



via electronic submission

August 25, 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 Aug 12 Meeting**

Dear Ms. Hooper:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to provide comments in follow-up to the August 12 meeting of the Clear Choice Stakeholder Group. 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.

While ACS CAN believes it is important to look at the experience of other states when developing the clear choice benefit design, we encourage the Bureau to develop a proposal that works best for Maine and helps move Maine toward achieving the goals set out in LD 2007, as presented by Commissioner Lambrew, Superintendent Cioppa, Senate President Jackson, House Speaker Gideon and supported by numerous patient advocates like ACS CAN. These goals are to make health care coverage more accessible, more affordable and better designed to meet the needs of all Mainers. As Superintendent Cioppa noted in his testimony on the bill, the clear choice designs are intended to "simplify deductibles, coinsurance, and copayments and allow consumers and small employers to make apples-to-apples comparisons between health plans." It is the hope of our organization that these clear choice designs allow consumers to focus on network, price, and plan quality rather than complicated cost-sharing variations when shopping for coverage.

A study conducted by the American Cancer Society showed that people who are uninsured or underinsured are more likely to be diagnosed with cancer at its more advanced stages when treatment is more expensive and patients are more likely to die from the disease.<sup>i</sup> While COVID-19 was not on the radar as LD 2007 was being developed, it is important to note that COVID-19 has shone a spotlight on the significant barriers to affordable health care that cancer patients have long faced.<sup>ii</sup> COVID-19 has not only placed significant financial stress on many

cancer patients, it has also increased the overall stress associated with a cancer diagnosis. As such, making health insurance coverage easier to understand and more predictable in terms of what is covered and the associated expected out-of-pocket costs will reduce the overall stress someone faces when navigating a cancer diagnosis and treatment.

Numerous studies have documented the myriad of problems associated with consumers' confusion with their health coverage and cost-sharing structures that are unpredictable or unaffordable.<sup>iii</sup>

The negative impacts include:

- High levels of cost-sharing are associated with reductions in unnecessary/low-value *and* necessary/high-value care.
- Consumer confusion can result in purchasing plans that may not be optimal for the consumer – e.g., those who can afford a higher premium and low deductible plan often purchase that plan even though they can likely afford a higher deductible, lower premium plan; some consumers are attracted to lower premium plans even though their health care needs may result in out-of-pocket costs that are higher overall than would be under a higher premium plan due to the differences in cost-sharing provisions in the plan. These scenarios are especially true in the absence of decision-making tools.
- High levels of cost-sharing lead to increased health disparities as they may have disproportionate impacts on patients with lower incomes and health conditions, whose utilization is most likely to be impacted when cost-sharing is increased.

We offer the below principles as a decision-making guide for how to design benefits to ensure that those with chronic or life-threatening conditions like cancer have affordable, quality options to choose from.

***1. Guarantee that patients have transparent and predictable out-of-pocket costs***

Co-insurance instead of flat-fee copayments can make it challenging for patients to understand how much they will have to pay for medical services and prescription drugs and also present challenges in affording necessary health care services. Coinsurance makes it especially challenging when patients are shopping for coverage and trying to compare anticipated annual out-of-pocket costs since it is nearly impossible for a patient to determine the negotiated rate to which the coinsurance percentage is applied. Moreover, numerous studies have shown that many consumers do not understand what the term coinsurance means or how coinsurance structures work in practice.<sup>iv</sup>

Copays offer greater certainty to patients who require health care services and prescription drugs as consumers will know precisely what the health care services and medications will cost to them. This allows consumers to plan financially for the care they'll need over the course of the year. For these reasons, we recommend that the standardized plans utilize copays instead of coinsurance.

**2. Ensure that the out-of-pocket cost for any one prescription is manageable**

As you know, coinsurance for prescription drugs has become common in Maine plans, especially for specialty medications that are critical to the treatment of life-threatening conditions. Coinsurance for specialty medications, especially levels of 30% or higher, can translate to thousands of dollars in out-of-pocket costs for patients. When cost-sharing becomes a barrier to access, patients do not use their medications appropriately, skipping doses in order to save money or abandoning a treatment altogether.

While copays typically offer more reasonable cost-sharing instead of a coinsurance, we recommend that consumers have more affordable cost-sharing in all metal tiers for prescription drugs. We recommend using a copay structure like DC, especially for specialty tier drugs. If coinsurance is used, we recommend capping out-of-pocket costs for a single specialty tier script as is done in DC. Evidence shows that adherence to medication diminishes as cost-sharing increases. In a survey done of people with employer sponsored insurance, approximately half of respondents reported skipping or postponing care or prescription drugs due to cost.<sup>v</sup>

**3. Eliminate the shock of a high, upfront deductibles**

The challenges of high coinsurance are worsened by the growing prevalence of high deductibles.

Massachusetts' structure is an example of utilizing reasonable copays in the pharmacy benefit that are applied pre-deductible. We support benefit design options at all metal level tiers that would include pre-deductible cost-sharing in the pharmacy benefit. A recent survey showed that consumers' top affordability challenge was paying medical bills prior to meeting their plan deductible.<sup>vi</sup>

**Other States to Consider**

We recommend that you review the efforts of Washington state on standardized benefits. The 2021 standard benefit plans for Washington can be found here:

[https://www.wahbexchange.org/wp-content/uploads/2020/04/2021-Standard-Plans-April-2020\\_UPD.pdf](https://www.wahbexchange.org/wp-content/uploads/2020/04/2021-Standard-Plans-April-2020_UPD.pdf). Numerous materials from the workgroup that helped develop the plans, including the reports of the independent actuarial firm hired by the insurance department, can be found online: <https://www.wahbexchange.org/about-the-exchange/cascade-care-2021-implementation/>

**Other Recommendations**

We recommend that the Bureau designate only one plan per metal level, rather than also offering a secondary option. Designating a single plan will be clearer to stakeholders and consumers as well as better meet the intent of the authorizing legislation.

We recommend that the Bureau work with patient and consumer groups to recruit a focus group of patients and consumers to review the draft standardized plans and share their understanding. This could be done remotely using the technology the Bureau is using for the stakeholder meetings. Patient and consumer groups could assist the Bureau in developing

questions for the focus group. The format could be similar to that used by the consultants hired on behalf of the consumer representatives of the National Association of Insurance Commissioners when looking at consumer understanding of short-term health plans. While this study was specific to short-term health plans, it included testing consumer understanding of basic insurance design – e.g., understanding of what the plan did and did not cover and understanding of cost-sharing terminology.<sup>vii</sup> This would allow the Bureau to determine if the standardized benefit design is meeting the goals of improved understanding and ability to compare plans on an apples-to-apples basis.

