EHB Benchmark Plan Public Stakeholder Meeting

February 27, 2024, 10:00 – 11:00 am

Computer Generated Meeting Transcript, light editing for readability

0:09
Good morning. I am Sarah Bailey the Life and Health Supervisor with the Division of Insurance, and I'm starting this stakeholder meeting to in which we hope to provide information on potential changes to Alaska's benchmark plan.

0:27
The time is 10:00 and this meeting is being held on February 27th, 2024, in Conference Room C on the 9th floor of the State Office Building in Juneau, AK and also in the Insurance Conference Room on the 15th floor of the Atwood Building in Anchorage as well as a virtual format online.

0:47
This meeting is scheduled to close at 11:00 AM, but it may be extended to accommodate discussion by those present before 11:00 AM. This meeting is being recorded.

1:05
Also, if you are online, please make sure that you are on mute. With those housekeeping items I will reference just a little bit of information. As was noted in the public notice, the Division of Insurance received a federal grant to review our insurance market. And as part of that, we have contracted with Wakely Consulting Group to look at our current benchmark plan. And as we have done that, we have come up with some potential ideas, but I will keep that brief. And I will now ask Matt Sauter from Wakely Consulting Group to present the current benchmark plan, the federal process for making changes to that benchmark plan and then some potential benefits and a timeline for making those changes. And the division will take questions after the presentation and as I said before, we hope this meeting will conclude around 11:00. So Matt, I will turn it to you.

2:32
Thank you, Sarah. Let me know if you do not see my full screen coming up here with the PowerPoint.

2:40
But as Sarah said, we'll talk through the Alaska Essential Health benefit analysis and potential application process and that's going to cover a variety of things, including an overview of the essential health benefits and what we're really talking about in this realm, the federal regulations we must comply with as we're going through this process, the benefit pricing and selection process, the remaining project timeline and then some additional information. And then finally we will wrap up with a few questions.

3:13
As Sarah noted, my name is Matt Sauter, Senior Consulting Actuary here at Wakely. I've

supported several states on these EHB application processes and so far all successful that have been submitted and I hope to continue that trend with Alaska.

3:33
Before diving into the report, did want to note that these estimates, numbers, benefits are all draft and preliminary.

3:41
We're here today that's we're going through this process, get any initial feedback that you have. But these numbers are still subject to change and are still currently being refined and peer reviewed.

4:01
So what are EHBs or essential health benefits under the ACA? They're really a set of benefits that are defined and set the benchmark plan for a given state in the ACA commercial market. So this typically includes the care, treatment and services that all issuers are required to cover at a minimum. So each and every issuer are offering a plan in in the commercial market, fully insured commercial market.

4:29
The individual small group, individual ACA, small group ACA and certain large group plans are affected by this EHBs aren't defining the coverage of the benefit and not the administration. So we're really thinking what benefits are covered, not necessarily how the benefit is covered. So benefit administration things like utilization management providers that are providing the care, how they're delivering that care and also items such as cost sharing other you know the insurance amount co-pay amounts, those benefit administration items are not covered by EHBs. Those are still subject to issuer discretion to a degree.

5:18
And then a benchmark plan is really the state's health plan that that defines those sets of EHBs that must be covered. So this was initially set back in maybe as early as 2012 for that 1st 2014 planned year in the ACA and a lot of states have not revisited that that EHB benchmark plan up until recently when I believe it was in the 2019 notice of benefit in the payment parameters, CMS added some additional flexibility for states to change the benchmark plan and I believe maybe effective 2021 was when issuers or states first started making some changes.

6:04
And now there is a good number, maybe a little over 9 that have successfully applied for a benchmark plan change. And it should be noted that each state does have its own unique benchmark plan. There is a good bit of overlap between them as these EHBs are set in a defined standard 10 benefit categories. So there's a lot of similarities but also a lot of differences once you get into the details.

6:35
So Alaska is pursuing or at least evaluating a new essential health benefit benchmark plan to

better serve members and better serve, better aligned with state goals. Again, this will affect that fully insured commercial individual and small group market.

