The Commonwealth of Massachusetts
Commonwealth Health Insurance Connector Authority
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MARYLOU SUDDERS
Board Chair

LOUIS GUTIERREZ
Executive Director

Board of the Commonwealth Health Insurance Connector Authority

Minutes

Thursday, March 10, 2016
2:00 PM to 4:00 PM

One Ashburton Place
Boston, MA 02108
21st Floor Conference Room

Attendees: Louis Gutierrez, Marylou Sudders, Daniel Judson, Mark Gaunya, Rina Vertes, Celia Wcislo, Nancy Turnbull, Louis Malzone, Kristen Lepore, Michael Chernew, Dimitry Petion. Andrew Stern attended as the designee of Dolores Mitchell.

The meeting was called to order at 2:06 PM.

I. Minutes: The minutes of the February 11, 2016 meeting were unanimously approved.

II. Executive Director's Report: Mr. Gutierrez began the meeting by comparing current Health Connector enrollment to enrollment last year. He stated that currently, there are approximately 208,000 members enrolled in Qualified Health Plans (QHPs), compared to 124,000 QHP enrollees at this time last year. He noted that the ConnectorCare population has nearly doubled in size in that time. He added that unsubsidized and Advance Premium Tax Credit (APTC)-only membership increased from 44,482 last year to 51,695 this year and that as of March 1, dental membership was at approximately 55,000, up from about 30,000 last year. He stated that improvements are also reflected in customer service, with an overall satisfaction rate of 73% in February 2016 compared to 38% in February 2015. He noted that Massachusetts Association of Health Plans (MAHP) commended the Health Connector's operational improvements on behalf of MAHP's member insurers. Mr. Gutierrez then reviewed the agenda for the meeting, noting that one contract matter will be discussed, followed by two policy issues: finalizing the 2017 affordability schedule and a

preliminary look at the proposed 2017 Seal of Approval (SOA). He stated that the SOA process is an important expression of policy and that the Health Connector is trying to balance the ability for consumers to shop easily while promoting plan choice. He added that the SOA proposal aims to reduce administrative overhead for carriers and the Health Connector. He noted that the SOA proposal promotes, where possible, value and health outcomes in plan designs. He stated that the Health Connector worked closely with insurance carriers on early drafts of SOA recommendations and made adjustments in response to their feedback. Lastly, Mr. Gutierrez introduced the Health Connector's new Chief Actuary, Edith Boucher Calvao.

III. Risk Adjustment Data Validation Work Order (VOTE): The PowerPoint presentation "Risk Adjustment Data Validation Work Order (VOTE)" was presented by Edward DeAngelo and Michael Norton. Mr. Norton began by stating that the Health Connector seeks approval to execute a work order governing services with its existing Risk Adjustment Data Validation (RADV) auditor from March 2016 to February 2017 for an amount not to exceed $1.6M. He stated that the existing RADV auditor, FTI Consulting, Inc. (FTI), was approved for selection at the April 2015 Board of Directors meeting. He explained that although Massachusetts suspended RADV for the 2014 benefit year, FTI had begun work that can be leveraged for the 2015 benefit year. He stated that federal and state funds, as well as an issuer user fee, will support the costs of the RADV audit. Mr. Norton then provided an overview of the RADV process, stating that the Affordable Care Act (ACA) requires a state operating its own risk adjustment program to perform RADV to ensure program integrity. He noted that since 2015 is considered a pilot year for the program, there will be no financial implications if errors are found during RADV this year. In response to a question from Ms. Turnbull, Mr. Norton replied that risk adjustment calculations are based on data supplied by carriers and that if the error rate found during RADV is above a certain threshold, it would be extrapolated and relativities would be rerun, which could result in debits or credits among insurers. Mr. Chernew clarified by saying that risk adjustment is moving forward but that the auditing portion will not modify the current risk adjustment process. Next year, he added, once RADV is completed, it may result in financial consequences for some plans. Mr. Norton then reviewed the RADV auditor's scope of work for the 2015 benefit year.

