CALIFORNIA'S PROPOSAL TO WAIVE AFFORDABLE CARE ACT REQUIREMENTS TO EXPAND ACCESS TO UNDOCUMENTED INDIVIDUALS

DRAFT FOR PUBLIC COMMENT

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California's Proposal to Waive Affordable Care Act Requirements to Expand Access to Undocumented Individuals

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I. Executive Summary

California seeks a State Innovation Waiver under Section 1332 of the Affordable Care Act in order to build upon the success of the implementation of health reform in the state. Millions of Californians have benefitted from coverage purchased through the State-based Marketplace, Covered California, as well as through the expansion of Medi-Cal, the state's Medicaid program. However, while residents classified as not lawfully present under the ACA regulations have been able to purchase coverage "off-exchange," they have been unable to purchase coverage through the California Health Benefit Exchange (Covered California). These residents include undocumented immigrants and individuals granted Deferred Action for Childhood Arrivals (DACA). As used in this application, the terms "undocumented immigrants" and "undocumented residents" also refer to DACA recipients. Covered California seeks a State Innovation Waiver to offer new health insurance options, called California Qualified Health Plans (CQHPs), to individuals ineligible to purchase Qualified Health Plans (QHPs) because of their immigration status. CQHPs will be mirror plans to the QHPs currently offered through Covered California, with the same issuers providing the same benefits, cost sharing, and networks, and meeting all of the same requirements as QHPs. Undocumented individuals will not be eligible to receive Advance Payments of Premium Tax Credits (APTCs) or Cost Sharing Reductions (CSRs) and will not be subject to certain immigration-related eligibility requirements.

California's proposal meets all of the Section 1332 State Innovation Waiver parameters:

- **Equivalent or greater scope of coverage:** Covered California's proposal will increase the current scope of coverage in California by allowing undocumented immigrants the opportunity to purchase unsubsidized coverage through the State-based Marketplace.

- **Equivalent or greater affordability of coverage:** Covered California's proposal will not impact affordability of coverage.

- **Equivalent comprehensiveness of coverage:** Covered California's proposal will provide coverage that is as comprehensive as that available in the absence of the waiver.

- **Deficit neutral:** Covered California's proposal will not increase the federal deficit. Federal subsidies will not be offered to consumers under the waiver program, and administrative costs will be paid by Covered California.

- **No impact on federal administrative functions:** Because Covered California is a State-based Marketplace, this proposal will not impact the Federally-facilitated Marketplace or other functions operated by the Centers for Medicare & Medicaid Services or the Department of Treasury.

- **Meaningful public input:** Covered California has conducted an extensive public input process in the development of the waiver proposal and will continue to provide opportunities for public input after submission of its waiver application.

II. Proposed Waiver: Providing Coverage to those Ineligible due to Immigration Status

Enacted State Legislation in Effect

Senate Bill 10 (Lara, Chapter 22, Statutes of 2016) was signed by Governor Edmund G. Brown on June 10, 2016 and went into effect upon signature. Senate Bill 10 was enacted by a two thirds vote of both houses of the California Legislature with bipartisan support. The enacted legislation requires Covered California to apply to the U.S. Department of Health and Human Services for a Section 1332 State Innovation Waiver to allow individuals who are ineligible to purchase health care coverage through Covered California due to immigration status to purchase a non-QHP. The legislation requires Covered California to apply to waive the requirement that health insurance Exchanges only offer Qualified Health Plans (QHPs), as defined in the Affordable Care Act. The legislation also requires that issuers offering QHPs through Covered California concurrently offer a California Qualified Health Plan (CQHP) that mirrors each QHP, for purposes of enrolling the waiver population. In addition, Senate Bill 10 specifically prohibits Covered California from offering any other non-Qualified Health Plan aside from CQHPs.

The requirement for QHP issuers to concurrently offer CQHPs would be effective on January 1, 2018, for coverage effective beginning January 1, 2019. The legislation requires eligible undocumented consumers to pay for the full, unsubsidized cost of coverage in Covered California, and prohibits access to any federal financial assistance for the purchase of CQHPs. The legislation also ensures protections for the privacy of information provided to Covered California for purposes of determining eligibility for the waiver program.

To view the final language of the law authorizing this Section 1332 State Innovation Waiver application, please refer to Appendix A.

Description of the Proposed Waiver Program

This proposed State Innovation Waiver seeks to grant undocumented Californians access to Covered California. Under the waiver, undocumented individuals will have the option of applying for health insurance coverage through Covered California. Coverage will be provided through CQHPs, which will mirror corresponding QHPs. Undocumented individuals who enroll in CQHPs through Covered California will not be eligible to receive financial assistance and will have to pay for the full cost of coverage. Undocumented individuals and their families will be able to file a single application for coverage through Covered California and receive access to health coverage through the applicable state program. Undocumented immigrants often live with family members, frequently their children, who are citizens or legal residents. These households are referred to as “mixed-status families.” Although undocumented immigrants are able to purchase coverage off the exchange, providing a single door for plan shopping and selection would give mixed-status families a level playing field and access to the same streamlined process for accessing health coverage available to other families.

Should this waiver be approved, any issuer offering a QHP through Covered California will be required to offer a mirrored CQHP for each of its QHP offerings. These CQHPs will offer identical benefit packages and utilize identical cost sharing structures, provider networks, and service areas to QHPs. CQHPs will undergo the same annual QHP certification process as QHPs and will be subject to state rate and form filing review. QHP issuers will be required to submit plan data on CQHPs in the same manner currently utilized for QHPs.

Table 1: Comparison of QHP and CQHP Requirements

Covered California QHP Program vs. Proposed CQHP Waiver Program		
Requirement	**QHP Program**	**CQHP Waiver Program**
Shop and Enroll through Covered CA	Yes	Yes
Citizenship/ Immigration Status	California resident ineligible for Medi-Cal and a US Citizen or lawfully present immigrant, as defined in 45 CFR §152.2	California resident ineligible for Medi-Cal and unable to purchase a QHP due to immigration status
Health Coverage Benefits	CA Essential Health Benefits	CA Essential Health Benefits
APTC or CSR	Yes	No
Plan Subject to Annual Certification Process	Yes	Yes
State Rate and Form Filing Review	Yes	Yes
Included in the Single Risk Pool	Yes	Yes

Proposed Provision to be Waived

This waiver application seeks to waive Section 1311(d)(2)(B)(i) of the Affordable Care Act, which prohibits Exchanges from making available any health plan that is not a QHP. Covered California seeks to waive this provision in order to offer mirrored health plans through the Exchange to the target population. The waiver of this provision is necessary due to the requirement that QHPs are only available to Qualified Individuals (Section 1312(a)), a term that can only refer to a "citizen or national of the United States or an alien lawfully present in the United States" as specified in Section 1312(f)(3) of the Affordable Care Act.

Impacted Populations and Demographics

Nearly 50 percent of undocumented immigrants have been in the country for more than a decade, and many of them are homeowners.[i] Undocumented immigrants often live with family members, frequently their children, who are citizens or legal residents. Approximately 13 percent of California's school-aged children (grades K-12) have a parent who is an undocumented immigrant.[ii] And when it comes to children of all ages, over one in six children in California have an undocumented immigrant parent.[iii]

Many California immigrants remain excluded from health coverage programs because of their immigration status. By allowing Covered California to offer CQHPs in addition to QHPs, all members of mixed-status families in the state would be able to browse and select health coverage in the same place at the same time, simplifying their shopping and enrollment experience. This program will also likely increase all family members' appropriate use of health care, particularly children. Research shows that insured children whose parents are also insured are more likely to receive check-ups and other preventive care.[iv]

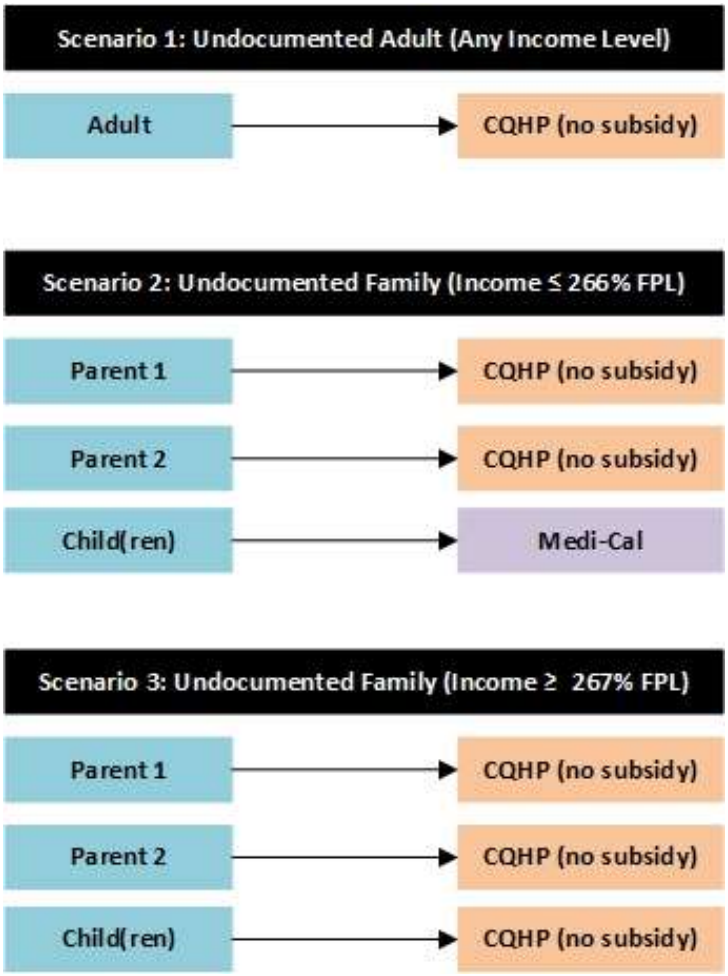
If this waiver request is not granted, the decision will restrict health coverage options for California's undocumented immigrants to purchasing coverage off the exchange. This restriction on purchasing is an unfair barrier for these residents who make a significant contribution to the economy, paying more than $3 billion a year in state and local taxes.[v] The greatest impact will fall on California's mixed-status

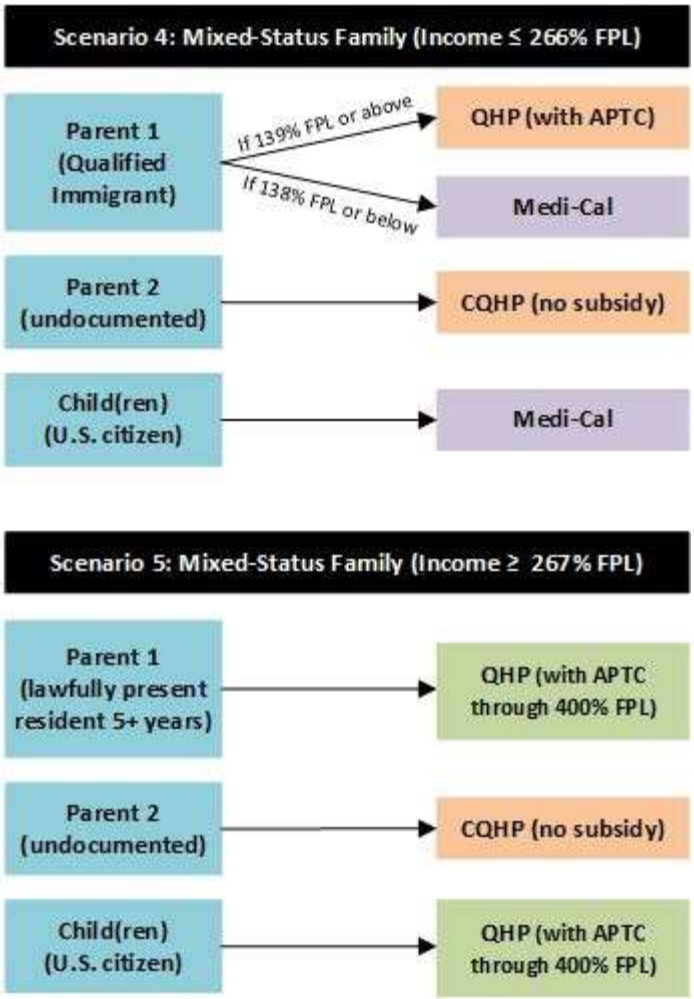
families, in which members of different immigration statuses and citizens all live under one roof. Allowing all family members to choose and purchase coverage through a single point of entry will provide an improved shopping and enrollment experience.

Scenarios Illustrating Eligibility and Plan Selection Process

Figure 1 illustrates the most common enrollment scenarios related to this waiver proposal. These examples are provided to help demonstrate the health coverage options available for undocumented individuals under the waiver program.

