



To: Co-Chairs of the Advisory Committees to the Exchange
From: Peter Van Loon and Grant Porter
Re: Defining the Standard Plan Designs
Date: February 15, 2013

I. Summary

On February 12, 2013, the staff developed proposed standard benefit designs to complement the work done last month on the medical portion of the benefits. The team reviewed and recommends benefit designs for the out-of-network benefits for each of the Exchange's standard plan designs as well as a benefit design for the exchange's standard dental plans. The team also offered a recommendation that the exchange should sell an additional type of dental plan through the exchange; the working group defined the benefits and cost sharing parameters of this "wellness-only" dental plan. Exchange staff supports the addition of this other dental plan.

Appendix A presents the recommended out-of-network benefit for each of the standard plans. **Appendix B** presents the recommended cost sharing parameters for the different dental plans to be offered through the exchange.

Additionally, the team reviewed and supported some modest revisions to the previous recommendation for the specific cost sharing parameters of benefits included in Connecticut's essential health benefits ("EHB") package but not accounted for in the AV Calculator. **Appendix C** presents these revisions.

II. Background

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 participating in the non-group exchange must also submit the three Silver alternative standard plans that reflect cost sharing reductions.

In both exchanges, carriers have the option to offer a standard plan design for the Platinum tier.

Each of these plans must meet the actuarial values defined under Section 1302(d) by the Affordable Care Act for each of the metal tiers and cost sharing reduction plans.¹ As part of the proposed exchange rules published on November 26, 2012, the Center for Consumer Information and Insurance Oversight ("CCIIO") included a draft AV Calculator.

¹ 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.

The three Silver alternative plans reflecting cost sharing reductions are 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: 200-250% of FPL - 94%; 150-200% of FPL - 87%; 100-150% of FPL - 73%.

The proposed rule indicates that every non-grandfathered health plan must have their actuarial values computed against this AV Calculator. (Beginning in 2015, states may use their own data, if approved by the Department of Health and Human Services.) This applies both to the exchanges' standard QHPs and non-standard QHPs alike.

In January, exchange staff met with a working group established by the co-chairs of the four advisory committees to define the standard plan designs that would be offered at each of the metal tiers and cost sharing reduction levels. This group contributed their clinical expertise, market knowledge, and consumer and employer advocacy to the discussion.

Through a series of half-a-dozen meetings the working group came to a recommendation that emphasized three interrelated principles:

1. Simplicity – Standard plans should be simple to understand by the consumers and administer by carriers and providers.
2. Consumer-Focused – Plans should enable and encourage consumers to get routine and basic care at minimal out-of-pocket expense.
3. Primary Care Focus – Plans should enable people to maintain their health status.

The plan designs recommended by the working group and presented by staff at an informational session open to all advisory committees met these principles.

In addition to defining the benefits accounted for by the AV Calculator, the working group offered its recommendation on the cost sharing parameters for those benefits not accounted for in the AV Calculator as well as certain benefits that were included but needed clarification (i.e. maternity coverage).

At its January 24, 2013 meeting the Board approved the cost sharing parameters for the various standard plan designs as well the "other" benefits as recommended by the working group.

III. Updating the Standard Plans

Over the past two weeks the exchange has reconvened its standard plan team to define the outstanding components of the exchanges' standard plans, including the standard plans' out-of-network benefits and required dental benefits.

The working group took the opportunity to revisit some of the cost sharing parameters for those "other" benefits already approved.

i. Out-of-Network Benefits

The AV Calculator and actuarial value of the metal tiers are calculated with regard to in-network benefits only. As such, the exchange needs to separately define the out-of-network ("OON") benefits for each of the standard plans. Staff consulted with Gorman Actuarial, LLC to devise the OON benefit so that it would not skew the plan's overall actuarial value or adversely impact premiums.

The general assumption behind the standard plans is that networks will be sufficient to meet the medical needs of their members and so there should be no need to seek an OON provider and the benefit.

For all metal tiers, the OON maximum out-of-pocket (“OOP”) will be set at twice the in-network maximum. The proposed maximum OOPs presume a reduction in the in-network maximum OOP for the standard plans. Most significantly for the Gold and Platinum standard plans, the exchange expects a reduction in their maximum OOP from \$5,000 to \$3,000 and \$2,000, respectively.

For all metal tiers, the OON deductible will be integrated and will be waived only for preventative care (subject to coinsurance, however), ambulance and emergency room services, and pediatric vision services. For the Bronze and Silver plan, the OON deductible limit will be double the in-network deductible: presumably, \$4,000 and \$2,500 respectively—but subject to revision based on final AV Calculator. For the Gold and Platinum plans that have low in-network deductibles, a minimum OON deductible is defined.