In response to a question from Mr. Petion, Mr. Norton stated that FTI's work was capped at $1.6M last year, but FTI was only paid approximately $300,000 because RADV was suspended mid-year. He added that while some work from last year can be leveraged this year, new data needs to be used to create a stratified sample of 2015 members. In response to a question from Mr. Malzone, Mr. Norton explained that only $300,000 was paid last year because work was suspended and confirmed that the $1.6M figure is a not-to-exceed amount. Mr. Norton then reviewed RADV funding sources, noting that carriers, the Commonwealth and the federal government will share the costs of RADV. He added that the carrier user fee is estimated to be about $728,000, and that federal Level 2 Establishment grant funds may also be used if available. He noted that remaining costs to the Health Connector were included in the Fiscal Year 2016 budget approved by the Board in July 2015. Next, Mr. Norton discussed next steps in the RADV process. The Board voted unanimously to authorize the Executive Director to enter into a new work order with

FTI Consulting, Inc. to perform RADV auditing for benefit year 2015 during the period of March 11, 2016 to February 28, 2017. In response to a question from Ms. Wcislo, Mr. Norton confirmed that carriers hire their own vendors to collect medical records.

IV. Final Affordability Schedule for Calendar Year 2017 (VOTE): The PowerPoint presentation "Final Affordability Schedule for Calendar Year 2017 (VOTE)" was presented by Marissa Woltmann. Ms. Woltmann explained that the proposed affordability schedule was released for public comment following the last Board meeting. She stated that for individuals with household incomes up to 400% of the Federal Poverty Level (FPL), the proposed schedule applies the 2016 affordability standards to updated FPL standards, and for individuals with household incomes over 400% FPL, the proposed schedule would result in a slight increase from 8.13% to 8.16% to keep pace with an indexed federal standard. She added that staff researched two potential policy changes to the affordability schedule – the inclusion of cost sharing and automatic indexing – but decided not to pursue such changes at this time. Next, Ms. Woltmann reviewed the public comments received, stating that the only comment was received from the Affordable Care Today (ACT)!! Coalition. She stated that the comment letter expressed support for progressivity in affordability standards for low-income individuals, conveyed appreciation for the Health Connector's exploration of ways to incorporate cost sharing into the affordability schedule, and encouraged the Health Connector to continue considering its role in addressing rising out-of-pocket costs for consumers. She stated that, as no changes were requested, Health Connector staff recommend adoption of the affordability schedule as proposed at the February Board meeting. In response to a question from Secretary Sudders, Ms. Woltmann confirmed that the ACT!! Coalition did not recommend changes to the affordability schedule but encouraged continued discussion around affordable health coverage for consumers. Ms. Turnbull commented that it is important to continue to determine ways to incorporate cost sharing into the affordability schedule. The Board voted unanimously to approve the issuance of the Affordability Schedules for Individuals, Couples and Families for Calendar Year 2017, as set forth in the staff recommendation, as final.

V. 2017 Qualified Health and Dental Plan Seal of Approval: The PowerPoint presentation "2017 Qualified Health and Dental Plan Seal of Approval (SOA)" was presented by Heather Cloran, Ashley Hague and Brian Schuetz. Ms. Hague began the presentation by providing an overview of the SOA process, stating that the process begins early each year and runs through Open Enrollment. She stated that it is important to streamline the shopping experience for consumers and allow them to do "apples-to-apples" comparisons before choosing a plan. She explained that this year, the SOA aims to focus the number of QHPs for sale as well as align Qualified Dental Plan (QDP) rules to be in parity with the QHP product shelf. She added that the 2017 SOA also aims to reduce the administrative effort required of carriers, such as leveraging data submitted to other agencies to reduce duplicative submissions, and explores ways to improve health outcomes through opioid use disorder therapy and chronic disease management. Mr. Schuetz then highlighted the proposed changes in the 2017 SOA for QHPs. In response to a question from Ms. Wcislo, Mr. Schuetz explained that SHOP is the Small Business Health Options Program, the federal name for the small business platform. Ms. Hague added that under the ACA, SHOP

