Connecticut Health Insurance Exchange
Health Plan Benefits and Qualifications Advisory Committee
(HPBQ AC) Special Meeting

Remote Meeting

Thursday, February 25, 2021

Meeting Minutes

Members Present: Grant Ritter (Chair); Theodore Doolittle; Mark Schaefer, Matthew Brokman; Tu Nguyen; Neil Kelsey; Ellen Skinner; Jill Zorn; Paul Lombardo (Subject Matter Expert – SME)

Other Participants: Access Health CT (AHCT) Staff: James Michel; Ann Lopes; Charmaine Lawson; Ellen Kelleher; Susan Rich-Bye; Marcin Olechowski
Wakely Consulting: Julie Andrews; Brad Heywood
Cecelia Woods

A. Call to Order and Introductions

Chair Grant Ritter called the meeting to order at 10:00 a.m.

Roll call for attendance was taken.

B. Public Comment

No public comment.

C. Vote

Chair Ritter requested a motion to approve the January 28, 2021 Health Plan Benefits and Qualifications Advisory Committee Special Meeting Minutes. Motion was made by Theodore Doolittle and seconded by Tu Nguyen. Roll call vote was taken. Ellen Skinner abstained. ***Motion passed.***

D. Legislative Activity

Susan Rich-Bye, Director of Legal and Governmental Affairs, provided a legislative activity update at the federal and state levels that may have an impact on AHCT. Ms. Rich-Bye stated that on the federal level, the American Rescue Plan currently is going through the budget reconciliation process in Congress with the aim of passing this legislation by mid-March. Ms. Rich-Bye noted that among many elements pertaining to mitigation of the COVID-19 pandemic, this legislative proposal consists of provisions that will increase the generosity of the Premium Tax Credits (PTC), increasing affordability for consumers. Ms. Rich-Bye noted that the proposals that are in the bill would impact Plan Year (PY) 2021 and 2022. The legislative proposal would lift the cap on eligibility which currently stands at 400 percent of the Federal Poverty Level (FPL). It would also decrease the maximum amount of money that an individual would have to contribute to payment of premium to a maximum of 8.5 percent of income and consumers at 200 percent of the FPL and below would have a 0% premium contribution requirement. Ms. Rich-Bye noted that this is for the Essential Health Benefits (EHB) portion of the premium, therefore consumers may have to pay small amounts of premiums for benefits above EHB. Ms. Rich-Bye added that the American Rescue Plan contains a provision that would increase PTCs for individuals who are eligible for unemployment in 2021. Finally, another provision would have the federal government provide financial assistance to COBRA participants for 85[1] percent of the cost through September of 2021.

Ms. Rich-Bye reviewed legislative proposals on the state level that would have an impact on AHCT if enacted. Ms. Rich-Bye noted that Senate Bill 842 has provisions that would have an impact on the market and affordability in 2022, which includes a public option plan for certain businesses, increased affordability for consumers with APTCs, and elevated Medicaid eligibility levels for adults among others. Ms. Rich-Bye explained the provisions related to the market in the Governor's Bill No. 6447. They include adding state financial assistance to the PTCs and collaborating with Massachusetts to limit price increases on pharmaceuticals. Discussion ensued around the idea of the new PTCs being introduced in the middle of the PY and how it would affect the Exchange, the carriers, and consumers. James Michel, Chief Executive Officer, indicated that a dedicated team at AHCT is already working on the possible implementation of those changes from a technological perspective. The next steps will be coordination with the carriers. Jill Zorn questioned whether this proposed legislation will affect the decisions that this Committee is considering now. Mr. Michel stated that we are going with what we know and will adjust as needed. Mr. Nguyen stated he does not believe these will affect plan design development. Mr. Lombardo concurred, indicating the possible changes to subsidies are behind the scenes, but they could impact consumer decision making.

[1] This percentage was changed to 100% in subsequent versions of the bill.

E. Review of Enrollment and Premium Information

Robert Blundo, Director of Technical Operations and Analytics presented the Review of Enrollment and Premium Information Update. Mr. Blundo stated the 2021 Open Enrollment Summary is available on the Agency's website, along with reports for previous years. Mr. Blundo outlined enrollee metal tier selection on a year by year basis since 2014, and then described the enrollment by subsidy eligible individuals by metal tiers. He provided information on changes to the consumer shopping portal, where individuals eligible for premium subsidies, but not Cost Sharing Reduction plans, will see all their options, not just the Silver plans. He noted that the plan display is sorted by the lowest premium and stated that 85% of enrollees who were auto-renewed did not change plans. Chair Ritter commented that consumers should realize that with the Cost Sharing Reductions, the Silver metal tier is better than other options, especially the Bronze. Mr. Blundo noted that most of those enrollees who do not receive any financial assistance tend to gravitate toward the lowest cost plans which are found in the Bronze metal tier.

