Clear Choice Workgroup

Comments of NFIB Maine

November 6, 2020

Clear choice plan designs and a merged individual and small group markets are two major reform proposals contained in LD 2007. Neither of these reforms were suggested or supported by business groups such as NFIB, the Maine State Chamber of Commerce and others that collectively represent thousands of employers in Maine. However, NFIB and the Maine Chamber took an active interest in LD 2007 with particular focus on the merged markets idea. (NFIB alone has a dues-paying membership of nearly 3,000 in Maine, all of which are independently owned and operated small businesses.)

NFIB members have complained for years about the cost of health insurance. They do not complain that policies fail to provide enough benefits – that policies are not generous enough – rather, they complain about ever-increasing costs and the ability of small employers and their employees to afford health insurance.

We echo the observations and comments of others that pursuit of simplicity should not be accomplished through elimination of flexibility in plan design and choice for small employers. The interests of small employers are very different from that of individuals. Individuals in Maine are making decisions for themselves; they are not buying a group plan for multiple individuals who live in different households. On the other hand, the considerations of small employers vary based on their industry, nature of their workforce, and financial situation of the small business. Clear choice in the individual market could be confounding choice in the small group market where a small employer may be forced into a plan design that does not fit very well.

We also share the interests of others in the workgroup who have raised questions about how clear choice designs may impact costs. We have yet to see a meaningful discussion of clear choice vis-à-vis the individual and small group markets and the impacts on costs or market participation.

Additionally, we are concerned about the interaction of clear choice and merger of the individual and small group markets. We urged in September that the merged market decision be postponed due to a lack of clear and meaningful savings for small employers as well as the lack of a statutory mechanism reverse the curse, escape, unwind, if a merged market accelerates the exit of small employer participation.

Comments on the insurer and employer sides have urged that a move to clear choice plans be slowed down. We support that recommendation and its rationale. Further analysis and discussion are needed.

Thank you for the opportunity to participate in this workgroup and provide these comments.

David R. Clough
State Director in Maine

Clear Choice Design Committee

Comments from Maine Association of Health Underwriters

October 30, 2020

Plan Design:

Although not highlighted in the most recent document, it appears there is now a copayment option available for Tier 3 and Tier 4 drugs in the Bronze Low and Silver Low plans. We think this will eventually lead to adverse selection in those plans without sufficient revenue to offset the costs. The design document from the previous meeting only had coinsurance options for Tier 3 and Tier 4 drugs which results in much better pricing. We understand the concern from consumers about the extremely high cost of those drugs and don't mean to discount that concern. However, to achieve the best pricing possible for the largest segment of the population, we feel those should be coinsurance options only. The impact of the pandemic is, for the most part, still unknown so designs should be focused on minimizing current costs to allow for this unknown impact. This allows the BOI to improve benefits in future years if appropriate which is much easier than cutting benefits.

We question the MOOP of $8550 for the Bronze HSA plan. The Federal limit for 2021 is $7000, the same amount as was listed in the previous version of the proposed plan designs. Is this an intended change since this would disqualify the Bronze Plan from being an HSA.

Plan Options:

The requirement for carriers to offer all metal levels except for Platinum will likely result in no Platinum option being offered since no carrier will want to be the only Platinum offering on the Exchange due to the adverse selection. Making it an option is the same as denying a Platinum option to the Individual marketplace. Over 75% of participants will be getting some sort of APTC to help with cost so very few will bear the entire premium on their own. The fact that very few will be paying the full price of the Platinum plan should be taken into consideration so that this option is available to individuals

