MEMORANDUM

From: Noel Hudson
To: Board Members
Date: 1/20/17
Re: Qualified Health Plans and Rx Out-of-Pocket Maximums

The following memo is a brief review of the basics of Qualified Health Plans (QHPs) to be marketed on Vermont Health Connect during the 2018 plan year, offered to assist the Board in preparing for the QHP presentations scheduled for the Board meeting on Thursday morning, January 26. Yearly changes to the standard QHPs marketed on the exchange must receive Board approval. One new feature of the 2018 presentations will be Bronze plans containing modified prescription drug out-of-pocket maximums (Rx MOOPs). Also new for 2018, there will be brief presentations from Blue Cross and MVP on proposed non-standard Bronze QHPs with modified Rx MOOPs. Slides containing plan specs and recommended changes should arrive on January 23 for review in advance of the presentations.

Qualified Health Plans

All health plans marketed on VHC must be qualified under the ACA. Qualification requirements include coverage for the ACA's ten essential health benefits and coverage for all benefits contained in Vermont's "benchmark plan" approved by the Board every three years. Also, the plans' benefits and cost-sharing features must result in specific total actuarial values for each plan. As a comparison tool for consumers, the required total actuarial values (AV) by plan are denoted by "metal level": Bronze (60% AV), Silver (70%), Gold (80%), and Platinum (90%).[1] Since yearly changes to the QHP benefit packages are relatively minor and largely at federal discretion, the QHP presentations will focus primarily on proposed modifications to the cost-sharing features necessary to keep existing QHPs within the prescribed AV ranges.

Total Actuarial Value

Using total actuarial value as a central measure of health insurance products was an innovation of the ACA. It was difficult even for the insurance industry to digest at first, and understanding it remains difficult for consumers. Key points: 1) A total actuarial value figure for a given plan indicates the estimated financial contribution of the insurer toward the total expense of the plan benefits *as applied to a statistically significant population*. A total AV figure attached to a QHP does *not* describe the actuarial value of that plan for any given individual purchaser.[2] Also important is that actuarial value denotes the insurer's share of the expense of the plan's covered benefits only, not the insurer's share of the covered population's total conceivable healthcare expenses. 2) As a legal and practical matter, a plan is qualified at a given total AV because that AV level results when the plan's benefits and cost-sharing features have been run through HHS's AV calculator. This tool applies its own built-in actuarial assumptions regarding population, which do not necessarily correspond to the actual Vermont populations that will eventually

[1] Federal regulations allow small +/- variation on the exact AVs, with Bronze plans having the largest acceptable range. Also, the many income-sensitive Silver plans with subsidized cost-sharing reductions are most easily understood as Gold- and Platinum-range plans by another name.

[2] For example, if a perfectly healthy purchaser selects a 60% AV Bronze plan and does not make a single claim during the 2018 plan year, the actuarial value of that plan for that person would be exactly 0.0%. In contrast, if an extremely unhealthy purchaser of the same 60% AV Bronze plan is facing six-figure medical bills in 2018, the actuarial value of the plan for that individual could exceed 90%.

purchase the plan. In consequence, total AV levels are a fairly rough measure, and are intended to allow consumers to compare the relative benefit-richness of the plans from which they are choosing. Because total AV levels are not terribly accurate in absolute terms, they are not effective premium rate-setting tools and are not required to be used as such. Accordingly, they do not factor into the QHP rate filings reviewed by the Board each summer beyond identifying specific plans by metal level.

Standard QHPs vs. Non-Standard QHPs

Most of the time during the QHP presentations will be spent on DVHA's presentation on the so-called "standard" plans marketed on VHC. These plans are designed by DVHA and DVHA's contract actuary (Julie Peper, from Wakely). After the Board's approval, both Blue Cross and MVP use the standard plan specifications issued by DVHA when making their own insurer-branded standard plans, submitting them to DFR for form review along with Ms. Peper's actuarial certification regarding their AV levels.[3] VHC also markets non-standard plans from each carrier. These plans are built in-house by the insurers, though each must contain the benchmark plan's benefit package and must conform to the ACA's required AV values and metal levels. Otherwise, they are developed by the carriers' product designers and actuaries. Prior to 2018, the Board has reviewed rates for these non-standard plans, but did not review non-standard plan designs during the QHP certification process.

Rx MOOP

Vermont law requires that QHPs (and large group plans) include a cap on cost-sharing for prescription drugs. For the 2017 plan year, that cap was $1300 for individual coverage, and $2600 for family coverage. Absent federal action, the same levels will apply in 2018. By statute, the Rx MOOP is variable, and keyed to the minimum deductible figure allowed by the federal tax code for a high deductible health plan (HDHP) used with tax-favored health savings accounts (HSAs).[4] Matching Vermont's Rx MOOP to the federal minimum deductible figure assures that the state-mandated Rx MOOP will never force a level of first-dollar Rx coverage that would defeat the federal tax-favored status of a Vermonter's HSA.

Vermont's Rx MOOP is an extremely rich benefit to consumers with high prescription drug expenses, and it puts a corresponding upward pressure on a plan's total AV level. For 2018, that upward pressure would prevent some existing Bronze plans on VHC from staying within prescribed AV levels if those plans also contain all mandated benefits and overall out-of-pocket maximums, as they must. Eventually, with enough time and inflation, Vermont's Rx MOOP would disqualify all Bronze plans from compliance with the ACA, and would start disqualifying Silver plans as well. To address this issue while preserving the Rx MOOP to the greatest extent possible, the Vermont Legislature passed Act 165 of 2016, which authorized DVHA to convene a QHP stakeholder-advisory group. The group was charged with formulating and recommending alternative Rx MOOPs for select standard Bronze plans that are higher than the statutory limit, and proposing standard Bronze plans with variant Rx MOOPs to the Board during the Board's annual QHP approval. The presentations on 1/26 will reflect the work of the Act 165 stakeholder group, and, as authorized by Act 165, will also include brief presentations from the carriers regarding non-standard Bronze plans with similarly "non-compliant" Rx MOOPs requiring Board approval (note: although the carriers will present the non-standard plan specs for context, the Board's

[3] A small part of DFR's form review of the standard plans is making sure the carriers' relevant plan specs match DVHA's.

[4] The minimum high deductible figure allowed by the Internal Revenue Code is itself variable and keyed by federal statute to an inflation index. As a result, the figure changes periodically by IRS regulatory action rather than by federal statutory revision.

approval would apply to the variant Rx MOOP figures only; DFR's full review of non-standard plan compliance starts in March).