via electronic submission

September 30, 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 comments on the 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.

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.

Clear Choice Plans Should be Transparent and Easy to Compare

For most consumers, navigating the health coverage and health care system can be daunting and frustrating. For cancer patients, in particular, the stress of their diagnosis and prognosis is compounded by the challenges they face navigating a system that is complex and confusing. Their cancer journey may involve appointments with multiple providers in multiple locations with different administrative and billing systems, involving multiple prescriptions and/or treatment regimens.

Clear Choice plan design provides Maine with the opportunity to reduce the confusion and stress consumers often experience by making coverage more predictable and easier to understand. As we stated in our previous comments, it has been well documented that most consumers struggle with health insurance literacy, lacking a clear understanding of insurance terminology outside of the terms premium and appeal.[1] In addition, health insurance literacy is lower for racial and ethnic minorities, non-English speakers, and individuals who do not have a college education.[2] While a Summary of Benefits document may provide consumers with some basic information, cancer patients and survivors often need more detailed information related to cost-sharing and coverage that can only be found in other plan documents and/or may necessitate the patient calling their insurance provider.

Clear Choice Plans Should Offer Affordable Cost-Sharing

While we support the standardization of the plan designs, we believe the proposed Clear Choice plan designs can be improved to provide a better experience for the consumer. For instance, the plans as proposed miss the opportunity to embrace a copay-only structure for prescription coverage. In previous comments, we cited[3] numerous[4] examples of the tremendous burden placed on patients by unmanageably high cost sharing requirements. This is exacerbated by the use of coinsurance in plan design, which consumers often do not understand. There is some evidence that lower health insurance literacy may be associated with greater avoidance of both preventive and non-preventive services.[5] Moreover, when consumers are confronted with such high out-of-pocket obligations once they *have* coverage, they may abandon their treatments because they cannot afford them.[6]

When patients cannot afford the cost of needed medical care, the costs do not disappear. Either the patient does not pursue treatment, thereby threatening their survival, or the patient

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[1] Consumers Union, University of Maryland College Park and American Institutes for Research, Measuring Health Insurance Literacy: A Call to Action, February 2012, available at https://www.air.org/sites/default/files/Health-Insurance-Literacy-Roundtable.pdf; Paez K, Mallery C. "A Little Knowledge Is a Risky Thing: Wide Gap in What People Think They Know About Health Insurance and What They Actually Know." American Institutes for Research, October 2014, available at https://www.air.org/sites/default/files/Health%20Insurance%20Literacy%20brief_Oct%202014_amended.pdf.

[2] Villagra V, Bhuva B, Coman E, Smith D, Fifield J, Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference. Am J Manag Care. 2019;25(3):e71-e75. https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference

[3] Devane, Katie, Katie Harris, and Kevin Kelly. "Patient Affordability Part Two: Implications for Patient Behavior & Therapy Consumption." IQVIA, May 2018, available at: https://www.iqvia.com/locations/united-states/patient-affordability-part-two

[4] 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.

[5] Tipirneni R, Politi MC, Kullgren JT, Kieffer EC, Goold SD, Scherer AM. Association Between Health Insurance Literacy and Avoidance of Health Care Services Owing to Cost. *JAMA Netw Open.* 2018;1(7):e184796. doi:10.1001/jamanetworkopen.2018.4796, available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2714507?resultClick=1

[6] *Ibid*.

incurs medical debt. Many studies have documented that those who are diagnosed with cancer are more likely to file for bankruptcy compared with those who are not diagnosed with cancer. These costs do not only affect cancer patients and their families, but also the entire health care system through cost shifts from uncompensated care and/or by patients qualifying for Medicaid as household income declines and assets are liquidated to cover health care costs.

In addition, 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.[7] 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.

Lastly, we recommend the plan design include a first drug tier covering drugs that are available at no cost-sharing to the enrollee. This will provide greater transparency to consumers regarding the plan's coverage for no-cost prescription drugs covered under the preventive services benefit such as tobacco cessation drugs. Plans may also add other drugs to this no cost-sharing tier to make the plan attractive to consumers.

Consumers' Cost-Sharing Responsibilities Should be Transparent

In addition, as demonstrated by using the 2021 federal actuarial value calculator, which is publicly available, small changes can be made to copays for other drug tiers in the draft silver low plan design and coinsurance can be removed from the prescription drug benefit design with no impact on the actuarial value (AV).[8] For example, shifting to copays across all drug tiers (with a maximum of $100 copay for the highest tier) had no impact on AV if the generic drug copay is increased by $0.40 ($15 to $15.40). In addition, drug deductibles can be removed for all drug tiers (with copays) without impacting AV by further increasing the generic copay by $2.05 ($15.40 to $17.45).