Similarly, we would welcome the opportunity to work with the Bureau on developing template decision-making tools to be used alongside the standardized benefit plans that would assist patients and consumers in understanding key health insurance terminology and to assist them in choosing the plan that best meets their health care needs.

## Conclusion

On behalf of the American Cancer Society Cancer Action Network, we thank you for the opportunity to provide comments and input as the Bureau of Insurance develops a draft plan for the Clear Choice benefit design. If you have any questions, please feel free to contact me at [hilary.schneider@cancer.org](mailto:hilary.schneider@cancer.org) or 207-373-3707.

Sincerely,



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

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<sup>i</sup> Ward E. Association of Insurance with Cancer Care Utilization and Outcomes. *CA: A Cancer Journal for Clinicians*. 2008; 58(1).

<sup>ii</sup> See <https://www.fightcancer.org/policy-resources/covid-19-pandemic-early-effects-cancer-patients-and-survivors-april-2020> and <https://www.fightcancer.org/policy-resources/covid-19-pandemic-ongoing-impact-cancer-community-may-2020> for more details.

<sup>iii</sup> For example, see: Kane, Ben, “Spring 2019 Journal: The Case for Standardization in Health Insurance Marketplaces,” *Berkeley Public Policy Journal*, March 7, 2019, <https://bppi.berkeley.edu/2019/03/07/the-case-for-standardization-in-health-insurance-marketplaces/#:~:text=Federal%20and%20State%20Activity%20toward%20Standardization&text=Comparing%20the%20market%20before%20and,also%20benefit%20from%20the%20change.>; Quincy, Lynn, “What’s Behind the Door: Consumers’ Difficulties Selecting Health Plans,” Consumers Union Health Policy Brief, January 2012, [https://advocacy.consumerreports.org/wp-content/uploads/2013/03/Consumer\\_Difficulties\\_Selecting\\_Health\\_Plans\\_Jan2012.pdf](https://advocacy.consumerreports.org/wp-content/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf)

<sup>iv</sup> Letter from NAIC Consumer Representatives, presented at April 2019 NAIC meeting, “New Consumer Testing Shows Limited Consumer Understanding of Short-Term Plans and Need for Continued State and NAIC Action,” [https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report\\_NAIC-Consumer-Reps.pdf](https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report_NAIC-Consumer-Reps.pdf); Loewenstein, George, et al., “Consumers Misunderstanding of Health Insurance,” *Journal of Health Economics*, Volume 32, Issue 5, September 2013, pp. 850-862, <https://www.sciencedirect.com/science/article/abs/pii/S0167629613000532?via%3Dihub>; Radius Global Market Research, “Health Insurance Literacy Survey,” October 17, 2016, Prepared for Policygenius, <https://www.policygenius.com/health-insurance/health-insurance-literacy-survey/>; Quincy, Lynn, “What’s Behind the Door: Consumers’ Difficulties Selecting Health Plans,” Consumers Union Health Policy Brief, January 2012, [https://advocacy.consumerreports.org/wp-content/uploads/2013/03/Consumer\\_Difficulties\\_Selecting\\_Health\\_Plans\\_Jan2012.pdf](https://advocacy.consumerreports.org/wp-content/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf)



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<sup>v</sup> Hamel, L., Munana, C. & Brodie, M. (May 2, 2019). Kaiser Family Foundation/LA Times Survey Of Adults With Employer-Sponsored Insurance. *Kaiser Family Foundation*. Retrieved from: <https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-section-2-affordability-of-health-care-and-insurance/>

<sup>vi</sup> Hamel, L., Munana, C. & Brodie, M. (May 2, 2019). Kaiser Family Foundation/LA Times Survey Of Adults With Employer-Sponsored Insurance. *Kaiser Family Foundation*. Retrieved from: <https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-section-2-affordability-of-health-care-and-insurance/>

<sup>vii</sup> See Kleiman Communication Group, *Report on Testing Consumer Understanding of a Short-Term Health Insurance Plan*, March 15, 2019, found at: [https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report\\_NAIC-Consumer-Reps.pdf](https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report_NAIC-Consumer-Reps.pdf), accessed on August 21, 2020.

## Greenleaf, Brittnee L

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**From:** Ossenfort, Kristine <Kristine.Ossenfort@anthem.com>  
**Sent:** Friday, August 28, 2020 4:38 PM  
**To:** Cioppa, Eric A; Rawlings-Sekunda, Joanne; Hooper, Mary M  
**Cc:** Greenleaf, Brittnee L  
**Subject:** Clear Choice Plan design comments

**EXTERNAL: This email originated from outside of the State of Maine Mail System. Do not click links or open attachments unless you recognize the sender and know the content is safe.**

Dear Superintendent Cioppa, Ms. Rawlings-Sekunda, and Ms. Hooper:

Thank you for the opportunity to offer comments with respect to the Bureau's effort to create standardized plan designs pursuant to 24-A M.R.S. §2793. As discussions continue, we may seek to expand on these comments and will undoubtedly have additional comments to share but at the present time, Anthem would like to offer the following:

### ***General comments***

1. The development of Clear Choice plan designs has the potential to create significant disruption in the market, which will likely lead to significant member abrasion. We would note that the risk of disruption and abrasion increases significantly if the individual and small group markets are merged and the Clear Choice plan design requirements are imposed at the same time. As a result, we would suggest that the Bureau start with establishing Clear Choice plan design requirements for just a few essential health benefits (EHBs) in this first year.
2. It has not yet been determined whether the individual and small group markets will merge, it will be necessary to develop three sets of Clear Choice plan designs:
  - Individual market;
  - Small group market; and
  - Merged market
3. A variety of Clear Choice plan design options should be developed for each metal level in order to maximize choice, create a number of different price options, and minimize disruption and abrasion. Carriers should be provided as much flexibility as possible in plan design in order to achieve lower price points and maintain affordability. As was noted in the call on August 12, standardized plan elements do not lead to lower costs and maintaining affordability of these products will be critically important.
4. There are significant differences in plan designs in the individual and small group markets. Since Clear Choice plan designs will apply to both the individual and small group markets, current plan designs in both markets must be taken into account as the Clear Choice products are developed. Understanding that there are resource constraints and that there are a number of different plan offerings in the market today, we would suggest that the BOI could ask each of the carriers to select three plans by metal level in both the individual and small group markets for consideration as the BOI moves to develop the Clear Choice plan designs.
5. Clear choice plan designs must be available for a variety of plan structures and networks (HMO, POS, PPO, tiered networks)
6. In order to maintain affordability, we would suggest that office visit copays apply to the office visit only, with other services within the visit subject to deductible and coinsurance.

