BUREAU OF INSURANCE
BASIS STATEMENT AND SUMMARY OF COMMENTS
AMENDMENT OF 02-031 C.M.R. CHAPTER 851
CLEAR CHOICE DESIGNS FOR INDIVIDUAL AND SMALL GROUP HEALTH PLANS

Acting Superintendent of Insurance Timothy N. Schott hereby adopts amendments to rule Chapter 851, "Clear Choice Designs for Individual and Small Group Health Plans," pursuant to 24-A M.R.S. §§ 212 and 2793. The purpose of the proposed amendments is to revise the process for developing health plan cost share designs for individual and, as applicable, small group health plans to conform to amendments to 24-A M.R.S. § 2793 by P.L. 2021, c. 361 § 3 (L.D. 1725, An Act To Clarify the Deferral of the Pooled Market and Link Small Employer Clear Choice to Pooling in the Made for Maine Health Coverage Act), and to make technical changes related to implementation issues observed during the Clear Choice program's first year.

Former Superintendent Eric A. Cioppa delegated full authority to Senior Attorney Benjamin Yardley, by order issued March 24, 2022, to act on the Superintendent's behalf in this rulemaking proceeding. On May 2, 2022, the Bureau published a Notice of Rulemaking setting the public hearing at 10:00 a.m. on June 2, 2022 and closing the comment period at 4:30 p.m. on June 13, 2022. On May 18, 2022, the Bureau published an Updated Notice of Rulemaking extending the comment period to 4:30 p.m. on June 27, 2022. The Bureau did so to give the public an opportunity to comment on changes in the proposed amendment to Section 5(2) related to the designated Basic Silver Plan. The Bureau posted the revised proposed amendment to its website, distributed it to subscribers to the Bureau's e-mail subscription service, and filed a revised Rule-Making Fact Sheet with the Maine Secretary of State, published in the State Rulemaking Register on May 25, 2022, and with the Executive Director of the Legislative Council.

The public hearing took place as originally scheduled by videoconference. The public comment period was open until June 27, 2022 at 4:30 p.m.

Comments

The following persons commented at the hearing and submitted written comments by June 27, 2022:

Kristine Ossenfort, Esq.
Senior Government Relations Director
Anthem Health Plans of Maine, Inc. (Anthem)

Kate Ende
Policy Director, Consumers for Affordable Health Care (CAHC)

Summary of Comments and Bureau of Insurance Responses

A. Section 3(2), definition of "Actuarial Value" – Anthem urged the Bureau to set the default actuarial value (AV) for each Clear Choice plan. Anthem asserted that this would be consistent with California's and New York's approaches to standardized plan designs and would avoid the potential for different results among the carriers. At the public hearing, Anthem said that it had had to make some adjustments in the first year of Clear Choice but that the company had faced challenges in meeting AV requirements. It argued that establishing default AVs would put all carriers in compliance and make the

benefits the same. Under Anthem's proposal, the Bureau would establish each plan's AV with input from the carriers, or the AV could vary by a set amount such as a half percent.

Bureau Response:

The Centers for Medicare & Medicaid Services (CMS), through the Center for Consumer Information and Insurance Oversight (CCIIO), publishes an Actuarial Value Calculator that issuers must use to determine the AV of a plan. The AVC accommodates most plans, but some plan designs have features that the AVC does not support. In these instances, a carrier may either modify the calculator inputs to represent the plan design more closely or may modify the results of the AVC to account for the unsupported features. An actuarial certification documenting the development of the AV for these plan designs is required.

The Bureau sets the AV for standardized plans with the basic cost-share structure as a starting point for consumers to understand how the various plans' features compare. Unlike states with fully standardized plans, Maine standardizes only the general cost-sharing design and authorizes carriers to vary other aspects of their Clear Choice plans. Because they are responsible for the accuracy of their filings, carriers must make their own calculations based on their experience, expense, and unique coverage aspects.

For these reasons, the Bureau rejects this proposal.

B. Section 3(3), definition of "Carrier" – Anthem suggested that Multiple Welfare Employer Arrangements (MEWAs) and the State of Maine Employee Health Plan (SEHP) be removed from the definition of "carrier."

Bureau response:

The definition of "carrier" comes from the Health Plan Improvement Act and was included in the original rule without receiving any comment when it was initially proposed. Anthem has not asserted that there is any ambiguity in the scope of the rule. MEWAs and SEHP do not issue pooled market health plans, so this rule does not apply to them. Likewise, carriers that issue only large group health plans are not subject to this rule. Nevertheless, they are all carriers and they all provide health coverage. There is no reason to redefine those terms to mean something narrower than their commonly understood meanings.

The Bureau therefore rejects this proposal.

