



**COVERED**  
**CALIFORNIA**

**PLAN MANAGEMENT ADVISORY GROUP**

April 9th, 2015

# AGENDA

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**Plan Management and Delivery System Reform Advisory Group**  
**Meeting and Webinar**  
**Thursday, April 9th, 2015, 10:00 a.m. to 12:00 p.m.**

<b>April Agenda Items</b>	<b>Suggested Time</b>
I. Welcome and Agenda Review	10:00 – 10:05 (5 min.)
II. Advisory Group Charter Review	10:05 – 10:15 (10 min)
III. Marketing, Outreach and Enrollment Assistance Overview of SEP	10:15 – 10:25 (10 min.)
IV. Specialty Drug and Network Recommendation	10:25 – 10:45 (20 min)
V. Impacting Rural Area Access	10:45 – 11:25 (40 min.)
VI. Benefit Design	11:20 – 11:55 (30 min.)
I. Deductible and MOOP	
II. Bronze	
VII. Wrap-Up and Next Steps	11:55 – 12:00 (5 min.)

# ADVISORY GROUP CHARTER REVIEW

ANNE PRICE, DIRECTOR, PLAN MANAGEMENT

BRENT BARNHART, CHAIR, PLAN MANAGEMENT ADVISORY GROUP

# Plan Management Advisory Group Charter

## Introduction

Covered California strives to assure that it effectively engages a broad range of stakeholders to inform policy development and shape implementation to meet its mission and goals. The Board of Covered California has identified as among its core operating values its commitment to be guided in its work by partnerships with the full range of stakeholders and earning the public's trust by being transparent and accountable in how it operates. Consistent with that value, Covered California has established the Plan Management Advisory Group to provide input to Covered California Board and staff on these critical issues.

## Purpose

The purpose of the Plan Management Advisory Group is to collect California-specific perspectives from key experts and stakeholders, provide advice and recommendations, and serve as a sounding board to Covered California Board and staff to assist in the continual refinement of policies and strategies to ensure Covered California offers high quality and affordable health plans and that it operates in way that promotes better value and improves the health care delivery system.

## Scope

Insurance plans offered in Covered California must be certified to ensure they meet federal and state requirements for “qualified health plans.” The Group provides input on qualified health plan contracting strategies and ongoing benefit design issues as well as strategies to promote health care value and drive delivery system reform.

## Objectives

The core objectives of the Plan Management Advisory Group is to provide advice and recommendations to Covered California to inform policy-making related to:

- Qualified health plan selection, monitoring, re- and decertification;
- Qualified health plan quality rating;
- Benefit design issues including standardized benefit packages;
- Delivery system reform strategies including improving the health and wellness of Californians, improving health care quality, lowering health care costs and reducing disparities.

# Plan Management Advisory Group Charter

## Meetings

The Plan Management Advisory Group will meet at least quarterly, but may meet monthly on an ad hoc basis if the need arises. All meetings will be announced in advance, open to the public and opportunities will be provided for public comment at designated times during the meetings. Please visit the group webpage for details.

