



COVERED
CALIFORNIA

PLAN MANAGEMENT ADVISORY GROUP

January 14, 2016

WELCOME AND AGENDA REVIEW

BRENT BARNHART, CHAIR
COVERED CALIFORNIA PLAN MANAGEMENT ADVISORY GROUP

AGENDA

AGENDA

Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar

Thursday, January 14, 2015, 10:00 a.m. to 12:00 p.m.

Webinar link: <https://attendee.gotowebinar.com/register/1584384532714542849>

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|-------------|--|--------------------------------|
| I. | Welcome and Agenda Review | 10:00 - 10:05 (5 min.) |
| II. | Plan Advisory Membership and Charter 2016 | 10:05 – 10:15 (10 min.) |
| III. | 2017 Certification Discussion | 10:15 – 11:40 (85 min.) |
| | <i>A. Certification Policy</i> | <i>10:15– 10:40 (25 min.)</i> |
| | <i>B. Benefits</i> | <i>10:40– 11:10 (30 min.)</i> |
| | <i>C. Quality</i> | <i>11:10– 11:40 (30 min.)</i> |
| I. | Vision Benefits Status Update | 11:40 – 11:50 (10 min.) |
| II. | Wrap-Up and Next Steps | 11:50 – 12:00 (10 min.) |

PLAN ADVISORY MEMBERSHIP

BRENT BARNHART, CHAIR
PLAN MANAGEMENT ADVISORY GROUP

PLAN MANAGEMENT ADVISORY MEMBERS 2016

Brent Barnhart - Chair

Senior Advisor
California Health Policy Strategies

Doreen Bradshaw

Executive Director
Health Alliance of Northern California

Anne Donnelly

President
Project Inform

Jen Flory

Senior Health Attorney
Western Center on Law & Poverty

Colin Havert

Vice President and General Manager
Anthem Blue Cross

Betsy Imholz

Director, Special Projects
Consumers Union

Jennifer Jackman

Chief Operations Officer
Memorial Medical Foundation

April Martin

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Dignity Health

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Manager, Public & Government Affairs
Delta Dental of California

Timothy Nekuza

Exchange Implementation Manager
Dental Health Services

Cary Sanders

Director
Policy Analysis & Having Our Say Coalition
California Pan-Ethnic Health Network

William Wehrle

Vice President, Health Insurance Exchanges
Kaiser Permanente

Valerie Yv. Woolsey

Director
Health Care Reform Strategy
BAART Programs

PROPOSED 2017 CERTIFICATION

ANNE PRICE, DIRECTOR
PLAN MANAGEMENT DIVISION

2017-2019 INDIVIDUAL CERTIFICATION GUIDING PRINCIPLES

Provide stability for consumers by having a portfolio of carriers, products, and networks that offer distinct choice and quality healthcare at a cost with annual changes that are at, or below trend.

- May allow for the consideration of new carriers in 2018 and 2019 based on differentiation of product, network, operational capabilities, and quality innovations that will benefit Covered California consumers.
- Promote continued growth and implementation of integrated models of care such as Accountable Care Organizations (ACO), Medical Homes, and models that reimburse and support primary care.
- Implementation of new provider payment models that benefit consumers receiving the right care, at the right time and right place.
- Revision of contract requirements that require continued improvement in the quality of care provided to consumers and alignment of Quality Improvement Strategies (QIS) that focus on the unique economic, demographic and regional variations that exist within our membership.
- Allow for annual changes to benefit designs that promote preventative care, increase management of chronic conditions and increases access to needed care.

PROPOSED APPROACH FOR 2017 INDIVIDUAL PLAN CERTIFICATION

- For 2017, recommend one QHP Certification application that is open to all licensed health insurers. Covered California will review applications, negotiate with carriers and select Qualified Health Plans in July 2016.
- The 2017 application is for a multi-year contract term (2017 – 2019) with annual plan re-certification that includes review and Covered California approval of the following:
 - Contract compliance and performance review
 - Rates
 - Benefits
 - Networks
 - New products
 - Updates to Performance Requirements
- May allow new entrants in 2018 and 2019 if the carrier is newly licensed or a Medi-Cal managed care plan and the addition brings value to what is already being offered in the region(s).
- Exchange participation fee will be set at 3.5% of gross premium for 2017 and reviewed annually for 2018 and 2019 with the goal of reducing the percentage when possible.

