October 6, 2014

Recommendations of the Standard Plans Advisory Working Group to the District of Columbia Health Benefit Exchange Authority

This report is submitted by the Standard Plans Advisory Working Group, chaired by Leighton Ku and vice-chaired by Dania Palanker. The Working Group's charge was to (1) develop one standard benefit plan for all metal level tiers, starting with silver and gold; and (2) recommend a separate maximum deductible for pediatric dental benefits embedded in a QHP.

Background

A prior advisory working group, the Plan Offerings and Benefit Standardization Working Group, recommended that the exchange develop a standard plan at each metal level tier in 2015 and 2016, which was adopted by the executive Board on March 22, 2013. The Board vision at the time was to begin by 2015, but initiation of DC Health Link and operational issues delayed those plans. In addition, on May 14, 2014 recommendations from the Dental Plan Advisory Group were brought to the Board; two recommendations were adopted, but the Board requested more analysis of the recommendation on maximum deductibles for embedded pediatric dental plans. The formation of the Standard Plans Advisory Working Group was announced in the summer of 2014 and the group began a series of meetings on August 28, 2014. The members included representatives of each of the four insurers currently offering QHPs and of consumer and trade organizations (members are listed at the end of the report). In some cases, actuaries from carriers joined to offer technical advice.

It is important to note that the working group addressed benefits and cost-sharing, not networks or prescription drug formularies. The recommendations contained in this report are for standard plans to be available in 2016 for the individual market.

Working Group Discussion Generally

Two general concerns influenced the deliberations of the group:

(1) Standardized benefit plans would be offered by all carriers offering QHPs in the individual exchange. This would not preclude carriers from offering other plans that do not use the standardized designs. These standardized designs would be featured in the DC Health Link portal, would enable consumers to make apples-to-apples comparisons and could be used as platforms for consumer education. Many consumers have been confused about deductibles, copays, coinsurance and in and out-of-network concepts.

(2) A goal was to select plan designs that balance lower cost-sharing for key benefits and lower premium levels. Inherent in the nature of the four metal tiers are the target actuarial values (A/Vs) -- bronze at 60% to platinum at 90%-- which are largely differentiated by cost-sharing levels for the essential health benefits. In general, higher cost-sharing, which results in consumers paying a larger share of covered expenses, leads to lower actuarial values and lower premiums. The working group paid attention to the premiums and A/V levels of the most popular plans in DC Health Link in 2014 to check that standardized plans could be close to the premiums of plans enrollees have been accepting.

HBX staff distributed several materials to the working group prior to its first meeting, including the standard plans proposed for Covered California (Covered CA) and New York for 2015, and the 2014 standard plans in Connecticut, New York, Oregon and Vermont. HBX and Department of Insurance, Securities and Banking (DISB) staff developed charts, using the Covered CA model, based on the most popular silver and gold plans of the three carriers in the individual market.

The working group spent considerable time discussing the tradeoffs that are necessary to create a standard plan that is attractive to consumers, reduces barriers to care, and resembles plans that are actually purchased through DC Health Link. Particularly at the silver and bronze levels, it is important to reduce serious financials barriers for primary care, ambulatory care (labs, x-rays) and generic drugs, particularly deductibles and copayments/coinsurance. Where possible, consumer representatives preferred separate medical, drug and dental deductibles to ensure better

access to drug and dental benefits. Carriers noted, however, that combined deductibles can result in an overall lower deductible. Kaiser specifically noted its concern over a separate prescription drug deductible.

The working group decided to start with silver, then move to gold, then bronze, and last platinum. The working group decided to use the 2015 Covered CA standard copay plans as the starting point.[1] We noted that Covered CA had invested considerable effort into designing their plans and implemented them with a broad array of carriers across the state, so these designs were acceptable to both consumers and insurers.

The working group discussed whether small group standard plans would be the same as individual standard plans. Staff noted that the Covered CA small group standard plans are slightly different than the individual standard plans, but not by much. The working group started with individual standard plans.

The working group also discussed that a consumer education and outreach program was necessary.