Mr. Blundo went on to provide information on AHCT Consumers and their buying patterns with the top five most popular plans and comparing them with subsidized and non-subsidized enrollment from the 2018 Enrollment to the 2021 Enrollment and followed by the proportion of enrollment by plan metal level for the same period of time. He stated that the goal has been to have enrollees eligible for 87% and 94% (Cost Sharing Reduction) CSR plans move from Bronze, although he noted that individuals know their own health insurance needs and may select a Bronze plan for a reason, such as a lower premium. For 2021, AHCT made system changes so that when someone eligible for an 87% or 94% CSR plan selected a non-Silver plan, an alert was given regarding forfeiting the CSR benefits, giving the user the option to proceed, go back and shop again, or to get help from a broker. Another similar alert was given when an enrollee selected a plan that did not maximize APTCs he or she was eligible to receive. Theodore Doolittle noted that the work of the Technical Operations and Analytics Team has come to the attention of experts from other states and the work of the Team is recognized as a national model. Discussion ensued around consumer choices and why they are picking some plans over others when it seems to be a detrimental choice, and whether anything should be done for those who are auto-renewed to ensure they understand their options. Other areas of discussion touched upon the out of pocket costs for consumers on top of their spending on premiums and cost transparency for medical procedures.

Mr. Blundo then went on to describe the average monthly premiums based on the FPL level and age bands. Mr. Blundo emphasized that the average individual enrollee gross premium before APTC was applied was $692 in 2021. Mr. Blundo also explained the annual premium and APTC projection, indicating that it could change substantially if changes in premium subsidies are made at the federal level. He noted that attrition is not accounted for in the exhibit.

F. Certification Requirements

Ann Lopes, Carrier Product Manager, presented Certification Requirements. Ms. Lopes noted that as mentioned at last month's meeting, the listing of certification requirement topics has been discussed by this Committee in past years. Ms. Lopes noted that thus far for the 2022 plan year, this Committee's review of the certification requirements has been focused on the standardized medical plan designs in the Individual market.

Ms. Lopes described the diabetes legislation and the impact it has on plan designs. Ms. Lopes noted that this was passed by the Legislature last year and has an effective date of January 1, 2022. It requires that an enrollee's coinsurance, copayments, deductibles, and other out-of-pocket expenses may not exceed:

• Twenty-five dollars for each thirty-day supply of a medically necessary covered insulin drug

• Twenty-five dollars for each thirty-day supply of a medically necessary covered noninsulin drug

• One hundred dollars for a thirty-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices that are included in an insured's diabetes treatment plan Ms. Lopes noted that legislation outlines that it would apply to High Deductible Health Plans to the maximum extent permitted by federal law.

Ms. Lopes went on to say that the Schedule of Benefits document is submitted by insurance companies each year to the Insurance Department where it is reviewed to assure compliance with regulatory requirements. It contains cost sharing information for covered services under a plan. Ms. Lopes added that it is a useful resource for a consumer to use when comparing plan options and can be referenced upon enrollment to determine the member responsibility for a covered service. AHCT provides access to this document for each plan available through the Exchange within the consumer shopping portal.

Ms. Lopes indicated that there are a number of items that need to be resolved before standardized plans can be finalized for 2021 pertaining to the diabetes legislation. The first item has to do with the maximum cost share for devices used for the treatment of diabetes as clarification is needed on whether the $100 maximum would be applied on a cumulative basis within a 30-day period for all types of supplies combined, or whether the $100 maximum is separate for each of these. Ms. Lopes added that a second clarification is needed in the area of the maximum outlined in the legislation for the treatment of diabetes related to whether the maximum is for in-network services, combined for in-network and out-of-network services, or separate for in-network and out-of-network services . Ms. Lopes pointed out that the third item is related to information in the legislation about High Deductible Health Plans (HDHPs), which could affect the design for the standardized HSA Bronze plan. She stated that a sentence within the Public Act references cost sharing maximums may apply to the extent permitted by federal law for HDHPs and this could mean that the cost sharing maximums for medications, supplies

and equipment used for the treatment of diabetes should be in place from the point the deductible is met until the maximum out-of-pocket MOOP is reached under the HSA standard Bronze plan.

Assuming this is the case, the Plan Management Team would want to confirm the items would not differ for a HDHP, namely:

- whether the device maximum would be cumulative for all equipment and supplies used for diabetes treatment or separate for each item, and
- whether the applicability of the cost sharing maximums for diabetic equipment and supplies or medications used to treat diabetes are for in-network only costs or whether they apply for out-of-network as well, and if the latter, whether the maximum would be combined for in- and out-of-network.