As such, our organizations would like to restate the recommendation from our first round of comments that the Clear Choice plan designs include copay only structures, especially for prescription drug coverage. If the intended purpose of the standardization of plan designs is to allow individuals better opportunity to compare plan options, we question why plans would be permitted to use coinsurance, as it is not transparent to consumers.

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[7] 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

[8] Using the information available, it was not possible to replicate the exact AV reported by the Bureau. The modelling yielded 70.93%, while the Bureau's model yielded 70.8%. If we can get the AV inputs, the modelling can be re-run with the Bureau's exact inputs. This small discrepancy likely does not have a meaningful impact on the interpretation of the overall modelling results since all changes were only applied to the drug benefit.

If the Bureau decides it is necessary to include coinsurance, we would like efforts to be made to lower the coinsurance level and/or use a per script maximum out-of-pocket. Many oral cancer drugs, especially targeted therapies and/or immunotherapies, are often included in the specialty tier drug tier. These drugs can cost thousands of dollars – even tens of thousands of dollars – for a one-month prescription, which for consumers who need high-cost drugs, can result in thousands of dollars in out-of-pocket costs. Many Mainers would be unable to afford a monthly out-of-pocket expense of hundreds or thousands of dollars per prescription especially when taking into account that patients incur cost-sharing related to other medical services such as provider visits, or even cost-sharing on other prescription drugs. A recent study concluded that caps for spending on specialty drugs were associated with substantial reductions in spending on specialty drugs among patients with the highest out-of-pocket costs, without detectable increases in health-plan spending, a proxy for future insurance premiums.[9]

Clear Choice Plans Should be of High Quality to Consumers, Regardless of what is on the Market Today

The Bureau stated that they based the proposed Clear Choice options around the current "popular" plan selections. However, we believe using existing "popular" options presents a missed opportunity and locks the State into existing designs rather than embracing the opportunity for improvement. We find it unlikely that the intent behind the enabling legislation was simply to freeze the existing market options. We supported the legislation as an opportunity to do better, not simply more of the same. We feel that we, as stakeholders, owe it to the patients and consumers across the state to strive for improvements where we can.

We also note that consumers may gravitate to certain health plan models because those represent the existing options available to them. This is not necessarily the same thing as what options consumers may want. There are, currently, zero plans available through the marketplace in Maine that offer a copay-only prescription design. It is entirely likely that consumers would select more beneficial first-dollar coverage if that alternative was made available.

Clear Choice Plans Should be Standard without Unnecessary and Confusing Alternatives

On a related note, we strongly object to the concept brought forward on the previous stakeholder call that more plan design alternatives are needed within the Clear Choice design. The name "Clear Choice" implies, as we have said in previous comments, clarity and ease of understanding. We believe that allowing a large number of alternative plan designs would be confusing to the consumer and antithetical to the stated intent of the legislation. The literature shows that dozens of choices often lead to confusion and when faced with complex choices,

[9] Yeung K, Barthold D, Dusetzina SB, Basu A. Patient and Plan Spending after State Specialty-Drug Out-of-Pocket Spending Caps. N Engl J Med. 2020 Aug 6;383(6):558-566. doi: 10.1056/NEJMsa1910366. PMID: 32757524.

consumers often use mental short cuts to simplify the choices.[10] In some cases, the choice becomes so daunting, the consumer chooses not to make a choice. In this case, that results in consumers going without coverage.

We urge the Bureau to consider the patient experience as a primary determination in guiding its decision in designing the Clear Choice proposal. Will this help more consumers afford not only their premiums, but their necessary care? Will the total patient cost (premiums AND out of pocket obligations), and their understanding of what is being presented to them, be considered when finalizing standard designs? Does this maximize the opportunities available to enrich and improve the insurance experience for people in the state? Will this, then, make patient lives better? If we cannot say yes, our work is not done.

On behalf of the American Cancer Society Cancer Action Network and The Leukemia & Lymphoma Society, we thank you for the opportunity 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
Government Relations Director
American Cancer Society Cancer Action Network Maine

Steve Butterfield
Regional Director, Government Affairs
Leukemia & Lymphoma Society

[10] Taylor, Erin Audrey, Katherine Grace Carman, Andrea Lopez, Ashley N. Muchow, Parisa Roshan, and Christine Eibner, Consumer Decisionmaking in the Health Care Marketplace. Santa Monica, CA: RAND Corporation, 2016. https://www.rand.org/pubs/research_reports/RR1567.html.

Via Email 9/30/2020

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

Thank you for sharing the proposed Clear Choice plan design options that have developed by the Bureau, as well as the Bureau's responses to questions posed to date. We certainly appreciate the complexities of plan design—it is a difficult and time-consuming process with many nuances and moving parts.