Discussions

Silver Individual Plan

The working group began with the Covered CA individual silver plan. The working group asked the carriers to have their actuaries price the Covered CA individual silver and gold plans. Actuaries from two plans both advised that the key measure that would affect premium levels were the actuarial values and that it was reasonable to use the 2015 federal Actuarial Value (A/V) Calculator to approximate the impact of alternative designs on changes in premiums. In its deliberations, the working group paid close attention to the A/Vs of the Covered CA plans, of popular DC Health Link plans and differences in A/Vs due to different designs, using the 2015 federal A/V calculator.[2] The Covered CA copay plan had an A/V of 69.9% which was relatively

[1] http://board.coveredca.com/meetings/2014/4-17/

[2] The working group gratefully acknowledges the efforts of working group member Lydia Mitts who ran the A/V calculator estimates for us and the CareFirst and Kaiser actuaries who provided technical advice.

close to the A/Vs of the most popular DC Health Link plans (69.6% and 70.4%). There are some lower price plans also available in DC Health Link (e.g., A/Vs around 68%). To give a sense of the impact, a 1% increase in A/V from 69% to 70% would lead to an expected increase in premiums of 1.5% (70%/69% - 1). For a 40 year old this would be roughly equivalent to increasing premiums from around $250/month to $253/month. A 3% increase would be like increasing the premium by about $7.50 per month. We thus concluded that the Covered CA silver copay plan was relatively close to the current popular plans and should have relatively small effects on premium levels.

The Covered CA silver copay plan has a $2,000 medical deductible and a $250 drug deductible. But primary care, specialist, lab/x-ray/imaging, urgent care, mental health/substance use outpatient, outpatient surgery services, pregnancy and some other services and generic drugs are exempt from the deductible. Most ambulatory services have first dollar coverage. However, there are copays (or in some cases coinsurance) for those services. (Preventive services are free of cost-sharing under the ACA.)

In looking at the benefit levels, consumer groups were concerned that the primary care/mental health/substance use copays were too high at $45 and could create a barrier to care for some populations, especially those with chronic diseases. Consumer representatives wanted to reduce the copay to $25. Dr. Ku requested that they identify a tradeoff for such a copay reduction and they proposed subjecting outpatient surgery to the deductible. Ms. Mitts agreed to make some proposed changes and run them through the federal A/V calculator. Her estimates reduced the primary care, mental health and substance abuse disorder visits from $45 to $25, and specialist visits from $65 to $50. In a tradeoff, she subjected outpatient surgery fees (facility and surgeon) to the deductible. Those changes resulted in a computed A/V of 69.2% which suggests that this option might be less expensive than current plans.

A carrier representative noted that it might be possible to apply the deductible to hospital surgery centers, but not freestanding ones. Ms. Palanker thought that outpatient surgery is important, and the tradeoff is lessened if the services are not subject to the deductible in a freestanding facility. Ms. Otley said the plan can be designed that way, even though the A/V calculator can’t reflect it.

It was pointed out, however, that some apparently freestanding surgery centers are actually owned by hospitals and it may be difficult for consumers to differentiate them. A technical problem was that the federal A/V calculator could not differentiate the two, so it was difficult to assess the impact.

Dr. Ku and Ms. Tarrant were concerned that the $25 primary care copay proposed for silver plans was lower than the $30 copay used in the Covered CA plans and that it would be odd to have a lower cost-sharing level in a silver plan than a gold plan. Mr. Chandra noted that the working group could modify the DC gold plan to be in accord. Ms. Otley noted it would impact premiums, potentially.

The working group then discussed the difference between the Covered CA coinsurance and copay silver plans. The primary differences were in advanced imaging (20% versus $250), subjecting the hospital stay facility fee to the deductible but not the physician fee, home health care (20% versus $45) and pediatric dental benefits (50% versus set copays for services). Both Ms. Mitts and Ms. Palanker were leaning towards the copay plans because they brought a little more certainty to budgeting and because of the difficulty in explaining coinsurance to the less health insurance literate consumer.