7. The Clear Choice plan designs must allow for value added benefits such as “right to shop” incentives, wellness incentives, etc. In addition, it must be permissible to include those benefits in some plans and not others (such as small group plans but not individual plans). For example, the “right to shop” legislation intentionally excluded individual market plans from its application because of the complexities it would create for members who receive advance premium tax credits.
8. What will be the process and timing for obtaining approval of alternative plan designs? Would that occur during the normal rate/form filing process, or will it need to be obtained in advance?
9. We encourage the Bureau allow three alternate plan designs for each metal level. Again, consumer choice and affordability will be extremely important in order to minimize disruption and abrasion.
10. As previously noted, changes to the AV calculator for 2021 cause a number of plans to fall out of AV compliance. How will changes that may need to be made in order to maintain AV compliance be addressed?

***Comments on questions posed by the Bureau:***

11. How should pediatric dental be handled? Currently, pediatric dental is embedded in individual products sold off exchange, but not in those on exchange. We are still considering this question and may provide the Bureau with additional feedback on this issue.
12. HSA plans—we believe it is important to provide HSA plan options at the gold, silver, and bronze levels for both individual and small group purchasers.
13. Mental health parity--do carriers have any suggestions on how to implement? As the Bureau staff noted, mental health parity will be challenging to implement successfully. We would suggest that the Bureau may wish to consult with an expert early in the process in order to evaluate whether such designs can meet the requirements of mental health parity, particularly since the plan designs must pass quantitative testing for different levels of utilization. (It is our understanding that the State of Connecticut may have had to redesign its plans as carriers began testing and the plans did not pass the quantitative testing.)
14. Timing—In order to determine which plans we will offer, pair them with networks, price them, and make any required system changes to build and implement the benefit structures, the Clear Choice plan designs should ideally be finalized by the end of 2020, but no later than January 2021.

***Comments on the BOI Spreadsheet (Standardized Plans 08-12-2020)***

15. It is difficult to comment on the plan designs developed for other markets, as many of those states have very different landscapes in terms of health care costs and provider competition; products that offered in those states may not translate well to a state like Maine. We will continue to review and may provide additional feedback to the Bureau.

Thank you again for the opportunity to share these comments and questions. Please let me know if you have any questions, and we look forward to further discussions on September 15.

Sincerely,

Kris

**Anthem, Inc.**

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**Kristine M. Ossenfort**, *Senior Government Relations Director*

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**SAFE SPACE ALLY** *Pronouns: She, her, hers*

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Dear Ms. Hooper,

Consumers for Affordable Health Care (CAHC) appreciates the opportunity to participate in the Clear Choice stakeholder group and to provide the following comments. CAHC is a nonprofit, nonpartisan organization with the mission to advocate for Maine people to be heard, respected, and well-served in a health system that provides coverage, access and quality, affordable care to all. CAHC serves as Maine's Health Insurance Consumer Assistance Program, which provides toll-free access to certified application counselors, who help Mainers understand their health coverage options and how to apply and enroll in private health insurance.

Through this work, we often hear from Mainers who are confused about their health coverage options and how to select an insurance plan that best meets the needs of their families or employees. Clear choice designs can help to simplify this process and lessen consumers' burden when it comes to plan choice. A study in Massachusetts conducted by the National Bureau of Economic Research found that the introduction of standardized plans "increased consumer welfare."<sup>1</sup> This is partially due to the complexity of health insurance and low levels of health insurance literacy. Standardizing benefits enables consumers to make apples-to-apples comparisons and allows carriers to distinguish their plans based on price, provider networks, drug formularies, and quality. It's important to note that in addition to the benefit structure of clear choice plans, the design and format of the exchange website and how clear choice plans are displayed and identified on the website will also be crucial to realizing the potential benefits and goals of standardizing benefits.<sup>2</sup>

### **Improving Access to Affordable Coverage**

We strongly urge the Bureau to consider the impact of changes to the rate and benefit design of the second-lowest-cost silver plan (SLCSP) offered on the Marketplace in any given region. As these plans are used as the benchmark for calculation of advance premium tax credits ("APTC") received by all consumers in a region purchasing Marketplace plans, the SLCSP has an outsized impact on all consumers receiving APTC, regardless of which particular plan or metal level an individual selects, as the Bureau is well aware.

For this reason, New York requires silver plans offered in the individual market, including both standard and non-standard silver plans, to have an actuarial value (AV) of at least 70%, with a

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<sup>1</sup>Keith M. Marzilli Ericson, Amanda Starc, "How Product Standardization Affects Choice: Evidence from the Massachusetts Health Insurance Exchange," the National Bureau of Economic Research, Working Paper No. 19527. Available at <https://www.nber.org/papers/w19527>.

<sup>2</sup> Sabrina Corlette, Sandy Ahn, Kevin Lucia, and Hannah Ellison, "Missed Opportunities: State Based Marketplaces Fail to Meet Stated Policy Goals of Standardized Benefit Designs." Available at <https://www.urban.org/sites/default/files/publication/82611/2000862-Missed-Opportunities-State-Based-Marketplaces-Fail-to-Meet-Stated-Policy-Goals-of-Standarized-Benefit-Designs.pdf>

permissible de minimus variation of +2% AV.<sup>3</sup> We believe it is extremely important that the benefit structure for silver-level clear choice design plans in Maine have an actuarial value (AV) of at least 70%, to ensure consumers are able to afford the most comprehensive and rich benefits possible.

Given the potential market incentives for offering the lowest cost or second-lowest cost silver Marketplace plan in a particular region, we also strongly encourage the Bureau to reject any clear choice design opt-out requests for individual market silver plans that do not have an AV metal level of at least 70%, in order to prevent the availability of a lower value from undermining consumer's purchasing power and ability to afford a silver clear choice design plan.

### **Out-of-Pocket Costs**

It is a simple truth; cost is a barrier to care, including the cost of high deductibles. According to survey data of collected in 2018 by the Kaiser Family Foundation, more than half of individuals covered by employer sponsored insurance (ESI) report that they or a family member have delayed or skipped getting health care or filling a medication within the last 12 months. Workers with deductibles of \$1,500 or higher for individuals or \$3,000 or higher for families were more than 50% more likely to report delaying or skipping care than those without a deductible.<sup>4</sup> Only one of the individual plans that will be offered in Maine next year will have a deductible less than \$1,500 or \$3,000 for a family, and deductibles for silver-level plans will be as high as \$6,000.

