January 9, 2017

Recommendations of the Standard Plans Advisory Working Group to the District of Columbia Health Benefit Exchange Authority

This report is submitted by the Standard Plans Advisory Working Group, chaired by Leighton Ku and vice-chaired by Dania Palanker. The working group's charge was to modify the standard benefit plan for all metal level tiers, if necessary, to comply with the federal Actuarial Value Calculator (AVC) for Plan Year (PY) 2018. Additionally, the working group was charged with deliberating whether there should be more than one standard plan at each metal level tier in the individual market, whether there should be standard plans in SHOP, whether health savings account (HSA)-compatible standard plans should be a required offering in the individual market, and if so, at what metal levels. Other issues that arose and were discussed were the designation convention of Simple Choice plans versus standard plans, and some pediatric dental nomenclature.

Background

The working group had previously recommended standard benefit plans for all metal level tiers for PY 2017. Those recommendations were adopted by the Executive Board of the Health Benefit Exchange Authority (HBX) and are in effect for PY 2017.

Several issues were on the table for discussion by the working group for PY 2018:

1. Plan design and Actuarial Value Calculator – Changes to the federal AVC necessitated that the working group reconvene to address any necessary modifications to the standard plans. The HBX used its contract actuary, Oliver Wyman (OW), to run the PY 2017 standard plans through the proposed, and then final, AVC. Oliver Wyman concluded that the silver and bronze

plans no longer fell within the actuarial value range permitted under federal law, so that cost-sharing levels for those two plans would need to be increased to meet federal requirements. Throughout the course of meetings and discussions, OW developed options at the various metal level tiers for the working group to consider.

2. More than one standard plan in the individual market – Along with the other carriers, CareFirst filed its proposed PY 2017 forms and rates by the May 2, 2016 deadline. The filing disclosed that CareFirst, for both its PPO and HMO products, had eliminated any plans that were not the standard plans. The CareFirst offerings for PY 2017 were reduced to 10 from 15 offered in PY 2016. It was never the intent of this working group that carriers offer only standard plan options. Because of this development, the working group was charged to consider whether more than one standard plan at each metal level tier should be required in the individual market.

3. Standard plans in SHOP – Standard plans turned out to be a popular choice in PY 2016 in the individual market. The working group discussed whether standard plans should be a required offering in SHOP.

4. HSA-compatible plans – By eliminating any plans that were not standard plans in its PY 2017 forms and rates filings, CareFirst also eliminated all HSA-compatible plans, a high deductible plan meeting IRS requirements, from its PY 2017 offerings. HBX received consumer and broker complaints about this development. The working group was charged to discuss whether HSA-compatible plans should be a required offering in the individual market.

5. Simple Choice designation – The Center for Consumer Information & Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS), the federal agency that operates the federally-facilitated marketplace (FFM), uses the designation "Simple Choice" for standard plans for sale on healthcare.gov. The working group discussed whether using the Simple Choice designation would be beneficial for DC Health Link customers.

6. Pediatric dental nomenclature – HBX's standard plans display was based on Covered California's display. Covered California had changed its nomenclature in this area. The working group discussed whether a similar change should occur in the HBX display.

All of the working group's documents over six meetings, including meeting minutes, can be viewed on its HBX webpage.

Discussion

1. Plan Design and Actuarial Value Calculator

a. Platinum: The existing platinum standard plan falls within the acceptable AV range using the draft 2018 AVC (88.20% versus 90.99% PY 2017). The working group discussed three alternatives for PY 2018. Two plans featured copays that were slightly lower than the existing plan, and one plan lowered the out-of-pocket maximum from $2,000 to $1,500 and retained all other cost-sharing from the existing plan. Some working group members supported the plans with lower copays on the basis that consumers expect lower copays at this level of coverage, while Kaiser Permanente cautioned that any decrease in cost-sharing could potentially increase premiums. CareFirst supported the plan that only changed the out-of-pocket maximum because CareFirst stated it would be the least disruptive to existing enrollees.

The working group expressed consensus for keeping the current platinum standard plan. Although a few members preferred the plans with slightly lower copays, they were comfortable with maintaining the existing plan for PY 2018. The existing platinum plan was tested through the final AVC upon its release and remained within the acceptable AV range (88.20%).

Consensus: Recommend keeping the existing platinum standard plan for PY 2018.

b. Gold: The existing gold standard plan falls within the acceptable AV range using the draft 2018 AVC (88.91% versus 88.89% PY 2017). The working group considered two alternative gold plans: a plan that only changed the cost sharing for specialty drugs from a coinsurance (20%) to a copay ($150), and a slightly leaner plan that increased copays for some benefits by $10 and increased the deductible by $500. Working group members and HBX staff heard from multiple consumer groups that expressed a desire to have copays for specialty drugs instead of coinsurance, which would make it easier for consumers to estimate their costs. The working group reached a consensus to recommend the gold standard plan that retained the existing gold standard plan's cost-sharing for all benefits except specialty drugs, which would have a copay instead of coinsurance.

