March 4, 2013

Recommendations of the Working Group on Plan Offering and QHP Benefit Standardization to the District of Columbia Health Benefit Exchange Authority

This report is submitted by the Plan Offering and QHP Benefit Standardization Working Group, chaired by Kate Sullivan Hare and Claire McAndrew (Vice Chair). Its purpose is to present recommendations which either were unanimously endorsed or endorsed by such a vast majority of participants as to carry considerable weight, to identify issues on which the working group could not get even close to consensus, and to summarize the arguments for and against such positions. In addition, the co-chairs invited individual participants to express their views on issues that could not be resolved by consensus, and these are appended to the report.

Background

The Affordable Care Act (ACA) prescribes standardization for non-grandfathered plans through the establishment of a minimum set of covered essential health benefits (EHB), four allowed actuarial value levels for covering those EHBs (metal tiers), zero cost-sharing for certain preventive services, limits on annual out-of-pocket spending for EHB services, and limits on deductibles for small group plans. An additional form of standardization implemented by the ACA is the requirement of Insurers participating in the Exchange to offer at least one Silver and Gold level plan. Further standardization of plan designs (i.e. prescribing the type of product (HMO, PPO, etc.) and/or subscriber cost-sharing responsibilities (deductibles, coinsurance, etc.) within metal tiers), may reduce consumer confusion, simplify choice, and ultimately help consumers choose coverage that best meets their needs. On the other hand, further standardization may reduce choice and discourage carrier participation.

The Board gave the working group a charge to sort through these issues: “Make recommendations on whether to specify the number of policy variations offered through the Exchange (within metal levels), whether to require a standardized QHP benefit design which includes cost-sharing, and whether to allow or limit benefits not part of the EHB benchmark.”

The working group broke this charge into five distinct elements:

1. What should be the number of QHPs offered per Issuer per metal tier?
2. Should the Exchange standardize cost-sharing designs for QHPs?
3. Should the Exchange require “meaningful differences” among plan designs?

4. Should issuers be required to offer plans at Bronze and Platinum tier levels?
5. Should issuers be allowed to add benefits beyond Essential Health Benefits (EHB)?

The working group was very well attended. Upwards of 20 people in person and on the phone attended all four meetings, which lasted 2-3 hours each. To determine how close to unanimity the working group could come, it took "straw votes" on each issue. The language and wording of each question was carefully considered and thoroughly deliberated in order to win support. The Board is requested to pay particular attention to the phrasing of each question when considering recommendations made by the working group. The questions put to a vote were as follows:

1. What is the maximum number of non-standardized plans per metal tier per Issuer, separately for both the Individual and the SHOP Exchanges, which you prefer for 2014?
2. In 2014, and if the Board determines it is not feasible then no later than 2015, should the Exchange develop one standardized plan per metal tier, with appropriate consideration of consumer preferences and the need for affordable access to health care services? (Insurers would be required to offer the standardized plan for each metal tier on which they participate.)
3. Should Issuers be allowed to add benefits to EHBs, defined as services eligible for claims submission and reimbursement?
4. Should the Exchange require that an Issuer demonstrate meaningful differences among the various QHPs it proposes to offer?
5. Do you support a requirement for Issuers to offer at least one Bronze plan?
6. Do you support a requirement for Issuers to offer at least one Platinum plan?

Process of the Working Group

Working group members were asked to vote and provide a recommendation to the Board for each of the six questions defined above. The body of this report focuses on recommendations to the Board. Where a unanimous consensus was not reached, supporting and opposing viewpoints are presented. Responses to each of the six questions are broken down by member and stakeholder group in Appendix A. Wakely Consulting facilitated working group meetings and provided the group with supporting information. Discussions were held on various standardization topics and working group members were able to voice their preferences and concerns. For further details on discussions of the working group, a review of each of the four working group meetings can be found in Appendix B. Working group members were also invited to include a brief one-page statement to clarify their positions to the Board, which are attached in Appendix C.

Recommendations

Number of QHPs offered per Issuer per metal tier

Question 1: What is the maximum number of non-standardized plans per metal tier per Issuer, separately for both the Individual and SHOP D.C. Exchanges, which you prefer for 2014?

Recommendation:
A clear consensus could not be reached, so the Board may want to refer this question to committee to determine if a limit should be placed on the number of plans that Issuers can offer at each metal tier level on the Exchange, and (if so) what the number of plans should be. However, members did agree that, if the Board defines a cap on the number of plans offered, it should cap the total number of plans that an Issuer can offer per metal tier, allowing the Issuer to determine how to distribute its plans across licenses (HMO, PPO, etc.).

Commentary:
Individual views on the number of QHPs that should be allowed per metal tier ranged from 2 to 16 for both the individual and small-group markets. Some members preferred a higher maximum for the small-group market versus the individual market. Most of those that responded on the higher end of the range (12 to 16 plans), stated that they prefer an unlimited number of plans, however if a limit was determined to be necessary, they would settle for their stated answer.

The Board should note that if it decides Issuers should be required to offer a standardized plan at each metal tier level (Question 2), responses to this question do not include the standardized plan and therefore one plan should be added to members' answers to arrive at a total number for the maximum number of plans offered per metal tier.

As mentioned in the recommendation, the group has agreed to approach this question with the "umbrella" concept. This contrasts with Maryland's approach, which limits the number of plans that an Issuer can offer on the Exchange to four plans per license per tier. The working group prefers that any limit per tier apply to all licensed products under a single corporate umbrella.

Members who preferred a relatively lower number for a limitation are mostly concerned that too many choices would confuse consumers and lead them to choose a plan that would not best suit their health coverage needs. Supporters of a lower limit also expressed concern that having an unlimited number of plan designs could allow some issuers to "flood" the market with many QHPs in order to gain market share or segment risk. Members (mostly Insurers and Brokers) who preferred a relatively higher number for a limitation believe that without a high maximum, innovation may be stifled and Issuers would not be able to provide consumers with the range of plans they require. One insurer stated that insurers have no intention of flooding the market with plans and would only offer plans that consumers demand. In addition, some members thought that, as a transition, the Exchange should offer a higher number of

plans at first and the Exchange can reduce the number of plans in the future by removing those that are not demanded by consumers. Members noted that a higher number would allow better transition of the existing range of plans for current enrollees, particularly small business plans.

Standardized cost-sharing designs for QHPs

Question 2: In 2014, and if the Board determines it is not feasible then no later than 2015, should the Exchange develop one standardized plan per metal tier with appropriate consideration of consumer preferences and need for affordable access to health care services?

Recommendation:
A large majority of members voted that issuers should be required to offer a standardized plan at each metal tier level, if the Insurer is offering any plans at that metal tier.

Commentary:
Of the 19 present members, 17 voted "Yes", 2 voted "No", and no members abstained. The two dissenting votes were from Insurer members, but it should be noted that there was not unanimous dissent among Insurers in the working group. Members supporting the requirement for standardized cost-sharing designs believed that consumers require the ability to make an "apples-to-apples" decision across plans being offered by different Insurers. Dissenting members argued that standardization is not necessary, that IT software will help consumers sort through and screen options, and that experienced insurers are best able to determine the plan structures that meet consumer demand. Concern was expressed about requiring plans that might not sell, and the negligible uptake of Maryland's existing, non-QHP standard plan was cited, hence the reference in the recommendation to designing plans for which there is market demand.

Some members were also concerned about the feasibility of designing standardized plans in time for 2014, which was recognized as a legitimate concern. The group therefore recommended that standardized plans be developed for 2014, unless the Board determines that it is not feasible to do so until 2015. The working group also recognized that the value of having standard plans might depend on their content, but felt that it would be far beyond the charge of this group to recommend specific designs. To address these concerns, the wording of the question was thoroughly deliberated before calling a vote. Members also discussed the importance of standardizing both in-network and out-of-network cost-sharing if a standard plan is developed.

The Board should note that the working group determined that the required offering of one standardized plan per metal tier depends on whether the Insurer is offering plans at that metal tier level at all. Therefore, whether an issuer offers a standardized plan at every metal tier is dependent on the Board's decision regarding Questions 5 and 6, and/or whether an issuer chooses to offer plans at Bronze and Platinum. The ACA requires Insurers participating in the Exchange to offer plans at Silver and Gold

levels. But if, for example, the Exchange does not require Insurers to offer a Platinum plan, then Insurers would not be required to offer a standardized Platinum plan if they do not offer other Platinum plans.