The enhanced coverage for the first 3 primary care and behavioral health office visits under LD 2007, the *Made for Maine Health Coverage Act*, will go a long way to helping ensure Mainers can actually use the coverage they're paying for, instead of delaying or forgoing care due to high deductibles. Not only is cost-sharing waived for the first visit for each type of service, but plans also will not be able to apply a deductible or coinsurance to the 2<sup>nd</sup> and 3<sup>rd</sup> visits. This will improve accessibility to services in two ways: 1) it provides "first-dollar" coverage by eliminating the requirement to meet expensive deductible amounts, and 2) it utilizes copayments over coinsurance, making it easier for consumers to understand what costs they will be responsible for paying.

Numerous surveys have revealed low levels of health insurance literacy among consumers and that many people do not understand basic insurance terms like "deductible," "copay," or "coinsurance."<sup>5</sup> Coinsurance, however, is a particularly difficult concept for people to

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<sup>3</sup> Invitation and Requirements for Insurer Certification and Recertification for Participation in 2021, NY State of Health. Available at <https://info.nystateofhealth.ny.gov/sites/default/files/2021%20NY%20State%20of%20Health%20Plan%20Invitation%2C%20revised%205-8-20.pdf>

<sup>4</sup> Ashley Kirzinger, Cailey Muñana, Bryan Wu, and Mollyann Brodie, "Americans' Challenges with Health Care Costs," Kaiser Family Foundation. Available at <https://www.kff.org/health-costs/issue-brief/data-note-americans-challenges-health-care-costs/>.

<sup>5</sup>Altman, D. "A Perilous Gap in Health Insurance Literacy."

understand and use to calculate their expected out-of-pocket costs for a covered benefit, since coinsurance requires consumers to use math skills on top of comprehending health insurance terms. Results from a survey conducted by the Kaiser Family Foundation revealed consumers were less likely to be able to successfully calculate out-of-pocket costs for a service when doing so required math.<sup>6</sup> For this reason, we encourage the Bureau to build on the improvements under LD 2007 by prioritizing the use of pre-deductible copays over coinsurance, particularly for prescription drugs and frequently used services.

### **Coverage for Mental and Behavioral Health Services**

Through our Consumer Assistance Program HelpLine, we have heard from Mainers with private Marketplace insurance coverage who face financial barriers to accessing mental and behavioral health services or experience difficulty finding a health plan that meets their needs. This is partially due to health plan benefit structures that subject all mental and behavioral health office visits to a deductible, even when the deductible is waived, and copays are used for office visits to treat and manage physical health conditions.<sup>7</sup> The new coverage requirements required by LD 2007 will help address this issue by removing or minimizing financial barriers for the first 3 behavioral health office visits. However, many Mainers with mental and behavioral health and substance use issues may need ongoing support and counseling or for an extended period of time. We encourage the Bureau to ensure Mainers receive equitable coverage for mental and behavioral health services and that office visit cost sharing requirements for these services do not exceed the cost of primary care office visits, as California and DC have done in the benefit designs for their standard health plans.

### **Coverage for Pediatric Dental Benefits**

In general, embedding pediatric dental into Qualified Health Plan (QHP) benefits is the best way to ensure that any family purchasing coverage on the Marketplace actually gets affordable dental coverage for their children (no additional premium, no need to shop for another plan, no risk that they check out without a dental plan, etc. One analysis published in *The Journal of Pediatrics* compared the difference in premiums and out-of-pocket costs between embedding pediatric benefits in QHP versus and the costs of stand-alone dental plans for various patient profiles. The impact of embedding pediatric dental benefits to QHP premiums was found to be minimal (about \$7/month) and in almost every scenario, total out-of-pocket spending (including on premiums and cost-sharing) are lower for families when pediatric dental is embedded in the QHP. This is true even when pediatric dental benefits are subject to the deductible, however given that medical deductible are usually quite high, this would likely still

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*The Wall Street Journal*, September 4, 2014. Available at: <https://blogs.wsj.com/washwire/2014/09/04/a-perilous-gap-in-health-insurance-literacy/>

<sup>6</sup> <https://www.kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/>

<sup>7</sup> For example, Anthem Bronze X HMO 5000 Online Plus health plan waives the deductible for PCP and specialist office visits, which have \$35 and \$80 copays, respectively, but applies the \$5,000 deductible and 35% coinsurance applies to mental and behavioral health office visits.

create significant cost barriers for families to access the pediatric dental benefits.<sup>8</sup> For this reason, we would recommend looking to DC, CT, and CA, which have all structured their standard plan designs such that pediatric dental is exempt from the QHP deductible.

## Conclusion

Thank you very much for this opportunity to provide these comments. We understand and appreciate the hard work that has already and will continue to go into developing clear choice plan designs. If you have any questions, please feel free to contact me at 207-485-1476 or [kende@mainecahc.org](mailto:kende@mainecahc.org).

Sincerely,

Kate Ende  
Policy Director  
Consumers for Affordable Health Care

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<sup>8</sup> Marko Vujicic, PhD, and Cassandra Yarbrough, MPP, “Estimating Premium and Out-of-Pocket Outlays Under All Child Dental Coverage Options in the Federally Facilitated Marketplace,” *The Journal of Pediatrics*, Vol. 182. P349-355.E1, March 01, 2017. Available at: [https://www.jpeds.com/article/S0022-3476\(16\)31275-6/fulltext](https://www.jpeds.com/article/S0022-3476(16)31275-6/fulltext).



## Greenleaf, Brittnee L

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**From:** Hooper, Mary M  
**Sent:** Friday, August 28, 2020 5:02 PM  
**To:** Rawlings-Sekunda, Joanne; Cioppa, Eric A; Wake, Robert A; Yardley, Benjamin  
**Cc:** Greenleaf, Brittnee L  
**Subject:** FW: Clear Choice comments

To post or email to stakeholders?

Marti

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**From:** Whitmore, William <Bill\_Whitmore@harvardpilgrim.org>  
**Sent:** Friday, August 28, 2020 4:24 PM  
**To:** Hooper, Mary M <Mary.M.Hooper@maine.gov>  
**Cc:** Boles Welsh, Erin <Erin\_Boles\_Welsh@harvardpilgrim.org>; Regan, David <David\_Regan@harvardpilgrim.org>  
**Subject:** Clear Choice comments

**EXTERNAL: This email originated from outside of the State of Maine Mail System. Do not click links or open attachments unless you recognize the sender and know the content is safe.**

Marti, thank you for the opportunity to comment on the Clear Choice benefit design being worked for the individual and small group market sin 2022. Following are some comments and questions for consideration:

1. Currently, insurers can introduce new product options during the calendar year in the small group market. Will the ability to do so be maintained?
2. Tiered and narrow networks make up a significant portion of both the individual and small group markets. If possible benefit structures that retain the ability to offer these products is important.
3. Our understanding of the market is that copays are easier to understand for the consumer than coinsurance.
4. In the previous meeting with constituents there was some discussion of only applying the standardized benefits to a limited set of services. If this is the case and insurers then apply other cost sharing to other services this would create a more confusing set of benefits than currently exists.
5. Insurers will be allowed to file for approval an additional three benefit sets. Will that be three per year or just three in total that roll year to year? Also, will insurers be able to file additional products off Exchange?
6. The BOI might consider using the most popular (by membership) benefit designs in the market and modeling the standardized benefits off these designs.
7. Has the BOI considered a glide path into the full slate of Clear Choice designs? For example, possibly only introduce one standardized benefit per metal level in 2022, learn, and then go further in 2023.
8. There are some products offered by insurers currently that are available in different regions for individuals and small groups. Will that still be possible inside Clear Choice?
9. Will insurers be required to offer identical HMO and PPO options (with the difference being out of area benefits)?
10. Below is a table as a potential starting point. Note that this is HMO only, no HSA, PPO, or tiering contemplated (focus on medical benefits).

