Agenda Item VIII: Benefit Design Data

Presenters: Jill Yegian, HPD Consultant, HCAI (or designee)

For Today

- Overview of benefit design data
- Previous feedback from the Advisory Committee
- What benefit design data is available in HPD?
- Use cases
- Discussion questions

Benefit Design Data Elements (not complete list)

Key data elements:

- Actuarial value
- Metal tier
- Copayment or coinsurance
- Deductible
- Out of pocket maximum

COVERED CALIFORNIA

2025 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Silver 73 CA Enhanced CSR	Silver 87 CA Enhanced CSR	Silver 94 CA Enhanced CSR	Gold	Platinum
Percent of cost coverage	Covers **0%** until out-of-pocket maximum is met	Covers **60%** average annual cost	Covers **70%** average annual cost	Covers **73%** average annual cost	Covers **87%** average annual cost	Covers **94%** average annual cost	Covers **80%** average annual cost	Covers **90%** average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	**>$30,120 (Above 200% FPL)**	**$22,591 to $30,120 (>150% to ≤200% FPL)**	**up to $22,590 (100% to ≤150% FPL)**	N/A	N/A
Free Preventive Care Visit	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Visit	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	$60	$50	$35	$15	$5	$35	$15
Urgent Care		$60	$50	$35	$15	$5	$35	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$90	$85	$25	$8	$65	$30
Emergency Room Facility		40% after deductible is met	$400	$350	$150	$50	$330	$150
Laboratory Tests		$40	$50	$50	$20	$8	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$95	$95	$40	$8	$75	$30
Imaging			$325	$325	$100	$50	$75 copay or 25% coinsurance***	$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	$19	$18	$15	$5	$3	$15	$7
Tier 2 (Preferred Drugs)		40% up to $500 per script after drug deductible is met	$60**	$55	$25	$10	$60	$16
Tier 3 (Non-preferred Drugs)			$90**	$85	$45	$15	$85	$25
Tier 4 (Specialty Drugs)			20% up to $250** per script	20% up to $250 per script	15% up to $150 per script	10% up to $150 per script	20% up to $250 per script	10% up to $250 per script
Medical Deductible - The amount you pay before the plan pays	N/A	Individual: $5,800 Family: $11,600	Individual: $5,400 Family: $10,800	N/A	N/A	N/A	N/A	N/A
Pharmacy Deductible - The amount you pay before the plan pays	N/A	Individual: $450 Family: $900	Individual: $50 Family: $100	N/A	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$9,200 individual $18,400 family	$8,850 individual $17,700 family	$8,700 individual $17,400 family	$6,100 individual $12,200 family	$3,000 individual $6,000 family	$1,150 individual $2,300 family	$8,700 individual $17,400 family	$4,500 individual $9,000 family

Drug prices are for a 30 day supply.

* Copay is for any combination of services (specialist) for the first three visits. After three visits, future visits will be at full cost until the medical deductible is met.

** Price is after pharmacy deductible amount is met.

*** See plan Evidence of Coverage for imaging cost share.

Covered California may approve deviations from the benefit plan designs for certain services on a case by case basis if necessary to comply with the California Mental Health Parity Act or federal Mental Health Parity and Addiction Equity Act (MHPAEA).

HCAI Department of Health Care Access and Information

Prior Feedback from the Advisory Committee on Benefit Design Data

- Helpful to incorporate some combination of benefit design and premium alongside out-of-pocket costs to support analysis and interpretation
- Useful to have a summary of:
  - data elements in HPD that are related to out-of-pocket cost (e.g. premium, metal tiers, actuarial value, high-deductible plan indicator)
  - restrictions on those data elements, e.g., only applies to Qualified Health Plans offered in the marketplace
  - information about data element completeness

Benefit Design and Related Data Available in HPD

APCD-CDL Number	Data Element Name	Description	Qualified Health Plans or All Plans?	Required for HPD?
CDLME053	HIOS Plan ID	16-character ID, unique plan identifier	QHP	For QHPs
CDLME054	Metal Tier	Catastrophic, bronze, silver, gold, platinum	QHP	For QHPs
CDLME064	High Deductible Plan	Y/N, as defined by the IRS at start of plan year	All	As available
CDLME065	Total Monthly Premium Amount	For fully-insured premiums, the monthly fee paid by a subscriber and/or employer	All	As available
CDLME066	Actuarial Value	Percentage from HHS Actuarial Value Calculator	QHP	As available
CDLME068	Cost-Sharing Reduction Indicator	8 values indicating CSR under ACA, e.g. 94% AV Silver Plan	QHP	As available
CDLME070	Tiered Network	Indicates varying levels of payments for in-network providers; 5 values, 1-4 tiers + other	All	As available
CDLMC137	In Plan Network Indicator	Yes/No indicator for provider in network	All	Required
CDLPC064	In Plan Network Indicator	Yes/No indicator for services in-network	All	Required