Figure. 1. Typical Enrollment Scenarios under the Proposed Waiver





III. Analysis of Proposed Waiver

To inform the development of the financial and economic analyses required for this waiver application, Covered California retained support from independent experts, specifically the UC Berkeley Center for Labor Research and Education, the UCLA Center for Health Policy Research, and Dr. Wesley Yin of the Luskin School of Public Affairs, Department of Public Policy at the University of California, Los Angeles. Their analyses can be found in Appendix B and Appendix C at the end of this document.

Coverage

Coverage Estimates under the Waiver Program

Research conducted by our retained experts estimates a small increase in the number of people who purchase health insurance coverage under the waiver program as compared to in the absence of the waiver. Using administrative data and the California Simulation of Insurance Markets (CalSIM) model version 1.94, they calculate that between zero and 27,000 additional undocumented Californians could enroll in unsubsidized insurance coverage as a result of the proposed waiver. Using their assumptions that result in their best estimate, referred to as “preferred” in Appendix B, the CalSIM team estimates that approximately **17,000 Californians would gain coverage as a result of the waiver**. These people are expected to be uninsured in the absence of the waiver. An increase of 17,000 individuals represents 0.7% of the current (2015) 2.3 million person individual market in California.

Because the proposed waiver does not provide subsidies, the CalSIM team estimates minimal additional enrollment in the individual market. They anticipate that the only detectable change in enrollment would be among the undocumented, concentrated among those with higher-incomes and those in mixed immigration status families who would already be enrolling eligible members of the family in coverage through Covered California. Undocumented Californians can currently purchase coverage without subsidies on the individual market, but they can only do so outside of Covered California.

Furthermore, the CalSIM team does not anticipate any measurable impact on other health coverage as a result of this proposed waiver program. They also do not anticipate any impact on vulnerable groups. Table 2 below provides estimated enrollment impacts with the waiver and without the waiver, and provides an estimate of the difference associated with the implementation of the waiver program.[vi] **Please see Appendix B for a detailed discussion of the estimated impact on enrollment from the proposed waiver program and the methodology used to develop this estimate.**

Table 2: Projected Health Insurance Coverage for Californians under age 65, Millions of people by calendar year

	2019	2020	2021	2022	2023
Without the Waiver					
ESI	17.25	17.46	17.59	17.67	17.80
Medi-Cal	8.58	8.47	8.38	8.27	8.26
Subsidized Individual Market	1.53	1.55	1.57	1.63	1.63
Unsubsidized Individual Market	1.97	1.94	1.95	1.96	1.94
Other Public	1.32	1.32	1.33	1.33	1.34
Uninsured	3.29	3.35	3.41	3.50	3.54
Total	33.95	34.09	34.23	34.37	34.51
With the Waiver					
ESI	17.25	17.46	17.59	17.67	17.80
Medi-Cal	8.58	8.47	8.38	8.27	8.26
Subsidized Individual Market	1.53	1.55	1.57	1.63	1.63
Unsubsidized Individual Market	1.99	1.96	1.97	1.98	1.96
Other Public	1.32	1.32	1.33	1.33	1.34
Uninsured	3.27	3.33	3.39	3.48	3.52
Total	33.95	34.09	34.23	34.37	34.51
Difference					
ESI	0	0	0	0	0
Medi-Cal	0	0	0	0	0
Subsidized Individual Market	0	0	0	0	0
Unsubsidized Individual Market	+0.017	+0.017	+0.017	+0.017	+0.017
Other Public	0	0	0	0	0
Uninsured	-0.017	-0.017	-0.017	-0.017	-0.017
Total	**0**	**0**	**0**	**0**	**0**

Affordability

Affordability of Coverage under the Waiver Program

Our retained experts do not expect a decrease in affordability of coverage under this waiver, either for undocumented Californians who will be purchasing plans through Covered California, or for other residents of the state, including vulnerable groups.

Affordability for the Waiver Population

This waiver program will allow undocumented Californians to purchase coverage through Covered California in CQHPs, which will be identical to QHPs. Undocumented immigrants would have the benefit of purchasing coverage through a health insurance company with which Covered California has selectively contracted. The health insurers contracted with Covered California go beyond just offering the essential health benefits outlined by the Affordable Care Act. Covered California health insurance companies must also meet high standards of quality, affordability, and accountability as they compete in the marketplace. Because all Covered California health insurance companies are required to adhere to Covered California's patient-centered benefit plan designs for each metal tier, they must compete with one another based on premium, network, quality, consumer tools, and service.

In the absence of the waiver program, undocumented Californians are able to purchase health insurance coverage in the individual market outside the Exchange. California state law requires that all QHP issuers offer mirrored plans that are identical to their QHPs outside the Exchange, and the Affordable Care Act requires that the same plan must be offered at the same rate outside the Exchange. As a result of these requirements, it is likely that most undocumented Californians who purchase coverage outside the Exchange are enrolling in products with similar premiums and cost sharing to those offered through Covered California. Additionally, federal subsidies are not available outside the Exchange and will also not be available to undocumented individuals through Covered California under the waiver program. Therefore, there is no expected change in affordability for this population.

Affordability for all California Residents

The experts retained for this analysis do not expect any measurable change in the affordability of health care coverage for state residents under the proposed waiver program, including both premiums and expected out-of-pocket costs. They also do not expect any reduction in the affordability of health care coverage for vulnerable residents, including individuals who are low-income, elderly, or have serious health issues or greater risk of developing serious health issues.

Enrollees in the waiver program will be part of the state's single risk pool, as are the undocumented immigrants who currently buy coverage outside the Exchange. The addition of the individuals who enroll through Covered California to the risk pool is expected to have a negligible, but beneficial, impact on premiums within Covered California and in the outside market and could potentially reduce premiums overall (see Table 3 below). **See Appendix C for a detailed discussion of the estimated impact of these additional enrollees in the individual market on the single risk pool.**

Table 3: Percent Change in Premiums due to Waiver-induced Enrollment

Uptake Scenario	% Change in Premiums
27,000 (upper bound)	-0.02%
17,000 (best estimate)	-0.01%
0 (lower bound)	0%

Estimated Out-of-Pocket Spending for Covered California Enrollees

Covered California utilizes standard patient-centered benefit plan designs with set co-pays and co-insurance for covered benefits. All Covered California enrollees, including undocumented Californians purchasing CQHPs, will be offered the same patient-centered benefit plan designs. CQHPs and QHPs will have identical cost-sharing structures under the waiver program. The example below presents estimated out-of-pocket costs for Covered California enrollees for a particular coverage example, heart disease. There is no expected impact on cost-sharing under Covered California plans as a result of this waiver program. The inclusion of an additional 17,000 unsubsidized individuals in the individual market is not expected to negatively impact the risk profile of the single risk pool.

As an example of expected out-of-pocket spending associated with Covered California health plans, Table 4 below shows potential health costs, by metal tier, for a person who discovers during a preventive care visit that they may be at risk for heart attack or stroke. The scenario includes routine diagnostics and medication, and does not involve an actual heart attack or stroke (which would significantly increase costs).

Table 4: Estimated Out-of-Pocket Costs for Heart Disease (based on 2016 Patient-Centered Plan Designs)[vii]

COST DETAIL FOR HEART DISEASE					
	Average cost — no insurance**	BRONZE covers 60%	SILVER covers 70%	GOLD covers 80%	PLATINUM covers 90%
Out-of-pocket maximum	—	$6,250	$6,250	$6,250	$4,000
Deductible: Medical/Brand Rx	—	$5,000	$2,000 / $250	—	—
Month 1 preventive care visit	$180	$0	$0	$0	$0
Month 2 specialty care visit	$281	$281 counts towards deductible	$65	$50	$40
Month 3 surgery or procedure	$8,831	$5,953 deductible met plus 30% coinsurance	$1,766 20% coinsurance	$600	$250
Generic Rx $213 per month for 10 months	$2,130	$16 out-of-pocket maximum reached	$150	$150	$50
Your total cost (not including premiums)	$11,422	$6,250	$1,981	$800	$340

The patient-centered benefit plan designs offered through Covered California adhere to the Bronze, Silver, Gold, and Platinum actuarial values, as well as the required deductible and out-of-pocket limits set forth by CMS. Therefore, there is no expectation for there to be any reduction in the number of individuals with coverage that provides a minimal level of protection against excessive cost sharing as a result of this waiver program.

Impact on Employer Contributions to Health Coverage or in Wages

Covered California does not expect any impact on employer contributions to health coverage or wages as a result of this waiver program.

Comprehensiveness

There will be no change to the comprehensiveness of coverage provided under the waiver program as compared to the coverage provided in the absence of the waiver. California's proposed waiver will have no impact on the comprehensiveness of coverage otherwise available to its residents under the Affordable Care Act and current state requirements. QHPs, as required by the Affordable Care Act, offer the prescribed essential health benefits (EHBs). Covered California further requires QHPs, and under the waiver CQHPs, to offer plans that adhere to the patient-centered benefit plan designs. The patient-centered benefit plan designs specify acceptable cost sharing amounts for covered benefits. **Please see Appendix D for the 2017 Patient-Centered Benefit Plan Design for Covered California.**

California utilizes the Kaiser Foundation Health Plan Small Group HMO shown below as the EHB benchmark and the basis for the development of the patient-centered benefit package.

Table 5: California EHB Benchmark Plan

Plan Type	Plan from largest small group product, Health Maintenance Organization
Issuer Name	Kaiser Foundation Health Plan, Inc.
Product Name	Small Group HMO
Plan Name	Kaiser Foundation Health Plan Small Group HMO 30 ID 40513CA035
Supplemented Categories	• Pediatric Oral (State CHIP) • Pediatric Vision (FEDVIP)

The benefits that are required to be offered through Covered California will remain the same under the waiver program. Therefore, the waiver will not decrease the number of residents with coverage at least as comprehensive as the current EHB (in total and within each EHB category) and it will in no way decrease the comprehensiveness of coverage for vulnerable groups, including low-income, elderly, or those with or at risk of serious health issues. There will be no impact on the comprehensiveness of coverage that is available to all California residents in the commercial market nor through Medi-Cal, the state's Medicaid and CHIP program. Lastly, there will be no impact on the comprehensiveness of coverage throughout the five years of the waiver.

Deficit Neutrality

The analysis conducted by our retained independent experts indicates that there will be no increased cost to the federal government as a result of this waiver program. The sections below discuss that there is no expected budgetary impact on federal APTCs and cost-sharing reductions, or other federal programs.

Advance Payments of Premium Tax Credits (APTCs)

The population that will be able to purchase coverage through Covered California under this waiver program will not be eligible for APTCs or CSRs. Therefore, there will be no federal spending on APTCs or CSRs for this population.

According to analyses conducted to support this waiver application, there is no expected increase in the cost of APTCs for individuals who are eligible to receive financial assistance through Covered California because the inclusion of the target population under this waiver is not expected to increase premiums for other Covered California enrollees. Under the best estimate—adding 17,000 undocumented individuals to California's single risk pool—our retained experts anticipate a modest *decrease* in

premiums for the individual market as a result of this waiver (see Table 3). Average spending risk of immigrants is estimated to be 35 percent lower than natives[viii], due largely to language and assimilation barriers.[ix] Our experts would only expect to see increases in premiums if the average spending among the newly enrolled population far exceeded spending observed for the sickest risk pools, e.g. the federal Pre-existing Condition Insurance Plans (PCIP), which is an extremely unlikely scenario. Therefore, the analysis concludes that there is no reason to expect premiums to increase as a result of this population's addition to the individual market through Covered California.

For a detailed analysis of the impact on the single risk pool, please see the attached analysis in Appendix C.

Given the small number of additional people in the individual market that are estimated to enroll in Covered California as a result of this waiver program (17,000), our independent experts do not expect a measurable increase in the enrollment of individuals who are eligible for APTCs or CSRs. Considerable outreach and enrollment has been conducted to reach this population throughout the operation of Covered California, and California has already taken numerous steps to enroll eligible families in both Covered California and Medi-Cal (**see Appendix F**). Therefore, it is anticipated that the only measurable increase in enrollment will be among the undocumented population who are not eligible for financial assistance under this waiver program.

Impact on Other Federal Programs

Similarly, according to the analyses carried out by our independent experts, there is no expected measurable impact on federal spending on other federal programs as a result of the waiver program. Covered California has made significant effort and investment in outreach to Latino, Asian Pacific Islander, and African-American Communities. In addition, the state is currently conducting extensive outreach to families with undocumented children to enroll them in the new Medi-Cal expansion for this population as well as to mixed status families to encourage them to enroll in Covered California and Medi-Cal each year. Additionally, the US Department of Health and Human Services has recently funded an extensive outreach effort for families in California similar to the waiver's target population through the Connecting Kids to Coverage Initiative.[x] Given the small number of additional undocumented individuals expected to enroll as a result of this program (approximately 17,000), any impact on other enrollment as a result of this waiver program will be negligible and cannot be isolated to this single policy change.