6:51
And if this would move forward and get approved, the new EHB benchmark plan would require issuers to update the benefits, although we, we would expect generally the updates to be relatively minor in the grand scheme of things. And yes, so it looks like as of February 2024, it was 9 states that have successfully updated their benchmark plan. So we're kind of in the middle of this.

7:16
We actually started at least on the Wakely end as early as 2022 evaluating Alaska's current benchmark plan and how that stacked up to other plans in the nation and maybe other plans that that may be associated, or you know, similar policies as Alaska, so maybe thinking Pacific Northwest for example.

7:39
And so we started with reviewing Alaska's current plan and then we did some outreach to various stakeholders in Alaska such as the issuers and then did some discussion there, just preliminary discussion and then talked about how there could be potential pathways just at a high level to move forward with those. Those discussions with issuers and with CMS and federal regulations.

8:08
We're currently at this bolded time frame in in the plan in the process where we're currently analyzing the benefits and working to define what a new EHP benchmark plan may look like. We're now trying to get some stakeholder feedback on this and make sure we're keeping you all informed before deciding on a on a final pathway forward. And then ultimately, if and when we do decide on a good pathway forward, we will submit to CMS who will then review the application and give us feedback before eventually, hopefully approving that application.

8:51
So as we look nationally at what other states have done, this table is just summarizing at a very high level some of the benefit additions that states have made. So we see there's drug additions that had a pretty good theme and concentration on the opioid epidemic. So there is opioid reversal agents added alternatives to opioids and other benefits like that.

On the medical side, a variety of benefits have been added, various mental Wellness and psychiatric benefits, expansion of acupuncture and chiropractic visit limits.

One popular one has been hearing aids and hearing exams adding that to the benchmark plan for the ACA and a variety of other benefits.

And on this slide we're not gonna go into all the details here, but this is just a more detailed list of all the benefits that the various states have added.

9:57
So with that background, we'll now jump into the federal regulations that kind of define what we're able to do with the EHB plan and the guidelines and tests that we have to comply with to work towards a successful benchmark plan application. So as mentioned earlier that the 2019 NBPP really opened the door to these changes making it a little easier and approachable for states to make the change and the options they provided.

10:31
States were to select an EHB benchmark plan that another state used for the 2017 benefit year. You could also replace one or more categories of the of the benchmark plan with another benchmark plan. Or you could you know starting from scratch is maybe too strong of a phrase but you could start from scratch and select a new set of benefits to become the state's EHP benchmark plan assuming all those other categories and conditions are met. And this third option there that the start from scratch in quotes is what all states have done so far. But really what that looks like is, it's just starting with your current benchmark plan and then trying to add a generally a couple benefits that that may fit within those CMS guidelines and with that application CMS requires a reasonable public comment period.

11:31
So that would probably be in the March or April time frame, at least historically for other states. And then we have to comply with certain document submissions as well as complying with the CMS federal typicality and generosity standards which we'll get to here. As we look at that timeline, the next application deadline is actually May 4th of 2024 and that would be a benchmark plan that would go into effect for the benefit year 2026. So there is a relatively large lag there or at least the disconnect between the application date and when that becomes effective.

I know we're kind of ramping into that 2025 pricing season right now this any changes would be effective as early as 2026 nothing would go into a play for 2025 yet.

12:34
And also as we think about these EHBs it's also important we noted we can't define benefit administration and utilization management.

The ACA and other EHB regulations also put limits on or exclusions on any lifetime or annual limits. So for example, if there would be a preference to have a $3000 cap on hearing aids that that would be a maximum dollar amount or an annual limit and those are no longer allowed in the ACA. So those are not possible to include any EHBs.

13:16
And CMS is also putting emphasis on discriminatory benefits and the most common one we've seen there is foot care is only available for diabetics. And CMS is is asking plans to kind of revise their benchmark plans to not be discriminatory on a condition such as diabetes and instead revise that to foot care is covered as medically necessary. And often times this medical necessity may still be only for certain conditions, but that that medical necessity is based on, you know empirical medical evidence and can change over time. So it's really ensuring flexibility and clear definitions for members there.