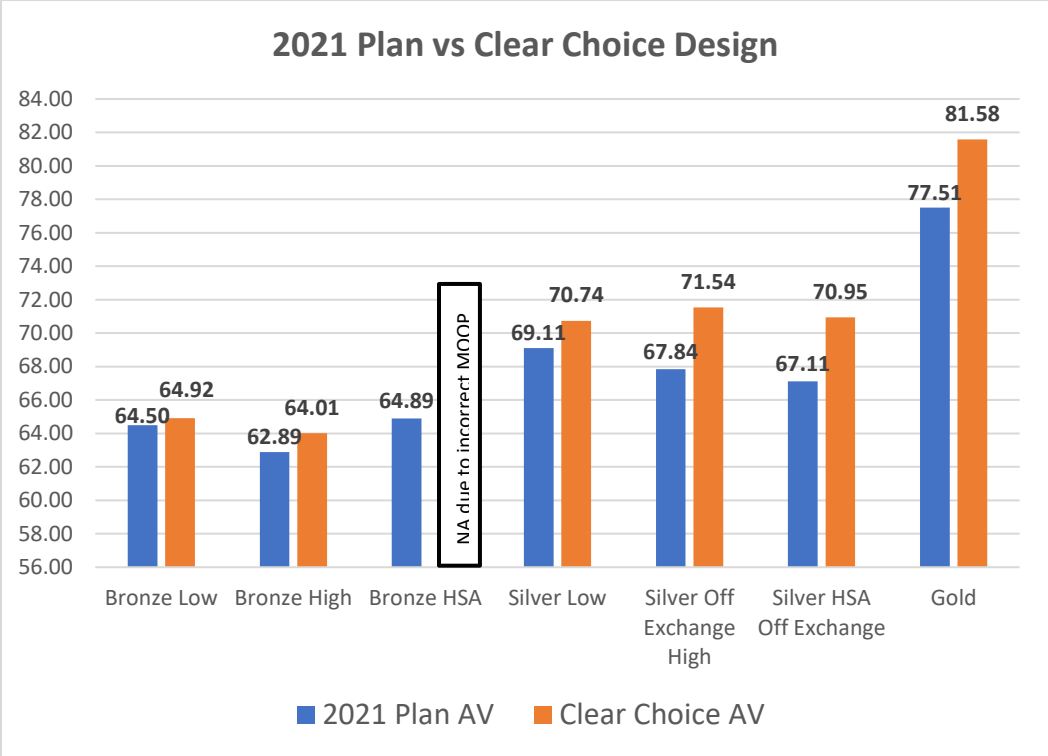
November 6, 2020

Superintendent Eric Cioppa
Maine Bureau of Insurance
76 Northern Ave.
Gardiner, ME 04345

Dear Superintendent Cioppa:

We appreciate the opportunity to provide our perspectives on the Clear Choice Design plans as proposed. In response to your request for reactions and consideration of the proposal, Community Health Options evaluated the proposed plan designs through the lens of the actuarial value (AV) tool provided by the Centers for Medicare and Medicaid Services (CMS). The outcome points to the overall increase in the richness of benefits and resulting expectation of higher premium pricing.

Actuarial Value Calculations - As requested, we ran the proposed plans through the current AV calculator. The results showcase the escalation of benefit richness under the set of clear choice plan designs as measured by the resulting AVs.



In general, it was difficult to achieve the desired AV value for Bronze Low, Silver Off Exchange High and Gold. Additionally, the Bronze HSA Clear Choice Design includes a maximum out-of-pocket (MOOP) amount of $8,550, which does not comply with current IRS Regulation. The 2021 MOOP for HSA plans is $7,000. When the lower HSA-compatible MOOP was applied, the AV resulted in a level falling outside the metal level.

In a couple of designs we had to apply all forms of cost sharing – deductible, copayments and coinsurance – *in tandem* in order to derive AVs that fit within the metal levels. We are unaware of any plan in the Maine market that has all three of these cost-sharing structures on a single plan. For example, with this

COMMUNITY Health Options™

structure in place a consumer would initially pay a copay for an office visit, but then the remainder of the claim would be applied to the policy deductible. This defeats the purpose of the copay in providing certainty regarding financial responsibility for the cost of the visit.

2022 Flexibility – There will certainly be unintended and unanticipated consequences of implementing Clear Choice plans across newly merged individual and small group markets. To reduce potential adverse impact to consumers, we would encourage a more flexible approach to Clear Choice plan implementation during the first year. Community Health Options supports and believes the Bureau should consider a process where the Clear Choice plans are required to be offered by all carriers, but that carriers be permitted to sell additional ACA-compliant plans without limitation. This approach will limit market interruption/disruption and avoid the necessity of involuntary cross-walking of consumers into the Clear Choice plans. Increasing implementation flexibility would allow the State to determine consumer interest in Clear Choice plans for subsequent plan years. The number of alternative plans could be narrowed over time.

Market-At Large – Perhaps the most significant consequence of Clear Choice plans will be the increase in premiums for health insurance. It is expected that the overall price of the Clear Choice plans will be higher than the current offerings in the market. This is based on the actuarial value calculations for the richer set of prescribed benefits. While some or all of that rating increase could be offset by increased APTC for those obtaining coverage through the Marketplace, those purchasing policies off exchange would presumably bear the brunt of the higher pricing. Enabling a flexible Clear Choice plan implementation will allow for consistent market pricing and remove Clear Choice as a driver of rate increases in 2022.