Ms. Palanker was concerned about hospital stays, including maternity stays, and one night stays in particular. What was the cost-sharing vehicle most advantageous to the consumer?

Ms. Otley said most CareFirst plans are coinsurance, but CareFirst was not opposed to copay; it has a few. She said that bronze, silver and most gold plans are coinsurance while platinum is copay. The A/V calculator can change on a regular basis; and the percentage does not need to be changed when the A/V calculator changes.

Ms. Tarrant said Kaiser has both as well. Kaiser tries to make richer plans copay. Coinsurance corresponds to higher deductibles.

Ms. Tarrant asked if the cost-sharing ultimately adopted would remain the same in future years. Dr. Ku stated he foresaw that the standard plans might need to be tweaked year to year. He also noted that staff should have the ability to recommend changes for 2016 in the unlikely event CCIIO changes something drastic before open enrollment begins.

Gold Individual Plan

Again, the working group began by looking at the Covered CA gold copay plan. That plan has no deductibles, but has copays or coinsurance in most areas and an A/V of 78.6%. DC Health Link's most popular individual gold plans had similar A/Vs, but had significant deductibles. Research by HBX staff showed, however, that almost one-third of enrollees in the gold plan had zero deductible policies. The working group discussed that some of the gold plans available on DC Health Link were Health Savings Account (HSA) plans. The working group decided that the standard gold plan should not be an HSA plan. The working group was concerned that the Covered CA plan A/V values might not correspond with the carriers' assessments and asked their actuaries to price the Covered CA individual gold plan. They reported that the pricing and benefits were similar to products they had on the exchange. The working group decided that it should lower the copay for primary care, mental health and substance abuse outpatient visits to $25 from the $30 listed for Covered CA gold, since the silver level for those benefits had been set at $25. That change increased the actuarial value of the plan by 0.2% to a level of 78.8%. This is similar to popular gold plans on DC Health Link (78.3% and 81.2%), so there should be little impact on premiums.

Ms. Palanker would like to see the hospital copay reduced from the $600/day five days maximum in the Covered CA plan, but the working group could not price it with the A/V calculator. The working group chose to leave the hospital copays at the level used in Covered CA.

Bronze Individual Plan

The Covered CA bronze plan has substantial cost-sharing, including a $5000 integrated medical and drug deductible. Virtually every service except for preventive and pregnancy services is subject to the deductible, except that the first three primary care, mental health/substance use,

and urgent care visits are excluded. There are also substantial copays or coinsurance. In reviewing the Covered CA standard bronze plan, consumer representatives asked if, in addition the three excluded primary care and related visits, deductibles could be excluded for generic drugs. Ms. Mitts ran the federal A/V calculator and determined that in order to eliminate generic drug copays from being subject to the deductible, the deductible would need to be raised to $5500 from $5000.

In reviewing bronze plans presently available on DC Health Link, it seemed that there were local plans with lower deductibles and better benefits. Some of these plans were HSAs and some were not. Ms. Otley noted that the HSA plans are a bit cheaper because a rating factor is used reflecting less utilization occurring in HSA plans. Kaiser had a low premium, non-HSA bronze plan with a deductible of $4500, with generic drugs, primary care and specialist visits and urgent care not subject to the deductible. Mr. Chandra proposed that, rather than start with the Covered CA plan for bronze, the working group start with an existing bronze plan. Kaiser submitted a chart for this plan in the format the working group had been using. The working group asked CareFirst if it could price the Kaiser plan.

CareFirst reported that it had priced the Kaiser bronze $4500 plan as an HMO plan (no out-of-network benefits) for a 40-year old and came up with a $208 premium, versus $217 for a BlueChoice+ plan. Dr. Ku stated that seemed reasonable. He noted that the Kaiser plan had a lower deductible but higher cost-sharing than the Covered CA platinum plan. The working group agreed to use the Kaiser 4500/50/dental/pediatric dental as the DC Health Link bronze standard plan.

