Access Health Connecticut

Health Plan Benefits & Qualifications Advisory Committee (HPBQ AC) Meeting
March 25, 2021

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Agenda

- Call to Order and Introductions
- Public Comment
- Vote: Meeting Minutes (March 12, 2021)
- Follow-ups from Prior Meeting
- Legislative Activity
- 2022 Individual Market Standard Plan Designs
  - Possible Votes
- 2022 Plan Year (PY) Timeline: Certification Requirements
- HPBQ AC Meeting Schedule
- Next Steps

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Public Comment

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Vote:

Review and Approval of Minutes:
March 12, 2021 HPBQ AC Special Meeting

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AHCT Vision and Mission

AHCT Vision

- The CT Health Exchange supports health reform efforts at the state and national level that provide CT residents with better health, and an enhanced and more coordinated health care experience at a reasonable, predictable cost.

AHCT Mission

- To increase the number of insured residents, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and provider that give them the best value.

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AHCT Values in Action

At Access Health CT, it is with our customers and our employees in mind that we seek to promote these collective values and to live by these behaviors. Our culture of acceptance welcomes and values everyone. We challenge the status quo to find new ways to grow and improve our community, our company and ourselves. Our people take pride in the service we provide, and in the spirit of the common good that we share.

Authenticity	Integrity	Excellence	Ownership	One Team	Passion
Act with sincerity, credibility and self-awareness.	Commit to doing the right thing with genuine intention.	Aim high and challenge the status quo.	Take responsibility and initiative.	Collaborate to succeed.	Dedication to creating opportunities for greater health and well-being.

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Follow-Ups from Prior Meeting

Action Item	Status
Plan Design Alternatives: Standardized HSA Bronze Plan	Wakely Consulting will review during the presentation today

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Legislative Activity

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State of Connecticut Public Act No. 20-4: An Act Concerning Diabetes and High Deductible Health Plans

- July 2020 Special Session - House Bill No. 6003
- Affects Connecticut General Statute (CGS) 38a-492d (individual health insurance policy) and 38a-518d (group health insurance policy) “Mandatory coverage for diabetes testing and treatment”
  - Effective January 1, 2022
    - Coverage is required for the treatment of all types of diabetes, including laboratory and diagnostic testing and screening, insulin drugs, non insulin drugs, diabetes devices (including diabetic ketoacidosis devices) in accordance with the insured's diabetes treatment plan,
    - Enrollee 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 non insulin drug
      - One hundred dollars for a thirty-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices for such insured that are in accordance with such insured's diabetes treatment plan
    - These provisions apply to a high deductible health plan to the maximum extent permitted by federal law

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Diabetes Legislation and 2022 Plan Designs

- Cost sharing changes for standardized plans for 2022
  - Cost sharing maximum for diabetes devices
    - $100 maximum for 30-day supply is cumulative for all medically necessary covered diabetes devices and diabetic ketoacidosis devices (i.e., combined, not separate for each different device)
  - Cost sharing maximums apply for in-network covered diabetes devices, diabetic ketoacidosis devices and insulin/non-insulin drugs used to treat diabetes
  - Cost sharing maximums may apply to High Deductible Health Plans (HDHPs) to the extent permitted by federal law
    - Inclusion of cost sharing maximums between deductible and maximum out-of-pocket limit is carrier decision
      - AHCT may choose to include this coverage in standardized plan, or not

United States Code (USC) – Title 26 Internal Revenue Code

- 26 USC §223(c)(2): Health savings accounts
  - Definition: High deductible health plan (HDHP)
    - Has an annual deductible not less than $1,400 for self-only/$2,800 for family coverage for calendar year 2021*
    - The sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed $7,000 for self-only/$14,000 for family coverage for calendar year 2021*
    - Coverage outside of plan network is not taken into account
    - Shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care
    - For plan years beginning on or before December 31, 2021, shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for telehealth and other remote care services.