Additional benefits beyond Essential Health Benefits (EHB)

Question 3: Should Issuers be allowed to add benefits to EHBs, defined as services eligible for claims submission and reimbursement?

Recommendation:
There was a unanimous recommendation from working group members that yes, Insurers should be allowed to add benefits to EHBs, as defined as services eligible for claims submission and reimbursement.

Commentary:
There was unanimous consent for this recommendation and accordingly, few concerns were expressed by members. Some members initially expressed concern that allowing Insurers to offer additional benefits beyond EHB may promote risk selection. However, the group discussed that adding benefits that require a claim submission are unlikely to promote preferential risk selection. The working group was silent on whether other benefits, such as discounted or free gym memberships and wellness programs, should be permitted. Members want to be clear to the Board that the working group did not take a position on these other plan offerings.

Reasons for supporting additional benefits, denoted as those that require a claim, include a concern that EHBs may not adequately cover all health needs of consumers. By allowing additional benefits, Insurers will have the flexibility to offer and consumers will have the option to choose a health plan that meets coverage needs that may not be addressed by the EHB benchmark.

"Meaningful difference" among plan designs

Question 4: In 2014, should the Exchange require that an Issuer demonstrate meaningful difference among the various QHPs it proposes to offer?

Follow-up question: Do you agree that the following statement should be included in the report to the Board? "There is a sense of the working group that meaningful difference standards may be more relevant when more plans are offered per carrier per tier and less relevant when fewer plans are offered per carrier per tier."

Recommendation:
A consensus was not reached on Question 4. The majority of Insurers and Brokers did not support a

requirement that issuers be required to demonstrate meaningful difference in 2014, while the majority of Consumers and Employers did. However, there was not unanimous agreement among all Insurers or all Employers.

The working group believes that the following generalization may be helpful to the Board. With unanimous consensus, it suggests that a meaningful difference standard is more relevant if a "greater" number of plans are to be offered on the Exchange, and less relevant if fewer plans are offered. Therefore, the Board should consider meaningful difference standards in conjunction with its decision about the maximum number of plans that can be offered (Question 1).

Commentary:
Of the 18 members present, 10 voted in favor of requiring meaningful differences, 6 voted against, and 2 abstained. Members from the consumer stakeholder group voted unanimously "Yes", while Employer members and Insurer members were split in their decision. Brokers unanimously voted "No".

Before voting, the working group reviewed meaningful difference standards in other State-based Exchanges (specifically, from Connecticut and Vermont) to gain a better understanding of meaningful difference. However, it was agreed that defining specific meaningful differences was out of the group's scope.

Overall, Insurers indicated that the ACA will cause a reduction in the number of plan designs they offer, compared to the number of plans currently offered, and therefore they will be required to carefully consider the differences between plans to meet consumer demands. They stated that there is no reason to place further restrictions on Insurers. Consumer members believe that meaningful difference is important to reduce consumer confusion and will allow consumers to adequately choose a plan that meets their coverage needs, particularly if a greater number of plans are offered on the Exchange.

Some members, such as brokers and benefits consultants, expressed concern that their answer to Question 1 (maximum number of plans per Issuer per tier) might have been different had they known that the Exchange could impose a meaningful difference standard. As members deliberated, it seemed there was a consensus that the need for meaningful difference increases as the number of plans offered on the Exchange increases. This discussion led the group to vote by unanimous consent that meaningful difference standards are more relevant when more plans are authorized on the Exchange and less relevant when fewer plans are offered.

Requirement to offer plans at Bronze and Platinum tier levels

Question 5: Do you support a requirement for Issuers to offer at least one Bronze plan in the Exchange?

Recommendation:
A consensus was reached, with two members abstaining, that Issuers should be required to offer at least one Bronze plan in the Exchange.

Commentary:
Insurers indicated that they intend to offer Bronze plans anyway and there is no need for a requirement, but they compromised and agreed to the requirement. Other members supporting a Bronze requirement indicated that a requirement would ensure that the Exchange offers consumers affordable coverage and a breadth of options.

Question 6: Do you support a requirement for Issuers to offer at least one Platinum plan in the Exchange?

Recommendation:
A consensus could not be reached on this question.

Commentary:
Of the 19 members, 10 voted "Yes", 5 voted "No", and 4 members abstained. Amongst Consumer members, there was a consensus that Insurers should be required to offer a Platinum plan. They believe that one purpose of the ACA is to offer consumers a wide range of health coverage options. One Consumer member indicated that an insurance company may not have the ability to offer a Platinum plan and a requirement would be harmful to their business operations. This member suggested that Exchange policy could include some type of exception for insurers that demonstrate a Platinum requirement would have an adverse impact on their operations. An additional concern was that enforcing a Platinum requirement may influence Insurers to not participate in the Exchange at all.

Consensus was not reached among Insurer, Employer, or Benefit Consultant members. Insurers indicated that the majority of their small group business is currently on the Platinum level and they plan to offer Platinum plans anyway, but one member expressed that there is no need to place an additional requirement on insurers. Overall, Insurer members seemed to believe that the market and consumer demand should dictate which plans are offered and a requirement is not necessary.

Summary of Recommendations to the Board

Question #	Question	Recommendation
1	What is the maximum number of non-standardized plans per metal tier per Issuer, separately for both the Individual and SHOP D.C. Exchanges, which you prefer for 2014?	A consensus recommendation was NOT reached
2	In 2014, and if the Board determines it is not feasible then no later than 2015, should the Exchange develop one standardized plan per metal tier with appropriate consideration of consumer preferences and need for affordable access to health care services?	Yes, majority consensus recommendation
3	Should Issuers be allowed to add benefits to EHBs, defined as services eligible for claims submission and reimbursement?	Yes, unanimous consensus recommendation
4	In 2014, should the Exchange require that an Issuer demonstrate meaningful difference among the various QHPs it proposes to offer?	A consensus recommendation was NOT reached
5	Do you support a requirement for Issuers to offer at least one Bronze plan in the Exchange?	Yes, unanimous consensus recommendation
6	Do you support a requirement for Issuers to offer at least one Platinum plan in the Exchange?	A consensus recommendation was NOT reached

Appendix A: Working Group Member Responses to Questions

Question 1: What is the maximum number of non-standardized plans per metal tier per Issuer, separately for both the Individual and SHOP D.C. Exchanges, which you prefer for 2014?

Working group member responses:

Stakeholder Group	Name	Organization	Individual	SHOP
Insurers	Stephanie Laguna	Kaiser Permanente	3	3
	Chris Culotta	Care First	8	8
	Colleen Cohan (filling in for Troy Pelfrey)	United Health Care	4	16
Employers	Michael Dudich	Hillwood Museum	8*	8*
	Katherine Stocks	DC Chamber of Commerce	Unlimited	Unlimited
	Stacy Mills	Adventurous Consulting	8	8
	Ayoka Jack	Georgetown Day School	4	8
Brokers	Lee Bethel	Comprehensive Benefit Services	8	8
	Hannah Turner	Keller Benefit Services	8	8
	Len Gross	PSA Financial	12	12
Health Care Providers	Marjorie Shovlin	Acupuncture Society of DC	Abstained	Abstained
	Dr. Kemesha Delisser	National Spine and Pain Centers	6	6
Benefit Consultants	Philip Chao	Chao & Co.	4	4
	Frank McArdle	Independent Consultant	16	16
Consumers	Stephanie Akpa	Legal Aid Society of DC	3	4
	Dania Palanker	National Women's Law Center	2	2
	Wes Rivers	DC Fiscal Policy Institute	2	3
	Rob Fleming	DC Recovery	4	4
	Dave Chandra	Center on Budget Policy Priorities	3	5

*Total for tier desired in Exchange across all QHP issuers, did not answer as per Insurer

Question 2: In 2014, and if the Board determines it is not feasible then no later than 2015, should the Exchange shall develop one standardized plan per metal tier with appropriate consideration of consumer preferences and need for affordable access to health care services?