Ms. Zorn inquired whether the Connecticut Insurance Department (CID) is involved in the area of the legislation clarification. Paul Lombardo stated that CID is researching one of the three issues, while one of them is the Internal Revenue Code issue. Mr. Lombardo added that language in this legislation is somewhat ambiguous and CID is reviewing with the State Legislature. Theodore Doolittle encouraged CID and AHCT to do an analysis and come up with the answer that would clarify the ambiguousness of the issue. Discussion ensued around issues dealing with legislative intent and clarification efforts in order to ensure that the legislative intent was fulfilled and there is consistency amongst the carriers.

Ms. Lopes provided an outline of the level of in-network cost sharing detail included within the Schedule of Benefits that AHCT creates for the standardized plans for coverage of "Diabetic Equipment & Supplies". Ms. Lopes stressed that this is only an example of what the cost sharing might look like within the Schedule of Benefits for these plans for this coverage when obtained from an in-network provider – the Plan Management Team would review this type of change in advance with the Insurance Department prior to finalizing, and after clarification of the legislative intent.

Ms. Lopes went on to describe an example of how the Schedule of Benefits might convey information regarding the cost sharing maximums for insulin & non-insulin medications under the prescription drug benefit. For prescription drug coverage, this can be more complicated than a benefit like Diabetic Equipment and Supplies as the cost sharing is split out to display what applies for each drug tier. Ms. Lopes noted that there would be a separate row for Tier 1, Tier 2, Tier 3, and Tier 4 drugs, typically identified as Generic, Preferred Brand, Non-Preferred Brand and Specialty, respectively.

G. 2022 Individual Market Standard Plan Designs

Brad Heywood and Julie Andrews of Wakely Consulting presented the 2022 Individual Market Standard Plan Designs. Mr. Heywood stated that there were no updates since last Committee meeting pertaining to regulatory changes for 2022. Mr. Heywood stated that the final Federal

Actuarial Value Calculator (AVC) for 2022has not yet been released. Mr. Heywood went on to present the summary of the preliminary results of the 2022 AV for all standardized plans. Ms. Andrews presented the follow-ups from the previous meeting related to including Lab Services not subject to the plan deductible in the standard plans noting that plans have been reviewed for AVC and Mental Health Parity (MHP) by the carriers with the Diabetes legislation. Ms. Andrews pointed out that after incorporating changes related to the Diabetes Legislation, the 2022 Gold Plan AV was not compliant with MHP by both carriers. Ms. Andrews provided caveats that this is based on the carriers' best understanding of the diabetes legislation. Mr. Heywood went on to describe the Silver Plan 70, 73 and 87 Cost Sharing Reductions (CSR) plans with alternative options to waive the deductible for Lab Services and keep the AV compliant. Mr. Heywood also described the 94 percent AV, which does not need an alternative option since the deductible for this plan is $0. Discussion ensued around average cost for laboratory services, as the trade-off could be for those with high claim costs vs. those with lower claim costs may benefit from a plan with $0 deductible for lab services. Wakely Consulting indicated that the AVC assumes an individual would have 4.8 outpatient labs per year with a total cost of $86 but can review this as a follow up item for the next meeting.

The Bronze Non-HSA and Bronze HSA summary followed. For the standardized Bronze HSA plan, two elements included in the IRS Notice from 2019 (coverage for glucometer and A1C screening) could be included by both carriers as a preventive service not subject to the deductible and be compliant with AV, although the coinsurance between the deductible and MOOP for the state diabetes legislation may need to be considered. Ms. Zorn requested that the plans be reviewed to determine if the copay for laboratory services could be increased to $20 from $10 without application of the deductible to offset the increases presented for the standardized plans in the deductible and/or MOOP   Ms. Andrews stated that Wakely would work with the carriers to determine if that could mitigate those increases.

H. I. and J. (2022 Plan Year Timeline: Certification Requirements; HPBQ AC Meeting Schedule and Next Steps)

Ms. Lopes presented the 2022 Plan Year Timeline and pointed out the Plan Management Team works towards releasing the annual Solicitation document that includes the certification requirements for late April. Other benchmark dates were provided as well. HPBQ AC Meeting Schedule and Next Steps were briefly described.

K. Adjournment

Chair Grant Ritter requested a motion to adjourn. Motion was made by Theodore Doolittle and seconded by Ellen Skinner. Roll call vote was ordered. **Motion passed unanimously.** Meeting adjourned at 11:57 a.m.