**Minimum deductible and maximum out-of-pocket (MOOP) evaluated by IRS each year;*
IRS Revenue Procedure 2020-32 outlined minimum deductible and MOOP for calendar year 2021

IRS Notice 2019-45: Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under §223

- Summary of IRS Notice 2019-45
  - Effective July 19, 2019
  - Per section 223(c)(2)(A) of the IRC, a high deductible health plan (HDHP) cannot not provide benefits for any year until the minimum deductible for that year is satisfied
  - However, a HDHP can provide preventive care benefits without a deductible or, subject to requirements in section 2713 of the Public Health Service Act (PHS Act) with a deductible below the minimum annual deductible
  - List of preventive care benefits that could be provided by a HDHP without a deductible, or with a deductible below the applicable minimum deductible was expanded
    - Certain medical care services (including prescription drugs) for specified chronic conditions are classified as preventive care for treatment of the condition
    - Services or items not on the list are not treated as preventive care

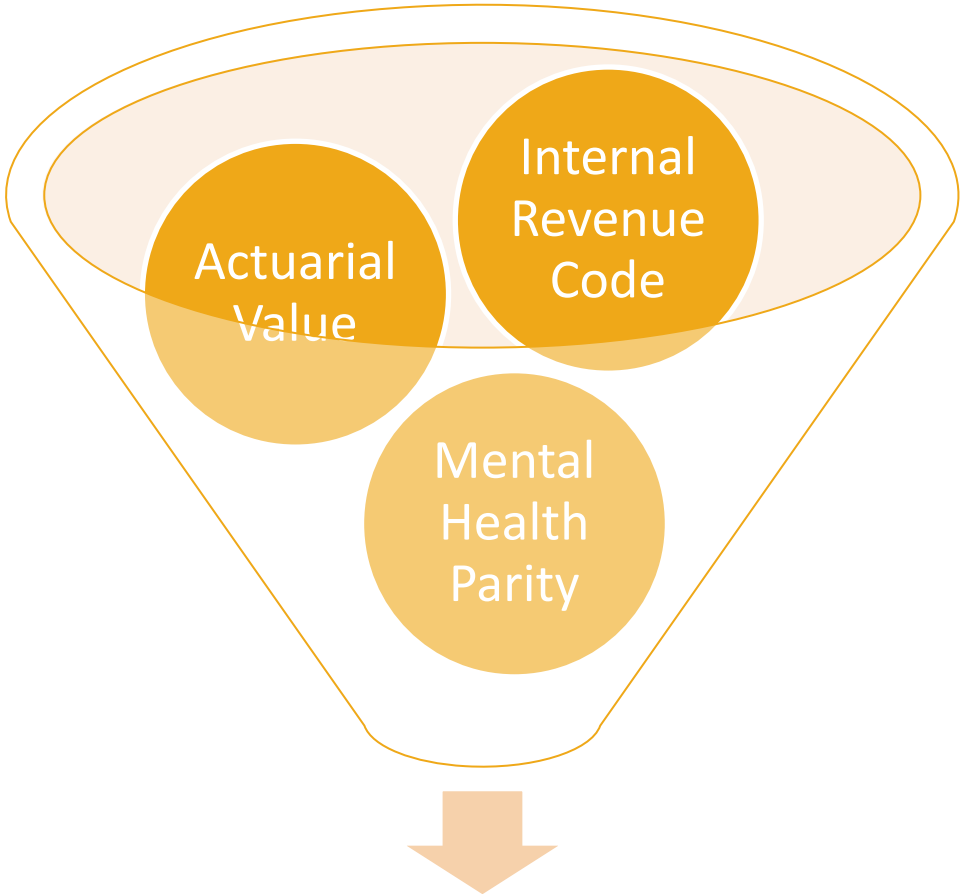
IRS Notice 2019-45: Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under §223

Preventive Care for Specified Conditions:	For Individuals Diagnosed with:	Service Category
Insulin and other glucose lowering agents	Diabetes	Prescription Drug
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease	
Statins	Heart disease and/or diabetes	
Glucometer	Diabetes	Diabetes Equipment & Supplies
Hemoglobin A1c testing	Diabetes	Laboratory
Retinopathy screening	Diabetes	Physician Office Visit
Anti-resorptive therapy	Osteoporosis and/or osteopenia	Does not pertain to diagnosis of diabetes
Beta-blockers	Congestive heart failure and/or coronary artery disease	
Blood pressure monitor	Hypertension	
Inhaled corticosteroids	Asthma	
Peak flow meter	Asthma	
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders	
Low-density Lipoprotein (LDL) testing	Heart disease	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression	

IRS Expanded List of Preventive Care Pertaining to Diagnosis of Diabetes Compared to Requirements of CT Public Act No. 20-4

