Affordability Work Group

Meeting 2

March 1, 2019

A service of Maryland Health Benefit Exchange

MARYLAND HEALTHBENEFIT EXCHANGE

Agenda

- Welcome and Introductions
- Charter Ratification
- Member Welcome and *Getting to Know You* Activity
- Discussion on Current Authorities Afforded Under the ACA
- Other State Actions
- Establish Focus Areas/Conceptual Framework
- Public Comment
- Adjournment

Changes in Consumer Experience

- Premiums:
  - The State Reinsurance Program (SRP)
  - Cost sharing reduction (CSR) payments “Silver-loading”
  - Advanced Premium Tax Credits (APTC)
- Out-of-pocket costs:
  - Before deductible services
  - Deductible
  - Plan generosity (Actuarial Value, AV)
  - Health Savings Account (HSA)

Changes in Premiums

2018 to 2019 Premiums without APTC[1]

Carrier (Network)	Enrollment[2] (on/off MHC)	2019 Rates (w/o Reinsurance)	2019 Rates (w/ Reinsurance)
CareFirst (HMO)	109,368	18.5%	-17%
CareFirst (PPO)	13,074	91.4%	-11.1%
Kaiser Permanente (HMO)	69,837	37.4%	-7.4%
Total	192,279	30.2%	-13.2%

[1]As of October 1, 2018, 18,009 enrollees do not receive APTC on Maryland Health Connection.
[2]Enrollment as of June 30, 2018.

Changes in Premiums

2018 to 2019 Premiums with APTC[3]

- Consumers will receive less APTC in 2019 than in 2018, but still more than otherwise due to "silver-loading":
  - The SRP reduced premiums for silver plans from -7.2% to -14.5%.
  - Silver plan premiums on Maryland Health Connection are 11% to 28% higher than off-Exchange premiums.
- Depending on their plan and carrier, assuming no change in income, some consumers will pay more in 2019 than in 2018, others will pay less.
  - The SRP reduced premiums differently depending on metal level and carrier
    - Bronze plans -4.4% to -19.1%
    - Silver plans -7.2% to -14.5%
    - Gold plans -9.3% to -15.3%
- Consumers will pay less in 2019 if their premium decrease was greater than their APTC decrease and vice versa.

[3]As of October 1, 2018, 112,587 enrollees receive APTC.

Changes in Premiums

2018 to 2019 Premiums with APTC

- Consumers enrolled in the lowest cost gold plan will experience a premium decrease.
- Consumers enrolled in the lowest cost bronze plan may experience a premium increase, or decrease, depending on family composition and income.
- Consumers enrolled in the lowest cost silver plan will experience a premium increase, the amount depends on family composition and income.
- Consumers enrolled in CareFirst-only areas will experience a premium decrease. The impact of “silver-loading” is most pronounced in these areas.
- Scenarios may be found in the Appendix of this presentation.

Changes in Out-of-pocket Costs

Market Trends

- All premiums are going down, but some out of pocket costs are rising
- Different experience depending on the carrier and plan
- Even more important to shop

Top 5 Plans: 2018 to 2019 Deductible and Actuarial Value (AV) Changes.*

2018 Plan	2019 Plan	Deductible Change	AV Change
KP MD Silver 6000/35/Dental	KP MD Silver 6000/35/Dental	$0	+.47% (67.08% → 67.55)
BlueChoice HMO Silver $3500 VisionPlus	BlueChoice HMO HSA Silver $3000 VisionPlus	- $500	-4.4% (70.70% → 66.30%)
HealthyBlue HMO Gold $1000	HealthyBlue HMO Gold $1750	+ $750	- .63% (78.54% → 77.91%)
BlueChoice HMO Bronze $6550	BlueChoice HMO Bronze $7900	+ $1350	-1.96% (60.49% → 58.53%)
KP MD Bronze 6200/20%/HSA/Dental	KP MD Bronze 6200/20%/HSA/Dental	$0	+.44% (60.59% → 61.03%)

*Top 5 Plans account for 80% of enrollments on Maryland Health Connection.