C. Section 4(2)(E), Plan options within a Clear Choice design – This section, which remains unchanged from the original rule, requires that two plans be treated as different options within a single Clear Choice design or alternative plan design if the plans' only differences are characteristics that the cost-sharing design does not specify or that may vary by rule. Anthem proposed that the Bureau amend this provision to clarify that the same Clear Choice plans offered in the individual and small group markets complies with § 2792(1) if they differ by characteristics that the cost-sharing design does not specify. Anthem used "right-to-shop" as an example because 24-A M.R.S. § 4318-A requires this incentive for small group HSA-compliant plans but not for individual plans. Anthem characterized right-to-shop as an incentive that is not an integral part of the product.

CAHC did not offer a specific proposal to change this paragraph, and did not cite it directly, but they did "strongly recommend limiting the characteristics that may vary between plans offered within a single Clear Choice or alternative benefit design," which if adopted would take the form of a revision to this paragraph.

Bureau response:

Anthem's proposal is beyond the scope of this rule. The Clear Choice program does not dictate whether a feature such as "right-to-shop" incentives can lawfully be offered to small employers but not to individuals, or whether that would violate the all-plan guaranteed issue requirement of 24-A M.R.S. § 2792(1). The interpretation and implementation of Section 2792 is addressed by Rule 856, the Pooled Market rule, not by this rule, which interprets and implements Section 2793. If this type of variation is permitted, Section 4(2)(E) of this rule already makes clear that "Two plans shall be treated as different options within a single Clear Choice Design or within a single Alternative Plan Design if they differ only by characteristics that are not specified in the cost-sharing design," including but not limited to "right-to-shop" incentives cited by Anthem.

While the Bureau agrees with CAHC that excessive variations within the same cost-sharing design could be confusing, the Legislature has chosen to allow carriers a degree of flexibility rather than prescribing the details of plan design. The best way to prevent carriers from abusing that flexibility is through the form review process.

For these reasons, the Bureau rejects these proposals.

D. Section 4(3), Discontinuation of non-grandfathered plans – Anthem asked the Bureau to confirm that when their current small group plans are discontinued upon the implementation of the pooled market, carriers should map the employers to new plans on a rolling basis upon renewal, not all on January 1, 2023.[1] Anthem was also concerned that carriers might be prohibited from renewing small group members in their current plans in 2022 because those plans would extend into 2023 – the pooled market implementation year. Anthem therefore suggests this further revision to the first sentence of section 4(3):[2]

> ~~Carriers~~ In the pooled market implementation year, carriers shall discontinue all non-grandfathered small group health plans offered in ~~2021~~ the year preceding the pooled market implementation year, with the exception of any existing plan that the carrier chooses to offer as an Alternative Plan pursuant to Section 6.

Bureau response: The Bureau agrees with Anthem's proposal but believes that further clarification is also necessary. The Bureau therefore revises this subsection as follows:

> Carriers shall discontinue all non-grandfathered ~~individual and~~ small group health plans offered in ~~2021~~ the year preceding the pooled market implementation year.

[1] Anthem's comments were submitted before CMS approved Maine's Section 1332 waiver amendment, the last step in definitively establishing 2023 as the pooled market implementation year. Accordingly, the comment spoke in terms of how "the merger of the markets is currently proposed under the State's pending 1332 waiver application." Anthem cited the uncertainty of the pending application as an additional area of concern, but that issue has been resolved.

[2] The Bureau's proposed changes to Rule 851 appear in red font. Further changes appear in blue font.

No such plans may be issued or renewed during the pooled market implementation year, with the exception of any existing plan that the carrier chooses to offer as an Alternative Plan pursuant to Section 6. ~~The~~ On renewal, the carrier shall map ~~policyholders~~ each policyholder with a discontinued plan to its most similar plan offered in the ~~same~~ pooled market in ~~2022~~ the pooled market implementation year.

E. Active Marketing – Rule 851 does not currently address active marketing, and the Bureau did not propose language concerning this issue. Anthem suggested that, because the Bureau has previously indicated that carriers need not actively market all plans to both the individual and small group markets, language to that effect be included in Rule 851.

Bureau Response: The Bureau agrees that such language is necessary, but this is another issue that is within the scope of Rule 856 rather than Rule 851, and Anthem's proposal is already addressed by Rule 856(5)(1)(C), which says:

> This subsection does not require carriers to market all pooled market health plans in the same manner to all customers. A carrier may vary its marketing strategies and distribution channels, including the decision whether to offer a plan on the Maine Health Insurance Marketplace established pursuant to 22 M.R.S. §5403, between one plan and another, between one service area and another, or between individuals and small employers, as long as the carrier does not discriminate on the basis of actual or perceived health risk or other prohibited classifications.

For these reasons, the Bureau rejects this proposal.

