Covered California Plan Options

Participant Guide

Version 1.0

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1 INTRODUCTION

The Plan Options course covers the pathways to insurance coverage through the Covered California marketplace. It explains the insurance options available and provides details and tips for helping consumers compare and choose from among their Covered California Health Plan choices.

1.1. LEARNING OBJECTIVES

At the end of this course, you will be able to explain:

- ✓ The three paths to health insurance coverage
- ✓ An overview of Medi-Cal and Medi-Cal plan selections
- ✓ An overview of Covered California Health Plans, including an overview of covered services and policies
- ✓ How to compare plan choices:
  - Across Regions
  - Across Plan Types
  - Across Benefits
  - Across Different Costs/Premiums, including options for premium assistance-eligible consumers
- ✓ Helpful resources for plan selection and additional information

2 LESSON 1: HEALTH INSURANCE OPTIONS THROUGH COVERED CALIFORNIA

This lesson will provide an overview of the plan options, the three consumer paths available and who is eligible to for each path. The CoveredCA.com website and tools needed to provide plan options will also be discussed.

2.1. LEARNING OBJECTIVES

At the end of this lesson you will be able to:

- ✓ Describe health insurance options
- ✓ Describe the three consumer paths to health insurance

2.1.1. Overview of Health Insurance Options

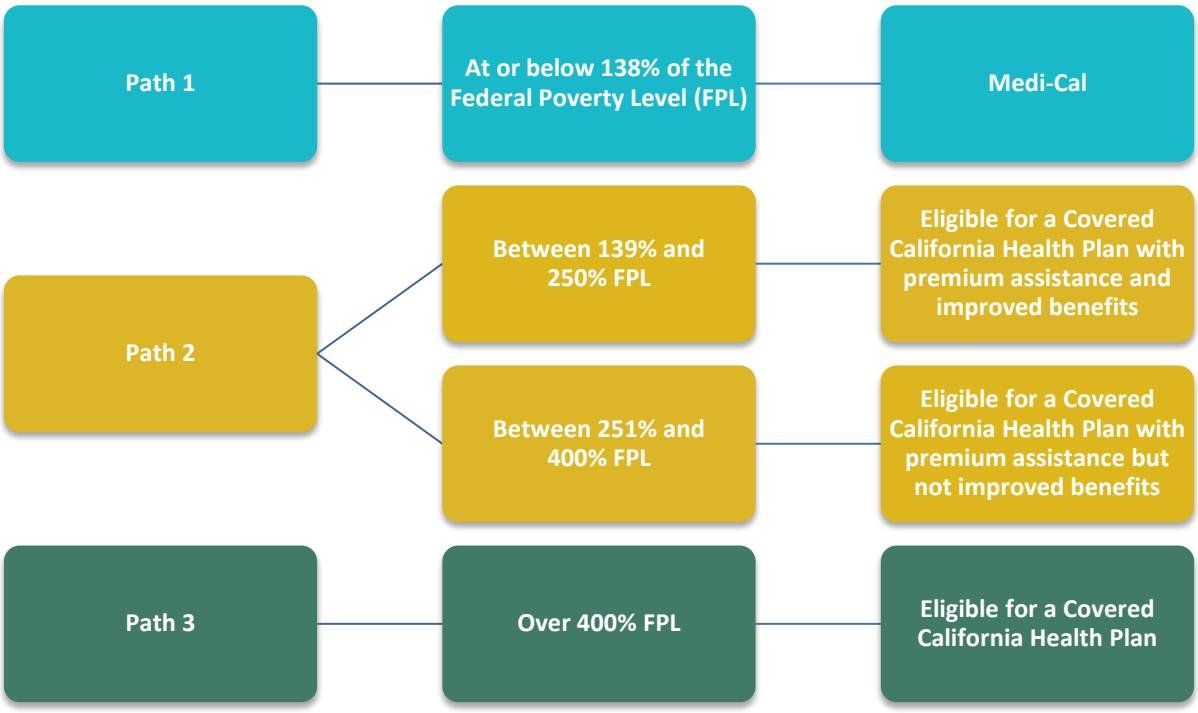
Covered California is a one-stop, convenient marketplace for Californians to get health insurance. Whether consumers want to shop for quality, affordable private insurance or enroll in Medi-Cal, they can do it through Covered California.

Covered California also helps small businesses purchase health insurance. The Small Business Health Options Program (SHOP) is designed for small businesses with 50 or fewer eligible employees. Through SHOP, small businesses have the opportunity to purchase competitively priced health insurance offered by private health insurance companies, and offer their employees a choice from an array of comprehensive plan options. Some small businesses may qualify for tax savings (credits) which may offset their cost of health insurance for their employees.

The discussion in this course is specific to Covered California's individual consumer marketplace, including Medi-Cal.

2.1.2. Three Consumer Paths to Health Insurance

Health care coverage and costs through Covered California are driven by household income. There are three paths to coverage, each of which results in different health plan options for individuals. The paths are:



Covered California is the only place eligible individuals in California have access to Path 2 and thus can receive the premium assistance and the improved benefits to reduce the overall cost of their health insurance. The Eligibility for Individuals and Families course discusses in more detail the various ways consumers apply and qualify for these paths.

2.1.3. CoveredCA.com Website and Tools

CoveredCA.com is a web-based marketplace designed to make it easy for consumers to determine which path to health coverage is the right one. CoveredCA.com will make it easy to search for health plan availability and benefit plan options within each path as well as enabling eligible individuals to enroll in Medi-Cal or qualify for additional assistance.

All eligible Covered California Health Plans are listed on the Covered California website. To simplify shopping, CoveredCA.com features a smart sort option. Consumers answer three basic questions about what is most important to them (for example, a low monthly premium) and then CoveredCA.com finds and displays the plans that most closely match your preferences.

CoveredCA comparison tools let users compare options to find the coverage that meets both their health and budget needs. Additional details on how individuals can leverage the CoveredCA.com tools to shop for health plan options are addressed later in this course.

3 LESSON 2: MEDI-CAL OVERVIEW AND PLAN SELECTION

This lesson will provide an overview of Health Insurance Options and also describe the three consumer paths to Health Insurance.

3.2. LEARNING OBJECTIVES

At the end of this lesson you will be able to:

- ✓ Describe health insurance options
- ✓ Describe the three consumer paths to health insurance

3.2.1. Medi-Cal Overview

The first path to coverage for individuals whose income is at or below 138% of FPL is Medi-Cal. Medi-Cal is California's Medicaid program. It was created for low-income Californians who are U.S. citizens, as well as most legal immigrants.

Consumers and families can apply for Medi-Cal benefits regardless of gender, race, religion, color, national origin, sexual orientation, marital status, age, disability or veteran status. If determined to be eligible, a consumer or family can get Medi-Cal as long as eligibility is maintained.

