Bridge Plan: A Strategy to Promote Continuity of Care & Affordability through Contracts with Medi-Cal Managed Care Plans

SUMMARY

Offering affordable health plans is a critical priority for Covered California; ensuring high enrollment of low income Californians can't be done without it. Consistent with Covered California's mission and vision, other important goals include encouraging continuity of care for those who have coverage, and maintaining community safety net programs for those who do not have coverage.

At the December 14, 2012 Board meeting, an Options Brief was discussed that considered alternative strategies to promote affordability through contracting with Medi-Cal Managed Care plans. The options that were presented suggested several approaches that would build on Covered California's selective contracting process to provide even more affordable options for low income Californians between 139% and 200% of FPL, and to promote continuity of care with safety net providers. Covered California will continue to explore and develop these options.

This Board Recommendation Brief outlines an approach that builds on those concepts to achieve these objectives addressed in the earlier Board Options Brief, including: promoting continuity of coverage, reducing churn, and creating a more affordable product that, in turn, encourages greater enrollment among those eligible for subsidies. Covered California's Plan Management Advisory Committee discussed the proposal on January 9, 2012,and a draft Brief was released the following day. Over fifteen stakeholder organizations submitted formal comments, which have been considered and have helped to shape this Brief.

There are three elements in the approach recommended in this Brief:

1. Covered California would begin the administrative processes in 2013 to allow low cost "Bridge" plan options to be offered in 2014. In 2013, Covered California would negotiate contracts with qualified Medi-Cal Managed Care plans that serve as a "bridge" plan between Medicaid/CHIP coverage and private insurance. Consistent with federal guidance, this proposal would allow individuals transitioning from Medi-Cal or Medi-Cal/CHIP coverage to Covered California to stay with the same issuer and provider network. It would also allow family members to be covered by a single issuer with the same provider network. These Medi-Cal Managed Care Bridge plans could offer very low out of pocket premiums for their transitioning enrollees through contracts with Covered California. An initial estimate of the eligible transitioning population in 2014 is in the 1.1 million range. In addition, between 150,000 and 300,000 parents of Medi-Cal/CHIP children could benefit from the program. .

2. Covered California would support authorizing state legislation and seek federal approval to allow Bridge plan choices to be offered to the broader population of newly subsidy eligible of low income Californians up to 200% of FPL. In addition, parents of children in Medi-Cal/CHIP with incomes up to 250% of FPL – consistent with Recommendation #1 – would also be eligible.

With the necessary authorization and approvals, these Bridge plans would be available as soon as possible. Approximately 930,000 Californians would be eligible based on CalSIM projections.

3. To foster maximum participation of Medi-Cal Managed Care plans in Covered California, an array of proposals is recommended to streamline the Qualified Health Plan certification process.

BACKGROUND

For low income Californians, the monthly premium cost for health coverage may be the most significant factor in determining whether they will enroll in a plan. Federal subsidies – based on household income will significantly reduce premiums and out of pocket costs. For illustration purposes, Table 1 provides an example of how these federal tax credits impact monthly premiums of a hypothetical 40 year-old policy holder.

In addition to premium subsidies, cost-sharing reductions will reduce point-of-service costs for individuals with incomes between 100 and 250 percent of the federal poverty level in the silver plan. These federal subsidies effectively cap out-of-pocket expenditures, such as deductibles, copays, and coinsurance, at a lower level for individuals in this income range in order to help ensure that both premiums and the cost of accessing care remains affordable for lower income Californians.
In low income households, where discretionary income is extremely limited, policies that offer the potential for reducing what consumers pay are likely to encourage higher enrollment. Particularly for individuals and families who transition from Medi-Cal into Covered California coverage, affordability will be a primary concern.