Platinum Individual Plan

In reviewing the Covered CA individual standard platinum plan, Ms. Palanker said she would prefer that the specialty drug benefit be a copay and not 10% coinsurance as in Covered CA. She was concerned about recent reports of very high cost-sharing for some specialty drugs. She suggested $100, which was between Kaiser and CareFirst's copay for specialty drugs in their platinum plans. Ms. Mitts ran the federal A/V calculator and found a $100 copay did not change the A/V for the plan. A $50 or $30 copay (Kaiser's copays) changed the estimated A/V by 0.1%.

Mr. Smith noted that the copays for a United four-tier formulary were $10, $30, $50 and $100, with specialty drugs in the fourth $100 tier. He also noted that from a consumer perspective, copays were preferred. The working group agreed to changing the specialty drug cost-sharing from 10% in the Covered CA plan to $100 copay.

Ms. Palanker wanted to discuss lowering the out-of-pocket maximum (MOOP); she noted that the MOOP in the Covered CA platinum ($4,000) was twice as high as a CareFirst platinum plan. Since the copays and coinsurance were low in Covered CA platinum, it would likely be people requiring multiple hospitalizations that would reach the MOOP. Since people buying platinum probably have one or more health conditions, a lower MOOP would materially help them. Ms. Mitts had estimated that this would raise the A/V from 88.0% in the Covered California plan to 89.4%. While this was a significant increase, this was still slightly below current A/Vs of 89.8% for the popular CareFirst and Kaiser platinum plans, so the premiums ought to be comparable to those currently used.

The proposal was to adopt the Covered CA platinum plan, with amendments as follows: change specialty drugs to $100, and reduce the MOOP to $2,000. No one objected to the proposal.

During the course of the discussion, the possibility of establishing a definition for specialty drug was raised. There is no standard definition for specialty drugs, although CMS establishes a criterion of drugs costing more than $600 per month for Part D benefits. However, the working group determined not to attempt a definition of specialty drug. The issue came up late in the conversation, and working group members were not comfortable tackling that issue without further research and discussion.

Additional Benefits

Some DC Health Link plans offer additional benefits that are not specified in the federal Essential Health Benefits (EHBs), such as chiropractic services, acupuncture, abortion or adult dental. The working group discussed whether the standard plans should be standardized for all benefits or only for EHBs. To require identical benefits in all plans would force carriers to either

drop such benefits from their plans (which could hurt consumers who had been using those benefits) or would mandate coverage for such benefits, even though they are not otherwise required by federal or DC law. In many cases, the cost-sharing for these services is defined by the general service category (e.g., a chiropractic visit is counted as a physical therapy visit.) The working group agreed that the scope of the standard benefits would relate only to EHBs. Carriers could propose additional non-EHB benefits in the standard plans, subject to DISB and HBX approval. Dr. Ku asked that HBX consider how to clearly display this information for consumers.

In-Network and Out-of-Network

The working group discussed whether the cost-sharing displayed on the charts was for in-network benefits. Working group members noted that HMOs do not provide out-of-network benefits except in limited circumstances. With respect to the Covered CA plans, conflicting information had been brought forward about whether the cost-sharing levels extended to out-of-network services. The working group agreed that the DC Health Link standard plan cost-sharing levels applied to in-network services, and that there need not be specific rules concerning out-of-network services.

SHOP

As the working group considered these issues, it focused on individual plans. One open issue as the working group continued discussions was whether these designs could also be used for SHOP plans. One consumer representative believed that standard plans would be even more valuable in the small group market. Mr. Chandra believed that most employers would eventually offer employee choice, which makes standard plans even more relevant.

Dr. Ku thought that the working group did not have the right mix of stakeholders on this issue; no small employers were represented, and UnitedHealthcare, one of the small group carriers, had not participated in most of the meetings. Moreover, the expected growth of SHOP members under the market unification plan in 2016 may create other issues that the working group did not fully explore. The Covered CA standard SHOP plans were slightly different from those used in its individual market and the working group did not know why they varied. While Dr. Ku was

not aware of any particular disadvantages to requiring the same standard plans in SHOP, he was of the opinion that the working group had not had enough time to give it adequate consideration. Dr. Ku suggested that the working group present the issue to the Board without offering a specific recommendation. Even if no policy decision had been made, if carriers elect to offer an individual standard plan on SHOP, the Board can say that is the standard SHOP plan.