Also part of Medi-Cal is the Targeted Low-Income Children's Program (TLICP). It is a low-cost insurance program for children and teens who fall at or below 250% of FPL. It provides health, dental and vision coverage to children and teens that do not have health insurance. This program replaces the Healthy Families Program (HFP). The Department of Health Care Services (DHCS) began the transition of the Healthy Family children into the Medi-Cal program on January 1st, 2013. The transition of HFP enrollees to Medi-Cal simplifies eligibility and coverage for children and families, while providing additional benefits and lowering costs for children at certain income levels.

For more information on Medi-Cal or TLICP visit www.dhcs.ca.gov

3.2.2. What Medi-Cal Covers

Medi-Cal pays for a variety of medical, mental health, vision and dental services for children and adults with limited income and resources. Medi-Cal is supported by federal and state taxes.

Medi-Cal coverage for adults includes medical services, pharmacy and vision services, as well as durable medical equipment.

Medical	Pharmacy and Vision	Durable Medical Equipment
• Clinic services • Drug and alcohol treatment • Inpatient/outpatient services • Long-term care • Mental health	• Prescription drug coverage • Eye exams and tests	• Wheelchairs • Wheelchair repair • Hearing aids • Batteries for hearing aids and/or pacemakers

Medical	Pharmacy and Vision	Durable Medical Equipment
• Physician-administered drugs • Physician services • Podiatry services		

Adult Medi-Cal coverage also includes:

• Acupuncture	• Audiology and hearing aids	• Chiropractic
• Medical transportation	• Orthotics and prosthetics	• Therapies: occupational, physical and speech

For children and young adults under age 21, there is no charge for the following:

Medical	Pharmacy	Dental and Vision
• Physician, medical and surgical services • Preventive health care exams • Immunizations • Well-child services • Medically necessary hospitalization • Inpatient and outpatient services • Family planning services • Laboratory and x-ray services • Mental health services • Occupational, physical and speech therapies	• Prescription drug coverage	• Vision benefits, including an eye exam and eyeglasses every 24 months • Dental benefits, including preventive and diagnostic services

3.2.3. Medi-Cal Share of Cost and Bridge Plan

There are two options in Medi-Cal that people should be aware of when helping individuals who are in or eligible for Medi-Cal. The first is Share of Cost and the second is the Bridge Plan, which will be available sometime in 2014.

3.2.4. Medi-Cal Share of Cost

In rare instances, Medi-Cal consumers must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share of Cost (SOC). A Medi-Cal subscriber's SOC is similar to a private insurance plan's out-of-pocket deductible.[i]

- The SOC amount depends upon a person or family's monthly income.
  - The SOC is determined first by subtracting certain exemptions and deductions from a consumer's or a family's gross monthly income, and then subtracting an additional amount for living expenses (called a "maintenance need").
  - The remaining amount is the SOC.
  - County social service departments calculate the SOC amounts.
- When a Medi-Cal beneficiary uses medical services and would like Medi-Cal to pay for them:
  - The SOC amount must first be met in that month before Medi-Cal will pay for the service(s)
  - A SOC is required only in those months in which services are used

The Medi-Cal member needs to keep his/her permanent Benefits Identification Card (BIC) in case medical services are needed in the future.

3.2.5. Bridge Plan

The Bridge Plan will be deployed in 2014 and is not currently available. The Bridge Plan will initially only be available to individuals that, due to eligibility changes, would transition from Medi-Cal or Medi-Cal TLICP to Covered California. Covered California will certify certain Medi-Cal Managed Care plans as QHP's so they serve as a "bridge" plan between Medicaid/TLICP coverage and Covered California private insurance. This would allow individuals whose income increases to change from Medi-Cal or Medi-Cal/TLICP coverage to Covered California and stay with the same health insurance company and provider network to ensure continuity in care if they choose. It would also allow family members to be covered by a single health insurance company with a largely similar provider network. The Bridge Plan will offer low premiums for their marketplace eligible enrollees through contracts as Covered California plans. These Medi-Cal plans will then serve both Medi-Cal eligible individuals and some Covered California members.

Additional details on the Bridge Plan will be available closer to April 1, 2014.

3.2.6. Medi-Cal Health Plan Selection

Most individuals who qualify for Medi-Cal will need to enroll with a health insurance company to receive benefits. Health insurance companies contract with Medi-Cal to provide services to Medi-Cal beneficiaries. This means that many individuals who qualify for Medi-Cal may choose the health insurance company they want. Medi-Cal enrollees can choose one plan for the entire family or choose a different plan for each family member.

Medi-Cal health plans are available to individuals based on their county of residence. The counties listed below require Medi-Cal individuals to enroll in a plan while individuals who live in other counties may choose to enroll either in a health plan or remain in fee-for-service Medi-Cal.

Counties requiring enrollment into a health plan are:

- Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare

Individuals in Medi-Cal may choose a health plan or change health plans at any time. For more information on how to enroll with a health plan or change a health plan go to, http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/Enrollment/Choice_Enrollment_Form.aspx or call Medi-Cal Health Care Options at 1.800.430.4263.

4 LESSON 3: INSURANCE OPTIONS THROUGH COVERED CALIFORNIA

Paths 2 and 3 both lead to Covered California Health Plans. A Covered California Health Plan is the name for our state's Qualified Health Plans (QHPs) as defined in the Affordable Care Act (ACA). These plans are certified by Covered California, provide Essential Health Benefits, use our standard benefit designs and meet quality and access requirements. Any individual purchasing coverage through the Covered California marketplace has access to Covered California Health Plans. This lesson addresses Covered California certification, explains benefit tiers and metal levels and addresses Covered California plans premiums and out-of-pocket costs.

4.1. LEARNING OBJECTIVES

At the end of this lesson you will be able to:

- ✓ Define Covered California Certification Criteria
- ✓ Describe the Metal Tiers and Actuarial Values
- ✓ Gain an overview of Premium Rates and Costs
- ✓ Gain an overview of Covered Services

4.1.1. Covered California Certification Criteria

Covered California Health Plans are private health plans that are certified by Covered California. This means that these health plans underwent an in depth review in order to be offered in the Covered California marketplace. Covered California Health Plans are required to meet the criteria specified in the ACA and established by Covered California. The certification criteria include:

- Provide Essential Health Benefits (describes scope of covered benefits)
- Follow established limits on cost-sharing (such as deductibles, copays and out-of-pocket maximum amounts)
- Offer benefit or plan designs to all that do not discriminate against consumers because of age, present or predicted disability, degree of medical dependency, life expectancy or other health conditions
- Meets network adequacy requirements, including Medi-Cal non-profit providers who serve predominately low-income, medically underserved individuals
- Comply with premium rating rules and requirements
- Be accredited by an approved accrediting entity and submit quality measures
- Meet other requirements as set by Covered California

