PLAN MANAGEMENT ADVISORY GROUP

May 14th, 2015

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
Thursday, May 14th, 2015, 10:00 a.m. to 12:00 p.m.

May Agenda Items	Suggested Time
I. Welcome and Agenda Review	10:00 – 10:05 (5 min.)
II. Benefit Design Updates and Consumer Clarity	10:05 – 10:45 (40 min.)
I. Deductibles and Caps	
II. Clarity Discussion	
III. DMHC Networks and Rural Access Discussion	10:45 – 11:25 (40 min.)
IV. 2016 Contract Update	11:25 – 11:40 (15 min.)
I. 2016 Certification/Recertification Update	11:40 – 11:55 (15 min.)
II. Wrap-Up and Next Steps	11:55 – 12:00 (5 min.)

BENEFIT DESIGN UPDATES AND CONSUMER CLARITY

JAMES DEBENEDETTI, DEPUTY DIRECTOR
COVERED CALIFORNIA PLAN MANAGEMENT DIVISION

Update: Pharmacy changes to the 2016 Standard Benefit Plan Design

Covered California reassessed the cap dollar amounts on Tier 4 (specialty) drugs and requested data from QHPs on Tier 4 cost and utilization to inform the final recommendation to the Board.

- Covered California will recommend 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), the Bronze plan now has a separate medical and pharmacy deductible.
- The maximum cap applies to a script of up to a 30-day supply.
- A member in a Bronze or Silver plan filling a high-cost drug will spend the pharmacy deductible, then pay a percentage of the cost of the drug up to the cap (maximum possible for a high-cost script).

Premium, Utilization and Cost of Tier 4 Drugs

To help determine the recommendation for the maximum cap to set for Tier 4 drugs, 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

Proportion of membership filling Tier 4 scripts, by plan

- Bronze: 0-2% fill Tier 4 scripts
- Platinum: 5-9% fill Tier 4 scripts

Premium, Utilization and Cost of Tier 4 Drugs (continued)

Average number of Tier 4 fills among members filling Tier 4 scripts:

- On average, Bronze members fill fewer Tier 4 scripts than the other tiers.
- Platinum, Gold, and Silver members fill more Tier 4 scripts.
- Silver 94 and 87 members fill the fewest Tier 4 scripts.

Allowed Cost Per Tier 4 Script

- Plans provided utilization of Tier 4 drugs within a specified range of cost (e.g. <$1,000, Between $1,001 and $3,000, and > $3,000)
- There was wide variation by plan with the percent of consumers who utilized Tier 4 drugs within each dollar range
- As a result, Covered California was not able to determine accurately the change in percentage of consumers who would be impacted by a lower versus higher maximum cap

Proposed 2016 Action for Specialty Pharmacy

Implementation of a Maximum Coinsurance for Tier 4 Drugs

Covered California recommends modifying the 2016 Standard Benefit Plan Designs to put a maximum ceiling on the member cost-share for Tier 4 prescription fills.

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 per script. This applies to all metal levels.

2016 Standard Benefit Plan Design: Summary of Member Cost Shares 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	88.50
Platinum Copay	4	10%	$0	$4,000	$250	$250	89.45

Glossary: Deductible and Maximum Out of Pocket

- Current definitions:
  - Deductible: The amount you owe for health care services your health insurance plan covers before your plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you have met your deductible for covered health care services. The deductible may not apply to all services
  - Out of Pocket Limit: The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100 percent of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance plan doesn't cover. Some health insurance plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit. In Medicaid and Children's Health Insurance Program, the limit includes premiums.

- Recommendations:
  - Change “Out of Pocket Limit” to “Maximum out of Pocket”
  - Proposed definitions:
    - Deductible: Typically, the amount of money you have to pay for your health care before your health insurance company will pay for the costs.
    - Maximum out of Pocket: The most money you will pay for your health care over an entire year. This amount includes deductible and costs of all health care.
  - Have consistent definitions in all consumer publications*

*Timing of changes will be subject to flexibility of CalHEERS system.

Bronze Plan Discussion

Issue: In 2016, the Bronze plan MOOP and Deductibles will combine to $6,500 with a 100% coinsurance, meaning the consumer is fully responsible for all health care costs until the MOOP is met*. Covered California would like to message “100%” coinsurance to be clear that members pay the full amount of health care costs until the MOOP is met.