Nomenclature and Consumer Education

Dr. Ku raised the issue of how to present these plans to consumers, whether as "standard" plans or something else, perhaps "value" plans or "recommended" plans. Mr. Smith suggested "comparator" plans. Ms. Kuiper asked not to take "standard" plans off the table. Ms. Mitts was wary of "value" plan; she said research shows that consumers do not think of value in health care the same way they do in other contexts. The working group agreed that HBX should conduct further research about what to call the plans and perhaps use focus groups to validate the name. The working group further agreed that HBX should develop consumer education and outreach around the standard plans.

Maximum Embedded Pediatric Dental Deductible

With respect to the separate maximum deductible for the pediatric dental essential health benefit, staff reminded the working group that a recommendation on maximum levels had gone to the Executive Board, which felt it was premature to approve the specific levels without further analysis, but did approve that there be a separate maximum deductible for pediatric dental. This working group agreed to conduct further analysis.

The working group asked carriers to examine the potential impact of a maximum deductible for pediatric dental and whether it was appropriate for the entire market: $50/individual in-network, $100 out-of-network; $100/family in-network, $200 out-of-network. It is a separate deductible from the medical deductible. If one child in the family has $50 in dental bills, full coverage for that child kicks in. If a second child also has $50 in dental bills, full coverage for that child and the entire family (if there are more children) kicks in. The maximum deductible applies to both SHOP and individual. It is important to note it is a maximum deductible; carriers may choose a lower dollar amount or a zero pediatric dental deductible. Carriers agreed that this would have

negligible impact on premiums: Kaiser already uses $0 deductible (and would prefer to retain that level) and CareFirst uses deductibles similar to these (it does not currently have a family limit). The working group noted that the standard plans discussed actually have $0 deductibles for embedded pediatric dental, but that is permissible and that the maximum deductible applies for all QHPs sold under DC Health Link.

DC Health Link does not require adult dental benefits, but some plans offer family benefits, which essentially structure adult benefits quite differently from pediatric benefits. Rather than think of the family deductibles as applying to a whole family, it is more appropriate to think of them in reference to multiple children in a family on the same plan. This recommendation also does not apply to standalone dental plans, which have separate federal rules and would have separate deductibles anyway.

Recommendations

One: In a series of votes on September 30 and October 6, the working group agreed by consensus to recommend that the Executive Board adopt standard plans for DC Health Link at the platinum, gold, silver and bronze metal level tiers as set forth in Attachments One through Four.

Two: The working group has no recommendation on whether the standard benefit plans described above should apply to SHOP, but flags this as an issue the Executive Board may wish to consider. Options include: (1) the recommended standard designs apply in SHOP too, (2) they apply only for individual plans, (3) carriers may choose to offer SHOP plans with the same design and they could be featured in a similar fashion, or (4) different designs could be considered for SHOP.

Three: The working group agreed by consensus to recommend that the cost-sharing levels in the standard plans apply only to in-network benefits, and that no fixed rules apply to out-of-network benefits.

Four: The working group agreed by consensus to recommend that the scope of the standard benefits would relate only to EHBs. Carriers could propose additional non-EHB benefits in the standard plans, subject to DISB and HBX approval.

Five: The working group agreed by consensus to recommend that HBX conduct further research into the nomenclature to be used for the standard plans, and that HBX develop consumer outreach and education on these plans.

Six: The working group agreed by consensus to recommend that the maximum deductible in embedded pediatric dental plans be $50/$100 (individual in and out-of-network) and $100/$200 (family in and out-of-network).

Working Group Members

The Standard Plans Advisory Working Group is comprised of representatives from qualified health plans, consumer and trade associations. Seven meetings were held, on August 28, September 3, 10, 15, 23 and 30, 2014, and October 6, 2014 all with in-person and telephone participation. Votes on recommendations were taken at the sixth and seventh meetings and involved those attending at the time. In some meetings, actuaries from insurance firms participated to offer their technical input regarding the financial impact of potential policies.