Working group member responses:

Stakeholder Group	Name	Organization	Response
Insurers	Stephanie Laguna	Kaiser Permanente	Yes
	Chris Culotta	Care First	No
	Troy Pelfrey	United Health Care	No
Employers	Michael Dudich	Hillwood Museum	Yes
	Katherine Stocks	DC Chamber of Commerce	Yes
	Stacy Mills	Adventurous Consulting	Yes
	Ayoka Jack	Georgetown Day School	Yes
Brokers	Lee Bethel	Comprehensive Benefit Services	Yes
	Hannah Turner	Keller Benefit Services	Yes
	Len Gross	PSA Financial	Yes
Health Care Providers	Alex Knox	Acupuncture Society of DC	Yes
	Dr. Kemesha Delisser	National Spine and Pain Centers	Yes
Benefit Consultants	Philip Chao	Chao & Co.	Yes
	Frank McArdle	Independent Consultant	Yes
Consumers	Stephanie Akpa	Legal Aid Society of DC	Yes
	Dania Palanker	National Women's Law Center	Yes
	Wes Rivers	DC Fiscal Policy Institute	Yes
	Rob Fleming	DC Recovery	Yes
	Dave Chandra	Center on Budget Policy Priorities	Yes

Question 3: Should Issuers be allowed to add benefits to EHBs, defined as services eligible for claims submission and reimbursement?

Working group members' responses:

Stakeholder Group	Name	Organization	Response
Insurers	Stephanie Laguna	Kaiser Permanente	Yes
	Chris Culotta	Care First	Yes
	Troy Pelfrey	United Health Care	Yes
Employers	Michael Dudich	Hillwood Museum	Yes
	Katherine Stocks	DC Chamber of Commerce	Yes
	Stacy Mills	Adventurous Consulting	Yes
	Ayoka Jack	Georgetown Day School	Yes
Brokers	Lee Bethel	Comprehensive Benefit Services	Yes
	Hannah Turner	Keller Benefit Services	Yes
	Len Gross	PSA Financial	Yes
Health Care Providers	Alex Knox	Acupuncture Society of DC	Yes
	Dr. Kemesha Delisser	National Spine and Pain Centers	Yes
Benefit Consultants	Philip Chao	Chao & Co.	Yes
	Frank McArdle	Independent Consultant	Yes
Consumers	Stephanie Akpa	Legal Aid Society of DC	Yes
	Dania Palanker	National Women's Law Center	Yes
	Wes Rivers	DC Fiscal Policy Institute	Yes
	Rob Fleming	DC Recovery	Yes
	Dave Chandra	Center on Budget Policy Priorities	Yes

Question 4: In 2014, should the Exchange require that an Issuer demonstrate meaningful difference among the various QHPs it proposes to offer?

Working group members' responses:

Stakeholder Group	Name	Organization	Response
Insurers	Stephanie Laguna	Kaiser Permanente	Yes
	Chris Culotta	Care First	No
	Troy Pelfrey	United Health Care	No
Employers	Michael Dudich	Hillwood Museum	Yes
	Katherine Stocks	DC Chamber of Commerce	No
	Stacy Mills	Adventurous Consulting	Yes
	Ayoka Jack	Georgetown Day School	Yes
Brokers	Lee Bethel	Comprehensive Benefit Services	No
	Hannah Turner	Keller Benefit Services	No
	Len Gross	PSA Financial	No
Health Care Providers	Alex Knox	Acupuncture Society of DC	Abstain
	Dr. Kemesha Delisser	National Spine and Pain Centers	Yes
Benefit Consultants	Philip Chao	Chao & Co.	Abstain
	Frank McArdle	Independent Consultant	Not Present
Consumers	Stephanie Akpa	Legal Aid Society of DC	Yes
	Dania Palanker	National Women's Law Center	Yes
	Wes Rivers	DC Fiscal Policy Institute	Yes
	Rob Fleming	DC Recovery	Yes
	Dave Chandra	Center on Budget Policy Priorities	Yes

Question 5: Do you support a requirement for Issuers to offer at least one Bronze plan in the Exchange?

Question 6: Do you support a requirement for Issuers to offer at least one Platinum plan in the Exchange?

Stakeholder Group	Name	Organization	Question 5 Bronze	Question 6 Platinum
Insurers	Stephanie Laguna	Kaiser Permanente	Abstain	Abstain
	Chris Culotta	Care First	Yes	No
	Troy Pelfrey	United Health Care	Yes	Yes
Employers	Michael Dudich	Hillwood Museum	Yes	No
	Katherine Stocks	DC Chamber of Commerce	Yes	No
	Stacy Mills	Adventurous Consulting	Yes	Yes
	Ayoka Jack	Georgetown Day School	Yes	No
Brokers	Lee Bethel	Comprehensive Benefit Services	Yes	Yes
	Hannah Turner	Keller Benefit Services	Abstain	Abstain
	Len Gross	PSA Financial	Yes	Yes
Health Care Providers	Alex Knox	Acupuncture Society of DC	Yes	Abstain
	Dr. Kemesha Delisser	National Spine and Pain Centers	Yes	Abstain
Benefit Consultants	Philip Chao	Chao & Co.	Yes	Yes
	Frank McArdle	Independent Consultant	Yes	No
Consumers	Stephanie Akpa	Legal Aid Society of DC	Yes	Yes
	Dania Palanker	National Women's Law Center	Yes	Yes
	Wes Rivers	DC Fiscal Policy Institute	Yes	Yes
	Rob Fleming	DC Recovery	Yes	Yes
	Dave Chandra	Center on Budget Policy Priorities	Yes	Yes

Appendix B: Reviews of Working Group Meetings

After each meeting, working group members were provided a document which reviewed the previous meeting, in an effort to facilitate discussion at the next meeting (Note that the review of the last meeting below was not provided to members). The review documents are attached below to provide the Board with further details of the working group's discussions.

DC HBX Plan Offerings & QHP Benefit Standardization Working Group Review of Meeting #1 Held on 2/20/2013

The first meeting of the DC HBX Plan Offering and QHP Benefit Standardization Working Group was held on February 20, 2013 from 9:30 am – 12:00 pm. This document provides an overview of discussion and primary outcomes, or take-aways, from the meeting.

The Working Group's Charge

The Charge of the working group was clarified during the meeting. The Charge consists of the following four points (or questions) to address with a possible fifth, if time permits:

1. Should the Exchange limit the number of QHPs Issuers can offer at each metal tier level
2. Should the Exchange prescribe specific cost-sharing designs for QHPs
3. Should the Exchange allow issuers to add benefits to QHPs that are not Essential Health Benefits (EHB) as defined by the D.C. Exchange.
4. In deciding these issues, a number of states have also decided to require "meaningful differences among plan designs proposed by issuers, if they propose their own, non-standard designs; depending on what the working group recommends about non-standard plan designs, the issue of meaningful difference may also be relevant to the charge

Time permitting, the working group may choose to address a fifth question:

5. Should the Exchange require Issuers to offer QHPs at certain metal tier levels beyond Silver and Gold (the ACA mandates that Issuers participating in the Exchange offer at least one plan at both Silver and Gold levels)

Balance of Stakeholder Representation and Voting

The meeting included discussion of the process and procedures for the working group, including membership and voting. The chairs are currently reviewing the official list of members, to ensure the working group includes the proper balance of representation amongst stakeholders. Because the Board will give particular deference to unanimous recommendations, and refer issues lacking unanimity to a

subcommittee for further deliberation—where the various "arguments" of working group participants will be useful but not decisive--voting may not be important or even necessary. Therefore, the co-chairs decided after the meeting to leave questions of whether and how members would vote as an open issue at this time.

Official Members of the Working Group

The following table lists all members of the working group and their determined stakeholder group. As noted above, the chairs are currently determining if voting is necessary, and the list below does not indicate members with voting capability. If you believe you have been designated to the incorrect stakeholder group, or if your name does not appear on the list, please inform Wakely.