*With the exception of the first three doctor visits

Considerations

- CalHEERS: Limitations exist on how benefits can be displayed.
  - System for Electronic Rate and Form Filing (SERFF) templates
  - Ability to change hover text in CalHEERS is difficult, but something we are continuing to look into.

- Areas where we have more change flexibility are:
  - Shop and Compare tool
  - Covered California Rate Book

- Other ideas?

Covered California 2015 Health Plan Booklet

http://www.coveredca.com/PDFs/CC-health-plans-booklet-2015.pdf

2015 STANDARD BENEFIT DESIGNS BY METAL TIER				
Coverage Category	**Bronze**	**Silver**	**Gold**	**Platinum**
	Covers **60%** average annual cost	Covers **70%** average annual cost	Covers **80%** average annual cost	Covers **90%** average annual cost
Preventive Care Copay*	No cost	No cost	No cost	No cost
Primary Care Visit Copay	$60 for 3 visits	$45	$30	$20
Specialty Care Visit Copay	$70	$65	$50	$40
Urgent Care Visit Copay	$120	$90	$60	$40
Emergency Room Copay	$300	$250	$250	$150
Lab Testing Copay	30%	$45	$30	$20
X-Ray Copay	30%	$65	$50	$40
Generic Medicine Copay	$15 or less	$15 or less	$15 or less	$5 or less
Annual Out-of-Pocket Maximum Individual and Family	$6,250 individual and $12,500 family	$6,250 individual and $12,500 family	$6,250 individual and $12,500 family	$4,000 individual and $8,000 family

*In most situations, this is true for one visit per year.

2015 STANDARD BENEFIT DESIGNS BY INCOME			
Coverage Category	**Enhanced Silver 94**	**Enhanced Silver 87**	**Enhanced Silver 73**
Eligibility Based on Income and Premium Assistance	Covers **94%** average annual cost	Covers **87%** average annual cost	Covers **73%** average annual cost
Single Income Ranges	**up to $17,235 (≤150% FPL)**	**$17,236 to $22,980 (>150% to ≤200% FPL)**	**$22,981 to $28,725 (>200% to ≤250% FPL)**
Annual Wellness Exam	$0	$0	$0
Primary Care Vist	$3	$15	$40
Specialist Visit	$5	$20	$50
Laboratory Tests	$3	$15	$40
X-Rays and Diagnostics	$5	$20	$50
Imaging	10%	15%	30%
Generic Drugs	$3	$5	$15 or less
Annual Out-of-Pocket Maximum Individual and Family	$2,250 individual and $4,500 family	$2,250 individual and $4,500 family	$5,200 individual and $10,400 family

- *Proposed changes to 2016 display:*
  - *Show all pharmacy tiers (not just Generic aka Tier 1)*
  - *Change language on Tier 4 to say "Up to a cap of $xxx"*
  - *Add deductible*
  - *Change language to say Maximum out of Pocket*

Covered California 2015 Shop and Compare Tool

Key benefits	Bronze 60	Silver 70
	Benefits in Blue are Subject to Deductibles	
Individual Deductible	$5,000 deductible for medical & drugs	$2,000 medical deductible $250 brand drug deductible
Family Deductible	$10,000 deductible	$4,000 medical deductible $500 brand drug deductible
Preventative Care Copay[1] (deductible does not apply)	no cost	no cost
Primary Care Visit Copay	$60 [2]	$45
Specialty Care Visit Copay	$70	$65
Urgent Care Visit Copay	$120 [2]	$90
Generic Medication Copay	$15	$15
Lab Testing Copay	30%	$45
X-Ray Copay	30%	$65
Emergency Room Copay	$300	$250
High cost and infrequent services (e.g. Hospital Stay)	30% of your plan's negotiated rate	20% of your plan's negotiated rate
Preferred brand copay after Drug Deductible (if any)	$50	$50
Maximum Out-of-Pocket For One	$6,250	$6,250
Maximum Out-of-Pocket For Family	$12,500	$12,500
[1] in-network only	[2] First 3 visits each year are not subject to the deductible	

- *Proposed changes to 2016 display:*
  - *Show all pharmacy tiers if possible, and if not possible, show Tier 4*
  - *Change language on Tier 4 to say "Up to a cap of $xxx"*

http://www.coveredca.com/shopandcompare/2015/#benefits

RURAL ACCESS PART II: DEPARTMENT OF MANAGED HEALTH CARE

Health Plan Provider Networks: Access & Availability

Kacey Kamrin, Senior Attorney, Office of Plan Licensing

John Boskovich, Assistant Chief Counsel, Help Center

Health Plan Provider Networks: Access & Availability

May 14, 2015

Kacey Kamrin and John Boskovich
Office of Plan Licensing
California Department of Managed Health Care