There is not expected to be any impact on federal tax revenues as a result of this waiver program.

10 Year Budget Plan

Because there is no measurable impact on the federal deficit as a result of this waiver program, a 10-year budget plan is not provided.

IV. Actuarial Certification

Please refer to **Appendix E** for the actuarial certification of the analyses included in this application.

V. Federal Pass Through Funding

There is no pass through funding requested under this waiver program.

VI. Implementation Timeline

The proposed implementation timeline for this State Innovation Waiver program is presented in Table 6 below.

Table 6: Proposed Implementation Timeline - Dates Subject to Change

QHP/CQHP Rate Calendar	**Date**
QHP/CQHP Application for Individual Marketplace Released	February 2018
2019 QHP/CQHP Application for Individual Marketplace Responses Due	May 2018
Covered California & QHP/CQHP Rate Negotiations	June 2018
2019 QHP/CQHP Preliminary Rate Announcement	July 2018
2019 Rate Announcement	October 2018
Open Enrollment	November 2018 – January 2019
Go-Live	January 1, 2019
System Changes	
Begin Implementation Planning	April 2017
Draft New Business Rules	May 2017 – September 2017
Begin Joint Application Design Phase	September 2017
New Functionality Implemented	June 2018

VII. Additional Information

Administrative Burden

Covered California anticipates varying effects on administrative burden for individuals, insurers, and employers, as outlined below.

Anticipated Impact on Administrative Burden for Individuals

Under the proposed waiver program, undocumented individuals will have a choice of whether to purchase coverage through Covered California or the outside market. Undocumented individuals are likely to experience increased administrative efficiency if purchasing a CQHP. It is more convenient for this population to be able to apply for coverage under the waiver program because they will be taking advantage of California's "no wrong door" approach to applying for health coverage in state programs. Undocumented individuals will be able to complete one application for coverage under the waiver

program, rather than having to apply separately for individual market coverage outside of Covered California in the absence of the waiver program.

Additionally, undocumented individuals with family members who would be eligible to enroll in QHPs may experience more convenience by being able to enroll in health plans offered by the same QHP issuer as other members of the family, which will allow them to access the same family doctor and to have one premium payment process.

Anticipated Impact on Administrative Burden for Insurers

Covered California anticipates a manageable increase in administrative burden for health insurers in the state who offer QHPs through Covered California. Under the waiver program, insurers will be required to provide mirrored plans, or CQHPs, through Covered California, which will require the submission of additional plan information. These CQHPs will be subject to the state's rate and form filing process and will need to be approved during the annual certification process. However, because they are mirrored plans, Covered California does not anticipate duplicate review and will streamline this process as much as possible. Health plan IT systems and other back-end processes will also need to be altered to accommodate the addition of CQHPs as separate plans for certain administrative functions. Health insurance issuers will also be required to prepare 1095-B forms for these individuals.

Anticipated Impact on Administrative Burden for Employers

Covered California does not anticipate any impact on the administrative burden for employers as a result of providing access to Covered California for undocumented individuals.

Effect on other Provisions of the Affordable Care Act

Covered California does not expect any effect on other provisions of the Affordable Care Act as a result of this waiver. Covered California will continue operating as it does today and will continue to provide coverage through QHPs to eligible individuals and families. We do not expect any impact on the market reforms set forth in Part I of the ACA or on the Medicaid or other reforms that are included in the Affordable Care Act. Additionally, this waiver proposal is not requesting to waive any of the market reforms in the Affordable Care Act or the Public Health Services Act. Covered California anticipates that all health insurance issuers will be in compliance with the market reforms in the Affordable Care Act and the Public Health Services Act.

Residents Accessing Services out of State

The proposed waiver program does not have any impact on the ability of California residents to access health care services outside of the state. The proposed waiver will not impact provider networks. The networks offered through CQHPs will be identical to those currently offered through each corresponding QHP.

Information for the Federal Government

The federal government will not administer any portion of the proposed waiver program. Covered California will determine eligibility for the program. Covered California is entirely a State-based Marketplace and does not utilize federal services to operate its Exchange outside of the eligibility verification process, which will not be utilized for this additional population. This waiver program will be fully administered by Covered California with no impact to the federal government.

Fraud, Waste, and Abuse

This proposed waiver program would allow undocumented immigrants in this state to purchase unsubsidized health insurance through Covered California. Because the waiver will not create additional

pathways for individuals to obtain financial assistance (i.e. APTCs or CSRs), Covered California believes that the proposed waiver will be absent of any foreseeable waste, fraud, or abuse of this kind. Divisions of Covered California and various agencies throughout this state have been established with the intent to detect and combat waste, fraud, and abuse in the marketplace. Covered California will monitor 1332 Waiver enrollees, where allowable, through existing controls established through its Program Integrity Division, Internal Audit Services, and Office of Consumer Protection along with California's Office of the Attorney General, California's Department of Insurance, and California's Department of Managed Health Care.

VIII. Reporting Targets

Covered California will submit quarterly reports that will notify HHS of any ongoing operational challenges and plans for resolving them. Covered California will also submit annual reports to HHS that will include information on the progress of the waiver and data on compliance with the guardrails in Section 1332. California will continue to meet current reporting requirements as well.

IX. Evidence of Compliance with Notice and Comment Requirements

Summary of Public Input Informing Waiver Application

Senate Bill 10, the legislation requiring this waiver application, was authored by State Senator Ricardo Lara, who also authored the measure to extend state-funded Medi-Cal to undocumented children. Senator Lara's office worked closely with stakeholders in the development and eventual passage of the legislation, including California Immigrant Policy Collaborative, Health Access California, the California Labor Federation, National Health Law Program, PICO, United Ways of California, and Western Center on Law and Poverty as well as health insurers, including Blue Shield of California and Kaiser Permanente.

Prior to pursuing the development of the State Innovation Waiver application, Covered California received input on potential Section 1332 waiver proposals throughout the first quarter of 2016. Public input included:

- Public webinar on the structure and guidelines for the waiver (January 26, 2016).
- Open forum that included California Department of Health Care Services leadership and two Covered California Board members to hear from health care experts and members of the public about potential waiver proposals (February 23, 2016).[xi]
- Open process for receiving comments and suggestions; Covered California received a total of 12 comment letters from a range of groups including consumer advocates and trade associations.[xii]

Expert testimony provided at the February 23, 2016 public forum on the issue of allowing undocumented immigrants to purchase coverage through Covered California included:

- Testimony indicating that by offering non-QHPs for undocumented Californians, all members of mixed immigration status families would be able to apply for coverage directly through Covered California, thus simplifying their health insurance shopping and enrollment experience.

- Testimony from the Children's Coalition that one in six children in California have at least one parent who is an undocumented immigrant and 81% of these children are citizens. Even if different family members qualified for different subsidy levels or some family members did not qualify for subsidies at all, a one-stop shop approach would go a long way to reducing barriers to enrollment by providing a single point of entry for all family members.

- Testimony from the California Pan-Ethnic Health Network that allowing undocumented immigrants to purchase coverage in Covered California will help to dispel immigration enforcement myths.

In addition to the February forum, the Section 1332 waiver proposal was an agenda item at each of the Covered California board meetings in January, April, and June of 2016. Public comments on potential waiver proposals were welcomed at each meeting.

Posting of 508 Compliant Application Online

This application is posted online in a 508 compliant format.

30 Day Notice and Comment Period on Draft Application

The posting of this draft application will commence a 30 day notice and comment period.

Tribal Consultation Process

Covered California will hold a webinar on August 8, 2016 to introduce our Tribal community to the proposed Section 1332 waiver program.

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[iii] Capps, R., M. Fix, and J. Zong. (2016). "A profile of US children with unauthorized immigrant parents." *Migration Policy Institute*.

[iv] Center on Budget and Policy Priorities and the Georgetown University Center for Children and Families. 2013. "Expanding Coverage for Parents Helps Children."

[v] Gardner, M., Johnson, S., & Wiehe, M. (2016). Undocumented Immigrants' State & Local Tax Contributions. *Washington, DC: The Institute on Taxation & Economic Policy (ITEP)*. Available online: http://itep.org/itep_reports/2016/02/undocumented-immigrants-state-local-tax-contributions-1.php#.V4T60pMrJE6

[vi] CalSIM is based on survey data, which tend to underestimate Medi-Cal enrollment and overestimate Individual Market coverage when compared to administrative data. For this reason our projections for Medi-Cal may be too low and Unsubsidized Individual Market coverage may be too high.

[vii] Based on the 2016 standardized benefit package. Available online here: http://www.pinnacletpa.com/sites/pinnacletpa.com/files/heartdisease-example.pdf

[viii] Stimpson, J. P., Wilson, F. A., & Eschbach, K. (2010). Trends in health care spending for immigrants in the United States. Health Affairs, 29(3), 544-550

[ix] Derose, K. P., Escarce, J. J., & Lurie, N. (2007). Immigrants and health care: Sources of vulnerability. Health Affairs, 26(5), 1258-1268. doi:10.1377/hlthaff.26.5.1258

[x] For information on California awardees, please see: https://www.insurekidsnow.gov/downloads/initiatives/grantssummary-2016.pdf

[xi] Meeting materials provided here: http://hbex.coveredca.com/stakeholders/Covered%20California%201332%20Waiver/February%2023,%202016%201332%20State%20Innovation%20Waiver%20Public%20Meeting/index.shtml

[xii] Comments received can be viewed here: http://hbex.coveredca.com/stakeholders/Covered%20California%201332%20Waiver/February%2023,%202016%201332%20State%20Innovation%20Waiver%20Public%20Meeting/index.shtml

Appendix A: SB 10

Senate Bill No. 10

CHAPTER 22

An act to add Section 100522 to the Government Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor June 10, 2016. Filed with Secretary of State June 10, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 10, Lara. Health care coverage: immigration status.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, and meets certain other requirements. PPACA specifies that an individual who is not a citizen or national of the United States or an alien lawfully present in the United States shall not be treated as a qualified individual and may not be covered under a qualified health plan offered through an exchange. Existing law creates the California Health Benefit Exchange (the Exchange) for the purpose of facilitating the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA.

This bill would require the Exchange to apply to the United States Department of Health and Human Services for a waiver to allow individuals who are not eligible to obtain health coverage through the Exchange because of their immigration status to obtain coverage from the Exchange. The bill would require the Exchange, after that waiver has been granted, to require an issuer that offers a qualified health plan in the individual market through the Exchange to concurrently offer a California qualified health benefit plan, as specified, to these individuals. The requirement to offer California qualified health plans would become operative on January 1, 2018, for coverage effective for California qualified health plans beginning January 1, 2019, as specified. The bill would require that individuals eligible to purchase California qualified health plans pay the cost of coverage without federal assistance and meet other specified requirements. The bill would require that information provided by an applicant for coverage under the bill be used only for the purposes of, and to the extent necessary for, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through the Exchange, and would prohibit that information from being disclosed to any other person except as provided by the bill.

This bill would declare that it is to take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

SECTION 1. Section 100522 is added to the Government Code, to read:

100522. (a) (1) The Exchange shall apply to the United States Department of Health and Human Services for a waiver authorized under Section 1332 of the federal act as defined in subdivision (e) of Section 100501 in order to allow persons otherwise not able to obtain coverage by reason of immigration status through the Exchange to obtain coverage from the Exchange by waiving the requirement that the Exchange offer only qualified health plans solely for the purpose of offering coverage to persons otherwise not able to obtain coverage by reason of immigration status.

(2) The waiver of the requirement that the Exchange offer only qualified health plans as described in paragraph (1) shall be limited to requiring the Exchange to offer California qualified health plans consistent with this section only and shall not be construed to authorize the Exchange to offer any other nonqualified health plan.

(b) The Exchange shall require an issuer that offers a qualified health plan in the individual market through the Exchange to concurrently offer a California qualified health plan that meets all of the following criteria:

(1) Is subject to the requirements of this title, including all of those requirements applicable to qualified health plans.

(2) Is subject to the requirements of subdivisions (a), (b), and (d) of Section 1366.6 of the Health and Safety Code and subdivisions (a), (b), and (d) of Section 10112.3 of the Insurance Code in the same manner as qualified health plans.

(3) Is identical to the corresponding qualified health plan, except for the eligibility requirements set forth in subdivision (c).

(c) Persons eligible to purchase California qualified health plans shall pay the cost of coverage and shall not:

(1) Be eligible to receive federal advanced premium tax credit, federal cost-sharing reduction, or any other federal assistance for the payment of premiums or cost sharing for a California qualified health plan.

(2) Otherwise be eligible for enrollment in a qualified health plan offered through the Exchange by reason of immigration status.

