AB 133 Health Care Affordability Working Group
Meeting #1

September 30, 2021

HOUSEKEEPING ITEMS

- Working group members have been unmuted by Covered California. Please mute yourselves until you're ready to speak.
- We will take questions from working group members frequently throughout the meeting. Please wait to raise your hand until we call for questions.
- We will take public comment after each agenda item. Attendees can raise their hands and they will be unmuted. They then must unmute themselves.

AGENDA

1. Welcome, Introductions, and Agenda Review
2. Overview of AB 133
3. Overview of Federal Cost Sharing Program
    A. Program Overview
    B. Program Financing
    C. Covered California Benefit Designs
    D. Eligibility and Enrollment Data
4. Overview of Other State Cost Sharing Programs
5. Overview of Options To Be Modeled and Potential Outputs
6. Agenda Review For October 14 Meeting and Next Steps

Website: https://hbex.coveredca.com/stakeholders/AB_133_Health_Care_Affordability_Working_Group/

AB 133 WORKING GROUP MEMBERS

Working Group Member	Organization
Dawn McFarland	Agent
Rick Krum	Anthem
Robert Spector	Blue Shield
Anete Millers	California Association of Health Plans
Faith Borges	California Association of Health Underwriters (CAHU)
Stesha Hodges	California Department of Insurance
Janice Rocco	California Medical Association
Cary Sanders	California Pan-Ethnic Health Network (CP-EHN)
Mike Odeh	Children Now
Diana Douglas	Health Access
Amy Frith	Health Net of California
John Newman	Kaiser
Alicia Emanuel	National Health Law Program (NHLP)
Marjorie Swartz	Policy Consultant to Senate President Pro Tempore Toni Atkins at California State Senate
Cicely Rucker	Sharp
Jen Flory	Western Center on Law and Poverty
Jerry Fleming	Covered California Board Member
Jarrett Tomás Barrios	Covered California Board Member
Teri Boughton	Senate Committee on Health
Ryan Witz	California Hospital Association
Doreena Wong	Asian Resources
Anika Lee	California Consortium of Urban Indian Health Consortium (CCUHI)

OVERVIEW OF AB 133

Katie Ravel, Director, Policy, Eligibility, and Research Division

HEALTH CARE AFFORDABILITY RESERVE FUND REPORT

- The 2021-2022 State Budget (AB 128) and Health Omnibus trailer bill (AB 133):
  - Redirected $333.4 million from the General Fund to the Health Care Affordability Reserve Fund to be used for affordability programs operated by Covered California starting in plan year 2023; and
  - Directed Covered California to produce a report developing options for providing cost sharing reduction subsidies.

HEALTH CARE AFFORDBILITY RESERVE FUND REPORT

- In developing the report, Covered California must:
  - Consult with stakeholders and the Legislature to develop options for providing cost sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians;
  - Submit options to the Legislature, Governor and the Healthy California for All Commission for consideration for the 2022-23 budget process;
  - Include options for all Covered California enrollees with income up to 400 percent of the federal poverty level to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs;
  - Include options to provide zero deductibles for all Covered California enrollees with income under 400 percent of the federal poverty level and upgrading those with income between 200 percent and 400 percent inclusive of the federal poverty level to gold-tier cost sharing; and
  - Address any operational issues that might impede implementation of enhanced cost-sharing reductions for the 2023 calendar year.
- Report due by January 1, 2022.

OVERVIEW OF FEDERAL COST SHARING PROGRAM

A. PROGRAM OVERVIEW

Katie Ravel, Director, Policy, Eligibility, and Research Division

MARKETPLACE BENEFITS AND COVERAGE LEVELS

- The Affordable Care Act (ACA) requires that products sold in the individual market cover 10 essential health benefit categories.
- The ACA defines four “metal tiers” of coverage for these benefits that vary by actuarial value (AV), which is the average portion of the total health care costs that are covered by the health insurance issuer versus the portion covered by a consumer paying out-of-pocket costs.
- The remaining portion is collected through consumer cost-sharing in the form of deductibles, copays and coinsurance.
- Plans with a lower AV have lower monthly premiums but higher cost-sharing.

MARKETPLACE BENEFITS AND COVERAGE LEVELS

- The four metal tiers are:
  - Bronze: 60 percent AV
  - Silver: 70 percent AV
  - Gold: 80 percent AV
  - Platinum: 90 percent AV
- Catastrophic coverage is also defined, although it is only available to individuals younger than 30 or with a valid exemption from the individual mandate.

ADVANCED PREMIUM TAX CREDITS

- The ACA provides advanceable tax credits to lower monthly premium costs for individuals up to 400 percent of the FPL who buy coverage through marketplaces and are not eligible for other affordable coverage.
- The premium tax credit structure caps the amount individuals must pay for their monthly premiums.
- In 2020, California implemented a three-year state premium credit program that expanded eligibility for subsidies to those over 400 percent of the FPL and reduced contributions for individuals below 400 percent.
- For 2021 and 2022, the American Rescue Plan expanded premium subsidies to individuals over 400 percent of the FPL and significantly reduced premium contributions for individuals under 400 percent of the FPL.
- The American Rescue Plan subsidies replaced the California program for 2021 and 2022.