I recognize that this was the comment deadline but also that this will be a collaborative and iterative process. Please let me know of questions.

Bill

## Clear Choice Benefit Suggestions

### Non-HSA plan Type (HMO)

Benefit	Suggested Value	AV (weighted)	Notes
<b>Ded</b>	\$0 - maximum	Medium	Varies by metal level
<b>OOPM</b>	\$2000 - maximum	Medium	Varies by metal level
<b>Coinsurance</b>	0% - 50%	Medium	Varies by metal level
<b>PCP*</b>	Copay (\$20 - \$50)	Low	Varies by metal level
<b>Specialist</b>	Copay (30 - \$70)	Low	Varies by metal level.
<b>ER</b>	Ded then Coinsurance or Ded then Copay	High	Varies by metal level. Individual ER has been high. May want to consider ER at
<b>Labs</b>	Copay	Low	Is there opportunity for Site
<b>Inpatient</b>	Ded then Coinsurance	High	
<b>Day Surgery</b>	Ded then Coinsurance	High	
<b>Urgent Care</b>	Copay	Low	Non-Hospital owned
<b>X Rays</b>	Copay	High	
<b>High End Radiology</b>	Ded then Coinsurance	Low	Is there opportunity for Site
<b>Mental Health Outpatient</b>	Copay or Ded then CIF	Low	Must follow FMHP guidelines. CIF. Typically follows OV co other benefits
<b>PT/OT/ST</b>	Copay	Medium	Will Visits limits have to be

**\*Free PCP, Copay (second & third visit), 4th can be at a Ded**

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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 Aug 12 Meeting

Dear Ms. Hooper:

On behalf of The Leukemia & Lymphoma Society (LLS), thank you for the opportunity to provide the following comments regarding the August 12<sup>th</sup> meeting of the Clear Choice Stakeholder Group. While LLS was not a participant in that initial meeting, we have reviewed notes and since been added to the stakeholder distribution list. We are grateful for the opportunity to provide insight and recommendations to help inform the Group's work going forward.

At LLS, our 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. We represent the nearly 1.4m 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. It is our focus on patient access to quality and affordable health care that drives the following input into the Group's work.

In short, our recommendations fall along three broad lines. We feel it is imperative that Clear Choice plans:

- Keep plan designs transparent and comprehensible, so that patients know what they're buying;
- Keep prescription costs manageable, so that patients can afford their treatments;
- Keep pre-deductible coverage robust, so that patients can manage costs.

#### **Transparent and comprehensible plan design**

The name "Clear Choice" implies exactly that: clarity. Given how important it is for patients and consumers to know what they're buying when they seek to purchase insurance for themselves and their families, Clear Choice plan designs offer a compelling opportunity for Maine to dramatically simplify the process of comparing coverage. We urge the State to carefully consider ways to meet consumers where they are when it comes to their health literacy and a lay understanding of insurance design terminology, ensuring that Clear Choice plans offer benefits that consumers can reasonably be expected to understand.

A 2019 report to the National Association of Insurance Commissioners found that participants in a focus group were unfamiliar with the term coinsurance and struggled to comprehend what it meant as far as their exposure to costs associated with plan benefits.<sup>1</sup> That same study found that disclosure notices went “largely unnoticed”: we therefore do not expect that this is a problem that can simply be solved by providing more plan documentation as part of the enrollment process (though we certainly support the availability of plain-language explanations of insurance terms and robust plan documentation and disclosures being made available to patients, consumers, and potential enrollees).

We therefore suggest that Clear Choice plan designs be made available in as transparent a manner as possible. This includes simple, searchable provider network and pharmaceutical tier lists. Additionally, Clear Choice plans should offer copay-only prescription benefits coverage and avoid the use of coinsurance to the greatest extent possible, at all prescription tiers and all metal levels.

### **Manageable prescription costs**

Discussions of health literacy cease to be academic when a patient with a chronic condition is trying to buy a plan, where a mistake or a misunderstanding could result in potentially thousands of dollars in unanticipated costs. It is not enough for a plan to simply “cover” a needed drug on a formulary if the patient cost-sharing is so high as to make the drug functionally unobtainable.

Multiple<sup>2</sup> studies<sup>3</sup> have demonstrated that patient adherence to prescribed medication regimens correlates strongly with their exposure to out-of-pocket costs. Put simply, as costs go up, the number of patients who take their meds as prescribed goes down.

We therefore urge Maine, in addition to adhering to a copay-only structure for simplicity, to keep those copays as low as is possible in order to maximize the ability of patients to access the drugs they need. We feel this should be applied to all prescription tiers at all metal levels.

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<sup>1</sup> “New Consumer Testing Shows Limited Consumer Understanding of Short-Term Plans and Need for Continued State and NAIC Action,” [https://healthyfuturega.org/wpcontent/uploads/2019/04/Consumer-Testing-Report\\_NAIC-Consumer-Reps.pdf](https://healthyfuturega.org/wpcontent/uploads/2019/04/Consumer-Testing-Report_NAIC-Consumer-Reps.pdf) (Accessed August 26, 2020)

<sup>2</sup> Devane, Katie, Katie Harris, and Kevin Kelly. “Patient Affordability Part Two: Implications for Patient Behavior & Therapy Consumption.” IQVIA. (May 2018) Available online at: <https://www.iqvia.com/locations/united-states/patient-affordability-part-two> (Accessed August 26, 2020)

<sup>3</sup> Streeter, S.B., Schwartzberg, L., Husain, N., Johnsrud, M. “Patient and plan characteristics affecting abandonment of oral oncolytic prescriptions.” American Journal of Managed Care. 2011. 175 (5 Spec No.): SP38-SP44.