2019 Plan Offerings

QHP Characteristics

- One bronze option with first-dollar coverage (Kaiser Permanente)
- Two silver options with first-dollar coverage (Kaiser Permanente)
- Two options, gold and platinum, with $0 deductibles (Kaiser Permanente)
- Three gold options with deductibles from $1000 to $1750 (CareFirst PPO & HMO; Kaiser Permanente)

Carrier (Network)	Plans Offered	Metal Levels Offered (#)	HSA Offerings
CareFirst (HMO)	**4**	**Bronze (1), Silver (1), Gold (1), Catastrophic (1)**	**Bronze (1) Silver (1)**
CareFirst (PPO)	**3**	**Bronze (1), Silver (1), Gold (1)**	**Bronze (1) Silver (1)**
Kaiser Permanente (HMO)	**10**	**Bronze (2), Silver (3), Gold (3), Platinum (1), Catastrophic (1)**	**Bronze (1) Silver (1)**

2019 Plan Offerings

SADP Characteristics

- Many product and benefit options for consumers to select from
- All SADPs have a maximum OOP of $350 and $700 for the pediatric dental benefit
- Adult benefits vary from plan to plan, research is important before selecting dental benefits for adults

Carrier (Network)	Plans Offered	Tiers Offered (#)	Family/Child-only
Alpha Dental (HMO)	**2**	**Low (1) High (1)**	**Family (2)**
CareFirst (PPO)	**2**	**Low (1) High (1)**	**Family (2)**
Delta Dental (PPO)	**2**	**Low (1) High (1)**	**Family (2)**
Dominion National (HMO & PPO)	**8**	**Low (4) High (4)**	**Child-only (4) Family (4)**

Out-of-Pocket Costs and Actuarial Value

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Out of Pocket Costs

Premiums have decreased in 2019, but the deductible for many plans continued to increase. For example, for a 42 year-old consumer living in rating area 2, deductibles for bronze plans increased by as much as $1,350, depending upon the plan option selected.

Actuarial Value

When benefit requirements are added, the plan must still maintain the actuarial value, although “de minimis” variation is allowed. De minimis variation generally allows actuarial value thresholds to vary by a range of -4 to +2 percentage points. There is an exception to this rule for bronze plans covering a major service before deductible. In these cases, the threshold may vary from -5 to +5 percentage points.

State Examples: Massachusetts Health Connector

Minimum Creditable Coverage (MCC) Requirements and Affordability Schedule [4]

- Massachusetts implemented its individual mandate as part of its 2006 health care reports to help promote stability in the insurance market[1]
- The affordability schedule determines whether an individual must pay a penalty for not having Minimum Creditable Coverage (MCC)
- Exchange enrollees earning at or below 300% of FPL are enrolled in the ConnectorCare program
  - By state regulation, the premium these individuals pay is capped at the State affordability schedule for at least one plan in each region.

The affordability schedule does….	The affordability schedule does not…
• Support consumers in making choices about coverage and their household budgets by determining whether they would pay a penalty for not enrolling in coverage • Align with the ConnectorCare proram's lowest cost premium in each plan type, though this alignment is not technically required	• Require employers, issuers or other coverage providers to offer plans deemed affordable by the schedule • Penalize employers or issuers if individuals fail to enroll in the affordable coverage they offered

4. **Massachusetts Health Connector**, *Affordability Schedule for Calendar Year 2019 & Individual Mandate Awareness*, Presentation to the Board of Directors, https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2018/03-08-18/Affordability-Schedule-and-Individual-Mandate-VOTE-030818.pdf

Massachusetts Health Connector

Minimum Creditable Coverage (MCC) Requirements and Affordability Schedule continued[5]

- MCC-complaint plans must provide coverage for a broad range of medical services:
  - Ambulatory patient services, including outpatient day surgery
  - Diagnostic imaging and screening
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Medical/surgical care
  - Mental health and substance abuse services
  - Prescription drugs
  - Radiation therapy and chemotherapy

5. **Massachusetts Health Connector**, *Minimum Creditable Coverage (MCC) Requirements*, https://www.mahealthconnector.org/wp-content/uploads/MCCRequirements.pdf

Massachusetts Health Connector

Minimum Creditable Coverage (MCC) Requirements and Affordability Schedule, continued

- There are requirements on what the plan can charge for in-network services
  - Annual deductibles cannot be more than $2,000 for an individual and $4,000 for a family for services received in-network
  - For plans with up-front deductibles or co-insurance on core services, there is an annual maximum on out-of-pocket spending of no more than $6,850 for an individual and $13,700 for a family for services received in-network
  - The out-of-pocket maximum must include all co-payments, coinsurance and deductibles for in-network services, but does not include prescription drugs
  - For plans that have a separate prescription drug deductible, it cannot exceed $250 for an individual or $500 for a family
  - Doctor visits for preventive care must be provided prior to the deductible
- There can be no limits or caps on:
  - Prescription drug benefits
  - The total amount of paid for a particular illness or for benefits in a single year
  - Certain service, such as a fixed dollar amount per day or stay in the hospital with the patient responsible for all other charges