Avoiding disruptions in provider networks and continuity of care is also of critical importance to consumers. There are a variety of life experiences that may change an individual's eligibility for subsidized health coverage programs. Examples include changes in family income due to getting or losing a job; changes in family structure, perhaps due to the birth of a child or the "aging out" of a child; or re-location for work or to meet family responsibilities. For some individuals, the change could make them eligible for Medi-Cal; others may find themselves losing Medi-Cal eligibility but perhaps becoming eligible for subsidized coverage offered through the Exchange. This movement between programs is often referred to as "churn."

Several studies have attempted to quantify the magnitude of churn between Medicaid and the Exchange eligibility. Researchers Benjamin Sommers and Sara Rosenbaum used a national sample using the Survey of Income and Program Participation (SIPP) and reported their findings in a 2011 Health Affairs article. Looking at the proportions of adults whose family incomes were initially less than 133% of poverty and who experienced income fluctuations above that threshold over time, they found that nearly 40 percent of adults experienced a disruption in Medicaid eligibility within the first six months. After a year, 38 percent were no longer eligible, and an additional 16 percent had lost eligibility but then regained it.

Another study on income volatility related to the Basic Health Program also used SIPP "look back" data. This 2011 study by John A. Graves looked at the initial income of Californians between the ages of 19-64 at the beginning of a year and then 12 months later. In this study, 1.7 million California adults had an income that was initially below 138% FPL (so they would have qualified for Medi-Cal) but who, during the year experienced at least one period in which their income rose into the 138-200% FPL range while they were uninsured or have non-group coverage.

Using CalSIMS and adjusted SIPP data to represent the Medi-Cal enrollee population, the UC Berkeley Center for Labor Studies found that about 15.1% of Medi-Cal eligible individuals would have an income greater than 139% of FPL after 12 months. This is in addition to the 9% who obtain employer sponsored coverage. See Table 2 .

Although there are many administrative costs and complexities related to churn, the issue of continuity of care may be a greater concern for many enrollees. To the extent that churning results in individuals changing health plans with different provider networks, there is always the risk of disruption and confusion.

Allowing families – both parents and their children -- to maintain the option of being in the same health plan is also an important value that can simplify their consumer health care experience. This is a consideration for families with household incomes up to 250% of FPL in which a child is enrolled in the Healthy Families Program (HFP). In 2013, about 860,000 children will transition from HFP into Medi-Cal. Most will be served in Medi-Cal Managed Care plans. However, for families in which the household income is between 139% and 250% of FPL, the parents will be eligible for subsidized coverage in Covered California, enrolling in same Medi-Cal Managed Care plan as their children is only an option if that plan became a Qualified Health Plan (QHP) in Covered California.

Beyond the issue about the potential of individuals moving from one eligibility coverage category to another, there is also a concern about continuity of care at the provider level – clinics, individual clinicians, and hospitals. Making it easier for low income individuals to remain in their health plan – and existing provider network may reduce the disruption of on-going care, confusion, and unnecessary administrative complications.

The role of Medi-Cal Managed Care plans can be important to address both provider-level continuity and affordability. Today almost 5 million Medi-Cal beneficiaries in 30 counties receive their health care through these managed care programs. This number will grow due to the transition of the Healthy Families program and the potential Medi-Cal eligibility expansion of childless adults, many of whom are now enrolling in the county-based Low Income Health Program (LIHP). By encouraging Medi-Cal Managed Care plans to participate in Covered California, continuity of care can be promoted by giving low income consumers the option of staying in their same health plan even though their eligibility may shift between Medi-Cal and the Covered California.

