PROPOSED FEDERAL REGULATIONS AND POTENTIAL ADJUSTMENTS TO STANDARD PLAN DESIGNS

This draft working document examines potential ways to respond to the new proposed federal regulations released on February 15, 2017 if new de minimis limits are adopted for the 2018 Plan Year. Covered California is considering the three options presented here and seeks comments from stakeholders on the preferred approach. Covered California understands that some changes in the proposed federal regulations may require changes in state law. In those instances, Covered California will work with the regulators and federal partners to determine whether any changes in state law may be necessary.

March 7, 2017

PROPOSED RULE: PPACA MARKET STABILIZATION

Summary of proposed changes to levels of coverage (actuarial value) (§156.140)

- Amends the definition of the de minimis range to a variation of -4/+2 percentage points, rather than +/-2 (silver plan variations remain at +/-1)
- Bronze plans that either cover and pay for at least one major service, other than preventive, before deductible or meet HDHP requirements have a variation of -4/+5

Possible national implications:

- **APTC recipients:** This may result in an overall reduction in benefits among most or all contracted carriers in other states if all individual market plans move to 66% AV in the Silver plans, resulting in increased cost-sharing for low-income enrollees due to the narrowed scope of benefits (i.e. higher deductible and copays) and smaller tax credits.
- **Non-Subsidized enrollees** have higher cost-sharing, but cheaper premiums

Possible California market impacts:

- Covered California's Patient-Centered Benefit Plan Designs are a set of standard benefits that must be offered on and off Exchange, though carriers on the individual market may offer their own unique ACA-compliant benefit designs off-Exchange ("non-mirror" products), in addition to the standard benefit packages.
- An estimated 90% of the individual market on and off Exchange is enrolled in the standard benefit designs; a policy decision on whether to lower the Silver AV has APTC implications mentioned above and affects ability of standard-benefit products to compete with off-Exchange, non-mirror products. The current standard Silver has an AV of 71.5%.
- Non-subsidized enrolless may leave Exchange to seek cheaper products off Exchange

IMPLICATIONS FOR CALIFORNIA

- California state law limits the de minimis variation of all metal tiers to +/-2%. If the change to the de minimis limit in the proposed federal regulations is adopted, Covered California will work with regulators and federal partners to determine whether any changes in state law may be necessary.
- Covered California's current proposed Silver for 2018 is 71.9%: The proposed changes from 2017 to 2018 include a lower pharmacy deductible ($100) and making generic drugs subject to deductible.
- If future state law permits an expanded de minimis, carriers could alter cost sharing to offer "stripped-down" plans, particularly for Silver:
  - Three contracted carriers already offer Silver off-Exchange, non-mirror plans, two of which are "stripped down" (i.e. most services apply to deductible, deductible is higher than standardized Silver on Exchange)
- **Cheaper Silver plans could greatly reduce unsubsidized enrollment, moving these enrollees to much cheaper off-Exchange, non-mirror plans**

	SUBSIDIZED	UNSUBSIDIZED
	% enrollment	% enrollment
CATASTROPHIC	0.42%	0.71%
BRONZE	17.72%	3.71%
Bronze-HDHP	4.70%	1.38%
SILVER	10.79%	5.12%
Silver 73	9.21%	0.01%
Silver 87	23.57%	0.01%
Silver 94	14.62%	0.01%
GOLD	3.32%	1.56%
PLATINUM	2.02%	1.12%
Grand Total	86.38%	13.62%

2017 RATES: NON-MIRROR vs. STANDARD PLANS

SILVER

	ANTHEM				BLUE SHIELD			KAISER		
	Silver Pathway 1900	Silver Pathway 2000	Silver Pathway 2650	Standard Silver	Silver 1850	Silver Seven 3750	Standard Silver	Silver 70 1750/40	Silver HDHP 2700/15%	Standard Silver
Los Angeles, Age 32	$348	$340	**$243**	$389	**$322**	$336	$353	$293	**$268**	$310
Los Angeles, Age 55	$655	$641	**$458**	$734	**$608**	$633	$665	$553	**$506**	$585

