Qualified Health Plans
Plan Design Issues: Standardization, Vision and Dental Benefits, Wellness Incentives and Smoking Rating

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Qualified Health Plans
Plan and Network Design Issues

Rating Issues: Family Tiers, Age, Geography, Tobacco and Wellness

Proposed legislation that would require use of fixed geographic rating regions is being considered by the California Legislature. In addition, the Exchange staff believes it is likely that imminent federal rules will fix allowed family tiers, set age bands and potentially regulate the allowed variation between age bands with the 3:1 maximum allowable variation required by the Affordable Care Act. Also, pending state legislative proposals would disallow the use of tobacco as a premium rating factor.

1. Standardization of Family Structure Rating Factors		
Option A: Do not standardize	**Option B: Standardize family tier structure, but allow issuers to determine tier ratios**	**Option C: Standardize family tier structure and tier ratios**
Do not standardize the number of rate tiers, composition of tiers, or tier ratios	Standardize allowable rate tiers and composition to be used by all issuers, but allow issuers to choose tier ratios	Standardize allowable rate tiers, tier composition, and tier ratios to be used by all issuers
Preliminary Recommendation: Standardize family tiers and tier ratios, Option C		

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Rating Issues: Family Tiers, Age, Geography, Tobacco and Wellness

2. Standardization of Age Factors	
Option A: Do not standardize	**Option B: Standardize age factors**
Do not standardize age factors for premium rate development, subject to the 3 to 1 maximum age-based premium variation for adults	Standardize age factors for premium rate development by all issuers participating in the Exchange if not done by federal rules.
Preliminary Recommendation: Standardize age bands and age factors, Option B	

3. Requirement that Issuers Cover Entire Geographic Regions		
Option A: Do not require issuers to cover the entire region	**Option B: Require issuers to cover the entire region**	**Option C: Require issuers to cover the entire region for which they are licensed**
Do not require issuers to cover the entire region in order to offer coverage through the Exchange	Require issuers to cover the entire region in order to offer coverage through the Exchange	Requires issuer to cover the entire region for which it is licensed in order to offer coverage through the Exchange but allows regional plans to offer sub-regional products if the Exchange intends to select a sub-regional plan for the same geographic area
Preliminary Recommendation: Require coverage of licensed region but allow sub-regional plans, Option C		

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4. Allowable Rate Adjustment for Tobacco Use(in the absence of legislation)

Option A: Prohibit the application of tobacco use rating factors	Option B: Allow the application of the full magnitude of the tobacco use rating factors permitted by the ACA	Option C: Conduct further research on the pros and cons of requiring a limited (e.g. 5%) rate-up for tobacco use
Apply tobacco use rating factors to determine premiums.	Apply the full tobacco use rating adjustment to determine premiums, up to the 1.5 factor allowed under the Affordable Care Act	Conduct further research on the pros and cons of requiring or prohibiting a limited (e.g. 5%) rate-up for tobacco use that would be waived if the enrollee participates in a smoking cessation program

Preliminary Recommendation: Conduct further research on pros and cons of applying limited (e.g., 5%) rate up for tobacco use that could be waived if the enrollee participates in a smoking cessation program, Option C

5. Wellness Program Incentives for SHOP (with clear limits; measure impact on enrollment and care)

Option A: Prohibit wellness program incentives	Option B: Allow wellness program incentives
Prohibits employers from implementing wellness program incentives	Allows employers to implement wellness program incentives to encourage participation and achievement of health-related targets

Preliminary Recommendation: Allow wellness program incentives for SHOP plans with limits Option B

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Plan Design Standardization

Effective 2014, under the Affordable Care Act, all health benefit plans offered must provide coverage for all Essential Health Benefits and meet the actuarial value requirements for the Platinum, Gold, Silver, or Bronze metal tiers. While these requirements ensure minimum coverage and a level of standardization, they allow for a wide range of potential variation in plan designs.

1. Standardization of Cost Sharing Provisions		
Option A: No standardization of cost-sharing components of benefit plans offered in the Exchange	**Option B: Standardization of major cost-sharing components of benefit plans and allow limited customization**	**Option C: Strict standardization of all possible cost-sharing components of benefit plans**
Allows issuers to develop and sell any plan design in the Exchange as long as it falls within one of the metal tiers and meets other coverage requirements Issuers may be limited in the number of plans they can offer within each tier	Standardizes the major cost-sharing components, such as deductibles, co-pays, coinsurance, and out-of-pocket limits Value-based plan modifications and other innovations and limited variation of ancillary benefits would be allowed subject to approval by the Exchange	Standardizes all possible cost-sharing components Value-based plan modifications or other changes to benefits would not be allowed
Preliminary Recommendation: Standardize major components while allowing some customization, Option B		