FEDERAL COST-SHARING REDUCTION PROGRAM

- The ACA requires health insurance issuers to reduce out-of-pocket maximums and cost-sharing amounts (such as deductibles and copays) for consumers at 250 percent FPL and below.
- Eligible individuals access these benefits by enrolling in what are known as cost-sharing reduction (CSR) plans built on Silver-level coverage.
- For the lowest-income enrollees, cost-sharing reduction plans provide coverage at or near the Platinum level for Silver premium prices.
- Under the ACA, consumers up to 250% FPL are eligible for CSR benefits that increase the value of a Silver plan thereby lowering out-of-pocket costs as follows:
  - Silver 94 for consumers with income below 150% FPL
  - Silver 87 for consumers with income between 150% to 200% FPL
  - Silver 73 for consumers with income between 200% to 250% FPL

AMERICAN INDIAN/ALASKA NATIVE ZERO-COST AND LIMITED-COST SHARING PLANS

- **Zero-cost sharing plans:** If below 300 percent federal poverty level (FPL), consumer is eligible for AI/AN plan that is not subject to deductible, coinsurance and cost sharing. Does not need a referral from an Indian Health Clinic.

- **Limited-cost sharing plans:** If above 300 percent FPL, consumer is not subject to deductible, coinsurance and cost sharing if receiving health care services from an Indian Health Clinic or with a referral to a QHP provider from an Indian Health Clinic.

B. PROGRAM FINANCING

Robert Spector, Senior Director, State Public Programs, Blue Shield

COST SHARE REDUCTIONS

Lowering the amount consumers have to pay for deductibles, copayments & coinsurance

	Silver	Silver 73	Silver 87	Silver 94
Primary Care Visit	$40	$35	$15	$5
X-Ray	$80	$75	$40	$8
Deductible	$4,000	$3,700	$1,400	$75
Premium	$500	$500	$500	$500

All numbers are illustrative

HOW QHPs ADMINISTERED CSRs (2014-2017)

QHPs were “reimbursed” the difference in cost share, on a per claim basis, between the SILVER 70 and the SILVER CSR plan

$35 difference “reimbursement”

	Silver 70	Silver 73	Silver 87	Silver 94
Primary Care Visit	$40	$35	$15	$5
X-Ray	$80	$75	$40	$8
Deductible	$4,000	$3,700	$1,400	$75

Methodologies to calculate the value of cost-sharing reductions provided for each enrollee during the benefit year:

- Simple Methodology - estimation
- Standard Methodology – claims re-adjudication (required for 2017+)

OCTOBER 2017 – CSR REIMBURSEMENT ENDED JANUARY 2018 – "SILVER LOADING" BEGAN

For 2018, QHPs raised premiums for silver plans by 12.4% to offset the now-uncompensated cost of continuing to provide CSRs, a practice commonly called "silver loading"

	Silver 70	Silver 73	Silver 87	Silver 94
Primary Care Visit	$40	$35	$15	$5
Premium if CSRs were funded	$500	$500	$500	$500
Premium per CSR Plan w/o Funding	$500	$520	$558	$600
Final Premium	$562	$562	$562	$562

Covered California Keeps Premiums Stable By Adding Cost Sharing Reduction Surcharge Only To Silver Plans To Limit Consumer Impact 10/17/2021 Covered California Press Release

All numbers are illustrative

C. BENEFIT DESIGNS

Jan Falzarano, Deputy Director, Plan Management Division

BENEFIT PLAN DESIGN OVERVIEW

- The Affordable Care Act (ACA) requires that each plan offered on the Exchange include 10 Essential Health Benefits (EHBs).
- Actuarial Value (AV) describes the average consumer's share of cost and is calculated based on the provision of EHBs at four tiers: Bronze (60% AV), Silver (70% AV), Gold (80% AV), and Platinum (90% AV).
- California law mandates an allowable de minimis variation range for AV of +/- 2% (Bronze is allowed a variation of +5%/-2%).
- In the fall of each year, the federal Office of Management and Budget (OMB) releases a draft AV Calculator (AVC) and Notice of Benefit and Payment Parameters (NBPP). The AVC and NBPP are used to model how benefit cost shares can be changed to ensure all plans fit within the de minimis range for each metal tier.
- Under the ACA, consumers up to 250% Federal Poverty Level (FPL) are eligible for Cost-Sharing Reduction (CSR) benefits that increase the value of a Silver plan thereby lowering out-of-pocket costs. For example, consumers with income up to 150% FPL can enroll in a Silver plan that pays 94 percent of expected costs, leaving the enrollee with a small cost-sharing obligation. The ACA CSR plans are as follows:
  - Silver 94 for consumers with income below 150% FPL
  - Silver 87 for consumers with income between 150% to 200% FPL
  - Silver 73 for consumers with income between 200% to 250% FPL