(d) An applicant for coverage under this section shall be required to provide only the information strictly necessary to authenticate identity and determine eligibility under this section. Any person who receives information provided by an applicant under this section, whether directly or by another person at the request of the applicant, or receives information from any agency, shall use the information only for the purposes of, and to the extent necessary for, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through the Exchange. That information shall not be disclosed to any other person except as provided in this section.

(e) Subdivisions (b) to (d), inclusive, shall become operative on January 1, 2018, for coverage effective for California qualified health plans beginning

January 1, 2019, contingent upon federal approval of the waiver pursuant to subdivision (a).

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to request federal approval of the waiver to expand access to health care coverage in California as quickly as possible, it is necessary that this act go into immediate effect.

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Appendix B: UCB Center for Labor Research

UCLA CENTER FOR HEALTH POLICY RESEARCH
UC BERKELEY LABOR CENTER

Memorandum

Re: **California's proposed §1332 State Innovation Waiver would result in marginal increase in health insurance enrollment in the individual market**

To: **John Bertko**, Chief Actuary, California Health Benefit Exchange

From: **Miranda Dietz** and **Ken Jacobs**, UC Berkeley Center for Labor Research and Education,
Dylan Roby, University of Maryland School of Public Health & UCLA Center for Health Policy Research,
Gerald Kominski, UCLA Center for Health Policy Research & UCLA Fielding School of Public Health

Date: **July 6, 2016**

Summary

Using administrative data and the California Simulation of Insurance Markets (CalSIM) model version 1.94 we estimate that between zero and 27,000 additional undocumented Californians could enroll in unsubsidized insurance coverage as a result of the proposed waiver. Based on our preferred set of assumptions, approximately **17,000 Californians will gain coverage as a result of the waiver**. These people are expected to be uninsured in the absence of the waiver. No other changes to insurance coverage are anticipated. An increase of 17,000 represents 0.7% of the current (2015) 2.3 million person individual market in California.

Because the proposed waiver does not change financial incentives via new tax penalties or subsidies, we estimate very little additional enrollment in the individual market. We anticipate that the only detectable change in enrollment would be among the undocumented, concentrated among those with higher-incomes and those in mixed immigration status families who would already be enrolling eligible members of the family in coverage through Covered California. Currently undocumented Californians can already purchase coverage without subsidies on the individual market, but they can only do so outside of Covered California. By opening Covered California to undocumented members of the family, the entire family could enroll on the same application at the same time through the same portal. The increased convenience makes it somewhat more likely that undocumented family members will sign-up for coverage than under the current policy environment.

No measurable change in subsidized enrollees

We estimate that there will be no measurable change in enrollment among subsidy eligible individuals as a result of the proposed waiver. Given that the financial incentives do not change for families under the waiver, the waiver should not lead to any measurable change in enrollment among those eligible for subsidies. Even considering some small "welcome mat" effect for citizen and lawfully present members of mixed status families, it is those with higher incomes who are most likely to be affected since they are

the most likely to have the funds to pay for insurance. These higher income families are the least likely to actually receive premium tax subsidies, not only because the expected contribution increases with FPL, but also because mixed status families are less likely to receive subsidies because the cost of covering the undocumented family member is excluded from the cost of coverage while the undocumented family members' income is included in determining total household income for purposes of calculating the subsidy eligibility.[1] We therefore assume that any welcome mat effect on subsidized enrollment is too small to detect, and instead focus solely on the effect among undocumented, otherwise uninsured Californians.

Small increase in individual market enrollment among undocumented Californians

To understand the potential effect on the undocumented in California we use two data sources:

1. Estimates of the undocumented population predicted to enroll in coverage through the individual market and their associated demographics from the California Simulation of Insurance Markets (CalSIM) microsimulation model,[2] adjusted to the latest administrative data (2015) on the individual market and updated to reflect the planned phase in of the recently passed California minimum wage law.[3]
2. Administrative data from Covered California estimating the number of undocumented family members already attached to a submitted application in CalHEERS.

1. Estimates using CalSIM:

To estimate the change in enrollment under the waiver, we make two adjustments to the CalSIM 1.94 base scenario. First, we adjust the CalSIM 1.94 base scenario to match administrative data on enrollment in the non-group unsubsidized market in the state. After making this adjustment, we estimate that of the 1.59 million undocumented Californians under the age of 65 who are not enrolled in employer sponsored insurance and not eligible for full-scope Medi-Cal, 153,000 would take up coverage in the non-group market if they purchased coverage at the same rate as similarly situated lawfully present immigrants and citizens.[4]

Analysis using the California Health Interview Survey (CHIS) 2011-12 indicates that, controlling for various demographic characteristics, undocumented non-elderly adults with incomes at or above 138% FPL reported taking up individual market coverage at a fraction (65%) of the rate of similarly situated lawfully present immigrants and citizens.[5] This 'dampening factor' was not incorporated into CalSIM 1.94 estimates, but is incorporated here to better estimate the enrollment of the undocumented population.[6] Applied to the 153,000 from above, the estimate drops by 54,000 to 99,000 undocumented Californians expected to enroll in the individual market by 2019 in the absence of a 1332 waiver.[7]

Table 1. Revisions to CalSIM 1.94: Estimates of enrollment in the individual market among undocumented Californians.

Adjusted enrollment CalSIM 1.94 estimate Base 2019	Reduction in enrollment estimate due to dampening factor for undocumented immigrants	Projected enrollment absent a 1332 waiver and incorporating dampening factor for undocumented immigrants
153,000	- 54,000	99,000

If the effect of the waiver were to completely eliminate any dampening effect of being undocumented, the highest possible number of additional enrollees we could expect to enroll as a result of the 1332 waiver is 54,000. It is more realistic to consider that a waiver could reduce some, but not all, of the difference in take-up rates for the undocumented. The effect should be stronger for those with higher incomes who are better able to pay for coverage. Those most likely to be aware of the change are those whose family members are already eligible for coverage and so may be using the Covered California application to enroll members in coverage.[8]

To estimate the impact of the waiver on this group of 54,000, we use CalSIM 1.94 to divide the population by income (<138% FPL, 139-266% FPL, and 267+% FPL) and family type (single adults, adults in couples, and families with children age 18 or under). Table 2 shows the distribution by income and family type of the 54,000 who we estimate did not enroll due to the dampening factor. For each group we include a high and low estimate of the share that could be expected to enroll in coverage as a result of the waiver.[9] Using these estimates we calculate a likely range of 7,000 to 27,000 additional enrollees. **Our preferred assumptions result in a point estimate that falls at the midpoint of the range, at 17,000**.

Table 2. Estimate of additional undocumented enrollees in the individual market due to proposed waiver

	Estimated number not enrolling due to dampening factor for undocumented immigrants	Share additionally enrolling due to waiver		Number additionally enrolling due to waiver		
<=138% FPL, age 19-64		low	high	low	mid	high
single	3,000	0%	5%	0	80	200
couple	300	0%	10%	0	20	30
families w kids	5,000	0%	15%	0	400	800
139% FPL to 266% FPL, age 19-64						
single	10,000	10%	25%	1,000	1,700	2,400
couple	3,000	10%	50%	300	900	1,400
families w kids	10,000	10%	75%	1,000	4,200	7,400
267+% FPL, age 0-64						
single	7,000	10%	25%	700	1,200	1,800
couple	5,000	25%	50%	1,100	1,700	2,300
families w kids	11,000	25%	100%	2,700	6,800	10,900
Total	54,000			7,000	**17,000**	27,000

Note: Columns may not sum due to rounding

2. Estimates using Covered California administrative data:

Mixed immigration status families are already using Covered California to apply for coverage for their eligible family members. The most recent Covered California administrative data from CalHEERS shows that for 2016 there were 37,000 people linked to an application but not applying for coverage for themselves who had no Social Security number (SSN) because the person "does not qualify for a SSN." There were 13,000 who had no SSN but had an ITIN or ATIN available. There were another 32,000 people similarly linked to an application but not applying for coverage for themselves, for whom there is no data on why that person did not have a SSN. Depending on whether we assume these additional

32,000 are missing a SSN because they are undocumented or for some other reason, we estimate 50,000 to 82,000 potentially undocumented family members were already attached to a submitted application in CalHEERS.

Total enrollment is expected to increase by 2019, from 2% under the Covered California Economic Analysis & Sustainability Office's "low" scenario to as much as 23% under the "high" enrollment projection.[10] Applying these growth rates to the number of potentially undocumented family members already part of a Covered California application results in an estimate of 51,000 to 101,000 undocumented family members who would be part of Covered California applications in 2019.

Some of these undocumented family members are no doubt already purchasing coverage outside of the exchange through insurance brokers or via direct purchase from insurance carriers. As a result of the waiver, these existing undocumented enrollees may choose to enroll through Covered California. However, the relevant question is: how many people will enroll in coverage who would not otherwise have done so outside of Covered California? At a minimum, we might expect that some small share, perhaps 10%, of these family members might be likely to purchase coverage that they would not otherwise have bought if they were not able to do so as part of the same application to Covered California.[11] Depending on the number of people who are indeed undocumented family members, and the growth in Covered California's enrollment 2016 to 2019, these assumptions would result in a total of **5,000 to 10,000** additional enrollees as a result of the waiver.

We believe this is a low-end estimate for the following reasons:

- Some undocumented people in mixed status families with family members receiving coverage are not represented in this estimate because they did not apply for coverage through Covered California. This includes those whose children qualify for Medi-Cal who apply though a county office or other channel.
- Other undocumented Californians who are not part of mixed status families are not accounted for in this estimate but some small share may still be affected by the waiver (for example, by hearing about the ability to sign up from friends or other relatives who have done so) and would newly sign up.

Our estimate from administrative data is consistent with the lower bound of our estimate based on CalSIM 1.94; therefore, our preferred estimate continues to be the 17,000 based on CalSIM.

Resulting change in overall insurance coverage for Californians

No other changes in insurance status are expected as a result of the 1332 waiver. Table 3 below summarizes enrollment projections based on adjusted CalSIM 1.94 and the changes due to the waiver estimated above.

Table 3. Projected health insurance coverage for Californians under age 65, Millions of people by calendar year

	2019	2020	2021	2022	2023
Without the Waiver					
ESI	17.25	17.46	17.59	17.67	17.80
MediCal	8.58	8.47	8.38	8.27	8.26
Subsidized Individual Market	1.53	1.55	1.57	1.63	1.63
Unsubsidized Individual Market	1.97	1.94	1.95	1.96	1.94
Other Public	1.32	1.32	1.33	1.33	1.34
Uninsured	3.29	3.35	3.41	3.50	3.54
Total	33.95	34.09	34.23	34.37	34.51
With the Waiver					
	17.25	17.46	17.59	17.67	17.80
MediCal	8.58	8.47	8.38	8.27	8.26
	1.53	1.55	1.57	1.63	1.63
Unsubsidized Individual Market	1.99	1.96	1.97	1.98	1.96
	1.32	1.32	1.33	1.33	1.34
Uninsured	3.27	3.33	3.39	3.48	3.52
	33.95	34.09	34.23	34.37	34.51
Difference					
ESI	0	0	0	0	0
MediCal	0	0	0	0	0
Subsidized Individual Market	0	0	0	0	0
Unsubsidized Individual Market	+0.017	+0.017	+0.017	+0.017	+0.017
Other Public	0	0	0	0	0
Uninsured	-0.017	-0.017	-0.017	-0.017	-0.017
Total	0	0	0	0	0

Notes: columns may not sum due to rounding

CalSIM is based on survey data, which tend to underestimate Medi-Cal enrollment and overestimate Individual Market coverage when compared to administrative data.[12] For this reason our projections for Medi-Cal may be too low and Unsubsidized Individual Market coverage may be too high.

Appendix: Estimated demographics of newly enrolling population

Our assumption that those likely to enroll are concentrated at the higher end of the income spectrum is reflected in the income breakdown of the estimated 17,000 enrollees using our preferred assumptions.[13]

Table A1. Distribution of income of those estimated to additionally enroll because of the proposed waiver, midpoint estimate

Income Category	Share of Total
<=138% FPL	3%
139% FPL to 266% FPL	40%
267+% FPL	57%
Grand Total	100%

Using CalSIM 1.94 we can look at the demographics of those estimated to enroll in individual market coverage (unadjusted for administrative data or the undocumented dampening factor).

Table A2. Demographics of CalSIM 1.94 base scenario undocumented enrollees in the individual market without subsidies in 2019, unadjusted

AGE	
0--18	6%
19--29	22%
30--44	39%
45--64	33%
RACE / ETHNICITY	
Latino	81%
Asian / Pacific Islander	14%
Black	1%
White	3%
Multi Racial, Other non-Latino	1%
Total	100%

Endnotes

[1] For example, a family with one undocumented parent, one citizen parent, and two citizen children with 300% FPL would be expected to pay 9.66% of family income to cover the three eligible members—one parent and two children. The cost of covering those three family members is much more likely to fall under the 9.66% of income cap, and thus make their subsidies $0, than if all four members of the family were eligible for subsidies and the cost to cover the other adult were also included.

