COVERED CALIFORNIA POLICY AND ACTION ITEMS

May 21, 2015

PROPOSED FISCAL YEAR 2015-16 BUDGET

Jim Lombard, Director, Financial Management Division

PROPOSED FY 2015-16 BUDGET: BACKDROP AND HIGHLIGHTS

- In the last two years Covered California has established a solid foundation and we are confident as we transition from startup mode to ongoing operations, and to relying on fees collected from health insurance companies and the extensive reserves we have saved while using federal funds.
- Because many of the startup expenses required during our opening days - such as the information technology build and certain outreach, education and marketing expenses - are no longer needed, the proposed budget for fiscal year 2015-2016 is approximately $58 million less than the current fiscal year's projected expenditures.

PROPOSED FY 2015-16 BUDGET: BACKDROP AND HIGHLIGHTS CONTINUED

- This 15 percent reduction is part of Covered California's managed launch and consistent with our vision that we would need to spend more in the early years to lay the foundation for this historic effort.
- We're happy to report that our budget for next fiscal year ensures there will be no job losses for our employees, substantial investments in marketing, outreach and customer service and we will continue working just as hard in the upcoming years to serve our consumers and improve our operations.
- The FY 2015-16 budgeting process utilized updated enrollment projections and while we recognize that the precise level of enrollment is hard to predict, our projections are well informed by experience to date and the experience of other programs.

BUDGET PLANNING FOR 2015-16: SELF SUFFICIENCY AND CONSUMER FOCUS

- The proposed FY 2015-16 Covered California Budget provides the resources to transition from federal establishment funds to operating funds generated from plan assessments.

- It seeks to strike a balance between funding critical program delivery and providing the necessary reductions to implement a multi-year plan that will allow revenue to exceed expenditures as early as FY 2017-18.

- Covered California's focus in FY 2015-16, will be to continue to build enrollment and increase retention through its outreach, sales, and marketing activities, complemented by efforts to continue to refine its organizational structure in order to effectively support its stakeholders.

BUDGET PLANNING FOR 2015-16:
SELF SUFFICIENCY AND CONSUMER FOCUS

- The proposed FY 2015-16 budget aligns with Covered California's vision to improve the health of Californians by assuring their access to affordable, high quality healthcare; and its mission to increase the number of insured Californians, improve health care quality, lower costs and reduce health disparities through a competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

- The proposed budget reflects the following:
  - Significant funding for outreach, sales and marketing to inform California consumers about our programs and encourage retention of those who have enrolled
  - Service center resources to provide funding at a level that is comparable to FY 2014-15
  - Resources to fund the FY 2015-16 program requirements of the CalHEERS 24 month road map

COVERED CALIFORNIA
FY 2014-15 RESULTS AND EXPENDITURES

	2014-15			
	June Adopted	**Projected**	**Difference**	**% Change**
Service Center	$ 97,022,224	$ 99,158,255	$ 2,136,031	2%
CalHEERS	$ 88,177,616	$ 82,113,445	$ (6,064,171)	-7%
Outreach & Sales, Marketing	$ 189,831,459	$ 180,062,748	$ (9,768,711)	-5%
Plan Management & Evaluation	$ 17,334,578	$ 13,585,029	$ (3,749,549)	-22%
Administration	$ 37,796,386	$ 36,487,453	$ (1,308,933)	-3%
Enterprise Shared Costs	$ 12,589,363	$ 1,543,057	$ (11,046,306)	-88%
Total Expenses	**$442,751,626**	**$ 412,949,987**	**$ (29,801,639)**	**-7%**
CalHEERS Cost Sharing	$ (3,058,183)	$ (1,937,629)	$ 1,120,554	-37%
Reimbursements	$ (28,000,000)	$ (20,402,000)	$ 7,598,000	-27%
Total Operating Costs	**$411,693,443**	**$ 390,610,358**	**$ (21,083,085)**	**-5%**

- Covered California completed its first renewal and second open enrollment cycles by successfully renewing coverage for 92 percent, or 944,000, of its enrollees eligible to renew and adding 495,000 new enrollees, bringing total enrollment to about 1.4 million; the revised CalHEERS cost allocation plan was approved; the Service Center handled higher volumes at improved service levels; and a multi-year plan is in place to have a positive operating balance by FY 2017-18.

