Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations

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March 5, 2015

Commissioned by The Leukemia & Lymphoma Society

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EXECUTIVE SUMMARY

This report, commissioned by the Leukemia & Lymphoma Society (LLS), provides an analysis of several potential prescription drug cost sharing benefit design changes on members enrolled in health insurance exchange plans sold on the 2015 insurance marketplace.

In this report, we examined four potential benefit design changes relating to prescription drug cost sharing:

- Per-prescription cap set equal to $100, applied pre-deductible, for a 30 day supply
- Per-prescription cap set equal to $150, applied pre-deductible, for a 30 day supply
- Per-prescription cap set equal to $200, applied pre-deductible, for a 30 day supply
- Annual prescription drug out-of-pocket (OOP) max set at 20% of the total OOP max.

LLS commissioned this analysis to better understand the out of pocket costs faced by members of exchange plans, especially members who have high prescription drug spending. This report examines the above benefit design changes and the impacts these changes would have on premiums, compliance with actuarial value requirements, and member cost sharing, and what, if any, other benefit design changes could offset these increases. We examined these changes in the context of the benefit design requirements of the Patient Protection and Affordable Care Act (ACA). To understand how these changes would affect cost sharing for a typical enrollee, we looked at health costs for members of several different plans sold on healthcare exchanges. We modeled the proposals on the following plans sold in 2015:

- California Standard Platinum
- California Standard Gold
- California Standard Silver
- California Standard Bronze
- A Typical Silver Exchange Plan – based on national average cost sharing provisions for silver plans
- A Typical Bronze Exchange Plan – based on national average cost sharing provisions for bronze plans.

The California plans were chosen because the State of California has a standardized benefit design across all carriers within each metal tier. Thus, these standard plan designs would be offered by a wide range of healthcare payers across the entire state. California was also chosen because, among states, it has the highest number of members enrolled in exchange plans. In 2014, the majority of California enrollees purchased silver plans (62%), followed by bronze (25%), gold (6%), and platinum (5%) plans.[1] We are using the Covered California plan designs that were sold in 2015 as an illustration only. We did not calibrate our analysis to reflect California enrollment experience or cost levels, or any changes in Covered California plan designs that may occur after 2015. Actual projections for the Covered California program would need to consider these factors and others.

The typical silver and typical bronze plan designs represent average deductibles, copays, coinsurances, and out-of-pocket maximums across all plans within those metal tiers that are available through the federal-run exchanges in the 2015 plan year, selected from plans with a combined medical and prescription drug deductible. In 2014, 65% of enrollees in the US selected silver plan designs, while 20% selected bronze plan designs.[2] These six plans offer significant variation in cost sharing mechanisms across a range of coverage levels.

Our analysis shows that all four of the potential benefit design changes result in decreased total cost sharing (including for both medical and prescription drugs) for the average member for each of the exchange plans studied. The decreases in member cost sharing were largest for members enrolled in the less generous bronze and silver plans, and smaller for the richer gold and platinum plans.

[1] Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (May 2014); "Addendum to the Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period"; Retrieved January 18 2015, from http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollAddendum.pdf

[2] Ibid.

Among generics, brand, and specialty medications, these benefit design changes had the greatest impact on member spending for specialty drugs on a per script basis (although for the bronze plans the absolute PMPM impact was larger for non-specialty brand medications). Specialty drugs are often covered through coinsurance rather than copays, and thus are subject to higher member cost sharing than other drugs. Cost sharing for generic drugs, most often covered through small copays, remained relatively unchanged.

Of course, any change in benefit design might affect plan cost, premiums, and other important elements of an insurance program. In this report we attempt to answer whether the four potential benefit design changes have a large or small impact on Exchange plan premiums and actuarial value. Assuming no other changes to benefit design, a reduction in member cost sharing is expected to cause an increase in the plan's cost, and therefore premium. For the purposes of this paper, we considered how plans could limit the increase to 0.5% or less, which we labeled as a minimal increase. We recognize that others may choose a higher or lower threshold for "minimal," and that, in some circumstances an increase of 0.5% may be significant to a plan or to some of its members.

For the plans and the four potential benefit design changes we examined, most platinum and gold plans and about half of silver plans showed premium increases of less than 0.5% as a result of the potential benefit design changes. For those plans whose premiums were predicted to increase by more than 0.5%, many could offset this premium change with alterations in plan design like increasing the plan's office visit copays by $5. Under some scenarios, the bronze plans required plan design changes such as increases in deductible or maximum out-of-pocket limits. In a few cases, the bronze plans were unable to completely offset the increased premium under ACA regulations. For these plans, the increase in premium is estimated to be approximately $11-$14 per month.

For average members, the increase in premium (assuming no offsetting changes in other benefits are made) combined with decreased out-of-pocket spending would result in overall expected annual healthcare costs remaining relatively unchanged. If there were no changes in other benefits, the actuarial value of the insurance product purchased would increase, providing members with somewhat more generous insurance coverage for the higher premium.

We also modeled the impact of these benefit design changes on patients with high specialty drug utilization, using the following populations:

- People taking either imatinib or lenalidomide, which are oral drugs used for certain blood cancers.
- People taking sorafenib or sunitinib, which are oral drugs used for certain tumor-based cancers (non-blood cancer), including specific types of thyroid, liver, and kidney cancer.
- People taking Atripla (efavirenz/emtricitabine/tenofovir), which is an oral combination therapy for HIV infection.
- People taking adalimumab, a self-injected treatment for certain auto-immune conditions, including rheumatoid arthritis.

These members were chosen to represent patients with chronic and severe illnesses who often have very high healthcare costs. Nearly every plan scenario tested resulted in significantly decreased annual member cost sharing for these populations (ranging from approximately $140 to $2,450), exceeding the reductions in annual cost sharing for the average member.

Through these potential benefit design changes, the insurer's portion of health spending is expected to increase, therefore increasing the plan's actuarial value. In order to be sold on the healthcare exchanges (or off the exchanges), plans must fit within a specific actuarial value range for each metal tier, as calculated using the federal Actuarial Value Calculator. As a plan's coverage increases, as is the case with all four benefit design changes we modeled, the actuarial value runs the risk of increasing to the point of non-compliance. Under nearly all of the combinations of exchange plan and benefit design changes we modeled, the actuarial value did not increase enough to make the plans non-compliant with this particular requirement.

The California bronze plan was the only modeled plan for which any of the potential benefit design changes challenged the actuarial value requirements; three out of the four potential changes did result in an actuarial value that exceeded the allowable range for this plan. The increase in actuarial value in these cases was more from non-specialty brand medications than from specialty medications. However, in all three of these cases, the plan would be able to return to compliance with increases in copays for other benefits.

Summary Findings of Modeling

- Members with high spending on specialty drugs, such as those in the specialty drug populations with the conditions we modeled, are expected to see a significant reduction in annual healthcare spending, (premiums plus out-of-pocket costs for medical and pharmacy services) upon implementation of any of the potential benefit design changes. The expected reduction ranges from approximately $80 - $2,300.
- The average plan member would be expected to see very little change in their total expected annual healthcare spending (premiums plus out-of-pocket costs for medical and pharmacy services) upon implementation of any of the potential benefit design changes.
- For all plans we analyzed but the bronze plans, the plan cost is not expected to increase beyond 0.5%, or can be limited to a 0.5% increase through increases in the PCP/Specialist copays of $5 or lower. For the bronze plans we analyzed, more substantial changes in the plans' benefits are required to keep the plan premium within 0.5% of the original premium, including increases to the deductible and out-of-pocket maximum.
- For five of the six plans analyzed in our study, the benefit design changes resulted in plans that remained compliant under ACA actuarial value requirements, without requiring the plan to make any further changes to the benefit design. The remaining plan, the California standard bronze plan, could be made compliant through offsetting increases in the PCP/Specialist copays and prescription drug copays.