The movement to standardized plan designs will create significant disruption in both the individual and small group markets. Beginning January 1, 2022, members will no longer be able to purchase their current plan. This will undoubtedly create frustration and member abrasion. In many instances, employers and consumers will be forced to move to a more expensive plan, or drop to a lower metal level plan. This disruption will be further exacerbated if the individual and small group markets are merged.

In addition to the comments previously presented on August 28, we would like to offer the following comments on the proposed plan designs, some of which were expressed during the meeting on September 15, 2020.

1. ***Make more benefits subject to coinsurance, rather than copayments***. We understand the appeal of applying copays to many services across plans; however, although simpler, it also increases the cost of the plans. This at a time when health care costs continue to increase and both the individual and small group markets are decreasing in size. The movement to require co-pays rather than co-insurance will increase the premium, sometimes significantly and members will be force migrated into new plans that may offer very different coverage at a higher cost. For example, Anthem does not currently offer an individual market silver plan with an actuarial value equivalent to what is proposed. The increase in benefits will result in approximately an 8% increase in premium to our members, and this is prior to the application of other factors such as medical trend and the potential impact of a merger of the individual and small group markets. This may well have the unintended consequence of forcing those members into bronze plans in order for those members to be able to continue to afford their coverage.

2. ***More plan designs should be developed.*** We do not believe that enough plan design options are being developed, particularly given the disruption that will be experienced by the individual and small group markets and the fact that the proposed plan designs are not representative of plans purchased in the small group market. Having so few options available, both with respect to benefit design and price, will lead to significant disruption and abrasion, as well "sticker shock" as consumers are forced into higher cost plans or lower value plans in order to afford coverage. Providing employers and consumers with more options from which to choose will help to reduce disruption. It is important to remember that not everyone receives premium assistance, and a variety of plan options at different price points will be extremely important in order to allow consumers to find the plan that fits their needs.

3. ***Include plans that are representative of plans offered in the small group market today.*** The proposed clear choice plan design offerings are not consistent with small group offerings in the

market today, which is likely to result in even greater disruption for small groups and their employees.

4. ***Include more HSA plans.*** One HSA plan option is not sufficient to meet the needs of the marketplace. We would suggest an additional HSA plan with a deductible in the range of $2,800 to $3,500.

5. ***Provide clarification regarding catastrophic plans.*** It will be necessary to develop a catastrophic plan design, and to clarify the application of section 2792(1).
   - Pursuant to 24-A M.R.S. § 2793(2), "[c]lear choice designs apply to all individual and small group health plans offered in this State with effective dates of coverage on or after January 1, 2022"; there is no exclusion for catastrophic plans so a clear choice plan design must be developed.
   - Small groups are not eligible to purchase catastrophic plans; however, 24-A M.R.S. § 2792(1), requires that a carrier offering individual plans make the plan available to all eligible small employers within the plan's approved service area and all small group plans must be available to all eligible individuals residing within the plan's approved service area. We will need clarification on the application of this section to catastrophic plans.

6. ***Allow tiered plan designs to be offered.*** Tiered plans should be allowed if the Tier 1 benefits comply with the Clear Choice design requirements.

In addition to the foregoing general suggestions, we would like to offer more specific comments on the proposed plans:

7. The PCP benefit for all plans is listed as PCP/Behavioral with a copay. We would suggest that behavioral health office visits be treated as Specialist visits unless the service is performed by the PCP. It is not clear if it is permitted under Response #11, but Response #20 appears to allow for it.

8. Bronze plans
   - We would suggest that 0% coinsurance options should be avoided.
   - The PCP copays are high on the Bronze (both the $6,000 and $8550 are at $50). We would suggest lowering them slightly and making them different to allow for consumer choice. We would also note, however, that they may need to remain at that level if f behavioral health specialists are required to be covered In the same manner same as PCPs.
   - We would suggest lowering the urgent care copays from $95 to approximately $60.
   - There should be different deductible option for either the $6,000 non-HSA or the $6,000 HSA – while they are different types of plans it may be a missed opportunity to have different options to provide more consumer choice. We would suggest a lower coinsurance option in bronze besides 0% and 50%.

9. Silver plans
   - We would suggest at least one additional Silver plan design to provide consumer choice.
   - The most popular plans in the small group market have $3,500 and $5,000 deductibles, both of which are missing from the Clear Choice plans, and those plans generally have lower

coinsurances and copays. Similar plans should be added in order to meet the needs of small group purchasers.

- We would also suggest a silver level HSA plan with a deductible of $3,000.
- We would like to see lower PCP copay options if behavioral health specialist are not required to be covered same as PCP.
- Response #22 does not allow the Silver options to go below 70% AV – we would suggest that a lower AV be permitted, as CMS allows to 66%.