Pediatric Dental – While a promoter of pediatric oral health, Community Health Options believes that including pediatric dental in all IND and SG plans will also drive up premiums unnecessarily for consumers without that needed benefit. To ensure availability of coverage for those consumers with children, we recommend that the BOI allow for paired Clear Choice Plans with and without the pediatric dental benefit. In other words, carriers should be allowed to offer identical plans without pediatric dental that do not count towards the three alternative plans. This will avoid an across-the-board increase in premium pricing due to this aspect of coverage.

Health Options is concerned that multiple changes to the Maine health insurance market are occurring rapidly and simultaneously, leaving inadequate time to truly gauge the impacts on the market including most importantly consumers. The resulting upset and market upheaval could be averted through greater flexibility and time to convey the clarity that seems to be the principal objective of Clear Choice Designs.

We thank you for the continued opportunity to provide our comments to the Bureau on Clear Choice plan design.

Sincerely,

Kevin Lewis
Chief Executive Officer

Kristine M. Ossenfort
Senior Government Relations Director

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November 6, 2020

Mr. Eric Cioppa, Superintendent
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: Comments on Proposed Clear Choice Plan Designs

Dear Superintendent Cioppa:

Thank you for the opportunity to comment on the proposed clear choice plan designs. We understand the challenges of plan design, and we appreciate the Bureau's willingness to hear from stakeholders. We would like to offer general comments at the outset, followed by specific comments on the proposed plan designs.

1. Additional plan designs should be developed.

As we have previously noted, there are many plan designs available to consumers in the individual and small group market today; however, only nine plan designs are proposed, with one being a very rich and expensive platinum plan and one being a catastrophic plan. Forcing all of the consumers in the individual and small group market into just 7-9 plans will result in significant disruption, in terms of both price and benefits. Benefit disruption will be significant in both markets but price disruption will be most acute in the individual market and most detrimental to those members who do not receive Advanced Premium Tax Credits (APTCs) under the ACA. The price disruption is discussed more fully below.

In addition, it has not yet been determined whether the individual and small group markets will merge; therefore, it is very important that a set of plans be developed for the small group market in the event the markets are not merged. Given the timing of the two separate but related efforts, development of small group plans cannot be delayed until after a determination about merger of the markets has been made.

The stated goals of L.D. 2007 were to reduce the cost of health insurance and simplify the shopping experience for individuals and small groups. Those goals would not be compromised; in fact, they would be enhanced by the development of additional Clear Choice plan designs that would provide more choice and more price points, allowing purchasers to find the plan that best meets their needs. This is extremely important in order to minimize the amount of disruption and abrasion.

To that end, we have included with these comments a spreadsheet with proposed plan designs.

2. Tiered plans must be allowed in order to provide for more choice and more affordable options.

Tiered plans are gaining in popularity in the marketplace, particularly in the small group market. They allow access to a wide network of providers at a more affordable price. Thus far, the Bureau has taken the position that tiered plans could only be offered as one of the three alternative plans that a carrier may offer. We urge the Bureau to reconsider that position and allow tiered plans to be offered if Tier 1 meets the clear choice requirements. In support of this suggestion, we offer the following:

- According to our analysis, nearly 25% of the small group market is enrolled in a tiered plan across all carriers today. If tiered plans are not allowed, those groups will see significant price disruption—an increase of possibly as much as 10%.

- With respect to the tiered plans offered by Anthem, Tier 1 providers account for approximately 65% of the utilization—as a result, we would suggest that Tiered Plans should be allowed to be offered as a Clear Choice plan if either Tier 1 or Tier 2 complies with the clear choice plan design requirements.

- The Bureau has previously clarified that Clear Choice POS plans will be permitted We would note that, at their core, tiered network plans are not significantly different from POS plans—both provide for different levels of benefits depending on the status of the provider.

