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 cannot be done without it. This Board Recommendation Brief outlines an approach to using Bridge plans to achieve the following objectives: promote continuity of coverage, reduce churn, and create a more affordable product. Our emphasis on affordability is a cornerstone in our effort to encourage greater enrollment among those eligible for subsidies, especially the lowest income individuals eligible for subsidies in Covered California.

Governor's Brown's 2013-14 budget proposal has also embraced the Bridge concept for individuals under 200% of the Federal Poverty Level (FPL). The Brown Administration is sponsoring legislation to authorize the Bridge program in the Special Session on Health Reform Implementation.

A two-pronged implementation strategy is suggested to the Board for consideration:

- **Begin Implementation of "Narrow Bridge" in 2014.** Covered California would, contingent on federal approval, begin the administrative processes in 2013 to allow low cost "Bridge" plan options to be offered in as soon as possible in 2014. 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 Bridge plans could offer very low out of pocket premiums for their transitioning enrollees through contracts with Covered California. An April 1, 2014 implementation date is assumed due to timing challenges related to the development of information technology functionality issues. Based on this date, the UC Berkeley Center for Labor Research and Education estimates first year enrollment to be between 670,000 and 840,000.[*]

  To foster maximum participation of Medi-Cal Managed Care plans and their Bridge plans, the Qualified Health Plan certification process would be streamlined.

- **Conduct Further Discussions with the Federal Government and Research on Potential of Implementing "Broad Bridge."** Covered California would engage in research, assessment and continue working with our federal partners to develop a potential proposal for f a broader Bridge that would allow Exchange eligible Californians up to 200% FPL to participate. Implementation would be contingent on prior federal approval. This broader, more inclusive proposal would build on the eligible population of the Narrow Bridge plan concept and would

[*] Estimate is based on CalSIM data and assumes participation of all Medi-Cal Managed Care plans. An estimated 860,000 -1,080,000 are projected to be eligible in the first full year the program is in operation.

include both individuals who transition from Medi-Cal and Medi-Cal/CHIP, and also family members in Medi-Cal/CHIP households .

Note: Additional discussions with the federal government will be needed to determine if this approach can be approved. Given the uncertainties related to the Broad Bridge option, staff has not yet conducted a comprehensive analysis of the potential market impacts or consequences of implementation. Given the necessity for action in 2014, staff recommends focusing on implementation of the Narrow Bridge program.

Staff Recommendation: Approve implementation of the Narrow Bridge program, contingent on federal approval, but continue to research the Broad Bridge model and have discussions with the federal government to develop options for Board consideration for implementing a Broad Bridge.

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 138% 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 Medi-Cal/CHIP but the parents are eligible for subsidized coverage in Covered California. To allow these mixed program families to share a plan offered by the same issuer with a similar provider network, the issuer must become 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 plans. This number will grow due to the transition of the Healthy Families Program to Medi-Cal, 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 those 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 Center for Labor 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.

Governor's Brown's 2013-14 budget proposal also embraced the Bridge concept for individuals under 200% of the Federal Poverty Level (FPL). The Brown Administration is sponsoring legislation to authorize the Bridge program in the Special Session on Health Reform Implementation.

PROPOSAL FOR CONSIDERATION

Bridge Plan Strategy to Promote Continuity of Care and Affordability

A two-pronged implementation strategy is suggested for Board consideration:

- **Begin Implementation of "Narrow Bridge" in 2014**. Contingent on federal approval of the proposal, eligibility for the Narrow Bridge would include individuals transitioning from Medi-Cal or Medi-Cal/CHIP coverage, and also household members in Medi-Cal/CHIP coverage families. To foster maximum participation of Medi-Cal Managed Care plans and their Bridge plans, Qualified Health Plan certification process would be streamlined.

- **Conduct Further Discussions with Federal Government and Research on Potential of Implementing "Broad Bridge."** The broader Bridge proposal that would allow Exchange eligible Californians up to 200% FPL to participate.

Note: Additional discussions with the federal government will be needed to determine if this approach can be approved. Given the uncertainties related to the Broad Bridge option, staff has not yet conducted a comprehensive analysis of the potential market impacts or consequences of implementation. However, given the necessity for action, staff recommends focusing on implementation of the Narrow Bridge program.

Staff recommendation: Approve implementation of the Narrow Bridge, but continue to research the Broad Bridge model and have discussions with the federal government to develop options the Board can consider later for implementing a Broad Bridge.

Implement Narrow Bridge in 2014

Overview: Covered California would negotiate contracts with Medi-Cal Managed Care plans that become QHP's to 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 a largely similar provider network. These Bridge plans could offer very low out of pocket premiums for their Exchange eligible enrollees through contracts with Covered California.

A Bridge plans would need to be certified as a Qualified Health Plan, and would need to demonstrate that it only had sufficient capacity to provide adequate service to Bridge plan eligible individuals. It would be closed to other new enrollment. Medi-Cal managed care plan contracts with the Department of Health Care Services would be amended to establish a pre-existing contractual obligation to ensure that if the Plan became a Bridge Plan, it would serve all potential Bridge Plan eligible enrollees.

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. A modest differential

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.

To illustrate the concept, Tables 3 and 4 present the potential impact on members contributions based on a hypothetical scenario involving 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: (1) Premium Tax Credits for individuals in families with incomes between 138% and 400% of FPL; and (2) 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 shows the Bridge plan premium if it is 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. Covered California would establish a sequential bidding process to allow Bridge plans to bid after the rates for the broadly available QHPs were known.