2017-2019 DENTAL CERTIFICATION GUIDING PRINCIPLES (INDIVIDUAL AND CCSB)

With family dental being a new option for 2016 for the Individual market, the guiding principles for 2017 certification will be focused on stability in products offered and stability in future premium changes as we look to continue increasing enrollment in this line of business.

- Focus on strategies to retain members and increase new enrollment.
- Provide stability for consumers by having a portfolio of carriers, products, and networks that offer unique choice and quality dental care at a cost with annual changes that are at or below trend.
- Allow for annual changes to benefit designs that promote preventive care and value.
- Require continued improvement in the quality of care provided to consumers.

PROPOSED APPROACH FOR 2017 DENTAL PLAN CERTIFICATION (INDIVIDUAL AND CCSB)

- For 2017, recommend one QDP Certification application that is open to all licensed dental plans.
- The 2017 application is for a multi-year contract term (2017 – 2019) with annual plan certification that includes review and Covered California approval of the following:
 - Contract compliance and performance review
 - Rates
 - Benefits
 - Networks
 - New products
 - Updates to Performance Requirements
- May allow new dental issuer entrants in 2018 and 2019 if the issuer is newly licensed or the addition brings value to what is already being offered in the region(s).
- Exchange participation fee will be set at 3.5% of gross premium for 2017 and reviewed annually for 2018 and 2019 with the goal of reducing the percentage when possible.

2017-2019 SMALL GROUP CERTIFICATION GUIDING PRINCIPLES

- Provide a competitive portfolio of products that will offer employees of small groups the choice to enroll with a carrier that is focused on providing quality care at premiums that are at or below other options available in the small group market.
- Flexibility to adjust products, networks and premiums consistent with regulatory requirements.
- Certification and contract requirements that include expectations for quality improvement.
- Benefit designs that promote preventive care, increase management of chronic conditions and increase access to needed care.

PROPOSED APPROACH FOR 2017 SMALL GROUP CERTIFICATION

- Covered California for Small Business QHP certification application, open to all licensed health insurers and not limited to carriers who are QHPs for Individual
- Multi-year contract term (2017 – 2019) with annual carrier certification that includes review of premium competitiveness and stability, performance, and compliance with QHP contract requirements
- Allowance of new carrier entrant off annual certification cycle if the carrier is a 2017 Qualified Health Plan for the Individual product
- Allowance for quarterly change in rates, addition of new plans and networks (subject to Covered California approval)
- Exchange participation fee will be set at a percent (still to be determined) of gross premium for 2017 and reviewed annually for 2018 and 2019 with the goal of reducing the percentage when possible

2017 CERTIFICATION TIMELINE

Plan Management Advisory <ul style="list-style-type: none"> Benefit Design & Certification Policy recommendation 	January 14, 2016
Release draft 2017 QHP & QDP Certification Applications	January 19 - 21, 2016
January Board Meeting <ul style="list-style-type: none"> discussion of benefit design & certification policy recommendation 	January 21, 2016
Draft application comment period ends	January 22, 2016
Letters of Intent Accepted	February 1 – February 12
Final AV Calculator Released	February
February Board Meeting <ul style="list-style-type: none"> anticipated approval of 2017 Standard Benefit Plan Designs & Certification Policy 	February 18
Applicant Trainings <ul style="list-style-type: none"> electronic submission software, SERFF submission and templates 	February 16 -26
QHP & QDP Applications Open	March 1, 2016
QHP Application Responses Due	May 2, 2016
Evaluation of QHP Responses & Negotiation Prep	May 3 – June 5
QHP Negotiations	June 6 – June 17
QHP Preliminary Rates Announcement	Week of July 4
Regulatory Rate Review Begins (QHP)	Week of July 4
QDP Application Responses Due	June 1
Evaluation of QDP Responses & Negotiation Prep	June 2 – July 10
QDP Negotiations	July 11 – July 17
QDP Rates Announcement <ul style="list-style-type: none"> (no regulatory rate review) 	August 1
Public posting of proposed rates, if exception requested by Covered California (proposed date per CCIIO)	August 31
Public posting of final rates, if exception requested by Covered California (proposed date per CCIIO)	November 1