With respect to the proposed plan designs, we would offer the following comments:

3. **Pricing Impacts.**

Based on the benefits and cost shares proposed for the Clear Choice plans, we mapped plans from our current Individual and Small Group portfolios to similar Clear Choice plans and compared price relativities between the plans to estimate a pricing impact.

a. ***Individual***: We estimate that all our non-CSR members would receive a premium increase when moving to a Clear Choice plan in the range of 1% - 12%, with an average increase of 5%.

b. ***Small Group:*** Since the benefits and cost shares of the Clear Choice plans align more closely to the Individual market, we estimated the Small Group pricing impact in following two ways:

   i. Assuming the markets merge, the Clear Choice plans as currently designed have significantly leaner benefits than what is currently offered in the Small Group market today. Given that, we estimate that nearly 70% of our Small Group members would receive a premium decrease when moving to a Clear Choice plan and 30% would receive a premium increase, ranging from -7% to +12% with an average decrease of -1%.

   ii. If the markets do not merge, we assumed that Clear Choice plans would be designed that would be more representative of the benefits and cost shares currently offered in the Small Group market. Under this scenario, around 45% of our Small Group members would receive a premium decrease when moving to a Clear Choice plan and around 55% would receive a premium increase, ranging from -6% to +12% with an average change of 0%.

Not accounted for in these pricing impacts is the disruption due to network changes. A significant portion of membership is expected to be in tiered plans when Clear Choice plans become effective. With the inability to include tiered plans as part of the Clear Choice plans, we expect these members to potentially see additional premium increases in excess of 10%. We strongly recommend that the tiered plans be allowed to be included as part of the Clear Choice plans, as explained more fully above.

4. Pediatric Dental.

a. We would suggest that Pediatric Dental should not be embedded in the exchange plans. That is not required today and there is an increased risk of adverse selection by requiring Pediatric Dental be embedded in only a subset of on-exchange plans (at least one per metal level).

b. California's categorization of Pediatric Dental services was provided as an example of how services could be allocated amongst the various Pediatric Dental benefits listed in the plan grid. Are standard plans being created only for medical, or are does the Bureau envision requiring for exchange certified stand-alone dental plans (SADP)as well? If exchange certified SADP are required, are carriers expected to follow Covered CA's categorization of pediatric dental services by category?

c. Periodontal Maintenance Services are categorized as Basic service under Covered CA, but the industry standard would be to cover that as a Major service along with the other Periodontic services. It would also create consistency and less confusion for consumers. Would carriers have the flexibility to categorize that as a Major service?

5. AV Compliance.

The following four plans would be out of AV compliance based on Anthem's assumptions in the 2021 AV calculator. Also included are potential changes that would get each plan back into AV compliance:

a. Bronze Low: Increase deductible to $7,000

b. Bronze HSA: Increase deductible to $5,500.

c. Silver Off-Exchange High: Increase deductible to $4,300 or increase OOPM to $7,200

d. Gold: Increase deductible to $1,600 or increase OOPM to $4,100

Please note that these plans were tested using the 2021 AV calculator. These plans will need to satisfy AV compliance using the 2022 AV calculator, and the AVs generally increase approximately 1% each year as a result of a new AV calculator.

6. Federal Mental Health Parity Compliance.

The Bronze High plan is not in compliance. In order to become compliant, the Behavioral Health cost structure would need to be revised to cover the first three Behavioral Health office visits in full, and then apply the deductible and coinsurance to visits 4+.

7. Additional Comments and Questions.

a. Would carriers be allowed to offer a tiered Rx network as is common in the Individual market today?

b. Would carriers be allowed to offer split generic copays on Tier 1 as is common in the Small Group market today? If so, we would recommend the copay for low-cost generics be set at $5 and the copay for 2nd tier generics be set at $25 or more.

c. Would carriers be allowed to offer additional non-ACA preventive Rx benefits on HSA plans as is common in the Small Group market today?

d. Included with our comments are proposed changes to some of the cost shares for the Clear Choice plans under a merged market scenario and a non-merged market scenario. The plans proposed in the non-merged market scenario would be specific to the Small Group market. These changes are aimed at limiting both premium disruption and benefit/cost share disruption in the Individual and Small Group markets. We would also make special note of the following:

i. The Silver Off Exchange High plan was changed to be offered On and Off Exchange, with an AV at the high end of the Silver AV de minimis range.

ii. The Silver On Exchange Low plan was changed to get to an AV of 69%. The expectation is that the AV would move up to 70% using the 2022 AV calculator.

iii. Under the non-merged market portfolio, an additional Gold plan was added.

iv. Split generic copays were added to Rx Tier 1.