Stakeholder Group	Name of Member	Organization
Insurers	Chris Culotta Tonya Vidal Kinlow Laurie Kuiper Joseph Winn Troy Pelfrey Stephanie Laguna Sara Coleman Meghan Nechrebecki	Care First Care First Kaiser Permanente Aetna United Health Care Kaiser Permanente Care First Care First
Employers	Katherine Stocks Stacy Mills Michael Dudich Ayoka Jack	DC Chamber of Commerce Adventurous Consulting Hillwood Museum Georgetown Day School
Brokers	Len Gross Lee Bethel Hannah Turner	PSA Financial Comprehensive Benefit Services Keller Benefit Services
Health Care Providers	Dr. Kemesha Delisser Marjorie Shovlin	National Spine and Pain Centers Acupuncture Society of DC
Benefit Consultants	Frank McArdle Philip Chao	Independent Consultant Chao & Co.
Consumers	Rob Fleming Wes Rivers Dave Chandra Stephanie Akpa Dania Palanker	DC Recovery DC Fiscal Policy Institute Center on Budget Policy Priorities Legal Aid Society of the District of Columbia National Women's Law Center
Other – Neutral	Henry Aaron	Brookings Institute

Stakeholder		

Criteria for Framing Recommendations

Members of the working group proposed that the following criteria be considered when evaluating and making recommendations. This list of criteria may be refined, as the working group progresses. These criteria were "nominated," but never fully discussed and agreed upon. Moreover, there is some overlap among these criteria:

1. Accommodate existing market as much as possible so that there is not too much disruption
2. Make shopping experience as easy as possible
3. Accommodate demand for Platinum plans by employers in the current market (relates to #1 above, accommodating the current market)
4. Every Carrier should be required to offer a Bronze plan
5. Encourage Carrier participation
6. Facilitate and simplify consumer choice
7. Allow for account based plan designs(HRAs and HSAs), to which employers and employees can contribute on a tax-preferred basis
8. Ease of differentiation among QHPs
9. Clarity of choice without restricting the number of choices
10. Avoid choice overload
11. Address current market needs and future market trends
12. Accommodate demographic and taste differences among consumers
13. Choice should of those plans which "add value"
14. Administrative feasibility

Unified Market

It was pointed out that the analysis and recommendations may be heavily influenced by whether the DC Exchange is the only purchasing channel for individual households and small employers in a unified market. Until informed otherwise, the working group should assume that the market will be "unified," perhaps with a transition period.

Follow up Questions

Several follow-up questions resulted from the meeting.

- In a merged market, will individuals and small business employers/employees have the same choice of plans, or can certain plans be designated for each group? For example, can more plan choices be made available to small employers than to individuals, or must all choices available to one market segment be available to the other segment?
- What should be defined as additional plan benefits vs. "value add"?

- What happens to grandfathered plans in a unified market? For example, must the Exchange make them available to existing purchasers and enrollees?

Next Steps

A question was raised about which aspects of the charge to tackle first. The working group seemed to agree that it would be difficult to separate the question of whether to cap the number of QHPs offered from the question of whether the Exchange should prescribe one or all of them. It was suggested as a way to move the debate forward that Wakely draft some concrete alternatives (addressing both the number of QHPs and their standardization) for the work group to discuss at its next meeting, on February 22nd .

Wakely will also draft a summary of the provisions in ACA which will automatically align plan options for individual and small-group buyers in 2014.

DC HBX Plan Offerings & QHP Benefit Standardization Working Group Review of Meeting #2 Held on 2/22/2013

QHP Standardization Models

The working group reviewed six standardization model options. Each model is briefly described below and the matrix below further depicts each model. For a more detailed explanation of each model please refer to the document titled "Alternatives for Standardizing QHPs or Not".

Standardization Model Options

1. No prescribed cost-sharing designs and limited number of QHPs
2. Prescribed cost-sharing designs for all QHPs and limited number of QHPs
3. One prescribed cost-sharing design at each AV tier level and limited number of other QHPs
4. No prescribed cost-sharing designs and no limit on number of QHPs
5. Exchange prescribes an unlimited number of QHPs (logically impossible)
6. One prescribed cost-sharing design at each AV tier level and no limit on number of QHPs

Model Options Matrix

STANDARDIZATION	LIMITED NO. QHPS/ISSUER	UNLIMITED QHPS/ISSUER
None	1	4
Prescribed Designs Only	2	

Hybrid (Standard + Unique)	3	6

Standardization Model Recommendations

Each member of the working group was invited to state which model option(s) they believe the Exchange should pursue and include reasoning for their decision. The table below depicts the chosen model(s) and a summary of reasoning, by stakeholder group.

Stakeholder Group	Model Number Chosen and Reasoning
Insurers	Model # 1 or # 6 (Care First) • ACA already provides enough standardization • Consumers need options especially with a unified market • Will not disrupt market • Carriers will not want to flood market but need to meet everyone's needs • AV calculator will not allow for too many plans Model # 6 now with # 3 in the future (United) • Let the market dictate the popular plans Model # 2 (Kaiser Permanente) • Give consumers ability to make clear comparisons in a market where competition is driven by quality, service, and price rather than the basis of risk avoidance
Employers	Model # 3 • Standardization promotes competition • Allows consumers to more easily compare • Exchange can choose from variations • Eases HR admin burden and decreases confusion
Brokers	Model # 6 • Similar to model #3 but do not want to limit number of QHPs so that innovation can be maximized • ACA promotes enough standardization Model # 3 or # 6 • Standardization is necessary to provide a benchmark Model # 4 • Allows for variation with account based plans
Health Care Providers	Model # 6 • Provides both standardization and flexibility for consumers to meet

	their medical needs
Benefit Consultants	Model # 3 • Encourages consumer protection and innovation Model # 1 or # 3 • ACA already provides standardization and these models will allow the Exchange to get started easier
Consumers	Model # 3 • Gives ability of low income individuals to access their medical needs • Standardization and a limit on number of QHPs is necessary to decrease confusion • One standardized plan would not meet all consumer needs Model # 6 • Consumers need competition • Market will weed-out unwanted plans but some standardization is necessary
Other – Neutral Stakeholder	• Model #4 or # 6 do not disturb the market differently

Model numbers recommended by stakeholder group

Stakeholder Group	# 1	# 2	# 3	# 4	# 5	# 6
Insurers	X	X	X			X
Employers			X			
Brokers			X	X		X
Health Care Providers						X
Benefit Consultants	X		X			
Consumers			X			X
Other – Neutral Stakeholder						

DC HBX Plan Offerings & QHP Benefit Standardization Working Group
Review of Meeting #3 Held on 2/26/2013

Unified Market

DC's decision to unify the Exchange and the outside market was clarified as a result of a recent advisory committee meeting. The individual market will be unified at the beginning of Exchange operations, while SHOP will have a two year transition period, with the following caveats:

- New employers/employees, without previous coverage, will purchase through SHOP once the Exchange is operational and will not be subject to the transition period
- Employers previously with coverage that are switching carriers will be subject to the two year transition period
- Employers previously with coverage that are renewing coverage with the same carrier will be subject to the two year transition period

Grandfathered Plans

Individuals and employers/employees retaining coverage in grandfathered plans will do so directly through the carrier, so the Exchange will not need to offer these plans.

Addressing additional points of the Charge

Given the considerable support for either #3 or #6 above, and the sense that perhaps those who favored no limits on the number of QHPs might not want all that many plans, working group members were asked:

Questions posed to working group members

1. What is the maximum number of non-standardized plans per metal tier per issuer, for both the Individual and SHOP D.C. Exchanges, would you prefer, for 2014?
2. Should the D.C. Exchange require Insurers to offer a prescribed standardized plan at each metal tier, if the Insurer is offering plans at that tier level?
3. Because some who voted against standardization did so primarily because of their concern that there simply is not time to do so for 2014, they were asked whether their response to question 2 would change from "No" to "Yes" were it feasible to develop standard QHPs in time for 2014.

4. Finally, members were asked if they would oppose a requirement that issuers offer Bronze plans.

The table below shows the responses to the above questions by stakeholder group and member.