10. Gold plans
    - Current gold plan offerings in the small group market range from $1,500 to $3,000—the proposed gold plan design will likely be more expensive than the current gold plan offerings due to the lower out of pocket amount. As a result, we would suggest that there should be additional gold plan options

Finally, we have several questions about the proposed plan designs, as well as questions about the Cost Sharing Designs Responses shared in conjunction with the meeting on September 15 (some of which have already been shared with the Bureau):

11. Will cost-sharing for the CSR plans be standardized as well?

12. Can you confirm that cost-sharing based on site of service cost- will be allowed?

13. Response #3: The last sentence states that "[u]nder the merged market carriers do not have to offer identical choices of health plans to individuals and to small employers." This seems to contradict the requirements of 24-A M.R.S. § 2792(1). Could the Bureau reconcile Response #3 with the provisions of section 2792(1), and clarify whether carriers must offer the same plans to both individuals and small groups?

14. Response #4: Is the Tier 2 Rx copay proposed for Bronze plans after the deductible? The comments only indicate that Silver, Gold, and Platinum have it applied before the deductible. Would coinsurance be more appropriate for Tier 2 Bronze?

15. Response #4 has generic Rx with a copay at all metal levels. While that may be appropriate for Tiers 1 and 2, there may be instances where a generic drug falls under Tiers 3 or 4. If so, can you confirm it would be subject to coinsurance?

16. Response #11: There seems to be a contradiction between this response and Response #4 with respect to the Bronze Tier 2 Rx benefit. Response #4 indicates that only Silver, Gold, and Platinum Tier 2 Rx benefits are covered before the deductible, but Response #11 indicates that all metal levels would be subject to this.

17. Response #17: Prohibiting the offering of tiered network plans decreases consumer choice and discourages value based payment arrangements. Tiered plans should be allowed if the Tier 1 benefits comply with the Clear Choice design requirements.

18. Response #18 advises that a Platinum plan does not have to be offered--could a platinum plan be offered to small groups but not to individuals? And must all other clear choice plan designs be offered, or can a carrier choose to offer certain

19. Response #19—could you clarify what is meant by the statement "Unless otherwise noted carriers are permitted to assign any service to any benefit category if permissible under state and federal law"?

20. Response #22 states that all services with a copay that are not subject to the deductible and the copay amount does not accumulate toward the deductible. It is our assumption that this excludes the 2nd and 3rd visit copays for PCP and Behavioral health as required by LD 2007, which must accumulate to the deductible?

21. Response #22: The proposed AV for the Silver on/off exchange plan is 70.8%, which is significantly higher than the Silver AV's currently offered in the IND market. While members receiving APTCs may be somewhat protected from any rate increase associated with this, unsubsidized members are likely to see significant rate increases due to this change.

Thank you for the opportunity to submit the questions and comments. We would be happy to answer any questions to might have, and we look forward to continued discussion at the meeting on October 20.

Sincerely,

Kris Ossenfort

Anthem, Inc.

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

COMMUNITY Health Options™

September 29, 2020

Dear Superintendent Cioppa:

In response to the Bureau's request for comments on Clear Choice Plans and their ultimate design, I offer these recommendations on behalf of Community Health Options. In general Community Health Options believes that only allowing three non-Clear Choice plans is detrimental to Maine consumers and the Maine health insurance marketplace. We understand that the intent of Clear Choice is to assist consumers, make distinctive coverage options plain to consumers, and support meaningful consumer engagement. We believe that those objectives can still be met while not abandoning all of the variation that has been created in response to market demand over the years. We are also concerned that we retain some critical distinctions among plan designs that are currently available such as inclusion of pediatric dental, HSA-compatible plans, and network differentiation. Our specific recommendations are as follows:

- Limiting the number of non-Clear Choice Plans may prove to ultimately limit the availability of affordable healthcare plans that include pediatric dental or that are HSA compliant. We believe that any mirror plan of a Clear Choice Plan, with no difference except that of offering pediatric dental benefit or is a plan that is HSA compliant, should not count towards the quota of alternative plans.

- There are fundamentally different types of provider networks in the state and across all carriers (PPO, POS, HMO). Recognizing these varied networks Community Health Options believes it would be appropriate to allow multiple alternative non-Clear Choice Plans for each network type offered by a carrier.

- We further recommend that there should not be a Clear Choice plan design for catastrophic plans to ensure consistent and low-cost pricing of catastrophic plans. If the Bureau decides to implement a catastrophic Clear Choice Plan, then we recommend that any alternative catastrophic plans not count towards the quota of alternative plans.

COMMUNITY Health Options™

- With respect to SHOP we do not believe there should be any limit on the number of SHOP-only offered plans and any alternative SHOP only plans should not be counted towards the quota of alternative plans.