In responding to interest in other states in encouraging continuity of coverage and care, CMS recently commented on “Medicaid Bridge Plans” in its December 10, 2012 response to Frequently Asked Questions (FAQ). Specifically, the CMS response indicated that a state-based Exchange could certify a Medicaid Bridge Plan as a QHP. Such a plan “would allow individuals transitioning from Medicaid or CHIP coverage to the Exchange to stay with the same issuer and provider network, and for family members to be covered by a single issuer with the same provider network.” This approach, CMS said, is intended to promote continuity of coverage between Medicaid or CHIP and the Exchange. The FAQ outlined several requirements for Bridge Plan proposals:

- *The state must ensure that the health insurance issuer complies with applicable laws, and in particular with section 2702 of the Public Health Service Act.*
- *The Exchange must ensure that a bridge plan offered by a Medicaid managed care organization meets the qualified health plan certification requirements, and that having the Medicaid managed care organization offer the bridge plan is in the interest of consumers*.
- *As part of considering whether to certify a bridge plan as a qualified health plan, the Exchange must ensure that bridge plan eligible individuals are not disadvantaged in terms of the buying power of their advance payments of premium tax credits.*
- *The Exchange must accurately identify bridge plan eligible consumers, and convey to the consumer his or her qualified health plan coverage options.*
- *The Exchange must provide information on bridge plan eligible individuals to the federal government, as it will for any other individuals who are eligible for qualified health plans on the Exchange, to support the administration of advance payments of premium tax credits.*

Medi-Cal Managed Care plans play an essential role in supporting the local health care safety net, which is often the provider of last resort for without health insurance. In "Two Plan" model counties, Local Initiatives are required to include in their provider networks all traditional and safety net providers that agree to the terms and conditions set for other similar providers in its network. Commercial Medi-Cal managed Care plans in these counties are encouraged – but not required – to include these safety net providers in their network.

Although the implementation of the Affordable Care Act will significantly reduce the number of uninsured individuals in California, the need for safety net care will remain. In a November 2012 analysis, the UC Berkeley Labor Center for Research and Education projected that over 3.1 million California would remain uninsured in 2019, even assuming the Exchange's enhanced enrollment model. Of these, only 27% would be exempt from tax penalties – and from the individual mandate – due to immigration status. These uninsured individuals will continue to rely on a robust safety net for their health care needs.

RECOMMENDATIONS FOR CONSIDERATION

The recommendations presented in this brief address the following assumptions:

- Covered California should use its selective contracting authority to achieve health plan choice with very low out of pocket premiums for low income consumers.

- Medi-Cal Managed Plans should be selected to provide this affordable choice for low income consumers to improve continuity of care for consumers and reduce churn.

- To achieve the goals of affordability, continuity of care, and safety net maintenance, Covered California should adopt procedural accommodations that could encourage the maximum participation of Medi-Cal Managed Plans.

Implementing the recommendations in this Brief will require an aggressive and challenging schedule. Federal approval will be required. Also, there are a number of health plan contracting issues that would need to be addressed as soon as possible, including:

- CalHEERS system design specifications;
- Modifications to the Qualified Health Plan solicitation timeline and standards for Bridge plans and/or Medi-Cal Managed Care plans; and
- Coordination with regulators for review of good standing and rating.
- Risk Management. Although risk adjustment, reinsurance and risk corridors may address these concerns to some extent, there are many uncertainties about the potential risk pools that may result consumers make their plan selections.

However, the potential benefits of greater affordability, continuity of care, and reduced churn are compelling and are the basis upon which the following three recommendations are offered.

Recommendation 1. Covered California Should Contract with "Bridge" Plans for Transitional Medi-Cal Eligibiles and Parents of Medi-Cal/CHIP children.

Covered California would negotiate contracts with qualified Medi-Cal Managed Care plans that serve as a "bridge" plan between Medicaid/CHIP coverage and private insurance. Consistent with federal guidance, this proposal would allow individuals transitioning from Medi-Cal or Medi-Cal/CHIP coverage to Covered California to stay with the same issuer and provider network. It would also allow family members to be covered by a single issuer with the same provider network. These Medi-Cal Managed Care Bridge plans could offer very low out of pocket premiums for these enrollees through contracts with Covered California.

Eligible population. Consistent with current federal guidance, initial enrollment would be limited to individuals transitioning from Medi-Cal or Medi-Cal/CHIP coverage. It would also include parents of children receiving Medi-Cal/CHIP (formerly HFP) coverage. An individual would need to make the transition within 180 days after their Medi-Cal coverage had been terminated.

