connecticut Insurance Department to ensure standard plan designs are compliant with state regulations.

In addition to these state laws, the ACA mandates that preventative care—as defined on List A and List B of the U.S. Preventive Services Task Force—not be subject to any deductible and have $0 copayment. And the ACA limits out-of-pocket maximum to $6,250 for an individual (twice that for a household) and deductibles for small group products to $2,000 (twice that for a household). There are additional limits on maximum out of pocket for the Silver alternative plans reflected in the standard plans defined.

All these regulations direct how the Exchange and carriers may define these standard plans. There still remain many potential variations to the plan designs and the Exchange requests inputs from carriers, consumers, employers, brokers and other stakeholders on their preferred design.

For example, all the standard plans but the Bronze plan include a separate deductible for prescription drugs based on their popularity in the small group market. Also, all the standard plans rely strictly upon a copayment schedule. A co-insurance schedule may be preferable. Such a cost sharing decision will contribute to a comparably more or less expensive premium and/or contribute to a higher or lower AV.

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2 The later limitation could not be met using the proposed federal Actuarial Value calculator while also meeting the state’s current limits on certain copayments. The lowest deductible the Exchange could define and maintain with an AV of no more than 62% was $3,000 for an individual. The Exchange believes that state regulation should pre-empt the $2,000 dollar limit and that the higher deductible is justified under the “reasonableness” standard proposed by the federal government.
The Exchange is interested to learn what impact such decisions (and others) will have on both premium costs and the relative attractiveness of the plan to consumers and employers.

**Stand-Alone Dental**

Additional materials will be provided for standard plan design for Stand-Alone Dental. The Exchange will define a standard “Low” and standard “High” cost sharing schedule, with actuarial values of 75% and 85%, respectively, for the dental benefits included in the State’s essential health benefits package (as defined by the Connecticut Husky B program) and in accordance with the proposed federal regulation.

**Resources**

The Actuarial Value Calculator with Continuance Tables is available from the Center for Consumer Information and Insurance Oversight (“CCIIO”). This proposed tool allows users to measure the actuarial value of health plans and compliance with actuarial value standards established under Section 1302(d) by the Affordable Care Act. The Microsoft Excel file can be downloaded here: [http://cciio.cms.gov/resources/EHBBenchmark/av-calculator-final-locked-11-20-2012.xlsm](http://cciio.cms.gov/resources/EHBBenchmark/av-calculator-final-locked-11-20-2012.xlsm).


**Appendix C** provides an annotated screen shot of the AV calculator Excel file prepared by Exchange staff.


- Please submit any comments on above plans or suggestions for alternative plan designs to Connecticut Health Insurance Exchange c/o Grant Porter at grant.porter@ct.gov.
### Appendix A. DRAFT Standard Plan Designs

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### Medical Benefits

- **Office Visits**
  - Preventive Care/Screening/Immunization
  - Primary Care Visit to Treat an Injury or Illness
  - Specialist Visit
  - Mental Health Visits
  - Emergency Room Services
  - Inpatient Admission
  - Apply Inpatient Copay Per Day
  - Outpatient Surgery
  - High-Tech Imaging (CT/PET Scans, MRIs)
  - Laboratory Services/X-Rays
  - Rehabilitative Services (incl. PT, OT, ST)
  - Skilled Nursing Facility
  - Apply SNF Copayment per Day

### Prescription Drug Benefit

1. **Tier 1 (i.e. Generics)**
2. **Tier 2 (i.e. Preferred Brand Drugs)**
3. **Tier 3 (i.e. Non-Preferred Brand Drugs)**
4. **Specialty Tier (i.e. Specialty High-Cost Drugs)**

### NOTES:


2. Plan cost sharing parameters were constructed to adhere to ACA requirements for actuarial value ("AV") tiers, maximum deductible and out-of-pocket (excepting Bronze plan design that exceeds $2,000 deductible defined in Proposed Regulation) and Connecticut requirements on maximum copayments for certain services and prohibition against co-insurance on HMO products.

3. Maximum out of pocket is defined by the ACA. For a household, it is twice the individual maximum.

Observations from Gorman Actuarial, LLC survey of Connecticut carriers and products sold in 2012 (*Exchange comments in Italics*):

- The most popular plans in the CT Small Group market have a $2,500 Deductible. Exchange staff tried to stay within the HHS guidance of at most a $2,000 Deductible. This was not possible at Bronze level.
- Coinsurance plans are not prevalent in the CT Small Group market. Exchange staff used copayment schedule. However, for Outpatient Surgery the AV Calculator allowed only for a coinsurance percentage. Therefore, Exchange staff assumed cost of $1500 and so correspondingly set coinsurance rate (i.e. for Bronze, copayment of $500 is equivalent to coinsurance of 67% for typical outpatient surgery.)
- A large portion of the CT Small Group market are in plans that are within the "Platinum" metallic tier, using the HHS AV Calculator.
- A separate prescription drug deductible was common in CT small group market. In SHOP the Exchange encourages carriers to submit Health Saving Account eligible High Deductible Health Plans. This would require integrated deductible of at least $1,500.
Appendix B. DRAFT Standard Plan Design for Silver Alternative (i.e. Cost Sharing Reduction Plans)

NOTES:

1. Silver Alternatives are only available through the Exchange and are only available to individuals eligible for cost sharing reductions (with households incomes between 100 and 250% of FPL). These benefits will be priced as Silver, but have lower cost sharing and should not be viewed as a viable market option. The federal government will be reimbursing the carriers for reduction in out-of-pocket costs. CCIIO has defined specific rules in how to construct these alternatives in relationship to base Silver plan.

2. Cost sharing parameters and actuarial value of plans calculated using AV Calculator and continuance tables developed by CCIIO. Methodology and Excel file for developing plan designs available at: http://cciio.cms.gov/resources/regulations/index.html#pm.

3. Plan cost sharing parameters were constructed to adhere to ACA requirements for actuarial value ("AV") tiers, maximum deductible and out-of-pocket (excepting Bronze plan design that exceeds $2,000 deductible defined in Proposed Regulation) and Connecticut requirements on maximum copayments for certain services and prohibition against co-insurance on HMO products.

4. Maximum out of pocket is defined by the ACA. For a household, it is twice the individual maximum

FEEDBACK WELCOME:

- The Exchange wishes to define a standard plan for each metal tier that will meet the AV requirement, offer an attractive cost sharing arrangement for the market, and keep the benefits simple to understand while following all laws and regulations.

- Please submit any comments on above plans or suggestions for alternative plan designs to Connecticut Health Insurance Exchange c/o Grant Porter at grant.porter@ct.gov.

For plans with only a copayment schedule, uncheck "All" in Row 17 and Row 26 under "Subject to Coinsurance?" But, then check box in row 35 for "Outpatient Facility Fee (e.g. Ambulatory Surgery Center)."

Set copayment for each major service. The AV Calculator does not support copayments for Outpatient facility and surgery and so a co-insurance is used. Assume typical cost is $1,500 and so coinsurance of 67% = $500 copayment.

In Connecticut, there are a maximum number of days for which a plan can charge copay. Therefore, check box in row 27 and enter "4" in Row 48.

Press "Calculate" button to get AV of plan.

After pressing "Calculate", AV Calculator will provide AV of defined plan and will report whether or not proposed plan design was successful with respect to desired Metal Tier.