February 19, 2020

Green Mountain Care Board
Via Email Only

RE: STATE OF VERMONT 2021 STANDARD PLAN DESIGNS – FOLLOW UP ITEMS

Dear Board:

Following the Green Mountain Care Board (GMCB) meeting last week on February 12, 2020, there were a number of follow-up items requested of Wakely regarding the 2021 QHP standard plan designs presented. This memo details the requests and summarizes our responses. We will go through these items during the GMCB meeting on February 19, 2020.

1. What is the average cost of a specialist office visit in the federal actuarial value (AV) Calculator?

   Based on the Bronze plan continuance table the average cost for a specialist visit is approximately $179 per visit and for primary care physicians (PCP) is $161 per visit. Therefore, on the Bronze plan without Rx limit, the proposed 2021 PCP copay of $40 is less than 50% of the cost of the service and is not subject to the deductible, qualifying the plan for the expanded bronze range, even though the specialist and generic copays are greater than 50% of the cost of the service (based on the costs included in the calculator).

2. Provide a comparison among other exchanges of the range of PCP co-payment vs. Vermont's

   CMS releases public use files, which include the benefits for all QHP plans in 2020 on the federally-facilitated Exchanges, State Partnership Exchanges, and State-based Exchanges that rely on the federal platform. These files are located at: https://download.cms.gov/marketplace-puf/2020/benefits-and-cost-sharing-puf.zip

   State-based Exchanges that do not rely on the federal platform may publicly post information on those plans in a separate location from the link above.

   In addition, below is a chart of the PCP copays for standard plans in the states which have standard plans. These are based on the 2020 plan designs.

Table 1: 2020 Standard Plan Designs – Copay Ranges for PCP Office Visits

State	Platinum	Gold	Silver	Bronze
Vermont	**$15**	**$20**	**$35**	**$35 * - $40**
California	$15	$25 - $30	$40 - $50	$65 * (first 3 PCP visits prior to deductible)
Connecticut	N/A	$20	$40	$40
DC	$20	$25	$40	$55
Massachusetts	$20	$25 - $30	$30 * - $30	$30 *
New York	$15 *	$25 *	$30 *	Coinsurance *
Oregon	N/A	$20	$40	$45

Excludes standard plan designs that apply coinsurance to PCP visits (such as HDHPs)

* Deductible applies to services prior to copay

3. A (high-level) analysis of the increase trend for increases in the Medical out-of-pocket maximum (OOPM) and Rx

   As mentioned during last week's presentation, per Vermont regulation almost all ACA plans require that the Rx OOPM is limited to the minimum deductible for HDHPs as determined by the IRS[1]. The minimum deductible has only increased $150 (or 1.9% annually) from $1,250 in 2014 to $1,400 in 2020, while the allowable OOPM has increased $1,800 (or 4.2% annually) from $6,350 in 2014 to $8,150 in 2020. Particularly on Bronze plans where the Rx OOPM is at this limit and this limit is significantly less than the medical OOPM, additional increases are required to the medical deductible and OOPM in order to meet the AV de minimis requirements using the federal calculator.

   Additionally, the Medical OOPM has increased faster on the Bronze plans compared to other metal levels. This is due to the leveraging of the deductible and OOPM on the AV. At the higher limits on the Bronze plans, fewer members are estimated to hit the deductible and OOPM compared to the Platinum or Gold plans. Therefore, larger increases are required to have a similar reduction in AV.

4. More detail on the formula/process to determine the $400 increase in the Medical OOPM for PY2021 from the draft payment notice

   The annual limitation on cost sharing is set each year by taking the 2014 maximum annual limitation on cost sharing of $6,350 (for individuals) multiplied by the premium adjustment

[1] The minimum HDHP deductible is updated by the IRS each year for a cost of living adjustment based on inflation in the CPI-U, rounded to the nearest $50 increment.

percentage for the given year. The premium adjustment percentage is the percentage by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. For example, the 2021 percentage was calculated comparing the 2020 average per capita premium to the 2013 average per capita premium. Beginning with the 2020 plan year, the percentage includes individual and group market health insurance premiums. Prior to 2020, it was based only on the increase in employer-sponsored insurance premiums and excluded individual market premiums.

5. Considerations, Pros/Cons of creating a VT-specific AVC

   It is our understanding that for a state-specific AVC, the state can update the data underlying the calculator, but cannot alter the logic used to determine the AVs. There are also credibility requirements (based on the number of members covered) for each metal tier that may make it impossible for VT to meet the requirements without incorporating additional data sources.

   The primary benefit of creating a Vermont-specific AVC is that the data and bucketing of the metal plans will be more aligned with actual Vermont allowed costs and distribution of services. While a more detailed evaluation is needed, VHCURES could be viable and efficient source for the data. It is possible, although in no way guaranteed, that the bronze data in Vermont might result in more options for bronze plans (note there is likely a premium trade-off where if the cost sharing is kept richer, premiums will increase instead of cost-sharing).

   The cons of having a Vermont-specific AVC include the effort involved (even if VHCURES alone could be used, it would still require significant effort and testing), potential disruption in the plan designs primarily in the first year of implementation, and limitations on how much the Vermont data will actually change the actuarial values since the formulas will still be the same. A high level comparison of Vermont's allowed costs, in total and by the AVC service categories, would be warranted to understand how impactful the change might be for Vermont, especially for bronze plans.

   If Vermont is considering a Vermont-specific AVC, it is recommended that the State discuss with CMS since there may be additional flexibilities and/or requirements since the original requirements were released.

Please let us know if you have any additional questions.

Sincerely,

Brittney Phillips, ASA, MAAA
Consulting Actuary