14:04
So with the federal regulations, lots of lots of details that that could be covered, but it really boils down to two primary tests that are in the regulations and those are the typicality tests and the generosity test. I'll go more high level than getting into the weeds here, but really what this is doing is placing a floor and a ceiling on how rich a benchmark plan can be, how rich, how generous, the amount of total benefits that that can be in a benchmark plan. So the generosity test is really saying is really the one that puts the ceiling on the benefits.

And what that is saying is in CMS regulations they define not only the current benchmark plan that that Alaska has, but then also the options Alaska and other states can use for, for other benchmark plan options.

And then that those set of 10 plans are what are eligible for these two tests. So in other words as we're looking to set a ceiling, we're looking to understand what the ceiling is that we could add benefits into. We try to find the most generous or the richest plan out of those 10 plans.

And those 10 plans will be primarily three of the largest federal employee plans, three the largest state plans and then three of the largest small group plans. Those state plans are state employer. So out of these sets of plans we have to identify the most generous and then that's kind of puts a ceiling on the benefits that we can add and then on the other side the floor, there's also a floor and benefits. So we can't, you know, strip benefits entirely in any state.

16:04
And also as states are looking to revise their benchmark plan, CMS is also emphasizing a few other changes to just kind of make the benchmark plan and members interaction with it a little easier and more clear.

So we already touched on that potentially discriminatory language there also aligning prescription drug formulary with requirements a lot of drug changes since 2012/2014. So CMS is kind of revising some, some drug formularies, they're maybe not revising but just in really restating what those formularies are. So it's up to date and not using 2012 drugs.

16:50
And also historically plans have just been a plan branded benchmark plan. So that plan branded document will include various items that that we said aren't EHBs already. So it would include items about cost sharing, would include how to reach out to your providers and your health plan. So CMS is saying, OK, now as we're revising this, let's remove all that unnecessary non EHB language, the plan branded language, the cost sharing language and really just pare it down to the true EHBs and what benefits are covered. So hopefully as we go through this process that new plan document will be a little more clear to both members and issuers as they're going to look to be compliant with the new benchmark plan.

17:46
It should also be noted that the regulations we've talked to date are current regulations. In the latest 2025 proposed notice of benefit and payment parameters, emphasis on the proposed, there were several key changes proposed to EHB benchmark plan update process. Overall,

these updates are giving states a little more flexibility and making the process overall a little easier to be done. So generally good rules there. It will reduce burden on the application process.

18:25
It's also adding the option for Adult Dental to be included to be included as an EHB and historically Adult Dental was actually carved out as potential EHB. Only Pediatric Dental was required and allowed to be an EHB.

18:43
Also that it allows for more capture of large group changes over time. Specifically as you look at those 10 benchmark plan options, there used to be a year limit on which large group plans you could look at there. And now they're taking away some of those limitations or constraints. So you can better capture large group changes over time in the market.

19:08
There's also a relatively substantial change to the drug classification system that would have implications to EHBs. So that's something to keep an eye on.

19:18
And with all these changes and the analysis we've been working on the past two years or so, we're in the process of evaluating what is the best course of action here for Alaska given you know where we're at these proposed changes and potential future flexibility.

19:41
So with that background we'll jump into the next stage which was looking at the various benefits that may be of interest to add in pricing those benefits to ensure we're kind of complying with that floor and ceiling and other CMS regulations and components. So again, we started back as early as 2022 looking at some of these items. We did reach out to some issuers or the Alaskan issuers at that time and also looked to the Alaska Division of Insurance for a preliminary list of benefits that that could be considered. And we did also look nationally and kind of stacked up Alaska's to other states in addition to some public research to see what additional benefits might be of interest to consider for addition.

20:38
And then the next stage was starting to price some of these benefits. So we priced these based on our best understanding of the current coverage that was in Alaska's benchmark plan because we are just looking at the marginal difference of an addition. And there's lots of assumptions that that went into the pricing including utilization assumptions, unit cost assumptions and in some cases the benefits we're adding there just isn't great ACA data on it. So we had to use public sources and other actuarial judgment to price these.

21:12
So we did provide a range for each benefit just to ensure you know, we're kind of covering various scenarios there and of course ultimately, we need to make sure we're staying compliant with the CMS regulations and tests there.