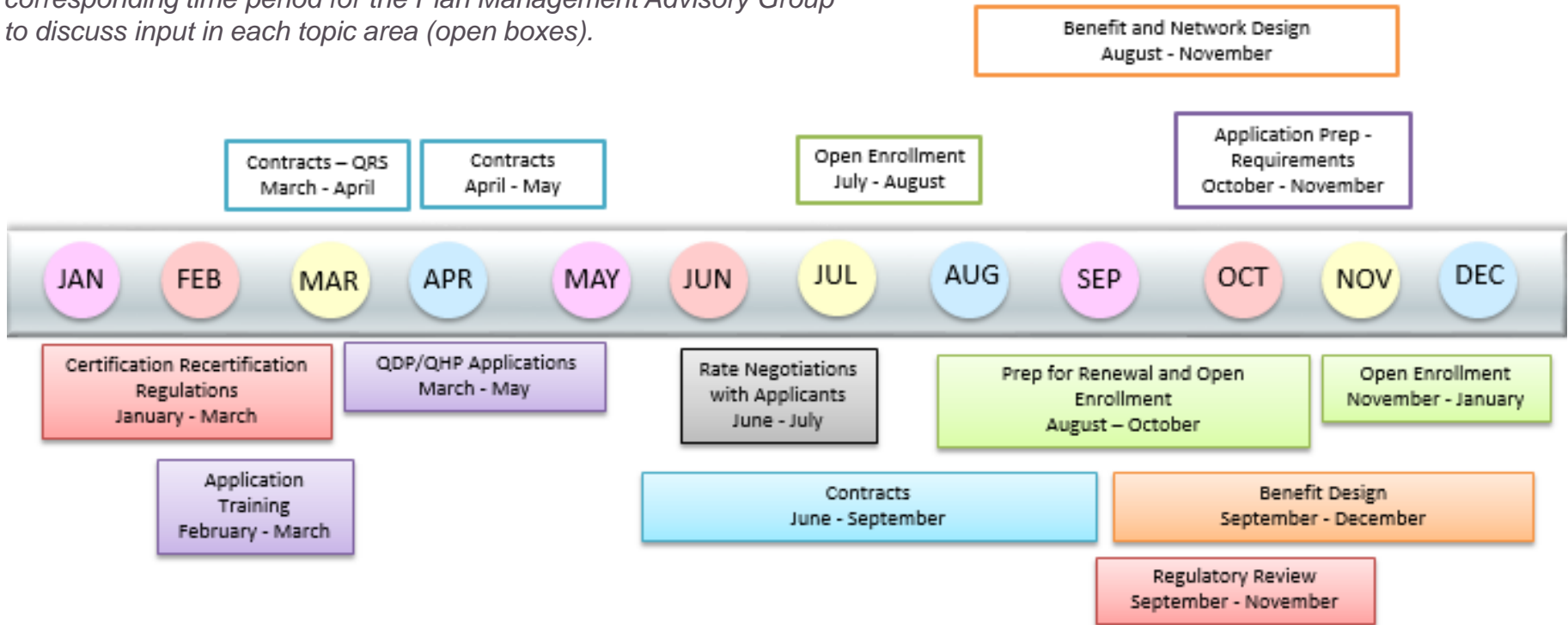
## Membership

Members are selected to assure a balance of expertise and viewpoints that are necessary to effectively address the issues to be considered by the group. These members represent California's cultural, geographic and economic diversity. Members are recognized experts in their fields, including:

- Health plans
- Health care providers
- Health care delivery and public health experts from independent academic, research or public health entities
- Dental plans
- Consumer advocates with direct and substantial experience in health care

# Plan Management Life Cycle: Plan Year 2016-2017

The timeline below represents focus areas for Plan Management during various stages of the year (solid boxes), and the corresponding time period for the Plan Management Advisory Group to discuss input in each topic area (open boxes).



**KEY:**

Solid Box = Covered Ca PMD Staff Work

Open Box = Plan Management Advisory Workgroup

# Advisory Group Discussion Topic Examples

## Contracts – QRS March - April

- CAHPS Survey Data
- Updates to Regulations – Federal and State
- Consumer Display and Communication

## Open Enrollment July - August

- QHP Education
- Messaging on Benefits
- Notices (in combination with Marketing) Advisory Group. Plan Advisory Group will focus on purpose.

## Benefit and Network Design August - November

- Benefits Impact due to Adjustments to the AV
- Benefit Changes needed as a result of data analytics:
  - Access Issues
  - Care Issues
- Value Based Design
- Behavior Incentives

## Application Prep - Requirements October - November

- Review of Questions
- Discussion of Additional Requirements

## Contracts April - May

- Performance Measures
- Carrier Requirements
- Networks

# MARKETING, OUTREACH AND ENROLLMENT ASSISTANCE ADVISORY GROUP UPDATE

PATRICK LE  
COVERED CALIFORNIA EXTERNAL AFFAIRS



# Recent Changes

## Inclusion of subcommittees into the advisory group:

- *African American Subcommittee*
- *Asian / Pacific Islander Subcommittee*
- *Latino Subcommittee*

# Recent Changes

## New structure for discussion and feedback

- *Quarterly meetings*
- *Plenary session and subcommittee breakouts*

# Immigration Fact Sheets



- Fact sheets developed in English, Spanish, Chinese, Korean and Vietnamese
- Informing Californians that immigration information submitted during the enrollment process will be kept secure and confidential and won't be used for immigration enforcement purposes.

# Feedback Received From Last Advisory Group

- *Targeting specific populations by SEP categories*
  - *Public / Private Partnerships*
  
- *Marketing content discussing health issues*

# OPPORTUNITIES FOR FEEDBACK

Name of Collateral	Descriptions
<b>APTC Letter #1</b>	Letter to members who are receiving APTC and a reminder that they need to report any changes that could affect their APTC amounts
<b>APTC Letter #2</b>	Letter to members that reported income/HH size changes that may have affected their APTC amount and they may face reconciliation
<b>Gold Selected, But Qualify for Enhanced Silver</b>	Letter to members that are enrolled in a GOLD plan but qualify for an Enhanced Silver plan. They are paying too much towards their monthly premium.
<b>Platinum Selected, But Qualify for Enhanced Silver</b>	Letter to members that are enrolled in a PLATINUM plan but qualify for an Enhanced Silver plan. They are paying too much towards their monthly premium.
<b>Bronze Selected, But Qualify for Enhanced Silver</b>	Letter to members that are enrolled in a BRONZE plan but qualify for an Enhanced Silver plan which would also allow them to receive Cost Share Reductions to reduce their out of pocket costs

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# SPECIALTY DRUG AND NETWORK RECOMMENDATIONS

ANNE PRICE, DIRECTOR  
COVERED CALIFORNIA PLAN MANAGEMENT DIVISION



# COVERED CALIFORNIA'S PRINCIPLES FOR ACTION – 2016 PHARMACY BENEFITS

- As part of its consideration of how to meet consumers' needs regarding specialty drug coverage and access, Covered California has solicited suggestions and proposals from health plans, advocates and others on how to best address specialty drug issues in 2016 and future years. The issue is multifaceted, involving many future unpredictable variables. Covered California believes that its decisions need to reflect the balancing of core principles:

- As with all benefits, drug benefit designs should foster consumers getting the right care at the right time. Benefits should steer patients to the most appropriate and cost effective drugs and not result in undue financial barriers for category of members with particular conditions
- At the same time we need to assure overall affordability of premiums including drug costs that are increasingly becoming a larger component of the total cost of healthcare, primarily driven by the introduction and continued development of high-cost specialty drugs
- Preserving the plan's ability to maximize savings and control drug costs through preferred formulary tier placement, cost-sharing, and manufacturer negotiations is an important factor in long term affordability