Consensus: Recommend the gold standard plan that only changed the cost sharing for specialty drugs from coinsurance to a copay.

The working group also discussed the possibility of adding an HSA-compatible gold standard plan. HBX board member Kate Sullivan Hare joined several calls to discuss the benefits of adding HSA-compatible standard plans, particularly at the gold level. Ms. Sullivan Hare believes there are District residents who know how to use an HSA account who want an HSA-compatible plan with richer benefits. Margarita Dilone, a broker and a board member of the Greater Washington Hispanic Chamber of Commerce, spoke to the working group about the frustration she has heard from her customers regarding CareFirst's discontinuance of HSA-compatible PPO plans for PY 2018. She stated that while it is important to have HSA-compatible plans at other metal levels, many consumers want one at the gold level because they want richer benefits and have experience using the tax benefit to lower their costs through HSA accounts. Additionally, the working group was informed of a consumer that attended an HBX Executive Board meeting to express his disappointment that CareFirst had eliminated HSA-compatible plans for PY 2018, including his specific plan.

The working group had mixed feelings on offering an HSA-compatible gold standard plan. Dr. Ku said adding such a plan would increase the choices available to consumers and potentially could have a slightly lower premium than the standard gold plan. Other members

were unconvinced that an HSA-compatible plan at the gold level was a real consumer need and felt it would be more appropriate to add an HSA-compatible plan at the bronze level only. One consumer representative on the working group expressed that if a second standard gold plan is to be added, it should not be an HSA compatible plan. CareFirst opposed adding an HSA-compatible gold standard plan on the basis that it has never offered a gold HSA-compatible plan in the individual market in any of its jurisdictions. Kaiser Permanente stated that it understands why an HSA-compatible gold standard plan would make sense in DC and would not be opposed to such a requirement. A majority of the working group opposed adding an HSA-compatible gold standard plan, with two members supporting its offering.

Since the working group was unable to reach consensus, this issue will be sent to the Insurance Market Committee for its consideration.

c. Silver: The existing silver standard plan does not fall within the acceptable AV range using the draft 2018 AVC (75.36% versus 71.72% PY 2017). The working group considered a variety of modifications to move the silver standard plan to the acceptable actuarial value (AV) range. Due to the amount of the discrepancy from the PY 2017 standard plan AV to the PY 2018 standard plan AV (3.64%), all options considered required an increase in the deductible and cost-sharing for some services. Additionally, working group members and HBX staff heard from multiple consumer groups that expressed a desire to have copays for specialty drugs instead of coinsurance, which would make it easier for consumers to estimate their costs. The working group coalesced on a proposed silver standard plan with a 71.95% AV that increases the medical deductible to $3,500 from $2,000, keeps the out-of-pocket maximum (MOOP) at $6,250, increases the cost share for some services, and changes the cost-sharing for specialty drugs from a coinsurance of 20% to a copay of $150.

Consensus: Recommend the silver standard plan as outlined above.

The working group briefly considered whether it should develop standardized cost-sharing reduction (CSR) plans, which may apply for lower-income members using silver plans. The working group concluded quickly that because the District's CSR population is so small

(because the District's Medicaid eligibility criteria reach above 200 percent of poverty), and the majority of the population is in the 73% CSR variation, which has modest cost-sharing reductions, it was not necessary to develop standardized CSR plans. Carriers can make appropriate adjustments for the small number of members who are eligible for CSR.

Consensus: No recommendation for a standardized CSR plan.

The working group also discussed the possibility of adding an HSA-compatible silver standard plan. Generally speaking, one carrier said that if the group decides to have an HSA-compatible plan, its preference would be that the group modifies the existing bronze or silver standard plan to have the HSA-compatible plan instead of adding more plans. However, a consumer representative was not comfortable with that idea. The representative expressed concern about making existing silver or bronze standard plans HSA compatible. The member expressed a desire to have more services covered pre-deductible because many silver plans have high deductibles. The member was opposed to anything that would shift the current silver or bronze standard plan to just having an HSA-compatible standard plan because it would require most benefits to be subject to the deductible.