PROPOSED 2017 BENEFIT DESIGN

JAMES DEBENEDETTI, DEPUTY DIRECTOR
PLAN MANAGEMENT DIVISION

STRATEGY FOR 2017 BENEFIT DESIGN

Organizational Goal

Covered California should have benefit designs that are standardized, promote access to care, and are easy for consumers to understand.



Subcommittee Goal

Provide input to Covered California staff as we develop recommendations for the 2017 benefit plan designs that considers a progressive strategy of potential benefit changes through 2019

Subcommittee Objectives

1. Address benefit design priority areas that will reduce barriers and improve consumers' access to needed care
2. Consider benefit changes that align value with improved health outcome
3. Identify and recommend benefits changes that may be necessary to meet Actuarial Value (AV) requirements
4. Identify benefit design areas that should be improved for consumer understanding of coverage and ease of plan comparison

SUMMARY OF PROPOSED CHANGES IN 2017 BENEFIT DESIGN

Plan Design:

- Reduce primary care / mental health / rehab copays by \$5-10 in every metal tier except Bronze
- Reduce urgent care copays to amount set for primary care in every metal tier
- Increase ED facility copay by \$75-100 in Silver and Gold Plans
 - Remove ED physician fee from all plans
 - Remove deductible from ED visits
- Apply drug cap after deductible in the HDHP plans (per AB 339)
- Increase specialist copay by \$5-10
- Increase x-rays / diagnostics by \$5-15
- Increase imaging by \$25-50
- Increase deductible by \$100-300 for Silver and Bronze
- Increase MOOP by \$550 (Silver and Gold), \$300 (Bronze), \$100-250 (Enhanced Silver)

Endnotes:

- Added clarifying language on endnotes for mental health outpatient items, “other practitioner” category, tiered networks, cost-sharing for services subject to MHPAEA
- New endnote clarifying benefit category for inpatient and SNF physician fees
- New endnote specifying benefit category for autism/pervasive developmental disorder
- New endnotes for diabetes education and diabetes self-management

Covered California is reviewing comments from DMHC and CDI on the proposed endnotes and will present an updated version at the January Board meeting.

PROPOSED 2017 DENTAL BENEFIT DESIGN

TAYLOR PRIESTLEY, CERTIFICATION PROGRAM MANAGER
PLAN MANAGEMENT DIVISION

PROPOSED DENTAL STANDARD BENEFIT DESIGN 2017

- **Copay Plan Design (Pediatric & Adult)**
 - Standardize copays for all procedure codes.
- **Adult Coinsurance Design**
 - Include Periodontal Maintenance benefits in Basic Services.
 - Reduce out-of-network levels of coverage. Proposed plan coinsurance:
 - Diagnostic & Preventive: Plan pays 90%
 - Basic Services: Plan pays 70%
 - Major Services: Plan pays 50%
 - Standardize the following exclusions: Tooth Whitening, Adult Orthodontia, and Implants.
- **Employer-Sponsored Adult Coinsurance Plan Design**
 - No waiting period for any service category.
 - Periodontal Services included in Basic Services.

QUALITY INITIATIVES 2017

DR. LANCE LANG, CHIEF MEDICAL OFFICER
PLAN MANAGEMENT DIVISION

COVERED CALIFORNIA AND A QUALITY DELIVERY SYSTEM

Covered California is focused on achieving the triple aim on behalf of all Californians and our contract requirements for 2017 – 2019 will continue to move us towards achieving that goal

Guiding principals for raising the bar on quality requirements include the following:

- We will promote alignment with other purchasers as much as possible which will allow us to have similar focus and requirements across the delivery system
- Certain requirements may also apply to a contracted health plan's entire book of business which is consistent with the ACA's healthcare reform goals
- Consumers will have access to networks that offered through the Qualified Health Plans (QHPs) that are based on high quality and efficient providers
- Enrollees have the tools needed to be active consumers including both provider selection and shared clinical decision making
- Reduction in healthcare disparities through increased identification, measurement and reporting of race and ethnicity related to management of chronic illness
- Align payment with value and proven delivery models
- Minimize variation in the delivery of quality service by assuring that each provider meets minimum standards

ALIGNED CMS AND EXCHANGE STRATEGY

Starting in 2016, Covered California is evolving its work with QHPs from “tell us what your doing” to a required set of initiatives resulting in demonstrated improvement over time.

- Aligned with CMS Quality Improvement strategy starting in plan year 2017*
- Improved Health outcomes
- Prevent hospital readmissions
- Improve patient safety and reduce errors
- Reduce Disparities
- Promote health and wellness

With emphasis on aligning financial incentives with improvement strategy.

*To be successful, especially in collecting baseline data, QHPs will need to start work in 2016.

Success in Quality Improvement and Delivery System Redesign

Covered California is setting a high bar and intending to work with QHPs to drive significant improvement over the next contract period and beyond. Success will depend on rigorous evaluation of progress and negotiating goals annually based on experience.

ARTICLE 1: IMPROVING CARE, PROMOTING BETTER HEALTH AND LOWERING COSTS

Covered California supports provider networks that are designed based on quality, satisfaction and cost efficiency standards to insure that enrollees have access to quality care.

Requirements of the Qualified Health Plan will include:

- Provider network composition includes measurement that is based on quality in addition to other plan factors and provide methodology for doing so by January 1, 2018.
- Work with the Exchange to develop and report baseline performance for a defined set of metrics (detailed in later articles in Attachment 7) and negotiate annual targets for improvement starting in 2018.
- Ensure providers with outlier poor performance in metrics targeted under Attachment 7 will not be included in the network in 2019 or Contractor will report rationale for continuing participation.
- Report how enrollees with conditions that require highly specialized management such as transplant or burn patients are directed to providers with documented experience and proficiency based on volume and outcome data.

COLLABORATIVE PARTICIPATION

Collaboratives are often the strongest way to drive change especially at the point of care.

Qualified Health Plan shall participate in two collaborative efforts:

1. CalSIM Maternity Initiative

- Supported by CMQCC and CHCF
- <http://www.chhs.ca.gov/PRI/CalSIM%20Maternity%20Initiative%20WriteUp%20April%202014.pdf>

2. Statewide workgroup on Overuse

- Multi-stakeholder work group with leadership from DHCS, CalPERs and Covered California
- <http://www.iha.org/grants-projects-reducing-overuse-workgroup.html>

Additional collaboratives aligned with Covered California goals that the carriers are encouraged but not required to participate in include the following:

1. Clinical Transformation (<https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/>)
2. Partnership for Patients (<http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2014.html>)
3. California Joint Replacement Registry California Immunization Registry (CAIR)
4. Payment reform initiatives sponsored by IHA or CMMI
5. CMMI ACO Program (including Pioneer, Savings Sharing, Next Gen ACO, and other models)
6. California Perinatal Quality Care Collaborative
7. California Quality Collaborative
8. Leapfrog

ARTICLE 2: PROVISION AND USE OF DATA FOR IMPROVEMENTS IN QUALITY CARE

Covered California will coordinate annual reporting of all quality and delivery system reform requirements and targets using the following mechanisms and may request additional information, such as interim status reports and data, during the term of the contract.

Requirements of the Qualified Health Plan will include:

- Provide contracted claims and clinical data for exchange enrollees as specified in Attachment 7 to use in the Exchange's Enterprise Analytics Solution (EAS).
- Report HEDIS, CAHPS, and other performance data for each product type as required for use in Covered California's Quality Rating System (QRS).
- Report work plan and annual progress of the federally-required Quality Improvement Strategy (QIS) through the annual certification application.
- Report on broader quality improvement and delivery system reform efforts through annual reporting in the Covered California eValue8 Request for Information included in the annual certification application.