Network Adequacy

- Types of Network Review
  - New application filings
  - Service Area Expansions
  - Alternate Access Standards
  - Timely Access – Annual Network Assessment (SB 964)
  - Block Transfers
  - 10% Change in Names
  - Medi-Cal Inter Agency Quarterly Network Reviews – conducted on behalf of DHCS, not a KKA required submission

Network Adequacy

- **Capacity**
  - **Primary Care**: 1 full-time equivalent PCP for every 2,000 enrollees (across all plans)
  - **All Physicians**: 1 full-time equivalent physician (PCP and Specialists) for every 1,200 enrollees (across all plans)
  - **Hospitals:** 80% or greater available bed occupancy rate needs explanation from plan
  - **All other providers**: sufficient to provide timely access.

Network Adequacy

- Geographic Access
  - **PCPs**: 15 miles or 30 minutes from work or home
  - **Hospitals**: 15 miles or 30 minutes from work or home
  - **Specialists**: “Reasonable”
  - **Mental Health**: “Reasonable”
  - **Ancillary**: “Reasonable” distance from PCP
- Alternate Access for PCPs and Hospitals can be requested, pursuant to Rule 1300.67.2.1.

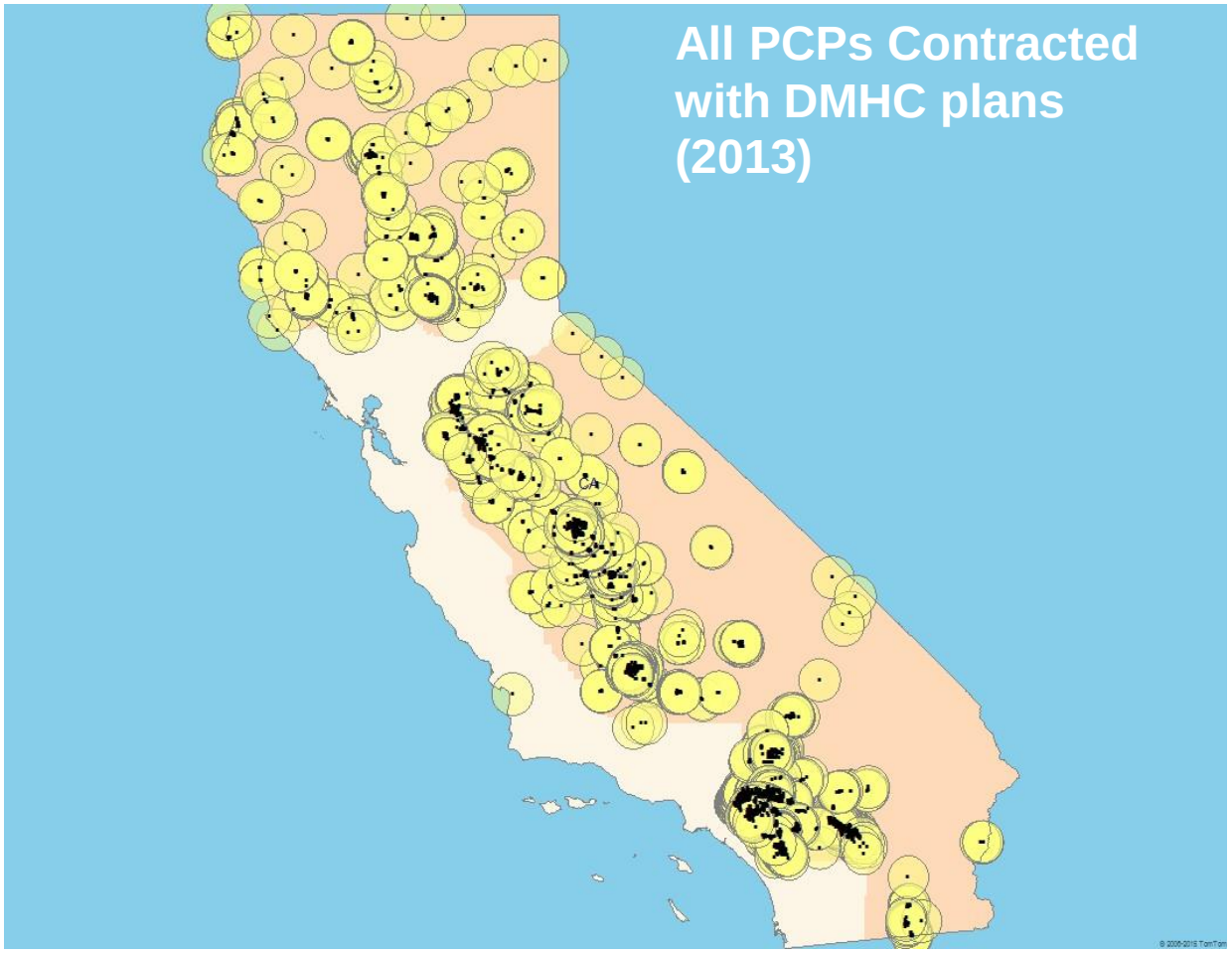
Network Adequacy

- Timely Access
  - **Primary Care**: 10 days (48 or 96 hours for urgent care)
  - **Specialty Care**: 15 days (48 or 96 hours for urgent care)
  - **Mental Health**: 15 days for non-urgent psychiatrist, 10 days for non-urgent non-physician mental health provider (48 or 96 hours for urgent care)
  - **Ancillary**: 15 days for non-urgent appointment with ancillary providers for treatment/diagnosis