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Plan Design Standardization

2. Standardization of Benefit Exclusions and Limits		
Option A: No standardization of benefit limits and exclusions in benefit plans offered in the Exchange	**Option B: Standardize major benefit limits and exclusions in benefit plans and allow limited customization**	**Option C: Strict standardization of all possible benefit limits and exclusions**
Allows issuers to apply benefit limits and exclusions in plan designs for sale in the Exchange as long as Essential Health Benefits coverage is satisfied	Standardizes the major benefit limits and exclusions, but allows for limited customization	Standardizes all possible benefit limits and exclusions, and allows the health plan to make no changes.

Preliminary Recommendation: Standardize major benefit limits and allow limited customization, Option B

3. Standardization of Drug Formularies	
Option A: Require formularies to meet at least the Affordable Care Act minimum standard of at least one drug per class or category	**Option B: Require formularies to meet at least the Medicare Part D minimum standard of at least two drugs per class or category**
Requires that issuers in the Exchange only meet the Affordable Care Act minimum requirement that drug formularies cover at least one drug per class or category	Expands the Affordable Care Act's minimum drug formulary requirement to provide additional lower cost drug options.

Preliminary Recommendation: Require formularies to include at least two drugs per class, Option B

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Plan Design Standardization

4. Value-Based Benefit Designs in the Context of Benefit Standardization	
Option A: Prohibit value-based benefit designs	**Option B: Allow value-based benefit designs that lower patient out-of-pocket costs or provide financial rewards**
Prohibits issuers from including value-based benefit designs in benefit plans offered through the Exchange.	Allows issuers to offer value-based benefit designs that lower patient out-of-pocket costs or provide financial rewards
Preliminary Recommendation: Allow designs that lower out-of-pocket costs or provide positive incentives Option B	

5. Standardization of Minimum Out-of-Network Benefits	
Option A: Do not standardize minimum out-of-network benefits	**Option B: Standardize minimum out-of-network benefits**
Allows issuers to customize the out-of-network benefits included in benefit plans offered through the Exchange	Standardize minimum out-of-network benefits included in benefit plans offered through the Exchange May include minimum actuarial value, maximum deductibles or coinsurance, and the maximum charge allowed by out-of-network providers for balance billing purposes
Preliminary Recommendation: Standardize minimum out-of-network benefits, Option B	

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Premium Subsidies and Cost Sharing Reductions

The Affordable Care Act provides for premium subsidies and cost sharing reductions for lower income individuals and families that are linked to the premium rate charged for the second lowest cost "silver" plan, but does not provide clear guidance on the how those subsidies and cost sharing reductions may be used by eligible individuals. Various issues and options are under consideration by the Exchange.

1. Plan Choices for Individuals Income between 100% and 250% FPL		
Option A: Allow choice only among any silver plan available to that individual and their family	**Option B: Allow choice only among bronze and silver plans available to that individual and their family**	**Option C: Allow choice of plans from any tier**
Allows individuals with family income between 100% and 250% FPL to purchase silver-level plans only	Allows individuals with family income between 100% and 250% FPL to purchase any plan within the silver and bronze tiers	Allows individuals with family income between 100% and 250% FPL to purchase from any metal tier
Preliminary Recommendation: Allow choice only among bronze and silver plans with clear description of risks/benefits, Option B		

2. Plan Choices for Individuals with Income between 250% and 400% FPL		
Option A: Allow choice only among any silver plan available to that individual and their family	**Option B: Allow choice only among any bronze and silver plans available to that individual and their family**	**Option C: Allow choice of plans from any tier**
Allows individuals with family income between 250% and 400% FPL to purchase silver-level plans only	Allows individuals with family income between 250% and 400% FPL to purchase from any plan within the silver and bronze tiers	Allows individuals with family income between 250% and 400% FPL to purchase from any metal tier
Preliminary Recommendation: Allow choice from any tier plans with clear description of risks/benefits, Option C		

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Premium Subsidies and Cost Sharing Reductions: Illustrations of Impact of Cost Sharing Reductions for members below 250% FPL

Examples of Impact of Cost Sharing Reductions for members below 250% FPL

Income (percent of Federal Poverty Level)	Family Size	Annual Income (based on 2012 FPL)	Premium Cost Net of Tax Credit for the Second Lowest Cost Silver Plan	
			Percent of Income	Monthly Amount (based on 2012 FPL)
Below 133%	Single	$14,856	2.00%	$25
150%	Single	$16,755	4.00%	$56
200%	Single	$22,340	6.30%	$117
250%	Single	$27,925	8.05%	$187
300%	Single	$33,510	9.50%	$265
400%	Single	$44,680	9.50%	$354

