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

Remote Meeting

Thursday, March 25, 2021
Meeting Minutes

Members Present: Grant Ritter (Chair); Theodore Doolittle; Matthew Brokman; Tu Nguyen; Neil Kelsey; 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 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 March 12, 2021 Health Plan Benefits and Qualifications Advisory Committee Special Meeting Minutes. Motion was made by Tu Nguyen and seconded by Jill Zorn. Roll call vote was taken. ***Motion passed unanimously.*** Matthew Brokman and Theodore Doolittle were not present for the vote.

D. Follow-Ups from Prior Meeting

Ann Lopes, Product Carrier Manager provided follow-ups from prior meeting. Ms. Lopes summarized the action items from Committee's previous meeting. Ms. Lopes indicated that Wakely Consulting will provide the Committee with reviews of the previously presented modifications for the non-HSA standardized plans with the intention of getting a vote on designs to be recommended to the Board for approval as the standardized plans for the 2022 plan year. Ms. Lopes added that a vote could also be taken on the standardized Bronze HSA plan if the Committee chooses to do so.

E. Legislative Activity

Paul Lombardo, Director of the Life and Health Division at the Connecticut Insurance Department (CID) reviewed information pertaining to the state legislation on diabetes that was passed during the Special Session last summer. Mr. Lombardo stated that in July of 2020, House Bill No. 6003 was passed by the State Legislature which affects individual and group health insurance policies and dictates mandatory coverage for diabetes testing and treatment.

Mr. Lombardo noted that 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, and diabetes devices in accordance with the insured's diabetes treatment plan. Mr. Lombardo emphasized that enrollee coinsurance, copayments, deductibles, and other out-of-pocket expenses may not exceed certain thresholds. Mr. Lombardo added that these provisions apply to a high deductible health plan to the maximum extent permitted by federal law. Mr. Lombardo stated that a number of questions came up regarding these issues. One of the outstanding issues was the $100 cap on devices and Mr. Lombardo noted that CID is working on a bulletin that will be issued in the near future that will outline how the cost sharing maximums are to apply. The bulletin is based on interpretation of the statute along with testimony during the Special Session last year as it was clear that the legislative intent was to have a cap for a 30-day supply which would be cumulative for all medically necessary covered diabetes devices and diabetic ketoacidosis devices.

Mr. Lombardo stated that the CID recommendation is that people coordinate the purchase of those 30-day supplies, so they are obtained at the same time and the cap would be applied to all of them. Jill Zorn stated that it may be a challenge to those individuals using diabetic devices because it is not how they purchase them now. Ms. Zorn added that there may be a need to let people know about those changes so they can adjust their actions accordingly. Mr. Lombardo stated that the carriers would be the ones that will have to comply with the cap, but that it could be difficult to administer when the purchases overlap. He stated that, like other legislation, the cost sharing caps will be applicable when obtained in-network.

Mr. Lombardo stated that the cost sharing maximums may apply to High Deductible Health Plans (HDHPs) to the extent permitted by federal law. Mr. Lombardo added that inclusion of cost sharing maximums between the deductible and maximum out-of-pocket limit is a carrier decision and pointed out that AHCT may choose to include this coverage in standardized plan or not. Mr. Lombardo stated that when CID approves policy forms to be used in the market, it does not review and approve for tax qualification status in the HDHPs. Mr. Lombardo added that a requirement exists for the carriers that issue HDHPs to have language in the member contract advising individuals choosing those plans to consult their own tax advisors on the tax qualification status of the HDHP. Mr. Lombardo addressed the issue of the deductible and the maximum out-of-pocket limit and pointed out that carriers must make sure plans are in compliance with federal requirements. The Connecticut legislation on cost sharing caps apply more extensively to devices than allowed in the Internal Revenue Service (IRS) guidance from July 2019, so carriers need to resolve, or if this body decides to include caps before the deductible, it should be sure that only the services allowed to be offered before the deductible are to be covered not subject to the deductible.

Ms. Lopes provided a definition of a HDHP which is outlined in the section noted here in terms of the benefit design. Ms. Lopes added that to qualify as a HDHP, a plan must:

- have an annual deductible of at least $1,400 for a single individual or $2,800 for a family effective for 2021;
- have an out-of-pocket maximum of no greater than $7,000 for a single enrollee or $14,000 for a family effective for 2021.

Ms. Lopes outlined that these elements, minimum deductible & maximum out-of-pocket, are evaluated each year by the IRS relative to inflation. For calendar year 2021, these values were conveyed in IRS Revenue Procedure 2020-32 that was released in May of last year. Ms. Lopes noted that Wakely Consulting has mentioned in previous meetings that we will likely not know whether these are changing for 2022 until sometime this Spring.