[2] For more on the methodology of the CalSIM model, see the version 1.8 methodology document, and the version 1.9 methodological update.

[3] The bill increases minimum wage annually, from the current $10 per hour in 2016 up to $15 per hour by 2022 for employers of 26 or more. The scheduled increases are delayed by one year for smaller employers.

Appendix C: UCLA Deficit Neutrality Memo

UNIVERSITY OF CALIFORNIA, LOS ANGELES **UCLA**

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July 7, 2016

INFORMATION MEMORANDUM

TO: John Bertko and Dennis Meyers, Covered California

FROM: Wesley Yin, UCLA and NBER

SUBJECT: Projected Premium and Budget Impact of Increased Enrollment in the CA Individual Market due to the Section 1332 Waiver

Summary
This memo reports projected premium and budgetary impacts of the Section 1332 waiver. Projections take several key parameters as inputs: total size of the combined mirrored and QHP risk pools; the enrollment increase among undocumented individuals induced by the waiver; average load prices in the market; and estimated spending risk among the new enrollees, accounting for potential adverse selection.

Assuming a marginal increase in enrollment by undocumented individuals of 17,000—the CalSIM point estimate for uptake rates—we estimate that the waiver would cause premiums to decrease 0.01 percent (based on preferred estimates of adverse selection and differential health spending among immigrants). Under upper bound estimates for adverse selection and immigrant claims costs, an uptake of 17,000 is projected to raise premiums by 0.27 percent. Non-negligible increases in premiums (e.g. above one percent) could only be generated if uptake exceeded upper bound projections, and the average spending among the newly enrolled far exceeded spending observed for the sickest risk pools, e.g. the federal pre-existing conditions insurance plans (PCIP).

In summary, we project that the Section 1332 waiver to have a negligible impact on premiums and subsidy spending, with our preferred specifications projecting negligible *declines* in premiums and federal subsidy outlays.

Key Parameters
Total size of the risk pool: ~1.5 million individuals in Covered CA's individual market, plus ~1 million in the off-exchange individual market, for a total of ~2.5 million individuals.

Number of marginal (undocumented) enrollees: number of undocumented individuals who take-up as a result of the 1332 waiver is estimated to range from 0-27,000, as projected by the CalSIM model (henceforth "marginal enrollees"), with a point estimate of 17,000, based on preferred CalSIM specifications.

Spending risk of marginal enrollees: Spending risk is comprised of two factors, which taken together provide an estimate of the average spending among the marginal enrollees:

1. *Average spending risk of immigrants* is estimated to be 35 percent lower than natives (Stimpson, Wilson & Eschbach, 2010), due largely to language and assimilation barriers (Derose, Escarce & Lurie, 2007; Gorospe, 2006). Similarly, while 20 percent of adult U.S. citizens reported going to the emergency room, only 13 percent of adult documented and non-documented immigrants reported going to the emergency room (Kaiser 2008), again a 35% lower utilization. An upper bound estimate for spending risk among immigrants would be parity with non-immigrants (a reduction factor of 0 percent).

2. *Adverse selection* among marginal enrollees is possible, given that enrollment among the undocumented is voluntary. Estimates of spending in the presence of adverse selection come from other voluntary individual markets. The COBRA market makes for a close comparator to the mirrored market, given that both are unsubsidized, markets to working ages, and potentially draws voluntary enrollment among those with the highest demand for health insurance. Average spending in COBRA is approximately 150% of the spending in its originating group market. Note that the American Community Survey reports that over 100,000 undocumented individuals have already taken up individual coverage in California (Pastor 2016).[1] These individuals likely have relatively high spending among the undocumented, suggesting that adversely selected undocumented individuals are already in the Single Risk Pool. Thus, while we use 1.50x as our estimate for spending due to adverse selection among the marginal enrollees, we view it as an overestimate.

We apply the adverse selection inflation factors to the immigrant spending reduction factor to get claims cost projections for the marginal enrollees. As a lower bound, we apply the 35 percent immigrant spending reduction to the (lowest projected) adverse selection spending ratio of 1.00, to get a final claims cost ratio (relative to the current Single Risk Pool) of 65 percent (=1.00 x [1-0.35]). As an upper bound estimate, we apply the smallest immigrant spending reduction (zero percent) to the upper bound adverse selection spending ratio of 1.50x, to get a final claims cost ratio of 150 percent (=1.50 x [1-0]). Our preferred estimate is 97.5% (=1.50 x [1-0.35] x 100%). As mentioned above, even this is likely to overestimate spending, due to the most adversely selection undocumented likely having already taken up individual insurance prior to the waiver.

Average premiums, administrative costs and profits: on average, total claims comprise 80 percent of premiums in California's individual market; the remaining 20 percent goes to administrative costs and profits. The average monthly unsubsidized premium in 2016 was $470, implying average claims of $375, and administrative costs and profit of $95.

Projections

Average monthly claims among newly insured undocumented individuals is projected to be $245 (=$375 x 0.65) to $563 (=$375 x 1.50), with a preferred estimate of $365 (=$375 x 0.975). As a reminder, the three estimates correspond to the low, preferred and high estimates of adverse selection and relative immigrant spending scenarios, described above. Table 1 below reports average claims and premiums (PMPM), under the three adverse selection and claim cost scenarios. In Panel A, we assume an uptake of 27,000—the largest uptake projected by CalSIM. These marginal enrollees would alter the average claims of the Single Risk Pool, which under this projected uptake, would number 2,527000.

Panel B reports changes in monthly premiums under the three adverse selection scenarios, assuming uptake of 0, 17,000 and 27,000. Assuming the CalSIM point uptake estimate of 17,000, premiums are projected to decline 0.01 percent, under preferred estimates of adverse selection and claims costs of the marginal enrollees. Under upper bound estimates for adverse selection and immigrant claims costs, an uptake of 17,000 is projected to raise premiums by 0.27 percent. Assuming the highest projected enrollment increase of 27,000, premiums would decline 0.02 percent, based on preferred estimates of adverse selection and claims costs; and would increase 0.43 percent under the upper bound estimates for adverse selection and immigrant claims costs.

For premiums to increase by a non-negligible amount—say, above one percent—uptake would have to exceed 27,000, and the average claims costs of the newly insured would have to exceed 350 percent of claims observed in commercial group plans, radically higher than our upper bound estimates of 150 percent. To place this figure in

[1] We thank Manuel Pastor, University of Southern California, for estimates, based on the 2015 American Community Survey.

perspective, for the marginally enrolled to affect premiums by more than 1 percent, spending among the marginally enrolled undocumented would have to exceed spending observed in pre-existing conditions insurance plan (PCIP) market (which covered individuals who were denied coverage before 2014 due to a pre-existing conditions, where claims were roughly 300 percent of average claims in the group market).

Table 1.
Panel A. Projected Premiums (PMPM) Under Section 1332 Waiver

	Enrollment	Level of Adverse Selection		
		Lower Bound	Preferred Projection	Upper Bound
Immigrant Spending		35% reduction	35% reduction	0% reduction
Adverse Selection		None	150% Spending	150% Spending
Average Claims for Pre-waiver Single Risk Pool	2.5 million	$375	$375	$375
Average Claims for Newly Enrolled Undocumented	27,000	$245	$365	$563
Average Claims for *New* Single Risk Pool	2.527 million	$373	$375	$378
Average Premiums for *New* Single Risk Pool	2.527 million	$468	$470	$473
Panel B. Percent Change in Premiums due to Waiver-induced Enrollment				
New Single Risk Pool (*Uptake of 27,000*)	2.527 million	-0.30%	-0.02%	+0.43%
New Single Risk Pool (*Uptake of 17,000*)	2.517 million	-0.18%	-0.01%	+0.27%
New Single Risk Pool (*Uptake of 0*)	2.500 million	0%	0%	0%

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Appendix D: Covered CA Patient-Centered Benefit Plan

Covered California 2017 Patient-Centered Benefit Plan Designs

June 16, 2016

Final Board-approved

2017 Patient-Centered Benefit Plan Designs
10.0 EHB
Date: June 16, 2016

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	89.7%	90.3%
Plan design includes a deductible?	No	No
Integrated Individual deductible	$0	$0
Integrated Family deductible	$0	$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Individual Out–of–pocket maximum	$4,000	$4,000
Family Out-of-pocket maximum	$8,000	$8,000
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$15		$15	
	Other practitioner office visit		$15		$15	
	Specialist visit		$40		$40	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$20		$20	
	X-rays and Diagnostic Imaging		$40		$40	
	Imaging (CT/PET scans, MRIs)		10%		$150	
Drugs to treat illness or condition	Tier 1		$5		$5	
	Tier 2		$15		$15	
	Tier 3		$25		$25	
	Tier 4		10% up to $250 per script		10% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)		10%		$250	
	Physician/surgeon fees		10%		$40	
	Outpatient visit		10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$150		$150	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$150		$150	
	Urgent care		$15		$15	
Hospital stay	Facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Physician/surgeon fee		10%		$40	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$15		$15	
	Mental/Behavioral health other outpatient items and services		$15		$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%		$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee		10%		$40	
	Substance Use disorder outpatient office visits		$15		$15	
	Substance Use disorder other outpatient items and services		$15		$15	
	Substance Use inpatient facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Substance use disorder inpatient physician fee		10%		$40	
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%		$250 per day up to 5 days	
		Professional	10%		$40	
Help recovering or other special health needs	Home health care		10%		$20	
	Outpatient Rehabilitation services		$15		$15	
	Outpatient Habilitation services		$15		$15	
	Skilled nursing care		10%		$150 per day up to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge		No charge	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		50%		See 2017 Dental Copay Schedule	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		50%		$1,000	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	80.9%	81.2%
Plan design includes a deductible?	No	No
Integrated Individual deductible	$0	$0
Integrated Family deductible	$0	$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Individual Out–of–pocket maximum	$6,750	$6,750
Family Out-of-pocket maximum	$13,500	$13,500
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$30		$30	
	Other practitioner office visit	$30		$30	
	Specialist visit	$55		$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$35		$35	
	X-rays and Diagnostic Imaging	$55		$55	
	Imaging (CT/PET scans, MRIs)	20%		$275	
Drugs to treat illness or condition	Tier 1	$15		$15	
	Tier 2	$55		$55	
	Tier 3	$75		$75	
	Tier 4	20% up to $250 per script		20% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		$600	
	Physician/surgeon fees	20%		$55	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$325		$325	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Emergency medical transportation	$250		$250	
	Urgent care	$30		$30	
Hospital stay	Facility fee (e.g. hospital room)	20%		$600 per day up to 5 days	
	Physician/surgeon fee	20%		$55	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	$30		$30	
	Mental/Behavioral health other outpatient items and services	$30		$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee	20%		$55	
	Substance Use disorder outpatient office visits	$30		$30	
	Substance Use disorder other outpatient items and services	$30		$30	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		$600 per day up to 5 days	
	Substance use disorder inpatient physician fee	20%		$55	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services – Hospital	20%		$600 per day up to 5 days	
	Delivery and all inpatient services – Professional	20%		$55	
Help recovering or other special health needs	Home health care	20%		$30	
	Outpatient Rehabilitation services	$30		$30	
	Outpatient Habilitation services	$30		$30	
	Skilled nursing care	20%		$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge		No charge	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures	20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Services				
Child Dental Major Services	Crowns and Casts	50%		See 2017 Dental Copay Schedule	
	Endodontics				
	Periodontics (other than maintenance)				
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		$1,000	

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Summary of Benefits and Coverage	Individual
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan
Actuarial Value - AV Calculator	71.5%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,500/ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$5,000/ $500 / $0
Individual Out–of–pocket maximum	$6,800
Family Out-of-pocket maximum	$13,600
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$35	
	Other practitioner office visit		$35	
	Specialist visit		$70	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$70	
	Imaging (CT/PET scans, MRIs)		$300	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$55	Pharmacy deductible
	Tier 3		$80	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350	
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		$250	X
	Urgent care		$35	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$35	
	Mental/Behavioral health other outpatient items and services		$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$35	
	Substance Use disorder other outpatient items and services		$35	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$45	
	Outpatient Rehabilitation services		$35	
	Outpatient Habilitation services		$35	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		20%	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		50%	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		50%	

See endnotes.