- FY 2014-15 expected expenditures are $21.1 million less than the Board approved budget as higher than budgeted expenditures in the Service Center, primarily associated with procurement of support for peak enrollment periods, are offset by lower expenditures in outreach, sales and marketing, CalHEERS, as well as unexpended reserve /initiative funding

COVERED CALIFORNIA
ENROLLMENT FORECASTS FOR 2015 – 2019: MAJOR ASSUMPTIONS

LOW	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
Effectuated Enrollment *(Individual at fiscal year end)*	1,299,521	1,366,329	1,548,359	1,689,065	1,854,521
MEDIUM	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
Effectuated Enrollment *(Individual at fiscal year end)*	1,299,521	1,476,342	1,666,617	1,809,095	1,977,792
HIGH	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
Effectuated Enrollment *(Individual at fiscal year end)*	1,299,521	1,542,380	1,807,166	1,953,172	2,101,643

- The FY 2015-16 proposed budget is based upon a financial plan that uses the medium enrollment forecast of 1.476 million effectuated enrollees at the end of FY 2015-16 and 1.809 million effectuated enrollees at the end of FY 2017-18.

- The multi-year financial plan assumes that annual spending will decrease by approximately 15 percent between FY 2014-15 and FY 2015-16, by 7 percent between FY 2015-16 and FY 2016-17, and by another 3 percent to reach $300 million by FY 2017-18.

- The FY 2015-16 proposed budget assumes the availability of approximately $100 million in federal grant funding at the start of the year.

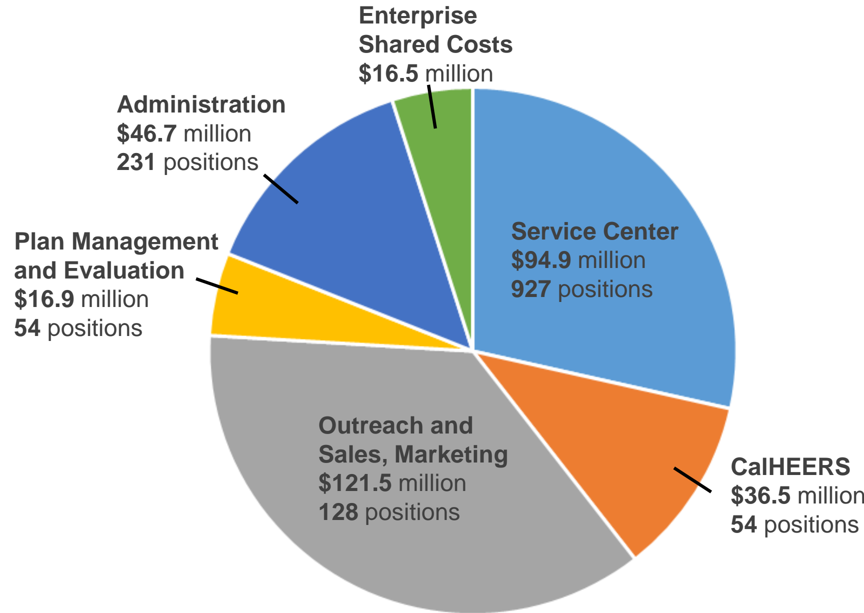
COVERED CALIFORNIA--MULTI-YEAR FINANCIAL FORECAST

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Effectuated Enrollment *(Individual at fiscal year end)*	1,299,521	1,476,342	1,666,617	1,809,095	1,977,792
Beginning Balance of Unrestricted Funds	$ 5.9	$ 192.0	$ 193.4	$ 152.6	$ 156.2
Balance of Federal Establishment Funds	$ 479.3	$ 100.0	$ -	$ -	$ -
Total Opening Balance	$ 485.2	$ 292.0	$ 193.4	$ 152.6	$ 156.2
Plan Assessments - Cash Basis	$ 197.4	$ 234.4	$ 269.2	$ 303.6	$ 329.2
Expenditures	$ 390.6	$ 332.9	$ 310.0	$ 300.0	$ 300.0
Funds Available at Year-End	$ 292.0	$ 193.4	$ 152.6	$ 156.2	$ 185.3
Minimum number of months expenditures covered by reserve	***9.0***	***7.0***	***5.5***	***5.2***	***6.0***