This report was commissioned by The Leukemia & Lymphoma Society (LLS), an organization that funds blood cancer research and provides free information and support services. The potential benefit design changes we examined were selected based on suggestions from LLS. LLS received funding from Pfizer, Celgene and Genentech for this report. This report should not be interpreted as an endorsement of any particular legislation by Milliman or the authors. Bruce Pyenson and Balthazar Ziomek are members of the American Academy of Actuaries and meet the qualification standards to render the opinions expressed in this report. The report reflects the authors' findings and opinions. Because extracts of this report taken in isolation can be misleading, we ask that this report be distributed only in its entirety.

BACKGROUND TO THIS STUDY

Benefits for insurance products offered on the health insurance exchanges must strike a balance between meeting regulatory requirements and offering affordable coverage to members. Under the ACA, benefit designs must provide mandated essential health benefits and also must meet "actuarial value" requirements, which are described in more detail below. The various requirements require a balance of many different factors. Our report focuses on this complex dynamic in the context of four potential benefit changes to reduce cost sharing for prescription drugs.

Prescription drug tiers are used in insurance benefit designs to apply different cost-sharing levels to different categories of drugs. Traditional drug benefit plans have fixed co-payments for drugs using the standard three tiers (generics, preferred brands, and non-preferred brands). In the majority of tiered arrangements, the lowest cost drugs (often generics) have the lowest cost-sharing, while the highest cost drugs (often specialty drugs) have the highest cost sharing.

In recent years there has been a trend in the commercial and employer markets where health plans are utilizing one or more "specialty" tiers in their formulary designs. Often, for drugs placed on this tier, patients may be required to pay a percentage of the cost of the drug (coinsurance), rather than a flat copayment. With the advent of exchange plans, formulary tiers have become even more complex, with four- and five-tier formularies the most prevalent (65% of plans using four tiers and 19% using five tiers), and some plans offering as many as seven formulary tiers.[3] The prevalence of coinsurance for drugs placed on specialty tiers in Exchange plans increased in 2015, and plans began charging higher coinsurance amounts; silver exchange plans charging coinsurance greater than 30% for specialty medications has increased from 27% of silver plans in 2014 to 41% in 2015.[4]

Specialty drugs include new and old products that treat a variety of conditions. The term "specialty drug" is not consistently defined. Specialty drugs include complex molecules and may include bioengineered proteins and blood derivatives, however not all such products are specialty drugs and some specialty drugs are relatively simple molecules. Many specialty drugs are administered to the patient by injection or infusion in the physician's office or are self-injected; however, they can also be oral drugs. They may require special handling such as refrigeration or radiation shielding. These drugs are often considered high-cost, with a prescription ranging in cost from several hundred to thousands of dollars.

The majority of prescriptions used in the U.S. are for lower cost medicines. Approximately 86% of U.S. prescriptions are for generics.[5] In commercial plans in 2013, specialty drug prescriptions represented approximately 1% of total scripts, but the expenses associated with them accounted for over 25% of gross pharmacy spending (before cost sharing).[6] Member cost sharing (i.e., member out-of-pocket costs relating to deductibles, copays, and coinsurance) for specialty medications is usually high for Silver or Bronze plans offered on the healthcare exchanges. Certain low-income people may qualify for "Cost Sharing Reduction" versions of Silver plans that significantly reduce member out-of-pocket costs. The benefit design for specialty medications in exchange policies typically requires that the member pay a percentage of the total cost of the drug (coinsurance). Because of the high prices of specialty medications, member cost sharing based on coinsurance can result in high out-of-pocket costs to a member taking these drugs. Alternatively, for generic and non-specialty brand drugs, the cost sharing is typically a flat copay of less than $100 per prescription per month, although many plans have deductibles that apply to prescriptions, which means the member may have to pay the full cost of the medication until the deductible has been met.

[3] Avalere Health LLC (December 2014); "Avalere PlanScape® Benefit Design Insights"

[4] Avalere Health LLC (December 2014); "Exchange Plans Increase Costs of Specialty Drugs for Patients in 2015"; Retrieved February 20 2015, from http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1417539841_20141202_Exchange_Coinsurance_FINAL.pdf

[5] IMS Institute for Health care Informatics(April 2014); Medicine Use and the Shifting Costs of Healthcare Retrieved February 20 2015, from http://www.imshealth.com/portal/site/imshealth/menuitem.762a961826aad98f53c753c71ad8c22a/?vgnextoid=2684d47626745410VgnVCM10000076192ca2RCRD

[6] The Express Scripts Lab (April 2014). "2013 Drug Trend Report,"; Retrieved January 22 2015, from http://lab.express-scripts.com/drug-trend-report

High member cost sharing has been shown to be associated with patients' reduced adherence to their prescription drug treatment program.[7, 8] This suggests that patients with high monthly out-of-pocket prescription drug costs may face reduced adherence. For this reason, some states have set limits on cost-sharing for prescription drugs. Some current state efforts include:

- Annual out-of-pocket maximums for prescription drug spending – Legislation has been passed in Maine and Vermont limiting the annual prescription drug member cost sharing below the federal limit on combined medical and prescription drug cost sharing.[9, 10]

- Per prescription out-of-pocket caps for specialty drug spending – Legislation has been passed in Delaware, Maryland, and Louisiana limiting the monthly member cost sharing per specialty drug prescription to a predefined amount. These limits apply after the plan's deductible has been met.[11, 12, 13]

- Limits on cost sharing differentiation for specialty drugs - Legislation has been passed in New York and Alaska prohibiting the use of higher copays, coinsurance, or deductibles for specialty drugs than required for non-preferred brand drugs.[14, 15]

While some of these efforts focus only on cost sharing limits for specialty drugs, the benefit changes we model in this report apply to all prescription drugs, including generics, brands, and specialty drugs and thus, have a more significant impact than if they applied to specialty drugs only.

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[7] Streeter, S. B., Schwartzberg, L., Husain, N., & Johnsrud, M. (2011). Patient and Plan Characteristics Affecting Abandonment of Oral Oncolytic Prescriptions. *Journal of Oncology Practice*, 7(3 Suppl), 46s–51s.

[8] Gleason, Patrick., Starner, Catherine., Gunderson, Brent., Schafer, Jeremy. (2009). Association of Prescription Abandonment with Cost Stare for High-Cost Specialty Medications; *Journal of Managed Care Pharmacy,* 15:648–658.