ARTICLE 3: REDUCE HEALTH DISPARITIES AND ASSURE HEALTH EQUITY

Covered California recognizes that promoting better health requires a focus on addressing health disparities and health equity while recognizing that some disparity results from determinants outside the control of the health care delivery system.

Requirements of the Qualified Health Plan will include:

- Increase self reported identity annually 2017 and 2018, achieving 85% by year end 2019.
- Track, trend and improve quality measures by ethnic/racial group using a combination of self-reported and proxy identification and by gender.
 - Initial focus: Diabetes, Hypertension, Asthma and Depression
- Report baseline data in 2017 application for certification.
 - Baseline per cent of self-reported racial/ethnic identity
 - Baseline quality measures as available
- Achieve negotiated targets for annual reduction in disparities.

**All California Health Plans have been required to collect race, ethnicity, and language data on their enrollees under SB 853 since 2003.*

ARTICLE 4: PROMOTING DEVELOPMENT AND USE OF CARE MODELS – PRIMARY CARE

Primary care is the foundation of an effective healthcare delivery system. Adults who have a personal care physician have 33 percent lower health care costs and 19 percent lower odds of dying than those who see only a specialist (Starfield, Milbank Quarterly, 2005).

Primary Care redesigned as “Patient Centered Medical Home” (PCMH) is supported by a growing body of evidence that primary care can exceed the track record documented by Starfield including improved management of total costs of care. (<https://www.pcpcc.org/results-evidence>)

The Exchange has structured standard benefits to minimize enrollee cost share for primary care visits.

Requirements of the Qualified Health Plan will include:

- For 2017, assure that all enrollees either select or are provisionally assigned to a Personal Care Physician and report results in the Application for Certification for 2018. This requirement is not to be interpreted as requiring that the Primary Care Physician (PCP) serve as a gatekeeper.
- The Exchange and QHPs will cooperate in evaluating various PCMH accreditation and certification programs as well as other frameworks for defining a consistent standard for determining the percent of primary care provided by PCMHs for Exchange enrollees and for the QHP’s book of business.
- The Exchange and QHPs will apply this standard to determine a baseline that will be included in the certification application in 2018 and negotiate annual target increases.
- Adopt and progressively expand a contracting and payment strategy that creates a business case for PCPs to adopt accessible, data-driven, team-based care (alternatives to face to face visits and care by non-MDs) with accountability for improving triple aim metrics including total cost of care

ARTICLE 4: PROMOTING DEVELOPMENT AND USE OF CARE MODELS – ACCOUNTABLE CARE ORGANIZATIONS (ACO) OR INTERGRATED MODELS OF CARE

“Despite the social need and the feasibility of measurement, actual pursuit of the Triple Aim remains the exception...success requires...existence of an “integrator” able to focus and coordinate services to help the population on all three dimensions at once.” (Berwick, The Triple Aim, Health Affairs, 2008)

The Exchange places great importance on promoting integrated/coordinated care and is adopting the description of an Integrated HealthCare Model (IHM) from CalPERS. However, no standard metrics for measuring success of integrated healthcare models exist.

Requirements of the Qualified Health Plan will include:

- Describe how the requirements of an ACO or integrated model of care are met
- Report the percent of Exchange and book of business membership that receives care from the ACO or integrated model of care in the certification application for 2018.
- Report how these models ensure accountability for triple aim metrics including both quality and total cost of care across specialties and institutional boundaries.
- The Exchange and QHPs will negotiate targets for a progressively greater share of enrollees for whom care is provided under these models.

ARTICLE 5: HOSPITAL QUALITY AND SAFETY

Best estimates are that between 250,000 and 450,000 people die in US hospitals each year from Hospital Avoidable Complications (HAC) (James, J. of Patient Safety, Sept 2013). Based on population size, approximately 10 percent of these deaths are in California.

The HACs listed above were selected through broad consultation. They are a subset of the quality metrics relevant to the exchange population that QHPs may include in their payment strategy that will provide a great opportunity for improvement and contribution in reducing avoidable deaths.