Thank you again for the opportunity to share these comments and suggestions. We are happy to answer any questions you might have, and we look forward to discussing this further on November 20

Sincerely,

Kristine M. Ossenfort, Esq.
Senior Government Relations Director

Cc: Marti Hooper, ASA, MAAA,
Life and Health Actuary

Anthem Proposed Merged Market Designs - 11/6/2020

Anthem Proposed Merged Market Designs - 11/6/2020	Catastrophic	Bronze Low	Bronze High	Bronze HSA	Silver Low	Silver On Exchange High	Silver HSA Off Exchange	Gold	Platinum
HIOS ID Plan Used as Reference	48396ME0790011	33653ME0550001	33653ME0550002	96667ME0310028	48396ME0710048	33653ME0550003		96667ME0310023	
Anthem AV Value	N/A	64.90%	64.94%	64.94%	68.96%	71.40%	69.93%	79.83%	90.13%
Deductible	$8,550	$6,500	$7,500	$5,500	$3,500	$4,000	$3,000	$1,500	$500
Maximum OOP	$8,550	$8,550	$8,550	$7,000	$8,550	$7,000	$7,000	$5,000	$3,000
Coinsurance	0%	40%	50%		50%	30%		30%	20%
PCP*	$50 for 1st 3 visits then deductible	$40	$50		$40	$30		$25	$20
Behavioral Health Outpatient Services		$40	$50		$40	$30		$25	$20
Specialist Visit		$80 AD	$100 AD		$80 AD	$60 AD		$50 AD	$40 AD
Urgent Care		$60 AD			$60 AD	$45 AD		$40 AD	$25 AD
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)									
Outpatient Surgery and Physician/Surgical Services				50%			20% Coins. After Ded.		
Inpatient Hospital Services and ER	0% Coins. After Ded.	40% Coins. After Ded.	50% Coins. After Ded.		50% AD	30% after deductible		30% Coins. After Ded.	20% Coins. After Ded.
Inpatient Physician and Surgical Services									
Inpatient Rehabilitation									
Ambulance									
All other benefits									
RX - Tier 1 Generic		$10 / $35	$5 / $25		$5 / $25	$5 / $25		$5 / $25	$0
RX - Tier 2 Preferred Brand		40% AD	50% After Deductible		$50	$50		$50	$15
RX - Tier 3 NonPreferred		40% AD			50% AD	30% AD		30% AD	20% AD
RX - Tier 4 Specialty		50% AD			50% AD	50% AD		50% AD	20% AD
Pediatric Dental Deductible	$100								
Pediatric Dental - Preventive & Diagnostic	0%								
Pediatric Dental - Restorative & Basic Services	20% Coin. After Dental Ded.								
Pediatric Dental - Major Services & Medically Necessary Orthodontics	50% Coin. After Dental Ded.								
Preventive Benefits, Diabetes Ed & Supplies, Nutritional Counseling, Pediatric Vision	0%								

* 1st PCP and Behavior Office Visit have $0 copay,subsequent visits have copay before deductible except HSA and Catastrophic plans