[9] http://legislature.maine.gov/statutes/24-A/title24-Asec4317-A.html; Retrieved February 27, 2015

[10] http://law.justia.com/codes/vermont/2014/title-8/chapter-107/section-4089i/ ; Retrieved February 27, 2015

[11] http://law.justia.com/codes/delaware/2014/title-18/chapter-33/section-3364; Retrieved February 27, 2015

[12] http://mgaleg.maryland.gov/webmga/frmStatutesText.aspx?article=gin&section=15-847&ext=html&session=2015RS&tab=subject5; Retrieved February 27. 2015

[13] http://www.legis.la.gov/legis/BillInfo.aspx?s=14rs&b=SB165&sbi=y; Retrieved February 27, 2015

[14] http://open.nysenate.gov/legislation/bill/s5000B; Retrieved on February 27, 2015

[15] http://www.legis.state.ak.us/basis/get_fulltext.asp?session=27&bill=HB218; Retrieved on February 27, 2015

ACTUARIAL VALUE AND ITS IMPORTANCE IN CONSIDERING BENEFIT DESIGN CHANGES

Overview

The ACA requires issuers in the individual and small group markets, inside and outside of the Exchange, to offer minimum levels of coverage for Essential Health Benefits (EHB). These levels of coverage are measured in the form of actuarial values, as described in the following formula, and are determined by the Actuarial Value (AV) Calculator issued by the U.S. Department of Health and Human Services (HHS):

$$Actuarial\ Value = \frac{Anticipated\ Plan\ Paid\ Allowed\ Charges\ for\ EHB\ Coverage\ for\ a\ Standard\ Population}{Anticipated\ Total\ Paid\ Allowed\ Charges\ for\ EHB\ Coverage\ for\ a\ Standard\ Population}$$

The actuarial value of a health plan is an approximate measurement of the portion of essential health benefits that the plan will cover. As a result, the actuarial value will only vary based on plan design, and is not impacted by other factors such as the demographics of the population and the type of provider reimbursement contracts in place.

The levels of coverage offered in the individual and small group markets must fall within certain actuarial value levels, as described in the following table:

METALLIC LEVEL	ACTUARIAL VALUE RANGE
Bronze	58%-62%
Silver	68%-72%
Gold	78%-82%
Platinum	88%-92%

HHS developed and updates the AV Calculator that issuers must use to evaluate their existing plan designs and to ensure that future plan offerings meet the above criteria. The underlying costs in the AV Calculator cover all federally mandated EHB's and are intended to reflect costs of a standard individual and small group population. All metallic plans must demonstrate AVs from the AV Calculator appropriate to their metallic level (within +/- 2 percentage points), or they cannot be sold.

Because the potential benefit design changes in this study would increase the level of coverage provided for prescription drugs, they are expected to increase the actuarial value of the plans and therefore have the potential to cause plans to exceed acceptable ranges of actuarial value, although reductions in other benefits could bring the plans back into the range. Any plan that exceeds the acceptable AV range cannot be sold on or off the exchange marketplace. Therefore, it is important to assess the impact of any potential benefit design changes on the plan's actuarial value.

We note that use of the term "AV" can be confusing, because there are two different AVs for any plan. For purposes of determining whether a plan is Platinum, Gold, Silver, or Bronze, actuaries use the "HHS AV". This is a number from a tool – the AV Calculator - produced by the HHS. The HHS AV tool uses relatively few inputs about a plan and cannot accommodate many detailed plan features. The "real AV" reflects the plan's experience or expected experience—the ratio of total paid amounts to total allowed amounts. The real AV is often very different from that produced by the AV Calculator. In particular, the HHS AV is much less sensitive to coverage for specialty medications than the real AV is. However, for the purposes of identifying a plan as offering platinum, gold, silver or bronze coverage, the HHS AV is used, not the real AV.

BENEFIT DESIGNS, PLANS, AND POPULATIONS STUDIED

The purpose of this study was to estimate the impacts of four potential benefit design changes that would reduce member cost sharing for prescription drugs. We modeled the effect that each of these benefit design changes would have on both average members as well as for specific patient populations that utilize drugs typically placed on specialty tiers. We looked at the impact on:

- Total annual member out-of-pocket spending (for both medical and pharmaceutical services)
- Premiums
- Actuarial value

Modeled Benefit Design Changes

The potential benefit design changes that we analyzed are discussed below:

Total Dollar Cap of $100, $150 or $200 on Member Spending per 30 Day Prescription Applied Pre-deductible

We modeled the impacts of a $100, $150, and a $200 cap on member cost sharing for a 30 day supply of any single prescription drug. This cap applies pre-deductible, meaning that the cap would take effect before any applicable deductible towards the pharmacy benefit (or combined medical and pharmacy benefit) is met. For a plan without a deductible, this typically impacts member costs only for specialty drugs, as member cost sharing for most brand and generic prescriptions fall under this cap.

Annual Out-of-Pocket Maximum of 20% of the Total Annual Out-of-Pocket (OOP) Maximum

We modeled the impact of limiting the annual member out-of-pocket spending for prescription drugs to 20% of the plan total annual out-of-pocket maximum.

Modeled Plan Designs

To determine the effects of these benefit design changes on a range of available coverage options, we modeled cost sharing under six different health plans based on 2015 plan designs: Four standard copay plans from California and two typical exchange plans. We are using the Covered California plan designs that were sold in 2015 as an illustration only. We did not calibrate our analysis to reflect California enrollment experience or cost levels, or any changes in Covered California plan designs that may occur after 2015. Actual projections for the Covered California program would need to consider these factors and others.

The four standard plans from California are available to individuals through Covered California, California's health insurance exchange, for the 2015 plan year. Insurers in California who participate in the exchange offer standardized plan designs on the individual exchange. The cost sharing in these plans, as with all metallic plans, range from the richer Platinum plan, which covers roughly 90% of allowed costs, to the less rich Bronze plan, which covers roughly 60% of allowed costs. In addition to its standardized benefit designs, California was an appealing choice because of its high exchange enrollment. California had the greatest number of individuals enrolled in marketplace plans out of any state in 2014.[16]

The California plan designs we modeled offer four drug tiers, with flat copays for generic and brand drugs and coinsurance for specialty drugs. The Bronze plan has an integrated medical/prescription drug deductible, and the Silver plan has separate deductibles for medical services and brand drugs. The remaining plans have no deductible. These plans offer significant variation in cost sharing mechanisms, which make them appropriate for

[16] Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (May 2014); "Addendum to the Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period"; Retrieved January 18 2015, from http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollAddendum.pdf

our analysis. In 2014, the majority of enrollees were found in the silver California plan designs (62%), followed by the bronze plan designs (25%), gold plan designs (6%), and platinum plan designs (5%).[17]

The following is an overview of the benefit designs for the four 2015 California standard plans:

	Platinum 90 PPO	Gold 80 PPO	Silver 70 PPO	Bronze 60 PPO
Deductible	$0	$0	$2000 Medical / $250 Brand Drug	$5000
Out of Pocket Maximum	$4000	$6250	$6250	$6250
PCP/Specialist Visit	$20 / $40	$30 / $50	$45 / $65	$60 / $70 after deductible
Inpatient Hospital Stay	$250	$600	20%	30%
Generic Drugs	$5	$15	$15	$15 after deductible
Preferred Brand Drugs	$15	$50	$50 after deductible	$50 after deductible
Non-preferred Brand Drugs	$25	$70	$70 after deductible	$75 after deductible
Specialty Drugs	10%	20%	20%	30%

* All copays are paid prior to meeting the deductible, and all coinsurances are paid after the member has met the deductible, unless otherwise stated

Utilizing datasets available through the federal healthcare exchange website we also created two plans designed to represent typical Silver and Bronze plans sold on the federally-facilitated exchange markets. These plans represent a national average of benefit provisions for Silver and Bronze individual plans that are available through the federal-run exchange in the 2015 plan year, selected from plans with a combined medical and prescription drug deductible. We selected plans with a combined deductible, as these types of plans had the greatest prevalence in 2015. Furthermore, for the silver plan, this provides an opportunity to test the potential policies on a plan design with a different deductible design than the California silver plan, which has separate medical and prescription drug deductibles. Both the Typical Bronze and Typical Silver plans were AV compliant. In 2014, 65% of enrollees in the US selected silver plan designs, while 20% selected bronze plan designs.[18]

[17] Ibid.

[18] Ibid.

An overview of the benefit design for these two plans is shown in the following table.