BRONZE

	ANTHEM				BLUE SHIELD		KAISER	
	Bronze Pathway 5250	Bronze Pathway 5850	Bronze Pathway 6900	Standard Bronze	Bronze 5550	Standard Bronze	Bronze HDHP 5500/40%	Standard Bronze
Los Angeles, Age 32	$272	**$266**	$277	$274	**$285**	$300	**$223**	$225
Los Angeles, Age 55	$513	**$501**	$523	$517	**$538**	$566	**$421**	$424

Red Bold = cheapest plan in metal tier ***offered in market***

Orange Bold = cheapest plan in metal tier ***offered by the carrier***

OPTIONS FOR CONSIDERATION

If CMS proceeds with a change to the de minimis range, Covered California will need to reconsider its standard design options to retain healthy, unsubsidized enrollment and to be able to compete with off-Exchange, non-mirror products.

Covered California is considering the following options:

1) Maintain current standard Silver proposal (AV=71.9%)

    1a) Maintain current standard Silver proposal while lowering AV for Bronze, Gold, and Platinum. Note that low-AV options already exist in the Platinum and Gold copay plans.

2) Reduce Silver plan AV by 2-4% in expectation of cheaper Silver offerings in the off-Exchange, non-mirror market

3) Offer a “Bronze Plus” plan with an AV of 63-65% and a “Bronze Lite” with an AV of 56-58%

The following slides outline pros and cons for each option and include sample plan designs to illustrate cost-sharing tradeoffs for options 2 and 3.

OPTION 1

Maintain current standard Silver proposal (AV=71.9%)

Rationale: Maintain consistency year-to-year regardless of federal changes

PRO

- Consistent with Covered CA principles on standard benefit design
- Easy messaging to consumers on plan design changes
- Approval already in progress
- Generous APTC (relative to other options presented in these slides)

CON

- Expensive premiums compared to off-Exchange Silver offerings
- Could lose most healthy unsubsidized to off-Exchange market (but mitigated by inertia and better benefits)
- Loss of Covered CA revenue stream

OPTION 2

Reduce Silver plan AV by 2-4%

Rationale: Offer a cheaper Silver in expectation of low-AV Silver offerings in the off-Exchange, non-mirror market (see options on next slide)

PRO

- Ability to tout lower Silver premiums in 2018
- Keep unsubsidized, healthy enrollees in Silver plans

CON

- Dramatic changes required from previous years, including applying deductible to more services
- Inconsistent with Silver approach built up over four years
- Could be a major “gotcha” to consumers settled into the Silver design
- Higher cost-sharing could result in barriers to care
- Lower APTC (Average of $70 per enrollee)

OPTION 2 (cont.): SILVER PLAN DESIGN OPTIONS (AV 70, 68, 66)

Benefit	Current Proposed Silver		Silver 70		Silver 68		Silver 66	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible								
Medical Deductible		$2,500		$3,000		$4,350		$5,500
Drug Deductible		$100		$100		$100		$250
Coinsurance (Member)		20%		20%		20%		20%
MOOP		$7,000		$7,000		$7,000		$7,000
ED Facility Fee		$350	X	$350	X	20%	X	20%
Inpatient Facility Fee	X	20%	X	20%	X	20%	X	20%
Inpatient Physician Fee	X	20%	X	20%	X	20%	X	20%
Primary Care Visit		$35		$35		$50		$50
Specialist Visit		$70		$70		$75		$75
MH/SU Outpatient Services		$35		$35		$50		$50
Imaging (CT/PET Scans, MRIs)		$300		$300	X	20%	X	20%
Speech Therapy		$35		$35		$50		$50
Occupational and Physical Therapy		$35		$35		$50		$50
Laboratory Services		$35		$35		$35		$35
X-rays and Diagnostic Imaging		$70		$70		$70		$70
Skilled Nursing Facility	X	20%	X	20%	X	20%	X	20%
Outpatient Facility Fee		20%		20%	X	20%	X	20%
Outpatient Physician Fee		20%		20%	X	20%	X	20%
Tier 1 (Generics)	X	$15	X	$15	X	$15	X	$15
Tier 2 (Preferred Brand)	X	$55	X	$55	X	$55	X	$55
Tier 3 (Nonpreferred Brand)	X	$80	X	$80	X	$80	X	$80
Tier 4 (Specialty)	X	20%	X	20%	X	20%	X	20%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250
Maximum Days for charging IP copay								
Begin PCP deductible after # of copays								
Actuarial Value (2018 AVC)		**71.87**		**69.71**		**68.08**		**66.20**