			Question 1		Question 2	Question 3	Question 4
Stakeholder Group	**Name**	**Organization**	**Ind.**	**SHOP**			
Insurers	Stephanie Laguna	Kaiser Permanente	3	3	Y		
	Chris Culotta	Care First	8	8	N		
	Colleen (filling in for Troy Pelfrey)	United Health Care	4	16	N		Y
Employers	Michael Dudich	Hillwood Museum	8*	8*	NA		
	Katherine Stocks	DC Chamber of Commerce	Unlimited	Unlimited	NA		
	Stacy Mills	Adventurous Consulting	8	8	Y		
	Ayoka Jack	Georgetown Day School	4	8	Y		
Brokers	Lee Bethel	Comprehensive Benefit Services	8	8	Y		
	Hannah Turner	Keller Benefit Services	8	8	N		Y
	Len Gross	PSA Financial	12	12	N		
Health Care Providers	Marjorie Shovlin	Acupuncture Society of DC	NA	NA	NA		
	Dr. Kemesha Delisser	National Spine and Pain Centers	6	6	Y		
Benefit Consultants	Philip Chao	Chao & Co.	4	4	Y		
	Frank McArdle	Independent Consultant	16	16	N	Y	
Consumers	Stephanie Akpa	Legal Aid Society of DC	3	4	Y		
	Dania Palanker	National Women's Law Center	2	2	Y		
	Wes Rivers	DC Fiscal Policy Institute	2	3	Y		
	Rob Fleming	DC Recovery	4	4	Y		
	Dave Chandra	Center on Budget Policy Priorities	3	5	Y		

*Total for tier, did not answer as per Insurer

Comments

Question 1

Consensus was not reached on this issue. Answers ranged from 2 to 16 plans per carrier per metal tier, and the majority of those who answered at the high end of the range preferred an unlimited number of plans, but would settle for their stated maximum. Also note that consensus did not exist within the insurer stakeholder group.

The working group addressed this question with the "umbrella" concept. For example, the Maryland Exchange has decided to limit Insurers to 4 plans per tier per license (HMO, PPO, etc.). Unlike Maryland, the working group decided that their answers would represent an "umbrella" for the number of plans that each Insurer could offer at each metal tier level – insurers would be able to determine how to distribute the number of plans offered across licenses.

Question 2

Consensus was also not reached on whether Insurers should be required to offer standardized plans, however the majority of members voted "Yes".

Question 3

The working group is not addressing the question of whether it is administratively feasible for the D.C. Exchange to require prescribed standardized plans for 2014. However, this question was posed to determine if this issue affected any members' decisions. One member voted "Yes" and several members still opposed standardization, even with sufficient time to make it practical.

Question 4

Two members voted "Yes" to this question. The question was posed in this manner because there were objecting viewpoints on this issue and the working group wanted to determine if a consensus could be reached. There were two primary stances:

1. Insurers are planning to offer plans at Bronze and Platinum levels anyway, there is no reason to place a requirement on Insurers. A requirement may have adverse effects on the market.(Primarily a viewpoint of Insurers and Brokers)
2. A requirement is necessary because consumers need assurance that plans will be available at all tier levels to meet financial and medical needs. (Primarily a viewpoint of Consumers and Employers)

Despite the split preferences, it seemed reasonably clear that the three issuers represented expect to offer plans at all four metal tiers. So, instead of an absolute requirement, some members suggested a more flexible approach in which either no requirement would be imposed unless the Exchange decides later it needed one, or a requirement could be waived under extenuating circumstances. Another member suggested that there might be consensus in favor of requiring all issuers to offer Bronze. Only two members voiced opposition to this requirement.

DC HBX Plan Offerings & QHP Benefit Standardization Working Group Review of Meeting #4 Held on 2/27/2013

Process for developing report to the Board

The process for developing a report to be submitted to the board was reviewed. Wakely will work with the Chairs to draft a report, which will be submitted to working group members for comment. Comments will be considered and a final version will be drafted. Members were invited to write a one-page statement, which will be attached to the end of the final report. The statement will allow members to express viewpoints to the board, which may not be detailed in the body of the report. Members also have the option to make oral comments at the March 7th Board meeting.

Re-addressing question of standardized cost-sharing designs for QHPs

During Meeting 3, members voted on the question of whether the Exchange should require Insurers to offer a prescribed standardized plan at each metal tier, if the Insurer is offering plans at that tier. In an effort to reach consensus and clarify administrative feasibility circumstances surrounding the question, the Chairs decided to re-phrase the question and present it to members for a re-vote.

It was determined that further clarification about the administrative feasibility of the Exchange designing a standardized plan for each metal tier level in time for 2014 was necessary. Members were concerned about the definition of administrative feasibility and believed that if Insurers did not want a standardized plan they could influence whether a plan could be designed in time for 2014. Due to the fact that the working group would not be determining the exact cost sharing elements of the standardized plan, members were also reluctant to vote on this issue without knowing that consumer preferences and their need for affordable access to health care services were being met.

As a result, the language of the question posed to the group was changed as follows, and a re-vote was taken:

“In 2014, and if the Board determines it is not feasible then no later than 2015, should the Exchange develop one standardized plan per metal tier with appropriate consideration of consumer preferences and need for affordable access to health care services?

Of the 19 present members, 17 voted “Yes”, 2 voted “No”, and no members abstained. A majority consensus was achieved, and the two dissenting votes were from Insurer members.

Re-addressing question of requiring Insurers to offer Bronze and Platinum plans

The ACA requires Insurers participating in the Exchange to offer plans at the Silver and Gold metal tier levels. At the previously meeting, members voted on whether Insurers should be required to offer a Bronze plan. There was some confusion as whether members were voting on the requirement for just the Bronze level or both the Bronze and Platinum level. To eliminate any confusion, questions for a Bronze and Platinum requirement were recast separately as follows, and a re-vote was taken:

- Do you support a requirement for Issuers to offer at least one Bronze plan in the Exchange?
- Do you support a requirement for Issuers to offer at least one Platinum plan in the Exchange?

For the Bronze requirement, a unanimous decision was reached, with two members abstaining. For the Platinum requirement, 10 voted “Yes”, 5 voted “No”, and 4 members abstained. Insurer members indicated that insurers plan to offer at Bronze and Platinum and there is no need to place a requirement on Insurers. Members seemed to believe more strongly that there should be a requirement for Bronze vs. Platinum to ensure that consumers have more affordable options.

Additional benefits beyond EHB

The working group discussed the potential for Insurers to offer additional benefits beyond EHB. It was determined that the group would only consider additional benefits that are defined as services eligible for claim submissions and reimbursement, and other plan offerings, such as gym memberships and wellness programs are outside the scope of the working group.

The group was posed the question, “Should Issuers be allowed to add benefits to EHBs, defined as services eligible for claim submissions and reimbursements?”

Members unanimously voted “Yes”. Members expressed that Insurers should be permitted to design plans with additional benefits to meet demanded health needs of consumers that deserve coverage.

Meaningful difference among plan designs

The group considered whether Insurers should be required to offer plans that have “meaningful difference” between plans. Meaningful difference policy decisions were reviewed from Connecticut and Vermont to give members examples of meaningful difference scenarios. However, it is outside the scope the working group to define the meaningful differences and it was discussed that members would only be recommending whether to require meaningful difference or not.

Connecticut examples of meaningful difference:

- 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 of $250 or more
    - Pharmacy deductible difference of $100 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
- Plans have difference care management (e.g. gatekeeper model; patient centered medical home; community health teams; wellness programs)
- Plans reflect different product offering (e.g. HMO, POS, PPO, ACO)
- Plan design features payment reform (e.g. pay-for-performance, tiered networks, accountable care organization)

Source: http://www.ct.gov/hix/lib/hix/Connecticut_QHP_Solicitation_(Final_12132012).pdf

Members expressed concern that their decision for the maximum number of plans that Insurers can offer per metal tier may be different depending on whether there was a meaningful difference requirement, or not.

Members voted on the question: “In 2014, should the Exchange require that an Issuer demonstrate meaningful difference among the various QHPs it proposes to offer?” There was not a unanimous consensus, as 11 members voted Yes, 6 voted No, and 2 abstained.

As members deliberated, it seemed there was a consensus among members that the need for meaningful difference increases as the number of plans offered on the Exchange increases. The group decided to vote on a follow-up question: Do you agree that the following statement should be included in the report to the Board?; “There is a sense of the working group that meaning difference standards may be more relevant when more plans are offered per carrier per tier and less relevant when fewer plans are offered per carrier per tier.”

Members agreed that a vote on the follow-question would provide the Board with guidance on whether decisions on meaningful difference should be made in conjunction with determining the maximum number of plans Insurers are allowed to offer per metal tier. There was unanimous consent for a “Yes” vote to the follow-up question.

Appendix C: Working Group Member Submissions of a Brief Statement

Working group members were invited to submit a one-page statement to the Board. The purpose of this statement is to allow members to express their views on non-unanimous issues, which may have not been fully captured in the body of the report. Individual statements submitted by members are attached below, in the order in which they were received.