We appreciate the Bureau's consideration of our comments on Clear Choice Plans and their ultimate design.

Sincerely,

Kevin Lewis
President & CEO

cc: Joanne Rawlings-Sekunda
Marti Hooper

Partnership for Children's Oral Health
A network to ensure that all children in Maine can grow up free from preventable dental disease
www.mainepcoh.org

Consumers for Affordable Health Care
www.mainecahc.org

Advocating the right to quality, affordable health care for every person in Maine.
Consumer Assistance HelpLine
1-800-965-7476

September 24, 2020

Dear Ms. Hooper,

The Partnership for Children's Oral Health, Consumers for Affordable Health Care, and the Maine Dental Association are working in collaboration with many partners to achieve a shared vision: to ensure that all Maine children can grow up free from preventable dental disease. On behalf of this network we are pleased to provide comments with regards to the Clear Choice stakeholder group's efforts on standardizing benefits.

Oral health is an essential component of overall health at all stages in life. Children have the opportunity to establish good oral health that will have many benefits throughout their lives. Pediatric dental care is an essential health benefit and should be included in standard health plans for all children. Oral health has been included within Medicaid coverage for children since its inception, and children whose parents are purchasing standard plans through the Marketplace deserve equally comprehensive coverage.

To better understand the current picture of children's oral health, including insurance coverage and its connection with children's dental care access, the Partnership created a data brief.[1] Key findings include that at least one quarter of children in Maine lack dental coverage. Without a predictable way to pay for services, it can be challenging for these children and their families to maintain a relationship with a dental home and stay on top of preventive care. Including pediatric dental benefits in standard Marketplace plans would be an important step in the right direction.

For the children who are covered by insurance plans through the Marketplace, including pediatric dental in the Clear Choice plan design will help ensure that children can get the care they need. Cost is an important factor that prevents people from getting dental care.[2] In addition to making coverage easier to access, having dental care costs counted towards a health care deductible can help families secure the care their children need to restore their oral health and stay healthy.

It is confusing and challenging to apply for health insurance through the Marketplace. Wrapping this coverage into plans will benefit Maine children and result in better overall health outcomes for children across their lifespan.

[1] https://mainepcoh.org/publications/databrief.pdf
[2] https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/OralHealthCare-StateFacts/Oral-Health-Care-System-Full-Report.pdf?la=en

Sincerely,

The Partnership for Children's Oral Health, Consumers for Affordable Health Care, and the following organizational and individual partners who support including pediatric dental benefits in Clear Choice standard plans in the Marketplace:

Organizations	**Individuals**
Partnership for Children's Oral Health Promise Early Education Center-Head Start Maine Oral Health Coalition Maine Public Health Association The Bingham Program Maine Primary Care Association Market Decisions Research Maine Children's Alliance University of New England College of Dental Medicine Maine Dental Association Maine Equal Justice Lincoln County Dental Maine Medical Association Medical Care Development, Inc.	Lyvia Gaewsky - I am generally interested in children's oral health care Ashley Mills - I am a parent or caretaker of a child, I am a Marketplace health insurance consumer, I am generally interested in children's oral health care Vanessa Koch - I work with in other fields with children Jennifer Gunderman -I am a parent or caretaker of a child, I am generally interested in children's oral health care, I work in children's oral health care Stephen C Mills, DDS - I am generally interested in children's oral health care, I work in children's oral health care Kate OHalloran - I am generally interested in children's oral health care Angela Sclar - I help people find health care services and insurance coverage Jessica Shaffer - I am generally interested in children's oral health care, I work in children's oral health care, I work with in other fields with children

Harvard Pilgrim Health Care

September 30, 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. We share the vision of the Bureau, the Governor and the Legislature to provide Maine residents with value-driven, affordable health insurance and applaud efforts to think innovatively about how to achieve that. Harvard Pilgrim Health Care compiled our collective expertise to assist the Bureau in rolling out Clear Choice Plan designs that meet the statutory guidance of consumer simplicity while continuing to provide affordable and meaningful health insurance coverage to residents. In summary, our comments include:

- Proposed glidepath strategy to rolling out Clear Choice plans coupled with analysis and iterative improvements will ensure optimal consumer value
- Many support structures exist in the marketplace to assist consumers in decision making and our hope that the trade-off between affordability and simplicity is fully explored
- Lost market innovations that have helped lower premiums; including significantly limited cost containment opportunities in individual market through partnerships and discounts with providers
- Concerns meeting AV requirements with design limitations
- Other comments regarding cost-sharing, benefits, and prescription drugs

Glidepath To Standardized Plan Roll Out

Consulting with our staff experts in actuary, plan design, legal and strategy, Harvard Pilgrim continues to request a glidepath approach to initiating Clear Choice Plan designs. It is our hope that the Bureau decides to move forward with a strategy that is both statutorily compliant, while offering ample opportunity to roll the plans out slowly, one per metal tier in Year 1, to study the impacts of such standardized plan designs on consumer receptivity, premium cost, benefits access, and to avoid unintended consequences that may have an undesired impact on access to affordable care. We have significant concerns that the proposed plan designs will increase premiums. Moving slowly will ensure we don't accidently eliminate plans that offer the lowest cost to consumers.

