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

Remote Meeting

Friday, March 12, 2021
Meeting Minutes

Members Present: Grant Ritter (Chair); Theodore Doolittle; Mark Schaefer, Matthew Brokman; Heather Aaron; 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; Susan Rich-Bye; John Carbone; 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 2:00 p.m.

Roll call for attendance was taken.

B. Public Comment

No public comment.

C. Vote

Chair Ritter requested a motion to approve the February 25, 2021 Health Plan Benefits and Qualifications Advisory Committee Special Meeting Minutes. Motion was made by Tu Nguyen and seconded by Ellen Skinner. Roll call vote was taken. ***Motion passed unanimously.***

D. Follow-Ups from Prior Meeting

Ann Lopes, Product Carrier Manager summarized the action items from the Committee's previous meeting. Ms. Lopes stated that Mr. Kelsey inquired about the number of non-subsidized Silver enrollees who were auto-enrolled into a Silver plan – the Technical Operations and Analytics Team provided the response of approximately 2900 people. Ms. Lopes indicated that Mr. Doolittle asked what could be done to obtain data on the average and/or median information for the maximum out-of-pocket. Wakely Consulting provided an exhibit in the Appendix of their portion of this presentation that outlines, by metal level, including separately for Silver CSR variants, the maximum out-of-pocket at various percentile levels, as well as the mean and maximum values. Ms. Lopes pointed out that other action items, such as plan design alternatives and average cost of lab services are on the agenda to be discussed by the Wakely Consulting. Ms. Lopes referred to another question posed by a member of the Committee at the prior meeting, regarding

the availability of information on hospital costs to consumers.

Mark Schaefer joined at 2:05 p.m.

Mr. Schaefer stated that the hospitals were required under the new regulation to implement price transparency tools that allow consumers to understand the costs of particular procedures. Mr. Schaefer stated that some hospitals currently have a price estimator tool, but not all of them do. Mr. Schaefer stated that those that do not have a file of shoppable services. Mr. Schaefer described similarities between those price transparency tools, indicating that some are nicely organized to get to a broad category of services, such as imaging, and then get to a refined service such as an MRI of the head and neck. Others have a user enter copay and deductible information, and others require a written request for information. Chair Ritter inquired whether consumers could expect the so-called surprised billing when some of the services may be provided by the entities that are not in-network of a particular insurance carrier. Mr. Schaefer noted that health plans will have a requirement for price transparency also in the near future.

E. Legislative Activity

Susan Rich-Bye, Director of Legal and Governmental Affairs stated that President Biden signed into law the American Rescue Plan Act yesterday, greatly increasing the affordability for health insurance. Ms. Rich-Bye pointed out that the Rescue Plan Act provides for increased premium tax credits for consumers including for those who are above the 400 percent Federal Poverty Level (FPL) for plan years 2021-2022. Ms. Rich-Bye noted that that this law reduces the maximum contribution to no more than 8.5 percent of household income towards the cost of the benchmark plan. Ms. Rich-Bye indicated that anyone who qualified for at least one week of unemployment in 2021, will be treated as if they had income at 133 percent of the FPL for purposes of calculating premium tax credits. Ms. Rich-Bye added that during the Public Health Emergency nobody has been terminated from Medicaid due to income increase.

F. Certification Requirements

Ms. Lopes provided information on certification requirement topics that have been discussed in past years adding that this Committee's review of the certification requirements has been focused on the standardized medical plan designs in the Individual market for plan year 2022.

Wakely Consulting reviewed the results of the carriers' evaluations of alternative plan design options that were suggested at the Committee meeting on February 25. Ms. Lopes stated that Centers for Medicare and Medicaid Services (CMS) has indicated that the maximum out-of-pocket limit for the pediatric coverage under a Stand-alone Dental Plan (SADP) can increase by $25 for plan year 2022, and this will be reviewed further today.