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 Bridge plan, offered by a participating Medi-Cal Managed Care plan in which the individual has been previously enrolled.

Consumer Choice and Protection: 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. This option – both for lower premiums and continuity of care – would provide tangible benefits that advantage Bridge plan eligible enrollees. However, in recognizing the transitional nature of the Bridge concept, the Bridge plan would comply with any additional or further limitations in eligibility that are required for federal approval, including any related to income or duration.

Eligibility: 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 other members of a Modified Adjusted Gross Income household in which there were Medi-Cal or Medi-Cal/CHIP enrollees. The California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) would provide the on-line portal for the Bridge program. The proposed CalHEERS launch date for the Bridge program is now scheduled for April 1, 2014. Individuals who lose Medi-Cal coverage commencing January 1, 2014 would be eligible for four months of transitional Medi-Cal coverage. These individuals would then have the option – effective April 1, 2014 – for enrolling in a Bridge plan during the special enrollment period. It is proposed that parents or other members of a MAGI household could also enroll during the special enrollment period because of their eligibility for this program. In subsequent open enrollment periods, a Bridge plan could enroll Exchange eligible individuals who could demonstrate that their Medi-Cal or Medi-Cal/CHIP coverage was terminated based on income no more than 180 days prior to their application. As previously noted, the Bridge Plan would also comply with any additional or further limitations that are required for federal approval, including any related to income or duration.

The UC Berkeley Labor Center estimates that the potential Bridge Plan eligible population in 2014 would be between 670,000 and 840,000.[†]

[†] Estimate is based on CalSIM data and assumes participation of all Medi-Cal Managed Care plans offer Bridge plans. On an annual basis, an estimated enrollment of 860,000 -1,080,000 is projected.

Enrollment Issues & Data Exchange with Federal Government: As noted in the federal guidance, the successful implementation of the Bridge Program would require close coordination with the Medi-Cal program, which is administered by the Department of Health Care Services (DHCS). The CalHEERS system, which would be used for determining eligibility and enrollment for Bridge participants, is managed jointly DHCS and Covered California. CalHEERS would be the platform for ensuring that Bridge eligible consumers are accurately identified and informed of their plan coverage options. In addition, Covered California would work with DHCS to identify other pathways for notifying potential consumers who may be transitioning into Exchange subsidized coverage. County eligibility workers and Covered California's network of assisters would also be available to provide in-person help for Bridge eligible consumers.

CalHEERS would also be the mechanism for providing information on bridge eligible individuals to the federal government in the same manner as other Exchange eligible individuals.

CalHEERS Implementation Schedule: Recognizing that the Bridge proposal would require additional design and testing work to be incorporated into CalHEERS, a phased implementation schedule is recommended. The following timeline is proposed:

- July 1, 2013 – Business requirements completed.
- September 1, 2013 – Design Approved.
- January 1, 2014 – Plans are identified.
- April 1, 2014 – Bridge plans go live.

Streamlining Approaches for QHP Certification for Medi-Cal Managed Care and Bridge Plans:
Consistent with federal guidance, a Bridge plan product offered by a Medi-Cal managed care plan must be certified as a qualified health plan, and be in the interest of consumers. However, 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. 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. (See attachment 1.)

- Bridge plans would be required to offer both Silver and Gold precious metal benefit tiers as required by federal law. However, state law would be amended, pursuant to proposed legislation, to allow Covered California to waive the requirement that Bridge Plans offer all precious metal benefit tiers and catastrophic coverage.

- Bridge Plans would 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.

Determining Limited Provider Network Capacity: Consistent with federal guidance, Bridge plan issuers would be required to comply with applicable laws, and in particular, the guaranteed issue requirements of Section 2702 of the Public Health Service Act. If the issuer demonstrates that the provider network serving both Medi-Cal Managed care enrollees and Bridge enrollees is only sufficient to adequately handle this population, then the Bridge could be closed to non-bridge eligible individuals. The following elements are proposed to address this requirement:

- The Department of Health Care Services would ensure that there is a legally binding contractual obligation in place which would require a Medi-Cal managed care plan that offers a Bridge plan product to enroll Bridge eligible enrollees who were previous enrollees of that health plan's Medi-Cal managed care plan. This requirement is proposed to be included in legislation.

- The Department of Managed Health Care (DMHC) would be authorized by the federal government to review capacity for Bridge plan issuers in regard to the Bridge plan product in the following manner: A health care service plan offering a Bridge Plan would be determined to have reached capacity by looking solely at the capacity of the Bridge plan product and not on the capacity of the health care service plan. Enrollment of individuals who are members of the Modified Adjusted Gross Income household in which there are Medi-Cal or Healthy Families enrollees with that Bridge plan would not be considered new enrollment for purposes of determining capacity or state or federal provider network adequacy standards of the Bridge plan product.

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.

Attachment 1.

DRAFT QHP Solicitation Process for Bridge Plans[§]

1) Covered California issues Bridge Plan Application released (NOI simultaneous)– September 1, 2013

2) Bridge Plan applications-all info except bid including ECP network- November 1, 2013

3) Bridge plan networks due to regulators due- November 1, 2013

4) Bridge plan bids due- November 15, 2013

5) Tentative Bridge QHP certifications announced- December 1, 2014

6) Bridge QHP rate filings with regulators- November 15, 2013

7) Bridge QHP contracts signed- January 1, 2014

8) Bridge Plans go live- April 1, 2014

[§] Pending Board Approval of Bridge Proposal at Feb 26 Board meeting.