F. Section 5(1)(A), Range of available options – CAHC commented on the new requirement that the Superintendent ensure the availability of a range of designs meant to meet the needs of individuals and small employers for plan years in which these markets are pooled. CAHC asserted that there should be "an equally important charge" to provide these participants with a simplified shopping experience that allows an apples-to-apples plan comparison. CAHC was particularly critical of a practice that has been referred to as "'silver spamming,' which is when one carrier 'offers multiple very similar silver plans' that are priced below plans offered by other carriers in the same area." CAHC suggested limiting alternative plan design and requiring meaningful differences between plan designs and limiting the variation allowed within each Clear Choice or alternative benefit plan design. CAHC observed that the number of Clear Choice plan designs has increased from 12 in 2022 to 20 in 2023 year, with the possibility that each of these designs might turn into numerous plan options, in addition to alternative plan designs. In order to rid the market of what it sees as minimal and nuanced variations, CAHC suggested that the rule require the Superintendent to ensure that there are not an excessive number of plans, including all variations of plan designs; to limit the characteristics that may vary between the plans offered within a single Clear Choice or alternative plan design; and to require meaningful differences between that a carrier offers in the same area.

Bureau Response:

The market is in a transition period, so the Bureau thinks that narrowing the range of choices is an issue to consider for the future. The Bureau took care to ensure meaningful

differences and to protect against "silver spamming" when developing the 2023 plan designs. CAHC's specific request for the Rule is to add "a directive for the Superintendent to ensure there are not an excessive number of plans, including all variations of plan designs, available to consumers in any given area" and "to ensure that there are meaning[ful] differences between plans offered by the same carrier in a given area." The Bureau does not think the Rule should expressly prohibit "too many plans," but having meaningful differences between plans is reasonable. This is consistent with both the Affordable Care Act and the policy underlying Clear Choice, and a useful counterweight to the existing "availability of a range of designs" directive.

The Bureau therefore amends Section 5(1)(A) as follows:

> A. The Superintendent shall annually review market experience with the Clear Choice designs, and shall solicit stakeholder input on changes that might be desirable, including potential amendments to this rule. The Superintendent shall consider AV requirements, stakeholder input, ~~and~~ value-based plan design, and the need for meaningful differences between plans offered by the same carrier in a given service area. For years in which the individual and small group health markets are pooled, the Superintendent shall ensure the availability of a range of designs intended to meet the needs of individuals and small employers. The Superintendent shall expose any proposed revisions to the Clear Choice designs for public comment, and shall publish the final version in time for carriers to use it in their rate and form filings.

G. Former Section 5(2)(A), Elimination of Basic Silver Plan – CAHC "strongly" opposed eliminating the Basic Silver Plan, pointing out that the second lowest-cost silver plan (SLCSP) is the Marketplace benchmark for calculating consumers' advance premium tax credits (APTC). CAHC argued that the Basic Silver Plan's purpose is to prevent insurers from raising premiums for silver plans to offset for providing cost-sharing reductions. Although CAHC acknowledged that this change is in response to federal changes to the allowable AV variation between Silver plans, it expressed concern with CMS' history of changes in this area and urged the Bureau to retain existing rule language requiring what it characterized as at least 70 percent AV and prohibiting alternative silver plans with AVs lower than the Basic Silver Plan's. CAHC suggested restoring section 5(2)(A) with the following revision:

> The Superintendent shall designate one Clear Choice Design as a Basic Silver Plan. The Basic Silver Plan shall be designed to yield an actuarial value that is ~~reasonably close to~~ at least 70% ~~while avoiding unduly complex cost-sharing parameters~~. No Silver plan with an actuarial value lower than the Basic Silver Plan may be offered on the Marketplace.

Bureau Response: The existing requirement to designate a single Basic Silver Plan, and to prohibit any carrier from offering a lower-priced Silver plan on the Marketplace, has unintended consequences, because it impedes the ability to develop two different Clear Choice designs with an AV of 70% and significantly different structures. Consumers should not be limited to a single 70% option. The current federal requirement does not allow a Silver plan on the Marketplace to have an AV below 70%, so there is no need to use the Basic Silver plan for the purpose of holding Marketplace plans to a minimum AV

of 70%. Additional protection is provided by the renumbered Section 5(2)(A) (formerly 5(2)(B)) for each carrier's lowest-priced Silver plan to be a Clear Choice plan. The Bureau is prepared to revisit this issue if CMS proposes eliminating the current 70% AV requirement for Silver plans.

For these reasons, the Bureau rejects the proposal.

H. Section 5(5)(B), Deductibles – Because the rule now applies to small group plans, which are not necessarily offered on a calendar-year basis, the Bureau proposed amending this paragraph to eliminate the requirement for Clear Choice plans to have calendar-year deductibles. The Bureau kept the requirement that the default condition is that the deductible applies to all benefits except as otherwise specified. CAHC extensively discussed the hardship created by cost-sharing and suggested further amending section 5(5)(B) to read as follows:

> ~~Plans must include a calendar year~~ The plan's ~~deductible~~ Plan deductibles~~, which shall be applicable to all benefits except~~ must comply with requirements as ~~otherwise~~ specified in this rule.

Bureau response: Cost sharing, by definition, imposes costs on enrollees. Making fewer services subject to the deductible doesn't reduce cost sharing unless the plan's AV also increases, and the law requires offering a range of AV choices. Removing services from the deductible requirement merely changes who pays the cost sharing and what form it takes. The existing language is clearer and provides less discretion for carriers than the proposed language.

For these reasons, the Bureau rejects this proposal.