Requirements of the Qualified Health Plan will include:

- Report the quality performance of contracted network hospitals including at minimum the following (HACs): Catheter Associated Urinary Tract Infection (CAUTI), Central Line Associated Blood Stream Infections (CLABSI), colon surgical site infections, adverse drug events, C-difficile colitis and sepsis mortality.
- Covered California expects that hospitals with outlier poor performance by year 2019 will not be included in Exchange networks. QHPs are required to report and explain exceptions.
- The QHPs will develop a payment strategy for hospitals such as that employed by Centers for Medicare and Medicaid Services (CMS), putting at least 6 percent of reimbursement at risk based on quality performance. Each contractor will structure this according to their own priorities including HACs, readmissions, or Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS) scores.

ARTICLE 5: HOSPITAL QUALITY – APPROPRIATE USE OF C-SECTIONS

C-sections are used for a third of uncomplicated first pregnancies and have dramatically increased over previous years. Many of these represent costly interventions that are associated with increased neonatal and maternal morbidity and a six fold increase in C-section rate for subsequent deliveries (Main EK, Morton CH, Hopkins D, Giuliani G, Melsop K and Gould JB. 2011. Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality. Palo Alto, CA: CMQCC).

Requirements of the Qualified Health Plan will include:

- Report the performance of network maternity hospitals in meeting the national Healthy People 2020 goal of 23.9 percent for low risk first pregnancies in the 2018 certification application.
- Annual targets will be negotiated for increasing the number of hospitals that meet the target.
- Report on how physicians and hospitals are reimbursed for maternity services such that there is no financial incentive for surgical delivery
- Covered California expects that hospitals that are an outlier with high use of C-sections for low risk first pregnancies will not be included in Exchange networks by year 2019. Contractor will report and explain exceptions.

ARTICLE 6: POPULATION HEALTH – PREVENTIVE HEALTH, WELLNESS AND AT-RISK ENROLLEE SUPPORT

The Exchange and QHP recognize that access to care, timely preventive care, coordination of care and early identification of high risk enrollees are central to improving each part of the triple aim.

Requirements of the Qualified Health Plan will include:

- Report the number and percent of members who have utilized preventive care, tobacco cessation, and obesity management activities in eValue8.
- Report on any participation in evidence based community health and wellness initiative, such as those recommended by the Community Preventive Services Task Force in 2017, CMS Healthy Communities Initiative or other similar pilots.
- Report the results of ongoing health assessments and incorporate into monitoring and management through eValue8.
- Report programs to proactively identify and manage at-risk enrollees.
- Provide support to at-risk enrollees transitioning to or from coverage under the Exchange consistent with California law.

ARTICLE 7: PATIENT CENTERED INFORMATION AND COMMUNICATION, COST TRANSPARENCY DECISION SUPPORT TOOLS

Contractor negotiates Agreements with providers, including physicians, hospitals, physician groups and other clinical providers, which can result in varied provider reimbursement levels for identical services and or procedures. Improving the transparency of the consumer's share of cost and quality of providers offers significant benefit to Covered California enrollees.

Requirements of the Qualified Health Plan will include:

- Provide enrollees with tools or capability that allows consumers to understand their share of cost for medical services
- Report on tools provided with the percent of enrollees who utilize tools

Report on strategy to inform enrollees of the quality performance of providers with emphasis on target metrics for hospital quality defined in Exchange requirements

SECTION 8: PROMOTING HIGHER VALUE CARE AND REDUCING OVERUSE THROUGH CHOOSING WISELY

The Exchange requires deployment of decision making tools to support enrollees in understanding their medical diagnosis and treatment options to aid in discussion with their provider. Educating members on their diagnosis and alternative treatment options can help to reduce overused or misused clinical interventions.

One such set of decision aids is Choosing Wisely. National organizations representing medical specialists asked their providers to “choose wisely” by identifying tests or procedures commonly used in their field whose necessity should be questioned and discussed. The resulting lists of “Things Providers and Patients Should Question” (<http://www.choosingwisely.org/clinician-lists/>) will spark discussion about the need—or lack thereof—for many frequently ordered tests or treatments.