Ms. Lopes reminded the Committee about certain items regarding Public Act No. 20-4: An Act Concerning Diabetes and High Deductible Health Plans that will need to be clarified prior to finalizing standardized plan designs for 2022. Paul Lombardo stated that federal language is silent about caps on the benefits after the deductible is met in a High Deductible Health Plan and there is assumption that the language in the insulin bill allows for this to the extent allowed by federal law. Mr. Lombardo added that the insulin caps for three categories in the statute would be allowed to be implemented once the deductible is met. Mr. Lombardo added that for High Deductible Health Plans, there should be a general comment section on the website that consumers should check with their tax advisors on whether the plan would be qualified for use with a Health Savings Account (HSA). Discussion ensued regarding the state legislation on diabetes and IRS guidance from 2019 regarding the ability to permit certain services for specified medical conditions to be considered as preventive services, and not subject to the plan deductible. Julie Andrews of Wakely Consulting stated that some of these were reviewed with the carriers previously to determine if they could be incorporated into the AHCT standardized Bronze HSA plan. However, it is a challenge because the plan is currently at the top of the actuarial value (AV) range and plans must meet the federal requirements for AV. Ms. Andrews stated the review with the carriers included consideration of increases in cost sharing to incorporate some of the components outlined in the IRS notice.

Ms. Lopes went on to review information on Stand-Alone Dental Plans (SADPs) for 2021. Ms. Lopes noted that AHCT requires one standardized plan and permits up to 3 non-standard SADPs to be offered through the Exchange in both the Individual and Small Group markets. Ms. Lopes added that one participating carrier – Anthem, offers the one standardized plan for both markets and 3 non-standard plans in the Individual market, an increase of one from plan year 2020, and one non-standard plan through SHOP. Ms. Lopes added that the last time requirements were adjusted for the standard SADP was in 2018 for the 2019 plan year. That was due to a technical change issued by CMS regarding designation of SADPS in terms of Actuarial Value. Effective with the 2019 plan year, CMS removed the requirement that an SADP meet a specified AV range. These were 85% for a 'high' AV plan and 70% for a 'low' AV plan. Ms. Lopes reiterated that since only pediatric dental is considered to be an Essential Health Benefit – adult dental is NOT subject to AV requirements – the reference to AV is limited to the coverage offered for children under

age 19. Ms. Lopes went on to describe the member cost sharing for AHCT's standardized SADP. Ms. Lopes stated that the coverage under the standardized SADP is essentially the same for adults and children, however, there are some exceptions. Ms. Lopes indicated that the out-of-pocket maximum applies ONLY to the pediatric coverage, as this feature is a requirement of federal regulations for ACA compliant plans and that could be increased by $25 per CMS guidance for plan year 2022. Ms. Lopes outlined that since the pediatric dental benefit must be based on the Connecticut EHB base benchmark plan, coverage for orthodontia is required for children under age 19. Orthodontia is not included for adults in this plan.

Ms. Lopes informed the Committee that other cost sharing is uniform for children and adults in the standardized SADP, but the plan design for adults includes some components traditionally included in a dental plan that are not permitted for the pediatric coverage per federal guidelines. There is a 6-month waiting period before Basic services (fillings & simple extractions, for example) would be covered and a 12-month waiting period before Major services (such as crowns, root canals, etc.) would be covered. Ms. Lopes added that AHCT requires the waiting period to be waived for an enrollee in the situation where there would be continuous insurance coverage when looking at the prior plan.

Ms. Lopes stated that there is an annual plan maximum of $2000 for adults under this plan and compared it to the non-standard SADPs offered through the Exchange, which have a $1000 annual plan maximum. Ms. Lopes noted that back in 2017, effective with the 2018 plan year, this Committee recommended and the Board approve that OON coverage could be included at the choice of the insurance company, subject to CID review, therefore AHCT does not prescribe out-of-network cost sharing for the standardized SADP, however Anthem does offer it.

Ms. Lopes went on to describe the Pediatric OOP for SADP. Ms. Lopes remarked that current limits ($350 for one child and $700 for two or more children) were established for the 2015 plan year and have not been adjusted since then.

Ms. Lopes stated that the determination on whether an adjustment should be applied to the limit is based on increases in the Consumer Price Index, or CPI, specific to dental services, and would only be modified when the result is at least $25. For plan year 2022, the MOOP for SADP can be increased from $350 for one child to $375 (and from $700 to $750 for 2 or more children), based on the percentage point increase of the CPI. Ms. Lopes added that the change in the value is actually $32.56 per the formula, but in accordance with the regulation, it is rounded down to the next lowest $25 increment.

Ms. Lopes emphasized AHCT wanted the Committee to be aware that this change could be considered.