Preventive Care for Individuals Diagnosed with Diabetes:	CGS Coverage Requirements: 38a-492d(b) & 38a-518d(b)	Clarification	CGS Cost Sharing Requirements: 38a-492d(c) & 38a-518d(c)
Insulin and other glucose lowering agents Angiotensin Converting Enzyme (ACE) inhibitors Statins	Medically necessary insulin & non-insulin drugs in treatment of diabetes	38a-492d(b) & 38a-518d(b) define "Noninsulin drug" as a drug, including, but not limited to, a glucagon drug, glucose tablet or glucose gel, that does not contain insulin and is approved by FDA to treat diabetes	No policy shall impose coinsurance, copayments, deductibles & other out-of-pocket expenses that exceed: --$25 for each 30-day supply of a medically necessary covered insulin drug --$25 for each 30-day supply of a medically necessary covered noninsulin drug
Glucometer	Medically necessary diabetes devices in accordance with the insured's diabetes treatment plan	*(1) "Diabetes device" means a device, including, but not limited to, a blood glucose test strip, glucometer, continuous glucometer, lancet, lancing device or insulin syringe, that is (A) a legend device or nonlegend device, and (B) used to cure, diagnose, mitigate, prevent or treat diabetes or low blood sugar;*	No policy shall impose coinsurance, copayments, deductibles and other out-of-pocket expenses that exceed: --$100 for a 30-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices
Hemoglobin A1c testing Retinopathy screening	Medically necessary laboratory and diagnostic testing and screening	Not Applicable	Not Applicable

Federal Law Impacting High Deductible Health Plans (HDHPs) and State Legislation on Diabetes/HDHPs



HDHP Compliance

CT Public Act 20-4: Section 38a-492d & 38a-518d

"(d) The provisions of subsection (c) of this section shall apply to a high deductible health plan to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time, the provisions of said subsection (c) shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

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AHCT 2021 Standardized Plans: 2022 Plans To Incorporate Diabetes Maximum Cost Sharing

	AHCT 2021 Standardized Plan: In-Network Cost Sharing				
Benefit Category	**AHCT 2021 Standardized Gold Plan**	**AHCT 2021 Standardized Silver 70% Plan**	**AHCT 2021 Standardized Silver 73% Plan**	**AHCT 2021 Standardized Silver 87% Plan**	**AHCT 2021 Standardized Silver 94% Plan**
Medical Deductible	$1,300 (INN)/$3,000 (OON)	$4,300 (INN)/ $8,600 (OON)	$3,950 (INN)/ $8,600 (OON)	$650 (INN)/ $8,600 (OON)	$0 (INN)/ $8,600 (OON)
Rx Deductible	$50 (INN)/$350 (OON)	$250 (INN)/ $500 (OON)	$250 (INN)/ $500 (OON)	$50 (INN)/ $500 (OON)	$0 (INN)/ $500 (OON)
Out-of-pocket Maximum	$5,250 (INN)/$10,500 (OON)	$8,150 (INN)/ $16,300 (OON)	$6,500 (INN)/ $16,300 (OON)	$2,500 (INN)/ $16,300 (OON)	$900 (INN)/ $16,300 (OON)
Primary Care	$20	$40	$40	$20	$10
Specialist Care	$40	$60	$60	$45	$30
Urgent Care	$50	$75	$75	$35	$25
Emergency Room	$400	$450 (after ded.)	$450 (after ded.)	$150 (after ded.)	$50
Inpatient Hospital	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $2,000 max. per admission)	$500 per day (after ded., $2,000 max. per admission)	$100 per day (after ded., $400 max. per admission)	$75 ($300 max. per admission)
Outpatient Hospital	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)	$60@ASC/$100 otherwise (after ded.)	$45@ASC/$75 otherwise
Advanced Radiology (CT/PET Scan, MRI)	$65	$75	$75	$60	$50
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)	$40 (after ded.)	$30 (after ded.)	$25
Laboratory Services*	$10 (after ded.)	$10 (after ded.)	$10 (after ded.)	$10 (after ded.)	$10
Rehabilitative & Habilitative Therapy (PT,OT,ST) Combined 40 visit calendar year maximum	$20	$30	$30	$20	$20
Chiropractic Care (20 visit calendar maximum)	$40	$50	$50	$35	$30
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 / $35 / $60 / 20% (spec. after ded., $100 max per spec. script)	$10 / $45 / $70 / 20% (all but generic after ded., $200 max per spec. script)	$10 / $45 / $70 / 20% (all but generic after ded., $100 max per spec. script)	$10 / $25 / $40 / 20% (non-preferred brand and spec. after ded., $60 max per spec. script)	$5 / $10 / $30 / 20% ($60 max per spec. script)
Diabetic Equipment & Supplies	30% coinsurance per equipment/supply	40% coinsurance per equipment/supply	40% coinsurance per equipment/supply	40% coinsurance per equipment/supply	40% coinsurance per equipment/supply