# COVERED CALIFORNIA'S PRINCIPLES FOR ACTION (CONT.)

- Policies for drugs treating those facing ongoing maintenance of chronic illnesses raise different issues and need to reflect different strategies than for drugs that have more time-limited treatment
- Given the complexity and importance of this area, Covered California should take steps informed by data, regulatory, and other factors as we learn about potential impacts on consumers and the near and long-term impact to premiums

# APPROVED CHANGES TO IMPROVE TRANSPARENCY AND ACCESS IN 2016

- Plans to have an opt out retail option for mail order (allowing consumers that want/need in-person assistance to get such service at no additional cost)
- Plans to provide estimate for enrolled consumers the range of out-of-pocket cost for specific drugs
- Include statement on the availability of drugs not listed on the formulary
- **In tiers 1-4, the plans must include all of their formulary covered drugs used to treat HIV/AIDS, Hepatitis C, Rheumatoid Arthritis, Multiple Sclerosis, Systemic Lupus Erythematosus\***
- Exception process written clearly on formulary
- **All drugs that are covered in Tier 4 must be listed on the formulary (not just the Top 50 or highest use drugs)\***
- Dedicated pharmacy customer service line where advocates and prospective consumers can call for clarification

*\*Final federal payment notice, 45*

*Section 156.122(d), dated 2/27/2015, requires health plans to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list. This requirement will replace the approved changes highlighted in red*

# PROPOSED 2016 ACTION FOR SPECIALTY PHARMACY

## Implementation of a Maximum Coinsurance for Pharmacy

- Covered California recommends to modify the 2016 standard benefit designs to put a maximum ceiling on the consumers' share of cost per prescription fill
- The following maximum co-insurance per script is recommended for the 2016 Standard Benefit Designs for all formulary and plan approved (through an exception process) drugs:
  - Coinsurance up to a maximum of \$500 per script for Bronze on Pharmacy Tiers 1-4
  - Coinsurance up to a maximum of \$500 per script for Tier 4 on Silver 70 and Silver 73 plans
  - Coinsurance up to a maximum of \$200 per script for Tier 4 on Silver 87 and Silver 94 plans
  - Coinsurance up to a maximum of \$500 per script for Tier 4 on Gold plans
  - Coinsurance up to a maximum of \$300 per script for Tier 4 on Platinum plans

# PROPOSED 2016 ACTION FOR SPECIALTY PHARMACY

## Factors Considered With This Recommendation

- With the significant increase in the cost of specialty drugs, Covered California wants to insure that all consumers are not faced with undue financial barriers, particularly those members with medical conditions that have ongoing treatment with drugs that are not available in lower cost sharing pharmacy tiers
- Equally important is the consumers ability to have easy to understand benefit designs so they clearly know what is covered and at what cost
- It is important that we continue to assure overall affordability of premiums including drug costs that are increasingly becoming a larger component of the total cost of healthcare, primarily driven by the introduction and continued development of high cost specialty drugs
  - Although the recommendation's immediate impact to premium is relatively small, the impact to future premiums could be substantial and warrant monitoring
  - Setting a maximum ceiling at an amount close to what essentially is spreading the maximum out-of-pocket over 12 months should minimize the future impact, but may have an impact on drug adherence
  - It is Covered California's intent to monitor consumers' response to this change and we will annually review and refine as necessary based on utilization data and the introduction of new drug treatments

# QHP Analysis of Tier 4 Cap and Impacts to Premium in 2016

Estimated range of premium impact in the first year is generally less than 1%

Pharmacy Tier 4 Options for 2016 Certification Pricing: Projected Changes in Premiums Due to a Cap on Coinsurance	METAL LEVELS					
	Silver	Gold	Platinum	Silver 100-149	Silver 150-199	Silver 200-249
<b>Scenario 1: Tier 4 maintenance drugs ONLY</b>						
<b>Option A:</b> Tier 4 cost sharing to member will not exceed per script/per month \$ value of:	\$500	\$500	\$300	\$200	\$200	\$500
<b>% Change in premium from 2015 to 2016:</b>	<b>0.0-0.6%</b>	<b>0.0-0.6%</b>	<b>0.0-0.5%</b>	<b>0.0-0.5%</b>	<b>0.0-0.6%</b>	<b>0.0-0.5%</b>
<b>Option B:</b> Tier 4 cost sharing to member will not exceed per script/per month \$ value of:	\$200	\$200	\$200	\$100	\$100	\$200
<b>% Change in premium from 2015 to 2016:</b>	<b>0.0-0.6%</b>	<b>0.0-0.7%</b>	<b>0.0-0.5%</b>	<b>0.0-0.5%</b>	<b>0.0-0.7%</b>	<b>0.0-0.6%</b>
<b>Scenario 2: All Tier 4 drugs</b>						
<b>Option A:</b> Tier 4 cost sharing to member will not exceed per script/per month \$ value of:	\$500	\$500	\$300	\$200	\$200	\$500
<b>% Change in premium from 2015 to 2016:</b>	<b>0.0-0.6%</b>	<b>0.0-0.7%</b>	<b>0.0-0.5%</b>	<b>0.0-0.6%</b>	<b>0.0-0.7%</b>	<b>0.0-0.6%</b>
<b>Option B:</b> Tier 4 cost sharing to member will not exceed per script/per month \$ value of:	\$200	\$200	\$200	\$100	\$100	\$200
<b>% Change in premium from 2015 to 2016:</b>	<b>0.0-0.75%</b>	<b>0.0-0.77%</b>	<b>0.0-0.6%</b>	<b>0.0-0.71%</b>	<b>0.0-0.71%</b>	<b>0.0-0.71%</b>
<b>Scenario 3: Cost differentiation between maintenance drugs and all other specialty drugs</b>						
<b>For maintenance drugs,</b> Tier 4 cost sharing to member will not exceed per script/per month \$ value of:	\$200	\$200	\$200	\$100	\$100	\$200
<b>For all other specialty drugs,</b> Tier 4 cost sharing to member will not exceed per script/per month \$ value of:	\$500	\$500	\$300	\$200	\$200	\$500
<b>% Change in premium from 2015 to 2016:</b>	<b>0.0-0.7%</b>	<b>0.0-0.7%</b>	<b>0.0-0.6%</b>	<b>0.0-0.6%</b>	<b>0.0-0.7%</b>	<b>0.0-0.7%</b>