Ms. Lopes provided a summary of the SADP enrollment for the Individual plans offered through AHCT and added that the AHCT standardized plan has about 14% of the total enrollment. She noted that the very last slide in the Appendix of the presentation includes the premium rates for the SADPs available through AHCT.

G. 2022 Individual Market Standard Plan Designs

Brad Heywood and Julie Andrews from Wakely Consulting commenced with the discussion on 2022 Individual Market Standard Plan Designs. Mr. Heywood stated that there were no updates to the proposed regulation changes for 2022 and no updates for the proposed changes to the federal Actuarial Value Calculator (AVC) for 2022. He indicated that any proposed plan changes for 2022 would need to be reviewed again when the final AVC is released. Mr. Heywood provided a summary of the 2022 AV Changes for all metal tiers, including the Bronze HSA and non-HSA plans in the individual market. Mr. Heywood noted that the plans have been reviewed for AVC with additional diabetes bill requirements. Mr. Heywood presented Wakely's analysis on average cost of lab services. Discussion ensued around the needed adjustments to plan deductibles and maximum out-of-pocket (MOOP) in order to waive the deductible for laboratory services for the standard plans. Based on the plan options reviewed for the standard Gold plan, both carriers were not able to reach compliance for both Mental Health Parity (MHP) and AV. For the 70% and 73% Silver plans, a new alternative with a $20 copay for laboratory services was presented. These resulted in not needing to modify the plan deductible and less of an increase for the MOOP. For the 87% Silver plan, the plan was tested for a decrease in deductible with the $20 copay for laboratory services not subject to the plan deductible, but this design was found not to be compliant by both carriers, so it is suggested to use the plan option with the $10 laboratory copay. The 94% Silver plan does not require a change, as laboratory services are already not subject to a deductible. For the non-HSA Bronze plan, the result to change the lab services copay to $20 was similar to those of the Silver 70% and 73% plans, where the deductible did not need to be revised and the MOOP increase was lower. The HSA Bronze plan cannot be revised to waive the deductible for lab services and still meet federal guidelines for HDHPs. Ms. Andrews stated that Wakely would work with the insurance companies on an alternative HSA Bronze plan to incorporate the cost sharing maximums outlined in the state legislation between the deductible and the MOOP. After review of the plan options, some members expressed support for the 70 and 73 percent AV Silver Plan Alternative 2. Ms. Lopes stated that a vote on the plan options could be included on the agenda for the next meeting.

Item H. Small Group Market Update

John Carbone, Director of SHOP and Product Development presented an update for the Small Group Market. Mr. Carbone noted that Cigna has filed with the Insurance Department to offer off-Exchange plans in the Small Group market in Connecticut and will be partnering with Oscar, which is a New York-based technology health insurance company. Mr. Carbone stated that it will be a fifty-fifty partnership agreement, therefore the risk will be spread equally between both partners. Mr. Carbone noted that several small group medical plans will be proposed. He stated that Oscar has a customer app and virtual care is available. He will reach out to the carrier to learn whether there may be interest in participating on Exchange in the future.

Items I., J., and K. 2022 Plan Year Timeline: Certification Requirements; HPBQ AC Meeting Schedule and Next Steps

Ms. Lopes noted that that the same risk identified previously of not having a final AV Calculator tool and final guidance pertaining to the MOOP value at the time the standard plan design changes are put in front of the Board for review and approval at the April 15th Board meeting exists. Ms. Lopes stated that it is possible that guidance released after that date could result in needing to modify the standard plans again.

Ms. Lopes noted that the Committee could consider requesting that the Board approve a contingency plan in the event that final guidance released after the meeting results in some or all of the plans being non-compliant with AVC and/or MHP. In the past, it has been requested to have the ability to make modest changes to the plan designs, such as a tweak to MOOP or deductible up to a specified cap, without needing to take the plans back to the Board for review and approval.

Ms. Lopes reminded the Committee that in some years, a Special Board meeting has been held to review plan designs after the regularly scheduled April meeting because of this issue, or because the threshold requested as part of a contingency plan was insufficient.

Ms. Lopes added that no more than two additional meetings of the Committee are planned and are currently scheduled.

L. Adjournment

Chair Grant Ritter requested a motion to adjourn. Motion was made by Theodore Doolittle and seconded by Mark Schaefer. Roll call vote was taken. **Motion passed unanimously.** Meeting adjourned at 3:18 p.m.