**Cost sharing change outside of diabetes legislation also under consideration*

AHCT 2021 Standardized Plans: 2022 Plans To Incorporate Diabetes Maximum Cost Sharing

	AHCT 2021 Standardized Plan: In-Network Cost Sharing	
Benefit Category	**AHCT 2021 Standardized Bronze Plan**	**AHCT 2021 Standardized Bronze HSA Plan**
Combined Medical & Rx Deductible	$6,550 (INN)/$13,100 (OON)	$6,350 (INN)/$12,700 (OON)
Out-of-pocket Maximum	$8,550 (INN)/$17,100 (OON)	$6,900 (INN)/$13,800 (OON)
Primary Care	$50	20% (after ded.)
Specialist Care	$70 (after ded.)	20% (after ded.)
Urgent Care	$75	20% (after ded.)
Emergency Room	$450 (after ded.)	20% (after ded.)
Inpatient Hospital	$500 per day (after ded., $1,000 max. per admission)	20% (after ded.)
Outpatient Hospital	$300@ASC/$500 otherwise (after ded.)	20% (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75 (after ded.)	20% (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	20% (after ded.)
Laboratory Services*	$10 (after ded.)	20% (after ded.)
Rehabilitative & Habilitative Therapy (PT, OT, ST) Combined 40 visit calendar year maximum	$30 (after ded.)	20% (after ded.)
Chiropractic Care (20 visit calendar maximum)	$50 (after ded.)	20% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$20 / 50% / 50% / 50% (all but generic after ded., $500 max per spec. script)	20% / 25% / 30% / 30% (all after ded., $500 max per spec. script)
Diabetic Equipment & Supplies	40% coinsurance per equipment/supply after INET plan deductible is met	20% coinsurance per equipment/supply after INET plan deductible is met

**Cost sharing change outside of diabetes legislation also under consideration for non-HSA Bronze plan*

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2022 Individual Market Standard Plan Designs

March 25, 2021

PRESENTED BY

Julie Andrews, FSA, MAAA – Sr. Consulting Actuary

Brad Heywood, ASA, MAAA – Associate Actuary

Agenda

2022 Plan Design Review

- Proposed Regulatory Changes
- Proposed Federal Actuarial Value Calculator (AVC) Changes
- Preliminary 2022 Calculator Results
- Voting on Plans
- Bronze HSA Options and Possible Vote

Appendix: Notes and Caveats

Regulation Changes for 2022

- Proposed annual limitation on cost sharing was increased to $9,100 (from $8,550 in 2021)
  - Note: This limit does not apply to HSA (Health Savings Account) qualified High Deductible Health Plans (HDHPs). That limit is released by the IRS in the spring.
  - CSR (Cost Sharing Reduction) Variations proposed annual limitation on cost sharing. The 2022 and 2021 limits are:
    - 100-150% **FPL: $3,000/$6,000 (single/family)
      - 2021 - $2,850/$5,700 (single/family)
    - 150%-200% **FPL: $3,000/$6,000 (single/family)
      - 2021 - $2,850/$5,700 (single/family)
    - 200%-250% **FPL: $7,250/$14,500 (single/family)
      - 2021 - $6,800/$13,600 (single/family)
    - We anticipate the above limits will be increased upon the release of the Final 2022 Notice of Benefit and Payment Parameters (NBPP)
- Federal HDHP minimum deductible and Maximum Out of Pocket (MOOP) limits are not yet released for 2022.
  - For 2021 the single deductible is set at a minimum of $1,400 and the MOOP maximum limit is $7,000.

