



**COVERED**  
**CALIFORNIA**

**PLAN MANAGEMENT ADVISORY GROUP**

November 12, 2015

# 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

<https://attendee.gotowebinar.com/register/2739613904995903490>

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

October Agenda Items	Suggested Time
I. Welcome and Agenda Review	10:00 - 10:05 (5 min.)
II. 2017 Certification Discussion	10:05 - 10:35 (30 min.)
III. Benefits and Networks Subcommittee update	10:35 – 11:00 (25 min)
IV. Dental Technical Work Group Update	11:00 – 11:20 (20 min.)
V. Quality and Contracting Subcommittee update	11:20 - 10:50 (30 min.)
VI. Wrap-Up and Next Steps	11:50 – 12:00 (5 min.)

# 2017 CERTIFICATION

ANNE PRICE, DIRECTOR  
PLAN MANAGEMENT DIVISION

# 2017 CERTIFICATION PROCESS

- Covered California is in the process of determining our 2017 certification policies that takes into consideration a multi-year strategy.
- Subcommittees, comprised of stakeholders, regulators, and carriers have been meeting to review benefit design changes and new carrier quality requirements that could be included in the 2017 certification application and final contract for both Individual and Family dental lines of business.
- The certification strategy and policy for Covered California for Small Business (formerly SHOP) is also being reviewed by staff, Qualified Health Plans and stakeholders.
- The majority of work is expected to be completed in early January with a staff recommendation to the board in the January board meeting and final approval by the board expected during the February board meeting.
- The 2017 application process is expected to run through May 1st, with negotiations occurring late May through mid June.
- The 2017 announcement and publication of carriers and the 2017 preliminary rates is planned for mid July at which point the regulators will then begin their rate review for final approval.

# 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.
- Allows for annual changes to benefit designs that promote preventative care, increase management of chronic conditions and increases access to needed care.

# 2017-2019 INDIVIDUAL CERTIFICATION GUIDING PRINCIPLES (CONTINUED)

- 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 variation that exists within our membership.
- Require efforts that increase new enrollment, effectuation, and improve retention.
- Identify opportunities to reduce administrative costs to favorably impact affordability.

# PROPOSED APPROACH FOR 2017 INDIVIDUAL PLAN CERTIFICATION

- For 2017, recommend one QHP Certification application that is open to all licensed health insurers.
- 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).
- Consider changing exchange participation fee that includes changing the structure of the fee to a percent of gross premium.



# 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.
- Allows 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 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
- No new dental insurer entrants through 2019 except newly licensed.
- Allowance for changing exchange participation fee that includes changing the structure of the fee to a percent of gross premium for HMO and PPO dental plans.

# 2017-2019 SMALL GROUP CERTIFICATION GUIDING PRINCIPLES

Guiding principles for 2017 certification are focused on increasing Covered California enrollment in the expanded small group market with a strategy that offers long term cost sustainability for consumers

- 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.
- Opportunities to reduce administrative costs to favorably impact affordability.

# 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 Qualified Health Plan for the Individual product\*
- Allowance for quarterly change in rates, products, plans and networks (subject to Covered California approval)\*

\*staff is recommending that the last two items be changed in the 2016 regulations to allow for these changes in the 2016 calendar year