Assuming about 15% of Medi-Cal enrollees below 138% of FPL transition over a year into Covered California, the potential Bridge Plan eligible population in 2014 would be in the range of 1.1 million Californians. In addition, between 150,000 and 300,000 parents of Medi-Cal/CHIP children could also benefit

Affordability: To maximize enrollment, Bridge Plans would have a strong incentive to offer an attractive plan option with a very low premiums. Based on an analysis by Milliman, this level of affordability is achievable if the Bridge plan is designated as the lowest Silver Level Benefit Tier. In this case, a modest differential – in the range of 5%-15% between the second lowest silver plan and the lowest plan would be necessary. Because federal subsidies are based on the second lowest silver plan, this differential would allow low income enrollees to benefit from the federal subsidies in a manner that assures low premiums for these Californians.

Tables 3 and 4 present the potential impact on members contributions based on two lowest cost non-Medi-Cal Managed Care plan premiums (at second lowest premium at $400 and $500 per month respectively).

Additional Cost Sharing Federal Subsidies: The Affordable Care Act provides two types of federal subsidies to make coverage more affordable. Premium Tax Credits for individuals in families with incomes between 138% and 400% of FPL; and cost sharing subsidies for individuals in families between 100% and 250% of FPL. These cost sharing subsidies protect lower income people with coverage from high out-of-pocket costs at the point of service. For low income individuals who buy a silver metal tiered plan with an actuarial value of 70%, cost sharing subsidies boost the plan's actuarial value as follows:

Income Level	Actuarial Value
100-150% FPL	94%
151-200% FPL	87%
201-250% FPL	73%

These federal cost sharing subsidies significantly increase the revenue available to the participating plan. This additional revenue is used by the plan to pay providers the amounts they would have otherwise collected from the non-subsidized member cost sharing. As illustrated in Tables 5 and 6 , member co-pays for office visits would be limited to $3 for an individual at 133% of FPL and $20 for an individual at 150% of FPL.

Tables 5 and 6 illustrate two additional aspects of this proposal. First, in order to maximize the affordability of the Silver option offered by a Bridge Plan, the analysis discussed above suggests the Bridge plan premium should be 5% -15% less than the premium of the second lowest silver plan. One way this could be achieved is if the silver plans, other than the Bridge Plan, pay providers at rates similar to current commercial contracts, and the Bridge Plan pays providers at 5%-15% lower rates. While these Bridge Plan provider payment rates would be less than commercial rates, they would often be materially higher than Medi-Cal and possibly Medicare rates. Commercial provider payment contracts vary significantly within California, by region, provider type (hospital versus physician, etc.) and structure (percent of Medicare, percent of billed charges, hospital per diems and case rates, etc.). Purely for illustration, Tables 5 and 6 assume that the premium for the second lowest silver plan in a particular region is based on commercial provider contracts that average, across all provider types, 120% of what Medicare would pay providers for those same services. The column labeled "Reimb. As % of Medicare" shows that based on this assumption, if the Bridge Plan was to achieve a 5% lower premium solely through lower provider reimbursement, they would pay providers, on average, 5% less than 120% of Medicare, or 114% of Medicare.

Second, a significant benefit of having an affordable Silver option offered by a Bridge Plan is that low-income enrollees are more likely to choose this Silver plan and not drop down to the less expensive bronze Plan. Only enrollees in Silver plans are eligible for cost sharing subsidies. These subsidies increase the percentage of contracted payments that the provider receives from the plan, and reduces the percentage that providers must collect from the consumer. The column labeled "Silver 133% FPL Premium Plus Cost-Sharing Paid to Plan" estimates the impact of this cost sharing subsidy on the monthly revenue the carrier would have available to reimburse providers.