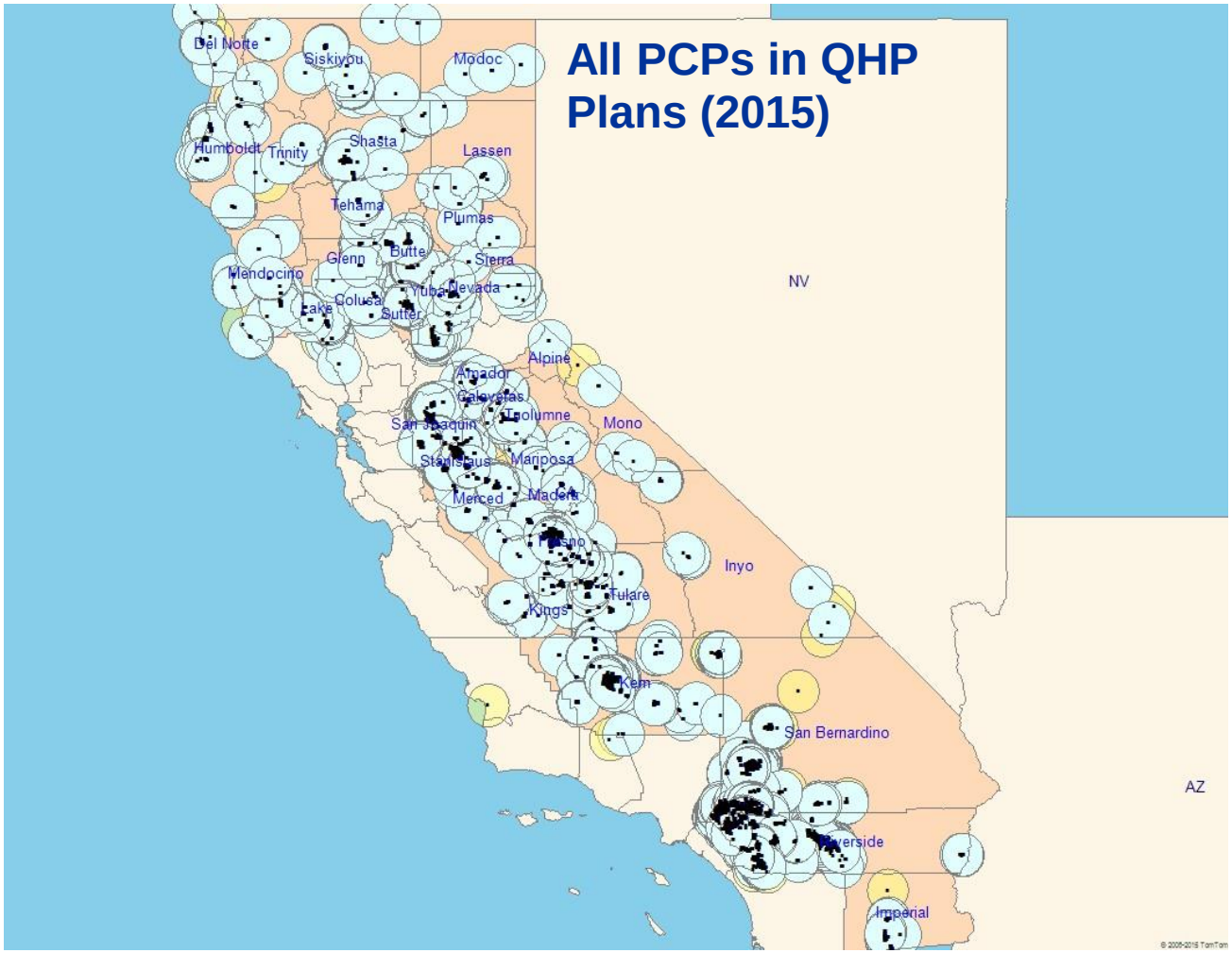
Network Adequacy

- Qualified Health Plan Review
  - Initial product application – existing vs. new network
  - 2015 Recertifications – full re-review of all networks
  - 2016 Recertifications – 10% change, adds/terms, full network review if >/= 10% change in names