Income (percent of Federal Poverty Level)	Reduction in Maximum OOP Limit **	Required Actuarial Value of Benefit Plan
100%-150%	0.667	94%
150%-200%	0.667	87%
200%-250%	0.500	73%
250%-300%	0.5	70%
300%-400%	0.333	70%

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Premium Subsidies and Cost Sharing Reductions: Illustrations of Recommendation to Allow Individuals with Income Below 250% of FPL to only purchase Silver or Bronze Plans

Examples of Impact of Recommended Choice by Members with Incomes at 150% and at 200% of FPL

Comparison of Total Costs for an Exchange Member based on Their Choice of Benefit Plans

	Joan Income at 150% of Federal Poverty Level				Jane Income at 200% of Federal Poverty Level			
Benefit Plan Information								
Benefit Tier	Platimum	Gold	Silver	Bronze	Platimum	Gold	Silver	Bronze
Plan Actuarial Value	90%	80%	70%	60%	90%	80%	70%	60%
Illustrative Monthly Premium before Tax Credit	$579	$514	$450	$386	$579	$514	$450	$386
Illustrative Benefit Plan Maximum Out-of-Pocket Expense	$2,000	$3,500	$5,000	$6,000	$2,000	$3,500	$5,000	$6,000
Premium Subsidies and Cost Sharing Reductions								
Monthly Tax Credit	$394	$394	$394	$394	$333	$333	$333	$333
Monthly Premium After Tax Credit	$185	$120	$56	$0	$246	$181	$117	$53
Adjusted Actuarial Value	90%	80%	94%	60%	90%	80%	87%	60%
Adjusted Maximum Out-of-Pocket Expense	$2,000	$3,500	$1,667	$6,000	$2,000	$3,500	$1,667	$6,000
Examples of Impact of Plan Choice on Total Costs								
Scenario 1: Joan & Jane have average healthcare use and expenses								
Annual Premium After Tax Credit	$2,220	$1,440	$672	$0	$2,952	$2,172	$1,404	$636
Annual cost sharing expense	$556	$987	$259	$1,482	$556	$987	$562	$1,482
Total Annual Costs	$2,776	$2,427	$931	$1,482	$3,508	$3,159	$1,966	$2,118
Scenario 2: Joan & Jane have high healthcare use and expenses								
Annual Premium After Tax Credit	$2,220	$1,440	$672	$0	$2,952	$2,172	$1,404	$636
Annual cost sharing expense	$2,000	$3,500	$1,667	$6,000	$2,000	$3,500	$1,667	$6,000
Total Annual Costs	$4,220	$4,940	$2,339	$6,000	$4,952	$5,672	$3,071	$6,636

Table 20: Appendix: Illustrative Standardized Benefit Plan Descriptions – Platinum and Gold					
	Platinum		Gold		
	Plan 1	Plan 2	Plan 1	Plan 2	Plan 3
Annual Deductible	$0	$250	$0	$500	$0
Out-of-Pocket Max	$6,350	$2,000	$6,350	$6,350	$3,500
Inpatient Hospital	$100 per day	10% coinsurance	$400 per day	$250 per day	$500 per day
Outpatient Hospital	$100-$200 copays	10% coinsurance	$200-$400 copays	15% coinsurance	$250 copay
Emergency Room	$100 copay	$150 copay	$150 copay	$150 copay	$150 copay
Preventive Care	No cost share	No cost share	No cost share	No cost share	No cost share
Primary Care Visit (for deductible plans, the first 4 PCP visits are exempt from the deductible)	$20 copay	10% coinsurance	$30 copay	$20 copay	$50 copay
Specialty Care Visit	$30 copay	10% coinsurance	$40 copay	15% coinsurance	$50 copay
Imaging-Advanced and X-ray	OP Hosp: $50 copay, Prof: $10-$30 copay	10% coinsurance	OP Hosp: $50 copay, Prof: $10-$40 copay	15% coinsurance	OP Hosp: $50 copay, Prof: $10-$30 copay
Lab tests	$10 copay	10% coinsurance	$10 copay	15% coinsurance	$10 copay
PT/OT/ST	$30 copay	10% coinsurance	$40 copay	15% coinsurance	$50 copay
Mental Health/Substance Abuse - Inpatient	$100 per day	10% coinsurance	$400 per day	$250 per day	$500 per day
Mental Health/Substance Abuse - Outpatient	$20 copay	10% coinsurance	$30 copay	$20 copay	$50 copay
Prescription Drugs	$0 deductible	$0 deductible	$250 brand deductible	$0 deductible	$250 brand deductible
Generic	$5 copay	$5 copay	$15 copay	$10 copay	$15 copay
Brand-Preferred	$15 copay	$15 copay	$30 copay	$25 copay	$35 copay
Brand-non-Preferred	$25 copay	$25 copay	$40 copay	$35 copay	$50 copay