	Typical Silver Exchange Plan	Typical Bronze Exchange Plan
Deductible*	$2,400	$5,100
Out of Pocket Maximum	$5,400	$6,250
PCP Office Visit	$28	25%
Specialist Office Visit	20%	25%
Inpatient Hospital Stay	25%	25%
Generic Drugs	$12	23%
Preferred Brand Drugs	$41	25%
Non-preferred Brand Drugs	25%	25%
Specialty Drugs	25%	25%

* All copays are paid prior to meeting the deductible, and all coinsurances are paid after the member has met the deductible, unless otherwise stated. Selected from plans with combined medical and prescription drug deductible.

The six plans represent a wide range of coverage levels available to a member of the health insurance exchanges. We did not examine any cost-sharing-reduction (CSR) plans in this analysis. The CSR plans are available to members enrolling through the exchanges who qualify for financial assistance with cost sharing, and the coverage is more generous for these types of plans than for those available through the silver non-CSR plans. CSR plans are designed to have lower member cost sharing; the reduced cost sharing in the CSR plans means these members are less likely than members with non-CSR silver plans to have drug spending affected by the analyzed benefit design changes.

Populations of Specialty Drug Users

In addition to examining the impact of the benefit design changes on the "average" member, we analyzed four populations of specialty drug users. Each population was identified as a household where at least one member of that household fell into one of the following categories:

- People taking either imatinib or lenalidomide, which are oral drugs used for certain blood cancers.
- People taking sorafenib or sunitinib, which are oral drugs used for certain tumor-based cancers (non-blood cancer), including specific types of thyroid, liver, and kidney cancer.
- People taking Atripla (efavirenz/emtricitabine/tenofovir), which is an oral combination therapy for HIV infection.
- People taking adalimumab, a self-injected treatment for certain auto-immune conditions, including rheumatoid arthritis.

These households have at least one member taking the above specialty drugs to treat their illness. Please see the Methodology section for further details.

FINDINGS

Average Member Cost Sharing

Attachment A shows the *average* member's expected annual cost sharing (including both prescription drug and medical out-of-pocket costs)[19] for each plan design under all potential benefit design changes, as well as the dollar and percentage impact of the potential benefit design changes on an average member's annual cost sharing. The expected reduction in annual member cost sharing under each benefit design change is summarized in the following table:

Expected Decrease in Annual Member Cost Sharing (Including Medical and Pharmacy) for Average Member

Plan Design	Per-prescription cap ($100)*	Per-prescription cap ($150)*	Per-prescription cap ($200)*	Annual Rx OOP max set to 20 % of total annual OOP max
California Platinum	$7	$5	$3	$11
California Gold	$16	$13	$11	$32
California Silver	$29	$17	$13	$32
California Bronze	$121	$75	$47	$139
Typical Silver	$18	$14	$10	$29
Typical Bronze	$116	$72	$45	$133

*Applied pre-deductible, for a 30 day supply

The potential benefit design changes have little impact on the average member's annual cost sharing for the relatively richer platinum and gold products. The reductions range from $3 to $11 for the California platinum plan, and from $11 to $32 for the California gold plan. These plans have relatively richer benefits, including lower coinsurance for specialty drugs, and no deductibles. Therefore, the potential benefit design changes have less of an impact on these plans. The impact on average annual member cost sharing in the two silver plans is also relatively small, with reductions ranging from $10 to $32.

The impact of the benefit design changes is greatest for the two bronze plans, where the reductions in annual average member cost sharing range from $45 to $139. These plans have the highest deductibles of the plans we analyzed and have higher levels of coinsurance for specialty drugs than most other plans, which provide more opportunity for the potential benefit design changes to limit the member's cost sharing. For these plans, the benefit design changes have a large impact on member cost sharing not just for specialty drugs, but for non-specialty brand drugs as well, due to the high cost of many brand drugs to the member when subject to the plan's deductible.

Our models show that the potential benefit design changes result in a greater percentage reduction in the member's expected annual cost for specialty drugs than for brand or generic drugs. This is consistent with our expectations, as specialty drugs tend to be higher cost and are typically covered by a coinsurance rather than by a copay, thereby making them the most likely medication type to exceed the cost sharing limits restricted by the potential benefit design changes.

[19] Health plans typically have deductibles and out-of-pocket maximums that apply to both medical and prescription drug claims. Therefore, it is important to re-adjudicate all claims, not just prescription drug benefit claims.

Impact on Specialty Drug Populations

For members in the defined specialty drug populations (households that contain at least one patient taking specific specialty drugs), the potential benefit design changes can reduce the affected member's healthcare spending significantly, by reducing their specialty drug costs. Attachment B shows the expected member cost sharing for a typical member of one of the four populations that we identified as needing specialty medications, as well as the changes in cost sharing for these members under each of the potential benefit design changes.

The table below shows a range of the expected decreases in annual per-member member cost sharing. The table's basis is per member of a household where at least one member is using these specialty drugs. We show the decreases for the four potential benefit design changes. The range is across the four tested changes.

Expected Decrease in Annual Member Cost Sharing (Including Medical and Pharmacy) due to Potential Benefit Changes
Selected Populations – per member of the household with a person taking a specific specialty drug, insured by a modeled plan

	Blood Cancer[1]	Non-Blood Cancer[2]	HIV[3]	Rheumatoid Arthritis[4]
California Platinum	$321 - $713	$241 - $400	$143 - $1138	$186 - $612
California Gold	$801 - $1167	$495 - $657	$1440 - $2328	$784 - $1169
California Silver	$586 - $878	$324 - $437	$1385 - $2221	$683 - $1031
California Bronze	$310 - $540	$144 - $253	$1583 - $2454	$573 - $936
Typical Silver	$370 - $550	$158 - $234	$1483 - $2160	$611 - $869
Typical Bronze	$307 - $522	$142 - $245	$1546 - $2382	$560 - $899

[1] People taking either imatinib or lenalidomide, which are oral drugs used for certain blood cancers.
[2] People taking sorafenib or sunitinib, which are oral drugs used for certain tumor-based cancers (non-blood cancer), including specific types of thyroid, liver, and kidney cancer.
[3] People taking Atripla (efavirenz/emtricitabine/tenofovir), which is an oral combination therapy for HIV infection.
[4] People taking adalimumab, a self-injected treatment for certain auto-immune conditions, including rheumatoid arthritis.

These decreases are much higher than those for the average member, due to the significant reduction in cost sharing for the prescription drugs needed to treat these conditions, which are typically placed on specialty tiers.

Greater decreases in member spending are expected for plans with no deductible, or with separate prescription drug and medical deductibles, such as the California Platinum, Gold, and Silver plans. Under these plan designs, the impact on prescription drug cost sharing is not expected to be offset as significantly by increased member cost sharing for medical benefits. For these types of plans, medical and prescription drug benefits have no combined cost sharing mechanism except for the plan's overall OOP maximum. Unless the member cost sharing exceeds the plan's overall OOP maximum, any reduction in member cost sharing for prescription drugs would not result in higher medical cost sharing.

For plans with a combined prescription drug and medical deductible - such as the bronze plans and our typical silver plan – we expect to see slightly smaller overall savings for members. This is because, although the cost sharing for prescription drugs is reduced, members still have to meet the combined deductible. That is, OOP spending from prescription drug cost sharing that previously counted toward meeting the deductible, may be instead replaced by medical costs that count toward the deductible.