Reflects Medium enrollment forecast

- The latest forecast assumes a $333 million budget in FY 2015-16. The multi-year outlook assumes a $310 million budget in FY 2016-17 and a $300 million budget in both FY 2017-18 and FY 2018-19. Annual expenditures are subject to the annual budget process and board approval.
- The multi-year plan is designed to balance plan assessment revenues and expenditures by FY 2017-18.
- Provides a six month operating reserve throughout FY 2015-16 with a fiscal year-end position of $193 million.

COVERED CALIFORNIA--PROPOSED FY 2015-16 BUDGET



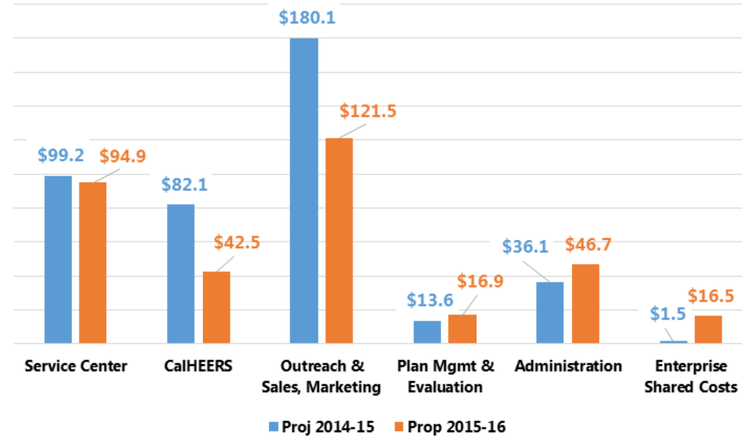
- The proposed budget incorporates the resources to transition from federal establishment funds to operating funds generated from plan assessments as envisioned by the Affordable Care Act.
- It provides 1,394 positions and $332.9 million to fund program operations.

COVERED CALIFORNIA
FY 2015-16 BUDGET – ORGANIZATIONAL DETAIL

	2014-15 Projected	2015-16 Proposed	Difference	% Change
Service Center	$ 99,158,255	$ 94,919,232	$ (4,239,023)	-4%
CalHEERS	$ 82,113,445	$ 42,542,356	$ (39,571,089)	-48%
Outreach & Sales, Marketing	$ 180,062,748	$ 121,463,472	$ (58,599,276)	-33%
Plan Management & Evaluation	$ 13,585,029	$ 16,925,582	$ 3,340,553	25%
Administration	$ 36,487,453	$ 46,656,803	$ 10,169,350	28%
Enterprise Shared Costs	$ 1,543,057	$ 16,493,138	$ 14,950,081	NM
Total Expenses	**$ 412,949,987**	**$ 339,000,582**	**$ (73,949,405)**	**-18%**
CalHEERS Cost Sharing	$ (1,937,629)	$ (6,055,000)	$ (4,117,371)	212%
Reimbursements	$ (20,402,000)	$ -	$ 20,402,000	-100%
Total Operating Costs	**$ 390,610,358**	**$ 332,945,582**	**$ (57,664,776)**	**-15%**

- From an operations perspective, the proposed budget includes resources to fund the following goals:
  - $121.5 million is made available for outreach, sales and marketing efforts, including $50 million for marketing campaigns and a $10 million Navigator program to inform California consumers about our programs and encourage retention of those that have already enrolled.
  - $95 million is provided for Service Center resources to provide funding that is comparable to FY 2014-15.
  - It includes $36.5 million to fund the FY 2015-16 requirements of the CalHEERS 24 month road map.