Participation Mechanism: Any Medi-Cal Managed Care plan that met QHP certification requirements could become a Bridge Plan. These plans would be required, consistent with federal guidance, to demonstrate that their provider network serving the Medi-Cal managed care and bridge plan enrollees has sufficient capacity *only* to provide adequate services to those eligible individuals. The Bridge Plan would have the option of bidding only to their Medi-Cal enrollees who become eligible for Covered California in the coming year, and the bid process would be conducted after the bidding cycle for broadly available QHPs.

The calculation for determining the lowest cost silver plan is based on the age, geography and income for any individual. This proposal would add an additional and more affordable plan choice for individuals who are transitioning from a Medi-Cal Managed Care plan. The lowest silver plan *for that individual* would most likely be the participating Medi-Cal Managed Care plan in which the individual has been previously enrolled.

Consumer Choice: To facilitate continuity and coverage, individuals would be encouraged, but not required to stay in their prior Medi-Cal Managed plan – the Bridge plan. However, the enhanced affordability option would *only* be available if the individual remained in their Medi-Cal Managed Care plan.

Recommendation 2. Bridge Plans Should Cover Eligible Population up to 200% FPL & Parents of Medi-Cal/CHIP children

Covered California should support authorizing state legislation and seek federal approval so that Bridge plan options could be offered to a broader population of low income Californians up to 200% of FPL. In addition, parents of Medi-Cal/CHIP children up to 250% of FPL would be eligible. With the necessary authorization and approvals, these Bridge plans could be available as soon as possible. Broadening eligibility should be pursued as a matter of equity so that similarly situated individuals with the same FPL would have the same access to the more affordable Bridge Plan choices. As in Recommendation 1, consumers would have access to more affordable plan choices and would have a choice of any plan options offered through Covered California.

Expanding the eligibility for Bridge Plans would allow about 930,000 Californians to have access to this program.

Although the contracting mechanism is likely to be similar to the approach proposed in Recommendation 1, additional details would need to be defined in a manner that can achieve federal approval. As Covered California explores a workable pathway to expand eligibility to low income Californians up to 200% of FPL and parents of Medi-Cal/CHIP children, staff will work with the federal government to identify an applicable contracting mechanism.

Recommendation 3. Streamlining Approaches for QHP Certification for Medi-Cal Managed Care Plans & Bridge Plans

Covered California has already adopted policies that will benefit low income consumers by encouraging Medi-Cal Managed Care plans to become QHP's. This has a twin benefit: better continuity of care for consumers whose eligibility shifts between Medi-Cal and Covered California; greater inclusion of community safety-net providers. In addition to the policies already adopted (e.g., allowing Medi-Cal plans to potentially join Covered California in 2015 and the schedule for accreditation), these goals could be promoted by streamlining the application process for Qualified Health Plan certification for Medi-Cal Managed Care plans.

Medi-Cal Managed Care plans are already engaged in intensive implementation efforts relating to an array of new policy initiatives that are bringing new populations into managed care. These populations include individuals with both Medi-Cal and Medicare eligibility - called "Dual Eligibles," Seniors and Persons with Disabilities, children now covered through the Healthy Families Program, and others.

As Medi-Cal Managed Care Plans consider participation in Covered California, they are likely to be mindful of taking on an additional set of implementation challenges, as well as the management and staff "bandwidth" to take more -- at least for a 2014 launch. These challenges could include:

- Developing and submitting a bid package that meets the QHP requirements);
- Establishing a provider network and negotiating rates to the extent the plan does not use existing Medi-Cal contracts and needs to negotiate different terms;
- Defining a rate structure that differs from the current state wrap-around payments for FQHC PPS rates or for carve outs of mental health or certain children services; and
- Creating an administrative structure to handle premium collection from the IRS and individuals, and, to the extent not already done by the plan, the management of deductibles, coinsurance and copayments

In recognition of the unique role that Medi-Cal Managed Care Plans offer and the potential benefits to Covered California consumers, the following revisions to the QHP solicitation process are recommended for Medi-Cal Managed Care plans that operate only in the non-commercial market:

- Allow Medi-Cal Managed Care plans to respond only to those elements of the solicitation that are applicable to a non-commercial health plan (e.g., waive their completing eValue8 elements in 2014).