is more synonymous with Employee Choice but for the Health Connector, SHOP encompasses the whole small business platform. Mr. Schuetz then reviewed proposed SOA changes for the 2017 QDP shelf and noted that proposed changes for QDPs focus on bringing parity between the QHP and QDP shelves. In response to a question from Secretary Sudders, Mr. Schuetz clarified that "parity" refers to aligning the QHP and QDP shelves with the same restrictions and opportunities. He added that previously, there was variation in the number of non-standard QDPs that carriers could offer. Mr. Malzone expressed concern that parity could introduce too many plans, and Ms. Hague stated that rules are being instituted that suggest the number of dental plans would decrease. Mr. Schuetz then reviewed the framework guiding the 2017 SOA proposal: standardization, choice, administrative simplification and promoting value and health outcomes.

Mr. Schuetz first discussed standardization. He stated that currently, some but not all benefits are standardized, making a complete "apples-to-apples" comparison difficult for consumers. He stated that this year, the SOA proposal recommends standardizing seven additional benefits. He added that this proposal reflects feedback received from stakeholders. In response to a question from Ms. Turnbull, Mr. Schuetz stated that not all benefits are standardized because there are more than 90 benefits and complete standardization would represent a significant change from the current state. He added that Health Connector staff aimed to standardize those benefits most valuable to consumers in this proposal. Mr. Chernew noted that insurance designs tend to be confusing for patients because insurance is designed to support payment to different entities and patients do not think of their care in different segments. For example, he stated, primary care and lab tests can be billed separately, yet the patient may not be aware that those are considered separate benefits. He added that Medicare Part D has decision support tools to help educate consumers. Ms. Hague stated that the Health Connector has considered a formulary search, but noted that it would change often and require frequent updates. Ms. Wcislo emphasized the importance of supplying consumers with aids to help them in the shopping experience, and Secretary Sudders echoed the need to create a user-friendly experience. Mr. Schuetz then discussed Bronze plans and noted that last year, carriers were asked to develop non-standardized Bronze plan designs that met the challenge of satisfying both the 2016 Actuarial Value (AV) calculator and Minimum Creditable Coverage (MCC) requirements. This resulted in a broad array of plan designs, he stated. He stated that Health Connector staff recommend creating an MCC-compliant plan leveraging co-pays for prescription drugs, known as Bronze B, but noted that other designs were offered for consideration. In response to a question from Ms. Turnbull, Mr. Schuetz stated that Bronze B is recommended because it is MCC compliant and because co-pays present consumers with additional certainty when compared to coinsurance. In response to a question from Ms. Vertes, Mr. Schuetz stated that Bronze D is not recommended because it is not MCC compliant and would therefore require carriers to resubmit their plans for MCC accreditation. Ms. Hague added that carriers submitted last year for MCC accreditation so it would be possible to choose the Bronze C or Bronze D options, yet they would not meet MCC as originally submitted. In response to a question from Mr. Chernew, Ms. Hague stated that, under the ACA, cost-sharing reductions (CSRs) do not apply to any tier other than Silver. Ms. Turnbull noted that the recommendation favors a lower deductible but has slightly higher co-pays. Mr. Gaunya stated that MCC was established in 2006 and that