Statement #1

March 4, 2013
Health Benefit Exchange Authority Executive Board

Distinguished Members of the Board:

I am a long time resident of the District of Columbia and the principal of Chao & Company, Ltd., an employee benefit consulting and investment management firm. Our clients include small businesses, tax exempt organizations, as well as national organizations. I have served as a member of the Plan Offering and QHP Benefit Standardization Working Group and participated in all four sessions. I am writing to supplement the Report to the Board.

There are numerous considerations regarding the "right" number of QHPs to be made available on the DC Health Benefit Exchange (DCX). In this regard, one tends to think of balancing choice and ease, or freedom and prudence. Decisions and considerations should not be made in silos or without regards to other components or factors. Even the best of intentions can often lead to unintended consequences. The following are a few considerations:

1) Assuming a unified market, if the DCX intends to embrace a "defined contribution" approach for the SHOP component, the number of choices to be made available under SHOP can be minimal (however defined) while the choices for individuals should be robust. Under this scheme, an employer may select a defined contribution amount for each employee and employees have the freedom to select that SHOP choice or among a wide variety of individual plan offerings to meet their needs. Further, the individual coverage if selected is portable when they leave their employment.

2) The Internet or phone based navigation system, if deigned intelligently with intuitive operational ease, guides a buyer through a series of questions and selection queries so that the buyer is never exposed to all the QHP options available on the DCX. These screening tools serve in a critical guidance role. In this case, there should be a large number of QHP options so that the outcome from the navigation can be more customized or precise to the need of the buyer.

3) Stifling innovation is one of the oft-quoted reasons to not limit choice. I think history will demonstrate that it is scarcity and limitation that is the mother of innovation. Balancing choice with selection simplicity is critical to consumer sanity and satisfaction. The Board should give serious consideration to the process consumers need to undertake in judging the merits from excessive QHP options (in the name of freedom or innovation) in order to arrive at the right selection decision. This will most likely be daunting. If the navigation tools are not robust and consumer friendly, choice becomes the enemy. The

history of 401(k) plans offers a comparable example of where participants were given significant investment choices to invest for their retirement. Twenty plus years of participant behavior has overwhelmingly demonstrated that education, communication, and disclosure have failed to make savers into good investors. Today, investment menu simplification, auto enrollment and default investing in pre-defined investment funds are the new reality.

Thank you for giving consideration to these comments. I am available to respond to any follow up questions the Board may have regarding the subject matter.

Respectfully,

Philip Chao.

703-847-4380, pchao@chaoco.com

Statement #2

COMMENTS TO DC HEALTH BENEFIT EXCHANGE WORKING GROUP ON PLAN OFFERINGS AND BENEFIT STANDARDIZATION

Acupuncture Society of the District of Columbia March 4, 2013

Summary: The Acupuncture Society of D.C. is pleased that the Working Group voted unanimously on Feb. 26, 2013 to permit carriers to offer plan benefits beyond the Essential Health Benefits (EHBs). These benefits should be structured to be both meaningful and easily evaluated by the consumer.

Who We Are: The Acupuncture Society of the District of Columbia (ASDC) is a non-profit organization dedicated to broadening opportunities for practitioners and consumers through education, legislative action, and communication. We also protect and promote the integrity of the medicine. We are the sole professional organization of Oriental medicine practitioners in D.C.

Our Comments: We would like to elaborate ***how this consensus serves consumers and where concerns may lie*:**

- Plans offering CAM give consumers a wider range of choice to meet their needs and preferences. Some consumers prefer non-invasive, non-pharmacological interventions when those interventions are safe and effective. For example, physicians are increasingly referring patients to licensed providers for acupuncture, particularly where allopathic interventions have been ineffective, or where the patient does not tolerate the allopathic interventions well.

- Studies have shown that consumer use of CAM services is on the rise. For example, a 2013 Rand study found a 16% increase in the number of users of acupuncture from 2002 (950,00 users) to 2008 (1.1 million users).[1] The NIH estimates that almost $12 billion was spent on visits to CAM practitioners in 2007, which is about 25 percent of total out-of-pocket expenditures on physician visits.[2]

- Public use and impact of acupuncture in D.C. is substantial. As of Dec. 2012, D.C. had

171 licensed acupuncturists, who delivered an estimated 17,000 treatments every month. Nationally, the profession is expected to grow 10%-19% annually, according to the Bureau of Labor and Statistics.

Plans offering CAM may reduce health care costs:

- The Rand study concluded that offering some CAM services could help accountable care organizations reduce costs and increase satisfaction, because CAM interventions are typically less costly than allopathic interventions, and because of the relatively high patient satisfaction with CAM services. For example, a Danish study showed that some acupuncture patients were able to avoid knee surgery, saving $9,000 per patient.[3]

- Research assessing cost saving achieved by acupuncture showed that "existing evidence suggests cost savings in the use of acupuncture for treating some common health problems, according toThe American Association of Acupuncture and Oriental Medicine (AAAOM).[4]

***Plans offering CAM, when properly designed, are unlikely to engender confusion among consumers but must be meaningful*:**

- Consumers interested in using CAM should be able to easily discern whether or not a given plan has a CAM option.

- Regulations should ensure that consumers choosing a plan with a CAM option are actually receiving a meaningful benefit in terms of what is covered, number of visits, reimbursement rates, etc.[2] For example, some plans offer acupuncture only for anesthesia. This service is rarely offered in the U.S., thus rendering the benefit almost meaningless.

[1] Davis, Matthew A. *et al,* US Spending on Complementary and Alternative Medicine During 2002--08 Plateaued, Suggesting Role in Reformed Health System, Health Aff January 2013 vol. 32 no. 1 45-52

[2] Nahin, R.L., et al, Costs of Complementary and Alternative Medicine (CAM) and Frequency of Visits to CAM Practitioners: United States, 2007 (/sites.nccam.nih.gov/files/news/camstats/costs/nhsrn18.pdf) National Health Statistics Reports; no. 18. Hyattsville, MD: National Center for Health Statistics, 2009.

[3] Christiansen, B.V. *et al.,*Acupuncture treatment of severe knee osteoarthritis: A long-term study. *Acta Anaesthesiol Scand,* 36(6):519-5235,http://www.ncbi.nlm.nih.gov/pubmed/1514335. 1992.

[4] American Association of Acupuncture and Oriental Medicine (AAAOM) Position Statement in Support of the Designation of Acupuncture as an Essential Health Benefit Service, January 27, 2012.

Statement #3

Comments for the Report to the Board on the Plan Offering and QHP Standardization Working Group

Provided by Hannah Turner, Legislative Compliance Consultant, Keller Benefit Services

Question 1: What is the maximum number of non-standardized plans per metal tier per Issuer, separately for both the Individual and the SHOP Exchanges, which you prefer for 2014?

Since the DC HBX will be the sole marketplace for individual and small group health insurance policies, this may be one of the most important policy decisions. It is critical HBX consumers have access to an adequate number of non-standardized QHPs from each carrier that satisfies the diverse needs of District individuals and small employers.

As was reiterated by several of the carriers participating in the working group, ACA rules (including actuarial value/metal tiers and limits on deductibles in the small group market) already limit the number of plan designs a carrier could actually create. Therefore, I recommend the Board initially impose no limit on the number of plan options and wait to see how many plan designs carriers actually file for 2014 before making a decision to limit the number of QHPs that can be offered per carrier.

However, if the DC HBX chooses to limit the number of non-standardized QHPs that a carrier can offer per metal tier, I suggest some criteria by which this limit could be formulated:

- Ensure that there are adequate plans to meet the diverse constituencies being served by the HBX. Individual consumers, very small employers (2-19 employees), small employers (20-50), and larger small employers (51-100) all have very different needs in terms of familiarity with the current market, cost sensitivity, and expectations of their health plan benefits. Too restrictive of a limit on plan offerings would make it very difficult to ensure enough plans are available to meet each constituent group's needs.
- Ensure carriers can offer several of each type of product (i.e. HMO, POS, PPO, HSA-qualified plans) per metal tier. At a minimum, 2 of each product type would equal 8 QHPs per metal tier.
- Recognize that the vast majority of existing DC small employer plans are Gold & Platinum level benefits (80%, per one carrier). If the number of plans per metal tier is limited to 4 per carrier, then existing small employers would be limited to at most 8 plans per carrier since they are expected to continue shopping at the Gold & Platinum levels. While 8 plans per carrier may seem adequate, it actually translates to 1-2 PPO options, 1-2 HMO options,… etc. **This is not enough choice for the current small employer marketplace.**

A number of stakeholders expressed support for very limited number of plan offerings per metal tier out of concern that consumers would be overwhelmed by too many choices. While I understand this concern, I propose that too much consumer choice is mitigated by other HBX capabilities and resources:

- The HBX has sophisticated filter capabilities which ask consumers a handful a simple questions in order to narrow the plan options displayed to those that best meet that consumer's needs. The District can customize these questions to best meet the specific needs of our consumers.
- Brokers, navigators, and assisters are available at no cost to consumers to provide expert guidance through the plan selection process.