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	CCSB Silver Coinsurance Plan	CCSB Silver Copay Plan
Actuarial Value - AV Calculator	71.6%	71.3%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,000/ $250 / $0	$2,000/ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,000 / $500 / $0	$4,000 / $500 / $0
Individual Out–of–pocket maximum	$6,800	$6,800
Family Out-of-pocket maximum	$13,600	$13,600
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$45		$45	
	Other practitioner office visit		$45		$45	
	Specialist visit		$75		$75	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$40		$40	
	X-rays and Diagnostic Imaging		$70		$70	
	Imaging (CT/PET scans, MRIs)		20%		$300	
Drugs to treat illness or condition	Tier 1		$15		$15	
	Tier 2		$55	Pharmacy deductible	$55	Pharmacy deductible
	Tier 3		$85	Pharmacy deductible	$85	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible	20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees		20%		20%	
	Outpatient visit		20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350		$350	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$250	X	$250	X
	Urgent care		$45		$45	
Hospital stay	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%	X	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$45		$45	
	Mental/Behavioral health other outpatient items and services		$45		$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X	20%	X
	Mental/Behavioral health inpatient physician fee		20%	X	20%	X
	Substance Use disorder outpatient office visits		$45		$45	
	Substance Use disorder other outpatient items and services		$45		$45	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X	20%	X
	Substance use disorder inpatient physician fee		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%	X	20%	X
Help recovering or other special health needs	Home health care		20%		$45	
	Outpatient Rehabilitation services		$45		$45	
	Outpatient Habilitation services		$45		$45	
	Skilled nursing care		20%	X	20%	X
	Durable medical equipment		20%		20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge		No charge	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		50%		See 2017 Dental Copay Schedule	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		50%		$1,000	

See endnotes.

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	CCSB Silver HDHP Plan
Actuarial Value - AV Calculator	71.3%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$2,000 integrated
Integrated Family deductible	$4,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$6,550
Family Out-of-pocket maximum	$13,100
HSA plan: Self-only coverage deductible	$2,000
HSA family plan: Individual deductible	$2,600

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		20%	X
	Other practitioner office visit		20%	X
	Specialist visit		20%	X
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		20%	X
	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Tier 1		20% up to $250 per script	X
	Tier 2		20% up to $250 per script	X
	Tier 3		20% up to $250 per script	X
	Tier 4		20% up to $250 per script	X
Outpatient services	Surgery facility fee (e.g., ASC)		20%	X
	Physician/surgeon fees		20%	X
	Outpatient visit		20%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		20%	X
	Emergency room physician fee (waived if admitted)		0%	X
	Emergency medical transportation		20%	X
	Urgent care		20%	X
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		20%	X
	Mental/Behavioral health other outpatient items and services		20%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		20%	X
	Substance Use disorder other outpatient items and services		20%	X
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		20%	X
	Outpatient Rehabilitation services		20%	X
	Outpatient Habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice service		0%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		20%	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		50%	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		50%	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan 100%-150% FPL	Silver Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.1%	87.5%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$75 / $0 / $0	$650 / $50 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$150 / $0 / $0	$1,300 / $100 / $0
Individual Out–of–pocket maximum	$2,350	$2,350
Family Out-of-pocket maximum	$4,700	$4,700
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$5		$10	
	Other practitioner office visit		$5		$10	
	Specialist visit		$8		$25	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$8		$15	
	X-rays and Diagnostic Imaging		$8		$25	
	Imaging (CT/PET scans, MRIs)		$50		$100	
Drugs to treat illness or condition	Tier 1		$3		$5	
	Tier 2		$10		$20	Pharmacy deductible
	Tier 3		$15		$35	Pharmacy deductible
	Tier 4		10% up to $150 per script		15% up to $150 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
	Outpatient visit		10%		15%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$50		$100	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$30	X	$75	X
	Urgent care		$5		$10	
Hospital stay	Facility fee (e.g. hospital room)		10%	X	15%	X
	Physician/surgeon fee		10%	X	15%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$5		$10	
	Mental/Behavioral health other outpatient items and services		$5		$10	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%	X	15%	X
	Mental/Behavioral health inpatient physician fee		10%	X	15%	X
	Substance Use disorder outpatient office visits		$5		$10	
	Substance Use disorder other outpatient items and services		$5		$10	
	Substance Use inpatient facility fee (e.g. hospital room)		10%	X	15%	X
	Substance use disorder inpatient physician fee		10%	X	15%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	X	15%	X
		Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care		$3		$15	
	Outpatient Rehabilitation services		$5		$10	
	Outpatient Habilitation services		$5		$10	
	Skilled nursing care		10%	X	15%	X
	Durable medical equipment		10%		15%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge		No charge	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		20%		20%	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		50%		50%	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		50%		50%	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.7%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,200 / $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,400 / $500 / $0
Individual Out–of–pocket maximum	$5,700
Family Out-of-pocket maximum	$11,400
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$30	
	Other practitioner office visit		$30	
	Specialist visit		$55	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$65	
	Imaging (CT/PET scans, MRIs)		$300	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$50	Pharmacy deductible
	Tier 3		$75	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350	
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		$250	X
	Urgent care		$30	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$30	
	Mental/Behavioral health other outpatient items and services		$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$30	
	Substance Use disorder other outpatient items and services		$30	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$40	
	Outpatient Rehabilitation services		$30	
	Outpatient Habilitation services		$30	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		20%	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		50%	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		50%	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator	61.9%	62.0%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	$4,800 integrated
Integrated Family deductible	N/A	$9,600 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$6,300 / $500 / $0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$12,600 / $1,000 / $0	N/A
Individual Out–of–pocket maximum	$6,800	$6,550
Family Out-of-pocket maximum	$13,600	$13,100
HSA plan: Self-only coverage deductible	N/A	$4,800
HSA family plan: Individual deductible	N/A	$4,800

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$75	After 1st three non-preventive visits	40%	X
	Other practitioner office visit		$75	After 1st three non-preventive visits	40%	X
	Specialist visit		$105	After 1st three non-preventive visits	40%	X
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$40		40%	X
	X-rays and Diagnostic Imaging		100%	X	40%	X
	Imaging (CT/PET scans, MRIs)		100%	X	40%	X
Drugs to treat illness or condition	Tier 1		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
	Tier 2		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
	Tier 3		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
	Tier 4		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
Outpatient services	Surgery facility fee (e.g., ASC)		100%	X	40%	X
	Physician/surgeon fees		100%	X	40%	X
	Outpatient visit		100%	X	40%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		100%	X	40%	X
	Emergency room physician fee (waived if admitted)		No charge		0%	X
	Emergency medical transportation		100%	X	40%	X
	Urgent care		$75	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)		100%	X	40%	X
	Physician/surgeon fee		100%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$75	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health other outpatient items and services		$75	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		100%	X	40%	X
	Mental/Behavioral health inpatient physician fee		100%	X	40%	X
	Substance Use disorder outpatient office visits		$75	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services		$75	After 1st three non-preventive visits	40%	X
	Substance Use inpatient facility fee (e.g. hospital room)		100%	X	40%	X
	Substance use disorder inpatient physician fee		100%	X	40%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	100%	X	40%	X
		Professional	100%	X	40%	X
Help recovering or other special health needs	Home health care		100%	X	40%	X
	Outpatient Rehabilitation services		$75		40%	X
	Outpatient Habilitation services		$75		40%	X
	Skilled nursing care		100%	X	40%	X
	Durable medical equipment		100%	X	40%	X
	Hospice service		No charge		0%	X
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge		No charge	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		20%		20%	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		50%		50%	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		50%		50%	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$7,150 integrated
Integrated Family deductible	$14,300 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$7,150
Family Out-of-pocket maximum	$14,300
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		0%	After 1st three non-preventive visits
	Other practitioner office visit		0%	After 1st three non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Tier 1		0%	X
	Tier 2		0%	X
	Tier 3		0%	X
	Tier 4		0%	X
Outpatient services	Surgery facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
	Outpatient visit		0%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		0%	X
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		0%	X
	Urgent care		0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)		0%	X
	Physician/surgeon fee		0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services		0%	After 1st three non-preventive visits
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		0%	X
	Mental/Behavioral health inpatient physician fee		0%	X
	Substance Use disorder outpatient office visits		0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services		0%	After 1st three non-preventive visits
	Substance Use inpatient facility fee (e.g. hospital room)		0%	X
	Substance use disorder inpatient physician fee		0%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care		0%	X
	Outpatient Rehabilitation services		0%	X
	Outpatient Habilitation services		0%	X
	Skilled nursing care		0%	X
	Durable medical equipment		0%	X
	Hospice service		0%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		0%	X
Child Dental Diagnostic and Preventive	Oral Exam		No charge	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		0%	X
	Periodontal Maintenance Services			X
Child Dental Major Services	Crowns and Casts		0%	X
	Endodontics			X
	Periodontics (other than maintenance)			X
	Prosthodontics			X
	Oral Surgery			X
Child Orthodontics	Medically necessary orthodontics		0%	X

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	89.7%	90.3%
Plan design includes a deductible?	No	No
Integrated Individual deductible	$0	$0
Integrated Family deductible	$0	$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Individual Out–of–pocket maximum	$4,000	$4,000
Family Out-of-pocket maximum	$8,000	$8,000
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$15		$15	
	Other practitioner office visit		$15		$15	
	Specialist visit		$40		$40	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$20		$20	
	X-rays and Diagnostic Imaging		$40		$40	
	Imaging (CT/PET scans, MRIs)		10%		$150	
Drugs to treat illness or condition	Tier 1		$5		$5	
	Tier 2		$15		$15	
	Tier 3		$25		$25	
	Tier 4		10% up to $250 per script		10% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)		10%		$250	
	Physician/surgeon fees		10%		$40	
	Outpatient visit		10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$150		$150	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$150		$150	
	Urgent care		$15		$15	
Hospital stay	Facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Physician/surgeon fee		10%		$40	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$15		$15	
	Mental/Behavioral health other outpatient items and services		$15		$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%		$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee		10%		$40	
	Substance Use disorder outpatient office visits		$15		$15	
	Substance Use disorder other outpatient items and services		$15		$15	
	Substance Use inpatient facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Substance use disorder inpatient physician fee		10%		$40	
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%		$250 per day up to 5 days	
		Professional	10%		$40	
Help recovering or other special health needs	Home health care		10%		$20	
	Outpatient Rehabilitation services		$15		$15	
	Outpatient Habilitation services		$15		$15	
	Skilled nursing care		10%		$150 per day up to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics				Not Covered	
	Periodontics (other than maintenance)				Not Covered	
	Prosthodontics				Not Covered	
	Oral Surgery				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	80.9%	81.2%
Plan design includes a deductible?	No	No
Integrated Individual deductible	$0	$0
Integrated Family deductible	$0	$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Individual Out–of–pocket maximum	$6,750	$6,750
Family Out-of-pocket maximum	$13,500	$13,500
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$30		$30	
	Other practitioner office visit	$30		$30	
	Specialist visit	$55		$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$35		$35	
	X-rays and Diagnostic Imaging	$55		$55	
	Imaging (CT/PET scans, MRIs)	20%		$275	
Drugs to treat illness or condition	Tier 1	$15		$15	
	Tier 2	$55		$55	
	Tier 3	$75		$75	
	Tier 4	20% up to $250 per script		20% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		$600	
	Physician/surgeon fees	20%		$55	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$325		$325	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Emergency medical transportation	$250		$250	
	Urgent care	$30		$30	
Hospital stay	Facility fee (e.g. hospital room)	20%		$600 per day up to 5 days	
	Physician/surgeon fee	20%		$55	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	$30		$30	
	Mental/Behavioral health other outpatient items and services	$30		$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee	20%		$55	
	Substance Use disorder outpatient office visits	$30		$30	
	Substance Use disorder other outpatient items and services	$30		$30	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		$600 per day up to 5 days	
	Substance use disorder inpatient physician fee	20%		$55	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services – Hospital	20%		$600 per day up to 5 days	
	Delivery and all inpatient services – Professional	20%		$55	
Help recovering or other special health needs	Home health care	20%		$30	
	Outpatient Rehabilitation services	$30		$30	
	Outpatient Habilitation services	$30		$30	
	Skilled nursing care	20%		$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam	Not Covered		Not Covered	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures	Not Covered		Not Covered	
	Periodontal Maintenance Services				
Child Dental Major Services	Crowns and Casts	Not Covered		Not Covered	
	Endodontics			Not Covered	
	Periodontics (other than maintenance)			Not Covered	
	Prosthodontics			Not Covered	
	Oral Surgery			Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage	Individual
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan
Actuarial Value - AV Calculator	71.5%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,500/ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$5,000/ $500 / $0
Individual Out–of–pocket maximum	$6,800
Family Out-of-pocket maximum	$13,600
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$35	
	Other practitioner office visit		$35	
	Specialist visit		$70	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$70	
	Imaging (CT/PET scans, MRIs)		$300	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$55	Pharmacy deductible
	Tier 3		$80	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350	
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		$250	X
	Urgent care		$35	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$35	
	Mental/Behavioral health other outpatient items and services		$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$35	
	Substance Use disorder other outpatient items and services		$35	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$45	
	Outpatient Rehabilitation services		$35	
	Outpatient Habilitation services		$35	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	CCSB Silver Coinsurance Plan	CCSB Silver Copay Plan
Actuarial Value - AV Calculator	71.6%	71.3%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,000/ $250 / $0	$2,000/ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,000 / $500 / $0	$4,000 / $500 / $0
Individual Out–of–pocket maximum	$6,800	$6,800
Family Out-of-pocket maximum	$13,600	$13,600
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$45		$45	
	Other practitioner office visit		$45		$45	
	Specialist visit		$75		$75	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$40		$40	
	X-rays and Diagnostic Imaging		$70		$70	
	Imaging (CT/PET scans, MRIs)		20%		$300	
Drugs to treat illness or condition	Tier 1		$15		$15	
	Tier 2		$55	Pharmacy deductible	$55	Pharmacy deductible
	Tier 3		$85	Pharmacy deductible	$85	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible	20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees		20%		20%	
	Outpatient visit		20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350		$350	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$250	X	$250	X
	Urgent care		$45		$45	
Hospital stay	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%	X	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$45		$45	
	Mental/Behavioral health other outpatient items and services		$45		$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X	20%	X
	Mental/Behavioral health inpatient physician fee		20%	X	20%	X
	Substance Use disorder outpatient office visits		$45		$45	
	Substance Use disorder other outpatient items and services		$45		$45	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X	20%	X
	Substance use disorder inpatient physician fee		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%	X	20%	X
Help recovering or other special health needs	Home health care		20%		$45	
	Outpatient Rehabilitation services		$45		$45	
	Outpatient Habilitation services		$45		$45	
	Skilled nursing care		20%	X	20%	X
	Durable medical equipment		20%		20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics				Not Covered	
	Periodontics (other than maintenance)				Not Covered	
	Prosthodontics				Not Covered	
	Oral Surgery				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	CCSB Silver HDHP Plan
Actuarial Value - AV Calculator	71.3%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$2,000 integrated
Integrated Family deductible	$4,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$6,550
Family Out-of-pocket maximum	$13,100
HSA plan: Self-only coverage deductible	$2,000
HSA family plan: Individual deductible	$2,600

