April 4, 2016

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) 2017.

Background

The working group had previously recommended standard benefit plan for all metal level tiers for PY 2016. Those recommendations were adopted by the Executive Board of HBX and were in effect for PY 2016. Changes to the AVC necessitated that the working group reconvene to address any necessary modifications to the standard plans. HBX used its contract actuary, Oliver Wyman, to run the PY2016 standard plans through the AVC. Oliver Wyman concluded that the Bronze plan no longer fell within the actuarial value range permitted under federal law. Additionally, CareFirst concluded that the Gold plan also no longer fell within the actuarial value range permitted under federal law.

Although the Platinum plan's benefits have not changed, the actuarial value does change, but it is still within the permissible range of +/- two percent.

At the request of the Department of Insurance, Securities and Banking (DISB), HBX staff asked OW to test the standard plans for compliance with federal mental health parity (MHP) requirements. The OW result was that modifications needed to be made to the silver and bronze standard plans to comply with MHP.

Introduction

Dr. Ku stated that the working group, in these initial discussions, would be discussing the standard plans in the individual market as outlined above. He noted that after the standard plans in the individual market were set, the group would reconvene in the future to discuss whether there should also be standard plans in the small group market, DC Health Link SHOP. Also, in a recent rule, CMS set forth optional standard plans for the FFMs. Dr. Ku thought the working group should review CMS' work to see if anything proposed was worthy of incorporating into DC Health Link standard plans.

Discussion

Gold Individual Plan

The working group first discussed the discrepancy between OW and CareFirst about the Gold plan. Oliver Wyman stated that it had assumed that any benefit not listed in the standard plans grids was subject to any applicable deductible and cost-sharing. CareFirst, however, had a different benefit that it used in its calculations. CareFirst utilizes a facility copay for non-surgical services that is different from the outpatient surgery facility copay. The incorporation of that benefit into the AVC accounted for the different results between OW and CareFirst.

CareFirst contended that its facility copay for non-surgical services was more consumer-friendly in that it was less out-of-pocket to the consumer than an outpatient surgical facility copay. Working group members ultimately concurred, and a new benefit reflecting the different copay was added to the gold plan grid. For consistency, the new benefit was also added to all the metal level tier standard plan grids. However, due to Kaiser's staff model HMO, the new benefit did not apply in that those services are received in a Kaiser facility without an additional copay. The working group decided to "asterisk" the benefit to make it clear that it might not apply in a staff model situation. Working group members noted that the grids are used by carriers, not consumers, and that the SBCs (summary of benefits and coverage) would give more precise information to consumers in this regard.

The working group noted that moving forward, any benefit not listed in the standard plans grids was subject to any applicable deductible and cost-sharing with no deviations.

Bronze Individual Plan

As part of its work for the working group, OW set forth a few scenarios for Bronze plan AVC compliance. CareFirst also offered a new scenario for Bronze that was very similar to one of the OW options. The working group noted that it wanted to maintain the cost-sharing for services received that are not subject to the deductible as they are without raising them as much as possible. Such services in include preventive care and generic prescription drugs. However, in order to accomplish that goal, it would be necessary to increase overall cost-sharing. The medical deductible needed to rise by $500 to $5,000 and the prescription drug deductible by $50 to $300.

Mental Health Parity

As noted above, OW reviewed the standard plans for Mental Health Parity (MHP) compliance. There are two tests that MHP benefits must pass; the first is called the Predominant Test and the second is the Substantially All test. MHP compliance divides mental health services into six categories: inpatient in-network; inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care; and Rx. Each of the two outpatient categories may be further subdivided into office visits and all other outpatient services. Calculations are made so that when performing these tests, services are measured by dollars.

Oliver Wyman concluded that the standard Silver and Bronze plans are not compliant. The issue is that there cannot be two different "types of financial requirement" between mental/behavioral (M/B) health outpatient services and all other outpatient services. Under the CMS regulation the types of financial requirements are defined as deductibles, coinsurance, copayments and out-of-pocket limits. Therefore, M/B services in an outpatient hospital setting must have the same type of financial requirement as the predominant type of financial requirement (defined as the type of financial requirement that applies to at least two-thirds of the non-M/B costs in the category). The predominant type of financial requirement for outpatient services for these plans is deductible and coinsurance. However, office visits may be defined as a separate category, so M/B office visits can have a different type of financial requirement.

The working group originally wanted to keep cost-sharing low for M/B office visits to enhance availability of and access to services. Therefore, the working group decided to amend the M/B benefit grid to accommodate a third category of services, the office visit. For the Silver and Bronze standard plans, the office visit correlates to the primary care office visit at $25 and $50, respectively. For M/B outpatient services in Silver and Gold, the copay needed to be translated into an actuarially equivalent coinsurance. Those amounts need to be changes from $25 and $50 to 5% and 10%, respectively, the lowest coinsurance that will still pass the AVC.
For consistency, the M/B grid on Platinum and Gold were changed to reflect the M/B office visit.

Recommendations

Over the course of the meetings, the working group reached consensus to recommend amendments to the 2016 standard plans as noted above and reflected in the attached grids for PY 2017. (Attachment)

Working Group Members

The Standard Plans Advisory Working Group is comprised of representatives from qualified health plans, consumer and trade associations. Four meetings were held, on March 3, 11, 23, and 28, 2016 by conference call. Consensus recommendations were reached over the course of the meetings.

Leighton Ku, Chair	GWU Center for Health Policy Research
Dania Palanker, Vice-Chair	National Women's Law Center
Marcy M. Buckner	National Ass'n of Health Underwriters
Dave Chandrasekaran	DC Health Link Consumer
Stephanie Cohen	Golden & Cohen (NFP)
Kelsey Grigsby	Aetna
Lydia Mitts	Families USA
Cindy Otley, Robert Metz, Brad Boban, others	CareFirst
Pia Sterling, David Wilson	Kaiser Permanente

Colin Reusch	Children's Dental Health Project
Staff Advisors & Support	
Mary Beth Senkewicz	HBX
Howard Liebers	DISB
Tammy Tomczyk	Oliver Wyman

The working group gratefully acknowledges the work of Ms. Tomczyk in support of the working group's deliberations.