If there are 150+ QHPs available to be sold in the HBX, no consumer would ever see that many QHPs in their search results. Therefore, this policy decision should be focused on ensuring enough plans are available to be offered that meet the needs of consumers, and less focused on concerns regarding consumer choice which are already addressed by other system capabilities and resources.

Statement #4

(Submitted by Troy Pelfrey of United Healthcare)

Question 2: In 2014, and if the Board determines it is not feasible then no later than 2015, should the Exchange develop one standardized plan per metal tier with appropriate consideration of consumer preferences and need for affordable access to health care services?

Comments: The desire to provide consumers on the exchange with an "apples to apples" comparison is understood. However, the standardization language as presented is too vague.

The reference to "affordable access to health care services" can be interpreted in many ways beyond benefits and cost sharing. The language is not clear as to what factors will be taken into account in developing the standardized plans. For example, will network or medical management policies become standardized across all insurers?

In addition, in the DC market today, the majority of the membership is on Platinum and Gold level plans. The insurers in the workgroup confirmed there is virtually no membership in Silver and Bronze. If there is no "consumer preference" today, what will be the criteria for determining the Silver and Bronze standardized plans?

Lastly, if the metallic levels are defined by actuarial values (determined by in network EHB cost share), this also needs to be included in the language. A standardized plan that meets consumer preference and affordable access will still be required to attain a satisfactory actuarial value per tier. The reference to the AV calculator was requested, but not included in the language above.

Statement #5

March 4, 2013

Mr. Jason Aurori, Analyst
Wakely Consulting Group on behalf of DC Health benefit Exchange Authority

Please see my comments to the DC Standardization Working Group Report:

Question 1: What is the maximum number of non-standardized plans per metal tier per Issuer, separately for both the Individual and SHOP D.C. Exchanges, which you prefer for 2014?

Comments: I initially voted for unlimited and I offered to go to a cap twelve of plans as the majority of those surveyed opted for a limit. I am still in favor of a high cap or unlimited.

It was my understanding that the majority of those who voted for a low limit on the number of plans to be offered was to avoid confusion amongst consumers primarily in the Individual Health market. Why penalize employers due to the perception that many of the Individual shoppers are not sophisticated insurance purchasers, who can

become easily overwhelmed by having too many choices? However, if the Individual and Group markets were separated, then I would be in favor of a low limit for Individual plans and a high limit for Group plans.

There are a great many employers which presently have benefits that exceed the Platinum level. This is another argument for offering many plan options, as there will be disruption; at least provide employers with many choices to replace the plans which are being terminated by ACA.

Choice - Employers have been accustomed to having many choices in developing plan offerings for their employees, based upon their understanding of what fits into their business model. As carriers presently have a multitude of plan options available, including; HMO, POS, PPO, Account based plans and multiple Rx options, carriers should be permitted to offer many plans to meet the varied market demands. Also need to take into consideration the Account based plans which will have to be created separately based upon the employer contribution to a H.S.A. or H.R.A.

Although Maryland has limited the number of plans that an Issuer can offer, Maryland is not a unified / exclusive market in 2014 or 2016 and their limit of four plans should not have a bearing on the DC HBX.

Question 4: In 2014, should the Exchange require that an Issuer demonstrate meaningful difference among the various QHPs it proposes to offer?

Comments: I oppose the additional regulation of defining what constitutes a meaningful difference. Given that issuers must offer plans that meet + or – the 2% variance of the metal plans actuary values and the great likelihood that issuers will be limited in the number of plan offerings, the meaningful differences will naturally occur.

Question 6: Do you support a requirement for Issuers to offer at least one Platinum plan in the Exchange?

Comments: Yes, Issuers should be required to offer the Platinum plan to provide consumers with choices. I understand that a Platinum plan level of benefits currently exceeds the level of benefits commonly offered on the Individual market, so an option is to not mandate the Platinum plan be offered in the Individual market, to avoid adverse selection.

Thank you for your consideration and for including me in the working group.

Sincerely,

Len Gross, Employee Benefits Advisor
PSA Insurance & Financial Services
2275 Research Boulevard, Suite 500
Rockville, MD 20850
Direct Line: 301.646.5431 Email: lgross@psafinancial.com

Statement #6

Mid-Atlantic Permanente Medical Group, P.C.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc

March 4, 2013

Kate Sullivan Hare
Chair, Plan Offerings and QHP Benefit Standardization Working Group
kate@hcwonk.com

Claire McAndrew
Vice-Chair, Plan Offerings and QHP Benefit Standardization Working Group
CMcAndrew@familiesusa.org

Re: Additional comments related to Plan Offerings and QHP Benefit Standardization

Dear Ms. Hare and Ms. McAndrew:

Thank you for the opportunity to participate in the District of Columbia's Plan Offerings and QHP Benefit Standardization Working Group. I am writing to provide additional comments on those areas within the Working Group's charge for which a consensus recommendation was not achieved.

Limitations on Number of QHPs and Standardized Cost-Sharing Designs for QHPs
Kaiser Permanente supports limiting the number of QHPs per issuer per metal tier and standardizing the cost-sharing definitions as much as possible. We believe this will prevent carriers from deploying risk selection strategies and will help consumers by minimizing confusion. Consumers will be able to make clear comparisons in a market where competition is driven primarily by quality of care, service, and price. Specifically, we recommend limiting issuers to no more than 3 non-standardized plans per metal tier per market.

The Working Group recommended the Exchange develop one standardized plan per metal tier but did not discuss associated details for those plan designs, except for some limited discussion on standardizing out-of-network benefits in addition to in-network benefits. When the standardized plans are developed, we strongly suggest that carriers not be allowed to offer out-of-network benefits as part of the standardized plan. Limiting the standardized plan to in-network benefits only will enhance the continuity of care for individuals with chronic conditions. Kaiser Permanente currently does not offer, and does not intend to offer in the future, plans on the individual Health Benefit Exchange that include out-of-network benefits, due to our integrated care delivery model and our focus on continuity of care.

Meaningful Differences between QHPs
Kaiser Permanente supports a requirement for carriers to demonstrate meaningful differences between QHPs, regardless of the number of plans required or offered per metal tier. We believe requiring meaningful differences will minimize consumer confusion. We would caution against developing meaningful difference criteria based on very specific changes in cost-sharing for key service categories (e.g. drug deductible) given the requirements of designing plans to meet Actuarial Value thresholds. Instead, we would suggest using other criteria such as product type (HMO, PPO, etc.) or plan payment structure (copay vs. coinsurance).

We appreciate your consideration of these additional comments on this important topic. Please feel free to contact me at 301-816-5817 or Stephanie.Laguna@KP.org, if you have any questions. Again, thank you for the opportunity to participate in the Working Group.

Sincerely,

Stephanie Laguna
Director, Market Strategy and Analysis
Kaiser Foundation Health Plan of the Mid-Atlantic States

Statement #7

March 4, 2013

Wes Rivers
Policy Analyst
DC Fiscal Policy Institute
820 First St. NE Suite 410
Washington, DC 20002

Comments on Non-consensus Item for DC HBX Plan Offering and QHP Standardization Work Group

Thank you for the opportunity to provide comments on the non-consensus items presented in the Plan Offering and QHP Benefit Standardization Work Group Recommendations. I provide these comments only as supplementary, updated views for the Exchange Board's consideration, and not to detract from or correct the proceedings presented by Wakely Consulting's report.