Another consumer representative did not want an HSA-compatible silver plan because the advance payments of the premium tax credit (APTC) amount is tied to the second-lowest cost silver plan. The member recognized that the APTC population in the District is a small percentage, but having the second-lowest cost silver plan be HSA-compatible could decrease the APTC for all of those eligible for APTCs, regardless of what type of plan they select The member was concerned further about people enrolled in HSA-compatible plans who receive APTCs. The member stated that enrollees may not understand that they should set up an account and are more likely to have economic instability. The member said some enrollees may end up only receiving preventive services because they did not realize everything else was subject to the deductible and were unaware that they could get better coverage if they paid a little more. No working group member objected to either of these arguments, and the working group did not discuss the issue further.

Consensus: No recommendation for an HSA-compatible standard silver plan.

d. Bronze: Bronze plans currently must have an AV of 60%, with a de minimus variation of +/- 2 percentage points. In the Notice of Benefit and Payment Parameters for 2018 proposed rules, CMS proposed (and later finalized) to amend the de minimus range for bronze plans that cover at least one major service (other than preventive services) before the deductible to allow a variance in AV of -2 percentage points and +5 percentage points.[1] The existing bronze standard plan did not fall within the acceptable AV range using the draft 2018 AVC (66.89% versus 61.96% PY 2017). The working group narrowed down the numerous alternatives to two plans, both of which had an AV of 64.81%. The first alternative plan increased the medical and drug deductibles, the out-of-pocket maximum, and certain copays and coinsurance, while also converting the current standard plan's coinsurance for preferred brand, non-preferred brand, and specialty drugs into copays. The second alternative plan also increased the medical and drug deductibles, the out-of-pocket maximum, and certain copays and coinsurance, although to a lesser extent than the first alternative plan, and retained the current standard plan's coinsurance for preferred brand, non-preferred brand, and specialty drugs. Both alternative plans cover primary care visits and specialist visits before the deductible.

Some members supported the first plan based on its copays for prescription drugs and cautioned that the $100 copay for specialist visits in the second plan could be prohibitively expensive for some consumers. Kaiser Permanente supported the second plan because its deductible was lower, noting its perspective that keeping the deductible below $6,000 is important to preserve consumer choice. The carrier also noted that current enrollees would be used to having coinsurance for prescription drugs, and the second plan lowers the coinsurance for preferred brand, non-preferred brand, and specialty drugs by 20%. CareFirst stated that it did not have a preference between the two plans and would support the majority's decision.

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018, 81 FED. REG. 61456, 61510-61511 (proposed Sept. 6, 2016).

The working group decided upon the first plan described above, which will keep the specialist visit copayment below $100.[2]

Consensus: Recommend the bronze standard plan as outlined above.

The working group also discussed the possibility of adding an HSA-compatible bronze standard plan. CareFirst stated that its bestselling plan in all of its jurisdictions is a lean bronze HSA plan that has a 58% AV. Over the course of the discussions, all working group members became comfortable with having an alternative bronze plan that is HSA-compatible. Kaiser Permanente wanted the HSA-compatible plan to have a lower AV, close to 58%, for people who are price sensitive. Ms. Sullivan Hare pointed out that since HSA-compatible plans prohibited embedded deductibles, people with family coverage would have to pay thousands of dollars before the carrier pays for coverage. She said families would be unable to set aside the amount of money they needed in an HSA account because it would exceed the permitted annual contribution amount. CareFirst responded that historically the individual market has served mostly individuals without dependents. The carrier stated that HSA-compatible plan would not be a family's first option; many families choose plans with lower deductibles. According to CareFirst, many people who buy HSA-compatible plans use them as catastrophic coverage, and many people purchase HSA-compatible plans when they age-out of eligibility for catastrophic plans. The carrier stated that there is a market for HSA-compatible plans, but it is not the market for everyone.

In further discussions, it became clear that even the most minimal HSA-compatible plan would have an AV above 60%, because these plans must have a somewhat lower out of pocket maximum than other non-HSA-compatible plans. The working group members agreed to support an HSA-compatible plan with an AV of 60.95%. The medical deductible

[2] The proposed variance in AV of -2 percentage points and +5 percentage points for bronze plans that cover at least one major service (other than preventive services) before the deductible was adopted as proposed. *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program, 81 FED. REG. 94058, 94142-94143 (Dec. 22, 2016).

is $6,200 and the MOOP is $6,550.[3] The group recognized that relatively few low-income people who purchase bronze plans would be able to deposit much into actual HSAs, but felt that making HSA-compatible plans available could reduce monthly premiums, as many consumers desire.

Consensus: Recommend the Bronze Standard HSA-compatible plan as outlined above.

e. Additional standard plans: Whether to require the offering of more than one standard plan in the individual market was discussed throughout the above discussions and primarily in the context of adding an HSA-compatible plan. The working group decided only to add another plan to bronze which was HSA-compatible, and did not reach consensus on additional standard plan offerings.