Premiums and Total Cost to Health Plan Members

Assuming no other changes to benefit design, the expected reduction in member cost sharing is expected to be accompanied by an increase in the plan's cost, and therefore premium – unless the plan decides to absorb the extra cost, and reduces its profits. However, the key question is how large of an impact on premiums these benefit design changes are expected to have, considering the expected reduction in member cost sharing.

As premiums are based primarily upon plan cost, which rises in proportion to the reduction in member cost sharing, we expect that any resulting increase in premiums would be only slightly higher than the reduction in average member cost sharing.[20] Therefore, the average plan member is expected to see very little change in their total expected annual healthcare spending (premiums plus out-of-pocket costs) upon implementation of any of these benefit design changes. The estimated change in annual premium by plan under each benefit design change, holding all other benefits constant, and assuming the plan does not absorb the extra cost through a reduction in profits, is provided in Attachment C.

However, members with high spending on specialty drugs, such as those with the conditions we modeled, are expected to see a larger reduction in annual healthcare spending (inclusive of premiums and cost-sharing for both medical and pharmacy services and treatments). The decrease in member cost sharing for these populations would be higher than the average member, and therefore would outweigh any resulting premium increases, as premium increases must be spread across the whole membership.

On the other hand, members with low spending on high-cost drugs may not see any reduction in their cost sharing; therefore the increase in premiums resulting from the additional coverage could increase these members' total annual cost by the amounts detailed in Attachment C.

Potential Benefit Reductions to Offset Increased Plan Costs

As described in previous sections, the four potential benefit design changes would lead to lower member cost-sharing. As a result, insurers would pay a larger share of medical costs on average. The insurers may offset this cost by increasing member cost sharing for other benefits instead of increasing premiums. For all plans considered apart from the bronze plans, such reductions in plan cost can be achieved through increases of $5 or less in the copays for other benefits, such as office visits.

For practicality, we consider benefit design changes to have minimal premium impact if the new plan's rates are not expected to increase by more than 0.5% of the original premium. Attachment C shows which benefit design changes keep a plan premium within this threshold, and which benefit design changes require some offset in the cost-sharing to keep the plan premium within this threshold. This is also summarized in the following table.

[20] Premiums are expected to rise slightly more than the reduction in member cost sharing due to retention loadings applied by insurance companies to the plan's claim costs. These include loadings for administrative expenses, risk, and profit, among others.

Possible Actions a Plan may Take to Offset Increased Plan Costs						
Scenario	California Standard Platinum Plan	California Standard Gold Plan	California Standard Silver Plan	California Standard Bronze Plan	Typical Silver Exchange Plan	Typical Bronze Exchange Plan
Monthly per-prescription cap, applied pre-deductible ($100)						
Estimated % Increase in Premium*	0.2%	0.4%	0.8%	4.2%	0.5%	4.0%
Possible actions a plan may take minimize premium increase to 0.5%	No action required	No action required	Increase PCP copay by $5	Cannot minimize premium increase to 0,5% under ACA out-of-pocket limits	No action required	Cannot minimize premium increase to 0,5% under ACA out-of-pocket limits
Monthly per-prescription cap, applied pre-deductible ($150)						
Estimated % Increase in Premium	0.1%	0.3%	0.5%	2.6%	0.4%	2.5%
Possible actions a plan may take minimize premium increase to 0.5%	No action required	No action required	No action required	Increase deductible by $800; Increase out-of-pocket maximum by $350	No action required	Increase deductible by $600; Increase out-of-pocket maximum by $350
Monthly per-prescription cap, applied pre-deductible ($200)						
Estimated % Increase in Premium	0.1%	0.3%	0.3%	1.6%	0.3%	1.6%
Possible actions a plan may take minimize premium increase to 0.5%	No action required	No action required	No action required	Increase out-of-pocket maximum by $350	No action required	Increase out-of-pocket maximum by $350
Annual Rx OOP max set at % of total annual OOP max (20%)						
Estimated % Increase in Premium	0.2%	0.8%	0.9%	4.8%	0.9%	4.6%
Possible actions a plan may take minimize premium increase to 0.5%	No action required	Increase PCP copay by $5	Increase PCP copay by $5	Cannot minimize premium increase to 0,5% under ACA out-of-pocket limits	Increase PCP copay by $5	Cannot minimize premium increase to 0,5% under ACA out-of-pocket limits

* Assuming plan applies 15% load for retention and that all loadings are included in this retention

As shown in the table above, the California standard platinum plans' rates are not expected to increase by more than 0.5% under any benefit design change. This is also true for the majority of benefit design changes under the California standard gold and "typical" silver exchange plans, and for two of the benefit design changes under the California standard silver plan. For those benefit design changes requiring an offsetting medical cost sharing change for the standard California gold or both silver plans, minor changes in medical cost sharing could keep the plan premium within our threshold of 0.5% of the original premium. For these plans and benefit design changes, the increased plan cost could be offset by increases in the office visit copays of $5 or less.

For the bronze plans, more substantial changes in the plan cost sharing are required to keep the plan premium within our threshold of 0.5% of the original premium. Because bronze plans have a high deductible, and because coinsurance and copays apply after the deductible, changes in medical copays or coinsurance have little impact on premiums. Therefore, to reduce the new premiums to close to prior levels for these plans, a plan would need to increase the maximum out-of-pocket spending and/or deductible. However, the ACA sets a maximum on out-of-pocket spending of $6,600 for plans offered in 2015. This ACA maximum, along with other ACA requirements

means no permissible cost sharing changes could accommodate two of the benefit design changes within our premium increase threshold for both bronze plans in this study. Those two potential benefit design changes that could not be accommodated are the annual prescription drug out-of-pocket (OOP) max set at 20% of total OOP max, and the per-prescription cap set equal to $100, for a 30 day supply. These two potential changes would be expected to increase monthly premiums by approximately $11 - $14 if no additional benefit provisions are changed.

Impacts on HHS Actuarial Value

The four potential benefit design changes are expected to reduce the average member's cost sharing, and therefore increase the portion of spending paid for by the insurer. As a result, assuming no other modifications to plan designs are made, the four benefit design changes would all increase the actuarial value of the product. A key question is whether the increase in actuarial value would exceed HHS' allowable actuarial value range for the plan's metallic tier. Plans that exceed the allowable actuarial value range will be deemed non-compliant and cannot be offered on or off the healthcare exchanges.

Attachment D provides the impacts of the four potential benefit design changes on the actuarial values of the plans we examined. For the platinum, gold, silver, and for both typical plans that we analyzed all potential benefit design changes had a minimal impact on actuarial value and these plans remained compliant. For the California bronze plan, three of the potential benefit design changes – the per-prescription caps of $100 and $150 on member spending for a 30 day supply applied pre-deductible, and setting the annual prescription drug out-of-pocket maximum at 20% of the design's overall out-of-pocket maximum - pushed the plan out of compliance. Corresponding reductions in other cost sharing provisions would be required to bring the plan back into compliance if the three potential benefit design changes were made.

The table below, as well as Attachment E, provides steps that could be taken to bring the California bronze plan back into compliance. Of the benefit design changes that require action to bring the plan with the potential benefit design changes back into an acceptable actuarial value range, all require only a few copay increases in the PCP/Specialist copay and prescription drug copays.