Covered California set additional standards for selecting health plans to ensure that they offer the optimal combination of choice, value, quality and service. Covered California used

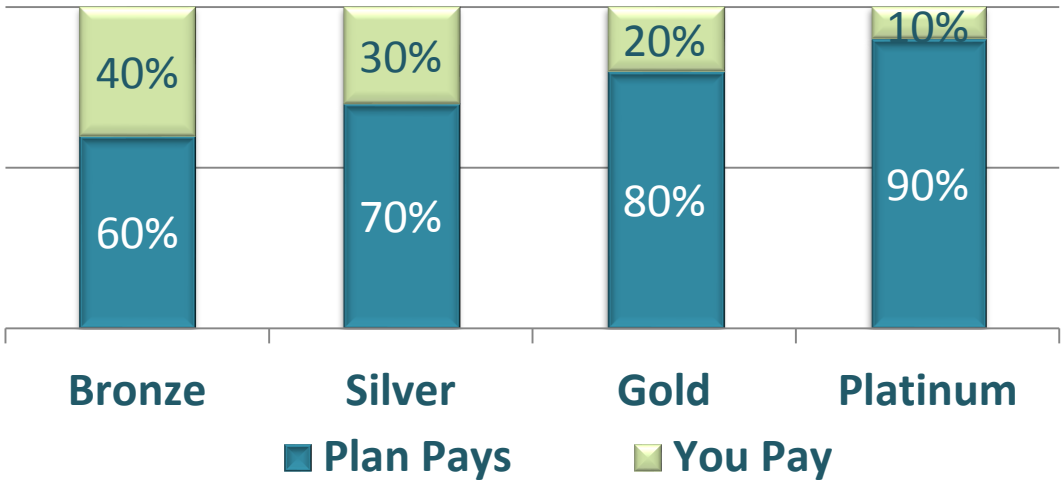
its purchasing power to negotiate health plan rates that provide the best value for consumers.

To be a Covered California Health Plan, health plans must also be licensed, solvent and in good standing with the state. In California, health plans may either be licensed as health care service plans under the Knox-Keene Health Care Service Plan Act of 1975 administered by the Department of Managed Health Care, or possess a Certificate of Authority as an insurer from the California Department of Insurance.

4.1.2. Understanding Metal Tiers and Actuarial Value

Covered California plans are organized into categories of coverage, called metal tiers, based on actuarial value. The idea is to make it easier for consumers to compare coverage options and tradeoffs.

- A health plan's actuarial value is the percentage of total average costs for benefits that a plan covers. Starting in 2014, all health plans in the market will be described by the metal tier corresponding to their actuarial value: bronze, silver, gold or platinum.
- The higher the metal value, the higher the percentage of health care expenses paid for by the health plan.
- This means the platinum-level plans are actuarially designed to cover the highest percentage of health care expenses (90%) on average. These expenses are usually incurred at the time of health care services, for example, when you visit the doctor or the emergency room. The health plans that cover the greatest percentage of health care expenses also usually have higher premium payments. Gold plans are designed to cover 80% of health care expenses.



- Within the silver plan, your insurance company pays 70% of the average costs. Some consumers who are eligible for premium assistance to offset the premium cost are also eligible to enroll in enhanced versions of the silver plan that cover up to 94% of costs thereby reducing the enrollee's out-of-pocket costs.

- All health plans participating in Covered California offer a plan for each of the four metal tiers, as well as a fifth product known as a Minimum Coverage Plan.
- A Minimum Coverage Plan is a high-deductible health plan offered through the marketplace. These plans are for consumers under age 30 (who are at a lower risk for ongoing, expensive health issues) or consumers who are allowed to purchase this low cost coverage because the cost of the cheapest Bronze plan exceeds 8% of their income. These plans still cover all Essential Health Benefits but feature lower premiums with higher deductibles and out-of-pocket costs. Minimum Coverage Plans are not available through SHOP.
- This five-plan offer requirement is required by California law.

4.1.3. Overview of Plan Premium Rates and Costs

Covered California Health Plans develop premium rates and as prescribed by the ACA and California law. It is important for consumers to understand how premium rates intersect with other health insurance costs, especially out-of-pocket costs.

The cost of health insurance is made up of the monthly premium and the costs due when covered services are used, referred to as out-of-pocket costs.

Premium Development

The premium is the amount paid to the health insurance company for coverage. Under the ACA and California law, health insurance companies are only permitted to vary premiums for particular plan products based on the following factors:

- Age: Health insurers may charge higher premiums to people who are older and low premiums for younger people. A particular plan will charge all consumers ages 0 to 20 years of age the same rate based on age, while consumers ages 21 and above will experience increases in premiums related to their age, up to age 64.
- Geographic pricing regions: There are 19 different pricing regions in California. This means health plan prices will vary by geography.

Good to know:

A 21 year old consumer who lives in Marin will likely have a different rate than a 21 year old consumer who lives in San Francisco, since Marin is in pricing region 2 and San Francisco is in pricing region 4.

- Family composition (for example, an individual versus a family): Each family member will be charged based on the premium for their age. However, health plans can charge for only three children under 21 in the family. For example, in a family of six, the rate would be the member rate + spouse rate + Child 1 rate + Child 2 rate + Child 3 rate. Child 4 would enjoy the same coverage as the other 3 children, but at no additional expense to the family. All children age 21 and older are charged premiums based on their ages and are not subject to the 3 child under 21 cap.

Individuals who qualify may receive help paying for their premiums. This help comes in two forms: premium assistance and access to enhanced silver plan benefits where out-of-pocket costs are lower.

All health insurance companies offering coverage through Covered California are required to accept all applicants during approved enrollment times regardless of their health status or other factors (age, gender, race, national origin, tobacco use etc.).

In talking with consumers about plans, it is also important to know that consumers can expect their rates to increase with their age and due to other factors such as medical inflation. However, Covered California Health Plan rates cannot change more than once a year. It is also important to emphasize that the rates for 2014 are fixed and will not change during 2014.

At the end of the year, health insurance companies must prove to their regulators that they have spent a t least 80% of premiums collected on clinical health care services and quality improvement activities. If they do not spend at least 80% they send refunds to consumers or employers. This rule helps keep premiums affordable.

4.1.4. Out-of-Pocket Costs

Out-of-pocket cost, also called cost-sharing, refers to the amount the consumer pays for covered services at the time they use them. It usually includes:

- Coinsurance (e.g. 20%)
- Co-payments, or similar charges (e.g. $45/doctor visit)
- Deductibles

Out-of-pocket costs generally do not include:

- Monthly premiums
- Balance billing amounts for out-of-network doctors and hospitals
- The cost of non-covered services or not medically necessary services

Consumers can use CoveredCA.com to estimate how much they will pay out-of-pocket for the health plans they're interested in.