COVERED CALIFORNIA'S 2022 ACA PLAN DESIGNS

Benefit	Individual-only Platinum Coinsurance		Individual-only Platinum Copay		Individual-only Gold Coinsurance		Individual-only Gold Copay		Individual-only Silver		Silver 73		Silver 87		Silver 94		Bronze		Bronze HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible																				$7,000
Medical Deductible										$3,700		$3,700		$800		$75		$6,300		
Drug Deductible										$10		$10		$0		$0		$500		
Coinsurance (Member)		10%		10%		20%		20%		20%		20%		15%		10%		40%		0%
MOOP		$4,500		$4,500		$8,200		$8,200		$8,200		$6,300		$2,850		$800		$8,200		$7,000
ED Facility Fee		$150		$150		$350		$350		$400		$400		$150		$50	X	40%	X	0%
Inpatient Facility Fee		10%		$250		20%		$600	X	20%	X	20%	X	15%	X	10%	X	40%	X	0%
Inpatient Physician Fee		10%		---		20%		---		20%		20%		15%		10%	X	40%	X	0%
Primary Care Visit		$15		$15		$35		$35		$35		$35		$15		$5	X	$65	X	0%
Specialist Visit		$30		$30		$65		$65		$70		$70		$25		$8	X	$95	X	0%
MH/SU Outpatient Services		$15		$15		$35		$35		$35		$35		$15		$5	X	$65	X	0%
Imaging (CT/PET Scans, MRIs)		10%		$75		20%		$150		$325		$325		$100		$50	X	40%	X	0%
Speech Therapy		$15		$15		$35		$35		$35		$35		$15		$5		$65	X	0%
Occupational and Physical Therapy		$15		$15		$35		$35		$35		$35		$15		$5		$65	X	0%
Laboratory Services		$15		$15		$40		$40		$40		$40		$20		$8		$40	X	0%
X-rays and Diagnostic Imaging		$30		$30		$75		$75		$85		$85		$40		$8	X	40%	X	0%
Skilled Nursing Facility		10%		$150		20%		$300	X	20%	X	20%	X	15%	X	10%	X	40%	X	0%
Outpatient Facility Fee		10%		$100		20%		$300		20%		20%		15%		10%	X	40%	X	0%
Outpatient Physician Fee		10%		$25		20%		$40		20%		20%		15%		10%	X	40%	X	0%
Tier 1 (Generics)		$5		$5		$15		$15	X	$15	X	$15		$5		$3	X	$18	X	0%
Tier 2 (Preferred Brand)		$15		$15		$55		$55	X	$55	X	$55		$25		$10	X	40%	X	0%
Tier 3 (Nonpreferred Brand)		$25		$25		$80		$80	X	$85	X	$85		$45		$15	X	40%	X	0%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%		15%		10%	X	40%	X	0%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$150		$150		$500*		
Maximum Days for charging IP copay				5				5												
Begin PCP deductible after # of copays																		3 visits		
Actuarial Value																				
2022 AV (Draft 2022 AVC)		**91.59**		**89.25**		**81.90**		**78.01**		**71.07†**		**73.42†**		**87.75†**		**94.66**		**64.78†**		**64.60**
2021 AV (Final 2021 AVC)		**91.59**		**89.25**		**81.90**		**78.01**		**70.51†**		**73.29†**		**87.78†**		**94.09**		**64.83†**		**64.60**
Enrollment as of June 2020		52,640				146,610				206,600		127,060		316,180		208,340		341,720		114,170
Percent of Total enrollment		3%				10%				13%		8%		21%		14%		22%		7%

KEY		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2021
		Decreased member cost from 2021
		Does not meet AV
		Within .5 of upper de minimis
		Securely within AV

QHP DEDUCTIBLES FROM 2014-2022

The deductible for Silver* plans has increased significantly over the years.

Cumulative increases in Silver medical deductibles through 2021 are between 50% - 64% for Silver 70 to 87. Minor increase to Rx deductibles

	2014	2015	2016	2017
Silver 70	$2,000 / $250	$2,000 / $250	$2,250 / $250	$2,500 / $250
Silver 73	$1,500 / $250	$1,600 / $250	$1,900 / $250	$2,200 / $250
Silver 87	$500 / $50	$500 / $50	$550 / $50	$650 / $50
Silver 94	$0 / $0	$0 / $0	$75 / $0	$75 / $0

	2018	2019	2020	2021	2022
Silver 70	$2,500 / $130	$2,500 / $200	$4,000 / $300	$4,000 / $300	$3,700 / $10
Silver 73	$2,200 / $130	$2,200 / $175	$3,700 / $275	$3,700 / $275	$3,700 / $10
Silver 87	$650 / $50	$650 / $50	$1,400 / $100	$1,400 / $100	$800 / $0
Silver 94	$75 / $0	$75 / $0	$75 / $0	$75 / $0	$75 / $0

*Bronze deductible has remained at $6,300 since 2015, Gold and Platinum plans have a $0 deductible

D. ELIGIBILITY AND ENROLLMENT DATA

Isaac Menashe, Deputy Director, Evaluation and Research

COST SHARE REDUCTIONS AND PLAN VALUE

- Consumer decisions to take-up coverage, and which plan to choose, are governed by perceptions of plan value.
- When reviewing and comparing enrollment choices, attitudes, and utilization between consumers in different cost-share variants, it is important to remember that eligibility for cost-sharing and the amount of financial help with premiums *both* increase as income decreases: it can be difficult to disentangle “cost-sharing” effects from “premium” effects, and the differences between the Silver variants cannot solely be attributed to the plan designs / CSRs.