### **Maximize first-dollar coverage**

Making plan coverage understandable and keeping prescription copays reasonable is only useful when first-dollar coverage is maximized. A copay that is comprehensible and affordable ceases to be either when it is walled behind a hefty deductible, which studies have shown is a significant barrier to patient access to covered services.<sup>4</sup> We therefore urge that, to the greatest extent possible within the constraints of actuarial value and other benefit design considerations, pre-deductible prescription coverage be prioritized when designing Clear Choice plans.

### **Additional considerations**

We feel that one of the greatest benefits that Clear Choice plans present to consumers is, as previously stated, their very clarity and simplicity. We therefore recommend against creating multiple variants, versions, or “tiers” of Clear Choice plans, and instead suggest uniformity in plan design within tiers.

We encourage the State to follow Washington state’s lead and hire external actuaries to assist in the review of Clear Choice designs. Stakeholders in Washington, including LLS, found the additional expertise and perspective of a third-party actuarial firm in the design process helped to balance stakeholder input.

We encourage the State to consider approving only Clear Choice designs that meet an actuarial value (AV) of 60% or greater for Bronze, 70% or greater for Silver, and 80% or greater for Gold plans. LLS opposed the expansion of the allowable de minimis AV variation for most plans from -2/+2 to -4/+2 in the 2017 Marketplace Stabilization Rule. Our position now is the same as it was then: we believe consumers are best served by plans that provide a healthy overall value proposition that balances premiums against out-of-pocket costs. That includes limitations to out-of-pocket exposure *within* a metal level, and by ensuring that plans demonstrate meaningful variance in AV *between* metal levels. While we appreciate that achieving a specific AV can be challenging, we would note that Silver-level plans offered to meet CSR requirements have been allowable only within a -/+1 de minimis variation to their 73%, 87%, and 94% values.<sup>5</sup> We are therefore confident that the State can achieve Clear Choice designs that meet our recommended thresholds.

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<sup>4</sup> Hamel, L., Munana, C. & Brodie, M. (May 2, 2019). Kaiser Family Foundation/LA Times Survey Of Adults With Employer-Sponsored Insurance. Kaiser Family Foundation. <https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-section-2-affordability-of-health-care-and-insurance/> (Accessed August 26, 2020)

<sup>5</sup> Jost, Timothy. “Examining The Final Market Stabilization Rule: What’s There, What’s Not, And How Might It Work? (Updated)” Health Affairs Blog. (April 14, 2017). Available online at: <https://www.healthaffairs.org/doi/10.1377/hblog20170414.059646/full/> (Accessed August 27, 2020)



We would note one clarification to the spreadsheet of standard benefit designs in other states: while New York does not limit plans to three tiers through the standard benefit design, New York state statute does prohibit the use of specialty drug tiers in plans sold in the state.

We welcome the opportunity to be of further assistance to the State and the Group as this work proceeds, and look forward to engaging as a member of the Group moving forward.

Please reach out to me directly with any questions, concerns, or requests for further information at [steve.butterfield@lls.org](mailto:steve.butterfield@lls.org) or 207-213-7254.

Steve Butterfield  
Regional Director of Government Relations  
The Leukemia & Lymphoma Society



August 28, 2020

Joanne Rawlings Sekunda  
Marti Hooper  
Maine Bureau of Insurance

Dear Joanne and Marti,

I am writing in response to your request for comments on the Bureau's development of Clear Choice (CC) products.

Several of the Plans are offering individual comments however, these comments from MeAHP address overriding concerns shared by all our members: 1) timing, 2) market disruption, and 3) skepticism about the value of moving to standardized plans. We also raise several questions and requests for clarification.

#### Timing

The Plans are concerned that an unrealistic timeline is being put forward that does not give sufficient time to operationalize the new product offerings. The development and pricing of new product designs involves substantial administrative complexity. All will need time to develop new products and materials, systems and computer changes, marketing and education plans, and whatever else is needed to ensure a smooth rollout. For all this to be accomplished in a timely manner, either CC designs need to be finalized by the end of October, or the whole process needs to be slowed down.

The challenges and disruptions due to COVID have been significant and will likely be ongoing and possibly even worse during the second wave anticipated this coming fall and winter. Responding to the coronavirus and ensuring that people get the care they need is rightly a top priority. With that in mind, resources are spread thin and we urge the Bureau to take a careful look at timing expectations to minimize unintended consequences. Our Plans want to bring strong products to market with the least possible disruption and foresee that some timing changes may be necessary to do so.

#### Market disruption and confusion

Whether the markets will be merged or not will have a tremendous impact on the work that Plans have to do under CC. Without the merger, plans will be developing separate products for individual and small group customers. If the markets are merged, far fewer products will be needed to serve the combined markets. In effect, Maine will go from

having 100's of plan options to a handful. This is not to suggest a preference for one path or another (we'll be offering separate comments on that at the appropriate time), but rather to emphasize the importance of knowing whether or not the merger is proceeding before designing and pricing CC products. Given the timelines for each, the Bureau may want to consider how they will work in relation to one another and if the current timing envisioned makes sense. For example, back to back disruptions may be more painful for longer than implementing both simultaneously.

Additional complexity and administration will be especially important for employers (and brokers) who will need to educate themselves, their employees and dependents about the new plan options. All will need time to understand the new products and materials, and develop marketing, education and enrollment strategies.

#### Skepticism about the value of CC plans

Expectations among consumers and policy makers that CC products will solve underlying market challenges need to be carefully managed. Current consumer concerns center around the pandemic as well as issues such as surprise billing and whether labs are covered as preventive services -- these concerns are not going to be solved or even addressed by CC plans. Limiting Plans' ability to use cost sharing to control premium cost may actually lead to higher premiums and/or reduced benefits. Moreover, forcing carriers to limit co-payments further shelters providers, allowing them to charge higher amounts without impacting consumer cost shares.

#### Outstanding questions and requests for clarification

- Please clarify that Plans do not have to offer plans at all metal levels – i.e. no platinum currently offered
- Please confirm that CC will standardize co-pays/cost-sharing, not services offered.
- How will the Bureau be educating and communicating to purchasers about changes to the marketplace?
- How will the Bureau handle AV calculations? Some states are running their own default calculation to mitigate risks of standardized plans producing different AV results across plans.
- Standardized plans are not typically required off Exchange and plans are not limited off Exchange. Will Maine adopt this approach?
- Has the Bureau considered minimizing its intervention by selecting only a subset of EHBs to regulate/standardize cost sharing on? This approach would permit some flexibility for the Plans that currently offer a lot of variety and choice to meet the needs of purchasers.