Under the ACA, out-of-pocket costs are capped at a specific amount, which may differ by metal level. This is called the annual out-of-pocket maximum.

4.1.5. Overview of Covered Services

Covered services are also known as medical benefits. They are the set of medical services, such as physician visits, hospitalizations and prescription drugs, covered by the health plan. Covered California medical plans cover all Essential Health Benefits except the pediatric dental benefit. Consumers can purchase the pediatric dental benefit through standalone dental plans which will be offered through the Covered California marketplace. Both dental HMO and dental PPOs will be available. Health and dental plans may not set have annual or lifetime dollar limits on Essential Health Benefits.

All Covered California plans cover the same, standard benefit packages across the metal tiers. The chart shows the categories and coverage options for consumers not eligible for premium assistance or improved benefits. When the chart below shows a dollar amount, the member will need to pay that amount as a copayment whenever the member receives that service. When the chart has a percentage, the member pays that percentage of the allowed amount as coinsurance for the covered benefit. Numbers in light blue are subject to a deductible; that means the member pays 100% of allowed costs for these benefits, up to the annual deductible, and then pays only the coinsurance or copayment after the deductible is reached. After the maximum out-of-pocket amount is paid, no additional cost-sharing is owed by the member and the plan pays for 100% of any covered service after that point in time.

	Platinum	Gold	Silver	Bronze
COPAYS IN GREEN SECTIONS ARE NOT SUBJECT TO ANY DEDUCTIBLE AND COUNT TOWARD THE ANNUAL OUT-OF-POCKET MAXIMUM			**BENEFITS IN BLUE ARE SUBJECT TO DEDUCTIBLES**	
Deductible (if any)	No Deductible	No Deductible	$2,000 Medical Deductible $250 Brand Drug Deductible	$5,000 Deductible for Medical and Drugs
Preventive Care Services Copay	No cost – one per annual year	No cost – one per annual year	No cost – one per annual year	No cost – one per annual year
Primary Care Visit Copay	$20	$30	$45	$60/visit for first 3 visits per year
Specialty Care Visit Copay	$40	$50	$65	$70
Urgent Care Visit Copay	$40	$60	$90	$120
Generic Medication Copay	$5	$19	$19	$19
Lab Testing	$20	$30	$45	30% of your plan's negotiated rate
X-Ray Copay	$40	$50	$65	30% of your plan's negotiated rate
Emergency Room Copay	$150	$250	$250	$300
High cost and infrequent services like Hospital Care, Outpatient Surgery	**HMO** Outpatient Surgery — $250 Hospital — $250 per day up to 5 days **PPO** 10%	**HMO** Outpatient Surgery — $600 Hospital — $600 per day up to 5 days **PPO** 10%	20% of your plan's negotiated rate	30% of your plan's negotiated rate
Imaging (MRI, CT, PET Scans)	$150	$250	$250	30% of your plan's negotiated

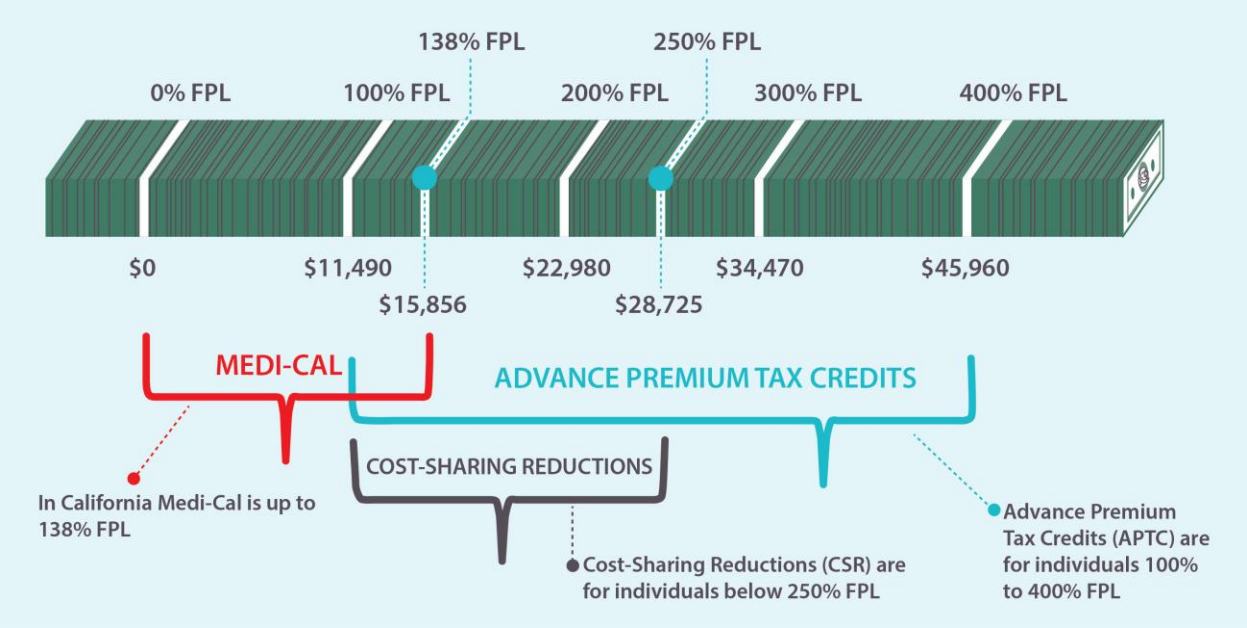
	Platinum	Gold	Silver	Bronze
				rate
Brand medications may be subject to Annual Drug Deductible before you pay the copay	No Deductible	No Deductible	$250 Deductible then pay the Copay amount	$50-$75 after meeting Deductible
Preferred brand copay after Drug Deductible (if any)	$15	$50	$50	$50
MAXIMUM OUT-OF-POCKET FOR ONE	**$4,000**	**$6,350**	**$6,350**	**$6,350**
MAXIMUM OUT-OF-POCKET FOR FAMILY	**$8,000**	**$12,700**	**$12,700**	**$12,700**

4.1.6. Continuum of Coverage

Eligibility for insurance affordability programs falls along a continuum based on income, age, and other eligibility factors.

On this continuum, income is measured as percent of the Federal Poverty Level, or FPL.

Children qualify for Medi-Cal and CHIP at higher income levels than their parents. As a result, families may have members in more than one insurance affordability program. The chart below illustrates 2013 thresholds for single adults California thresholds differ for children.



*Note: Amounts represent income for one person in household using 2013 FPL Annual Guidelines.