deductibles have not been indexed in the 10 years since MCC was created. Ms. Hague stated that the MCC regulations were revisited in 2012 and the concept of indexing was introduced but, since it was tied to ACA indexing that was subsequently repealed, indexing no longer occurs. She added that Health Connector staff are interested in revisiting indexing, but focused on creating a plan that met MCC this year. Ms. Wcislo commented that medical inflation should not be passed on to the consumer. Mr. Gaunya agreed that costs should not be passed on to consumers, but stated that the current cap does not recognize the rate of medical inflation. Mr. Chernew noted that if plans are made more generous, that would affect the discussion around affordability. Ms. Vertes stated that she thinks it is more consumer-friendly to have lower co-pays, particularly on primary care visits and prescriptions. She therefore prefers the Bronze D design, she stated. In response to a question from Secretary Sudders, Ms. Hague stated that the first SOA vote will be on the conditional SOA at the July Board of Directors meeting. She added that the conditional SOA is subject to formal rate filings. She noted that the Bronze B design, rather than Bronze D, was included in the Request for Responses (RFR) but added that the RFR could be amended. In response to a question from Mr. Malzone, Ms. Hague clarified that the Bronze B and Bronze D plan designs being proposed are not currently offered on the QHP shelf. She added that there are currently about 7,500 individuals enrolled in Bronze plans and that the most popular deductible is $2,750, followed by $2,500. Mr. Petion emphasized the need to be more customer friendly. He stated that it is difficult for individuals to discern the true cost of these insurance products and that the deductible does not truly address the cost for someone who is chronically ill. In response to a question from Mr. Petion, Ms. Hague stated that the Health Connector can provide demographic information of Bronze plan enrollees, such as age and geography, but that it does not have access to enrollee health outcomes data. Mr. Schuetz then discussed a recommended modification to plan names in the shopping experience, stating that Health Connector staff recommend including a "Standard" identifier, and the plan's metallic tier, in front of the plan marketing name in the shopping experience to help consumers more easily identify standard plans while shopping. In response to a question from Ms. Wcislo, Mr. Schuetz stated that the "Network Note" flag identifies plans with smaller or tiered networks and that consumers can hover over the flag for more information.

Next, Mr. Schuetz discussed choice considerations in the SOA proposal, stating that a goal in this year's SOA is to balance consumer choice with the need for simplicity. He reviewed the number of plan offerings by year and stated that the 2017 number is an estimate based on experience in prior years. Ms. Hague added that there was an increase in the number of plans offered when the ACA was implemented because many carriers that previously only offered Medicaid products began to offer commercial products. Mr. Schuetz then discussed Gold plans, stating that the 2017 SOA proposes to eliminate the Gold A plan design as there are currently two Gold plans. He added that this would be a removal of a carrier requirement, but that it does not prevent carriers from offering a second Gold as a non-standard plan. In response to a question from Ms. Turnbull, Mr. Schuetz stated that Neighborhood Health Plan's Gold A plan may be significantly more popular than its Gold B offering because of its price and its network access. Ms. Hague added that both network and price tend to drive consumer decisions. Mr. Chernew stated that although these Gold plans are equivalent under the federal AV calculator, the Gold A design may be less

generous than Gold B. Ms. Vertes stated that Gold A is likely the least expensive plan on the Gold tier. In response to a question from Secretary Sudders, Mr. Schuetz stated that Gold A plans would not necessarily be closed under this proposal because carriers could still offer them as non-standard or frozen plans. Mr. Schuetz then discussed non-standard and frozen plans, stating that carriers can offer up to three non-standard plans. He noted that carriers have a large number of potential offerings but, on average, carriers only offer 54% of their allowed maximum number of plans. He added that the Health Connector continues to seek feedback regarding the appropriate number of non-standard plans. He discussed frozen plans and stated that frozen plans do not count against the maximum number of plans a carrier can submit. He reviewed charts with the potential maximum plan offerings, but noted that actual plan counts will depend on individual carrier decisions. In response to Ms. Vertes' prior comment regarding the cost of the Neighborhood Health Plan Gold A plan, Ms. Hague stated that Boston Medical Center Health Plan's Gold A is the lowest cost Gold A plan and that Neighborhood Health Plan's Gold A is the second lowest.