No Updates

**Federal Poverty Level

Proposed Changes to the Federal AVC for 2022

- The Federal AVC has not yet been finalized, changes to the final model may impact results
- No underlying changes were made to the draft 2022 Federal AVC calculator
  - 0% Trend was applied for 2021-2022
- Changes made to the final 2021 calculator were as follows:
  - Data underlying the calculator was updated from prior year
    - Now based on 2017 individual and small group data trended to 2021
      - Medical Trend: 3.25% (2017-2018) and 5.4% Annually (2018-2021)
      - Pharmacy Trend: 9.0% (2017-2018) and 8.7% Annually (2018-2021)

No Updates

Summary of 2022 AV Changes

Individual Market	Gold	Silver	Bronze	Bronze HSA
Permissible AV Range	76.0%-82.0%	66.0%-72.0%	56.0%-65.0%	56.0%-65.0%
2021 AV (Final)	81.60% - 81.76%	70.69% - 71.83%	64.26% - 64.90%	64.98%
2022 AV - Preliminary	81.60% - 81.76%	70.69% - 70.81%	64.33% - 64.47%	64.98%

Individual Market - CSR Plan Variations: Silver	73% AV CSR	87% AV CSR	94% AV CSR
Permissible AV Range	72.0%-74.0%	86.0%-88.0%	93.0%-95.0%
2021 AV (Final)	72.83% - 73.85%	87.41% - 87.97%	94.71% - 94.96%
2022 AV- Preliminary	72.83% - 72.92%	87.37% - 87.97%	94.39% - 94.71%

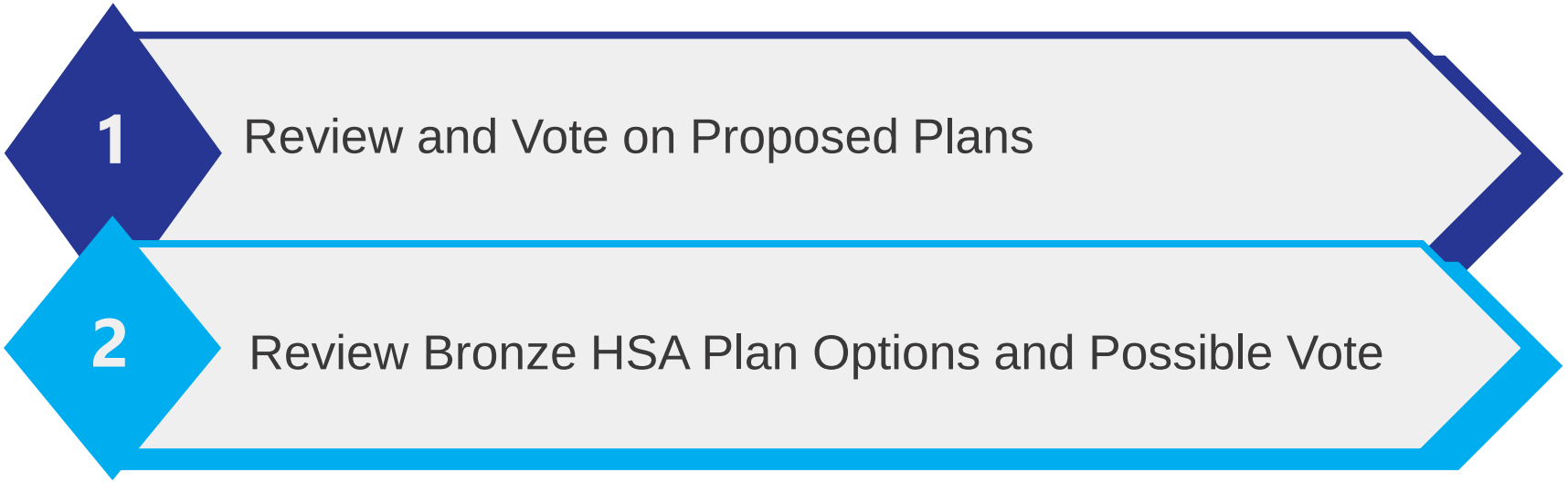
Note: 73.0% CSR Silver must have a differential of 2.0%+ with Standard Silver

Results preliminary until release of Final Federal AVC.

No Updates

2022 Plan Design Change Overview

Requested analysis/items from March 12th Meeting.



The plans **have been** reviewed for AVC with additional Diabetics Bill.
Mental Health Parity compliance **has been** reviewed by Carriers

Summary of 2022 Gold Plan AV

Benefit Category	2021 Ind. Standard Gold Plan
Medical Deductible	$1,300 (INN)/$3,000 (OON)
Rx Deductible	$50 (INN)/$350 (OON)
Coinsurance	30%
Out-of-pocket Maximum	$5,250 (INN)/$10,500 (OON)
Primary Care	$20
Specialist Care	$40
Urgent Care	$50
Emergency Room	$400
Inpatient Hospital	$500 per day (after ded., $1,000 max. per admission)
Outpatient Hospital	$300@ASC/$500 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$65
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)
Laboratory Services	$10 (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$20
Chiropractic Care 20 visit calendar maximum	$40
All Other Medical	30%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 / $35 / $60 / 20% (spec. after ded., $100 max per spec. script)
2022 AVC Results	***81.60% - 81.76%**

Option to cover lab services before the deductible fails MHP Testing.