Stephen Frayne voted against the comparatively high OON deductibles (relative to in-network deductibles). He argued that it seemed needlessly punitive to members needing to see OON member and that the carrier is protected by have their potential liabilities capped in relationship to their usual and customary rate.

For the Cost Sharing Reduction plans the benefits will be the same as for the Silver benchmark. Per federal regulations, the cost sharing reduction subsidies cannot be used to lower premiums, reduce spending on non-covered services, or pay for any balance billing for non-network providers.

Appendix A presents the working group’s recommended out-of-network benefits.

ii. Dental Benefit Design

In addition to defining the cost sharing parameters for the major medical and prescription drug benefits, the working group considered plan design for the required pediatric dental benefit as well as the optional adult dental benefits. A similar benefit design is intended for both—with the exception that the pediatric only benefit has no waiting periods on services and no plan maximum.

The dental benefits package is comprehensive and includes all dental benefits included in the State’s essential health benefits package (as defined by the Connecticut Husky B dental benefit).

In accordance with the proposed federal regulation, the working group defined a standard “Low” and standard “High” cost-sharing schedule, with actuarial values of 75% and 85%, respectively.

In addition to defining a standard “Low” and “High” plan, the working group recommends, and exchange staff concurs, that it would be beneficial to Connecticut’s consumers to have the choice of a low cost “Wellness Only” dental plan that would provide coverage for a limited set of benefits, restricted to preventative and diagnostic services and basic restorative care.

These plan designs reflect plans common to the market today. Given the limited set of parameters to adjust, the exchange does not anticipate the need for other, non-standard dental plans, to be sold. There would unlikely be any meaningful difference to justify the additional plans. The three different plans—“High”, “Low”, and “Wellness-Only”—offer sufficient choice for the consumer.

Appendix B presents the three dental plan designs.

Dental

In order to give consumer free choice in selecting the dental plan option that is best suited for their child and/or family, the Exchange's QHP certification requirements approved by the Board required all carriers submitting a qualified health plan separately price their pediatric dental essential health benefit.

Doing otherwise would severely limit competition in dental sector and greatly diminish the ability of dental carriers to maintain their independent presence in the individual and small group insurance markets.

Staff acknowledges the team's concern over the Exchange's decision to support stand-alone pediatric dental. The team is concerned that the policy decision could have the unintended consequence of negatively impacting the amount of advanced premium tax credits available to households with children.²

Staff was already aware of this potential issue and has been exploring whether to advocate a change of policy. Staff recommends we do not now change the QHP certification requirements with respect to the treatment of pediatric dental benefits.

iii. Changes to "Other" Benefits

Appendix C summarizes the changes to the other benefits that make the standard plans more consistent with products already sold in the market.

The working group voted 4 to 1 to accept the changes to the approved "other" benefits. Changes included the elimination of any copayment for home health care and hospice care (as is currently the practice among the most popular small group plan's sold in Connecticut).

Arlene Murphy from the Consumer Experience and Outreach Advisory Committee voted against the proposed changes. She objected to the proposed increase to the copay for maternity care services. The proposed changes increased the copayment from that associated with typical primary care visit copay to the specialist office. While an Ob/Gyn can be assigned as a member's primary care physician they remain a specialist. For consistency exchange staff recommended that the appropriate copayment apply.

Eliminating copayments—or even maintaining the lower copayments—for maternity services without adjusting the plan's deductible would inflate the actuarial value of the plans and unlikely cause the plan to not meet its metal tier requirements.³ Related, exchange staff clarified after for the working group that while specific preventative care screenings for the pregnant mother and unborn child must be provided at no cost to the member, the general office visit remain subject to copayment.

² The working group voted unanimously, 5-0, to recommend: "The Exchange staff and Board should revisit the decision to offer stand-alone dental in order to ensure that the exchange maximizes the federal subsidy available to the consumer by ensuring that the second-lowest Silver plan includes pediatric dental."

³ Pre- and post-natal maternity services for an uncomplicated pregnancy will cost at least \$2,000. Ten copayments of \$45 equates to less than a quarter of the cost of care and so this is an appropriate distribution of costs for a Silver tier plan that assumes 30% of costs are borne by user.

Staff recommends that the Board accept the recommendations detailed in the attached appendices.

IV. Next Steps

The standard plans were defined using the draft AV Calculator that was published as part of the proposed rules on November 24, 2012.