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		20%	X
	Other practitioner office visit		20%	X
	Specialist visit		20%	X
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		20%	X
	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Tier 1		20% up to $250 per script	X
	Tier 2		20% up to $250 per script	X
	Tier 3		20% up to $250 per script	X
	Tier 4		20% up to $250 per script	X
Outpatient services	Surgery facility fee (e.g., ASC)		20%	X
	Physician/surgeon fees		20%	X
	Outpatient visit		20%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		20%	X
	Emergency room physician fee (waived if admitted)		0%	X
	Emergency medical transportation		20%	X
	Urgent care		20%	X
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		20%	X
	Mental/Behavioral health other outpatient items and services		20%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		20%	X
	Substance Use disorder other outpatient items and services		20%	X
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		20%	X
	Outpatient Rehabilitation services		20%	X
	Outpatient Habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice service		0%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan 100%-150% FPL	Silver Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.1%	87.5%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$75 / $0 / $0	$650 / $50 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$150 / $0 / $0	$1,300 / $100 / $0
Individual Out–of–pocket maximum	$2,350	$2,350
Family Out-of-pocket maximum	$4,700	$4,700
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$5		$10	
	Other practitioner office visit		$5		$10	
	Specialist visit		$8		$25	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$8		$15	
	X-rays and Diagnostic Imaging		$8		$25	
	Imaging (CT/PET scans, MRIs)		$50		$100	
Drugs to treat illness or condition	Tier 1		$3		$5	
	Tier 2		$10		$20	Pharmacy deductible
	Tier 3		$15		$35	Pharmacy deductible
	Tier 4		10% up to $150 per script		15% up to $150 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
	Outpatient visit		10%		15%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$50		$100	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$30	X	$75	X
	Urgent care		$5		$10	
Hospital stay	Facility fee (e.g. hospital room)		10%	X	15%	X
	Physician/surgeon fee		10%	X	15%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$5		$10	
	Mental/Behavioral health other outpatient items and services		$5		$10	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%	X	15%	X
	Mental/Behavioral health inpatient physician fee		10%	X	15%	X
	Substance Use disorder outpatient office visits		$5		$10	
	Substance Use disorder other outpatient items and services		$5		$10	
	Substance Use inpatient facility fee (e.g. hospital room)		10%	X	15%	X
	Substance use disorder inpatient physician fee		10%	X	15%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	X	15%	X
		Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care		$3		$15	
	Outpatient Rehabilitation services		$5		$10	
	Outpatient Habilitation services		$5		$10	
	Skilled nursing care		10%	X	15%	X
	Durable medical equipment		10%		15%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.7%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,200 / $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,400 / $500 / $0
Individual Out–of–pocket maximum	$5,700
Family Out-of-pocket maximum	$11,400
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$30	
	Other practitioner office visit		$30	
	Specialist visit		$55	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$65	
	Imaging (CT/PET scans, MRIs)		$300	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$50	Pharmacy deductible
	Tier 3		$75	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350	
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		$250	X
	Urgent care		$30	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$30	
	Mental/Behavioral health other outpatient items and services		$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$30	
	Substance Use disorder other outpatient items and services		$30	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$40	
	Outpatient Rehabilitation services		$30	
	Outpatient Habilitation services		$30	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator	61.9%	62.0%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	$4,800 integrated
Integrated Family deductible	N/A	$9,600 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$6,300 / $500 / $0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$12,600 / $1,000 / $0	N/A
Individual Out–of–pocket maximum	$6,800	$6,550
Family Out-of-pocket maximum	$13,600	$13,100
HSA plan: Self-only coverage deductible	N/A	$4,800
HSA family plan: Individual deductible	N/A	$4,800

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$75	After 1st three non-preventive visits	40%	X
	Other practitioner office visit		$75	After 1st three non-preventive visits	40%	X
	Specialist visit		$105	After 1st three non-preventive visits	40%	X
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$40		40%	X
	X-rays and Diagnostic Imaging		100%	X	40%	X
	Imaging (CT/PET scans, MRIs)		100%	X	40%	X
Drugs to treat illness or condition	Tier 1		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
	Tier 2		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
	Tier 3		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
	Tier 4		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
Outpatient services	Surgery facility fee (e.g., ASC)		100%	X	40%	X
	Physician/surgeon fees		100%	X	40%	X
	Outpatient visit		100%	X	40%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		100%	X	40%	X
	Emergency room physician fee (waived if admitted)		No charge		0%	X
	Emergency medical transportation		100%	X	40%	X
	Urgent care		$75	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)		100%	X	40%	X
	Physician/surgeon fee		100%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$75	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health other outpatient items and services		$75	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		100%	X	40%	X
	Mental/Behavioral health inpatient physician fee		100%	X	40%	X
	Substance Use disorder outpatient office visits		$75	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services		$75	After 1st three non-preventive visits	40%	X
	Substance Use inpatient facility fee (e.g. hospital room)		100%	X	40%	X
	Substance use disorder inpatient physician fee		100%	X	40%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	100%	X	40%	X
		Professional	100%	X	40%	X
Help recovering or other special health needs	Home health care		100%	X	40%	X
	Outpatient Rehabilitation services		$75		40%	X
	Outpatient Habilitation services		$75		40%	X
	Skilled nursing care		100%	X	40%	X
	Durable medical equipment		100%	X	40%	X
	Hospice service		No charge		0%	X
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$7,150 integrated
Integrated Family deductible	$14,300 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$7,150
Family Out-of-pocket maximum	$14,300
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		0%	After 1st three non-preventive visits
	Other practitioner office visit		0%	After 1st three non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Tier 1		0%	X
	Tier 2		0%	X
	Tier 3		0%	X
	Tier 4		0%	X
Outpatient services	Surgery facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
	Outpatient visit		0%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		0%	X
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		0%	X
	Urgent care		0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)		0%	X
	Physician/surgeon fee		0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services		0%	After 1st three non-preventive visits
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		0%	X
	Mental/Behavioral health inpatient physician fee		0%	X
	Substance Use disorder outpatient office visits		0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services		0%	After 1st three non-preventive visits
	Substance Use inpatient facility fee (e.g. hospital room)		0%	X
	Substance use disorder inpatient physician fee		0%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care		0%	X
	Outpatient Rehabilitation services		0%	X
	Outpatient Habilitation services		0%	X
	Skilled nursing care		0%	X
	Durable medical equipment		0%	X
	Hospice service		0%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		0%	X
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

Endnotes to Covered California 2017 Patient-Centered Benefit Plan Designs

These endnotes and the Patient-Centered Benefit Plan Designs apply only to covered services.

Notes:

1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the issuer.
2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or $2,600 for Plan Year 2017. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.
7) For the Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits, which may include urgent care visits or outpatient Mental Health/Substance Use Disorder visits.
8) Member cost-share for oral anti-cancer drugs shall not exceed $200 per month per state law.
9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design,

regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.

12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2017 Dental Copay Schedule.
13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate.
18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than specialist for a service provided by one of these practitioners.
19) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
20) The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician

or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.

21) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in these patient-centered benefit plan designs if necessary for compliance with MHPAEA.

22) Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.

23) Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs or;
	2) Preferred brand name drugs or;
	3) Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or;
	2) Self administration requires training, clinical monitoring or;
	3) Drug was manufactured using biotechnology or;
	4) Plan cost (net of rebates) is >$600.

24) Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.

25) A plan’s formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan’s formulary.

26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member’s physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease

July 15, 2016

Mr. Peter V. Lee
Executive Director
Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

Re: Covered California 1332 Waiver Actuarial Certification

Dear Peter:

Covered California (Covered CA) is applying for a State Innovation Waiver pursuant to section 1332 of the Patient Protection and Affordable Care Act (ACA) that would allow individuals to purchase health insurance through Covered CA, the state's ACA marketplace, who are otherwise not eligible based on their immigration status. An actuarial certification is a requirement for the waiver application in which the actuary certifies the waiver complies with four requirements: comprehensive coverage, affordability, scope of coverage and deficit neutrality. Pursuant to this regulation, as Chief Actuary for Covered CA, I am providing this certification.

The purpose of this letter is to outline the considerations and assumptions used to conclude that Covered CA complies with the four waiver requirements and to provide an actuarial certification stating compliance. Other uses of this memorandum may be inappropriate. I do not intend to create a reliance by third parties and assume no duty or liability to such third parties. Any third parties obtaining this letter should rely on their own experts in interpreting the information and opinions.

Comprehensive Coverage

Recent guidance states that health care coverage under the waiver must be expected to be at least as comprehensive as without the waiver for all residents of the state overall. Comprehensiveness is defined by the benefits provided under the Essential Health Benefits (EHB). The guidance includes the following considerations to ensure compliance under the Comprehensive Coverage requirement:

- The Essential Health Benefits should be compared to the coverage under the waiver. The waiver cannot decrease any of the following:
    - The number of residents with coverage at least as comprehensive as the EHB requirement
    - The number of residents with coverage at least as comprehensive for each of the ten EHB categories; and

  - The number of residents with coverage at least as comprehensive as the state's Medicaid and/or Children's Health Insurance Program (CHIP) programs.
- The waiver must also not decrease the comprehensiveness of coverage for different types of vulnerable groups, including low-income, elderly and those with or at risk of serious health issues.

Since Covered CA is planning to offer "mirror plans" (which we are calling CQHPs), it has not requested a change in the Essential Health Benefits offered to waiver program enrollees; thus, the comprehensiveness of coverage will remain the same with the waiver. The waiver is not expected to impact the coverage under the Medicaid program or the number of residents who enroll in the program. Since the benefit coverage is remaining the same under the waiver, no analysis is needed to support the conclusion that the waiver complies with the above requirements in that it will not decrease the number of residents with coverage at least as comprehensive as the current EHB (in total and within each EHB category) and also does not decrease the comprehensiveness of coverage for vulnerable groups.

Affordability

The guidance states that health care coverage must be expected to be as affordable as without the waiver, overall for all residents of the state. Affordability includes both premiums paid and out of pocket cost sharing paid by the members. The guidance includes the following considerations to ensure compliance under the affordability requirement:

  - The premium contributions paid by residents should be at least as affordable under the waiver for each year the waiver would be in effect.
  - The cost sharing paid by residents (deductibles, copays and coinsurance) should be at least as affordable under the waiver for each year the waiver would be in effect.
  - If applicable, spending on services that are not covered by the plan must also be considered such that the cost of these is not greater under the waiver.
  - The number of residents with a higher cost of health care burden relative to their income should not increase.
  - The waiver must also not decrease the affordability of coverage for different types of vulnerable groups, including low-income, elderly and those with or at risk of serious health issues.
  - The waiver must not decrease the number of residents with minimal level of coverage under both Affordable Care Act (ACA) and Social Security regulations.
  - The impact on all state residents should be considered.