2022 Benefit changes:

- $25 for each 30-day supply of a covered, prescribed, medically necessary insulin or non-insulin drug, and
- $100 for a 30-day supply of all covered, medically necessary diabetes devices or diabetic ketoacidosis devices.

*2022 AVC Results include changes related to Diabetics Bill caps

Vote?

Summary of 2022 Silver Plan 70% AV

Benefit Category	2021 Ind. Standard Silver Plan	2022 Ind. Standard Silver Plan (Alt 1)	2022 Ind. Standard Silver Plan (Alt 2)
Medical Deductible	$4,300 (INN)/ $8,600 (OON)	$4,600 (INN)/ $9,200 (OON)	$4,300 (INN)/ $8,600 (OON)
Rx Deductible	$250 (INN)/ $500 (OON)	$250 (INN)/ $500 (OON)	$250 (INN)/ $500 (OON)
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	$8,150 (INN)/ $16,300 (OON)	**$9,100 (INN)/ $18,200 (OON)	**$8,600 (INN)/ $17,200 (OON)
Primary Care	$40	$40	$40
Specialist Care	$60	$60	$60
Urgent Care	$75	$75	$75
Emergency Room	$450 (after ded.)	$450 (after ded.)	$450 (after ded.)
Inpatient Hospital	$500 per day (after ded., $2,000 max. per admission)	$500 per day (after ded., $2,000 max. per admission)	$500 per day (after ded., $2,000 max. per admission)
Outpatient Hospital	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75	$75	$75
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)	$40 (after ded.)
Laboratory Services	$10 (after ded.)	$10	**$20**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30	$30	$30
Chiropractic Care 20 visit calendar maximum	$50	$50	$50
All Other Medical	40%	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$10 / $45 / $70 / 20% (all but generic after ded., $200 max per spec. script)	$10 / $45 / $70 / 20% (all but generic after ded., $200 max per spec. script)	$10 / $45 / $70 / 20% (all but generic after ded., $200 max per spec. script)
2022 AVC Results	***70.69% - 70.81%**	***70.68% - 71.82%**	***70.66%-70.81%**

**$8,600/$9,100 MOOP derived from proposed NBPP. Possible change once final NBPP is released, 2020 MOOP $8550

*2022 AVC Results include changes related to Diabetics Bill caps noted on the Gold plan slide

Vote?

Summary of 2022 Silver Plan 73% AV

Benefit Category	2021 Ind. Standard Silver Plan 73% AV	2022 Ind. Standard Silver Plan 73% AV (Alt 1)	2022 Ind. Standard Silver Plan 73% AV (Alt 2)
Medical Deductible	$3,950	$4,600	$3,950
Rx Deductible	$250	$250	$250
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	$6,500	$6,800	$6,800
Primary Care	$40	$40	$40
Specialist Care	$60	$60	$60
Urgent Care	$75	$75	$75
Emergency Room	$450 (after ded.)	$450 (after ded.)	$450 (after ded.)
Inpatient Hospital	$500 per day (after ded., $2,000 max. per admission)	$500 per day (after ded., $2,000 max. per admission)	$500 per day (after ded., $2,000 max. per admission)
Outpatient Hospital	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75	$75	$75
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)	$40 (after ded.)
Laboratory Services	$10 (after ded.)	$10	**$20**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30	$30	$30
Chiropractic Care 20 visit calendar maximum	$50	$50	$50
All Other Medical	40%	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$10 / $45 / $70 / 20% (all but generic after ded., $100 max per spec. script)	$10 / $45 / $70 / 20% (all but generic after ded., $100 max per spec. script)	$10 / $45 / $70 / 20% (all but generic after ded., $100 max per spec. script)
2022 AVC Results	***72.83% - 72.92%**	***72.98% - 73.13%**	***72.83%-72.92%**

*2022 AVC Results include changes related to Diabetics Bill caps noted on the Gold plan slide