Ms. Lopes expressed that additional items outlined in the Internal Revenue Code regarding HDHP design requirements include mention of 'Special rules for network plans' where out-of-network coverage is not taken into account for the minimum deductible and Maximum Out-of-Pocket (MOOP) and said that there is also a reference to meeting the qualifications of a HDHP when the deductible does not apply to preventive care. Ms. Lopes indicated that plans offered in 2021 could also waive the deductible for health services provided in a remote fashion, presumably in response to the Public Health Emergency.

Ms. Lopes stated a discussion about IRS Notice 2019-45 took place at Committee meetings last year as well as earlier this year but wanted to take a step back and review the guidance more closely. Ms. Lopes noted this document reiterates information outlined in the presentation about the minimum deductible requirement, and that a HDHP is permitted to include certain preventive care benefits without application of a plan deductible.

Ms. Lopes elaborated that it also specifies that an expanded list of services used to treat specified chronic conditions could also be considered preventive under a HDHP either without the deductible or with a deductible below the required minimum threshold, but indicates that if something was not on the expanded list, it could not be treated as a preventive service.

Ms. Lopes went on to provide a cross-reference summary of the 6 items included on the IRS expanded list that have at least 1 diagnosis of diabetes, and the service category through which they might be covered under a commercial health insurance plan.

Ms. Lopes referred to the presentation where the second column summarizes the coverage requirements for these as outlined for sections 38a-492d(b) & 38a-518d(b) of the CT General Statute within the Public Act. Ms. Lopes stated that these sections are for health insurance plans offered in the Individual and Group markets, respectively and these 6 items are grouped based on the type of coverage

Ms. Lopes summarized the third column and said that it outlines a definition included in the Public Act for those items that also have a specific cost sharing requirement per the ACA. The last two entries, Hemoglobin A1c testing and retinopathy screening were not included in the copay maximum requirements outlined in the Public Act.

Ms. Lopes elaborated that the last column simply summarizes the cost sharing requirement per the Public Act previously reviewed, including:

- insulin and non-insulin medications used to treat diabetes, which is a $25 maximum for each 30-day supply, and then
- diabetes devices and diabetic ketoacidosis devices, which as Paul Lombardo mentioned earlier, have a $100 combined maximum per 30-day supply

Ms. Lopes summarized the next slide in the presentation and stated that there are three major areas of federal guidance that must be taken into account to establish that a HDHP is compliant. Earlier, information included in the Internal Revenue Code was reviewed, specifically minimum deductible, maximum out-of-pocket and allowance for waiver of deductible under a HDHP for certain preventive services as well as the HDHP MOOP limit permitted for the 2021 calendar year per IRS guidance. Ms. Lopes remarked that AHCT does not know yet what the permitted MOOP limit will be for 2022 and conveyed that for the past three years, that information has been released in May.

Ms. Lopes added that earlier in the discussion information included in IRS Notice 2019-45 was also reviewed, and this guidance allowed for expansion of the list of services that could be considered preventive under a HDHP when used for the treatment of certain chronic conditions.

Ms. Lopes pointed out that non-grandfathered plans in the Individual and Small Group markets that must comply with ACA requirements have to fall within a specified Actuarial Value range that is based on plan metal level, with an allowance for certain Bronze plans, including a HDHP to be classified as Expanded Bronze, with an AV of between 56% & 65%. The current AHCT

standardized HSA Bronze plan for 2021 is very high in the AV range. Ms. Lopes stated that both carriers submitted it to the CID with an AV of 64.98%, however it has a MOOP of $6,900, so consideration of increasing that to the MOOP allowed by the IRS for 2021 of $7,000 for a single enrollee has been done in order to determine if the state legislation on diabetes regarding caps for insulin and non-insulin drugs and devices could be included for the standardized HSA Bronze plan between the deductible and MOOP.

Ms. Lopes discussed that the remaining item of major federal guidance that needs to be considered for ACA compliant plans, including HDHPs, is Mental Health Parity and plans must comply with this federal requirement, but information is very specific to an insurance carrier's own claim data. Ms. Lopes outlined that while one carrier may find that a plan design is compliant with both AV & MHP, another carrier may find a plan to be compliant only with AV.

Ms. Lopes summarized information on 2022 plans to incorporate diabetes maximum cost sharing. Along with that required change, there has also been discussion on whether the deductible could be waived for lab services for the non-HSA Gold, Silver and Bronze plans. Ms. Lopes added that, for the standardized HSA Bronze plan, the state legislation on diabetes caps could be incorporated between the deductible and MOOP and it would be something the Committee can recommend for approval to the Board.

F. 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 have been no updates yet to either the proposed regulation changes for 2022 or the proposed 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 stated that in response to a prior meeting of the Committee, the non-HSA plans have been reviewed for the AVC with additional coverage required per the Diabetes Bill with Mental Health Parity reviewed by the carriers. Mr. Heywood summarized the 2022 Gold Plan AV and indicated that it was different from the others, in that both carriers could not incorporate a design where Lab Services would not be subject to the deductible and be in compliance with both the Mental Health Parity and AV, so it does not have any change from the 2021 Gold Plan. However, Ms. Lopes noted it does include the changes required by the Diabetes Bill.