COVERED CALIFORNIA
FY 2015-16 BUDGET COMPARISON TO FY 2014-15



- **CalHEERS** – Projected FY 2015-16 expenditures are $40 million lower than in FY 2014-15, before reimbursements, due to adjustments in the cost allocation plan.
- **Outreach & Sales, Marketing** - Expenditures are anticipated to be $59 million lower than FY 2014-15 as community grants, in-person assistance and support of DHCS Medi-Cal enrollments do not continue into FY 2015-16, combined with reductions in other contractual support. As previously noted, the Navigator program does continue in FY 2015-16.
- **Administration** - Expenditures are anticipated to be $10 million higher due to an increase in personal services to support workload in the IT and Human Resources programs, increased support for IT infrastructure and funding for the establishment of Covered California University.
- **Enterprise Shared Costs -** Expenditures are anticipated to be $15 million higher in FY 2015-16 due to increased costs to state mandated SWCAP/Pro-rata cost distribution requirements and continuation of the provision of reserves for strategic initiatives.

COVERED CALIFORNIA: SUMMARY OF FEDERAL ESTABLISHMENT FUNDING

- Since September 2010, Covered California has received just over $1 billion in federal planning grants from the Department of Health and Human Services for implementation of the Affordable Care Act (ACA).
- These funds were authorized to build out key functions and activities, including:
  - The Exchange's administrative and operations infrastructure
  - Establish CalHEERS
  - Launch the SHOP Exchange
  - Evaluate, select, certify and contract with QHP issuers for the individual and SHOP Exchanges
  - Implement outreach, marketing, public education and consumer assistance programs
  - Collaborate with state partner agencies to maximize coordination and integration
  - Enroll and begin providing health coverage to eligible Californians
  - Maintain effective financial management and oversight systems
- The start-up funds were originally intended to support Covered California through 2014, the first full year of individuals being enrolled.
- Due to an extension from the federal government, Covered California anticipates having approximately $100 million in federal funding to spend in FY 2015-2016 to continue funding approved planning, development and implementation activities needed to establish the largest state exchange in the nation.
- Spending will be in accordance with the ACA, which after January 1, 2015, allows marketplaces to use grant funds for establishment costs for design, development and implementation, but not to support ongoing operations.

COVERED CALIFORNIA EXPENDITURES BY FEDERAL GRANT

TOTAL GRANT EXPENDITURES & PROJECTIONS as of February 28, 2015						
CATEGORY	**PLANNING GRANT**	**LEVEL 1.1**	**LEVEL 1.2**	**LEVEL 2.0**	**LEVEL 2.0 PROJECTIONS**	**TOTAL**
Personal Services	$33,410	$3,917,145	$16,183,918	$94,487,906	$48,578,660	**$163,201,039**
Supplies, Equipment & Travel	$65,854	$518,722	$1,919,026	$10,800,103	$2,926,828	**$16,230,533**
Contractual	$418,483	$34,175,307	$176,357,490	$434,617,330	$218,992,505	**$864,561,115**
Other Expenses	$12,253	$810,209	$2,019,195	$15,474,738	$2,838,009	**$21,154,404**
TOTAL	**$530,000**	**$39,421,383**	**$196,479,629**	**$555,380,077**	**$273,336,002**	**$1,065,147,091**
Total Budget	$530,000	$39,791,383	$224,092,909	$864,703,859		$1,129,118,151
Less: Reimbursement	$0	($370,000)	($27,613,280)	($35,921,815)		($63,905,095)
Total Federal Share	**$530,000**	**$39,421,383**	**$196,479,629**	**$828,782,044**		**$1,065,213,056**
FISCAL YEAR OF EXPENDITURES						
	2010/11 **2011/12**	**2011/12** **2012/13**	**2012/13** **2013/14**	**2012/13** **2013/14** **2014/15** **2015/16**		

COVERED CALIFORNIA 2016 DENTAL PMPM

Jim Lombard, Director, Financial Management Division

FAMILY DENTAL PMPM RATE FOR 2016

RECOMMENDATION FOR APPROVAL BOARD

- The Board is being asked to formally set the Exchange’s stand-alone family dental Per Member Per Month (PMPM) rate for 2016.