AD = After Deductible

Anthem Proposed Small Group Non-Merged Market Designs - 11/6/2020

Anthem Proposed Small Group Non-Merged Market Designs - 11/6/2020	Bronze Low	Bronze High	Bronze HSA	Silver Low	Silver Off Exchange High	Silver HSA Off Exchange	Gold (New Proposal for SG Market)	Gold	Platinum
HIOS ID Plan Used as Reference	33653ME0550001	33653ME0550002	96667ME0310028	48396ME0710048	33653ME0550003			96667ME0310023	
Anthem AV Value	64.87%	64.36%	64.94%	69.44%	70.95%	69.93%	78.04%	80.71%	86.60%
Deductible	$6,500	$7,500	$5,500	$3,000	$4,000	$3,000	$2,500	$1,500	$500
Maximum OOP	$8,700	$8,550	$7,000	$8,700	$8,700	$7,000	$6,000	$5,000	$3,000
Coinsurance	50%	50%		50%	30%		30%	30%	20%
PCP*	$60 BD	$50 BD		$40 BD	$30 BD		$25 BD	$25 BD	$20 BD
Behavioral Health Outpatient Services	$60 BD	$50 BD		$40 BD	$30 BD		$25 BD	$25 BD	$20 BD
Specialist Visit	$120 After Ded	$100 After Ded		$80 BD	$60 BD		$50 BD	$50 BD	$40 BD
Urgent Care	50% After Deductible			$40 BD	$30 BD		$25 BD	$25 BD	$20 BD
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	50% Coins. After Ded.	50% Coins. After Ded.	50% After Deductible *	50% After deductible	30% Coins. After Ded.	20% Coins. After Ded. **	30% Coins. After Ded.	30% Coins. After Ded.	20% Coins. After Ded.
Outpatient Surgery and Physician/Surgical Services									
Inpatient Hospital Services and ER									
Inpatient Physician and Surgical Services									
Inpatient Rehabilitation									
Ambulance									
All other benefits									
RX - Tier 1 Generic	$5 / $35 BD	$5 / $35 BD		$5 / $35 BD	$5 / $30 BD		$5 / $25 BD	$5 / $25 BD	$0/$15 BD
RX - Tier 2 Preferred Brand	50% After Deductible	50% After Deductible		70 BD	$60 BD		50 BD	$50 BD	$50 BD
RX - Tier 3 NonPreferred				50% BD up to $300	30% BD up to $300		30% BD up to $300	30% BD up to $300	30% BD up to $300
RX - Tier 4 Specialty				50% BD up to $600	50% BD up to $600		50% BD up to $600	50% BD up to $600	30% BD up to $600
Pediatric Dental Deductible	$100								
Pediatric Dental - Preventive & Diagnostic	0%								
Pediatric Dental - Restorative & Basic Services	20% Coin. After Dental Ded.								
Pediatric Dental - Major Services & Medically Necessary Orthodontics	50% Coin. After Dental Ded.								
Preventive Benefits, Diabetes Ed & Supplies, Nutritional Counseling, Pediatric Vision	0%								

* 1st PCP and Behavior Office Visit have $0 copay,subsequent visits have copay before deductible except HSA and Catastrophic plans

** Plan includes Preventive Rx which bypasses deductible for drugs on the Preventive Rx drug list

AD = After Deductible

BD = Before Deductible

via electronic submission

November 6, 2020

Marti Hooper
Actuary
Maine Bureau of Insurance
#34 State House Station
Augusta, ME 04333-0034

Re: Clear Choice Stakeholder Group Comments in Follow-up to Plan Design Draft

Dear Ms. Hooper:

The American Cancer Society Cancer Action Network (ACS CAN) and The Leukemia & Lymphoma Society (LLS) appreciate the opportunity to provide additional comments on the ongoing plan design drafts developed by the Bureau of Insurance as part of the Clear Choice Stakeholder Group process. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government. LLS' mission is to find cures for leukemia, lymphoma, Hodgkin's disease, and myeloma, and to ensure that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare. As the world's largest nonprofit focused on blood cancers, LLS represents the nearly 1.4 million blood cancer patients and survivors across the United States, including more than 7,400 Mainers who are in remission from or currently living with a blood cancer diagnosis.

As stated in our previous comments, ACS CAN and LLS supported the Clear Choice enabling legislation, in part, because we felt that the creation of standard plan designs presented a significant opportunity. We saw a chance for Maine to create plans that offered a meaningful improvement for consumers shopping for health coverage in the state. We offer the following comments to ensure the Clear Choice Plan Design meets this opportunity.

We appreciate and commend the Bureau of Insurance's efforts to include a greater reliance on copays in place of areas that used coinsurance in previous drafts. However, we remain concerned about the use of coinsurance for specialty tier prescription drugs. As stated in our previous comments, coinsurance is not transparent to consumers, and thereby does not meet the intended purpose of the standardization of plan designs, to allow individuals better opportunity to compare plan options, nor does it meet the opportunity to create higher quality plan options for consumers.

We ask that the Bureau consider our organizations' comments submitted on September 30, where we cited ways in which copay-only structures could be used for prescription drug coverage with modest increases in

the copays already proposed with little impact on AV. We respectfully request that the Bureau explore this as an option.

In addition, as mentioned in our September 30 comments, according to research by the actuarial firm Milliman, a first-dollar, copay-only structure for prescription drugs can be implemented with limited premium impact, and can be accommodated within the ACA's AV requirements by making minimal adjustments to other benefits.[1] In that research, the net cost benefit to patients significantly outweighed any minimal premium adjustments. In Maine, where 86% of consumers receive premium subsidies, the impact will be further ameliorated. We feel the benefit to patients is more than worth it.

If the Bureau must include coinsurance, at the very least we would recommend that the coinsurance level be lowered and coupled with a maximum out-of-pocket cost per prescription. As stated in previous comments, a 50% coinsurance level for specialty tier drugs would result in out-of-pocket costs that many cancer patients could not afford.