- Has the Bureau considered offering a range of co-pays instead of one specific number i.e. \$20-\$35 for PCP or standardization of co-pay corridors across CC products i.e. \$20-\$50-\$100?
- Has the Bureau considered permitting Plans to meet CC requirements by choosing among variables including deductibles and OOP Max. and/or cost shares?
- How will the Bureau ensure that Plans can continue to incentivize high value services and sites?
- Has the Bureau considered developing a wide range of CC products which could permit a broader range of health plan offerings? If only one CC product is determined for each metal level, Plans will be capped at 3 additional plans as approved by the Superintendent.

Thank you for the opportunity to offer these comments.

Sincerely,

A handwritten signature in cursive script, reading "Katherine D. Pelletreau".

Katherine D. Pelletreau

Cc: MeAHP Board of Directors

## Clear Choice Design Committee

### Comments from Maine Association of Health Underwriters

August 20, 2020

#### State specific comments

1. California:

- a. This set of benefits appears to be the most robust but in doing so, I believe they may have locked themselves into an overly rich program with not much opportunity to use cost sharing to reduce costs. For example, in the Silver and Bronze plans, other than the HDHP options, a lot of the services were prior to the deductible which greatly diminishes the impact of the deductible. In fact, it appears that the only significant item which is applied to the deductible is inpatient hospital but with diminishing inpatient care, that deductible has little impact. Our feeling is that the negative reaction from seeing a large inpatient deductible greatly outweighs its impact on costs. You can always increase the various copays, but it would really have to be an across the board increase to have any meaningful impact. I realize consumers like services with no deductibles, only copays but that's what the higher metal levels are for and also why they are more expensive. I would strongly urge the committee to resist including a lot pre-deductible items.
- b. Also, we don't recommend making dental an integral part of the plan. Preventive dental for children is the only required benefit so making it a rider allows members with no children to avoid this cost. We understand that including it spreads a relatively small cost over a larger population making the cost in the premium even smaller but it's a benefit that many members with no dependent children will ever be able to use.'

2. Connecticut:

- a. CT has no Platinum plans available which we don't agree with. All plans participating should offer all 4 metal levels. Also, it appears that CT has separate in network and out of network deductibles and Out of Pocket (OOP)Maximums. The fact that they offer POS plans as Standard designs is a plus but not a necessity. If the objective is cost, then requiring a POS plan as a Nonstandard benefit is probably better than making it the primary plan. However, if the networks of the primary carriers aren't sufficiently complete, then a POS may be a necessity.. A plan with good network coverage should be able to offer a more competitive premium than a POS plan, even with cost controls on OON reimbursements. We've found POS plans with higher member coinsurance causes a significant amount of issues when plan members are left with high Out of Pocket costs. Balance billing above the allowed amounts causes confusion with members as well

3. DC:

- a. DC has a similar issue with services covered prior to the deductible which we've already discussed.

4. MA:

- a. The MA plans do a better job of including benefits under the deductible with most services other than physician visits going towards the deductible and then having a

copay apply. We realize that it's more cost sharing for these services, but these are services that are not really considered insurable events in the purest sense. Insurance should be for those unexpected, high cost events, not physician visits. The tradeoff is a lower premium in return for paying more out of pocket when the service is needed.

5. NYS:

- a. The State allows up to three nonstandard plans per carrier per tier but does not allow any carrier to load up their nonstandard offerings in a single tier. This prevents what amounts to an avenue around medical underwriting.

6. OR/VT:

- a. We didn't really see anything specific in these plans that would warrant additional comments beyond those we've already made

### **Summary notes:**

Standardization of benefit plans is one of those decisions that is really not difficult to make. It should be done to achieve the goal of the ACA to allow consumers to make more informed decisions. By eliminating the need to read the minutiae of an insurance contract, enrollment will be facilitated and there will be a higher level of satisfaction with the plan chosen.

From the carrier's perspective, standardization allows plans to offer benefits they might not necessarily be inclined to for fear of adverse selection. If all plans must offer a particular therapy, for example, then any one particular plan won't be selected against if they are the only carrier to offer that benefit.

One note about benefit design of which I'm sure the Bureau is aware: any standard design needs to recognize the benchmark plan benefits and not go above since that would require the State to pick up the difference in premiums.

There needs to be a mechanism built in to regularly collect feedback from the people using the plans and also from those who choose to remain uninsured. While the collective wisdom of this Committee, the Bureau of Insurance and the Dept. of Health is broad, it certainly does not capture every sentiment from the members who will be using these plans. The feedback should be used to adjust benefits, identify gaps and possibly rating tiers. But also, it's a mechanism to provide to the members about why the plans operate the way they do. Many times, frustration can be minimized with explanations.

There have been several bills brought forward in the Legislature to offer a public option alongside private plans. While our organization has and will always oppose a public option, offering standardized plans could be a de facto public option with the Legislature determining benefits and the private carriers delivering the insurance.

To address a concern expressed on the 8/12/2020 call, the Actuarial Value (AV) calculation uses national data and is not plan specific. I think the issue was that if plan specific experience differs deductibles. e.g., will have different impacts for each plan. An inpatient deductible for a plan with a low Admission Rate per 1000 will have less of an impact on premium rates than a plan with a higher Admission Rate per 1000. We have done several Minimum Value (MV) Calculations for self-funded

Clients which is similar to the AV calculation. This also uses national data that HHS obtains from the MarketScan Commercial Claims and Encounters Database. While this is employer group data, our understanding is that the AV calculator uses similar national data which will negate any difference that may be caused by variations in plan specific experience

## Greenleaf, Brittnee L

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**From:** Barbara Leonard <bleonard@mehaf.org>  
**Sent:** Monday, August 31, 2020 5:59 PM  
**To:** Greenleaf, Brittnee L; Hooper, Mary M  
**Subject:** Clear Choice Plan Comments

**EXTERNAL: This email originated from outside of the State of Maine Mail System. Do not click links or open attachments unless you recognize the sender and know the content is safe.**

Dear Brittnee and Marti,

My apologies again for being a bit late with these comments. We had a bunch of major deadlines at MeHAF last week that required my full focus.

My comments are noted below. As I've mentioned, I'm not a plan design expert, but I'm sharing some thoughts based on my knowledge of Maine demographics, our work on integrated care, and my role as leader of a small business that must purchase in the individual market. Please reach out if you have questions about what I've noted.

### General comments:

- Simplifying the plan design to the extent possible will help people understand their benefits and make decisions about purchasing and comparing among plans.
- A family max out-of-pocket is important, in addition to individual max out-of-pocket – especially for inpatient hospital services. (Note: MeHAF currently has a plan with up to \$13,000 family max out-of-pocket for out-of-network – a potentially catastrophic amount for many people in Maine.)
- Can imaging coverage be managed to encourage appropriate alternative therapies to avoid low-value care? And if so, is there a way to ensure access to those alternative therapies?