# DECISION PROCESS AND SUBCOMMITTEE TIMELINE

Date	Event	Description
17-Sep	<b>Plan Advisory Meeting</b> Quality Subcommittee Meeting	Kick Off Meeting
22-Sep	Benefits & Networks Meeting	Kick Off Meeting
7-Oct	Benefits & Networks Meeting	Subcommittee Meeting
<b>15-Oct</b>	<b>Plan Advisory Meeting</b>	Workgroup Status Provided to Advisory
4-Nov	Benefits & Networks Meeting	Subcommittee Meeting
5-Nov	Dental Technical Work Group	Discuss 2017 Benefit Design
10- Nov	Quality Subcommittee Meeting	Subcommittee Meeting
<b>12-Nov</b>	<b>Plan Advisory Meeting</b>	Recommendations Provided to Advisory for Feedback
Mid Nov	Draft AV Calculator Release	Draft CMS rules and AV Calculator expected
<b>19-Nov</b>	<b>Board Meeting</b>	<b>Update on Activities</b>
1-Dec	Dental Technical Work Group	Discuss 2017 Benefit Design
2-Dec	Benefits & Networks Meeting	Subcommittee Meeting
9-Dec	Benefits & Networks Meeting	Subcommittee Meeting
<b>10-Dec</b>	<b>Plan Advisory Meeting</b>	<b>Recommendations Provided to Advisory for Feedback</b>
Early Jan TBD	Quality Subcommittee	Subcommittee Meeting (placeholder)
Early Jan TBD	Dental Technical Work Group	Finalize 2017 Benefit Design (placeholder)
<b>Jan TBD</b>	<b>Board Meeting</b>	<b>Proposal to Board (Pending Final Actuarial Value Calculator)</b>
Late Feb	Final AV Calculator Release	Final CMS rules and AV Calculator expected (based on prior year experience)
<b>Feb TBD</b>	<b>Board Meeting</b>	<b>Approval by Board of Changes to SBPD, Certification Policy, and 2017 Contract</b>

# BENEFITS AND NETWORKS SUBCOMMITTEE UPDATE

ANNE PRICE, 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

# 2016 BENEFIT WORKGROUP UPDATE

The Actuarial Values (AV) of the 2016 plan benefit designs are at the higher end of the deviation allowance which may require and increase in consumer cost sharing for the 2017 benefit design depending on the results of the AV calculator.

Based on the 2016 AV results, there was more cost sharing increases needed in the Bronze and Silver plans compared to Gold and Platinum, so they may be a similar result for the 2017 plan year.

The workgroup has discussed areas where we would like to decrease consumer cost sharing for the 2017 plan year where the change aligns with goals of promoting access to care and improving health outcomes but with the understanding that there will need to be a trade off for this to occur.

Additional major areas of discussion include the possible introduction of a value based benefit, cost share uniformity in less utilized services, and value of hospital network tiering.

	Bronze		Silver				Gold		Platinum	
	HSA	Standard	Silver	Silver 73	Silver 87	Silver 94	Copay	Coinsurance	Copay	Coinsurance
AV Target	60	60	70	73	87	94	80	80	80	80
Deviation Allowance	+/-2.0%	+/-2.0%	+/-2.0%	+/-1.0%	+/-1.0%	+/-1.0%	+/-2.0%	+/-2.0%	+/-2.0%	+/-2.0%
2016 Value	<b>61.1</b>	<b>61.9</b>	<b>70.4</b>	<b>72.8</b>	<b>86.8</b>	<b>93.8</b>	<b>81.0</b>	<b>80.2</b>	<b>89.5</b>	<b>88.5</b>
2017 AV	?	?	?	?	?	?	?	?	?	?



# SUMMARY OF AREAS IN DISCUSSION FOR DECREASED CONSUMER COST SHARE

CATEGORY 1: Minor AV impact and no necessary tradeoffs if done in isolation	CATEGORY 2: Major AV impact that requires tradeoffs
Make urgent care copay the same as a PCP visit <sup>1</sup>	Copay (no deductible) for Tier 1 drugs in Bronze
Remove physician fee from ER visit in all plans (and keep deductible on Silver plans)	Remove outpatient professional fee in all plans
Remove inpatient professional fee in all plans <sup>2</sup>	
Remove physician fee and deductible from ER visits in Silver plans	
Lowered PCP visit copay	

<sup>1</sup> Has no AV impact

<sup>2</sup> Appears to have minimal impact, but requires Milliman confirmation

**Note that any combination of benefit changes in Category 1 will require tradeoffs, i.e. increases in member cost-shares for other benefits.**

# SUMMARY OF AREAS IN DISCUSSION FOR INCREASED CONSUMER COST SHARE

To achieve any combination of Category 1 and Category 2 changes, what tradeoffs (i.e. increases in other areas) are we willing to make?

