2022 Clear Choice Cost Sharing Designs

This document applies to the Clear Choice standard plan cost sharing designs at all metal levels unless otherwise designated.

1. The proposed cost share plan structure is for individual and small group plans.
2. All Clear Choice plans for individual will be on/off exchange except for two Silver off exchange only due to Silver loading. The additional 3 plans allowed to differ from Clear Choice may be offered either both on and off exchange or only off exchange. There will not be 3 alternatives on/off exchange and an additional 3 off exchange allowed.
3. Small Group will not be required to have SHOP plans. Under the merged market carriers must offer identical choices of health plans to individuals and to small employers
4. With the exception of the HSA plan, services before the deductible in addition to preventive and the first three visits for PCP/Behavioral office visits are PCP/Behavioral with copay and Tier 1 generic prescriptions with copay for all metal levels. Only Silver, Gold and Platinum also cover preferred brand drugs before the deductible.
5. No mid-year new plans unless the market does not merge.
6. The standard plan designs do not address cost-sharing amounts for any out-of-network services except for those services required under state or federal law to have the in-network cost-share like emergency services.
7. Continue to allow carriers to customize their site of service incentive programs.
8. Mandated benefits and providers are all required to be covered by Clear Choice and will not be specifically stated in the structure/rule.
9. Plans follow EHB. Additional benefits may be offered.
10. All family deductible and MOOP are twice the individual amount like current plans for all metal tiers.
11. There may be a Clear Choice plan for each product line HMO, PPO, and POS.
12. PCP office visit does not include the related labs from the visit.
13. Pediatric Dental must be included on all off-exchange plans and at least one on-exchange in each metal tier.
14. Tiered plans may be offered as the alternative 3 plans.
15. Platinum does not have to be offered. If offered it must be available to individual and small group under the pooled market.
16. Unless otherwise noted carriers are permitted to assign any service to any benefit category if permissible under state and federal law.
17. Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in the standard plan design, if necessary, for compliance with MHPAEA.
18. For all services with a co-pay that are not subject to the deductible, the co-pay amount does not accumulate toward the deductible (except as required by PL 653 for PCP and behavioral health visits) but the full co-pay amount paid for the service will accumulate toward the maximum out-of-pocket amount.
19. For services with a co-pay that are subject to the deductible, the full amount of first-dollar out-of-pocket spending accrues toward the deductible.
20. Alternate on-exchange Silver plans must have an AV of at least 70%.
21. For prescription drugs in any tier, the cost-share defined is for a 30-day supply. Carriers may determine to allow for mail order prescriptions at a reduced per-unit cost (e.g.; a 90-day supply).
22. Office visits for the treatment of mental health, behavioral health, or substance use disorder conditions shall be categorized as Behavioral Health Outpatient Services, regardless of provider type. Outpatient services may be subclassified into office visits and all other outpatient items and services.