Our review of the statute supports such a glidepath strategy. Section 2793, Subsection 3 provides considerable flexibility to the Superintendent in altering the number and design of Clear Choice Plans through the annual review while Subsection 4 clearly ties alternative plan offerings to Clear Choice Plans both geographically and by metal tier. We therefore read this as allowing up to 3 alternative plan designs per Clear Choice plan, per metal tier. This provides the statutory structure for a glidepath approach. We propose that Year 1 rolls out one plan per tier, coupled with review, analysis, and iterative plan adjustments leading to the creation of improved plans in Year 2. No language exists

directing all existing market plans to be eliminated and replaced entirely by Clear Choice and related alternative designs, but rather simply that Clear Choice, and related alternative plans must exist, and we ask you to consider an even broader interpretation of the statute toward that end. A glidepath approach will allow vetting of standardized options through the experience of our consumers here in Maine.

Market Innovation

Insurers innovate to improve value to our members, through plan designs and other tools. Health insurance literacy has been a priority of HPHC resulting in tools such as MyHealthMath and others that assist members in choosing the best value plans to match their health care needs. Similar services are available across the market. Brokers and member services also offer significant assistance to small businesses and individual members in choosing plans to meet their needs. Through a glidepath model, consumer research could be conducted to understand plan literacy comparing existing market tools vs. Clear Choice Plan design to direct a data-driven path forward.

Significant innovation happens within the context of plan design themselves to reduce costs and increase value. We improve affordability through innovative partnerships with providers and accompanying discounts; it appears Clear Choice would limit opportunities for these partnerships resulting in increased premium. We believe it is critical that ample room exists for innovative plan designs and tiered and narrow network plans, specifically designed to improve affordability within the small and individual markets. Significantly limiting options before fully vetting consumer response and opportunities to resolve unintended consequences directly hits the market's capacity to reduce costs to Maine residents.

AV Concerns

The metal level parameters required by the AV calculator present a significant challenge to limited and rigid plan designs. If the intent is for Clear Choice plans to be the lowest prices on the market, we question the solutions offered through the proposed Clear Choice plans in meeting that intent. Currently HPHC's tiered Silver plans are comparably cheaper for consumers than the proposed Silver Clear Choice plans, and we question the value of restricting AV on silver plan alternatives to 70%+. We encourage Year 1 flexibility to vet and improve these unintended consequences.

Our attempts to run the proposed plans through the current AV calculator indicate that only the Platinum plan fits in the AV ranges. All other proposed plans are too rich in plan design. By the time the 2022 AV calculator is released, it should be expected that these plans will fail to meet 2022 AV targets even further given the trend for the calculator increase AVs over time. The plan designs will need to increase cost sharing to fit the AV calculator for 2022 .

Plan Design and Benefits

Cost-Sharing

We reiterate our hope that final plans chosen for the marketplace include as many options as reasonable to provide choice and suitability to small businesses and individuals. HSA plans have been a

critical tool for consumers and we request that every metal tier and plans on/off exchange include one or more HSA options to consumers.

The proposed standard plan designs do not address cost-sharing amounts for any out-of-network services except for those services required under state or federal law to have the in-network cost-share amount like emergency services. Additionally, the OOPM limit on proposed Gold plan appears very low. For example, our average OOPM for Individual Gold plans is $5,000 - $7,000 ($7,500 on tier 2 ME's Choice Plus). For Small Group, OOPM on average is $5,500 - $7,500 ($8,000 on tier 2 ME's Choice Plus). A Clear Choice Gold plan with a lower OOPM will be higher priced that our current Gold plan offerings. In addition, we request clarification on deductible and OOPM family amounts, for instance would they be two or three times individual OOPM and would this differ per metal tier.

We're concerned that the proposed Clear Choice plans include high copays for Specialist visits ($85) for Silver. Additional clarifications requested include whether site of service is a plan design provision that will be available in or limited by the Clear Choice designs or will we continue to have the opportunity to create such options in our proposals. While it adds complexity to plan design, it aids in cost containment and reduces premiums.