Table 21: Appendix: Illustrative Standardized Benefit Plan Descriptions - Silver				
	Silver			
	Plan 1	Plan 2	Plan 3	Plan 4
Annual Deductible	$500	$1,000	$1,500	$750
Out-of-Pocket Max	$6,350	$6,350	$5,000	$5,000
Inpatient Hospital	30% coinsurance	$400 per day	$250 per day	40% coinsurance
Outpatient Hospital	30% coinsurance	20% coinsurance	25% coinsurance	40% coinsurance
Emergency Room	$150 copay	$150 copay	$150 copay	$150 copay
Preventive Care	No cost share	No cost share	No cost share	No cost share
Primary Care Visit (for deductible plans, the first 4 PCP visits are exempt from the deductible)	$30 copay	$30 copay	$25 copay	$40 copay
Specialty Care Visit	$30 copay	20% coinsurance	$35 copay	$40 copay
Imaging-Advanced and X-ray	30% coinsurance	20% coinsurance	25% coinsurance	40% coinsurance
Lab tests	30% coinsurance	20% coinsurance	25% coinsurance	40% coinsurance
PT/OT/ST	30% coinsurance	20% coinsurance	25% coinsurance	40% coinsurance
Mental Health/Substance Abuse - Inpatient	30% coinsurance	$400 per day	$250 per day	40% coinsurance
Mental Health/Substance Abuse - Outpatient	$30 copay	$30 copay	$25 copay	$40 copay
Prescription Drugs	$150 brand deductible	$250 brand deductible	$0 deductible	$150 brand deductible
Generic	$10 copay	$10 copay	$10 copay	$10 copay
Brand-Preferred	$30 copay	$25 copay	$25 copay	$30 copay
Brand-non-Preferred	$50 copay	$35 copay	$35 copay	$50 copay

Table 22: Appendix: Illustrative Standardized Benefit Plan Descriptions – Bronze and Catastrophic			
	Bronze*		Catastrophic
	Plan 1	Plan 2	
Annual Deductible	$2,000	$3,000	$6,350
Out-of-Pocket Max	$6,350	$5,000	$6,350
Inpatient Hospital	$500 per day	30% coinsurance	0% coinsurance
Outpatient Hospital	30% coinsurance	30% coinsurance	0% coinsurance
Emergency Room	30% coinsurance	30% coinsurance	0% coinsurance
Preventive Care	No cost share	No cost share	No cost share
Primary Care Visit (for deductible plans, the first 4 PCP visits are exempt from the deductible)	$50 copay	$50 copay	0% coinsurance
Specialty Care Visit	30% coinsurance	30% coinsurance	0% coinsurance
Imaging-Advanced and X-ray	30% coinsurance	30% coinsurance	0% coinsurance
Lab tests	30% coinsurance	30% coinsurance	0% coinsurance
PT/OT/ST	30% coinsurance	30% coinsurance	0% coinsurance
Mental Health/Substance Abuse - Inpatient	$500 per day	30% coinsurance	0% coinsurance
Mental Health/Substance Abuse - Outpatient	$50 copay	$50 copay	0% coinsurance
Prescription Drugs	$500 brand deductible	$500 brand deductible	N/A
Generic	$15 copay	$15 copay	0% coinsurance
Brand-Preferred	$40 copay	$40 copay	0% coinsurance
Brand-non-Preferred	$50 copay	$50 copay	0% coinsurance

Promoting Wellness and Prevention

The vision, mission and values adopted by the California Health Benefit Exchange, the California legislation to establish the health benefits exchange, and the federal Affordable Care Act include provisions to promote wellness and disease prevention. The Exchange is considering the options related to wellness programs and initiatives and how such initiatives could be factored into the selection of Qualified Health Plans and benefit design requirements.