Benefit	Bronze Plan Increase from current cost share	AV Δ	Silver Plan Increase from current cost share	AV Δ	Priority for change (1, 2, 3....)
MOOP	\$6,500 → \$6,850 <sup>1</sup>	↓ 0.38	\$6,250 → \$6,500	↓ 0.23	
Medical Deductible	\$6,000 → \$6,350	↓ 0.68	\$2,250 → \$2,750	↓ 1.12	
Inpatient facility fee	--- <sup>3</sup>		20% → 25%	↓ 0.39	
ER facility fee	---		\$300 → \$400 <sup>2</sup>	↓ 0.17	
Imaging	---		\$250 → \$300	↓ 0.15	
X-rays	---		\$65 → \$80	↓ 0.24	
Specialist visit	\$90 → \$110	↓ 0.43	\$70 → \$85	↓ 0.24	
Tier 2 drugs	---		\$50 → \$60	↓ 0.56	
Tier 3 drugs	---		\$70 → \$80	↓ 0.08	

<sup>1</sup> Upper limit for MOOP and Standalone pediatric dental MOOP unknown for 2017, to be determined in forthcoming federal rule

<sup>2</sup> This amount includes both facility fee and professional fee

<sup>3</sup> Bronze cost shares for most services are already 100% member coinsurance so cannot model an increase for these benefits to offset decreases in other areas

# Value Based Insurance Design

- **Value-based Insurance Design (VBID)** is a strategy that uses certain components of plan benefits to encourage members' use of high value services.
- There are already areas in Covered California's current benefits that incent members to access care at a lower cost point where they are able to receive care that is comparable to the higher cost option
  - lower consumer cost share for primary care versus specialty care
  - lower consumer cost share for urgent care versus emergency care
  - lower cost share for Tier 1 medications
- The difference with VBID is the combination of lower cost and high value, where high value could be considered by a better health outcome for the consumer or increased effectiveness of the treatment
- There is increasing use of VBID concepts in benefit design to change payment dynamics so services are paid on value which should lead to better health outcomes and lower overall healthcare cost
- To improve health outcomes and reduce future healthcare premiums, Covered California is interested in including a value based benefit in the 2017 standard benefit designs with the opportunity to potentially increase the number of value based benefits through 2019.

# BENEFITS CHANGES TO CONSIDER WITH NEGLIGIBLE OR NO AV IMPACT

No.	Description	Question	Goal Consistency	Consider?
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?	--	TBD
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?	--	TBD
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	TBD
8	Diabetes education	Should Covered California clarify if this is a preventive service? It is currently listed as "no cost, no deductible" in the SERFF template but it is not included under the definition of preventive services. Does this category include Diabetes Self-Management training, or is it only diabetes prevention education?	access, consumer understanding	TBD
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 visit or the cost share for special food products and formulas for treatment?	consumer understanding	TBD
10	Skilled nursing	Should Covered California add a physician fee under SNF that matches the hospital physician/surgeon fee?	--	NO

# PRODUCT CHANGES FOR CONSIDERATION

	Description	Question	Goal Consistency	Consider?
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	TBD
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	TBD
7	Tiered networks	Should Covered California continue to allow tiered hospital networks (Endnote #23)?	access to care, consumer understanding	TBD

# DENTAL BENEFIT DESIGN UPDATE

JAMES DEBENEDETTI, DEPUTY DIRECTOR  
PLAN MANAGEMENT DIVISION

# Dental Standard Benefit Design Review for 2017

- Adult Dental
  - Waiting Period: Considering reducing or eliminating for major services
  - Annual Limit: Considering increasing or removing
- Children's Dental
  - CMS may increase child MOOP from current \$350 (would have QHP implications)
  - Standardize medically necessary orthodontia copay to apply to entire course of treatment (as opposed to each benefit period)
- Standardization of more procedures in copay design
  - 30 procedure codes cover approximately 91% of claim costs and 97% of pediatric utilization
  - 40 procedure codes cover approximately 90% of claim costs and 95% of adult utilization
- Seeking input for potential new plan design for employer-sponsored purchase only
  - No waiting period.
  - Periodontal services included in the Basic Services category rather than Major Services.
  - Endodontic services included in the Basic Services category rather than Major Services.

