Notes from Standard Plan Working Group Meeting
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Follow-up from last meeting

- Mary Beth emailed the comparison of DCHBX's PY17 platinum standard plan to Covered California's PY17 platinum standard plan; the sections in the PY18 Notice of Benefit and Payment Parameters proposed rule that address standardized plans and bronze plan flexibility; the percentage of employees in employee choice on SHOP; and premium information for standardized vs. non-standardized plans in the individual market.

General updates

- DISB has approved PY17 rates. On average, the CareFirst individual QHPs will have about a 23% average increase in rates, and the rates for Kaiser individual QHPs will increase by around 12%. The increases on the SHOP side are much smaller across the four carriers. Leighton noted it's conceivable that consumers in the individual market will be switching to other plans because of the rate increases, which makes the presence of standard plans so important.
- Leighton briefly mentioned that labeling standard plans as "Simple Choice" plans could be operationally feasible for PY17.

Updating the current standard plans in the individual market

Discussion of actuarial projections of PY17 standard plans using draft PY18 AV calculator

- Tammy presented the AV outputs for the current standard plans using the draft PY18 AV calculator, along with several alternate plans that demonstrated adjustments to cost sharing (3 alternate platinum plans, 1 alternate gold plan, 2 alternate silver plans, and 4 alternate bronze plans, one of which was HSA compatible).
- Tammy noted that "standard plan AV after adjustment" means the final AV for the current standard plans from the PY17 AV calculator after the actuarial adjustment was made to accommodate plans that applied a copay to outpatient surgery, a scenario the PY17 AV calculator didn't account for. (Note: the draft PY18 AV calculator now accommodates an outpatient surgery copay.)
- Tammy stated that in general, adjusting deductibles has the biggest impact on AV.
- One carrier expressed interest in developing standard plans for the silver CSR variations. DCHBX hasn't required these in the past because CSR-eligible population is so small, but carriers have to develop and file these variations because some of the population is eligible. Tammy believed she could easily develop the 94% and 87% variations, but the 73% variation would be more of a challenge. Another carrier stated that enrollment in its CSR plans is only 5% of the carrier's total enrollment, and the majority of those individuals are enrolled in the 73% variation.

- One member of the group expressed a desire for specialty drugs to have a copay instead of coinsurance in the gold or silver standard plan. Tammy said she'd make these changes and re-run the AV calculator to demonstrate the impact on AV on the next call. Leighton also requested the AV calculation for the bronze plan when the medical coinsurance was increased from 20% to 30% and the coinsurance on non-generic drugs was decreased from 50% to 30%.
- The group asked for more information about how drug manufacturer coupons for specialty drugs interact with private insurance (if at all), and one member suggested having background conversations with some patient groups in DC to see if there are specialty drugs that do not have coupons.

<u>Should there be more than one standard plan in each metal level?</u>

- Leighton stated that the draft PY18 AV calculator found an average of 66.89% for the current bronze plan (target range is 60% for bronze plan). Under the current federal rules, bronze plans must meet 60%, +/-2%, so 62% is highest allowed. The CMS proposed rule says a 65% AV would be permissible if the plan covers and pays for certain major services before the deductible applies. Tammy drafted some ways this could be done, and Leighton hoped the carrier representatives could take these to their actuaries for their feedback.

<u>Should we have standard plans in SHOP?</u>

- One carrier voiced concern that SHOP standard plans could hinder carriers' flexibility and innovation, which may impede competition. Leighton stated that carriers would need to offer a standard plan that would be common across carriers, but that carriers would still be allowed to offer as many non-standard plans as they want. Leighton stated that he understood that carriers may feel like they'd be forced to offer a new plan that's unlike their existing plans, but emphasized that any standard plan would be similar to plans they're already offering.
- Another carrier questioned the relevancy of SHOP standard plans, given that only 11% of SHOP employers offer their employees cross-carrier choice. There will be 152 SHOP plans in PY17, with a fair amount of variability. A member expressed support for SHOP standard plans given the time the working group has spent brainstorming how to increase access to benefits, and there is a population that has cross-carrier choice who could benefit. She asked for a breakdown of the number of PY17 SHOP plans per metal level.
- Tammy stated that the AV calculator is used for both individual (IVL) and SHOP plans. Last year the PY17 AV calculator didn't accommodate the situation in which a copay is applied to outpatient surgery, so we had to make an actuarial adjustment to those plans that applied a copay to that benefit. Because all actuaries don't use the same models, data, and methodologies, actuaries could get slightly different answers in the case where they have to adjust the AV calculator. But a plan that's entirely accommodated by the AV calculator would produce the same exact value for the same plan on IVL and SHOP, absent any disagreement about how the benefits should be entered into the calculator. In Tammy's perspective, a plan with an actuarial adjustment would produce the same exact value for IVL and SHOP, but one could argue that the adjustment for IVL could be different from SHOP depending on the standard population used for the adjustment. Tammy said Oliver Wyman uses the same standard population for IVL and SHOP, and there's a strong argument to use the same standard population when calculating AV for DCHBX plans because of the merged risk pool.
- One member requested information on the shopping experience of Congressional employees and whether they're on their own to compare plans. Mary Beth stated that Congressional employees have a choice of gold plans offered by the four carriers. There aren't any tools

specifically for Congressional employees, but the Plan Match tool gives information on projected out-of-pocket expenses based on factors like conditions, age, number of people in the family, etc.

- Tammy said she wasn't sure if the pediatric dental deductible was integrated into the medical deductible because the current standard plan designs show the dental deductible as zero. A pediatric dental deductible doesn't affect AV because it's not part of the calculation. Mary Beth said DCHBX would clarify that because there's a Board resolution that requires a separate pediatric dental deductible (a maximum of $50 for individual and $100 for family). Leighton asked Colin to look into whether an HSA plan can have a separate pediatric dental deductible.

<u>Follow-up</u>

- Mary Beth/Alexis will provide the number of PY17 SHOP plans by metal level; research on shopping experience of Congressional employees, including any guidance/outreach from House and Senate; research on drug coupons; research and follow up with Colin re: $0 pediatric dental deductible on current standard plan designs, interaction with HSA
- Tammy will run the PY18 AV calculator on the PY17 standard plans for these scenarios:
    - Bronze: increasing the medical coinsurance from 20% to 30% and decreasing the coinsurance on non-generic drugs from 50% to 30%.
    - Gold and silver: converting the coinsurance on specialty drugs to copays.