Prescription

Tiered prescription levels represent another opportunity to reduce premium costs to consumers while maintaining choice. Will the Clear Choice Plan designs include copay maximums on Tiers 3, 4, and 5, as we currently offer for small group plans? We currently offer such maximums only to small group; will this need to be consistent on individual plans as well? Would we need to make all prescription copays consistent in both markets and across Clear Choice and Alternate plans? Will there be flexibility in the number and name of tiers? For instance, we have 5 prescription tiers, other carriers have slightly different numbers and designs for prescription tiers, such as Tier 1A and 1B, etc. From a documentation standpoint, the limitation to specifically named prescription tiers will create complications at the corporate level and confusion across our service areas. Individual carrier consistency is important to carrier branding and administrative simplicity.

It is always Harvard Pilgrim Health Care's hope to provide constructive, experienced and data-based feedback when requested from the Bureau. Harvard Pilgrim Health Care pursues affordability through innovation and plan design and is concerned that such value will be lost in favor of perceived simplicity and uniformity. We urge you to take the time needed to fully vet these designs, ensuring consumer benefit and your serious consideration of a glidepath approach. Please know that we continue to be a constructive partner. The balance between affordability and simplicity has no simple answers, we know you will proceed thoughtfully through your directive.

Sincerely,

Bill Whitmore
Vice President, Maine Market

MAINE ASSOCIATION OF HEALTH PLANS

September 30, 2020

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

Dear Eric,

I am writing to reiterate the real and significant concerns members of the Maine Association of Health Plans (MeAHP) have about the Clear Choice proposals and the combined disruption of merging the markets and moving to standardized plans simultaneously.

We want to offer helpful comments and it is our obligation and responsibility to be candid about the problems we see ahead with each proposal and especially should these market changes go forward all at once. Both premium and disruption considerations for all the options individually or combined must be examined and understood.

Health plans are responsible for offering products that people want and will purchase and they do not want consumers to be confused or priced out of the market. It is the Plans' informed view that the Clear Choice plans as proposed will increase premiums and force people into lower metal tiers of coverage and some out of coverage all together. Merging the markets will create another layer of uncertainty and an additional learning curve for all parties, resulting in more people falling out of coverage or purchasing lesser benefit plans.

We are concerned that the Bureau's analysis so far looks only at Individual plans, not Small Group. Small Group, including HSA compatible plans, needs a thorough analysis to understand the impact of the proposed changes, review people's coverage preferences and see where they are today. This is important because the mapping required to move people to Clear Choice products needs to be reasonable, not extreme. With just seven Clear Choice plans, the gap between metal levels could be broad and people may be required to move significantly either up or down.

To avoid this, the Plans request that the Bureau consider creating a "glide path" towards standardized plans rather than implementing them all at once. Ideally, one Clear Choice Plan could be tested at a time for consumer interest, feedback, and to trial the many

standardizations that the Bureau wishes to implement. It appears, based on statutory language, that only one standardized plan per metal tier is required by the legislation. We submit that the statute can also be interpreted to allow up to three alternative plans per metal tier, rather than total, to allow for up to four plans per metal tier to be submitted per year, one of which would be Clear Choice in Year 1. This would provide ample opportunity to review and adapt for unintended consequences of cost-sharing and copays, impacts on pharmacy, changes to actuarial value calculations, etc. with the least disruption to consumer choice and market stability. With more thorough review, Clear Choice Plans could slowly be expanded with real consumer experience and plan performance to learn from.

For health plans, individual and small group are two separate portfolios of products. Competitive health plans will have to be building different products appropriate for offering in a merged market, an individual market, and a small group market. If the individual and small group markets remain separate, each will have its own Clear Choice products. We believe the more measured approach suggested by MeAHP would simplify the changes and result in a smoother transition.

Thank you for your consideration of these comments.

Sincerely,

Katherine D. Pelletreau
Cc: MeAHP Board of Directors

Clear Choice Design Committee

Comments from Maine Association of Health Underwriters

September 25, 2020

Plan Design:

Overall, we agree with the approach of using coinsurance in most of the designs instead of copay and limiting the pre-deductible benefits. In any new market offering such as this, the focus needs to be on year three pricing as much or more than the initial pricing. While there is some information available to make judgements on the distribution of members among the plans, much of the pricing for year one will be based on assumptions about member behavior when faced with new plan designs. A merger of the individual and group markets will increase the reliance on assumptions as opposed to historical claim patterns. Year two will have a minimal amount of claim information available when rates need to be submitted. That data is certainly not credible but is directional at best and skewed by high cost claimants at worst. Again, assumptions need to be made around member distribution among the options. Year three will have credible data from year one, assuming no major changes in plan choice by the members. This is the year when corrections to initial pricing assumptions are done since the carriers now have credible data. It's important to avoid a big spike in pricing in year three since that will undoubtedly result in members changing options and impacting the pricing. Although it's not a major influence, coinsurance does not leverage price inflation like copays do which helps moderate price changes.