Key:

Increase member cost from current proposed Silver

X Subject to deductible

Currently prohibited by state law

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OPTION 3

Offer a "Bronze Plus" plan with an AV of 63-65% and a "Bronze Lite" with an AV of 56-58%

Rationale: Offer a more generous Bronze plan, in addition to a low-AV standard Bronze, to compete with low-AV Silver plans off Exchange. *This would require a change to state law permitting an expanded de minimis range.*

PRO

- Would not interfere with APTC
- Compete with off-Exchange products
- Keep unsubsidized, healthy enrollees on Exchange with an in-between option (and potentially draw new enrollees)
- Offer a very low-cost option for Bronze enrollees

CON

- Increased differentiation and confusion in plan design options (presents a third Covered CA Bronze option)
- Inconsistent with Bronze approach built up over four years
- Operational challenges implementing a third Bronze plan (e.g. CalHEERS)

OPTION 3 (cont.): BRONZE PLAN DESIGN OPTIONS

This table models several plan design options if Covered California were to create ***two*** standard Bronze plans:

- "Bronze Plus" – a higher AV of 63-65%
- "Bronze Lite" – a lower AV of 56-58%

Note that current interpretation of state law on the MOOP limit, as well as California law on drug caps, limits the lowest-possible AV for "Bronze Lite" to 59-60%.

Refer to the appendix for further explanation of federal and state legal constraints on benefit design.

	OPTIONS: Low AV Bronze								OPTIONS: High AV Bronze					
	Bronze HDHP		Bronze Lite		Bronze Lite		Current Proposed Bronze		Bronze Plus		Bronze Plus		Bronze Plus	
	No drug cap		*Higher Rx deductible*		*Higher med deductible*				*Low deductible plan*		*Low deductible, low copays*		*ER not subject to deductible*	
Benefit	**Ded**	**Amount**	**Ded**	**Amount**	**Ded**	**Amount**	**Ded**	**Amount**	**Ded**	**Amount**	**Ded**	**Amount**	**Ded**	**Amount**
Deductible		$6,550												
Medical Deductible				$6,000		$6,500		$6,300		$3,000		$4,250		$5,500
Drug Deductible				$1,000		$500		$500		$500		$500		$1,000
Coinsurance (Member)		0%		100%		100%		100%		30%		30%		40%
MOOP		$6,550		$7,000		$7,000		$7,000		$7,000		$7,000		$7,000
ED Facility Fee	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%		40%
Inpatient Facility Fee	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Inpatient Physician Fee	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Primary Care Visit	X	100%	X	100%	X	100%	X	$75		$65		$50		$75
Specialist Visit	X	100%	X	100%	X	100%	X	$105		$105		$75		$105
MH/SU Outpatient Services	X	100%	X	100%	X	100%	X	$75		$65		$50		$75
Imaging (CT/PET Scans, MRIs)	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Speech Therapy	X	100%	X	100%	X	100%		$75		$65		$50		$75
Occupational and Physical Therapy	X	100%	X	100%	X	100%		$75		$65		$50		$75
Laboratory Services	X	100%	X	100%	X	100%		$40		$40		$40		$40
X-rays and Diagnostic Imaging	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Skilled Nursing Facility	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Outpatient Facility Fee	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Outpatient Physician Fee	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Tier 1 (Generics)	X	100%	X	100%	X	100%	X	100%	X	$16	X	$15	X	$15
Tier 2 (Preferred Brand)	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Tier 3 (Nonpreferred Brand)	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Tier 4 (Specialty)	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Drug Cap - Maximum Coinsurance			$500		$500		$500		$500		$500		$500	
Maximum Days for charging IP copay														
Begin PCP deductible after # of copays							3 visits							
Actuarial Value (2017 AVC)	**60.49**		**59.88**		**60.04**		**60.75**		**64.91**		**64.99**		**64.98**	