Note: OON Benefits aligns with 70% Silver Plan

Summary of 2022 Silver Plan 87% AV

Benefit Category	2021 Ind. Standard Silver Plan 87% AV	2021 Ind. Standard Silver Plan 87% AV (Alt 1)
Medical Deductible	$650	$650
Rx Deductible	$50	$50
Coinsurance	40%	40%
Out-of-pocket Maximum	$2,500	$2,725
Primary Care	$20	$20
Specialist Care	$45	$45
Urgent Care	$35	$35
Emergency Room	$150 (after ded.)	$150 (after ded.)
Inpatient Hospital	$100 per day (after ded., $400 max. per admission)	$100 per day (after ded., $400 max. per admission)
Outpatient Hospital	$60@ASC/$100 otherwise (after ded.)	$60@ASC/$100 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$60	$60
Non-Advanced Radiology (X-ray, Diagnostic)	$30 (after ded.)	$30 (after ded.)
Laboratory Services	$10 (after ded.)	$10
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$20	$20
Chiropractic Care 20 visit calendar maximum	$35	$35
All Other Medical	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$10 / $25 / $40 / 20% (non-preferred brand and spec. after ded., $60 max per spec. script)	$10 / $25 / $40 / 20% (non-preferred brand and spec. after ded., $60 max per spec. script)
2022 AVC Results	***87.37% - 87.97%**	***87.23% - 87.92%**

*2022 AVC Results include changes related to Diabetics Bill caps noted on the Gold plan slide

Note: OON Benefits aligns with 70% Silver Plan

Wakely

Summary of 2022 Silver Plan 94% AV

Benefit Category	2021 Ind. Standard Silver Plan 94% AV
Medical Deductible	$0
Rx Deductible	$0
Coinsurance	40%
Out-of-pocket Maximum	$900
Primary Care	$10
Specialist Care	$30
Urgent Care	$25
Emergency Room	$50
Inpatient Hospital	$75 ($300 max. per admission)
Outpatient Hospital	$45@ASC/$75 otherwise
Advanced Radiology (CT/PET Scan, MRI)	$50
Non-Advanced Radiology (X-ray, Diagnostic)	$25
Laboratory Services	$10
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$20
Chiropractic Care 20 visit calendar maximum	$30
All Other Medical	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 / $10 / $30 / 20% ($60 max per spec. script)
2022 AVC Results	***94.39% - 94.71%**

*2022 AVC Results include changes related to Diabetics Bill caps noted on the Gold plan slide

Note: OON Benefits aligns with 70% Silver Plan

Vote?

Summary of 2022 Bronze Non-HSA Plan AV

**$8,800/$9,100 MOOP derived from proposed NBPP. Possible change once final NBPP is released, 2020 MOOP $8550

*2022 AVC Results include changes related to Diabetics Bill caps noted on the Gold plan slide

Benefit Category	2021 Ind. Standard Bronze Non-HSA Plan	2021 Ind. Standard Bronze Non-HSA Plan (Alt 1)	2021 Ind. Standard Bronze Non-HSA Plan (Alt 2)
Combined Medical & Rx Deductible	$6,550 (INN)/$13,100 (OON)	$6,950 (INN)/$13,900 (OON)	$6,550 (INN)/$13,100 (OON)
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	$8,550 (INN)/$17,100 (OON)	**$9,100 (INN)/$18,200 (OON)	**$8,800 (INN)/$17,600 (OON)
Primary Care	$50	$50	$50
Specialist Care	$70 (after ded.)	$70 (after ded.)	$70 (after ded.)
Urgent Care	$75	$75	$75
Emergency Room	$450 (after ded.)	$450 (after ded.)	$450 (after ded.)
Inpatient Hospital	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)
Outpatient Hospital	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75 (after ded.)	$75 (after ded.)	$75 (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)	$40 (after ded.)
Laboratory Services	$10 (after ded.)	$10	**$20**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30 (after ded.)	$30 (after ded.)	$30 (after ded.)
Chiropractic Care 20 visit calendar maximum	$50 (after ded.)	$50 (after ded.)	$50 (after ded.)
All Other Medical	40% (after ded.)	40% (after ded.)	40% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$20 / 50% / 50% / 40% (all but generic after ded., $500 max per spec. script)	$20 / 50% / 50% / 40% (all but generic after ded., $500 max per spec. script)	$20 / 50% / 50% / 40% (all but generic after ded., $500 max per spec. script)
2022 AVC Results	***64.33% - 64.47%**	***64.32% - 64.82%**	***64.38%-64.47%**