Requirements of the Qualified Health Plan will include:

Join Covered California in partnership with DHCS and CalPERS in a statewide multi-stakeholder workgroup to support reduction of overuse through Choosing Wisely. Targeted conditions include:

- C-sections,
- Opioid Prescription and
- Imaging for Low Back Pain

ARTICLE 9: ACCREDITATION

All contracted health plans are required to be accredited by NCQA, URAC or AAAHC

VISION BENEFITS UPDATE

JAMES DEBENEDETTI, DEPUTY DIRECTOR
COVERED CALIFORNIA PLAN MANAGEMENT ADVISORY GROUP

WRAP UP AND NEXT STEPS

BRENT BARNHART, CHAIR

COVERED CALIFORNIA PLAN MANAGEMENT ADVISORY GROUP

APPENDIX: SUBCOMMITTEE SUMMARY

BENEFITS CHANGES AND CLARIFICATIONS REVIEWED

No.	Description	Question	Goal Consistency	OUTCOME
1	Mental/Behavioral Health other outpatient items and services	How do we modify Endnote #13 to provide more clarity and to account for MHPAEA rules on the cost share?	--	UPDATED ENDNOTE
2	Substance Use disorder other outpatient items and services	How do we modify Endnote #13 to provide more clarity and to account for MHPAEA rules on the cost share?	--	UPDATED ENDNOTE
3	Habilitative and Rehabilitative Services	Should Covered California provide additional clarity that cost share for habilitative and rehabilitative services are governed by these service categories regardless of provider type, i.e. they would not fall under "other practitioner visit" cost shares?	consumer understanding	YES
4	Non-standard / Non-EHBs	Should Covered California allow carriers to offer non-essential health benefits and/or non-standard benefits and what are the requirements and implications?	consumer understanding	NO
5	ER services	A) Can Covered CA remove the deductible and what is the impact to AV? B) Should Covered California remove physician cost sharing on the emergency room benefit? Option could be to increase facility cost sharing to be AV neutral. C) Can Covered CA add language, "Physician fee waived if admitted."	consumer understanding	YES
6	Mental health/substance use physician/surgeon fee	Should the word "surgeon" be removed from the benefit?	consumer understanding	YES
7	Out of network coverage - payment standards	Does Covered California have the ability to standardize out-of-network consumer share of cost?	consumer understanding, reasonable cost	NO
8	Diabetes education	Does this category include diabetes self-management training, or is it only diabetes prevention education?	access, consumer understanding	BOTH WILL HAVE \$0 COST SHARE
9	Inherited Metabolic Disorder – PKU	This benefit is referenced in the SERFF template as having the cost share of an office visit. Does this represent a primary care specialist visit or the cost share for special food products and formulas for treatment?	consumer understanding	SPECIALIST VISIT
10	Skilled nursing	Should Covered California add a physician fee under SNF that matches the hospital physician/surgeon fee?	--	NO

PRODUCT CHANGES REVIEWED

Optional Product Changes

	Description	Question	Goal Consistency	OUTCOME
1	Bronze Plan split med/Rx deductible with 100% coinsurance up to the MOOP	Is the 100% member cost share after deductible confusing to consumers?	consumer understanding	NO
2	Bronze Health Savings Account (HSA)	Name change to "High-Deductible Health Plan" required per Legal	regulatory	YES
3	Gold copay/coinsurance and Platinum copay/coinsurance plans	Should Covered California merge these plans into one metal offering similar to what we did for Silver in 2016?	consumer understanding	NO
4	CCSB Silver coinsurance/copay plans	Should Covered California merge these plans into one metal offering similar to what we did for the Individual Silver plans in 2016?	consumer understanding	NO
5	Alternate benefit designs	Should Covered California allow Alternative Benefit Designs (ABD) for the Individual exchange?	consumer choice	NO
6	Value-Based Insurance Design (VBID)	Should Covered California create an ABD that includes Value Based benefits that plans may offer on the Individual exchange?	consumer choice, affordable plans	NOT FOR 2017
7	Tiered networks	Should Covered California continue to allow tiered hospital networks (Endnote #23)?	access to care, consumer understanding	NO