Defined Contribution Risk Adjuster Board Minutes

State Office Building Room 3112

Approved

September 8, 2010

Attendees: Dave Jackson, First West; Tanji Northrup, UID; John Borer, PEHP; Bob Wilcox, UID; Norm Thurston, DOH; Stephanie Jensen, PEHP; Matt Spencer, OCHS; Mark Brown, Select Health; Tomasz Serbinowski, UID; Perri Babalis, Utah Attorney General; Neal Gooch, UID; Gabriela Benitez, GBS Benefits; Rick Fielding, GBS Benefits; Cathy Dupont, OLRGC; Chet Loftis, Regence; Mark Andrews, OLRGC; John Sweeney, Health Equity; Sue Watson, OCHS; Judi Hilman, Utah Health Policy Project; Jim Pinkerton, Regence (via telephone); Lucy Feldkircher, Health Equity (via telephone); Leanne Gassaway, AHIP (via telephone); Kim Miller, United Health Care (via telephone); George Korean, United Health Care (via telephone); Kiley Bracken, bSwift (via telephone); Jan O'Brien, bSwift (via telephone); Jody Atkinson, UHIA (via telephone); Scott Rose, Health Equity (via telephone); Ann Ibrahim, Regence (via telephone); Curt Howell, Humana (via telephone)

- Dave Jackson called the meeting to order at 1:02 PM
- Dave asked if there were any questions or concerns regarding the August 24, 2010 minutes
    - Mark Brown addressed his comment on the third page, about 2/3 the way down the page. Rather than stating 'Mark answered the commission should only be charged when a broker is used', the sentence should state 'Mark answered the commission and the Exchange determined brokers would be required on all groups during the pilot.'
    - Dave also noted a few changes. On the first page, the spelling of Luis should instead be Lewis. On the last page, neither Dave nor Perri recall having a discussion about setting up a meeting between them. This comment was removed from the minutes
    - The August 24, 2010 minutes carry with the above noted corrections
- Jim addressed Underwriting concerns
    - Underwriters have concluded there is not enough information available to attempt to use experience to combine experience. It made more sense to retain the group's current risk rating and apply these to the new rates. The exception being when there are significant enrollment changes through the year, then the risk will need to be reevaluated
    - Mark Brown asked if the group and individual risk factors would be the same
        - Ann answered no, stating the group's risk factor would change. Underwriters are assigned to review census changes and addition of new hires that change the risk profile. The group factor will adjust if necessary, but the individual risk factor will not change
    - Dave asked when there will be enough data to change the subscriber factor
        - Jim believes there will be enough data by next year
    - Jim gave the Underwriting recommendations to the Board: Rerate groups based on existing enrollment with only doing risk evaluation for new enrollees who come on through the year
    - Tomasz asked what happens if a group is being rerated and they do not agree with the original factor
        - Mark Brown answered they will have to accept the past rate
    - Mark Brown made the motion for those groups currently covered in the Exchange, their renewal group risk factors are determined using subscriber risk factors previously

determined, combined with risk factors determined for January 1 and the overall group factor is determined using those set factors subject to statutory requirements. Jim seconded the motion. All were in favor, none opposed

- Jim addressed an underwriting question to the Board that has not yet been answered
    - What role does the incumbent carrier play in the underwriting process? The Underwriting Subcommittee recommends the incumbent carrier be the mediator between the primary and secondary carrier
        - Dave stated the original recommendation from underwriting was for the incumbent to stay involved in the renewal. The Board felt a random algorithm made sense
        - Mark Brown thought this was approved in the workflows (Plan of Operation)
        - Jim stated there was confusion if a person waived enrollment in the original enrollment period prior to the effective date and then decided to join. Can their rates be adjusted?
        - Kim asked for an October enrollment period, if someone instead enrolled in the November enrollment period, if the primary and secondary carriers were notified of the new entrants to set the risk factor. The group risk factor might also change so carriers would need to be notified
        - Mark Brown answered the carrier reserves the right to go back and review. The same is done after the effective date to ensure someone did not bring a high risk person on after the rate was set
    - Kim made the motion to add to the Plan of Operation the requirement that all new adds in the enrollment process that initially refused and then renewed before the effective date, the new entrant's employee risk factor will be determined and the group risk factor will be recalculated. Mark Brown seconded the motion. There was need for discussion
        - Matt asked if this encompasses new hires and those who initially waived. Dave stated this applies to any late entrant
        - Matt asked if they were included in the census but waived coverage. Dave stated we would still have to look at the new group rate
        - Sue asked if the contribution will be revalued, since contribution is based off the initial rate and if you were able to back out. Dave answered you are able to back out at any time. It is key for the employer and broker to understand the need to get everyone in to risk rate and to get the total group rate
    - All were in favor of the motion. None opposed
    - Mark Brown referenced the motion that was approved for the Plan of Operation. Nothing was stated in the motion that underwriters are randomly assigned for the risk rating renewal. Mark made the motion to add a step to the risk rating renewal workflow that primary, secondary and mediator carriers are randomly assigned. Kim seconded the motion. There was no need for discussion. All were in favor. None opposed
- Jan asked if it was only desirable to collect the enrollment census, not a list of those who waived
    - Mark Brown noted those who waived may not work at the company any longer. If they want to come back, they would need to fill out a new application
    - Dave stated the audit process is legitimate, but it is not traditionally done. He recommended we ask for a new census from the client and do a quick comparison to see if they are still eligible. Mark Brown agreed this would work
    - Ann noted the census can be sent to the primary group, then once updated, that information along with the individual risk scores and the group risk factor can be sent to