TAKE-UP RATES AMONG THE SUBSIDY-ELIGIBLE POPULATION

Based on the available estimates of the subsidy-eligible universe that could take up coverage, overall marketplace take-up falls as income increases.

FPL Bracket	CalSIM 3.0 Subsidy Eligible	Effectuated Subsidized Enrollment as of June 2021	Implied Take-up Rate
At or below 200% FPL	784,000	694,600	89%
200 to 400% FPL	1,100,000	655,300	60%
400 to 600% FPL	222,000	65,000	29%
Greater than 600% FPL	134,000	12,800	10%
Total	**2,240,000**	**1,427,700**	**64%**

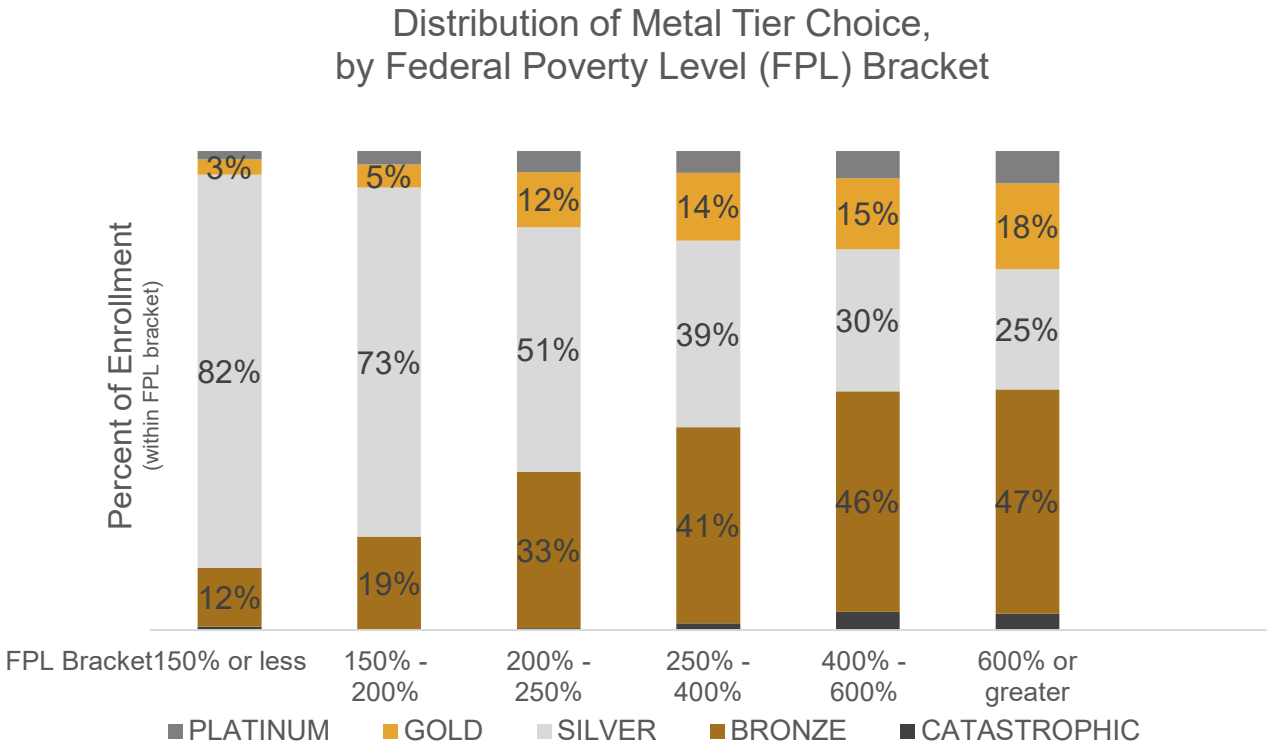
CalSIM 2021 estimates show Californians under Age 65 Eligible for Subsidies >$0 through Covered California.

Covered California subsidized enrollment reflects enrollees receiving subsidies > $0.

COVERED CALIFORNIA ENROLLMENT BY FPL AND METAL TIER

The selection of Silver plans decreases as income increases.