21:30
A bit more background on the pricing and claim and premium impacts of these EHBs. So as we're looking at EHB changes and being compliant with the CMS regulations, we are focused on the change in allowed costs. So we are looking at both insurer paid or plan paid and the member paid amounts. So it's a little different than just member paid and it is different than premium, although we are taking those aspects into account as well. But ultimately in the application, in the analysis and generosity ceiling tests we are looking at the change in total allowed costs. We are trying to price these benefits and the benefit differences using the most appropriate similar data. So in most cases that's ACA data sets where possible. We're also have taken into account Alaska issuer input and other commercial data where available and whenever those options weren't available or needed additional support. We did use public sources, emerging data and actuarial judgement. And as we're looking into the future to price these new benefits, we are looking at the steady state or the ongoing cost. We're not including estimates for any pent-up demand in in year one or anything like that. We are looking at the steady state there and furthermore we're really looking at the direct cost of the specific benefit being considered.

23:16
We're not looking at the downstream impacts of those benefits. So for example with hearing aids we're not looking at reduced ER inpatient stays from reduced falls. We are looking at just a direct cost of adding those hearing aids and again we are using assumptions for all this. So what we believe our assumptions are reasonable and going forward with best estimates actual impacts to the market and what issuers ultimately put in their premiums can vary especially with you know different assumptions they use potential anti-selection and pent-up demand. Specifically in that year one we could see deviations from our estimates and issuers' costs.

24:10
So that will show here a short list of benefits that we've been taking a harder to look at. This isn't an exhaustive list. We have looked at others, but this is kind of the short list that we've been spending the most amount of time on.

For hearing exam and hearing aids, we would be looking at adding a hearing aid for each ear every three years as medically necessary and then this benefit would also cover the hearing exam that would go with the hearing aids to see if a hearing aid was required and medically necessary.

Acupuncture, chiropractic are two that are already in the benchmark plan and we are looking at the potential of increasing that visit limit from 12 to 20 visits.

Massage therapy, which we've seen use in a variety of ways like across the nation and other states, benchmark plans as a pain management alternative and also in some cases alternatives to chiropractic procedures that is not currently included in the benchmark plan. And so we're looking to kind of pair that up similarly to acupuncture and chiropractic and evaluating that on 20 visits.

And I'll just maybe clarify as I'm going through these, these are benefits we're looking at analyzing and potentially adding we're not looking at adding all of these benefits in total. So

if I if I misspeak a little bit, please excuse that we're evaluating these and have not yet determined the set of benefits we'll go forward with. But it would likely be a subset of these not all if we would move forward with the new benchmark plan.

And then also on the list are our TMJ services and weight loss drugs.

We'll focus on weight loss drugs a bit more here in a second, increasing the visits of nutritional counseling and then also bariatric surgery.

So again some of these are relatively clear like increasing acupuncture from 12 to 20 visits.

26:28
We did want to just give a bit more background on a few of these.

26:32
So I'll start with hearing ends and hearing exam exams. Again, this would be one hearing aid per year, every three years and then also cover the exams for those hearing aids. And this would be for both adults and children. As we looked at this, this benefit in the ACA market, we found only about 12 states actually had this required for adult adults, but more than half of the states had this coverage for children and we're kind of talking about those discriminatory benefits before that also covers age so you can no longer in the ACA say this is only covered for children. Many states who had those child hearing aids already in the benchmark are now also covering those adult hearing aids under the under the Essential Health Benefit benchmark plan without an explicit change to the benchmark plan just because that's what's needed to comply with the new discriminatory regulations.

And as we've looked across the nation, there was a good bit of variation in what was covered, although we found the most consistent offering was covered hearing aids for each ear, every three years and mentioned this earlier but worth restating as it pops up in hearing aids a lot under current federal regulations these EHBs can't have annual lifetime dollar limits.

And also we're hoping and research has shown that with an addition of a hearing aid there, there would be quality of life additions to members. So reduced falls and therefore reduced medical costs and inpatient stays, surgeries and then other aspects of improved quality of life.

28:29
So, weight loss benefits are another area that we looked into pretty extensively and really gets quite nuanced and interesting as you dig into it. Currently the benchmark plan includes 4 nutritional counseling visits and drug coverage that can include weight loss benefits.