the carrier. The employer needs to validate the eligibility census to see if there has been any changes, to use the enrollment census to determine the participation guidelines
    - Dave stated anyone eligible can be added to the census and then the employer can declare who the people are and then do a comparison
- Tanji asked for those who already filled out a waiver application if they would need to fill out another application when waiving again
    - Mark Brown stated they would need to choose to waive again. Otherwise they would be enrolled in the default market
    - Norm asked if he forgot to enroll, if he would automatically be enrolled in the plan he had the previous year
        - Sue stated this would be the case if the plan still existed
        - Jim stated if the employer changes their default plan (from this year to last) and the person does not act, they should be enrolled in the employer's new default plan
        - Sue noted there are over 160 plan designs and it is possible a plan will not be offered the following year. There should be a note that pops up during enrollment stating the plan no longer exists
            - Tanji noted it is required by law that insurers have to give a 90 day notice if they are not using the same plans
            - Mark noted it depends on how you define a new plan. If benefits are being added, it qualifies as the same plan
        - Dave stated enrollment should be active. Demographics need to be checked and the elected plan should be reviewed. There should also be an electronic signature
        - Tanji stated before the plan selection period, the employer needs to inform each employee, they need to offer employees choice and notify them they will be enrolled in the default plan unless they select their own plan or deny coverage
    - Norm made the motion for the renewal process for employees who did not waive; employees are required to choose the next year's plan. If the employee fails to do so, they will be reverted to last year's default plan. If that plan is not available, they will be defaulted to the employer's new default plan. Mark Brown seconded the motion. There was no need for discussion. All were in favor. None opposed
- Jim addressed the other question to the Board that has not yet been answered: How are off anniversary renewals handled?
    - The recommendation from the Underwriting Subcommittee is the renewal rules do not apply. They should be considered a new group
        - Mark Brown asked how they would handle non-12 month renewals
        - Norm asked for those who join on a non-anniversary, will they be treated as new business without the 25% penalty?
        - Tomasz asked how the deductible will be adjusted
            - Mark Brown answered the deductible restarts at the start of the new policy year
            - Tomasz noted there will be a higher deductible for a shorter period
            - Matt stated this is the cost of moving the renewal date
- Judi asked what kind of training and information is being given to employees so that they receive consistent information from employers or brokers

    - Dave stated the brokers are being certified. There will be misconceptions and assumptions but when the system opens up, people will see the rules, boundaries and Plan of Operation
    - Matt stated along with certification, educational materials will go out to all parties
- Mark Brown provided an update on the Large Employer Pilot. Mark had asked Dave to identify 8-9 most frequent plans in the large employer market to offer choice, but to control risk. Of the 8-9 plans, some were pulled out that made the spread too wide and that were not that frequent in the market, ending with six plans. They felt this was a reasonable, given it offers variety and choice
    - Tanji noted the code lists the plans should be available in the Defined Contribution market. Her concern is these do not meet all requirements. The code also requires additional plans, outside these predefined plans, can be added. She needs to ensure this will be allowed
    - Mark Brown feels they did not constrain the plans and they offered enough options, without a lot of risk
    - There was discussion whether the code referred to small employer or large
    - Dave noted it was their intent to satisfy the structure the best they could – for small or large employer. The one challenge was to identify the five most common plans sold in the large employer market
    - Mark Brown asked what the most commonly five selected plans were. Tanji stated the Board can define that. It is okay to stick with the plans they agreed on as the most five commonly selected, then allow for others to be added. If the four insurers agreed upon these plans, there is no problem as long as the Board does not hinder them from offering anything else
        - Mark stated four representatives from the carriers agreed with the recommendations for the large employer pilot
    - Norm made the motion the Board deems their six plans, version 2.0 of the Utah Health Exchange Large Group Pilot Health Plan Options, meet criteria specified in statute. Mark seconded the motion. There was need for discussion
        - Kim stated United Health Care will come as close to those plans as possible. Their out of pocket max might be $1,000 off or the copay on the pharmacy plan might be $5 different than what was recommended
        - Mark Brown was concerned with a $1,000 variation
    - Norm made a substitute motion to accept the plans identified in version 2.0 as meeting the required offering in statute for the 2011 Large Group Pilot with an understanding that the carrier can offer slight variations that are acceptable to the Insurance Department. Kim seconded the motion. There was need for discussion
        - Mark Brown stated there needs to be more direction on what close means
        - Tomasz stated the copay or deductible can change significantly but you can still argue the plan is actuarially sound
- Sue asked what plans are offered for the 51-99 employee groups and what their process is for enrollment
    - Mark Brown stated health applications are required for groups of 51-99 before their rates are calculated. Each carrier calculates the rates for each group based on the plan offered, this process being different than that of the small employer
- Curt Howell joined the conversation, he does not agree with all the plan designs for the Large Group Pilot

    - Mark Brown suggested a few different options, changing the Emergency Room deductible and changes to pharmacy or office copays
    - Norm restated his substitute motion. For the purpose of the 2011 Large Group Pilot, we will accept the six plans as they meet the statutory requirement or small variations as permitted by the Insurance Department. Mark seconded the motion. All were in favor, none opposed
- Dave readdressed Sues question regarding the 51-99 groups. Most carriers can do an extension of the six plan offerings to the 51-99 market, given 51+ is the same design as 100+
- Meeting adjourned at 3:30 PM