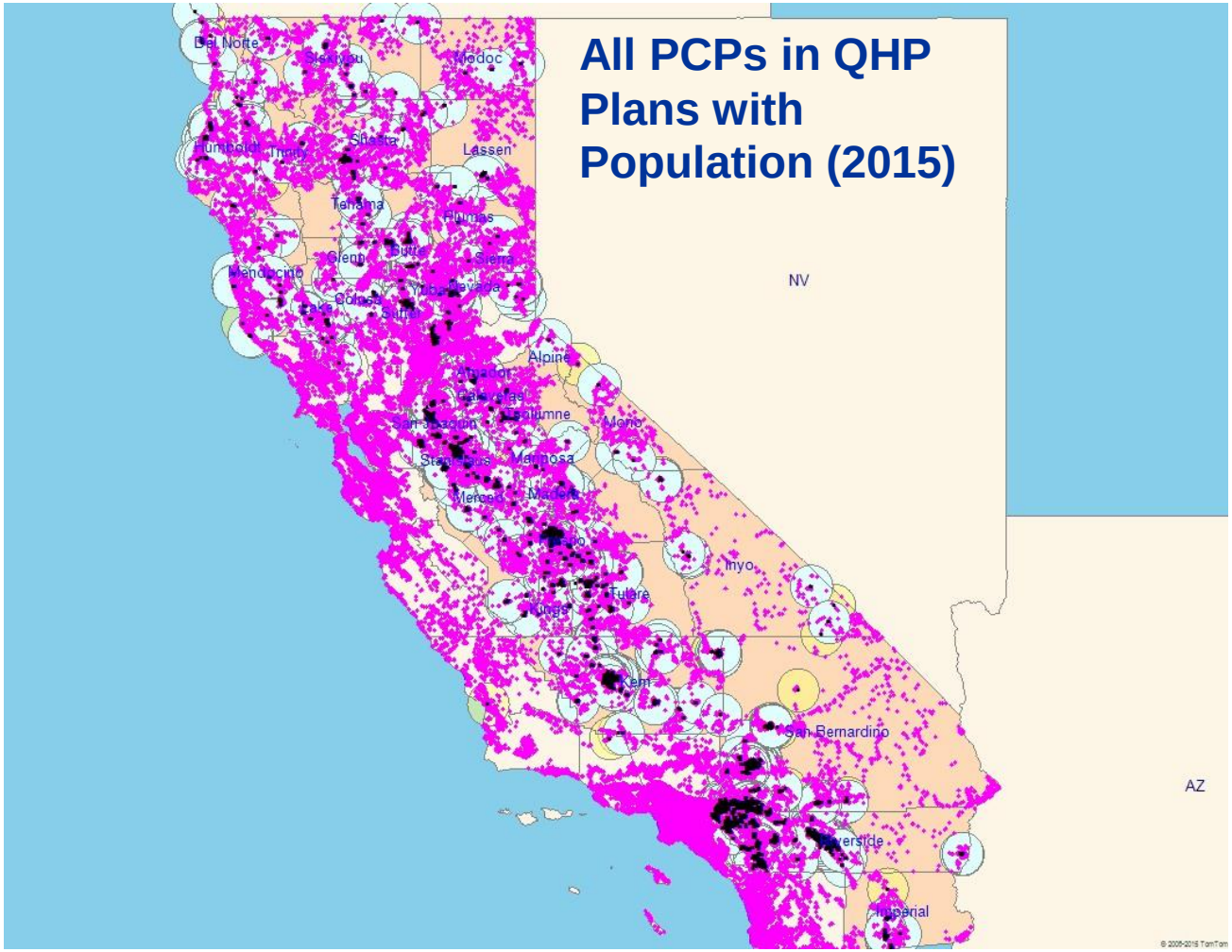
Provider Distributions



Provider Distributions