State Examples: Covered California

Patient-Centered Benefit Designs[6]

- Outpatient services in Covered California's Silver, Gold and Platinum plans are not subject to a deductible (primary care visits, specialist visits, urgent care, lab tests, X-rays, imaging and other services). Bronze plan enrollees can have three primary care or specialist visits without needing to satisfy a deductible.

- By having common benefits, copays and deductibles across health plans — both in Covered California and "off exchange" in the individual market — consumers are able to make apples-to-apples comparisons on the things that matter most, including the cost of the premium and the doctors and hospitals that are in the plan's network.

- Combining patient-centered benefit designs with the law's essential health benefits means consumers are getting real coverage and are not subject to surprise "gaps" in their benefits

6. **Covered California**, *Key Ingredients to Creating a Viable Individual Market that Works for Consumers: Lessons from California*

State Examples: Access Health Connecticut (AHCT)

Standardized Plan Designs[7]

- AHCT developed individual standardized plan designs for each metal tier which defined deductible, co-payment and/or co-insurance cost sharing on an in-network and out-of-network basis

- The AHCT standardized plan designs are not "gatekeeper" plans and were designed to provide enrollees with direct access to specialists.

- Accordingly, AHCT will not certify the standardized plan designs offered by an Issuer at any coverage level if the Issuer requires a referral from a Primary Care Provider (PCP) in order for an enrollee to be able to access a specialist. Should an Issuer impose the "gatekeeper" requirement in its non-standardized plans, AHCT will require an Issuer to identify this requirement in the Schedule of Benefits and/or the Issuer's Plan Marketing Name(s). Additionally, such requirement must be described explicitly and prominently in the Issuer's Evidence of Coverage.

7. **Connecticut Health Insurance Exchange,** *Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplaces*, http://agency.accesshealthct.com/wp-content/uploads/2018/05/2019-QHP-Solicitation_Amended.pdf

State Examples: New York State of Health

Standard Products w/ 3 PCP Visits[8]

- QHP may offer a standard product with 3 visits to a primary care provider that are not subject to the deductible. Co-payments with apply
  - For these purposes, primary care visits are defined as visits to a provider whose primary specialty is in family medicine, internal medicine, pediatric medicine, obstetrics/gynecology, outpatient mental health, or outpatient substance use
  - The additional produce will not count towards the number of non-standard products offered by the carrier

- If the carrier opts to offer this product, it must:
  - Be offered at the Gold, Silver, Silver CSR 73% AV, and, Silver CSR 87% AV metal levels, in every county of its QHP service

8. NY State of Health, Invitation and Requirements for Insurer Certification and Recertification for Participation in 2019, https://info.nystateofhealth.ny.gov/sites/default/files/2019%20NYSoH%20Insurer%20Invitation%20to%20Participate%20-%20REVISED%205.22.18%20.pdf

MHBE 2020 Plan Certification Standards

Value Plans[9]

- In response to public feedback on the increasing consumer cost-sharing and rising out-of-pocket costs in QHPs offered through Maryland Health Connection, MHBE will require that issuers offer "Value" plans, that meet certain cost sharing and branding requirements, at the bronze, silver, and gold coverage metal levels

9. **Maryland Health Benefit Exchange**, *2020 Letter to Issuers Seeking to Participate in Maryland Health Connection*

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Value Bronze Plan Office Visits Requirements

- Under the “Value” Bronze three office visits requirement issuers may allocate, at minimum, any three office visits across the Primary, Urgent, and Specialist Care Visits. Issuers are encouraged to allow maximum consumer flexibility to the extent possible under existing technical/operational limitations. To incentivize appropriate utilization of lower cost sites of care MHBE strongly recommends the inclusion of at least one urgent care visit in the selected allocation

- MHBE understands that “Value” plan requirements will increase QHP actuarial value and potentially premiums. MHBE encourages issuers to offer additional QHPs with lower actuarial value to support premium affordability for unsubsidized consumers and provide distinct options within each metal level.

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Discussion