# QHP Analysis of Tier 4 Cap and Impacts to Premiums through 2019

Estimated range of future premium impact with the lower maximum cost sharing ceiling could be as much as 3%

Projected Premium Impact of Pharmacy Tier 4 Options from 2016 to 2019: Changes in Premiums Due to a Cap on Coinsurance	METAL LEVELS					
	Silver	Gold	Platinum	Silver 100-149	Silver 150-199	Silver 200-249
<b>Scenario 1: Tier 4 maintenance drugs ONLY</b>						
Option B: Tier 4 cost sharing to member will not exceed per script/per month \$ value of:	\$200	\$200	\$200	\$100	\$100	\$200
<b>Cumulative % Change in premium from 2016 to 2019:</b>	<b>0.0-1.5%</b>	<b>0.0-1.5%</b>	<b>0.0-1.4%</b>	<b>0.0-1.5%</b>	<b>0.0-1.5%</b>	<b>0.0-1.5%</b>
<b>Scenario 2: All Tier 4 drugs</b>						
Option B: Tier 4 cost sharing to member will not exceed per script/per month \$ value of:	\$200	\$200	\$200	\$100	\$100	\$200
<b>Cumulative % Change in premium from 2016 to 2019:</b>	<b>0.0-3.10%</b>	<b>0.0-3.1%</b>	<b>0.0-2.8%</b>	<b>0.0-3.10%</b>	<b>0.0-3.10%</b>	<b>0.0-3.1%</b>
<b>Scenario 3: Cost differentiation between maintenance drugs and all other specialty drugs</b>						
For maintenance drugs, Tier 4 cost sharing to member will not exceed per script/per month \$ value of:	\$200	\$200	\$200	\$100	\$100	\$200
For all other specialty drugs, Tier 4 cost sharing to member will not exceed per script/per month \$ value of:	\$500	\$500	\$300	\$200	\$200	\$500
<b>Cumulative % Change in premium from 2016 to 2019:</b>	<b>0.0-2.1%</b>	<b>0.0-2.1%</b>	<b>0.0-1.9%</b>	<b>0.0-2.1%</b>	<b>0.0-2.1%</b>	<b>0.0-2.1%</b>

# ADDITIONAL RECOMMENDED UPDATES TO 2016 APPROVED BENEFIT DESIGNS

## Clarify carriers ability to have lower cost sharing for non-primary facilities

- Covered California currently allows carriers to set out-of-network cost sharing which is a benefit to consumers if they should end up receiving services in an out-of-network facility
- We believe this is an added benefit to consumers, however, we would like to update regulations to put more clarity around requirements of an out-of-network or “non-primary tier”
- A carrier must have a primary hospital tier where the hospital network meets the cost sharing requirements in the standard benefit plan design, meets Covered California requirements for impact on premium stability, quality, choice and value, and meets state network adequacy standards as applied by the applicable regulator
- A carrier may have a second hospital tier that is non-primary, or considered out-of-network, where the carrier has cost sharing requirements that are different than the standard benefit plan designs if the carrier can demonstrate that the non-preferred tier is in the best interest of the consumer as determined by Covered California
- The non-preferred tier cannot be used to meet state network adequacy standards as applied by the applicable regulator
- The non-primary or out-of-network tier cannot be displayed as the primary hospital network in provider directories and the higher cost sharing that may be associated with these facilities must be clearly called out and communicated to consumers



# IMPACTING RURAL ACCESS: STRATEGIES AND NETWORK REVIEW

DOREEN BRADSHAW, HEALTH ALLIANCE OF NORTHERN CALIFORNIA  
BRENT BARNHART, CHAIR, PLAN MANAGEMENT ADVISORY GROUP  
DMHC REPRESENTATIVES



# **Rural Healthcare Access in Northern California**

*Doreen Bradshaw, Executive Director  
Health Alliance of Northern California*



# **Obstacles Faced by Northern California Rural Communities**

- Economic Factors
- Cultural and Social Differences
- Educational Shortcomings
- Lack of Recognition by Legislators
- Sheer Isolation of Living and Working in Remote Rural Areas
- Poorer Health Status

# Things That Affect Rural Healthcare Access

- Physician and Provider Supply-many rural communities have Health Professional Shortage Area designations for primary, dental and mental health providers.
- Less employer-provided health care or prescription drug coverage.
- Travel to see primary care doctors and even greater distances to see specialists.
- Lack of public transportation, extreme weather conditions and challenging roads.
- Limited emergency services often staffed by volunteers and lengthy response times.