5 LESSON 4: PREMIUM PAYMENT FUNCTIONALITY

5.2. LEARNING OBJECTIVES

At the end of this lesson you will be able to:

- ✓ Explain premium payment functionality
- ✓ Understand initial and on-going enrollment premium payment functionality
- ✓ Describe premium payment functionality for unbanked consumers

5.2.1. Premium Payment Functionality

It is important to note that in order for coverage to start, payment must be received in full by the Covered California Health Plan that the consumer selects. The 12 Covered California Health Plans will offer a comprehensive menu of payment alternatives beginning in October 2013. All payments should be made payable to the selected health plan. Covered California will not accept forms of payment made payable to Covered California.

Covered California Health Plans accept payments via:

- Personal check
- Money order
- Re-loadable credit, debit and prepaid cards (contains Visa, Mastercard or American Express Symbol)
- Some Covered California Health Plans are planning to include other payment options including the ability for enrollees to make payments with cash, delivered in-person to a designated payment facility, or Electronic Funds Transfer (EFT)/Automated
- Clearing House (ACH) transactions.

The table below shows Covered California's Health Plan Payment Options.

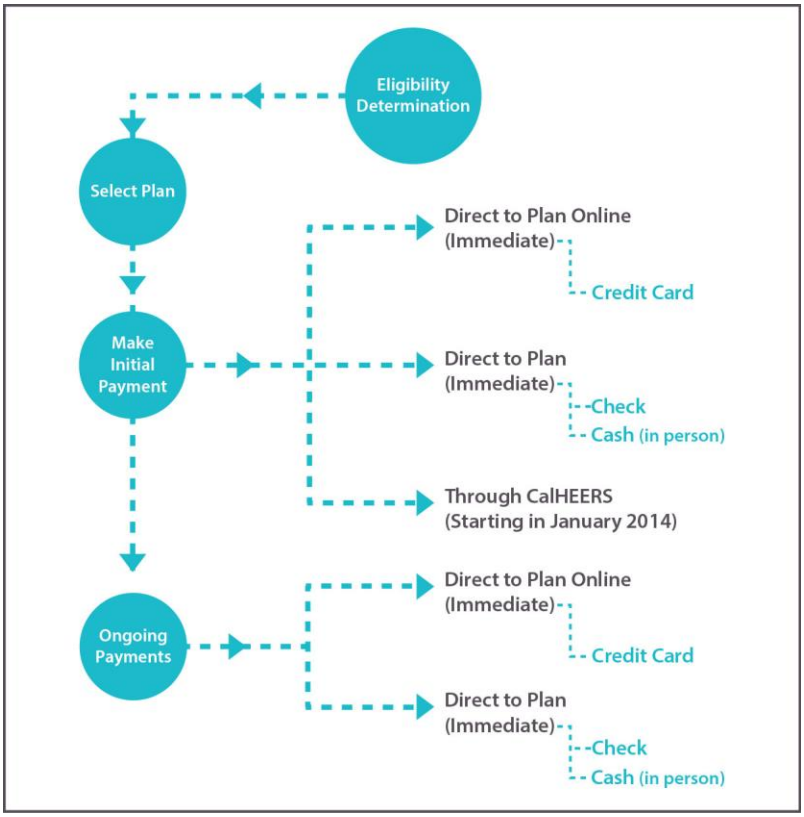
		Cash	Personal Check	Cashier's Check	Money Order	Credit Card	Debit Card	EFT/ACH	Wire Transfer
1.	Alameda Alliance for Health		Yes	Yes	Yes	V, MC	Yes		
2.	Anthem Blue Cross		Yes	Yes	Yes	V, MC	Yes	Yes	
3.	Blue Shield of CA*		Yes	Yes	Yes	V, MC	Yes	Yes	
4.	Chinese Community HP	Yes	Yes	Yes	Yes	V, MC	Yes	Yes	
5.	Contra Costa Health Plan	Yes	Yes	Yes	Yes	V, MC	Yes	Yes	
6.	Health Net of CA		Yes	Yes	Yes	V, MC	Yes	Yes	
7.	Kaiser Permanente		Yes	Yes	Yes	V, MC, AMEX, D	Yes	Yes	
8.	L.A. Care Health Plan	Yes	Yes	Yes	Yes	V, MC, D	Yes		
9.	Molina Healthcare		Yes	Yes	Yes	V, MC, D	Yes		
10.	Sharp Health Plan	Yes	Yes	Yes	Yes	V, MC	Yes		
11.	Valley Health Plan	Yes	Yes	Yes	Yes	V, MC, AMEX	Yes	Yes	Yes
12.	Western Health Advantage	Yes	Yes	Yes	Yes	V, MC, D	Yes	Yes	Yes

5.2.2. Initial Enrollment Premium Payment Functionality

Because of the complexity to establish separate payment functionality with each of the 12 Covered California Health Plans, CoveredCA.com provides a single payment portal, via a third party vendor, to provide payment functionality for the first month's premium. When implemented, the third party vendor (NIC) will provide a seamless transfer from CoveredCA.com to the payment portal where the enrollee can provide payment information and make the binder payment. The payments would then be forwarded from NIC directly to the plans. Covered California established this payment functionality for the Covered California Health Plans as an option, to provide a seamless transition and full payment functionality at the point of enrollment.

While the Covered California Health Plans are strongly encouraged to utilize this option for the first premium payment, it is not a requirement. For this fall, however, the option of a single payment portal for all Covered California Health Plans via CoveredCA.com will not be available. In the absence of a single payment portal, at the completion of the enrollment process, Covered California has taken steps to ensure that consumers are directed to a plan-specific URL that provides the following:

- Allows the consumers to make a payment online by transferring to a link designated by the Covered California Health Plan, but without transferring data from CoveredCA.com;
- Provides the consumers with instructions on how to make a payment offline.



For consumers who do not desire or are unable to make a payment through CoveredCA.com they can make direct payment to their selected health plans via direct mail, directly through the plans on-line portal or in person at a designated payment facility.

5.2.3. On-Going Enrollment Premium Payment Functionality

Ongoing enrollments premium payments will not be accepted through CoveredCA.com. All on-going payments must continue directly through the selected Covered California Health Plan. Covered California Health Plans will continue to accept payments via:

- Personal check
- Money order
- Re-loadable credit, debit and prepaid cards (contains Visa, Mastercard or American Express Symbol)
- Some Covered California Health Plans are planning to include other payment options including the ability for enrollees to make payments with cash, delivered in-person to a designated payment facility, or Electronic Funds Transfer (EFT)/Automated Clearing House (ACH) transactions.

5.2.4. Unbanked Consumers Premium Payment Functionality

Covered California appreciates that not all consumers have bank accounts or revolving lines of credit (such as a credit card). In order to facilitate both initial premium and on-going monthly premium payments, unbanked consumers may make payments directly to their selected health plan using the following mechanisms:

- Cash payments will be accepted at designated payment offices (cash should not be mailed);
- Money orders payable to the health plan may be mailed or delivered in person to designated payment offices
- Re-loadable credit, debit and prepaid cards (contains Visa, Mastercard or American Express Symbol)

6 LESSON 5: COMPARING PLAN CHOICES

In this lesson you will take a closer look at determining eligibility for premium assistance and better benefits. You will also learn how to identify plan options by region, by type, by benefits and by total cost.