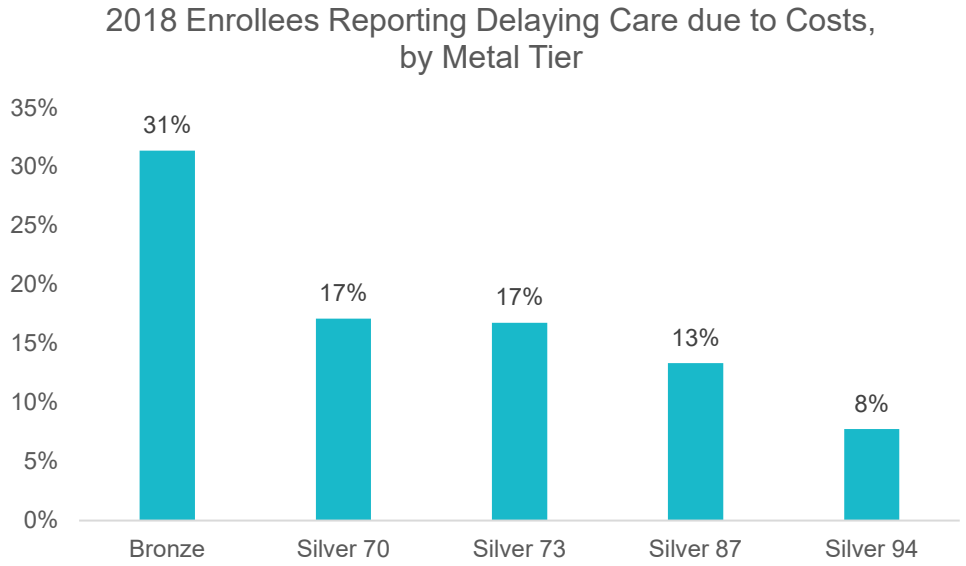
As FPL brackets increase, the level of premium assistance falls and the AV of Silver plans decreases, with no CSR plans above 250% of FPL.



Denominator is a total of each FPL bracket (consumers who applied on unsubsidized application are excluded). Population reflects June 2021 effectuated enrollment.

ENROLLEES WITH COST SHARING REDUCTIONS ARE LESS LIKELY TO REPORT DELAYING CARE DUE TO COST

- Three in ten Bronze enrollees report they delayed care due to cost in 2018, compared to less than one enrollees in ten Silver 94.
- Silver 70 enrollees reported delaying care due to cost at more than twice the rate of enrollees in Silver 94.



Source: 2018 Covered California Member Survey, asked of current year members: N=2,415. “In the last 6 months, how often did you delay visiting or not visit a doctor because you were worried about the cost? Do not include dental care.” Chart shows share of enrollees responding “Usually” or “Always.”

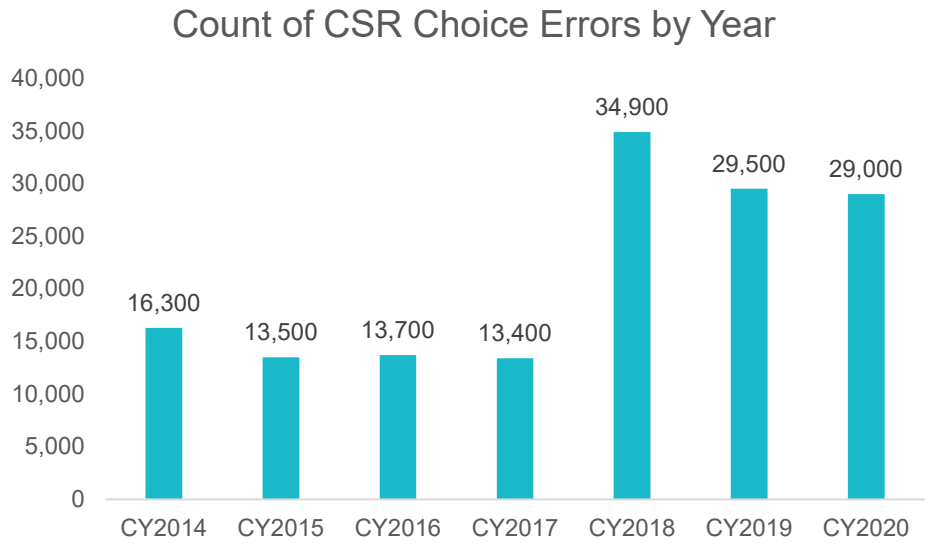
COST SHARE REDUCTIONS AND CHOICE ERRORS

- The Affordable Care Act's (ACA) Cost Sharing Reduction (CSR) Silver plans provide substantial financial protection to low-income consumers. But because enrollment into these plans is not automatic, every year hundreds of thousands of individuals across the ACA Marketplaces forgo CSR Silver plans for suboptimal alternatives—what is colloquially referred to as a "choice error"—and thereby pay more for worse coverage.*
- Between 2014 and 2020, over 150,000 low-income Californians effectuated into CSR choice error plans. In short, then, even when policymakers create plans with generous benefits and enhanced cost-sharing, individuals may not understand, or be aware of, these options.

* We define choice errors as instances in which a consumer enrolls in a lower actuarial value product for the same or higher premium (e.g., Silver 87-eligible in Gold or Silver 94-eligible in Gold or Platinum).