So there is some coverage for weight loss benefits in the current benchmark plan and also the benchmark plan not only covers medical benefits, you know we can talk about acupuncture, chiropractic, but also defines the drug coverage for these commercial plans. And how that is defined is it's essentially defined as a minimum number of drugs in USP category class.

So in a United States Pharmacopeia classification system, they basically go down and put drugs into different therapeutic classes, different functions and then the benchmark plan

would define how many unique drugs you need to cover in that class. There is current coverage for weight loss drugs and weight management drugs at least in the USB category class in the current benchmark plan. What the benchmark plan cannot do is it cannot under the strictest interpretation cannot go in and specify specific drugs or NDCS that must be covered. Again, it's just saying in this specific USB category of class that has various certain therapeutic use, a plan must cover X drugs in that class. So, plans do have some that they cover.

As we looked at Alaska State employer plans, we identified that they did have a more comprehensive or richer coverage of weight loss benefits. For example, we saw bariatric surgery, one treatment per lifetime that was included in some and there was also some that had various in them as well. As for potential expand some options explored, we're increasing or removing that visit limit.

30:50
Matt, you're kind of fading in and out. I'm not sure if maybe you've moved away from the microphone or not.

31:00
Oh sorry about that Is it a little better now?

31:04
Yes, it is.

31:06
So I'll just quickly restate that last item in case that was unclear.

31:10
But when we looked at the state employer plans in Alaska, we did find they had a little more coverage than the current benchmark plan. So items such as bariatric surgery was covered one treatment per lifetime. There's also some weight loss programs that that were covered there as well. As we're looking at all these moving pieces and we're looking at potential expansion, several options we have.
We could increase or even remove that visit limit for nutritional counseling as members seek nutritional counseling for weight loss management reasons. It could require additional coverage of drugs in those USP category classes that cover weight loss and there's also options to add coverage for bariatric surgery.

32:00
So let's dive deeper into some of those. I think weight loss benefits has been getting a lot of attention in the news and media and maybe even TikTok these days with drugs such as Ozempic and these drugs cover carry really large unit costs. So we're looking at maybe $1000 a month for some of these drugs and this is the total gross cost here. There are rebates that that issuers may be eligible for that that are typically large for these types of drugs that would bring that price lower. But there's also high demand for these drugs which could be just shortages and additionally various you know public sources and issuers have noted concerns on the medical efficacy and off script use of these drugs. And there's also potential you know

we're looking at these high unit costs right now at $1000 a month there is potential for cheaper alternatives to be available in the future considering along with weight loss drugs.

Again, just restating that the EHB benchmark plan cannot state specific drugs that must be covered, just states how many unique drugs must be covered in those categories in classes. And the two categories in classes that weight loss drugs are currently covered in are blood glucose regulators, anti-diabetic agents and also there's anti-obesity agents class as well in in going back to the proposed notice there could also be a substantive change to the drug classification system. So that's something else we're considering as we're going forward with these analysis and options. And in those USP category classes, we identified that Alaska's current benchmark plan is requiring 25 distinct RXCUIs to be covered in the anti-diabetic agents.

34:15
So again, you know this is an antidiabetic agent class, it's not a weight loss class. So there, there are various considerations there, but there are weight loss drugs or drugs that are used for weight loss in those USP category and classes that must be currently covered. And ultimately as with any of these EHBs they're gonna be subject to medical necessity and potentially issuer utilization management as well.

34:55
OK, moving on to nutritional counseling and bariatric surgery to other potential weight loss benefits. The current Benchmark plan does cover four nutritional counseling visits so we're looking at, you know, potentially expanding that to 12 visits per year. We're just entirely removing that that limit again, with you know, medical necessity and utilization management still being potentially present and just removing that limit entirely and for bariatric surgery potentially adding that but would not be able to do a lifetime. So they either limit on this just with the EHB regulations.