6.1. LEARNING OBJECTIVES

At the end of this lesson you will be able to:

- ✓ Determine eligibility for premium assistance and better benefits.
- ✓ Understand what an enhanced silver plan is and the value of reduced out-of-pocket costs in these plans
- ✓ Identify plan options by region, by type, by benefits and by total cost
- ✓ Understand how to compare premiums vs. out-of-pocket costs

6.1.1. Determine Eligibility for Premium Assistance and Better Benefits

Covered California provides a modern, new way to learn about health insurance options and enroll in coverage. CoveredCA.com is the online portal to Covered California and is designed to make the process of finding and buying affordable health insurance easy.

Four Steps to the Right Fit

There will be a number of options for consumers to compare when shopping in the Covered California marketplace. These four steps, done in order, simplify the process for determining eligibility for premium assistance so it's faster and easier for consumers to get the health insurance they deserve.

1. Determine eligibility for premium assistance and silver plans with better benefits
2. Compare and contrast plan options by:
    - Region
    - Type (HMO, PPO, etc)
    - Benefits
    - Total Costs
3. Select a health plan
4. Enroll

Note:

- The lower the household income, the larger the amount of premium assistance.
- As a result, the percentage of plan-covered expenses goes up lessening the members cost and the benefit coverage becomes more comprehensive or improved.

Here is how the income ranges relate to the 2013 FPL for the purpose of determining how much financial assistance consumers receive. As this chart below shows:

- Consumers with income up to 250 percent of FPL may receive both premium assistance and access to an enhanced silver plan. The improved benefits are reflected in the change in actuarial value (an average amount expected to be covered by the plan). There are three types of enhanced silver plans – 94%, 87%, and 73%.

To simplify things, Covered California is using the term "Enhanced Silver to distinguish the improved benefit coverage for eligible consumers. Enhanced Silver coverage looks like this:

Coverage Category	94% Silver	87% Silver	73% Silver
Eligibility based on Income Ranges and Associated Premium Assistance	**Covers 94% Average Annual Cost**	**Covers 87% Average Annual Cost**	**Covers 73% Average Annual Cost**
Income Ranges	**100%-150% FPL**	**150%-200% FPL**	**200%-250% FPL**
Annual Wellness Exam	$0	$0	$0
Primary Care Visit	$3	$15	$40

Coverage Category	94% Silver	87% Silver	73% Silver
Specialist Visit	$5	$20	$50
Laboratory Visit	$3	$15	$40
X-Ray Exam	$5	$20	$50
Imaging	10%	15%	20%
Generic Drugs	$3	$3	$10
Annual Out of Pocket Maximum Individual and Family	$2250 Individual and $4500 Family	$2250 Individual and $4500 Family	$5200 Individual and $10,400 Family

Note: The annual out-of-pocket maximum protects families from financial catastrophes which may lead to bankruptcies.

- Consumers eligible for both premium assistance and enrollment in the enhanced silver plans will receive a dramatically better value than enrolling in plans at a different metal level.

- Consumers whose income is between 250 percent and 400 percent of FPL are eligible for premium assistance but not for any of the enhanced silver plans. But all of the standard metal plan designs will be available.

Income Ranges Related to FPL								
	100%	150%	150%	200%	200%	250%	250%	400%
Consumer	$11,490	$17,235	$17,235	$22,980	$22,980	$28,725	$28,725	$45,960
2 in family	$15,510	$23,265	$23,265	$31,020	$31,020	$38,775	$38,775	$62,040
3 in family	$19,530	$29,295	$29,295	$39,060	$39,060	$48,825	$48,825	$78,120
4 in family	$23,550	$35,325	$35,325	$47,100	$47,100	$58,875	$58,875	$94,200
% of income the consumer pays	2-4%		4-6%		6-8%		8-9.5%	
Eligible for enhanced silver plans	Yes 94% coverage		Yes 87% coverage		Yes 73% coverage		No — standard coverage	

Good to know

Covered California Health Plan premiums are so low in some areas, that a consumer may not receive premium assistance because the overall cost of insurance is below the affordability threshold. For example, a consumer at 250% of FPL purchases a health plan that is $175/month. The premium payment is 7.3% of the consumer's annual income ($28,725) and thus is below the 8 to 9.5% affordability limit set by the ACA.

6.2.1. Plan Options by Region

Covered California has 19 plan pricing regions and prices differ between regions. While Covered California Health Plans have to participate within a single pricing region, they do not have to participate in every pricing region. Therefore it is important to ensure that consumers are only looking at plans that are in the pricing region that includes the enrollee's zip code.

CoveredCA.com will provide a tool which will allow consumer to search by region, thus filtering out plans that are not available in that zip code.

6.2.2. Plan Options by Type

Plan types that are common in Covered California include Health Maintenance Organizations (HMOs), Exclusive Provider Organizations (EPOs) and Preferred Provider Organizations (PPOs). Consumer should give consideration across these plan types to factor in which models appeal to them.

Additionally, looking at the provider network for each plan is an important part of comparing plans. Consumers looking to enroll in a health plan or change health plans may have existing relationships with certain care providers. Ensuring that trusted care providers are in network with the new plan will help ensure continuity of care for the consumer.

All health insurance companies that offer health plans through Covered California operate their own provider networks. Many doctors and hospitals participate in more than one plan network which increases choice for consumers who prioritize having their trusted care provider in their plan's network.

6.2.3. Plan Options by Benefit

All Covered California Health Plans conform to a standard benefit package specific to metal tier. Covered California plans are standardized so that consumers are able to easily compare across different types of plans based on an "apples-to-apples" comparison.

Benefit lists for all health plans are available online at CoveredCA.com. They show what members pay for services and describe any limits on services. Reviewing benefit grids is important in comparing plans and figuring out what a consumer's out-of-pocket costs are likely to be, based on the services he or she thinks will be used.

One benefit area which may have differences is a plan's formulary. All formularies must meet the same thresholds for number of drugs per class and drug coverage. However, a plan has discretion in which specific drugs it places on its formulary and the specific cost-sharing arrangements tied to that drug. It is important for consumers taking medications to ensure that their drug is on the formulary. To do this, consumers can click through the CoveredCA.com site to the health plan's site to view the formulary list, or call the health plan directly.

6.2.4. Plan Options by Total Costs

Since benefits are standardized, a primary consideration for consumers will be to determine what level of coverage they need. Platinum coverage provides the highest level of coverage for expected medical expenses, but also comes with the highest premium payment. Bronze Coverage offers a lower premium payment, but has the highest out-of-pocket costs when covered benefits are used. Consideration needs to be given to other out-of-pocket costs, such as deductibles and co-pays, so that consumers can assess the total potential cost associated with coverage when selecting a health plan.