# QUALITY SUBCOMMITTEE UPDATE

ALLISON MANGIARACINO, SENIOR QUALITY SPECIALIST  
PLAN MANAGEMENT DIVISION



# COMPASS FOR QUALITY CONTRACT CHANGES

## Organizational Goal

Covered California will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities



## Subcommittee Goal

- Provide input to Covered California staff as we develop recommendations for 2017 contract requirements that will target further improvements for the quality and delivery of care to consumers and align efforts for participation with other State and Federal initiatives
- Provide feedback on goal-setting with an eye for targeted improvements by 2020

# CONTRACTUAL AUTHORITY

## Attachment 7 to Contract for Plan Years 2014 and 2015

- Participation in Collaborative Quality Initiatives
- Accreditation by a national quality assurance organization
- Use Data for Quality Improvement
- Support Health and wellness
- Ensure Access and Coordination of Care
- Support members with cost and quality information
- Promote new models of care
- Support new payment models that promote value

## CMS Quality Improvement Strategy (QIS) for any plan qualified for 2 years

- Implement alternative value-based payment model to support
  - Improved health outcomes
  - Prevent hospital readmissions
  - Improve patient safety and reduce errors
  - Reduce Disparities
  - Promote health and wellness

# INDIVIDUAL PLAN RESPONSIBILITIES

## Including Draft Target Accountability

- Reduce Health Disparities
  - Track and trend quality measures by ethnic/racial group
    - Core measures starting in 2017 include Diabetes, Hypertension and Asthma (control and hospital admission rates)
    - By 2020, select additional 5 measures to track and trend including Depression
  - Demonstrate 20% relative reduction in disparities year over year
- Provide cost and quality decision support tools
  - In 2017, provide plan specific allowed charges
  - By 2020, include provider specific quality metrics
  - Demonstrate that members are using tools (specific target TBD)
- Promote integrated/coordinated models of care
  - Demonstrate a progressively greater share (specific target TBD) of membership receive care from integrated delivery system or accountable care organization
  - Require consumer selection of PCP in non-HMO products

# PRINCIPLES FOR COLLABORATIVE MULTI-PAYER STRATEGIES

- Support programs sponsored by
  - State (CalSIM),
  - Multiple purchasers (CalPERS, DHCS and CC), or
  - CMS innovation center (CMMI)
- Foster the “Triple Aim” through consistent expectations and metrics for both physician practices and hospitals
- Overcome concern for asymmetrical investment

# COLLABORATIVE INITIATIVES

## Including Draft Target Accountability

- CalSIM Appropriate Use of C-Sections
  - Target national Healthy People 2020 goal of 23.9% for low risk first pregnancies for each of 251 California maternity hospitals
- Hospital Safety
  - Promote participation in Partnership for Patients program by all California hospitals
  - Set 2020 targets for readmissions, surgical site infections, adverse drug events, C-difficile colitis and sepsis mortality
- Clinical Practice Transformation
  - Set target for proportion (possibly 33%) of primary care network for each plan functioning as medical home and able to improve triple aim metrics by 2020
  - Overcome problems of fragmentation to provide PCPs actionable patient data from hospitals and emergency rooms
- Payment reform
  - Set target aligned with CMS goal of alternative models representing 50% of payment by 2018 by adopting models promoting by CMMI
- Reduce overuse through Choosing Wisely
  - Support CalSIM C-section initiative and develop similar robust programs to reduce overuse of low back imaging and opioids

# WRAP UP AND NEXT STEPS

BRENT BARNHART, CHAIR  
COVERED CALIFORNIA PLAN MANAGEMENT ADVISORY GROUP