1. Use of a Health Risk Assessment Tool or Other Plan-based Wellness Promotion Initiatives		
Option A: Require completion of a health risk assessment as part of the enrollment process	**Option B: Require completion of a health plan health risk assessment as part of the enrollment process**	**Option C: Health plans provide an optional health risk assessment tool**
Requires individuals to complete a uniform health risk assessment sponsored by the Exchange as part of the enrollment process and is a precursor to eligibility for benefits	Requires individuals to complete an issuer's health risk assessment as part of the enrollment process The health risk assessment is not standardized among issuers	Promotes use of existing issuer services and relies on voluntary member participation Enrollment is not contingent on completion of a health risk appraisal
Preliminary Recommendation: Allow insurers to provide health risk assessment as an option to minimize complexity of the enrollment process, Option C		

Qualified Health Plans
Assuring Quality and Affordability

Promoting Wellness and Prevention

2. Provision of a Wellness Program by the Exchange		
Option A: Exchange selects an additional vendor to augment issuer-based programs	**Option B: Exchange promotes use of wellness programs offered by issuers**	**Option C: Exchange establishes requirements for the wellness programs that are offered by issuers**
Selects an outsourced vendor to brand its own health promotion and wellness program The design augments issuer-based programs	Leverages existing programs offered by issuers with back-end reporting on consumer engagement and population comparisons	Leverages existing programs offered by issuers with front-end design and content requirements and back-end reporting on consumer engagement and population comparisons
Preliminary Recommendation: Exchange establishes requirements for allowed wellness programs, Option C		

3. Use of Financial Incentives by Plans to Promote Wellness		
Option A: Allow health plan issuers to use incentives as an optional program	**Option B: Require health plan issuers to use a common set of incentives**	**Option C: Prohibit health plan issuers from using incentives**
Leverages existing issuer programs that use incentives to promote engagement in wellness	Establishes a common set of incentives across various issuers and benefit designs Potentially enables the Exchange to distinguish its plan offerings and create unified communications	Prohibits issuers from using incentives to engage members in wellness programs
Preliminary Recommendation: Allow health plans to offer wellness program incentives, Option A		

Qualified Health Plans
Assuring Quality and Affordability

Promoting Wellness and Prevention

4. Role of Exchange in Community and Public Health Issues

Option A: Engage in public and community health efforts	Option B: The Exchange encourages health plans to address public health issues	Option C: The Exchange does not engage in public and community health issues
Engages directly with public and community health efforts in conjunction with its outreach and marketing campaign	Encourages health plans to address public health issues, leveraging existing efforts and minimizing potential distraction from other Exchange priorities	Maintains focus on core operations and does not engage in public and community health issues, relying on other stakeholders to lead these efforts

Preliminary Recommendation: Exchange engages in public and community health issues, Option A
or Exchange encourages issuers to address public health issues, Option B

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Assuring Quality and Affordability

Promoting Wellness and Prevention

4. Apply to participate in the HHS Demonstration Program for Wellness in the Individual Market

The Affordable Care Act Section 2705 establishes a 10-state wellness program demonstration project for the individual market, which HHS, Treasury and Labor are directed to establish by July 1, 2014, which makes the wellness provisions which are applicable to employers apply to programs of health promotion offered by an issuer that offers coverage in the individual market.

Preliminary Recommendation: California should apply to participate in the ten state wellness program demonstration project slated to begin no later than July 1, 2014.

Supplemental Benefits: Dental and Vision

1. Offering Supplemental Benefits in the Individual and SHOP Exchanges

Option A: Offer supplemental benefits in both the Individual and SHOP Exchanges	Option B: Offer supplemental benefits in only the SHOP Exchange	Option C: Do not offer supplemental benefits
Supplemental benefits offered in both Individual and SHOP Exchanges	Supplemental benefits offered only in the SHOP Exchange	Supplemental benefits not offered in either Individual or SHOP Exchange

Preliminary Recommendation: Offer supplemental benefits in the SHOP Exchange as a first step (Option B)

2. Structuring Individual Supplemental Benefit Offerings

Option A: Offer dental and vision coverage only embedded as part of medical Qualified Health Plans	Option B: Offer stand-alone dental plans and medical plans	Option C: Offer a combination of (a) stand-alone dental, vision, and medical plans; and (b) medical plans with embedded dental and vision benefits
Dental and vision coverage is only accessible as part of medical Qualified Health Plans	Standalone dental plans and medical plans that include dental coverage will be considered.	Dental and vision coverage can be accessed either as a stand-alone plan or embedded in a medical Qualified Health Plan

Preliminary Recommendation: Offer stand-alone dental and medical plans that include dental(Option B)

Qualified Health Plans

Comments and Input Welcome

- Comments welcome on Board Recommendation Brief materials
- Please submit comments on the Stakeholder Input form by COB, Monday, August 6
- Send comments to info@hbex.ca.gov
- See the Stakeholder section of the Exchange Website for response form