35:36
However and as we are exploring these benefits, nutritional counseling seems like a pretty straightforward a change as we're just increasing that limit bariatric surgery. On the other hands we did have some issuers and research showing that there could be a few barriers to add in this benefit. For example, the location and proximity of bariatric specialists in surgery centers are pretty limited in Alaska. So you know having the benefit be added but then not having the right supply and access to that care is definitely something that's been considered. And also travel cost or the potential need to travel to the Pacific Northwest or elsewhere to actually receive these services could be a significant cost and something that we have not priced into the analysis here. And also there's been discussion on if that that cost is truly EHB or if it's more of a method and delivery of service there. So that's the high-level overview of some of the more complicated benefits we're looking at.

36:58
Just to give more background there on next steps as stated earlier we're currently looking at those benefit analysis, the pricing that we're coming out with there and how that fits into that that CMS regulatory puzzle, the floor and ceiling. So we're looking at that now we're trying to get closer to a finish line and ensure that we can be compliant and are within the kind of the guard rails there of all those tests.

37:34
So we're hoping to make a decision on the pathway forward here in March and then potentially have another stakeholder meeting similar to this with presenting those next steps and decisions here shortly in the future. And then we'll also then have a formal public comment soon after that before our official submission and application is CMS. Those items are still, you know, to be determined, but that's the high-level timeline.

38:07
And also as part of these stakeholder meetings, we are, hoping to receive feedback and especially if there's any concerns soon, so we can, you know, make sure that we're incorporating that into our considerations. So for that I I think we're going to open it up to any questions and maybe before getting there, I just asked there if there's any clarifications or items I missed there that we want to touch on.

38:45
I don't have any clarifications or questions corrections except for myself. I failed to let everybody know that Deputy Director Heather Carpenter is also in the conference room here with me as well. And so we will go ahead and open the floor for questions, you know, hopefully primarily for the division of insurance right now.

39:13
Are there any folks with questions today and feel free to use the raise hand function or just pop yourself off mute and go ahead and ask a question if you have any.

39:30
Teresa Barney.

39:33
Hi, Teresa Barney with Moda Health. I believe I saw that at the beginning, and I see in the upper corner that this session is being recorded. I know that there are some members of our team that might find this interesting just early on but weren't able to attend. Is the recording going to be posted anywhere for others to be able to access and listen to post the finalization?

39:55
I hope so, I did notice however that there are some people's phone numbers that are not being, I don't know the word that I'm trying, their phone numbers are out in the open. So if that shows up in the recording, we may not be able to release the recording in its entirety. We will definitely have a transcript and we can make the PowerPoint available as well.

40:25
Great. Thank you very much. Appreciate that.

40:27
You're welcome. Any other questions?

40:47
And while you're thinking of questions, we wanted to make sure that we had this informative session so you can go back. You can ponder what this means. The division will likely have another, you know, more informal stakeholder meeting before we do a formal public comment just to get that feedback. And at any time you can reach out to the division directly to Sarah or myself. We're trying to keep this very open. We understand updating EHBs is a very technical process and like Matt said, very actuarial, actuarially heavily influenced. But at the end of the day, we're trying to improve the health of Alaskans. So that is you know our ultimate goal as well.

41:34
Hi, I have a question about applied behavior analysis for individuals with autism. Can you compare current state of coverage and if there are any and I apologize, I couldn't see the slides because I had trouble getting on online versus just dialing in by phone. So if if that was there, I missed seeing anything in slides. Thank you.

41:58
And before I let Matt answer that, can you just share your name just so I can capture that 'cause I saw you're just a phone number.

42:05
My name is Kelly Hedrick, and I'm with the organization Autism Speaks.

42:10
It's HEADRICK.

42:14
Thank you.

42:14
Hi, thanks, Kelly.

42:19
So I we do not know if we looked at that specifically in this analysis, I'd have to go back to the current benchmark plan coverage and see exactly what is covered. And I think additionally as we've looked into similar benefits for other states, the conversation of mental health parity has also come up in in a good a good deal because there are questions of you know what benefits could be covered without an EHB change just from mental health parity and discriminatory regulations. So if you could actually restate the specific benefit or care there so I can write that down and make sure I'm capturing it, so I can look into that for you.

Sure. It's ABA, it's a therapy called applied behavior analysis and you are absolutely correct.

43:19
I know a number of states have done a bulletin to all payers because mental health parity is

really relevant to this and have gone about it that way instead of necessarily added it as a new way.