The group could not come to consensus on the following question: *What is the maximum number of non-standardized plans per metal tier per issuer, separately for both the Individual and the SHOP Exchanges, which you prefer for 2014?* Citing experiences of colleagues at community-based organizations and literature provided by Wakely, I voted for low limits on the number of non-standardized plan offerings per issuer per metal tier to alleviate confusion and overwhelming choice for the individual consumer or small employer. Upon further reflection, I believe the limits can be much more flexible for small employers than reflected in my previous vote, especially during the transition to a unified market.

I have concluded that greater flexibility on the number of plans offered in the SHOP is possible based on discussion and testimony provided at the DC Council Committee on Health Public Roundtable on February 28 and based on further reflection of the unified market proposal. Reasons we could have more flexible limits in the SHOP include:

1. With the transition approach into the unified market, several small employers voiced concern about the number of choices available in the Exchange. A more flexible limit will allow for a more seamless transition for all small groups into the unified market.
2. In the work group, carriers indicated that they are unlikely and probably unable to offer as many plans on the Exchange as they do today. However, they do need flexibility in offering multiple plans in each licensure category (HMO, PPO, POS) to provide small employers with needed choice.
3. Testimony by the DC HBX Executive Director indicated that the IT infrastructure of the Exchange will have strong filter and search options available to businesses selecting plans on the portal, limiting confusion and overwhelming information.

With these considerations in mind, I support more flexible limits on the number of plan offerings in the SHOP Exchange during the transition period if the proposal of a unified market is accepted. If the market is not unified, stricter limitation on plan offerings are necessary to limit confusion with the range of plans that would be sold in the parallel market. Any limits adopted by the Board should be revisited based on consumer experience and reaction as the transition period progresses.

Again, thank you for consideration and the opportunity to provide comments.

An Affiliate of the Center on Budget and Policy Priorities
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Statement #8

Comments on the Recommendations of the DC Health Benefit Exchange Plan Offering and QHP Benefit Standardization Working Group March 4, 2013

Dave Chandra
Senior Policy Analyst
Center on Budget and Policy Priorities
820 First St. NE Suite 510
Washington, DC 20002

I appreciate the thoroughness and accuracy of the report provided by Wakely Consulting that summarizes the recommendations and deliberations of the Plan Offering and QH Benefit Standardization Working Group. The comments I provide today are not intended to clarify or correct any information presented in the report, but rather, to provide an updated view in the hopes that the board might recognize that there is perhaps less variability in some areas of non-consensus.

In particular, one of the most controversial questions discussed by the Working Group was defining a maximum number of plan offerings permitted per carrier per tier. As the report indicates, multiple carriers and brokers appeared in favor of no limit or a high limit, to prevent the loss of flexibility for innovation and variety in plan design. Most consumer advocacy representatives, myself included, have prioritized mitigating the risk that excessive plan offerings would confuse consumers or segment the market in ways that result in risk selection.

One important issue that has a large impact on this question is the proposal of a unified market in DC in which all individuals and small employers would purchase coverage through the Exchange. This proposal has already been adopted by the Board, and so was not to be deliberated by the Working Group. Instead, the Working Group's charge was limited to the questions outlined in the report, with the understanding that the market unification proposal, while not yet officially enacted, would potentially be in place for 2014.

Based upon further reflection from discussion in the Working Group as well as information and arguments presented during the most recent DC Council Committee on Health Roundtable on the DC

Health Benefit Exchange Authority, I wish to clarify my position. Several statements contribute to this update, including:

- Several brokers indicated that carriers often provide options for an HMO, PPO, POS, and HSA/HRA plans; a per carrier per tier limit of four could essentially result in only one of each of these plan types per tier per carrier.
- Several carriers indicated that they are unlikely to file an overwhelming number of plans for sale on the exchange, and likely will file fewer than they do today. However, they have a desire to be able to offer enough products to ensure the availability of the specific plan types consumers may want to purchase.
- Several small business owners or representatives voiced concern at the hearing regarding the possibility of inadequate choice in a unified market.
- A broker representative stated at the hearing that comparably lower limits on plans per carrier per tier may be appropriate in a DC exchange, as long as a market outside of the exchange exists.
- Director Mila Kofman indicated her view that carriers could perhaps be permitted to offer a large number, possibly even unlimited number, of plans because the exchange intends to provide an effective plan finder tool to narrow options based on consumers' priorities and needs.

As a result, I believe that it may be prudent for the board to consider this important question in a similar manner to the recommendation provided by the Working Group on adopting a meaningful difference standard. Essentially, the Working Group agreed that a meaningful difference standard was more relevant in a scenario in which the Exchange permitted a greater number of plans per carrier per tier, and was less relevant if the Exchange set lower caps on the number of plans per carrier per tier. Similarly, I believe the specific standard on plan offerings per carrier per tier is contingent upon the enactment of market unification. Therefore, the Exchange could permit a higher cap on the number of plan offerings per carrier per tier than I previously supported, if the market unification proposal is adopted and takes effect in 2014. This could also include a phased-in approach of any caps, if appropriate. However, if market unification is overturned or delayed, then I maintain that reasonable plan limits are in fact necessary for the many arguments already cited in the report.

Any caps on plans per carrier per tier in the SHOP could likely be higher than those for the Individual Market Exchange. It is difficult to pinpoint an updated recommendation on what the caps should be, but this is a tentative updated recommendation including ranges:

Maximum number of plans permitted per carrier per tier in the DC Exchange		
	Individual Market*	SHOP*
Unified Market	4-8	12-20
Exchange and Parallel markets	3-5	5-10

*These values do not include any standardized benefit plan offering that may be required by the board.

Summary: If DC officially enacts the market unification proposal, I would support and potentially advocate for greater flexibility for carriers on the number of plans they may offer in each tier (or potentially a phased-in approach that would start with less restrictive limits initially). However, if the market unification proposal is reversed or delayed, then a lower cap on plans per carrier per tier should be adopted.

Statement #9

LEGAL AID SOCIETY OF THE DISTRICT OF COLUMBIA
COMMENTS ON NON-CONSENSUS RECOMMENDATIONS OF THE WORKING GROUP ON PLAN OFFERING AND BENEFIT STANDARDIZATION

For the District of Columbia Health Benefit Exchange Authority

The Exchange should limit carriers to 3[1] QHPs per metal tier in the individual market.

In Legal Aid's experience, allowing carriers to offer unlimited plans can create consumer confusion and limit meaningful choice. Legal Aid has extensive experience helping individuals who have prescription drug coverage through Medicare Part D to evaluate and enroll in drug plans that provide the most coverage with the least restrictions at the best cost. Every year we encounter individuals who are so overwhelmed with the available options that they decide to remain in their current drug plan even though a lower-cost and/or higher-coverage plan is available. Based on our experience with the Part D enrollment process, we believe that limiting the options in the individual market here will reduce consumer confusion and assist consumers with choosing the plan that best fits their health care needs. We believe that allowing carriers to offer up to 3 plans per metal tier in the individual market affords carriers sufficient flexibility to create a variety of different products without flooding the market with so many options so as to confuse consumers.

The Exchange should require meaningful differences among plan designs if carriers are permitted to offer more than 3 plans per tier.

Meaningful difference is a corollary to limiting the number of plans in the individual market. If carriers are limited in the number of plans they can offer in the Exchange, they will be incentivized to offer plans that are designed to capture large and diverse segments of the consumer market. The same is true if meaningful difference is required. Like limiting plan number, adding a meaningful difference requirement will reduce consumer confusion and expand meaningful choice, as consumers will be able to have a better sense of what distinguishes one plan from another. Accordingly, if carriers are permitted to offer more than 3 plans per tier, then the Board should include a meaningful difference requirement, with reference to the standards adopted in other states.

The Exchange should require Insurers to offer both Bronze and Platinum Plans on the Exchange.

The District of Columbia has one of the smallest populations compared to the States; it also has a lower rate of uninsured individuals. These are two of the characteristics that support a unified marketplace in the District. A sufficient risk pool is necessary for a successful Exchange, and requiring carriers to offer Bronze and Platinum plans will encourage individuals of all income levels as well as a wide array of small businesses to participate in the Exchange, as they will have choices

[1] As noted in the report, this number does not include a standardized plan, so one plan should be added to arrive at a total number for the maximum number of plans offered per metal tier if standardization is required.

in the metal levels that fit their needs. More participants and a more diversify pool of consumers participants will help to reduce the cost of premiums and ensure a vibrant Exchange.