CSR CHOICE ERRORS IN HISTORICAL CONTEXT

- From January 2014 to January 2021, over 150,000 individuals have effectuated into CSR choice error plans.
- This problem accelerated following the termination of CSR subsidies in the fall of 2017, prior to the start of the 2018 coverage year.

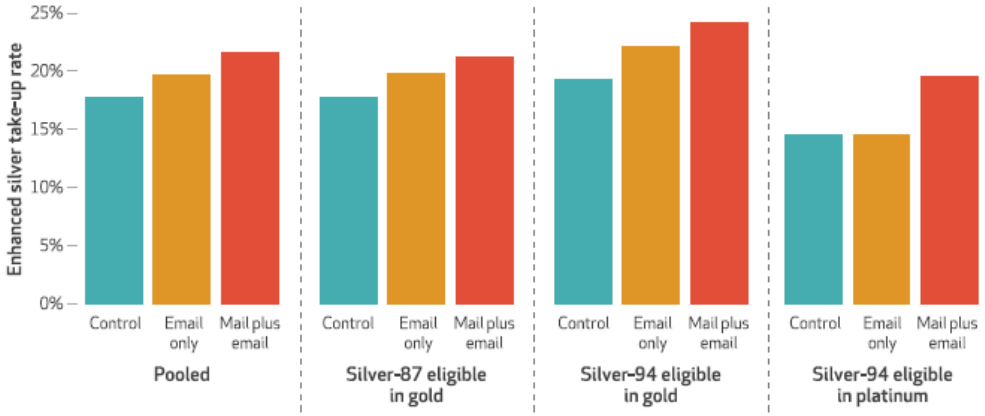


HELPING CONSUMERS TAKE-UP CSR PLANS

To address the incomplete take-up of CSR Silver plans, Covered California has rigorously tested different forms of low-cost outreach – emails, letters, and personalized phone calls from enrollment assisters – to see how they can improve plan choice quality.*

EXHIBIT 3

Effects of email and mail treatments on switching from choice error plans to enhanced silver plans in Covered California, 2019



SOURCE Authors' analysis of 2019 Covered California administrative data. **NOTES** The figure shows enhanced silver plan take-up rates in 2019 by treatment group and by choice error block among renewing enrollees who were in a choice error plan in 2018. The three choice error blocks are explained in the text. All estimates are statistically significant ($p < 0.05$ or $p < 0.01$) except for the email-only groups for silver-94-eligible patients in gold and platinum plans.

"Using Email And Letters To Reduce Choice Errors Among ACA Marketplace Enrollees," *Health Affairs* 40, no. 5 (May 1, 2021): 812–19, https://doi.org/10.1377/hlthaff.2020.02099.

HELPING CONSUMERS TAKE-UP CSR PLANS

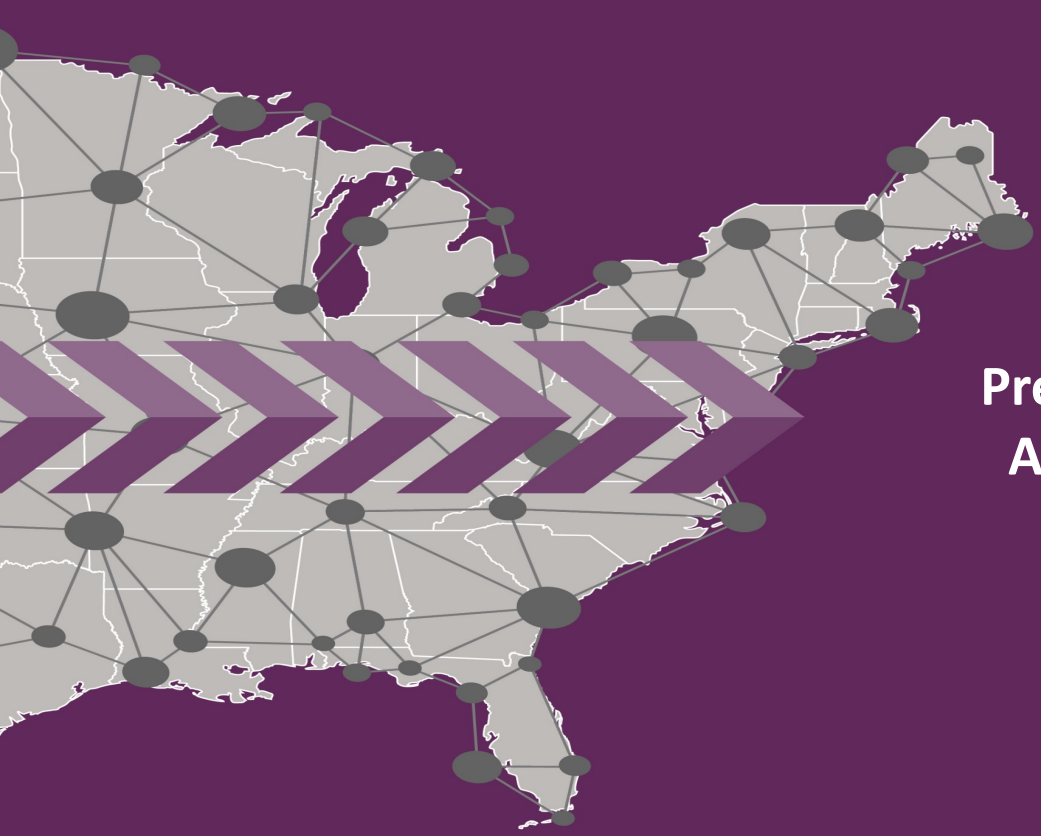
- While Covered California's outreach nudges caused small to modest increases in plan choice quality, inertia proved to be a considerable hurdle, such that the overwhelming majority of study participants remained in choice error plans.
- Outreach alone is insufficient: in the coming months, Covered California is instead implementing structural changes to improve plan choice quality among low-income households, including:

  (1) auto-renewing a subset of Bronze enrollees into free CSR Silver plans and

  (2) modifying its choice architecture to hide choice error plans from the plan display for low-income consumers.

OVERVIEW OF OTHER STATE COST SHARING PROGRAMS

Jason Levitis, Technical Assistance Provider, State Health and Value Strategies



Introduction to State Cost-Sharing Subsidies

Presentation to California Affordability Workgroup

Jason Levitis

September 30, 2021

STATE Health & Value STRATEGIES COVID-19

A grantee of the Robert Wood Johnson Foundation

About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Support for this meeting was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

About Jason Levitis

Jason Levitis is principal at Levitis Strategies LLC, a healthcare consultancy focused on the Affordable Care Act's coverage and tax provisions and state innovation waivers. He provides technical assistance to states officials in partnership with State Health and Value Strategies, a grantee of the Robert Wood Johnson Foundation housed at Princeton University. He's also a nonresident fellow at the Brookings Institution and a senior fellow at Yale Law School's Solomon Center for Health Law and Policy. He served at the U.S. Treasury Department from 2009 to 2017, where he led ACA implementation as Counselor to the Assistant Secretary for Tax Policy.

Contents

- Why a State Cost-Sharing Subsidy
- Federal Background
- Cost-Sharing Subsidies in Other States
- How State Cost-Sharing Subsidies Work
- Payment Options

Why a State Cost-Sharing Subsidy

Cost-sharing subsidies help people use the coverage they have and see the value in getting covered

- With the American Rescue Plan's premium tax credit (PTC) expansion, cost-sharing is perhaps the biggest remaining affordability concern
  - A family of 3 with income of $55,000 owes $2,300 per year for a benchmark silver plan after PTC but is ineligible for CSRs and faces an average deductible over $10,000
- Survey data suggests many people with health coverage cannot afford to use health care services
- The two states with cost-sharing subsidies (Mass. and Vermont) have long had among the nation's lowest uninsured rates
- Modeling by Oliver Wyman for Colorado suggests a strong coverage effect

Sources: CMS Plan Year 2021 Enrollment Data; JAMA: "Trends in Unmet Needs for…Services," KFF Health Coverage Data, Wyman Study of Colorado Indiv. Market Support Options for 2022

Federal Background

There is no federal legal barrier to state cost-sharing subsidies

- Sec. 1402 of the ACA requires carriers in the Marketplace to reduce cost-sharing for eligible consumers by providing silver variants with certain higher actuarial values (AVs)
  - This requirement remains in effect despite the termination of federal payments to support CSRs
- CMS has made clear on numerous occasions—including in writing—that state programs that further reduce cost-sharing for CSR-eligible consumers ***do not require a waiver or other federal approval***
- Massachusetts and Vermont have done so since 2014 without incident

Cost-Sharing Subsidies in Other States

Actuarial Values (AVs) Provided by Existing Cost-Sharing Subsidies

FPL Level	ACA	Mass.	Vermont	Col. (eff. 2022)
< 100%*	**94%**	**99.7%**	N/A (94%)	N/A (94%)
100-150%	**94%**	**95%**	N/A (94%)	N/A (94%)
150-200%	**87%**	**95%**	N/A (87%)	**94%**
200-250%	**73%**	**92%**	**77%**	N/A (73%)
250-300%	N/A (70%)	**92%**	**73%**	N/A (70%)
> 300%	N/A (70%)	N/A (70%)	N/A (70%)	N/A (70%)

* Individuals under 100% of FPL are generally eligible for CSRs only if "lawfully present" immigrants subject to the five-year Medicaid bar.