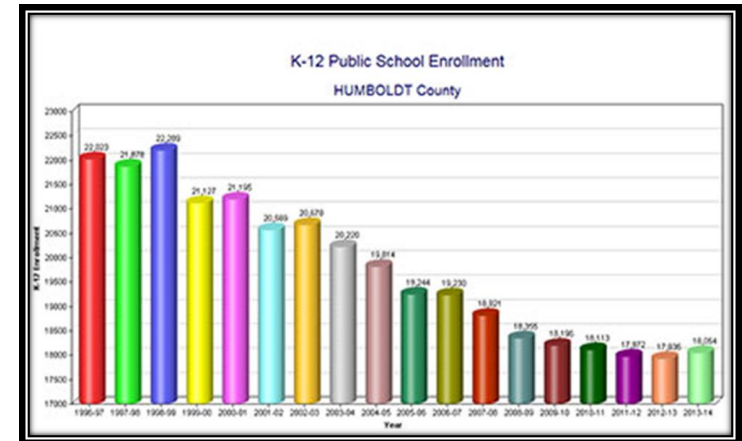
# Rural Health Environment

## Demographic

- Outmigration of rural residents
- Increased undocumented/Hispanic population
- Aging provider workforce
- Aging of rural population

## Rural Health System Changes

- Health Care Reform/Managed Care
- Coverage for Remaining Uninsured
- Payment based on quality outcomes
- More integration of local community health systems
- Technology
- Adequate resources to navigate the changes



# Covered CA

## Network Adequacy Challenges for Our Region

- Provider Shortages
- Directory Accuracy
- Specialty Care Access
- Lack of Plan Choice
- Provider Dissatisfaction
- Lack of Oversight

# Possible Solutions to Address Network Adequacy

## Easy

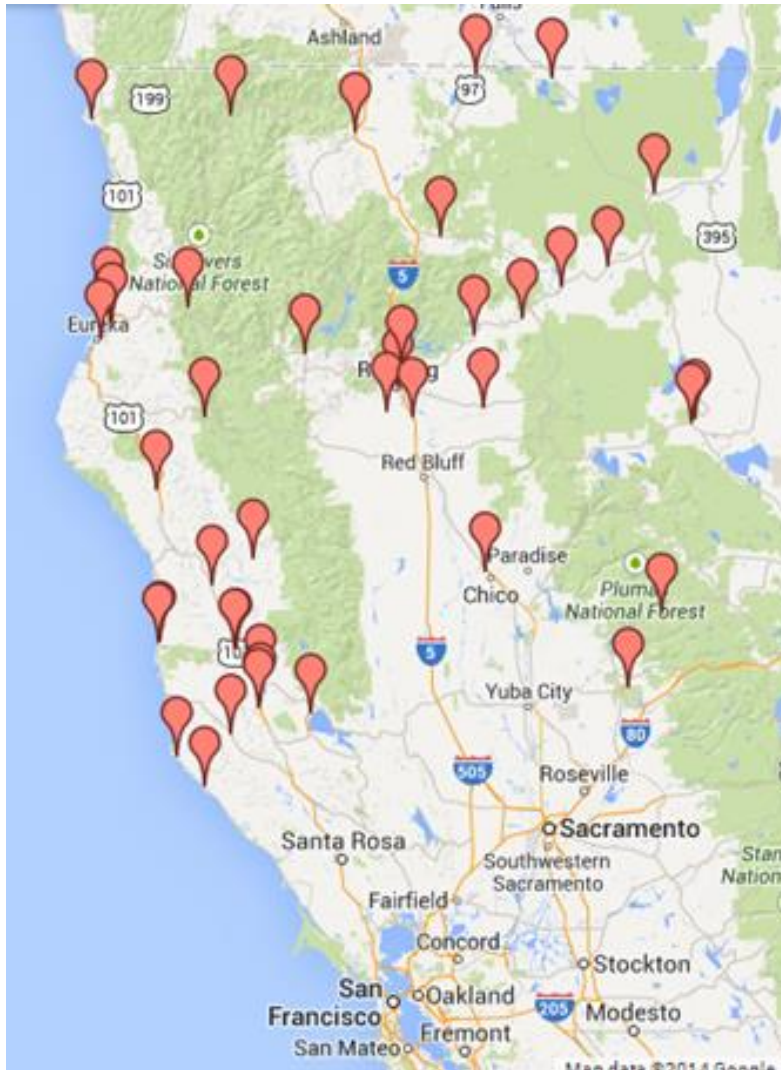
- Update Directories
- Use of Social Networking to Promote Covered CA
- More Marketing of Silver Plan
- Promote local collaboration between health plans and providers

## Not so Easy

- Align Covered CA and Medi-Cal Standards for Rural Networks
- Change the Model
- Reimbursement
- Pay for Performance