43:37
EHB they did more of a clarification. There is also a question about child only versus adult that comes up too in some places it's still child only.

43:52
Yeah in I'm gonna stretch my mind here so you know please use this informational and not definitive but I know with the child only. I recall some analysis and this would be several years ago at this point but some of that child only items it sounds discriminatory at the at the face but there may be medical evidence that that shows that is the really effective time for that behavioral analysis and intervention. So I think that's just another factor. Again, I'm not positive on this one, which is another factor to consider as we're looking at these benefits that you know, is there medical evidence to support an age cut off or various age, age bands and different effective care for those.

44:40
Yeah, understood it. The evidence is definitely stronger for children. There is some evidence for adults as well.

44:45
So, yeah, Thank you, Kelly.

44:50
This is Sarah Bailey with the Division. And we have a state mandate for ABA therapy and so if you're aware of some limitations or restrictions that people are encountering in Alaska I would really be interested in knowing about that. So feel free to reach out to me. My e-mail address is sarah.bailey@alaska.gov. It should be out on the notice and or if it's not you can send an e-mail to the insinfo@alaska.gov. I really would be interested in knowing.

45:29
OK. Thank you. Yeah, I haven't heard of the gaps or anything. I couldn't remember as it pertained to benchmarks, you know EHBs and ACA plans whether we had at the time that the law was changed, whether it was just large group or whether it was inclusive. So thank you for that clarification.

45:49
Absolutely. And if you have more questions on that we can discuss it because I do think that the way it was written, it was group but for our benchmark plan, we defaulted to a group plan and so that carried over. That was our position and so it should be in the individual plans as well, the mandate for ABA.

46:13
Terrific. Then it sounds like it probably doesn't need any fresh look at because I haven't, I haven't heard of any families saying that other than you know the broader provider challenges

at times of shortages. But in terms of denials, I haven't heard of a lot of denials or anything like that.

46:38
Well and I would add Kelly, you may hear complaints about payers that the division does not regulate. For instance, you know some of the state employee plans like AlaskaCare. So there could be some plans that there may be coverage issues, but I know Medicaid is not one and certainly like Sarah explained, the state mandates for Title 21, that fully insured plan should not be an issue.

47:07
Yeah, great.

47:08
But if they are, yes, sorry not to beat it to death. But we want to know if people are encountering issues.

47:16
Appreciate that. If I hear something come up and it's not an ERISA plan or you know what have you. I know that for those they now with mental health parity they can go to Department of Labor. I don't know do you all want to receive any awareness of ERISA plan barriers to or just state regulated plan

Just state regulated plans.

47:42
OK, that's what I figured. But I want to confirm, I know there's some insurance divisions that like to just have an awareness. Even if they're not, you know, they don't have the regulatory.

47:55
It doesn't hurt to share, but we want to make sure we know the ones that we can actually act on.

47:59
Yeah, sure makes sense.

48:07
Did anybody else have another question?

48:09
Or Sarah, was there anything in the chat?

48:11
So we had a question in the chat asking us to drop the current EHB listing into the chat box.

48:21
I don't know if I can do it from the conference room.

48:24
Ted, we're going to try. If not, I can send it to you afterwards and I'll just stay as another fail safe.

48:34
That CMS has a good EHB landing page that has each state's benchmark plan coverage in in the official plan document, so you could also find it there if you don't have access to the chat later. https://www.cms.gov/marketplace/resources/data/essential-health-benefits

50:15
Sarah, got those in the chat box. Ted, if you have follow-up questions after that just reach out. https://www.commerce.alaska.gov/web/ins/Insurers/RateAndFormFiling.aspx

50:58
We will stay in the rooms here until 11 just because that is when the meeting was noticed. But I know we're starting to lose folks and we didn't have any other formal comments planned for today. If there aren't any other questions, we will send out another notice when we're going to have any other formal meetings. And in the meantime, I know on our notices there was information on how to reach out to the division.

59:44
All right, it is now 11:00 AM Alaska time and we are closing this stakeholder meeting relating to the essential health benefits in the state of Alaska. Thank you for all who participated and have a great rest of your day.