Mr. Schuetz then discussed the third component of the 2017 SOA proposal: administrative simplification. He stated that the proposed changes represent administrative simplification for health insurance carriers in both the quantity of materials required as well as how materials are submitted. He added that required information will be formatted in a way that is easier to enter and consume. He stated that the Health Connector will leverage materials already submitted to other agencies and that signoff processes will be formalized.

Mr. Malzone remarked that providers bear the final burden of having to adjust to the proliferation of plan designs. He stated that they have requirements to meet to provide plans for Medicare, Medicaid, the Health Connector and the individual market, requiring extensive coding at doctors' offices. He noted that this is a large embedded cost that is often overlooked. He stated that $300 billion is spent on healthcare administration, and likely about $10 billion is spent in Massachusetts. Mr. Gaunya commented on the importance of transparency and stated that health insurance is expensive because healthcare is expensive.

Next, Mr. Schuetz reviewed the last piece of the 2017 SOA proposal: promoting value and health outcomes. He stated that one focus is on pediatric health services and that the inclusion of pediatric dental benefits is strongly encouraged in the SOA and that the Health Connector is considering requiring pediatric dental benefits in the 2018. Ms. Turnbull stated that she would like pediatric dental benefits to be required. Ms. Hague replied that carrier feedback was solicited and at least one responder was concerned about a pediatric dental requirement. She added that if a carrier says they will not include pediatric dental benefits, the Health Connector will require documentation outlining the obstacles the carrier faces that prevent it from offering the benefit. She added that this will inform the process if it becomes a requirement in the 2018 SOA. Ms. Turnbull stated that many carriers already provide this benefit through contracts with MassHealth. In response to a question from Secretary Sudders, Ms. Hague stated that the ACA requires pediatric dental as an Essential Health Benefit (EHB) but if an exchange is able to offer a standalone pediatric dental plan, carriers are not required to embed the pediatric dental benefit in their health plans. Ms. Vertes stated that if pediatric dental is required off of the exchange, it

should also be a requirement on the exchange. Mr. Gutierrez noted that the proposal to strongly encourage pediatric dental inclusion is a courtesy to carriers as the Health Connector transitions toward requiring that pediatric dental be required in 2018. Mr. Schuetz then discussed value-based insurance design (VBID), another focus of the 2017 SOA. He explained that VBID is an insurance design in which cost-sharing amounts are based on the value of services provided. He stated that the Health Connector is seeking feedback from carriers, academics and other experts to understand how VBID can be incorporated into the SOA going forward. Mr. Schuetz stated that through the 2017 SOA, the Health Connector is considering ways to support solutions to the crisis of opioid abuse. He stated that one consideration is to require carriers to report on their treatment and management of opioid use disorder, as well as through plan designs such as network adequacy requirements, for example. Ms. Hague stated that the Health Connector is keeping in mind the need to appropriately navigate mandated benefit requirements while also ensuring it effectively uses the tools it has to effect change. Ms. Wcislo stated that the Boston Public Health Commission piloted a program to provide emergency medical responders with Narcan, which has been very effective, but commented that support to treat this epidemic should be spread across the insurance industry.

Mr. Schuetz then reviewed the proposed 2017 standardized QHPs and noted that the newly-standardized benefits are highlighted in the chart. In response to a question from Mr. Chernew regarding how cost-sharing reductions are spread across different benefit categories, Mr. Schuetz explained that unique plan designs are defined as part of the ConnectorCare process. He stated that the Commonwealth and the federal government pay carriers in advance to cover the cost differences, which is then reconciled later based on actual utilization of services. He added that the consumer won't see the costs displayed in this chart. Ms. Hague stated that consumers will never see the cost-sharing designs on the base Silver plan and that the ConnectorCare plan designs are standardized. She added that the Health Connector can share with Mr. Chernew the alternate Silver plan designs used for the allocation between the federal government and the Health Connector. In response to a question from Mr. Malzone, Ms. Hague explained that the Gold plan in the chart represents the Gold B plan design and the Bronze plan represents the proposed Bronze B design. She added that there are no proposed changes to the Silver and Platinum designs.