- Stand-alone family dental will be offered in the individual market in 2016.
  - Stand-alone pediatric dental coverage was offered in 2014 but was embedded as a standard benefit in 2015.
  - In 2014, there were approximately 14,000 members enrolled in stand-alone pediatric dental policies which generated $94,900 in PMPM assessments.

- If enrollment in Family Dental policies was to reach 50,000 in 2016, annual assessments could total approximately $500,000.

- Revenue from family dental is <u>not</u> reflected in the proposed budget.

FAMILY DENTAL PMPM RATE FOR 2016
RECOMMENDATION FOR APPROVAL BOARD

- The Pediatric Dental PMPM rate was initially set at $0.83 for the 2014 plan year.
- This rate, set before the Exchange opened, reflected the same share of anticipated dental premiums that the $13.95 individual PMPM represented of anticipated individual premiums.
- Since the Board voted at its April meeting to leave the Individual PMPM unchanged in 2016, staff recommends also leaving the Dental PMPM rate unchanged in 2016.
- Per Government Code Section 100503(n), which authorizes the Board to charge per member per month fees to fund its operation, the plan year 2016 Family Dental Per Member Per Month fee rate of $0.83 is submitted to the Covered California Board for approval.
- Resolution 2015-36

ESTABLISHMENT OF AUDIT COMMITTEE

Jim Lombard, Director, Financial Management Division

AUDIT COMMITTEE

- Covered California has redesigned the internal auditing function by establishing a single internal audit division. This division will provide a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, controls and governance processes internal to Covered California.
- Since this division will be organizationally independent and statutory language (Section 13887(a)(1)) requires that the internal auditor "shall be accountable to the audit committee of the governing body", staff proposes the establishment of a audit committee comprised of two board members. This committee will receive regular reports on audit findings and recommendations from the internal audit staff.
- Resolution 2015-37

COVERED CALIFORNIA REGULATIONS

2016 BENEFIT DESIGN AND NETWORK RECOMMENDATIONS (ACTION)

James DeBenedetti, Deputy Director of Plan Management Division

2016 BENEFIT DESIGNS

Beginning in late September 2014, Covered California engaged consumer stakeholders, regulators, and carriers to do a comprehensive review of the 2015 benefit designs to recommend changes for the 2016 plan year. Primary considerations to the recommendations were:

- Design meets Target Actuarial Value (AV) as computed with the 2016 Proposed AV Calculator
  - Ideally, allow margin in the 2016 AV for each metal tier to allow for future year flexibility
- Generally increases transparency in cost and allows for easier comparison by benefit line across all metal tiers
- Lessen barriers to general care needs in Bronze plan
- Maintains aligned incentives between members, provider, and plans on quality and cost for benefits that generally have a wide variation in cost for the service
- Are operationally feasible for both Covered California and Qualified Health Plans (QHPs) to implement
- As medical treatments, services, and cost/quality tools evolve over the coming years, we have the ability to further refine benefit offerings

2016 KEY DESIGN CHANGES ALREADY APPROVED (NON PHARMACY)

- For the Bronze plan, visits to Specialists were added to the allowed services where the cumulative first three visits do not apply to the deductible (in addition to PCP, Mental Health Outpatient, and Urgent Care)
- For the Bronze plan, the deductible application for Lab and OP Rehab/Speech/OP Occ was removed
- Combined the Copay and Coinsurance Silver 70 plan designs into a single Silver offering (similar to Bronze) which reduced the Cost Sharing Reduction (CSR) Silver plans from six to three
- Additionally for the Silver plan, coinsurance for CTs, MRI, Ultrasound and PETS Scans was replaced with flat dollar copays
- Minimal changes were made to the Gold and Platinum plan designs for 2016

2016 PHARMACY BENEFITS ALREADY APPROVED

In addition to the updated recommendation that will limit consumer cost sharing for high cost drugs, the Board has already taken action and approved the following pharmacy-related requirements for 2016:

1. Plan formularies must include at least one drug in Tiers 1 or 2 or 3 if all FDA-approved drugs in the same drug class would otherwise qualify for Tier 4 and at least 3 drugs in that class are available as FDA-approved drugs
2. Plans to have an opt out retail option for mail order (allowing consumers that want/need in-person assistance to get such service at no additional cost)
3. Plans to provide enrolled consumers an estimate of the out-of-pocket cost for specific drugs
4. Include statement on the availability of drugs not listed on the formulary
5. Exception process written clearly on formulary
6. Dedicated pharmacy customer service line where advocates and prospective consumers can call for clarification

* These requirements are in addition to the final federal payment notice requiring health plans to publish an up-to-date, accurate and complete list of <u>all</u> covered drugs on its formulary list

PREMIUM, UTILIZATION AND COST OF TIER 4 DRUGS

To determine the final recommendation for what maximum cap to set for Tier 4 drugs, Qualified Health Plans (QHPs) provided Covered California data related to projected premium impact, prior utilization and cost information. Using the information received, we determined that setting a lower maximum cap is in the best interest of the consumer for the 2016 plan year

Premium

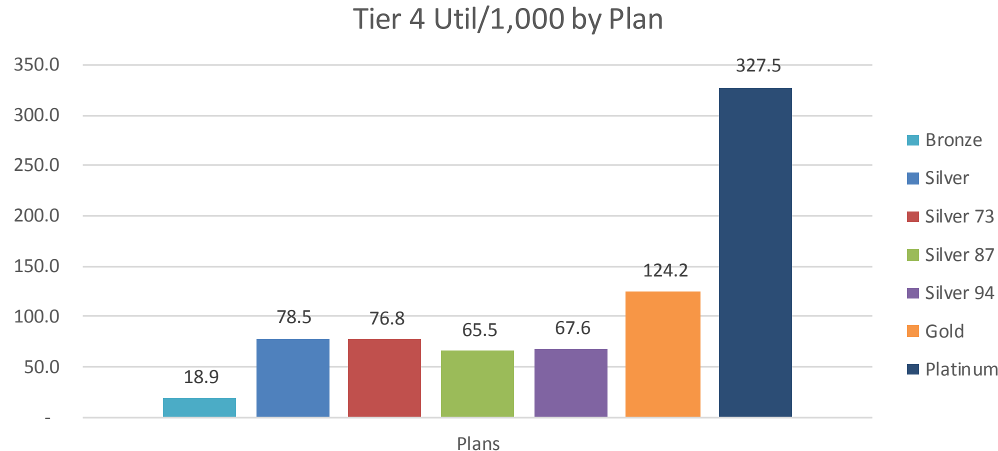
- Estimated range of premium impact in the first year is generally less than 1% for all metal levels
- Projected future 3 year premium impact varied widely by 0%-3%
- There is a high degree of uncertainty with the new introduction and pharmaceutical pricing of specialty drugs which makes projecting future year premium impacts difficult
- The annual evaluation of the pharmacy benefit is necessary to adjust benefits as needed

Adherence and Utilization Data

- Many factors influence medication adherence including income, consumers' share of cost, disease being treated, complexity of medication regimen, and side effects