- Accept state Medi-Cal quality and performance requirements as satisfying Exchange quality requirements for year one (2014) certification as a Qualified Health Plan.

- Coordinate with Department of Managed Health Care to streamline regulatory approval that may be required.

Additional recommended measures would only apply to Bridge Plans in recognition of their unique timelines and schedule requirements.

- Create a QHP certification timeline that is calibrated to respond to the Bridge program requirements for implementation.

- Support state legislation to allow Covered California to waive the requirement that Bridge Plans offer all precious metal benefit tiers and catastrophic coverage. If determined to be allowed under federal law, waive requirement to offer Gold benefit as well. The main benefit to low income consumers is based on their enrolling in the "Silver" benefit design – which is the only design that the cost-sharing subsidy accrues. However, federal law requires each issuer offering a QHP to offer at least one silver and at least one gold plan; state law goes further and requires QHPs to offer plan choices in each of the four precious metal tiers as well as catastrophic. Requiring participating Bridge plans to offer all benefit offerings may add unnecessary administrative burdens and complexity to the solicitation process.

- Support a policy to allow Bridge Plans to offer benefit contracts to their enrollees on an interim basis - not to exceed two years – while they pursue regulatory approval from DMHC. This policy would address the time constraints and timelines necessary for material modifications of existing plan licenses.

- Allow Medi-Cal quality reporting features such as HEDIS measures to be used in lieu of other quality data requirements.

Advantages and Disadvantages

Advantages/Pros:
- May help maximize enrollment for low income Californians by offering an affordable plan option with very low or zero premium. Could promote continuity of care by reducing churn between Medi-Cal and Covered California plans, while helping to maintain local safety net.
- Leverages the existing Covered California procurement, contracting and quality mechanisms to promote efficient plan processes and oversight.
- For participating Medi-Cal plans: advantages may include increased enrollment with the potential for reimbursement levels above Medi-Cal rates. Encourages participation of Medi-Cal Managed Care Plans in Covered California. As already noted, these plans will be needed if Covered California chooses to implement the contracting option for affordability outlined in this brief.
- Helps to support community safety net providers.

Disadvantages/Cons:
- Adds administrative complexity for Covered California, CalHEERS, and eligibility and enrollment processes.
- For Medi-Cal plans considering their participation: it is unclear the extent to which the benefits of incremental enrollment and higher than Medi-Cal payments would outweigh the costs (e.g., new application, managing premium collection from individuals and the federal government). This balancing of risks and benefits is particularly important in the context of the increased effort Medi-Cal plans are facing with the movement of dual eligible to managed care and the potential of Medi-Cal expansion:
- Preferential treatment to Medi-Cal Managed Care plans may give them a competitive advantage over commercial plans.
- May increases costs by requiring greater emphasis on contracts with safety net providers and increasing their bargaining power.

REFERENCE MATERIAL

Benjamin D. Sommers and Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*. Health Affairs. February 2011.

Rick Curtis and Ed Neuschler, *Income Volatility Creates Uncertainty about the State Fiscal Impact of a Basic Health Program in California*: Using Data from a SIPP analysis by John Graves – with support from the California HealthCare Foundation. September 2, 2011.

Laurel Lucia, Ken Jacobs, Miranda Dietz, Dave Graham-Squire, Nadereh Pourat, and Dylan H. Roby. *AFTER MILLIONS OF CALIFORNIANS GAIN HEALTH COVERAGE UNDER THE AFFORDABLE CARE ACT, WHO WILL REMAIN UNINSURED?* UC Berkeley Center for Labor Research and Education UCLA Center for Health Policy Research. September 2012. Available online: http://laborcenter.berkeley.edu/healthcare/aca_uninsured12.pdf

Table 1: Sample Tax Credit for Purchase in the Individual Exchange				
Percent of FPL	**Annual Income**	**Unsubsidized Premium for Month**	**Tax Credit**	**Monthly Premium after Credit**
138%	$15,500	$379	$340	$40
150%	$16,700	$379	$324	$55
200%	$22,300	$379	$262	$117
250%	$28,000	$379	$192	$187
300%	$33,500	$379	$114	$265

Example based on a 40-year-old policyholder using 2014 projected incomes, assuming a "silver" plan covering 70 percent of expected medical utilization costs. Source: UC Berkeley Labor Center "Calculator."