Finally, we would like to reiterate that the clear choice plan design should be of high quality to consumers, regardless of what is on the market today. While we can appreciate the Bureau's and the insurance carriers' concerns regarding the impact of a dramatic shock to the market, we believe consumers would welcome a shock that resulted in plans being higher quality and cost exposure more predictable. As stated in previous comments, premiums are not the only out-of-pocket costs consumers pay. If the cost-sharing arrangements of the plans are not affordable, then the premiums being spent on the plan are not worth much. More specifically, if patients forego care due to an inability to afford the out-of-pocket costs, then the patient is paying premiums without getting coverage for the care they need.

On behalf of the American Cancer Society Cancer Action Network and The Leukemia & Lymphoma Society, we thank you for the opportunity to continue to provide comments and input as the Bureau of Insurance further develops a draft plan for the Clear Choice benefit design. If you have any questions, please feel free to contact either of us - Hilary at hilary.schneider@cancer.org or 207-373-3707 or Steve at steve.butterfield@lls.org or 207-213-7254.

Sincerely,

Hilary Schneider
Maine Director of Government Relations
American Cancer Society Cancer Action Network

Steve Butterfield
Regional Director, Government Affairs
Leukemia & Lymphoma Society

[1] Milliman, Inc. "Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations." March 2015. Available at: http://www.lls.org/sites/default/files/National/USA/Pdf/Milliman%20Report%20on%20Prescription%20Cost%20Sharing%20Limits%20for%20Exchange%20Plans.pdf

MAINE ASSOCIATION OF HEALTH PLANS

November 6, 2020

Superintendent Cioppa
Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

Dear Superintendent Cioppa,

I am writing to further express MeAHP's significant concerns about moving forward with the Clear Choice Products approach outlined by the Bureau thus far. The more the Plans have dug into the details of pricing and AV calculations, the more certain (and worried) they are that the proposal ***raises*** costs, even into double digits.

We are also concerned that the substantial market disruption resulting from abruptly and dramatically reducing the number of plans available is being underestimated. If the merging of the markets goes forward, the disruption will be even worse, causing more confusion and frustration for all involved. We continue to believe that the best path forward is incremental adoption over time. A more measured approach would allow all to benefit from learnings gleaned along the way. The Bureau and the Plans would be able to review, learn, and adapt to meet the twin goals of providing high quality coverage at affordable cost. Consumers and purchasers would be helped by an incremental transitional period to familiarize themselves with the changed products and shopping tools.

As you know, heath insurance premiums reflect underlying costs present in any given marketplace. Maine's 2021 reductions in individual market premiums are largely attributable to Medicaid expansion and the Plans' improved experience with MGARA which resulted in the program's true impact flowing through to rates. These reductions, as with increases seen in other years, reflect Maine market conditions and costs at the time of development and cannot be counted on year over year.

The higher cost Clear Choice plans will come onto the market for the 2022 plan year amidst a fragile and (hopefully) post-pandemic economy. What is today envisioned by some as a simplification worth additional premium cost, may not be seen as viable to purchasers on the far side of the economic setbacks related to COVID-19. The market merger, if approved, and vastly higher attachment points at MGARA, will also be simultaneously hitting the market, exacerbating instability. We all know from ACA policy discussions that people

want the option of sticking with their plan if they like it. Under Clear Choice this will not be possible for many and some purchasers will be forced into one of the few plans available, even if it does not meet their needs as well.

The Plans, like you, are focused on reducing the cost of high-quality health insurance coverage and this proposal moves us in the opposite direction.

Thank you for your consideration of these comments.

Sincerely,

Katherine D. Pelletreau
Cc: MeAHP Board of Directors

Harvard Pilgrim Health Care

November 6, 2020

Superintendent Eric Cioppa
Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

Dear Eric,

Thank you for the continued opportunity to provide feedback through a stakeholder process on the development of Clear Choice Plan Designs per Maine Public Law Chapter 653 of 2020. In support of these initiatives by the Bureau, Harvard Pilgrim Health Care has compiled the following comments for your review and consideration.