Making ED not subject to the deductible results in higher cost sharing for all other services.

Not a typo; need to set copay at $16 to keep lab copay the same, decrease office visits slightly and lower deductible.

Lowest possible AV for an HDHP

Lowest possible AV due to CA law: MOOP limit and drug cap (see Appendix for explanation)

Key:

- Increased member cost from current proposed Bronze
- Decreased member cost from current proposed Bronze
- X — Subject to deductible

OPTION 3 (cont.): BRONZE PLAN DESIGN OPTIONS

This plan design for a "Bronze Lite" differs from the low-AV options presented in the preceding slide:

- This plan design assumes that California law can be interpreted to set the MOOP at the maximum allowed of $7,350 (i.e. MOOP is not set $350 lower to accommodate enrollees purchasing standalone pediatric dental products)
- "3-visit rule" (member pays a copay for the first 3 visits; visits afterward are subject to the deductible) is maintained for primary care, specialist, and MH/SU office visits.

This plan is less generous than the current proposed Bronze in the following ways:

- Medical deductible increased from $6,000 to $6,350
- Drug deductible increased from $500 to $1,000 (maximum allowed under CA drug cap laws)
- Speech/Occupation/Physical Therapy and Labs are subject to the deductible.

Benefit	Bronze Lite	
	Ded	Amount
Deductible		
Medical Deductible		$6,350
Drug Deductible		$1,000
Coinsurance (Member)		100%
MOOP		$7,350
ED Facility Fee	X	100%
Inpatient Facility Fee	X	100%
Inpatient Physician Fee	X	100%
Primary Care Visit	X	$75
Specialist Visit	X	$105
MH/SU Outpatient Services	X	$75
Imaging (CT/PET Scans, MRIs)	X	100%
Speech Therapy	X	100%
Occupational and Physical Therapy	X	100%
Laboratory Services	X	100%
X-rays and Diagnostic Imaging	X	100%
Skilled Nursing Facility	X	100%
Outpatient Facility Fee	X	100%
Outpatient Physician Fee	X	100%
Tier 1 (Generics)	X	100%
Tier 2 (Preferred Brand)	X	100%
Tier 3 (Nonpreferred Brand)	X	100%
Tier 4 (Specialty)	X	100%
Drug Cap - Maximum Coinsurance	$500	
Maximum Days for charging IP copay		
Begin PCP deductible after # of copays	3	
Actuarial Value (2017 AVC)	**59.34**	

The final 2018 Benefit and Payment Parameters set the 2018 annual limitation on cost sharing (MOOP limit) at $7,350.

As CMS considers an expanded de minimis range for Bronze, it is worth noting that a Bronze plan of 56% is technically impossible given the $7,350 annual limitation.

We estimate that a 56% plan can be achieved ***if*** CMS raises the annual limit to $8,500.

Key:

Increased member cost from current proposed Bronze

X Subject to deductible

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OPTION 3 (cont.): BRONZE PLAN PREMIUM ESTIMATES

The following table presents the estimated weighted-average bronze premium for “Bronze Plus” and “Bronze Lite” plans, using the weighted-average premium for the 2017 Bronze plan as a reference point.