Next, Ms. Cloran discussed the proposed 2017 QDP product shelf, following the same areas of focus as the QHP proposal: standardization, choice, administrative simplification and promoting value and health outcomes. She added that the proposal seeks to align QDP requirements with the QHP shelf. She began with standardization, stating that for 2017, all carriers will be required to submit three standardized plans. She stated that there will be a cap on variations, allowing one additional version on an alternate network for a maximum of six possible plans. She noted that this should result in a slight reduction in the total number of QDPs offered on the exchange. She then reviewed the cost-sharing amounts for different services in standardized QDPs and added that carrier attestation will be required for QDP submissions, as it is for QHPs. Also similar to the proposed QHP requirements, she stated, is the proposal that the shopping experience displays whether a QDP is standard or non-standard and continues to include the "Network Note" flag for plans with smaller or tiered networks. On the topic of choice, Ms. Cloran stated that

carriers may continue to submit no more than three non-standard QDPs and that, newly for 2017, this limit will be inclusive of network variation to align the dental and medical shelves. In response to a question from Ms. Turnbull, Ms. Cloran stated that most people buy standardized plans. Ms. Cloran added that a non-standardized plan new last year has a lower price point for preventive coverage. In response to a question from Mr. Malzone, Ms. Cloran answered that Delta offers three networks: Premier, which is the largest network, PPO and EPO, which are the smallest. Ms. Cloran then discussed frozen QDPs, stating that carriers can offer frozen plans in 2017. Ms. Hague added that the Health Connector can reject a carrier's proposal if the proposed frozen plan has very low enrollment. Ms. Cloran then reviewed the administrative simplification piece of the SOA proposal, stating that proposed modifications to the formatting of material mirrors the QHP changes. She added that materials previously submitted to other agencies will be used to avoid unnecessary submission from carriers. She discussed the SOA components around promoting value and health outcomes and stated that quality measurements are relatively new and limited in dental and that the Health Connector is seeking comments from carriers regarding how to measure and report on quality outcomes. Ms. Cloran then reviewed the certification criteria for both medical and dental issuers and highlighted that, new this year, the Health Connector is now considered a covered entity for the purposes of non-discrimination. She added that for the SOA, this means that the Health Connector will require attestations from issuers that they are following non-discrimination laws. In response to a question from Ms. Turnbull, Mr. Schuetz stated that discrimination is in regards to health status, sexual orientation and coverage, both in terms of allowing a member to enroll as well as how that member is treated.

Mr. Schuetz reviewed the SOA timeline, stating that submissions are due in May and that Health Connector staff will come back to the Board in July for a vote on the conditional SOA. He stated that final rates will be filed with the Division of Insurance (DOI) in July, followed by analysis and selection of ConnectorCare plans. He added that the final SOA vote will come before the Board at the September meeting. In response to a question from Secretary Sudders, Ms. Hague stated that the SOA RFR can be shared with Board members for individual comment, but noted that a subsequent group discussion is not permissible under open meeting laws. Mr. Gaunya remarked that last year, approximately 10,000 members were displaced when QHPs were eliminated. He stated that he would like members to be surveyed before the Health Connector considers removing a plan. Ms. Hague stated that this is a consideration for inclusion in the Health Connector's member survey. She noted that the option to freeze plans is being emphasized as it is a good tool to avoid member disruption. Mr. Malzone stated that it is important to know the differences between standardized and non-standardized plans when a carrier offers both options. He added that this may be helpful to determine which plan type is more valuable to consumers, in addition to reviewing which type has higher enrollment. Mr. Schuetz stated that the appendix includes information on plans, tiers and enrollment numbers. Secretary Sudders reviewed next steps for Board member feedback. Ms. Turnbull complimented Health Connector staff on their work on the SOA proposal and acknowledged the difficulty of balancing cost-sharing with other considerations.

The meeting was adjourned at 3:52 PM.

Respectfully submitted,
Maria H. Joy