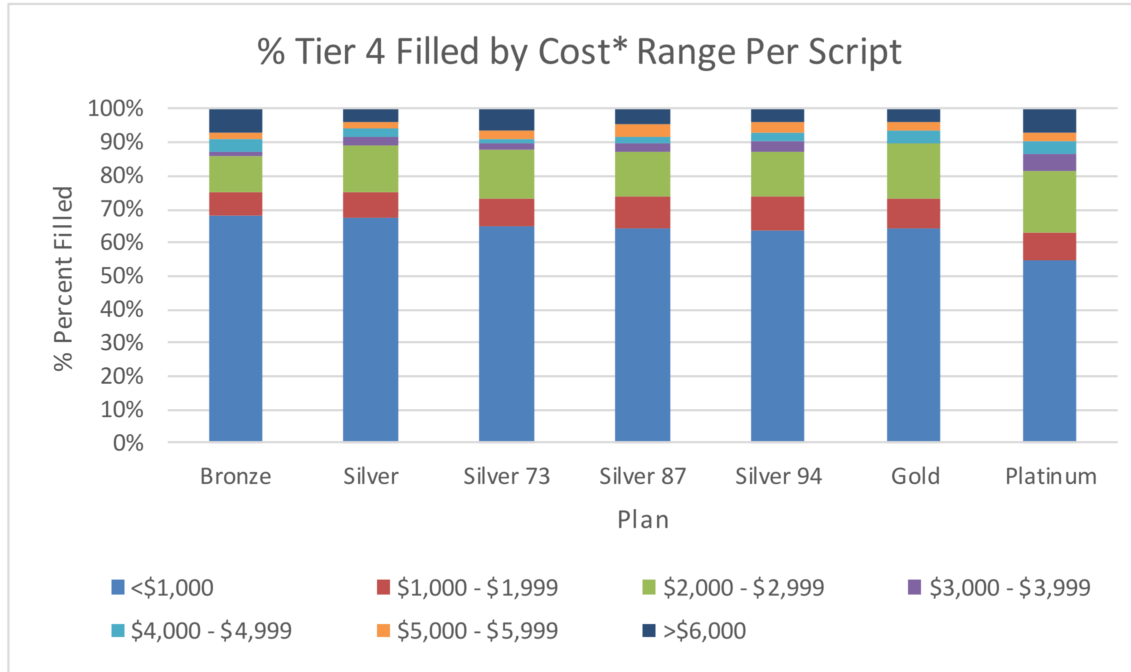
PREMIUM, UTILIZATION AND COST OF TIER 4 DRUGS (CONTINUED)

- There is data to support an increase in medication adherence when the consumer's out-of-pocket costs are less
- On average, Bronze members fill fewer Tier 4 scripts than the other plans while Gold and Platinum have higher utilization of Tier 4 medications
- In the future, further analysis of claims data will allow us to understand if the lower utilization is due to lack of adherence or consumers are knowingly selecting the plan that has lower pharmacy cost-sharing to fit their needs



PREMIUM, UTILIZATION AND COST OF TIER 4 DRUGS (CONTINUED)

- In total, >50% of Tier 4 fills are for medications with a carrier cost of <$1,000 which will result in cost sharing of $300 or less depending on plan
- There was wide variation, however, by each individual carrier



* Cost represents the carrier's contracted fee of which the consumer will pay 10% - 30% depending on plan

RECOMMENDED PHARMACY CHANGES TO THE 2016 STANDARD BENEFIT PLAN DESIGN 2016

- Covered California recommends Tier 4 drugs to be capped at a maximum of $250 for Silver, Gold, and Platinum plans and $150 for Silver 87 and Silver 94 plans
- A lower cap of $250 on all drug tiers in the Bronze plan does not meet the AV requirement. As such, we will be recommending all drug tiers have a member cost share of 100% coinsurance up to a $500 cap
- Due to operational challenges raised by plans (inability to cap the cost-share for a service with a combined medical and pharmacy deductible), it is recommended that the Bronze plan have a separate medical and pharmacy deductible. The maximum applies to each 30 day script
- A member filling a high-cost drug will first need to satisfy the pharmacy deductible, then pay a percentage of the cost of the drug up to the cap (maximum possible for a high-cost script)

RECOMMENDATION 2016 ACTION

Changes to the deductible and coinsurance are indicated in red.

- BRONZE: Coinsurance up to a maximum of **$500** per script* on Tiers 1-4 after deductible Medical Deductible $6,000 / Pharmacy Deductible $500 / Coinsurance 100%
- SILVER 70 AND 73: Coinsurance up to a maximum of **$250** per script for Tier 4 after deductible
- SILVER 87 AND 94: Coinsurance up to a maximum of **$150** per script for Tier 4 after deductible
- GOLD: Coinsurance up to a maximum of **$250** per script for Tier 4
- PLATINUM: Coinsurance up to a maximum of **$250** per script for Tier 4
- SHOP SILVER: Coinsurance up to a maximum of **$250** per script for Tier 4 after deductible Medical Deductible $1,500 / Pharmacy Deductible $250