Leighton Ku, Chair	GWU Center for Health Policy Research
Dania Palanker, Vice-Chair	National Women's Law Center
Marcy M. Buckner	National Ass'n of Health Underwriters
Dave Chandra	Center on Budget and Policy Priorities
Stephanie Cohen	Golden & Cohen (NFP)
Beth Good	Aetna
Lydia Mitts	Families USA
Cindy Otley	CareFirst
Jo Tarrant, Laurie Kuiper	Kaiser Permanente

Colin Reusch	Children’s Dental Health Project
Troy Pelfrey, David W.B. Smith	UnitedHealthcare
Geralyn Trujillo	AHIP
Staff Advisors & Support	
Mary Beth Senkewicz	HBX
Howard Liebers	DISB

Standard Plans Advisory Working Group
Draft Platinum Plan 2016

Attachment One

Actuarial Value			89.40%	
Individual Overall Deductible			$0	
Other individual deductibles for specific services				
Medical			$0	
Prescription Drugs			$0	
Dental			$0	
Individual Out-of-Pocket Maximum			$2,000	
Common Medical Event	**Service Type**		**Member Cost Share**	**Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$20	
	Specialist visit		$40	
	Preventive care/screening/immunization		$0	
Tests	Laboratory tests		$20	
	X-rays and diagnostic imaging		$40	
	Imaging (CT/PET scans, MRIs		$150	
Drugs to treat Illness or Condition	Generic		$5	
	Preferred brand		$15	
	Non-preferred Brand		$25	
	Specialty		$100	
Outpatient Surgery	Facility fee (e.g. hospital room)		$250	
	Physician/Surgeon fee			
Need Immediate Attention	Emergency room services (waived if admitted)		$150	
	Emergency medical transportation		$150	
	Urgent Care		$40	
Hospital Stay	Facility fee (e.g. hospital room)		$250 per day up to 5 days	
	Physician/surgeon fee			
Mental/Behavioral Health	M/B outpatient services		$20	
	M/B inpatient services		$250 per day up to 5 days	
Health, Substance Abuse needs	Substance abuse disorder outpatient services		$20	
	Substance abuse disorder inpatient services		$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception services		$0	
	Delivery and all inpatient services	Hospital	$250 per day up to 5 days	
		Professional		
Help recovering or other special health needs	Home health care		$20	
	Outpatient rehabilitation services		$20	
	Outpatient habilitation services		$20	
	Skilled nursing care		$150 per day up to 5 days	
	Durable medical equipment		10%	
	Hospice services		$0	

Child eye care	Eye exam	$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
	Space Maintainers - Fixed	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$25	
Child Dental Major Services	Root canal - molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

Standard Plans Advisory Working Group
Draft Gold Plan 2016

Attachment Two

Actuarial Value		78.8%	
Individual Overall Deductible		$0	
Other individual deductibles for specific services			
Medical		$0	
Prescription Drugs		$0	
Dental		$0	
Individual Out-of-Pocket Maximum		$6,250	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$25	
	Specialist visit	$50	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests	$30	
	X-rays and diagnostic imaging	$50	
	Imaging (CT/PET scans, MRIs	$250	
Drugs to treat Illness or Condition	Generic	$15	
	Preferred brand	$50	
	Non-preferred Brand	$70	
	Specialty	20%	
Outpatient Surgery	Facility fee (e.g. hospital room)	$600	
	Physician/Surgeon fee		
Need Immediate Attention	Emergency room services (waived if admitted)	$250	
	Emergency medical transportation	$250	
	Urgent Care	$60	
Hospital Stay	Facility fee (e.g. hospital room)	$600 per day up to 5 days	
	Physician/surgeon fee		
Mental/Behavioral Health	M/B outpatient services	$25	
	M/B inpatient services	$600 per day up to 5 days	
Substance Abuse needs	Substance abuse disorder outpatient services	$25	
	Substance abuse disorder inpatient services	$600 per day up to 5 days	
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services — Hospital	$600 per day up to 5 days	
	Delivery and all inpatient services — Professional		
Help recovering or other special health needs	Home health care	$30	
	Outpatient rehabilitation services	$30	
	Outpatient habilitation services	$30	
	Skilled nursing care	$300 per day up to 5 days	
	Durable medical equipment	20%	
	Hospice services	$0	