Studied Changes to California Standard Bronze Plan and Possible Offsets Required for AV Compliance	
Scenario	**Possible changes a plan may make keep this plan in compliance with AV requirements**
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	Increase PCP copay by $25; Increase SPC copay by $30; Increase brand drug copays by $20
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	Increase PCP copay by $10; Increase SPC copay by $10
Annual Rx OOP max set at % of total annual OOP max (20%)	Increase PCP copay by $25; Increase SPC copay by $25; Increase brand drug copays by $20; Increase generic copay by $10

METHODOLOGY AND SOURCES

In our analysis, we modeled the member cost sharing and plan cost using Milliman's 2014 Claim Simulation Model. This model simulates the payment of claims by the member and health plan under the specified plan's cost sharing features, using a large sample of medical and pharmacy claims-level data from Milliman's 2012 Health Cost Guidelines[21] (HCG's) Contributor database. This database has data for about 10 million covered lives and is nationally representative. The simulation was run on a sample of claims from 200,000 commercial members, chosen to be nationally representative and to have high quality (fully detailed) claims and exposure data. This sample is a random sample; the allowed charges were analyzed against the full HCG Contributor database to check for reasonability. The member and plan cost sharing was calculated claim by claim. All cost sharing was then aggregated to derive the average per member per month cost for the sample population.

To estimate the premium, we took the plan cost under the given scenario and added a retention charge equal to 15% of the premium. This retention charge is assumed to include all non-claim charges, including but not limited to administrative expenses, taxes and fees, and a provision for profit. This retention is illustrative and does not include the impact of some additional pricing adjustments, such as adjustments for expected reinsurance recoveries and risk transfer payments from HHS. In the exchanges, carriers' costs and strategic goals produce a wide range of premiums for any given benefit design. Our models produce premium estimates in the range of actual observed premiums.

We note that some of the benefit design changes may increase premiums, and increased premiums are associated with lower enrollment; we have not attempted to address this consequence.

We evaluated spending for each member in the context of the spending of the whole household they belong to. We took this approach because a plan's OOP maximum depends on the number of people covered under the plan. For example, a household may consist of one member who would be subject to the individual OOP maximum ($6,250 for the California Bronze plan). However, if that same member were part of a family contract, that member's spending would be accumulated with other family members' spending for the OOP maximum calculation (although for all plans, each member's annual spending is capped at the individual plan's limit). For the California Bronze plan, a family contract's OOP maximum would be twice that ($12,500) for someone with an individual contract. The ACA sets limits for how high the OOP Maximums can be. Under these limits, the family OOP maximum is twice that of the individual.

Due to the complex cost sharing features of the potential scenarios, we were unable to rely solely on the AV Calculator to determine the actuarial values of the modified California and "typical" exchange plans. We therefore used the AV Calculator only for the base scenario for each plan. After the base plan actuarial value was calculated, we relied on additional analysis outside of the AV Calculator to develop the remaining actuarial values, which is the method specified in the American Academy of Actuaries' Minimum Value and Actuarial Value Determinations Under the Affordable Care Act Practice Note.[22] We applied benefit relativity factors to the base plan's actuarial value to calculate the actuarial values of the plans under the additional scenarios. These factors reflect the differences in cost sharing between the different scenarios, and were calculated using the Claim Simulation Model. Other actuaries could produce different actuarial values for the modified plans in this report based on their own data sources, methods and actuarial judgment.

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[21] The *HCGs* are a cooperative effort of Milliman health actuaries and represent a combination of their experience, research, and judgment. An extensive amount of data is used in developing the *HCG*s and that data is updated annually.

[22] American Academy of Actuaries (April 2014). "Minimum Value and Actuarial Value Determinations Under the Affordable Care Act,"; Retrieved January 22 2015, from http://www.actuary.org/files/MVPN_042314.pdf

LIMITATIONS

The average values presented in this report are estimates based on historical data. Actual results for specific plans and for specific members will differ for a number of reasons. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made in our projections. Random or non-random fluctuations could cause actual results to be different from those presented here.

We are using the Covered California plan designs that were sold in 2015 as an illustration only. We did not calibrate our analysis to reflect California enrollment experience or cost levels, or any changes in Covered California plan designs that may occur after 2015. Actual projections for the Covered California program would need to consider these factors and others.

This report was commissioned by The Leukemia & Lymphoma Society (LLS), a voluntary health agency dedicated to blood cancer. LLS received funding from Pfizer, Celgene and Genentech for this report. LLS funds blood cancer research and provides free information and support services. This report should not be interpreted as an endorsement of any particular legislation by Milliman or the authors. Bruce Pyenson and Balthazar Ziomek are members of the American Academy of Actuaries and meet the qualification standards to render the opinions expressed in this report. The report reflects the authors' findings and opinions. Because extracts of this report taken in isolation can be misleading, we ask that this report be distributed only in its entirety.

ATTACHMENTS

Attachment A
Impacts of Benefit Design Changes on Member Cost Sharing
For Average Member

California Standard Plans

California Standard Platinum Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$380	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$373	$7	1.9%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$375	$5	1.3%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$377	$3	0.8%
Annual Rx OOP max set at 20% of total annual OOP max ($800)	$370	$11	2.8%

*Includes cost sharing for medical and prescription drug services

California Standard Gold Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$678	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$662	$16	2.4%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$665	$13	2.0%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$667	$11	1.6%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$646	$32	4.7%

*Includes cost sharing for medical and prescription drug services

California Standard Silver Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$1,030	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$1,000	$29	2.9%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$1,013	$17	1.7%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$1,017	$13	1.2%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$998	$32	3.1%

*Includes cost sharing for medical and prescription drug services

California Standard Bronze Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$1,782	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$1,661	$121	6.8%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$1,707	$75	4.2%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$1,735	$47	2.6%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$1,643	$139	7.8%

*Includes cost sharing for medical and prescription drug services

Attachment A
Impacts of Benefit Design Changes on Member Cost Sharing
For Average Member

Typical Exchange Plans

Typical Silver Exchange Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$1,263	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$1,245	$18	1.4%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$1,250	$14	1.1%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$1,253	$10	0.8%
Annual Rx OOP max set at 20% of total annual OOP max ($1,080)	$1,234	$29	2.3%

*Includes cost sharing for medical and prescription drug services

Typical Bronze Exchange Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$1,838	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$1,722	$116	6.3%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$1,766	$72	3.9%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$1,793	$45	2.4%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$1,705	$133	7.2%

*Includes cost sharing for medical and prescription drug services

Attachment B

Impacts of Benefit Design Changes on Member Cost Sharing

For Average Member of a Household with at Least One Member Taking Imatinib or Lenalidomide (Blood Cancer)

California Standard Plans

California Standard Platinum Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$2,141	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$1,535	$606	28.3%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$1,686	$455	21.2%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$1,820	$321	15.0%
Annual Rx OOP max set at 20% of total annual OOP max ($800)	$1,428	$713	33.3%

*Includes cost sharing for medical and prescription drug services

California Standard Gold Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$3,432	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$2,327	$1,106	32.2%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$2,483	$949	27.7%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$2,632	$801	23.3%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$2,266	$1,167	34.0%

*Includes cost sharing for medical and prescription drug services

California Standard Silver Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$3,662	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$2,829	$834	22.8%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$2,959	$703	19.2%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$3,076	$586	16.0%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$2,784	$878	24.0%

*Includes cost sharing for medical and prescription drug services

California Standard Bronze Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$4,149	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$3,665	$484	11.7%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$3,765	$384	9.3%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$3,839	$310	7.5%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$3,609	$540	13.0%

*Includes cost sharing for medical and prescription drug services

Attachment B

Impacts of Benefit Design Changes on Member Cost Sharing

For Average Member of a Household with at Least One Member Taking Imatinib or Lenalidomide (Blood Cancer)

Typical Exchange Plans

Typical Silver Exchange Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$3,396	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$2,911	$485	14.3%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$2,970	$426	12.6%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$3,026	$370	10.9%
Annual Rx OOP max set at 20% of total annual OOP max ($1,080)	$2,846	$550	16.2%