# Rural FQHCs



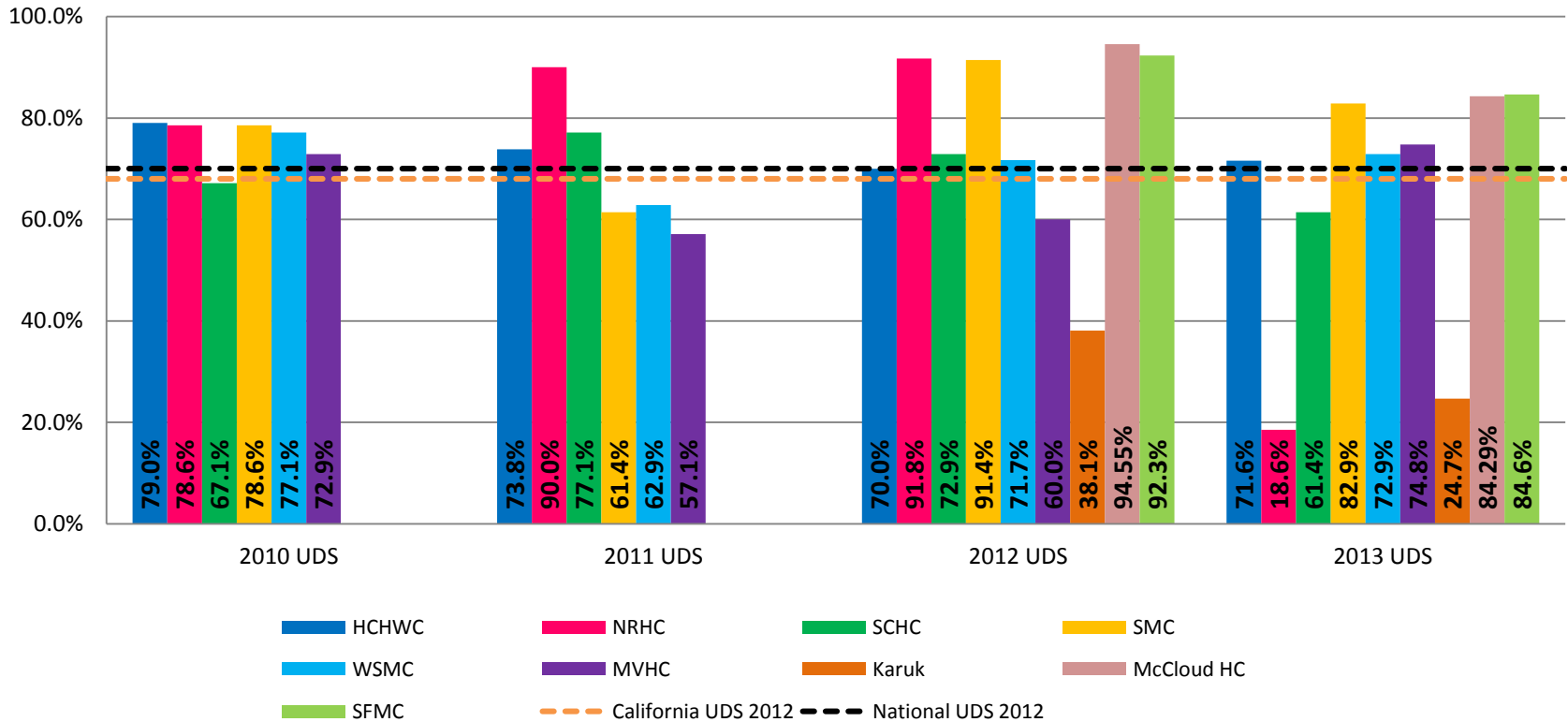
- Three regional community clinic associations together serving a geographic area of almost 40,000 square miles
- Home to about 2.2% of California's almost 39 million, together our 14 rural counties cover almost one quarter of the state's land mass

# Advancing Quality in Rural Health Centers

- 10+ years of experience building health center quality improvement capacity
  - Promoting a culture of quality and measurement
  - Supporting implementation of HIT systems
  - Improving data collection & reporting capabilities
  - Utilizing data to improve patient care
- *Telling the Story* of quality in health centers
- Importance of aligning measures to national datasets such as UDS or HEDIS

# Telling the Story

## % of Adult Patients with Controlled Diabetes



### Impact of Diabetes in Rural Northern California

- Diabetes is a leading cause of disability and death in rural Northern California, affecting about 8.6% of adults<sup>1</sup>. Overall, the prevalence of Diabetes in rural areas is 30% higher than in urban cities<sup>2</sup>.
- The incidence of diabetes is higher in low-income populations – 12% of non-elderly adults covered by Medi-Cal have diabetes as compared to 5% of adults not covered by Medi-Cal<sup>3</sup>.
- Obesity and sedentary lifestyle are associated with Type 2 Diabetes<sup>4</sup>. These factors are significant in rural areas as 1 in 3 adults in rural Northern California is overweight and 1 in 4 is obese<sup>5</sup>.
- It is common for individuals with diabetes to have additional chronic health problems. More than 80% of Medicaid enrollees with diabetes have at least one additional chronic illness<sup>6</sup>.
- The average medical expenditures among people with diabetes are more than twice the expenditures of people without diabetes<sup>7</sup>.

### How Health Centers Provide the Necessary Care

#### *Clinical Interventions*

- Use a continually updated online registry to plan and track the care for diabetic patients.
- Implement pre-visit summary reports for care teams to review the needs of patients coming to the health center and follow evidence-based clinical guidelines on retinal screening, foot care, lab testing, and glycemic management including improved support for patient self-management.
- In-house specialty diabetic services, such as retinal screening from contracted ophthalmologist and individualized consultation with a diabetic educator.
- Practice redesign to encourage group visits for diabetic patients in the health center.
- Utilize patient care coordinators to monitor the health of patients and coordinate their care during any encounter with a patient, even visits unrelated to their diabetes.
- Provide glucometers that record and store blood sugar levels and glucose test strips for low-income patients to support self-management.

#### *Community Interventions*

- Screen adults with high blood pressure (> 135/80 mm hg) for type 2 diabetes at health fairs.
- Teach at risk adults how to incorporate physical activity into their daily routines. Set up walking groups or other programs to support positive behavior change.
- Teach patients and community members how to use mobile technology to monitor diet and nutrition. Easy-to-use mobile device applications can assist individuals maintain a healthy lifestyle.
- Provide access to fresh foods through farmers markets and offer nutrition education.
- Connect patients with peer-led, community-based, chronic disease self-management programs.