* Up to a 30 day supply

2016 STANDARD BENEFIT PLAN DESIGN: SUMMARY OF MEMBER COST SHARING FOR DRUGS

Plan	Tier	2016 Member Rx Cost Share After Pharmacy Deductible	2016 Pharmacy Deductible	2016 MOOP	2016 Maximum Member Cost Share Per Script (after RX deductible is satisfied)	Maximum Member Cost Share for a Tier 4 Script (deductible plus cap)	AV WITH PROPOSED CHANGES
Bronze	1	100%	$500	$6,500	$500	$1,000	61.87
	2	100%	$500	$6,500	$500	$1,000	
	3	100%	$500	$6,500	$500	$1,000	
	4	100%	$500	$6,500	$500	$1,000	
Silver	4	20%	$250	$6,250	$250	$500	70.45
Silver 94 100-150	4	10%	$0	$2,250	$150	$150	93.84
Silver 87 150-200	4	15%	$50	$2,250	$150	$200	86.85
Silver 73 200-250	4	20%	$250	$5,450	$250	$500	72.83
SHOP Silver Coins	4	20%	$250	$6,500	$250	$500	71.57
SHOP Silver Copay	4	20%	$250	$6,500	$250	$500	71.26
Gold Coinsurance	4	20%	$0	$6,200	$250	$250	80.24
Gold Copay	4	20%	$0	$6,200	$250	$250	81.08
Platinum Coinsurance	4	10%	$0	$4,000	$250	$250	88.5
Platinum Copay	4	10%	$0	$4,000	$250	$250	89.45

COVERED CALIFORNIA

RECOMMENDED ACTION TO 2016 APPROVED BENEFIT DESIGNS: TIERED HOSPITAL NETWORKS

Covered California recommends the following clarifying language regarding carriers' requirements when the carrier has a second tier for non-preferred hospitals that have higher cost-sharing for consumers:

- For 2016, a carrier may offer a plan with two "in-network" hospital tiers if the lowest-cost tier, (Tier 1), network complies with the cost-sharing requirements in the standard benefit plan design, meets state network adequacy and timeliness standards as applied by the applicable regulator, and the carrier demonstrates that the two in-network tiers are in the best interest of the consumer as determined by Covered California. This determination will be completed on a case-by-case basis, based on premium stability, price, quality, choice and value. For non-Qualified Health Plans, the applicable regulator will determine if the plan's network meets regulatory requirements
- This policy will be reviewed for 2017 and carriers should plan to have only a "single" hospital tier

ADDITIONAL RECOMMENDED UPDATES TO 2016 APPROVED BENEFIT DESIGNS: TIERED HOSPITAL NETWORKS

This allowance is a benefit to consumers if they should end up receiving services in a Tier 2 in-network facility; however, the following will be required of the carrier if they have this type of network in 2016

- A carrier must have a primary hospital tier (Tier 1) where the hospital network meets the cost-sharing requirements in the standard benefit plan design, meets Covered California requirements for impact on premium stability, quality, choice and value, and meets state network adequacy standards as applied by the applicable regulator
- A carrier may have a second hospital tier (Tier 2) where the carrier has cost-sharing requirements that are different than the standard benefit plan design if the carrier can demonstrate that the Tier 2 network is in the best interest of the consumer as determined by Covered California
- The Tier 2 network cannot be used to meet state network adequacy and timely access standards as applied by the applicable regulator
- The Tier 2 network cannot be displayed or communicated as the primary hospital network (Tier 1) and the higher cost-sharing that may be associated with the Tier 2 facilities must be clearly called out and communicated to consumers
- Consistent with regulatory requirements, consumers that receive care at a Tier 2 hospital as a result of an emergency or certain circumstances where an authorization has been approved, benefits will be applied consistent with the standard benefit plan design which will be the same as Tier 1 benefits
- Any consumer cost-sharing at both Tier 1 and Tier 2 hospitals, must apply to the consumers deductible and maximum out of pocket

- Resolution 2015-38