6.2.5. Examples of Premium Costs vs. Out-of-Pocket Expenses

Jane is eligible for 94% coverage because her income qualifies her for the richest Enhanced Silver plan. Her premium assistance is $906 a year. Jane's eligibility for lower cost sharing translates reduces her out-of-pockets and costs for the Enhanced Silver Plan but not other metal tiers.

Starting Point…	What Jane Pays… (Silver Plan cost minus her $906 premium assistance)
Silver Plans Covers 70% Average Annual Cost	Enhanced Silver Covers 94% average annual cost
Plan A: HMO = $901	Plan A: HMO = $1
Plan B: EPO = $945	Plan B: EPO = $39
Plan C: PPO = $988	Plan C: PPO = $82
Plan D: PPO = $1,181	Plan D: PPO = $275

Note that these are illustrative examples and dollar amounts.

It is important that Jane understands her cost trade-offs. If she chooses one of the Enhanced Silver Plans, she may pay a monthly premium that she may not otherwise pay if she selected a bronze plan, but her costs will be a lot lower when she needs medical care.

Starting Point…	What Jane Pays…
Enhanced Silver Covers 94% average annual cost	Bronze Plan Covers 60% average annual cost
Plan A: HMO = $1	Plan A: HMO = $1
Plan B: EPO = $39	Plan B: EPO = $1
Plan C: PPO = $82	Plan C: PPO = $1
Plan D: PPO = $275	Plan D: PPO = $1

It is important for Jane to remember that there are trade-offs. Lower monthly premiums usually translate to higher out-of-pocket costs. With a bronze plan, Jane is taking on much greater financial risk in the event of an accident or when she seeks medical care, and is foregoing subsidies she is entitled to. On average, Jane will pay about six times as much in

out-of-pocket expenses for medical expenses she incurs if she enrolls in a bronze plan instead of one of the enhanced silver plans.

In talking with consumers, be sure to take the time to help them understand the value of insurance and the cost trade-offs between monthly premiums and out-of-pocket costs.

To consider total costs, consumers should evaluate:

- The frequency with which they used covered benefits (e.g. see a medical doctor, have routine appointments)
- Their ability to pay for a monthly premium versus out-of-pocket costs
- The level of financial risk they are willing to take on if an accident or sudden illness or injury occurs

6.2.6. Common Plan Types and Characteristics

As a review of material covered in the Introduction to Health Insurance course, these types of health insurance organizations offer health insurance through Covered California:

- **Health Maintenance Organization (HMO).** An HMO is a health plan that connects members with a primary care physician (PCP) or a team of physicians who work for or contract with the HMO. The PCP (or care team) coordinates the member's care.
    - Doctors, specialists and hospitals in the HMO network provide all services.
    - These plans generally require that a member receive a referral from the PCP before seeing other doctors, except in an emergency.
    - These plans generally do not cover out-of-network care (visits to doctors who are not part of that HMO) except in an emergency.
- **Exclusive Provider Organization (EPO). An EPO health plan has features of both HMO and PPO.**
    - Like an HMO, members have access to the health plan's provider network.
    - Like an HMO, the health plan does not cover out-of-network care except in an emergency.
    - Unlike an HMO, the member does not generally need a referral from a PCP to receive care from an in-network specialist.
- **Preferred Provider Organization (PPO). A PPO is a health plan that creates a network of preferred (or participating) providers by contracting with doctors and hospitals.**
    - Members choose their providers and where they get covered services.
    - Members pay less when they use a network provider but always have the option to see an out-of-network provider at substantially higher cost.

HMO, PPO and EPO Networks

Some health plans are building special networks for Covered California. PPO and EPO plan networks are often larger than HMO networks, featuring thousands of doctors and hospitals statewide.

Customized Networks

Some health plans also offer what is known as narrow, tailored or select networks. Each of these networks is a subset of one of the health plan's largest networks. They are often specific to a certain geographic area and include providers and medical groups that meet criteria for cost efficiency and access.

CoveredCA.com Network Directory

Consumers can search for doctors by name using the CoveredCA.com online directory which will include all network providers with all of the Covered California plans. Searching for your trusted care providers in this centralized database will make it easy to see how many plans include your provider. The CoveredCA.com directory is a centralized database of all the doctors that participate in one or more of the networks associated with Covered California Health Plans.

For consumers who do not have a regular doctor or who want to search by geographic area, it is best to use the health plan-specific network directories described below.

Using Health Plan Network Directories

The health plans that are part of Covered California have online network directories available on their websites. These directories include all the doctors and hospitals.

Reviewing the directories is a good way to assess options and find doctors. Most online directories have two steps:

1. Consumers enter their home zip code
2. The zip code search then enables you to search for doctors by:
   - Name
   - Type or specialty
   - Language(s) spoken
   - Location
   - Gender
   - Hospital affiliation

Online directories also list the doctors including specialists and hospitals who are part of the health plan's network.

Anyone can search the online directories, it is not necessary to be a member of the health plan. A list of all Covered California Health Plan organizations and their websites is available on CoveredCA.com.

Ready to Enroll

After a consumer selects a Covered California Health Plan, they can enroll in that health plan through CoveredCA.com.

7 LESSON 6: ADDITIONAL RESOURCES

This lesson will identify resources for Accreditation and Quality as well as guide participants on the right questions to ask consumers when considering plan options.

7.1. LEARNING OBJECTIVES

At the end of this lesson you will be able to:

- ✓ Identify resources for Accreditation and Quality
- ✓ Determine the right questions to ask when considering plan options

7.1.1. Overview of Additional Resources

The most important thing for consumers to know is that ***every*** Covered California Health Plan went through a rigorous quality review as part of the certification process. Covered California took into account member satisfaction scores, accreditation and third-party rankings.

Routine quality checks to evaluate Covered California Health Plan performance is a primary Covered California role, as is assessing and rating health care quality and outcomes. These measures are consistent with ACA regulations and are designed to continually improve quality.

In addition, there are several industry organizations that monitor and evaluate health plan quality. They publish rankings and reports so that consumers can get objective information about the quality of the health plans they are considering. Those resources, along with additional questions for aiding in plan selection, are listed below for reference.

7.1.2. Accreditation and Quality Resources

California Office of the Patient Advocate

The California Office of the Patient Advocate prepares health care quality report cards on HMO and PPO plans in California as well as medical groups. Over 16 million Californians are served by the reviewed plans and medical groups. This website is a great source of information about California health plan quality and many of the Covered California plans overlap with plans rated in these quality report cards available at:
http://www.opa.ca.gov/Pages/Home.aspx

National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) is nonprofit organization founded in 1990 to help drive improvement throughout the health care system.