Telling  
the  
Story

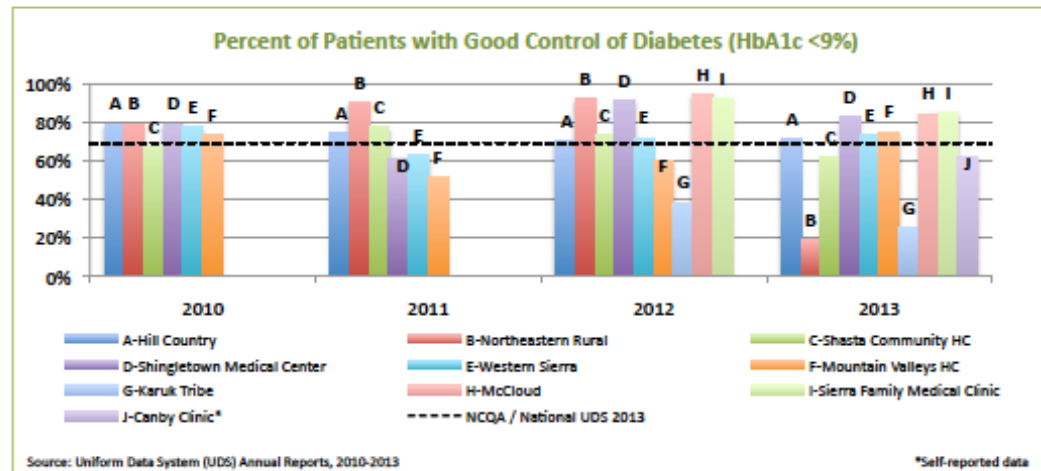
# Telling the Story

## Diabetes Management

### Health Alliance of Northern California Health Center Data

#### Key Points

- Health centers in rural Northern California serve low-income and uninsured populations that are heavily affected by diabetes and other chronic health conditions.
- In 2013, health centers from the HANC network provided care to 5,055 adult patients with diabetes.
- There are significant racial/ethnic health disparities. Rates of diabetes are 2 to 5 times higher among Native Americans and 87% higher among Mexican Americans than among whites. Lack of access to health care among migrant or seasonal farm workers places them at risk for diabetes related premature death.



#### Quality Measure Definitions

The percentage of adults with control of blood sugar levels as measured by an HbA1c test.

- Adults with diabetes receive regular blood tests to monitor whether their blood sugar level is under control. Blood sugar levels at or less than 9% are considered in control.
- For every 1% reduction in HbA1c, the risk of developing eye, kidney, and nerve disease decreases by 40% and the risk of heart attack decreases by 14%.

#### National Quality Goals and Benchmarks

- **National UDS 2013:** Average result among all federally qualified health centers was 68.9% in 2013.
- **Healthy People 2020 objective:** Increase to 59% the proportion of diabetic adults with an HbA1c test result that is less than 7%. (Not shown given difference in definition for target).
- **National Committee for Quality Assurance (NCQA):** The top 10% of Medicaid UMC plans (90th Percentile)



Partnership HealthPlan  
of California

## Quality Improvement Program (QIP)

### Fixed Pool Measures

- Earn up to 100 points across the measure set
- Fixed PMPM amount determines pool
- 100% of pool disbursed based on final member months and points earned by site

### Unit of Service Measures (Optional)

- Advance Care Planning
- PCMH Certification
- Peer-Led Self Management Group
- Utilization of CAIR
- Access/Extended Office Hours

### 2014-15 Fixed Pool Measures Set

#### Clinical

- Cervical Cancer Screening
- Diabetes Management
- Well Child Visits (3-6 yrs.)

#### Appropriate Use of Resources

- IP Bed Days/1000
- Readmission Rate
- Pharmacy Utilization

#### Access/Operations

- Avoidable ED Visits
- Practice Open to PHC Members
- PCP Office Visits
- 3NA or No Show rate

#### Patient Experience

# Today's Takeaways

- Marketing of Covered CA for rural needs to be different
- More promotion of Silver Plan
- Alternative models to improve workforce should be piloted
- Standardize Pay for Performance programs

# **BENEFIT DESIGN CLARITY: DEDUCTIBLE, MAXIMUM OUT OF POCKET, AND BRONZE**

**JAMES DEBENEDETTI, DEPUTY DIRECTOR  
COVERED CALIFORNIA PLAN MANAGEMENT DIVISION**



# Glossary: Deductible and Maximum Out of Pocket

- Current definitions:

- Deductible: The amount you owe for health care services your health insurance plan covers before your plan begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you have met your deductible for covered health care services. The deductible may not apply to all services
- Out of Pocket Limit: The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100 percent of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance plan doesn't cover. Some health insurance plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit. In Medicaid and Children's Health Insurance Program, the limit includes premiums.

- Recommendations:

- Change “Out of Pocket Limit” to “Maximum out of Pocket”
- Proposed definitions:
  - Deductible: The amount of money you have to pay for your health care before your health insurance company will pay for the costs.
  - Maximum out of Pocket: The most money you will pay for your health care over an entire year. This amount includes deductible and costs of all health care.
- Have consistent definitions in all consumer publications\*

\*Timing of changes will be subject to flexibility of CalHEERS system.