Wakely

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Summary of 2022 Bronze HSA Plan AV

Benefit Category	2021 Bronze HSA Plan
Combined Medical & Rx Deductible	$6,350 (INN)/$12,700 (OON)
Coinsurance	20%
Out-of-pocket Maximum	$6,900 (INN)/$13,800 (OON)
Primary Care	20% (after ded.)
Specialist Care	20% (after ded.)
Urgent Care	20% (after ded.)
Emergency Room	20% (after ded.)
Inpatient Hospital	20% (after ded.)
Outpatient Hospital	20% (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	20% (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	20% (after ded.)
Laboratory Services	20% (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	20% (after ded.)
Chiropractic Care (20 visit calendar maximum)	20% (after ded.)
All Other Medical	20% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	20% / 25% / 30% / 30% (all after ded., $500 max per spec. script)
2022 AVC Results	**64.98%**

Summary of 2022 Bronze HSA Plan AV - Alts

		Option 1	Option 2 (variation of 1)	Option 3	Option 4 (variation of 3)
	2021 Plan Design (Current)	2022:State Legislation assuming maximum is combined for all supplies, with maximum in place between deductible and MOOP	2022:State Legislation assuming maximum is combined for all supplies, with maximum in place between deductible and MOOP	2022: State Legislation assuming maximum is separate for each supply, with maximum in place between deductible and MOOP	2022: State Legislation assuming maximum is separate for each supply, with maximum in place between deductible and MOOP
Out-of-pocket Maximum	$6,900 (INN)	$6,900 (INN) -> $7000/$14000	$6,900 (INN) -> $7000/$14000	$6,900 (INN) -> $7000/$14000	$6,900 (INN) -> $7000/$14000
Specialist Care	20% (after ded.)	20% (after ded.)	20% (after ded.) Retinopathy screening treated as preventive ($0 copay, deductible waived)	20% (after ded.)	20% (after ded.) Retinopathy screening treated as preventive ($0 copay, deductible waived)
Laboratory Services	20% (after ded.)	20% (after ded.)	20% (after ded.) Hemoglobin A1c testing treated as preventive ($0 copay, deductible waived)	20% (after ded.)	20% (after ded.) Hemoglobin A1c testing treated as preventive ($0 copay, deductible waived)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	20% / 25% / 30% / 30% (all after ded., $500 max per spec. script)	*20% / 25% / 30% / 30% (all after ded., $500 max per spec. script);	*20% / 25% / 30% / 30% (all after ded., $500 max per spec. script);	*20% / 25% / 30% / 30% (all after ded., $500 max per spec. script);	*20% / 25% / 30% / 30% (all after ded., $500 max per spec. script);
Diabetic Equipment & Supplies	20% coinsurance per equipment/supply after plan deductible is met	**20% coinsurance	**20% coinsurance	**20% coinsurance	**20% coinsurance

**$25 maximum for each thirty-day supply of a medically necessary covered insulin drug; $25 maximum for each 30-day supply of a medically necessary covered non-insulin drug. Maximums apply after in-network deductible is met.*

***20% coinsurance after in-network deductible is met to a $100 maximum per month for all covered medically necessary equipment and supplies*

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Appendix

Notes and Caveats

- Other services not included in the AVC, but will be specified cost sharing for each standardized plan

In-Network Services
Other Services
Mammography Ultrasound
Chiropractic Services (up to 20 visits per calendar year)
Diabetic Supplies & Equipment
Durable Medical Equipment
Home Health Care Services (up to 100 visits per calendar year)
Ambulance Services
Urgent Care Center or Facility
Pediatric Dental Care (for children under age 19)
Diagnostic & Preventive
Basic Services
Major Services
Orthodontia Services (medically necessary)
Pediatric Vision Care (for children under age 19)
Out-of-Network Services
All services, deductible and maximum out-of-pocket

Notes and Caveats

- The cost sharing shown on the following slides represents costs for in-network services only.
- The deductible and MOOP limits shown are for individuals. The family limits are 2x the individual limit for all plans except where noted.
- Preventive care is covered at no cost to the member for all plans.
- Mental Health cost sharing is the same as Primary Care for all plans.
- Silver loading for defunded cost-sharing reduction plans will persist in 2021.
- All plans include ‘embedded’ deductible approach (not aggregate)