		Estimated Monthly Premium		
Plan Design Name	**AV**	**Age 25**	**Age 40**	**% difference from current Bronze**
Bronze Lite	**56.00**	**$ 194.08**	**$ 247.05**	**-9.6%**
Current 2017 Standard Bronze	61.93	$ 214.64	$ 273.21	--
Bronze Plus	**64.99**	**$ 225.24**	**$ 286.71**	**4.9%**

APPENDIX

BACKGROUND: What is the lowest-possible Bronze *without legal constraints?*

BACKGROUND:

The proposed federal rule allows for a Bronze lower limit of -4% (56%).

However, federal and CA state legal constraints prevent a Bronze plan design with an AV of 56%:

- **Federal rules:** The federal annual limit on cost-sharing ($7,350) is a technical constraint that limits the lowest possible Bronze AV to 58.54%.
  2018 Benefit and Payment Parameters
- **California law on de minimis range:** ACA-compliant plans in the individual market cannot vary beyond +/-2% from the metal tier AV.
  California HSC 1367.008(b)(1)
- **California regulatory interpretation of MOOP limit:** A plan's MOOP must be set at least $350 lower than the federal annual limit on cost sharing to account for potential consumer purchase of a standalone pediatric dental plan.
  California SB 639, approved 2013; HSC 1367.006 / CIC 10112.28
- **California law on drug caps in Bronze plans:** The annual deductible for outpatient drugs cannot exceed $1,000, and a script of up to 30 days cannot exceed $500.
  California AB 339, approved 2015; HSC 1342.71 / CIC 10123.193

A lowest-possible Bronze, without legal constraints, is shown here:

- **No first-dollar coverage for any service.** All services are paid at the full cost of the contracted rate until the member spends $8,500. Note that adding a "3-visit rule" increases the AV by 3%.
- **More member-cost sharing than catastrophic:** Higher MOOP, no "3-visit rule" for primary care (i.e. the first 3 non-preventive visits in catastrophic are no cost). The AV is 5.3% lower than catastrophic.
- **Cannot qualify as HSA-eligible:** MOOP is higher than IRS-determined annual limit.

Benefit	"LOW" BRONZE	
	Ded	Amount
Deductible		$8,500
Coinsurance (Member)		0%
MOOP		$8,500
ED Facility Fee	X	100%
Inpatient Facility Fee	X	100%
Inpatient Physician Fee	X	100%
Primary Care Visit	X	100%
Specialist Visit	X	100%
MH/SU Outpatient Services	X	100%
Imaging (CT/PET Scans, MRIs)	X	100%
Speech Therapy	X	100%
Occupational and Physical Therapy	X	100%
Laboratory Services	X	100%
X-rays and Diagnostic Imaging	X	100%
Skilled Nursing Facility	X	100%
Outpatient Facility Fee	X	100%
Outpatient Physician Fee	X	100%
Tier 1 (Generics)	X	100%
Tier 2 (Preferred Brand)	X	100%
Tier 3 (Nonpreferred Brand)	X	100%
Tier 4 (Specialty)	X	100%
Actuarial Value (2018 AVC)	**56.00***	

Increase member cost from 2017

X Subject to deductible

*AV estimate based on AV Calculator continuance tables

California could create a "low" Bronze plan with 56% AV ***if*** the following changes are made at the federal and state levels:

- CMS increases the annual limit on cost sharing to $8,500 in the final published rules.
- DMHC and CDI interpret SB 639 to ***NOT*** include purchase of standalone pediatric dental products.
- California law changes to remove the pharmacy deductible dollar limit on Bronze-equivalent products

- California law changes to remove dollar limits (drug caps) on a script of up to a 30-day supply on **Bronze-equivalent products**.

- California law changes to allow a Bronze range of -4/+5 de minimis

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