# Bronze Plan Discussion

Issue: In 2016, the Bronze plan MOOP and Deductible will both be \$6,500, meaning the consumer is fully responsible for all health care costs until the MOOP/Deductible are met\*. Covered California would like to message “0%” coinsurance to be clear that members pay the full amount of health care costs until Deductible/MOOP are met.

\*With the exception of the first three doctor visits

## Considerations

- Limitations exist on how benefits can be displayed in CalHEERS
  - SERFF
- Ability to change hover text in CalHEERS is difficult, but something we are continuing to look into. Areas where we have more change flexibility are:
  - Covered California website
    - Shop and Compare tool
    - Health Insurance Benefits page
  - Covered California Rate Book
- Other ideas?

# Covered California 2015 Health Plan Booklet

2015 STANDARD BENEFIT DESIGNS BY METAL TIER				
Coverage Category	Bronze	Silver	Gold	Platinum
	Covers 60% average annual cost	Covers 70% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Preventive Care Copay*	No cost	No cost	No cost	No cost
Primary Care Visit Copay	\$60 for 3 visits	\$45	\$30	\$20
Specialty Care Visit Copay	\$70	\$65	\$50	\$40
Urgent Care Visit Copay	\$120	\$90	\$60	\$40
Emergency Room Copay	\$300	\$250	\$250	\$150
Lab Testing Copay	30%	\$45	\$30	\$20
X-Ray Copay	30%	\$65	\$50	\$40
Generic Medicine Copay	\$15 or less	\$15 or less	\$15 or less	\$5 or less
Annual Out-of-Pocket Maximum Individual and Family	\$6,250 individual and \$12,500 family	\$6,250 individual and \$12,500 family	\$6,250 individual and \$12,500 family	\$4,000 individual and \$8,000 family

\*In most situations, this is true for one visit per year.

2015 STANDARD BENEFIT DESIGNS BY INCOME			
Coverage Category	Enhanced Silver 94	Enhanced Silver 87	Enhanced Silver 73
Eligibility Based on Income and Premium Assistance	Covers 94% average annual cost	Covers 87% average annual cost	Covers 73% average annual cost
Single Income Ranges	up to \$17,235 (≤150% FPL)	\$17,236 to \$22,980 (>150% to ≤200% FPL)	\$22,981 to \$28,725 (>200% to ≤250% FPL)
Annual Wellness Exam	\$0	\$0	\$0
Primary Care Visit	\$3	\$15	\$40
Specialist Visit	\$5	\$20	\$50
Laboratory Tests	\$3	\$15	\$40
X-Rays and Diagnostics	\$5	\$20	\$50
Imaging	10%	15%	30%
Generic Drugs	\$3	\$5	\$15 or less
Annual Out-of-Pocket Maximum Individual and Family	\$2,250 individual and \$4,500 family	\$2,250 individual and \$4,500 family	\$5,200 individual and \$10,400 family

<http://www.coveredca.com/PDFs/CC-health-plans-booklet-2015.pdf>

# Covered California 2015 Shop and Compare Tool

## Standard Benefits for Individuals

Key benefits	Bronze 60	Silver 70
Benefits in Blue are Subject to Deductibles		
Individual Deductible	<b>\$5,000</b> deductible for medical & drugs	<b>\$2,000</b> medical deductible <b>\$250</b> brand drug deductible
Family Deductible	<b>\$10,000</b> deductible	<b>\$4,000</b> medical deductible <b>\$500</b> brand drug deductible
Preventative Care Copay <sup>1</sup> (deductible does not apply)	no cost	no cost
Primary Care Visit Copay	<b>\$60</b> <sup>2</sup>	\$45
Specialty Care Visit Copay	<b>\$70</b>	\$65
Urgent Care Visit Copay	<b>\$120</b> <sup>2</sup>	\$90
Generic Medication Copay	<b>\$15</b>	\$15
Lab Testing Copay	<b>30%</b>	\$45
X-Ray Copay	<b>30%</b>	\$65
Emergency Room Copay	<b>\$300</b>	<b>\$250</b>
High cost and infrequent services (e.g. Hospital Stay)	<b>30%</b> of your plan's negotiated rate	<b>20%</b> of your plan's negotiated rate
Preferred brand copay after Drug Deductible (if any)	<b>\$50</b>	<b>\$50</b>
Maximum Out-of-Pocket For One	\$6,250	\$6,250
Maximum Out-of-Pocket For Family	\$12,500	\$12,500
<sup>1</sup> in-network only	<sup>2</sup> First 3 visits each year are not subject to the deductible	

<http://www.coveredca.com/shopandcompare/2015/#benefits>

# QUESTIONS, WRAP-UP, AND NEXT STEPS

BRENT BARNHART, CHAIR  
PLAN MANAGEMENT ADVISORY GROUP

# APPENDIX

# Special Enrollment: Comparison with Other States

Comparison of SEP Policy among the Federal and State-Based Exchanges		
FBE & SBEs	SEP Requirements	SEP as % of Total Enrollment
California	Attestation	10.5%
Colorado	Attestation	10.0%
Washington	Documentation	10.7%
Federal	Attestation	Not Available
Connecticut	Attestation	Not Available
District of Columbia	Attestation	Not Available
Hawaii	Attestation & Documentation (birth only)	Not Available
Kentucky	Attestation	Not Available
Maryland	Attestation	Not Available
Massachusetts	Attestation	Not Available
Minnesota	Documentation	Not Available
New York	Attestation	Not Available
Rhode Island	Attestation	Not Available