*Includes cost sharing for medical and prescription drug services

Typical Bronze Exchange Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$4,151	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$3,678	$473	11.4%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$3,773	$378	9.1%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$3,844	$307	7.4%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$3,629	$522	12.6%

*Includes cost sharing for medical and prescription drug services

Attachment B

Impacts of Benefit Design Changes on Member Cost Sharing

For Average Member of a Household with at Least One Member Taking Sorafenib or Sunitinib (Non-Blood Cancer)

California Standard Plans

California Standard Platinum Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$2,291	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$1,906	$385	16.8%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$1,986	$305	13.3%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$2,050	$241	10.5%
Annual Rx OOP max set at 20% of total annual OOP max ($800)	$1,891	$400	17.4%

*Includes cost sharing for medical and prescription drug services

California Standard Gold Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$3,688	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$3,031	$657	17.8%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$3,116	$572	15.5%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$3,193	$495	13.4%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$3,035	$653	17.7%

*Includes cost sharing for medical and prescription drug services

California Standard Silver Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$3,938	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$3,503	$435	11.0%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$3,566	$372	9.5%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$3,614	$324	8.2%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$3,501	$437	11.1%

*Includes cost sharing for medical and prescription drug services

California Standard Bronze Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$4,455	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$4,230	$225	5.1%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$4,278	$177	4.0%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$4,311	$144	3.2%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$4,203	$253	5.7%

*Includes cost sharing for medical and prescription drug services

Attachment B

Impacts of Benefit Design Changes on Member Cost Sharing

For Average Member of a Household with at Least One Member Taking Sorafenib or Sunitinib (Non-Blood Cancer)

Typical Exchange Plans

Typical Silver Exchange Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$3,624	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$3,422	$202	5.6%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$3,445	$179	4.9%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$3,466	$158	4.4%
Annual Rx OOP max set at 20% of total annual OOP max ($1,080)	$3,390	$234	6.5%

*Includes cost sharing for medical and prescription drug services

Typical Bronze Exchange Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$4,435	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$4,214	$220	5.0%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$4,261	$174	3.9%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$4,293	$142	3.2%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$4,190	$245	5.5%

*Includes cost sharing for medical and prescription drug services

Attachment B

Impacts of Benefit Design Changes on Member Cost Sharing

For Average Member of a Household with at Least One Member Taking Atripla (HIV)

California Standard Plans

California Standard Platinum Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$2,152	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$1,325	$827	38.4%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$1,683	$469	21.8%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$2,008	$143	6.7%
Annual Rx OOP max set at 20% of total annual OOP max ($800)	$1,013	$1,138	52.9%

*Includes cost sharing for medical and prescription drug services

California Standard Gold Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$3,956	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$1,765	$2,191	55.4%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$2,150	$1,806	45.7%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$2,515	$1,440	36.4%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$1,628	$2,328	58.8%

*Includes cost sharing for medical and prescription drug services

California Standard Silver Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$4,250	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$2,151	$2,099	49.4%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$2,522	$1,728	40.7%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$2,865	$1,385	32.6%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$2,028	$2,221	52.3%

*Includes cost sharing for medical and prescription drug services

California Standard Bronze Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$5,178	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$2,939	$2,239	43.2%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$3,297	$1,881	36.3%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$3,595	$1,583	30.6%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$2,724	$2,454	47.4%

*Includes cost sharing for medical and prescription drug services

Attachment B

Impacts of Benefit Design Changes on Member Cost Sharing

For Average Member of a Household with at Least One Member Taking Atripla (HIV)

Typical Exchange Plans

Typical Silver Exchange Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$4,305	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$2,313	$1,991	46.3%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$2,584	$1,721	40.0%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$2,822	$1,483	34.4%
Annual Rx OOP max set at 20% of total annual OOP max ($1,080)	$2,145	$2,160	50.2%

*Includes cost sharing for medical and prescription drug services

Typical Bronze Exchange Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$5,190	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$3,006	$2,183	42.1%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$3,353	$1,837	35.4%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$3,644	$1,546	29.8%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$2,808	$2,382	45.9%

*Includes cost sharing for medical and prescription drug services

Attachment B

Impacts of Benefit Design Changes on Member Cost Sharing

For Average Member of a Household with at Least One Member Taking Adalimumab (Rheumatoid Arthritis)

California Standard Plans

California Standard Platinum Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$1,516	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$1,011	$505	33.3%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$1,175	$341	22.5%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$1,329	$186	12.3%
Annual Rx OOP max set at 20% of total annual OOP max ($800)	$904	$612	40.4%

*Includes cost sharing for medical and prescription drug services

California Standard Gold Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$2,631	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$1,522	$1,108	42.1%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$1,686	$944	35.9%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$1,847	$784	29.8%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$1,462	$1,169	44.4%

*Includes cost sharing for medical and prescription drug services

California Standard Silver Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$2,933	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$1,951	$982	33.5%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$2,107	$825	28.1%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$2,250	$683	23.3%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$1,902	$1,031	35.1%

*Includes cost sharing for medical and prescription drug services

California Standard Bronze Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$3,644	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$2,808	$835	22.9%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$2,957	$687	18.9%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$3,071	$573	15.7%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$2,708	$936	25.7%

*Includes cost sharing for medical and prescription drug services

Attachment B

Impacts of Benefit Design Changes on Member Cost Sharing

For Average Member of a Household with at Least One Member Taking Adalimumab (Rheumatoid Arthritis)

Typical Exchange Plans

Typical Silver Exchange Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$2,944	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$2,163	$781	26.5%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$2,250	$694	23.6%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$2,332	$611	20.8%
Annual Rx OOP max set at 20% of total annual OOP max ($1,080)	$2,075	$869	29.5%

*Includes cost sharing for medical and prescription drug services

Typical Bronze Exchange Plan			
Scenario	Avg. Annual Member Cost Sharing*	Reduction in annual member cost sharing w.r.t "No change" scenario	% Reduction in annual member cost sharing w.r.t "No change" scenario
No change	$3,661	n/a	n/a
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$2,851	$810	22.1%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$2,992	$669	18.3%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$3,101	$560	15.3%
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$2,762	$899	24.6%

*Includes cost sharing for medical and prescription drug services

Attachment C
Potential Plan Offsets to Reduce Premium Increases

California Standard Plans

California Standard Platinum Plan			
Scenario	Estimated Annual Premium Increase*	% Increase in Premium	Possible actions a plan may take minimize premium increase to 0.5%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$9	0.2%	No action required
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$6	0.1%	No action required
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$4	0.1%	No action required
Annual Rx OOP max set at 20% of total annual OOP max ($800)	$12	0.2%	No action required

Current Plan Design	
Deductible	$0
Total OOPM	$4,000
PCP /SPC Visit	$20 / $40
IP Hospital	$250
Generic Drugs	$5
Preferred Brand Drugs	$15
Non-preferred Brand Drugs	$25
Specialty Drugs	10%

California Standard Gold Plan			
Scenario	Estimated Annual Premium Increase*	% Increase in Premium	Possible actions a plan may take minimize premium increase to 0.5%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$19	0.4%	No action required
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$16	0.3%	No action required
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$13	0.3%	No action required
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$37	0.8%	Increase PCP copay by $5

Current Plan Design	
Deductible	$0
Total OOPM	$6,250
PCP /SPC Visit	$30 / $50
IP Hospital	$600
Generic Drugs	$15
Preferred Brand Drugs	$50
Non-preferred Brand Drugs	$70
Specialty Drugs	20%