The NCQA seal is a widely recognized symbol of quality. Health insurance companies that incorporate the seal into advertising and marketing materials must first pass a rigorous, comprehensive review and must annually report on their performance. For consumers and employers, the seal is a reliable indicator that a health insurance company is well managed and delivers high-quality care and service.[ii]

NCQA publishes health insurance company report cards and health insurance plan rankings, along with reports like the State of Health Care Quality. These reports along with a list of health plans, physician networks, and medical groups that have received NCQA accreditation are listed at www.ncqa.org.

HEDIS

HEDIS stands for the Healthcare Effectiveness Data and Information Set. It is a tool used by more than 90 percent of America's health insurance companies to measure performance on important dimensions of care and service.

HEDIS consists of 75 measures across eight domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health insurance companies on an "apples-to-apples" basis.[iii]

HEDIS was developed and is maintained by NCQA, and is also one component of NCQA's accreditation process. Details about HEDIS measures are available at www.ncqa.org/HEDISQualityMeasurement.aspx.

URAC

URAC, an independent, nonprofit organization, is well-known as a leader in promoting health care quality through its accreditation, education and measurement programs. URAC offers a wide range of quality benchmarking programs and services that keep pace with the rapid changes in the health care system, and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry.

URAC's mission is to promote continuous improvement in the quality and efficiency of health care management through processes of accreditation and education.[iv] For more information on URAC go to: www.urac.org/healthcare/

Other ways to check quality

Health insurance company websites are a good place to see what accreditation and rankings have been received. Some health insurance companies also have online tools that consumers can use to compare medical groups and/or doctors in their network, based on quality of care and patient satisfaction. A list of websites for health insurance company offerings is available at CoveredCA.com.

7.1.3. Questions to Consider

Questions every consumer should consider when evaluating health plan options include:

- **What are my health care needs?**
  - Do I go to the doctor often or just once a year, if that?
  - Am I planning to start a family?
  - Do I need treatment for a specific condition?
- **What monthly premium versus out-of-pocket cost tradeoff fits my health and budget?**
  - A plan that covers more of a person's health care costs and helps keep out-of-pocket costs low will have a higher monthly premium. This may be a good choice for consumers who want more security.
  - A plan with a low monthly premium will cost more (in copayments and deductibles) when and if services are used. This may be a good trade-off for

people willing to accept the risk of paying significantly more when they access care.

- **What kind of coverage works for different members of my family?**
  - Covered California is the gateway to both Covered California Health Plans and Medi-Cal. This makes it easy for adults to enroll their children in Medi-Cal (if eligible) and choose a Covered California Health Plan for themselves. Once available, eligible individuals can also decide if a Bridge Plan option works best for them.
  - Most, but not all members of a family are required to enroll in the same Covered California Health Plan. For example, dependents who do not reside in the primary household may choose a different plan. There are other exceptions for special cases such as a family that includes an American Indian or Alaska Native.

The answers to these questions will help consumers decide what metal-tier plan works best for them. To compare choices within a tier, here are some things to consider:

1. Is it more important to save in premium or choose any doctor?
   a. This question helps consumers decide if a HMO, EPO or PPO is a better fit
      i. HMO and EPO plans generally have lower premiums than PPO plans, but members must use the HMO network and choose a primary care physician who will coordinate their care. EPOs do not require primary care referrals to specialists.
      ii. With a PPO, greater choice usually comes with a higher monthly premium. Out-of-pocket expenses are always higher if the member goes out of network to receive care.
2. Is my doctor in the network?
3. Are specialists that I use—or may need to use—in the network?
4. Are the specific drugs I need available on the formulary?
5. Should I keep my monthly premium or my out-of-pocket costs low?

   Tip: It is important to explain to consumers the cost trade-offs. A bronze plan will have the lowest monthly premium and that can be very attractive—especially for consumers who are eligible for premium assistance. For some, the premium cost may be $1. However, if and when they use services, consumers will pay a larger share of the cost, especially if the consumer would have been eligible to enroll in an enhanced silver plan.

Remember: All of this information will be available on CoveredCA.com for every Covered California Health Plan. The CoveredCA.com comparison tool will enable consumers to compare plans by specific costs and benefits.

8 ACTIVITIES

Check your knowledge of health care fundamentals and plan options available through Covered California. The answers follow the exercises.

Activity A
Answer true or false for each statement.

	True	False
1. HMO's, PPO's and EPO's all have networks of doctors and hospitals that members go to when they need care.		
2. Care provided through an HMO, PPO or EPO is the same as public health insurance.		
3. One reason that health care services cost less with insurance is because health plans negotiate rates with doctors and hospitals for their member group.		
4. Evaluating quality was a key criterion against which Covered California evaluated all health insurance companies before certifying them as Covered California Health Plans.		
5. A bronze plan is a good choice for people who want low out-of-pocket costs for the services they use.		

Activity B
For each question, circle all that apply.

	Answer
1. What makes health insurance a good value? a. It protects people financially in case of an accident or long illness. b. There is a set cost for doctor visits. c. Wellness programs are included to help people stay healthy. d. There is no charge for medication.	
2. In a Preferred Provider Organization (PPO), members: a. Have to use the health plan network. b. Have access to the health plan network but can go where they want for covered services. c. Pay less out-of-pocket when they use a network provider. d. Must get referrals from their primary care physician before they see a specialist.	

3. Insurance options through Covered California include: a. Medi-Cal b. Healthy Families Program c. Tri-Care d. Covered California Health Plans	
4. If a consumer enrolls in a bronze plan with 60% of the health care expenses paid by the health plan, then he or she will be responsible for: a. 20% of health care expenses b. 40% of the health care expenses c. 0% of the health care expenses d. Varies depending on the person's income	
5. Out-of-pocket costs are: a. A monthly premium b. Co-payment and deductibles c. Cost of services not covered by the health plan d. The amount consumers pay for the health plan covered services that they use	

9 ACTIVITY ANSWERS

Activity A

1. True
2. False
3. True
4. True
5. False

Activity B

1. a, b and c
2. b and c
3. a and d
4. b
5. b and d

10 ENDNOTES

[i] Share of cost per www.medi-cal.ca.gov

[ii] National Committee for Quality Assurance Website, accessed at www.ncqa.org/aboutNCQA.aspx

[iii] HEDIS & Performance Measurement, accessed at www.ncqa.org/HEDISQualityMeasurement.aspx

[iv] URAC Website, accessed at

https://www.urac.org/healthcare/

Other Sources

- Code of Federal Regulations — Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act [45 CFR 155]
- MedlinePlus, a service of the U.S. National Library of Medicine, National Institutes of Health. Accessed at www.nim.nih.gov
- California Office of the Patient Advocate **http://www.opa.ca.gov/Pages/Home.aspx**