Table 2: Reason enrollees leave Medi-Cal over the 12 months, enrollees under 138%, based on different time periods for income eligibility					
Eligibility for Med-Cal based on income from	**Income Increases, eligible for exchange subsidies**	**Income Increases, not eligible for exchange subsidies**	**Takeup ESI**	**Stay in Medi-Cal**	**Total**
Previous month	14.6%	1.8%	9.1%	74.5%	100%
Previous 6 months	13.1%	1.4%	8.8%	76.7%	100%
Previous 12 months	13.7%	1.4%	8.6%	76.4%	100%

Impact on Out of Pocket Premiums for Subsidy Eligibles

Table 3: Assuming Second Lowest Premium at $400				
		Member Contribution		
Lowest Premium	% Below Lowest Non-Medi-Cal	133% FPL	150% FPL	200% FPL
$380	5%	$16	$34	$94
$360	10%	0	$14	$74
$344	14%	0	0	$58
Source: Milliman. Illustrative example based on draft working analysis, 12/2/2012. Based on "average" enrollee cost sharing; actual would vary by age.				

Table 4: Assuming Second Lowest Premium at $500				
		Member Contribution		
Lowest Premium	% Below Lowest Non-Medi-Cal	133% FPL	150% FPL	200% FPL
$475	5%	$11	$29	$89
$450	10%	0	$4	$64
$430	14%	0	0	$44
Source: Milliman. Illustrative example based on draft working analysis, 12/2/2012. Based on "average" enrollee cost sharing; actual would vary by age.				

Impact of Cost Sharing Subsidies on Plan Reimbursement and Member Co-Pays*

Table 5: Assuming Second Lowest Premium at $400						
				Member Co-pay for Office Visit		
Lowest Premium	% Below Lowest Non-Medi-Cal	Silver 133% FPL Premium Plus Cost-Sharing Paid to Plan	Reimb. As % of Medicare	133% FPL (AV= 94.8%)	150% FPL (AV= 87.8%)	200% FPL (AV=78.1%)
$380	5%	$509	114%	$3	$20	$45
$360	10%	$482	108%	$3	$20	$45
$344	14%	$461	103%	$3	$20	$45
Source: Milliman. Based on draft working analysis, 12/2/2012. Based on "average" enrollee cost sharing; actual Premium would vary by age.						

Table 6. Assuming Second Lowest Premium at $500						
				Member Co-pay for Office Visit		
Lowest Premium	% Below Lowest Non-Medi-Cal	Silver 133% FPL Premium Plus Cost-Sharing Paid to Plan	Reimb. As % of Medicare	133% FPL (AV= 94.8%)	150% FPL (AV= 87.8%)	200% FPL (AV=78.1%)
$475	5%	$636	114%	$3	$20	$45
$450	10%	$603	108%	$3	$20	$45
$430	14%	$576	103%	$3	$20	$45
Source: Milliman. Based on draft working analysis, 12/2/2012. Based on "average" enrollee cost sharing; actual premium would vary by age..						

* Tables 5 and 6 assume that the premium for the second lowest silver plan in a particular region is based on commercial provider contracts that average, across all provider types, 120% of what Medicare would pay providers for those same services. The column labeled "Reimb. As % of Medicare" shows that based on this assumption, if the Bridge Plan was to achieve a 5% lower premium solely through lower provider reimbursement, they would pay providers, on average, 5% less than 120% of Medicare, or 114% of Medicare.