Completeness of Data Elements in HPD

Data Element Name	Completeness - Commercial	Completeness - Medicare Advantage	Details
Total Monthly Premim	73.9%	86.9%	At the Subscriber level (individual, individual plus one, family); 0 if no premium charged.
Zero Only	*29.3%*	*37.2%*	
Non-Zero Only	*44.6%*	*49.7%*	
High-Deductible Indcator	89.9%	68.4%	Y/N, as defined by the IRS at start of plan year
Tiered Network (in-etwork, multiple levels)	63.0%	82.5%	0 = Limited Network; 1 = Single Tier-Not tiered; 2 = Two Tier; 3 = Three Tier; 4 = Four Tier; 5 = Other.
In-Plan Network Indcator			Required data elements
Medical claims/ecounters	99.5%	95.3%	dicates the provider is w/in the network
Pharmacy claims/ncounters	100%	100%	ndicates services provided were w/in network

Notes: All data elements in this table are available on Eligibility File, except In-Network Indicators

Completeness of QHP-Specific Data Elements

Data Element Name	Completeness	Notes
HIOS Plan ID	97.6%	Required for QHPs
Metal Tier	99.8%	Required for QHPs
Actuarial Value	88.7%	As available for QHPs
Cost-Sharing Reductin Indicator		As available for QHPs
Include zero value	79.4%	0=non-CSR recipient or unknown CSR
Excludes zero valu	22.6%	Only CSR values 1-8 (e.g., CRS 1 = Enrollees in 94% Actuarial Value Silver Plan Variation)

QHPs only where HIOS_Plan_Indicator=1 or purchased thru exchange=1

Use Case Examples – Benefit Design Data

BENEFIT DESIGN MODELING

BENCHMARKING BENEFIT DESIGN

EVALUATING EFFECTIVENESS OF VALUE-BASED INSURANCE DESIGN

UNDERSTANDING FULL PICTURE OF AFFORDABILITY

Benefit Design Modeling: Covered CA Use Case (2019)

Use Case Title	Use Case Summary	Data Aggregation Level Needed for Analysis	Data Implications/ Augmentation	Primary Audience	Secondary Audience	Output Examples	User Value
Cost & Quality Management							
UC05 – Benefit Design Modeling	Generate PMPM cost & services utilization to model benefit design changes and actuarial value impact. Use results to evaluate likely candidates for benefit design changes, for example value-based insurance design (VBID) that incents consumers to utilize alternative care settings (telehealth, e-Consults, retail visits, etc.).	Commercial market, all carriers' benefit design information summarized by metal tier, service type-specific utilization and cost PMPM Allowed costs (Y) Provider-identifiable (N) Payer-identifiable (N) Enrollee-identifiable (N)	• HIOS ID and metal tier • Enrollee income level • AV / other benefits level indicator (ideally HPD already links to attributes of the plan design through available regulatory filings (SERFF).) • Standard medical service categories • CPT Category II Codes & HCPCS alpha codes (e.g. G-codes)	• *Government Users:* Covered California benefit design work is enhanced using the broader commercial market population utilization/cost experience. • *Public:* Consumer advocates seeking to provide input on the impact of benefit design changes on consumer welfare.	• *Researcher:* Analyze impacts of benefit design on access, utilization and costs • *Issuers & Providers:* Own performance compared to benchmarks and potential alignment of specific benefit design approaches such as VBID.	• *Public:* Market trends report on benefit design approaches • *Approved User:* Raw extracts for analytics, including core attributes of plan design linked to claims (e.g. linkage to SERFF filings for Individual/Small Group products)	• Advance innovative ways to provide cost-effective care (e.g. telehealth, VBID, etc.)

Discussion Questions

- What reaction/feedback do you have to the information shared on available data elements and completeness?
- How important is the availability of benefit design and related data for HPD analysis, compared to competing priorities?
- What guidance do you have for HCAI on enhancing benefit design data for use in the HPD?