How State Cost-Sharing Subsidies Work

State requires reduced cost-sharing and pays carrier the differential cost

- State requires carriers to provide higher-AV silver plans to certain consumers for the price of a base silver plan
- Required state AV levels may (a) rely on federal variants—extending them to higher incomes (CO), (b) rely on new variants (MA), or (c) both (VT)
- Carriers design plans at the required AV
  - Design may be standardized (MA) or give carriers flexibility (ACA)
- Consumers shopping and using plans see the required variant
  - Federal and state CSR contributions are invisible to consumers
- State pays carrier the differential cost over the federally required AV (see next slide)

Payment Options

States can pay carriers' actual cost or use an estimate

Option 1: Estimated pre-payment with reconciliation based on actual cost (Federal/Mass/VT)

- Estimated pre-payment is calculated using a premium multiplier
  - Includes induced demand factor
- Reconciled based on actual cost difference for affected enrollees
  - Requires reporting by carrier, similar to pre-2018 federal reporting

Option 2: PMPM based on expected carrier cost (Colorado)

- PMPM may be carrier-specific, based on a premium multiplier, or other
- May account for induced demand
- No reconciliation for actual utilization, though adjusts for enrollment

Discussion

Thank You

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OVERVIEW OF OPTIONS TO BE MODELED AND POTENTIAL OUTPUTS

Katie Ravel, Director, Policy, Eligibility, and Research Division

LEGISLATIVE DIRECTION

- Include options for all Covered California enrollees with income up to 400 percent of the federal poverty level to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs.
- Include options to provide zero deductibles for all Covered California enrollees with income under 400 percent of the federal poverty level and upgrading those with income between 200 percent and 400 percent, inclusive, of the federal poverty level to gold-tier cost sharing.

CONSIDERATIONS FOR OPTIONS

- Covered California will develop a set of options to be modeled by Milliman.
- In developing options for initial modeling, Covered California is considering the following factors:
  - Should we use existing AV levels (i.e. 80, 87, 90, 94), create new AV levels (i.e.. 85, 95), or use some combination of the two?
  - What options should be considered for each FPL group?
  - What are the AV and pricing impacts of eliminating deductibles?
- Note: these considerations may also impact operational discussions

PLANNED OUTPUTS FOR EACH OPTION TO BE MODELED

- Average PMPM cost of changing to a richer benefit by FPL group and by:
  - Northern California
  - Southern California
  - All California
- Estimated enrollment impacts of changing to a richer benefit by FPL group
- Total annual cost of changing to a richer benefit for 2023

Note that the modeling will be for the portion of new CSR that exceeds the existing federal CSR.

AGENDA REVIEW FOR OCTOBER 14 MEETING AND NEXT STEPS

Katie Ravel, Director, Policy, Eligibility, and Research Division

WORKING GROUP SCHEDULE AND POTENTIAL TOPICS

Date	Meeting Forum	Potential topics
September 30th	AB 133 working group #1	
October 14th	AB 133 working group #2	• Review initial modeling of options
October 28th	AB 133 working group #3	• Review additional modeling as needed • Discuss operations
November 10th *	AB 133 working group #4	• Continue discussion of operations
November 18th	**Board meeting**	Present cost sharing estimates and discuss operational issues
December 2nd	AB 133 working group #5	• Review ARPA modeling if needed • Review draft report
December 16th *	AB 133 working group #6	

** If needed.*

NEXT STEPS FOR MODELING DISCUSSION AND WORKING GROUP REMINDERS

- Recommendations for options to be modeled for the October 14th meeting can be submitted to policy@covered.ca.gov by Tuesday, October 5th
- Check the AB 133 website for agendas and meeting materials: https://www.hbex.ca.gov/stakeholders/AB_133_Health_Care_Affordability_Working_Group/

APPENDIX

AB 133 LEGISLATION

SEC. 12. Section 100520.5 is added to the Government Code, immediately following Section 100520, to read:

100520.5. (a) The Health Care Affordability Reserve Fund is hereby created in the State Treasury.

(b) Notwithstanding any other law, the Controller may use the funds in the Health Care Affordability Reserve Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381.

(c) Upon the enactment of the Budget Act of 2021, and upon order of the Director of Finance, the Controller shall transfer three hundred thirty-three million four hundred thirty-nine thousand dollars ($333,439,000) from the General Fund to the Health Care Affordability Reserve Fund.

(d) Upon appropriation by the Legislature, the Health Care Affordability Reserve Fund shall be utilized, in addition to any other appropriations made by the Legislature for the same purpose, for the purpose of health care affordability programs operated by the California Health Benefit Exchange.

(e) (1) The California Health Benefit Exchange shall, in consultation with stakeholders and the Legislature, develop options for providing cost sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians. On or before January 1, 2022, the Exchange shall report those developed options to the Legislature, Governor, and the Healthy California for All Commission, established pursuant to Section 1001 of the Health and Safety Code, for consideration in the 2022–23 budget process.

(2) In developing the options, the Exchange shall do all of the following:

(A) Include options for all Covered California enrollees with income up to 400 percent of the federal poverty level to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs.

(B) Include options to provide zero deductibles for all Covered California enrollees with income under 400 percent of the federal poverty level and upgrading those with income between 200 percent and 400 percent, inclusive, of the federal poverty level to gold-tier cost sharing.

(C) Address any operational issues that might impede implementation of enhanced cost-sharing reductions for the 2023 calendar year.

(D) Maximize federal funding and address interactions with federal law regarding federal cost-sharing reduction subsidies.

(3) The Exchange shall make the report publicly available on its internet website.

(4) The Exchange shall submit the report in compliance with Section 9795 of the Government Code.