Child eye care	Eye exam	$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
	Space Maintainers - Fixed	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$25	
Child Dental Major Services	Root canal - molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

Standard Plans Advisory Working Group
Draft Silver Plan 2016

Attachment Three

Actuarial Value		69.2%	
Individual Overall Deductible		N/A	
Other individual deductibles for specific services			
Medical		$2,000	
Prescription Drugs		$250	
Dental		$0	
Individual Out-of-Pocket Maximum		$6,250	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$25	
	Specialist visit	$50	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests	$45	
	X-rays and diagnostic imaging	$65	
	Imaging (CT/PET scans, MRIs	$250	
Drugs to treat Illness or Condition	Generic	$15	
	Preferred brand	$50	X
	Non-preferred Brand	$70	X
	Specialty	20%	X
Outpatient Surgery	Facility fee (e.g. hospital room)	20%	X
	Physician/Surgeon fee	20%	X
Need Immediate Attention	Emergency room services (waived if admitted)	$250	X
	Emergency medical transportation	$250	X
	Urgent Care	$90	
Hospital Stay	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee		X
Mental/Behavioral Health	M/B outpatient services	$25	
	M/B inpatient services	20%	X
Health, Substance Abuse needs	Substance abuse disorder outpatient services	$25	
	Substance abuse disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services – Hospital	20%	x
	Delivery and all inpatient services – Professional		x
Help recovering or other special health needs	Home health care	$45	
	Outpatient rehabilitation services	$45	
	Outpatient habilitation services	$45	
	Skilled nursing care	20%	x
	Durable medical equipment	20%	
	Hospice services	$0	

Child eye care	Eye exam	$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
	Space Maintainers - Fixed	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$25	
Child Dental Major Services	Root canal - molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

Standard Plans Advisory Working Group
Draft Bronze Plan 2016

Attachment Four

Actuarial Value		60.3%	
Individual Overall Deductible		4,500	
Other individual deductibles for specific services			
Medical		4,500	
Prescription Drugs		$0	
Dental		$0	
Individual Out-of-Pocket Maximum		$6,350	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$50	
	Specialist visit	$50	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests	$50	x
	X-rays and diagnostic imaging	$50	x
	Imaging (CT/PET scans, MRIs	$500	x
Drugs to treat Illness or Condition	Generic	$25	
	Preferred brand	50%	x
	Non-preferred Brand	50%	x
	Specialty	Applicable cost shares apply	x
Outpatient Surgery	Facility fee (e.g. hospital room)	20%	x
	Physician/Surgeon fee	20%	x
Need Immediate Attention	Emergency room services	20%	x
	Emergency medical transportation	0	
	Urgent Care	$50	
Hospital Stay	Facility fee (e.g. hospital room)	20%	x
	Physician/surgeon fee	20%	x
Mental/Behavioral Health	M/B outpatient services	$50	
	M/B inpatient services	20%	x
Health, Substance Abuse needs	Substance abuse disorder outpatient services	$50	
	Substance abuse disorder inpatient services	20%	x
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services – Hospital	20%	x
	Delivery and all inpatient services – Professional		x
Help recovering or other special health needs	Home health care (up to 90 visits for 4 hours per calendar yr)	$0	x
	Outpatient rehabilitation services	$50	x
	Outpatient habilitation services	$50	x
	Skilled nursing care	20%	x
	Durable medical equipment	20%	x
	Hospice services	20%	x

Child eye care	Eye exam (OD)	$50	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$41	
Child Dental Major Services	Root canal - molar	$512	
	Gingivectomy per Quad	$279	
	Extraction – single tooth exposed root or	$69	
	Extraction – complete bony	$241	
	Porcelain with Metal Crown	$523	
Child Orthodontics	Medically necessary orthodontics	$3,422	