### Prescription benefits:

- See above comment about simplifying. If a three-tier Rx plan could be possible, I think it would help consumers understand what they're purchasing.
- It's not clear which state has the \$35 insulin limit noted by asterisk – or is this a design aspect of the Maine plan that will be included no matter what?
- Other critical chronic disease management pharmaceuticals may warrant limits on pricing or no/minimal copays: e.g., for high blood pressure; for depression, anxiety, SUD.

### Questions:

- To what extent will some of the plan design align with MaineCare's value-based purchasing design?
- How will behavioral health/SUD treatment be included in plan design? Meaningful coverage for these, and integration of behavioral health with primary care may reduce other costs.
- OT/PT coverage? Diabetes supplies? OT/PT coverage? Durable medical equipment?
- Is there a way to "harmonize" the four insurance regions in the state so that those in more rural areas don't experience such a disparity in coverage costs?

Kind regards,

Barbara

*MeHAF staff members are working remotely until further notice as we do our part to flatten the curve and slow the spread of COVID-19.*

Barbara A. Leonard, MPH | President and CEO | [MeHAF](#)

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January 21, 2020

Submitted electronically via [PMPolicy@cms.hhs.gov](mailto:PMPolicy@cms.hhs.gov)

**Re: Covered California comments on Draft 2021 Actuarial Value Calculator and Methodology**

Covered California respectfully provides comments regarding the Draft 2021 Actuarial Value (AV) Calculator and Methodology, as published on December 20, 2019. Covered California is California's state-based Marketplace through which consumers can purchase affordable, high-quality health coverage. Through our strong relationships with the 11 health insurance companies participating in Covered California, consumer advocates, and clinicians, we have established patient-centered benefit designs that help mitigate the impact of deductibles, and thus increase value and access to care by the consumer. As such, Covered California has significant concerns that the proposed changes to the 2021 AV Calculator will drive cost-sharing increases for consumers.

Covered California observes significant AV increases in its Bronze plans from 2020 to 2021, to a degree that indicates potential non-compliance of all Bronze plans in meeting federal AV limits in future years. California's standard Bronze plan for 2020 includes pre-deductible coverage of several outpatient services and has an AV of 61.36%. Using the draft 2021 AV Calculator, this plan design increases by more than 4% and surpasses the federal AV upper de minimis limit of 65%. While previous annual changes have required minor cost-sharing increases to maintain a Bronze plan within the de minimis range in California state law (+/-2%), this year's update will require major changes to bring the plan into compliance in 2021.<sup>1</sup> These cost-sharing offsets may not be sufficient if a similar approach to the Bronze AV methodology is used in future AV Calculators. The following table demonstrates year-to-year changes in the AV of Covered California's standard Bronze plan and Bronze HDHP:

Annual Actuarial Value (AV) Change for Bronze Plans, 2018-2021				
	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021
Standard Bronze	-0.74%	1.39%	1.45%	<b>4.27%</b>
Bronze HDHP	-0.58%	1.24%	1.31%	<b>2.75%</b>

In review of the Draft 2021 AV Calculator Methodology, Covered California observed removal of Selection Effects in Bronze plans from the Standard Population Development and Adjustment from Primary Claims Data, which was included in the 2020 AV Calculator Methodology.<sup>2</sup> We understand this adjustment may have been removed in lieu of using claims data from 2017, which may not reflect the same sort of pent-up demand that was seen in the 2015 data and therefore may be driving the significant AV increase in Bronze plans. While Covered California understands that annual updates to the AV calculator are necessary to accurately reflect cost

<sup>1</sup> In response to similar AV constraints in 2020 on the Bronze HDHP, the AV de minimis range for HSA-qualifying HDHPs in state law was expanded to +/-2%.

<sup>2</sup> Centers for Medicare and Medicaid Services (CMS). Final 2020 Actuarial Value Calculator Methodology. March 19, 2019. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2020-AV-Calculator-Methodology.pdf>.



and utilization, Covered California is concerned that future Bronze plans may be out of compliance of the federal +5/-4% de minimis range as a result, even with cost-sharing set at the maximum-allowed amounts for the Maximum Out-of-Pocket (MOOP) and deductible.

Additionally, the Draft 2021 AV Calculator does not preserve some of the same relationships between the metal levels that existed in prior years related to total costs and utilization by metal tier continuance table. Specifically, when looking at the average allowed cost per enrollee, we observe the annual allowed cost increases with each metal level in the AV Calculators for 2018, 2019, and 2020. In 2021, we see that Gold costs are higher than Platinum costs. This is surprising given the historical pattern and the underlying methodology. We are seeing similar patterns when we compare the following metrics: IP Frequency, PCP Frequency, Specialist Frequency, and percent of zero spenders. We also see that Bronze is about \$400 less than Silver for average allowed cost each year until 2021, when it drops to \$1,000 less. Covered California assumes this is related to the 2021 removal of the upward adjustment that CCIO made to Bronze in prior years. Bronze also drops to a lower percentage of Platinum than in prior years.

To understand the changes in the continuance tables, we tested AVs for the 2020 standard Bronze plan design using the 2020 AV calculator and the four different metal level continuance tables, as well as the 2021 AV calculator and the four different metal level continuance tables. By keeping the plan design the same but changing the continuance table, we were able to compare how the continuance tables changed from 2020 to 2021. Previously, using a higher metal level continuance table resulted in a higher calculated AV. In the draft 2021 AV calculator, using a higher metal level continuance table results in a lower AV for Silver and Platinum, and an outlier higher AV for Gold. The pattern from 2020 seems to be consistent with the basic principles of greater induced utilization at higher metal levels, but the pattern from 2021 deviates from this basic principle.

<b>AV of Covered California's 2020 Standard Bronze Plan Design Using 2020 and 2021 AV Calculators and Different Metal Level Continuance Tables</b>				
AV Calculator Year	Bronze	Silver	Gold	Platinum
2020	61.36%	61.90%	62.08%	62.73%
2021	65.63%	65.02%	<b>67.75%</b>	65.23%

Together, the proposed updates to the Bronze claims experience as well as counterintuitive utilization and cost differences across continuance tables could drive significant cost-sharing increases for consumers and place many Bronze plans out of compliance with federal AV limits. Covered California requests CCIO's reconsideration of this approach as it finalizes the 2021 AV Calculator and strongly encourages use of additional factors that can smooth these differences between 2020 and 2021.

Thank you for your consideration of our comments. If you have any questions or would like more information, please feel free to contact me.

Sincerely,



Peter V. Lee  
Executive Director

cc: Covered California Board of Directors