2. Standard Plans in SHOP

The working group was charged to discuss whether standard plans should be a required offering in the SHOP market. With one exception (Kaiser), the carriers did not think standard plans in SHOP were necessary. At the first meeting, CareFirst thought was that SHOP standard plans aren't necessary since employers have brokers to explain the differences between plans. A consumer representative noted that not all employers use brokers, and employees of employers that have opted to have "employee choice" don't have the benefit of broker advice. (An employer that selects employee choice allows its employees to choose from all plans from a single carrier or a certain metal level tier from all carriers in lieu of enrolling all employees into a single plan.)

Over the course of the following meetings, HBX staff provided research into the number of SHOP plans by metal level, and statistics regarding how many employers offered choice to their employees. At the point in time the research was conducted, 11% of employers offered employee choice in SHOP, and a CareFirst questioned the relevancy given the low employer participation

[3] The IRS has not announced the 2018 inflation-adjusted minimum annual deductible and maximum annual out-of-pocket expenses limit for HSA-compatible high-deductible health plans (HDHPs).

in employee choice.[4] A consumer representative 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.

With the exception of Kaiser, carriers thought that standard plans in SHOP would require too much administrative work. Since the working group clearly had mixed opinions on this topic and in light of the multiple issues that needed to be addressed by the working group, the Chair and Vice-Chair, with the consent of the members, decided to set this issue aside for PY 2018.

Discussion of SHOP standard plans for PY 2018 tabled.

3. Simple Choice Designation

Dr. Ku told the working group that the federal government requires standard plans in the FFM to be called "Simple Choice" plans (instead of "standard" plans) in 2017 and wanted feedback on whether HBX should adopt this terminology for standard plans or come up with its own for PYs 2017 and 2018.

In thinking about the issue, some carriers and consumer representatives worried about the possibility of confusion since the HBX Simple Choice plans would not be the same as the FFM Simple Choice plans, and Virginia is in the FFM.

However, the main point that carriers were concerned about was the naming convention of the plans themselves. If a name change were required, that would provoke an enormous amount of administrative work, including re-filing all the forms with the Department of Insurance, Securities and Banking.

Dr. Ku said that renaming plans might not be necessary as it could be accomplished by changing how the plans are displayed on the website. The working group agreed that HBX could make display changes in the plan shopping, but that the carriers need not change the names of their

[4] The number of employers in SHOP has increased dramatically since this discussion took place. As of December 30, 2016, 55% of employers in SHOP participate in employee choice.

plans.

4. Pediatric Dental Nomenclature

HBX's standard plans grid was based on Covered California's grid. Covered California had changed its nomenclature in this area. The working group discussed whether a similar change should occur in the HBX grid. However, after research and discussion, the working group determined not to change the grid. The grid is primarily a tool for carriers and HBX, and is not a forward-facing consumer document. Since no problem has been encountered to date with the nomenclature, there is no reason to change it.

Recommendations

Over the course of the meetings, the working group reached consensus to recommend amendments to the 2017 standard plans as noted above and reflected in the attached displays for PY 2018. (Attachment)[5]

Non-Consensus Item

The working group did not reach consensus on whether to add an HSA-compatible gold standard plan, and the matter was referred to the Insurance Market Committee.

Working Group Members

The Standard Plans Advisory Working Group is comprised of representatives from qualified health plans, consumer groups and trade associations. Six meetings were held, on September 21 and 29, October 13, November 16 and 30, and December 14, 2016 by conference call. Recommendations were reached over the course of the meetings.

Leighton Ku, Chair	GWU Center for Health Policy Research
Dania Palanker, Vice-Chair	Georgetown
Marcy M. Buckner	National Ass'n of Health Underwriters

[5] After the working group set aside the standard plans in SHOP issue, the carriers that do not participate in the individual market either abstained from voting on the recommendations that affect only the individual market or were not on the call when the vote was taken.

Dave Chandrasekaran	DC Health Link Consumer
Stephanie Cohen	Golden & Cohen (NFP)
Kelsey Grigsby, John Anders	Aetna
Joshua Keepes, David Kennedy	America's Health Insurance Plans
Lydia Mitts	Families USA
Cindy Otley, Robert Metz, Jennifer Storm, Ranaye Weinapple, others	CareFirst
David Smith, Seung Baick, John Fleig	UnitedHealthcare
Pia Sterling, David Wilson, Tiffinie Severin, John Xu	Kaiser Permanente
Colin Reusch	Children's Dental Health Project
Staff Advisors & Support	
Mary Beth Senkewicz	HBX
Alexis Chappell	HBX
Purvee Kempf	HBX
Howard Liebers	DISB
Tammy Tomczyk, Sarah Langford	Oliver Wyman

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