I. Pricing impact of Clear Choice Plan Designs

We have evaluated the relative pricing of the proposed Clear Choice plan designs and found that, overall, the Clear Choice plan designs are higher priced than our current plans in the Individual market. Specific to metal levels we observed the following:

- The Gold Clear Choice plan with the revised out of pocket max will be priced higher than the current Gold plans by 3-5%. Unsubsidized consumers will be most impacted by this increase. They will have to pay more for a Clear Choice plan than for a similar plan found today.
- The Silver Clear Choice plans are significantly higher priced (18 -22%) than our lowest silver plan. This is mainly due to the Clear Choice Silver plans being full network plans while the lowest priced silver plan is a tiered network product. These existing plans lower priced plans are extremely popular with our members as a result of this lower pricing. There are other concerns regarding limited and tiered network plans which are addressed later.
- Without the ability to go below 70% on Silver plans, the lowest priced silver plan in the market will likely go up by about 10%. Additional APTC will offset the increased cost for subsidy eligible consumers while unsubsidized consumers will have fewer low-cost silver options to choose from. This is likely to shift consumers to bronze plans with higher cost sharing. Shifts in membership by metal level will create uncertainty in predicting risk adjustment and its impact on pricing
- We do not see any significant issues with the Clear Choice Bronze plans in terms of benefit pricing. However, if we are not able to use a tiered network plan within the Bronze level there will be fewer low-cost options on this tier as well.

II. Product and network options

In the Individual and Small Group markets today, there are three different healthcare provider network configurations offered in products: limited, tiered, and full network. Limited and tiered network products allow for significant premium savings for consumers due to exceptional discounts offered by participating providers, while such discounts are not permitted in full network products that have no steering mechanisms towards those providers. Tiered network plans contain a full geographic provider network, ours are inclusive of the Boston area hospitals for instance but, are not part of the Clear Choice plan designs. Limited network plans, which have geographically exclusive networks and do not provide coverage across the state nor out-of-state, presently appear to be permissible as Clear Choice designs. This creates a significant market advantage for limited network products in Clear Choice, but they will only be practical insurance options for residents in select areas in Maine. Due to their geographic exclusivity and other reasons, limited network products have historically proven to be unattractive to many consumers, especially in the Small Group market.

As currently structured, we expect that Clear Choice will be forced to largely comprise these limited network configurations focused on the Individual market in southern Maine, while consumers in other geographic areas or in Small Group will likely seek alternative options, such as self-insurance, in significant numbers. We would strongly suggest that Clear Choice plans allow for tiered network options which are not geographically exclusive. Tiered networks have been historically favored by the Individual and Small Group markets and have at times been the leading force of downward pressure on premium prices in Maine. Approximately 50% of Harvard Pilgrim's membership in those combined segments have chosen tiered network products for five consecutive years, and they are familiar products that are well understood by consumers, brokers, and providers.

Alternatively, Clear Choice plans could be restricted to full network products, which have no geographic limitations on covered healthcare providers within the state. Full network products could provide broader access for the entire geographic market, and particularly Small Group, albeit at significantly higher costs.

III. Other Concerns

- **Site-of-Service –** Site-of-service benefits have reduced member cost-share for services that are performed at a lower cost, typically by non-hospital providers. This type of benefit contributes to lower overall premiums. Accordingly, Clear Choice plans should allow for site-of-service benefits. The majority of services where a site-of-service benefit would apply fall within the "all other services" category of the Clear Choice plans benefit grid.
- **Limited Choice of plans/Focus on Individual market:** Current product offerings in the Small Group market provide a wide range of options, allowing groups to choose benefit plans and premium levels that meet their needs. Moving to Clear Choice plans will be particularly disruptive to the Small Group market, forcing groups to make significant plan changes that may mean paying higher premiums or offering less-rich benefits for their employees. With only three alternatives allowed, in a merged market situation where Small Group plans must be the same as what is offered to Individuals, we will be limited in what we can offer, particularly with HSA options which are very popular in the Small Group market.

- **Limited opportunity for Innovation:** With only three alternative product designs allowed, carriers are likely to choose to offer their most popular existing designs as the alternatives. This leaves little room to introduce innovative new products.
- **Consider phased approach:** A phased-approach timeline that allows Clear Choice benefit designs to be offered alongside existing products for the first several years of a merged market scenario would likely greatly diminish consumer and market disruptions. This would also provide an opportunity to examine the performance of Clear Choice products and any desirable modifications therein prior to the elimination of the existing products held by consumers.

Harvard Pilgrim Health Care maintains that the balance between affordability and simplicity has no simple answers, and we hope that our observations above ultimately help in that regard. Thank you for your review of these observations and your continued inclusive process as we move forward.

Sincerely,

Bill Whitmore
Vice President, Maine Market