Chair Grant Ritter requested a motion to recommend that the Board of Directors approve the Standard Gold Plan for the Plan Year 2022 presented by Wakely Consulting on behalf of Exchange Staff as the Standard Gold Plan for Plan Year 2022. Motion was made by Jill Zorn and seconded by Tu Nguyen. Roll call vote was taken. **Motion passed unanimously.** Matthew Brokman and Theodore Doolittle were not present for the vote.

Mr. Heywood presented the summary of the 2022 Silver Plan 70% AV. Mr. Heywood noted that the plan also includes implementation of the Diabetes Bill and two alternatives where Lab Services would not be subject to the plan deductible for the 2022 plan year.

Chair Grant Ritter requested a motion to recommend that the Board of Directors approve the 2022 Individual Standard Silver Plan Alt. 2. presented by Wakely Consulting on behalf of Exchange Staff as the Standard Silver Plan for Plan Year 2022. Motion was made by Jill Zorn and seconded by Neil Kelsey. Roll call vote was ordered. **Motion passed unanimously.** Matthew Brokman and Theodore Doolittle were not present for the vote.

Mr. Heywood went on to describe the possible options for the 2022 Silver Plan Cost Sharing Reduction (CSR) plans at AV levels of 73%, 87% and 94%. These all incorporate the cost sharing maximums required by the Diabetes Bill and for the 73% and 87% plans, Lab Services not subject to the plan deductible. The 94% CSR plan has a $0 deductible, so a change to cost sharing for Lab Services was not needed for that plan.

Chair Grant Ritter requested a motion to recommend that the Board of Directors approve the 73% AV Alt. 2, 87% AV Alt. 1, and 94% Silver CSR Plans for Plan Year 2022 as presented by Wakely Consulting on behalf of Exchange Staff as the Standard Silver Plan variants. Motion was made by Jill Zorn and seconded by Tu Nguyen. Roll call vote was ordered. **Motion passed unanimously.** Matthew Brokman and Theodore Doolittle were not present for the vote.

Mr. Heywood went on to provide a summary of the 2022 Bronze Non-HSA Plan AV alternative plans options that incorporate the state legislation on diabetes, and Lab Services not subject to the deductible.

Chair Grant Ritter requested a motion to recommend that the Board of Directors approve Alt. 2 as the Standard Bronze Non-HSA Plan for Plan Year 2022 as presented by Wakely Consulting on behalf of Exchange Staff. Motion was made by Tu Nguyen and seconded by Jill Zorn. Roll call vote was ordered. **Motion passed unanimously.** Matthew Brokman and Theodore Doolittle were not present for the vote.

Mr. Heywood provided a summary of the 2022 Bronze HSA Plan AV. Mr. Heywood noted that that the carriers tested for different options of applying the deductible in compliance with the diabetes legislation. Ms. Lopes added that when these requests to the carriers were released, it was prior to AHCT obtaining the guidance from the CID on the separate versus the combined diabetic supply maximum. Ms. Lopes pointed out that based on the current CID guidance, Options 3 and 4 cannot be taken under consideration anymore. Options 1 and 2 include the $100 maximum that is on a combined basis for all supplies for a 30-day supply and a $25 maximum for a 30-day supply of insulin and non-insulin medications between the deductible and the MOOP limit. Based on guidance provided by Mr. Lombardo earlier today, AHCT can choose to include these cost sharing maximums for this portion of the plan or not, but they could not be incorporated prior to the deductible. Discussion ensued around compliance issues, including tax qualification status for a Health Savings Account (HSA) associated with a HDHP.

Chair Grant Ritter requested a motion to recommend that the Board of Directors approve Option 1 presented by Wakely Consulting on behalf pf Exchange Staff as the Standard HSA Bronze Plan for Plan Year 2022. Motion was made by Tu Nguyen and seconded by Jill Zorn. Roll call vote was ordered. **Motion passed unanimously.** Matthew Brokman and Theodore Doolittle were not present for the vote.

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

Ms. Lopes noted that the timeline has not changed since the previous meeting. Ms. Lopes reiterated that no AV final calculator is available at this time as well as there is no final Notice of Benefit and Payment Parameters in which the MOOP would be conveyed and in addition, the IRS MOOP guidance is not yet available. Ms. Lopes pointed out that the Plan Management Team is preparing to present this Committee's recommendations to the Access Health CT Board of Directors on April 15, 2021. Ms. Lopes pointed out that if any changes occur before that, this Committee could still meet on April 8 to make any adjustments if necessary. Ms. Lopes also spoke about possible contingency plans if any adjustments need to be made after the Board decides to approve those plans.

J. Adjournment

Chair Grant Ritter requested a motion to adjourn. Motion was made by Jill Zorn and seconded by Tu Nguyen. Roll call vote was ordered. **Motion passed unanimously.** Matthew Brokman was not present for the vote. Meeting adjourned at 3:29 p.m.