The proposed federal regulation indicates that every health plan—with the exception of Catastrophic Coverage—are required to have their actuarial values (“AV”) confirmed by the federal AV Calculator. By requiring all carriers to use a common AV Calculator to confirm that their plans meet one of allowed actuarial value ranges the calculator is a necessary tool to establish a baseline for consumers to compare health plans.

The final version of the AV Calculator will not be made public until publication of the Final Rules. CCIIO recognizes the sense of urgency shared by the state exchanges and carriers with respect to the timing of the AV Calculator, and has communicated with exchange staff that it intends to publish the final rules “soon.” The final rules are currently at the Office of Management and Budget for review.

V. Additional Discussion Items

The team wanted to stress several other issues about which we spoke. There was particular concern about how the potential shift of people from Medicaid due to the Governor’s suggested changes will affect those people. There was continued discussion of the financial impact of this to individuals and families. Several other areas were brought up.

- Several team members were concerned about the impact the Out-of-Network provisions would have on access to care. The team reiterated its support for network adequacy in both standard and non-standard plans. The Exchange staff reiterated its commitment to transparency for evaluating networks of both standard and non-standard plans prior to certification.
- There were difficult discussions around the Dental Plan. There is a concern that the Governor’s proposal to shift thousands of HUSKY parents to the Exchange will effectively reduce the access to dental care. The staff was tasked to work with DSS to understand the potential impact. One member of the team voted “no” on the Dental because of the concerns to this financially vulnerable population, and desired that the decision be put off until this was change was fully understood.
- A member of the team pointed out that the Exchange must understand how the HUSKY parents medical benefits will change when they are shifted to the Exchange and that must be part of the Exchange’s aggressive outreach.
- The Exchange staff was tasked, as part of the maternity situation noted above, to ensure that prenatal care services available at no charge be made clear and unambiguous, and compared those to services for which there is a copay. The benefits in quality care and cost for prenatal care was reiterated during the discussion.

Appendix A. Standard Plan Working Group Recommendation - Out-of-Network Benefits

	Bronze	Silver [3]	Gold	Platinum
	Out-of-Network	Out-of-Network	Out-of-Network	Out-of-Network
Deductible [1]				
<i>Integrated</i>	\$ 8,000	\$ 5,000	\$ 3,000	\$ 2,000
Payment of Claims	60% coinsurance	60% coinsurance	70% coinsurance	80% coinsurance
Maximum Out-of-Pocket[2]	12,500	12,000	6,000	4,000
Exceptions to Deductible	preventative care (but may be subject to coinsurance); ambulance and emergency room; pediatric vision services	preventative care (but may be subject to coinsurance); ambulance and emergency room; pediatric vision services	preventative care (but may be subject to coinsurance); ambulance and emergency room; pediatric vision services	preventative care (but may be subject to coinsurance); ambulance and emergency room; pediatric vision services

Notes:

1. The out-of-network deductible for Bronze and Silver will be integrated and set at twice the in-network deductible. Presumably \$4,000 and \$2,500 respectively, but subject to revision based on final AV Calculator and precise parameters of standard plan cost.
2. The maximum out of pocket charges for out-of-network services presumes a reduction in in-network out-of-pocket maximums for the standard QHP. Most significantly for Gold and Platinum plans: reduction in in-network out-of-pocket maximum to \$3,000 and \$2,000, respectively. For all plans, the out-of-network maximum will be set at two times the in-network maximum. Maximums will be revised to remain compliant with final AV Calculator.
3. The out-of-network benefits for Silver Cost Sharing Reduction Plans are the same as they are for the Silver benchmark (i.e. no reduction on out-of-network benefits). Per federal statute and regulations, the cost-sharing reductions exclude reductions in premiums, balance billing amounts for non-network providers, and spending for non-covered services.
4. Similar to Cost Sharing Reduction plans, the Zero-Cost Sharing reduction plans do not have reduced out-of-network plans relative to metal tier plan is associated with.