Plan Options:

We feel that limiting and standardizing options in the Individual market will help the members make rational decisions. Giving the carriers the opportunity to offer three additional options will help with the level of satisfaction of the members since it allows the member to have some say in what their benefits are instead of having it forced upon them as a single option would do. Experience has shown that when the member feels they have a say in what their benefits are, they are more satisfied with their plan.

In the Shop, the purchasers tend to be more educated about plan designs and usually have a broker as an advisor. Therefore, more than three options per metal level in the Group market would not be detrimental and we would encourage the Bureau to consider that. Also, one suggestion would be to gradually phase in the Clear Choice designs rather than move everybody to the standardized plans in year one, giving the employers time to educate their workforce.

An HSA option at the Silver level would be advantageous since many employers help fund the HSA, so the employee doesn't have such a big deductible to pay on their own. The deductibles are more reasonable at the Silver level making it more manageable for employer and employee.

The prescription benefits are well designed, and we would encourage the Bureau to maintain coinsurance at Tier 3 and Tier 4. We realize that Tier 4 drugs are costly but moving to copays will significantly impact the premium for most members who are using Generics or Preferred Brand drugs. Generic Dispensing Rates (GDR) are in the 80% range or higher. We have clients who exceed 90% so while there may be calls for copays in the Tier 3 and 4 categories, we think they should stay at coinsurance for the sake of lower premiums for the majority of members. Options which limit the member coinsurance to a specific dollar amount (e.g., 50% to a maximum of $500 per script) have been used in some areas but that requires adjustment to the pricing of the plan's OOP maximum so the impact to premiums is still fairly significant.

Final Comment: As stated in the beginning of our comments, the first three years of a new product in a market are critical. Therefore, we feel that if adjustments are to be made to initial plan designs, they should wait until at least Plan Year 4 so that carriers have credible data in which to evaluate any changes.

From: Peter Gore
Sent: Wednesday, September 30, 2020 3:32 PM
To: Cioppa, Eric A
Cc: 'Dana.F.Connors@mainechamber.org'
Subject: Clear Choice Pan Design comments

Good afternoon Eric:

I know there has been a request for comments on the Clear Choice Plan design working group and their potential recommendations that you and I spoke of a while back. The Maine State Chamber wants to make a few observations and comments based on what we have heard from some businesses and busines groups with whom we have discussed the issue.

While simplicity has its benefits, under the direction of the enacting legislation, limiting the number of plans made available to small businesses and individuals also eliminates flexibility for those same groups. I know the goal of the legislation was to make shopping for a plan clearer, simpler, and more universal. So, significantly reducing the number of plan options for a handful of consistent plan designs on its face may in fact make choices by an employer and their employee more efficient and simpler. But we would ask, at what cost?

While the small group marketplace can be daunting for health insurance shoppers today, it also presents them with a vast array of plan options, and with that comes flexibility. Small businesses today, as you well know, are shopping for policies for their employee (and themselves) based on plan design, but more importantly on the affordability of those designs. Collapsing the large number of plans options available today into a handful of options may make it easier to pick a plan. But will such a change fulfill the mantra "if you like your plan you will get to keep it?" And most importantly, will it make those plans available less expensive then what can be bought today?

In our opinion, that is the one, most important question that moving forward with Clear Choice Plan Design *must* answer; *will these new plans cost consumers – defined as businesses and their employees - less?* If the answer is we don't know, we aren't sure, or even worse, no, then it is our position that any work in this area stop, or slow down, until definitive answer to these questions are known. We both know that there are considerable unknowns in the small group market absent Clear Choice Plans. Most notably the movement to merge the individual and small group markets. The cost savings associated with the merger for small group is questionable at best. We have concerns that limiting plan design will make the affordability of those plans any greater, particularly since any cost savings associated with limiting the markets to such a small number of plans, relies on the dependence of providers and carriers to successfully negotiate rates that are lower than current plans. Again, we would ask, where is the benefit of making this significant change if there are not cost savings to be gained for the small business community and their employees? Why would the Bureau and Administration go forward with this if it ultimately results in increased costs? The Chamber believes the Bureau should view *any* changes in this area going forward, through the lens of cost impact. We believe most small business would prefer lower cost plans over simplicity of shopping for them.

We would urge the Bureau to slow the process of developing Clear Choice Plans down until definite answers to the important questions discussed here can be answered clearly and convincingly to the small business community. While it is not the intent of the Bureau to exacerbate the problems in

the small group market, we have concerns that the speed at which this process is being driven does not take into account the unintended consequences on our small busines members.

Thank you for your time, and the opportunity to comment. Please stay Safe.

Peter M. Gore
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