California Standard Silver Plan			
Scenario	Estimated Annual Premium Increase*	% Increase in Premium	Possible actions a plan may take minimize premium increase to 0.5%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$35	0.8%	Increase PCP copay by $5
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$20	0.5%	No action required
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$15	0.3%	No action required
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$37	0.9%	Increase PCP copay by $5

Current Plan Design		
Deductible	$2000 Medical / $250 Brand Drug	
Total OOPM	$6,250	
PCP /SPC Visit	$45 / $65	Before Deductible
IP Hospital	20%	After Deductible
Generic Drugs	$15	Before Deductible
Preferred Brand Drugs	$50	After Deductible
Non-preferred Brand Drugs	$70	After Deductible
Specialty Drugs	20%	After Deductible

California Standard Bronze Plan			
Scenario	Estimated Annual Premium Increase*	% Increase in Premium	Possible actions a plan may take minimize premium increase to 0.5%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$143	4.2%	Cannot minimize premium increase to 0.5% under ACA out-of-pocket limits
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$88	2.6%	Increase deductible by $800; Increase out-of-pocket maximum by $350
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$55	1.6%	Increase out-of-pocket maximum by $350
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$164	4.8%	Cannot minimize premium increase to 0.5% under ACA out-of-pocket limits

Current Plan Design		
Deductible	$5,000	
Total OOPM	$6,250	
		PCP Before Ded, SPC
PCP /SPC Visit	$60 / $70	After Ded
IP Hospital	20%	After Deductible
Generic Drugs	$15	After Deductible
Preferred Brand Drugs	$50	After Deductible
Non-preferred Brand Drugs	$75	After Deductible
Specialty Drugs	30%	After Deductible

* Assuming plan applies 15% load for retention and that all loadings are included in this retention; rounded to nearest $

Attachment C
Potential Plan Offsets to Reduce Premium Increases

Typical Exchange Plans

Typical Silver Exchange Plan			
Scenario	Estimated Annual Premium Increase*	% Increase in Premium	Possible actions a plan may take minimize premium increase to 0.5%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$21	0.5%	No action required
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$16	0.4%	No action required
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$12	0.3%	No action required
Annual Rx OOP max set at 20% of total annual OOP max ($1,080)	$35	0.9%	Increase PCP copay by $5

Current Plan Design		
Deductible	$2,400	
Total OOPM	$5,400	
		PCP Before Ded, SPC
PCP /SPC Visit	$28 / 20%	After Ded
IP Hospital	25%	After Deductible
Generic Drugs	$12	Before Deductible
Preferred Brand Drugs	$41	Before Deductible
Non-preferred Brand Drugs	25%	After Deductible
Specialty Drugs	25%	After Deductible

Typical Bronze Exchange Plan			
Scenario	Estimated Annual Premium Increase*	% Increase in Premium	Possible actions a plan may take minimize premium increase to 0.5%
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	$136	4.0%	Cannot minimize premium increase to 0.5% under ACA out-of-pocket limits
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	$84	2.5%	Increase deductible by $600; Increase out-of-pocket maximum by $350
Per-prescription cap, applied pre-deductible, for a 30 day supply ($200)	$53	1.6%	Increase out-of-pocket maximum by $350
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	$156	4.6%	Cannot minimize premium increase to 0.5% under ACA out-of-pocket limits

Current Plan Design		
Deductible	$5,100	
Total OOPM	$6,250	
PCP /SPC Visit	25%	After Deductible
IP Hospital	25%	After Deductible
Generic Drugs	23%	After Deductible
Preferred Brand Drugs	25%	After Deductible
Non-preferred Brand Drugs	25%	After Deductible
Specialty Drugs	25%	After Deductible

* Assuming plan applies 15% load for retention and that all loadings are included in this retention; rounded to nearest $

Attachment D
Impacts of Benefit Design Changes on Actuarial Values (From HHS AV Calculator)

California Standard Plans

California Standard Platinum Plan							
	Base		Per-prescription cap, applied pre-deductible, for a 30 day supply				Annual Rx OOP max set at % of total annual OOP max
			$100	$150	$200		20%
Actuarial Value	88.0%		88.1%	88.1%	88.1%		88.2%
Compliant under ACA?*	Yes		Yes	Yes	Yes		Yes

*To remain compliant, the plan must have an actuarial value within the 88.0% - 92.0% range

California Standard Gold Plan							
	Base		Per-prescription cap, applied pre-deductible, for a 30 day supply				Annual Rx OOP max set at % of total annual OOP max
			$100	$150	$200		20%
Actuarial Value	78.6%		78.9%	78.9%	78.8%		79.2%
Compliant under ACA?*	Yes		Yes	Yes	Yes		Yes

*To remain compliant, the plan must have an actuarial value within the 78.0% - 82.0% range

California Standard Silver Plan							
	Base		Per-prescription cap, applied pre-deductible, for a 30 day supply				Annual Rx OOP max set at % of total annual OOP max
			$100	$150	$200		20%
Actuarial Value	69.9%		70.5%	70.2%	70.1%		70.5%
Compliant under ACA?*	Yes		Yes	Yes	Yes		Yes

*To remain compliant, the plan must have an actuarial value within the 68.0% - 72.0% range

California Standard Bronze Plan							
	Base		Per-prescription cap, applied pre-deductible, for a 30 day supply				Annual Rx OOP max set at % of total annual OOP max
			$100	$150	$200		20%
Actuarial Value	60.6%		63.1%	62.2%	61.6%		63.5%
Compliant under ACA?*	Yes		No	No	Yes		No

*To remain compliant, the plan must have an actuarial value within the 58.0% - 62.0% range

Typical Exchange Plans

Typical Silver Exchange Plan							
	Base		Per-prescription cap, applied pre-deductible, for a 30 day supply				Annual Rx OOP max set at % of total annual OOP max
			$100	$150	$200		20%
Actuarial Value	70.5%		70.9%	70.8%	70.7%		71.1%
Compliant under ACA?*	Yes		Yes	Yes	Yes		Yes

*To remain compliant, the plan must have an actuarial value within the 68.0% - 72.0% range

Typical Bronze Exchange Plan							
	Base		Per-prescription cap, applied pre-deductible, for a 30 day supply				Annual Rx OOP max set at % of total annual OOP max
			$100	$150	$200		20%
Actuarial Value	59.1%		61.5%	60.6%	60.0%		61.8%
Compliant under ACA?*	Yes		Yes	Yes	Yes		Yes

*To remain compliant, the plan must have an actuarial value within the 58.0% - 62.0% range

Attachment E
Leukemia and Lymphoma Society
Potential Plan Offsets to Bring Plan into Compliance with Actuarial Value Requirements

California Standard Bronze Plan	
Scenario	Possible changes a plan may make keep this plan in compliance with AV requirements
Per-prescription cap, applied pre-deductible, for a 30 day supply ($100)	Increase PCP copay by $25; Increase SPC copay by $30; Increase brand drug copays by $20
Per-prescription cap, applied pre-deductible, for a 30 day supply ($150)	Increase PCP copay by $10; Increase SPC copay by $10
Annual Rx OOP max set at 20% of total annual OOP max ($1,250)	Increase PCP copay by $25; Increase SPC copay by $25; Increase brand drug copays by $20; Increase generic copay by $10

Current Plan Design		
Deductible	$5,000	
Total OOPM	$6,250	
PCP /SPC Visit	$60 / $70	PCP Before Ded, SPC After Ded
IP Hospital	20%	After Deductible
Generic Drugs	$15	After Deductible
Preferred Brand Drugs	$50	After Deductible
Non-preferred Brand Drugs	$75	After Deductible
Specialty Drugs	30%	After Deductible