Appendix B. Standard Plan Working Group Recommendation - Stand-Alone Qualified Dental Plans

	"High Plan"	"Low Plan"	Wellness-Only Plan
Approximate Metal Tier <i>Estimated Actuarial Value(1)</i>	Gold+ 85%	Silver+ 75%	n/a
Diagnostic and preventive Diagnostic Services Oral Exams (2 per year) X-Rays Periapicals Bitewing Radiographs (once every 2 years) Panorex (once every 3 years) Preventative Cleanings (2 per year) Periodontal cleanings (once every 3 months following periodontal surgery) Flouride (2 per year, under age 19) Sealants (limit 1 per tooth per lifetime, under age 19)	100% no deductible	100% no deductible	100% no deductible
Basic Restorative <i>6 month waiting period applies</i> Fillings Simple Extractions	80% after deductible	60% after deductible	60% after deductible
Major Restorative <i>12 month waiting period applies</i> Surgical Extraction Endodontics (i.e. Root Canal Treatment) Periodontics Crowns and Cast Restorations Prosthodontics (i.e. Dentures) Implants	60% after deductible	50% after deductible	not covered, <i>but in-network discount may apply</i>
Orthodontics <i>12 month waiting period applies</i> Medically necessary <i>Non-medically necessary are not covered, but in-network discount may apply</i>	50% after deductible	50% after deductible	not covered, <i>but in-network discount may apply</i>
Deductible	\$50 per individual (up to maximum of \$150)	\$50 per individual (up to maximum of \$150)	\$50 per individual (up to maximum of \$150)
For Child-Only Stand Alone Dental Max Out-of-Pocket <i>No waiting periods or annual plan maximum (medical necessity applies)</i>	\$1,000 per child (up to maximum of \$2,000 per plan)	\$1,500 per child (up to maximum of \$3,000 per plan)	n/a
For Adult Stand Alone Dental Annual Plan Maximum <i>Annual Plan Max applies to adults only</i>	\$2,000 per adult	\$1,000 per adult	\$500 per member

Notes:

1. Actuarial value estimate provided by dental carrier and based on pediatric claims experience
2. Coinsurance and actuarial value of plan refers to in-network providers in a PPO plan.

Appendix C. Standard Plan Working Group Recommendation - Cost-Sharing for Benefits Not Included in AV Calculator

Proposed changes to "Other" benefits (as approved by Board at January 24, 2013 meeting) below:

1. Eliminate copay for hospice care. (was equivalent to one inpatient copay i.e. \$500/\$250)
2. Eliminate copay for home health care services. (was half of primary care copay for 80 visits)
3. Include copay for vision exams for gold and platinum. (was \$0 for gold/platinum)
4. Increase coinsurance on DME/Prosthetics/Diabetic supplies to 10 percentage points less than metal tier actuarial value. (was 50% across all plans)
- 5.a. Copay for maternity visits should be equivalent to specialist copay. (was primary care copay)
- 5.b. For Cost Sharing Reduction plans, for maternity services apply copay to first two visits only.

	Bronze - 60 AV	Silver - 70 AV	Gold - 80 AV	Platinum - 90 AV
Additional Benefits (Not necessarily included in AV Calculator)	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible
Emergency and Urgent Care Services				
Emergency Room <i>Same copay applies both In- and Out-of-Network Copay waived if admitted to hospital</i>	\$ 150 ✓	\$ 150	\$ 100	\$ 75
Urgent Care <i>No out-of-network coverage unless outside of service area</i>	75 ✓	75	50	50
Walk-In Centers <i>Applicable office visit copayment</i>	50 ✓	50	50	50
Ambulance	0 ✓	0	0	0
Routine Prenatal and Postnatal OB/GYN <i>For maternity services related to pre- and post-natal care, copays limited to 10 office visits for a pregnancy. Copay does not apply to any preventative care recommended by the U.S. Preventative Services Taskforce that must be provided at 100% cost sharing and not be subject to deductible.</i>	45 ✓	45	45	30
Chiropractic Services <i>20 visit limit per member per year</i>	45 ✓	45	45	30
Cardiac Rehabilitation	30 ✓	30	20	15
Habilitative Services <i>For treatment of children with Autism Spectrum Disorders</i>	30 ✓	30	20	15
Home Health Care <i>200 visit limit per member per year</i>	0 ✓	0	0	0
Hospice Services	0 ✓	0	0	0
Allergy Services - Office Visit and/or Injections	45 ✓	45	45	30
Prosthetics	50% ✓	60%	70%	80%
Durable Medical Equipment	50% ✓	60%	70%	80%
Diabetic supplies and equipment <i>Insulin and certain medical supplies used to inject insulin, such as syringes and oral diabetes drugs, are covered under Rx benefit</i>	50% ✓	60%	70%	80%
Diabetics Education <i>Applicable office visit copayment</i>	30/45	30/45	20/45	15/30
Pediatric Vision				
Eye Exam <i>Out-of-Network: up to fair health rate less copay</i>	30	30	20	15
Glasses <i>Out-of-Network: up to a minimum allowance of \$125</i>	1 pair per year			