Draft – for review only

The effect on California's ACA individual health insurance market will be negligibly positive, if any at all, by adding 1332 waiver enrollees. The analysis of Dr. Wesley Yin, a UCLA economist with who we have worked, is summarized later in this letter. His analysis is attached as an appendix to this letter.

As a result, there is no expectation that any resident's cost sharing or premiums would increase as a result of the waiver, all else being equal. Since the same plans will be offered, there is no foreseeable reason that the utilization or cost of services would increase with the waiver. Covered CA's extensive rate negotiation process, combined with the Department of Managed Health Care and California Department of Insurance rate review process also ensures that premiums and cost sharing will remain at least as affordable. Conversely, without a waiver it is possible that additional health care costs would be incurred as uninsured legal residents used "safety net" hospitals or clinics and were not able to reimburse these providers. The waiver would therefore make the premiums at least as, if not slightly more, affordable than without the waiver.

Since the waiver is not expected to impact the current level of coverage or costs for any residents in California, no additional analysis was completed either in the aggregate or by income/health status/etc. Since the premiums are not expected to be impacted to any measurable degree by the waiver, there is also no reason to believe other enrollees in the state would be affected. As discussed in Dr. Yin's assessment above, the "preferred scenario" indicates that there might be a very negligible positive impact (i.e., costs might be reduced by 0.01%) under the preferred scenario.

Scope of Coverage

The regulations state that health care coverage must be expected to be provided to at least a comparable number of residents under the waiver. Coverage is based on the number of residents having minimum essential coverage. The guidance includes the following considerations to ensure compliance under the coverage requirement:

- The number of covered individuals is expected to be no less than without the waiver for each year the waiver would be in effect.
- The impact on all state residents should be considered.
- The waiver must also not decrease the number of residents with coverage considering different types of vulnerable groups, including low-income, elderly and those with or at risk of serious health issues.
- Ensures the waiver proposal prevents gaps or discontinuation of coverage.

California currently has had exemplary success in reducing uninsured rates in the state through enrollment in a state-based exchange and expansion of its MediCal (Medicaid) program. Since the waiver is requesting an expansion of eligibility to make use of the Covered CA marketplace, it is not expected that the number of

citizens currently eligible for APTC or CSR subsidies would change by more than a very small amount.

The CalSIM modeling team from University of California projects that enrollment would be increased in a range from 0 to 27,000 people who would qualify under the waiver. Assuming a midpoint for the "preferred scenario" of 17,000 enrollees, the number of California residents (citizens and legally-present residents) would increase modestly. Similarly, the waiver would help prevent gaps or discontinuation in coverage since it allows legally present residents to obtain health insurance coverage under the same rules for Open Enrollment and Special Enrollment Periods as exist for citizens. Since the waiver is not expected to impact the market or the number of residents covered, a detailed analysis was not completed either in the aggregate or by income/health status/etc.

Deficit Neutrality

In considering deficit neutrality, the two main factors influencing this guardrail are those affecting the amount of APTC subsidies and any impact on premiums. Experts with the UC Berkeley CalSIM team do not foresee any factors or outcomes of this waiver affecting APTC or CSR subsidies. Also, when looking at the impact on premiums, experts cannot predict or measure whether there will be any material increase or decrease in premiums tied to the Waiver because the best estimates are within the normal range when projecting enrollment as well as normal market conditions. Based on the enrollment projections of the CalSIM team and the analysis by Dr. Yin of UCLA, under the best estimate, there would likely be a very modest effect, a possible decrease in premium rates of 0.01%. (See Panel B of Table 1 of Dr. Yin's paper.) If this enrollment projection and scenario hold true, then the amount of APTC subsidy for state residents might decrease slightly. Given the other more significant factors that affect health insurance premiums and APTC subsidies, this amount is so negligible as to most likely not be measurable. In any event, it is most likely that there is no effect on the deficit. Should there be an increase in the number of APTC eligible consumers, it would be negligible and impossible to measure due to the normal non-waiver factors affecting the healthcare market.

As Dr. Yin notes, under any reasonable adverse scenario, it would require both high enrollment and very high adverse selection of enrollees to create any deficit impact. For example, the average claims would need to be much higher than those experienced under the federal Pre-existing Claims Insurance Program in order to have an effect. Since high cost individuals can and are likely to have already enrolled in off-Exchange programs, it is extremely unlikely that this scenario could occur.

Reliance

I have relied on information provided by the staff of Covered CA, including their draft waiver application "1332 DRAFT waiver app for public comment.pdf". In addition, I relied on analysis by the CalSIM microsimulation modeling team of the

University of California and on analysis by Wesley Yin, Ph.D., economist at UCLA. I reviewed all of the information for reasonability but did not confirm the accuracy of the calculations of any of the information provided.

Actuarial Certification

I, John Bertko, am a Fellow in the Society of Actuaries (FSA), a member of the American Academy of Actuaries (MAAA), and am qualified to provide the following certification.

This actuarial certification applies to the Covered CA's 1332 waiver application that requests that legally present non-citizens in California be allowed to purchase health insurance policies through the Covered CA marketplace. This includes:

1. Covered CA's 1332 waiver complies with the comprehensive coverage requirement.
2. Covered CA's 1332 waiver complies with the affordability requirement.
3. Covered CA's 1332 waiver complies and the scope of coverage requirement.
4. Covered CA's 1332 waiver complies with all deficit neutrality requirements.
5. The certification conforms with the Actuarial Standards of Practice (ASOPs) :

In my opinion, Covered CA's 1332 waiver application complies with all of the scope of coverage, affordability, comprehensive coverage and deficit neutrality requirements. This certification does not cover any unforeseen events that may impact premiums, benefits or enrollment estimates.

Should you have any questions, please feel free to call to discuss.

Sincerely,

John M. Bertko
Chief Actuary, Covered CA
Fellow of the Society of Actuaries
Member, American Academy of Actuaries

Attachments:
1. Dietz, M; Jacobs, K; Roby, D and Kominski, J, "California's proposed §1332 State Innovation Waiver would result in marginal increase in health insurance enrollment in the individual market**";** July 1, 2016
2. Yin, W, UCLA, Information Memorandum "Projected Premium and Budget Impact of Increased Enrollment in the CA Individual Market due to the Section 1332 Waiver"; July 7, 2016

Press Release
December 3, 2014

*This press release was updated on Dec. 24, 2014, as new fact sheets became available in additional languages.□□*This press release was updated on Jan. 9, 2015, as new fact sheets became available in additional languages.

Covered California Partners with National Immigrant Rights Organizations to Reassure Consumers in California and Nationally That Immigration Information Is Safe, Secure and Confidential

LOS ANGELES, Calif. — Leading national and California immigrant rights organizations joined with Covered California to announce a partnership to spread the word to all communities that immigration status should not deter anyone who can benefit from obtaining coverage under the Patient Protection and Affordable Care Act. The federal government's leading official overseeing health insurance marketplaces across the nation joined the effort Tuesday to reinforce the fact that information shared in health coverage applications will be kept secure and confidential.

Any U.S. citizen or person who is lawfully present in California is eligible for health insurance through Covered California even if they have family members in their household who are undocumented.

With the president's recent executive order, there is renewed attention on undocumented residents, and they need to feel confident that they can apply for coverage for legal family members without any consequences.

"We want everyone to know that when you apply for health insurance through a health insurance marketplace like Covered California, all of your information is kept private and secure," said Covered California Executive Director Peter V. Lee. "It will not be shared with or used by any immigration agency to enforce immigration laws. All information you submit is used strictly to determine your eligibility for health insurance programs available under the Affordable Care Act."

The partnership involves MALDEF (the Mexican American Legal Defense and Educational Fund), the National Immigration Law Center, Asian Americans Advancing Justice — Los Angeles, the National Association of Latino Elected and Appointed Officials (NALEO) Educational Fund, the Coalition for Humane Immigrant Rights of Los Angeles and the California Immigrant Policy Center.

"Families need adequate health coverage, so no family should have to avoid seeking coverage because of understandable concerns about a political atmosphere that continues to demonize certain immigrants," said Thomas A. Saenz, MALDEF president and general counsel. "We are thankful that Covered California and the Department of Homeland Security have made it crystal clear that immigration enforcement and health coverage should not and will not mix."

"We are very excited about our partnership with Covered California informing our communities that they do not need to fear sharing their immigration status," said Stewart Kwoh, president and

executive director of Asian Americans Advancing Justice — Los Angeles. “There are an estimated 1.3 million undocumented Asian-Americans and Pacific Islanders in the nation, and we hope that this guidance encourages members of our community to seek coverage without fear of getting a family member deported.”

“With the highest rates of being uninsured, Latino immigrants who are eligible must take advantage of the opportunity to pursue health insurance coverage for themselves and their families,” said Arturo Vargas, NALEO Educational Fund executive director. “The health of Latinos will determine the future health of the state. Given the high stakes, we will continue to work to ensure that the Latino community is aware that any information given to California Covered or HealthCare.gov being used for purposes of health coverage eligibility determinations is strictly confidential and will not be shared with any other government agency, state or federal.”

In October 2013, Immigration and Customs Enforcement, an arm of the U.S. Department of Homeland Security, issued a letter assuring consumers that information provided by individuals for coverage at Covered California — and other health care exchanges — would not be used for any other purpose than to ensure the efficient operation of the exchange (the full letter can be found atwww.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf).

The partners in this effort want all consumers to know that noncitizens or undocumented family members on an application for insurance for other legal resident members of the household are not at risk. If a household includes both legal residents and non-legal residents, the legal residents can apply for coverage without fear. Their information will remain safe, secure and confidential and will not be used for immigration enforcement purposes. In addition, applying for insurance through Covered California does not affect an individual’s immigration status, nor will it affect the immigration status of any family member on the application or their ability to become U.S. citizens or permanent residents in the future.

As part of this effort, the partners have developed and will distribute a fact sheet for California in several languages, as well as a fact sheet for other states.* The available fact sheets are online at the following links:

California fact sheets:
English: www.CoveredCA.com/news/PDFs/immigration-fact-sheet-ca.pdf.
Spanish: www.CoveredCA.com/news/PDFs/immigration-fact-sheet-sp.pdf.
Chinese: www.CoveredCA.com/news/PDFs/immigration-fact-sheet-ca-chi.pdf.
Vietnamese: www.CoveredCA.com/news/PDFs/immigration-fact-sheet-ca-vie.pdf.
Korean: http://www.coveredca.com/news/pdfs/immigration-fact-sheet-ca-kor.pdf

Fact sheets for other states:
English: www.CoveredCA.com/news/PDFs/immigration-fact-sheet-us.pdf.
Spanish: http://www.coveredca.com/news/PDFs/immigration-fact-sheet-us-sp-12-16-14.pdf
Chinese: www.CoveredCA.com/news/PDFs/immigration-fact-sheet-us-chi.pdf
Vietnamese: www.CoveredCA.com/news/PDFs/immigration-fact-sheet-us-vie.pdf
Korean: http://www.coveredca.com/news/PDFs/immigration-fact-sheet-us-kor.pdf

Finally, while noncitizens or undocumented residents will not be eligible for Covered California health insurance plans, they may be eligible for specific, limited Medi-Cal programs. Individual consumers and their families are encouraged to research their options through Covered California to see what health coverage options are available to them. Help is available in local communities by visiting www.CoveredCA.com and clicking “Find Local Help.” On that page, families can find a Certified Enrollment Counselor or a Certified Insurance Agent near them who can answer any question or concern and can help consumers enroll in an affordable, quality health plan.

About Covered California
Covered California is the state’s marketplace for the federal Patient Protection and Affordable Care Act. Covered California, in partnership with the California Department of Health Care Services, was charged with creating a new health insurance marketplace in which individuals and small businesses can get access to affordable health insurance plans. Covered California helps individuals determine whether they are eligible for premium assistance that is available on a sliding-scale basis to reduce insurance costs or whether they are eligible for low-cost or no-cost Medi-Cal. Consumers can then compare health insurance plans and choose the plan that works best for their health needs and budget. Small businesses can purchase competitively priced health insurance plans and offer their employees the ability to choose from an array of plans and may qualify for federal tax credits.

Covered California is an independent part of the state government whose job is to make the new market work for California’s consumers. It is overseen by a five-member board appointed by the governor and the Legislature. For more information about Covered California, please visit www.CoveredCA.com.

*This press release was updated on Dec. 24, 2014, as new fact sheets became available in additional languages.

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