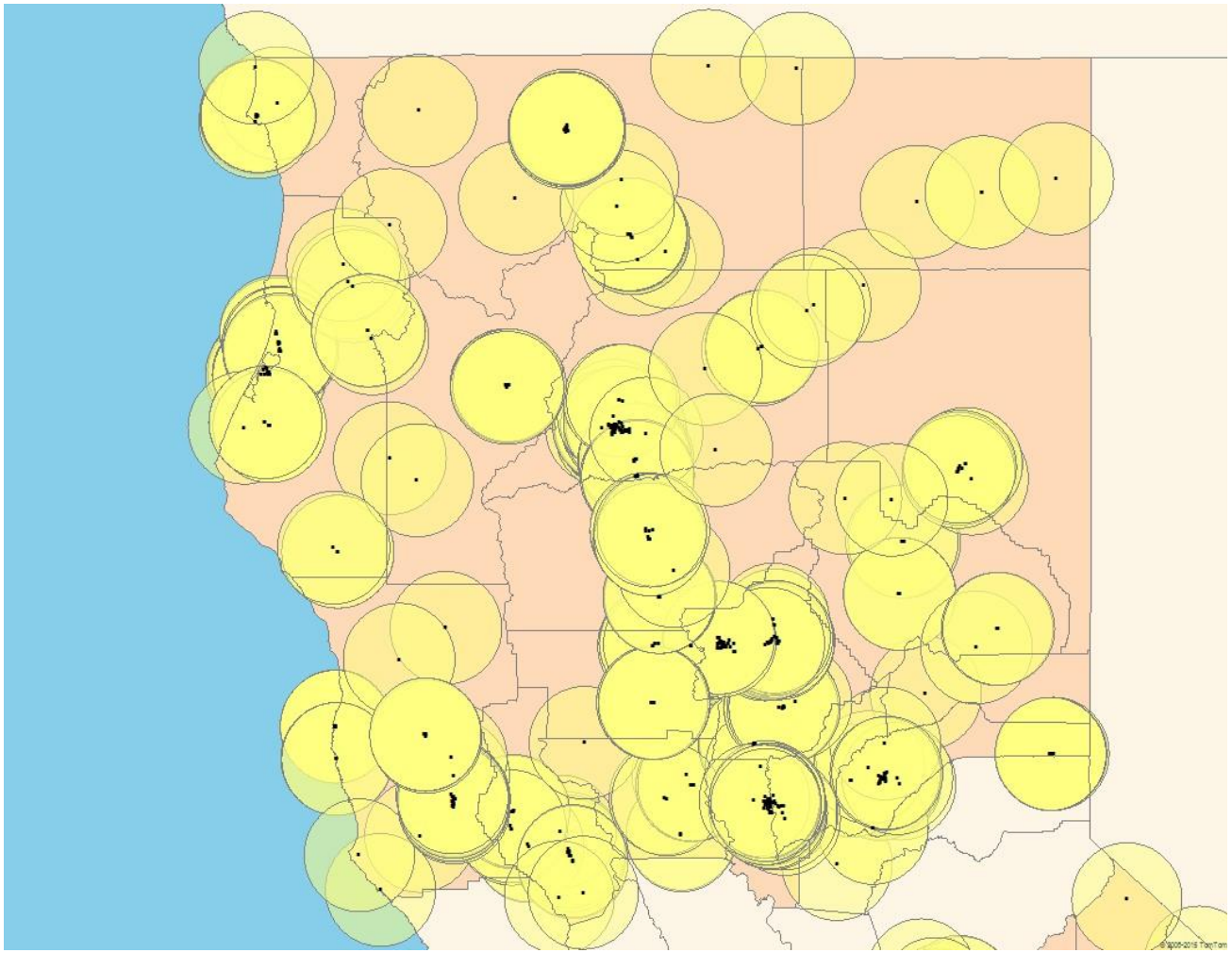


Provider Distributions



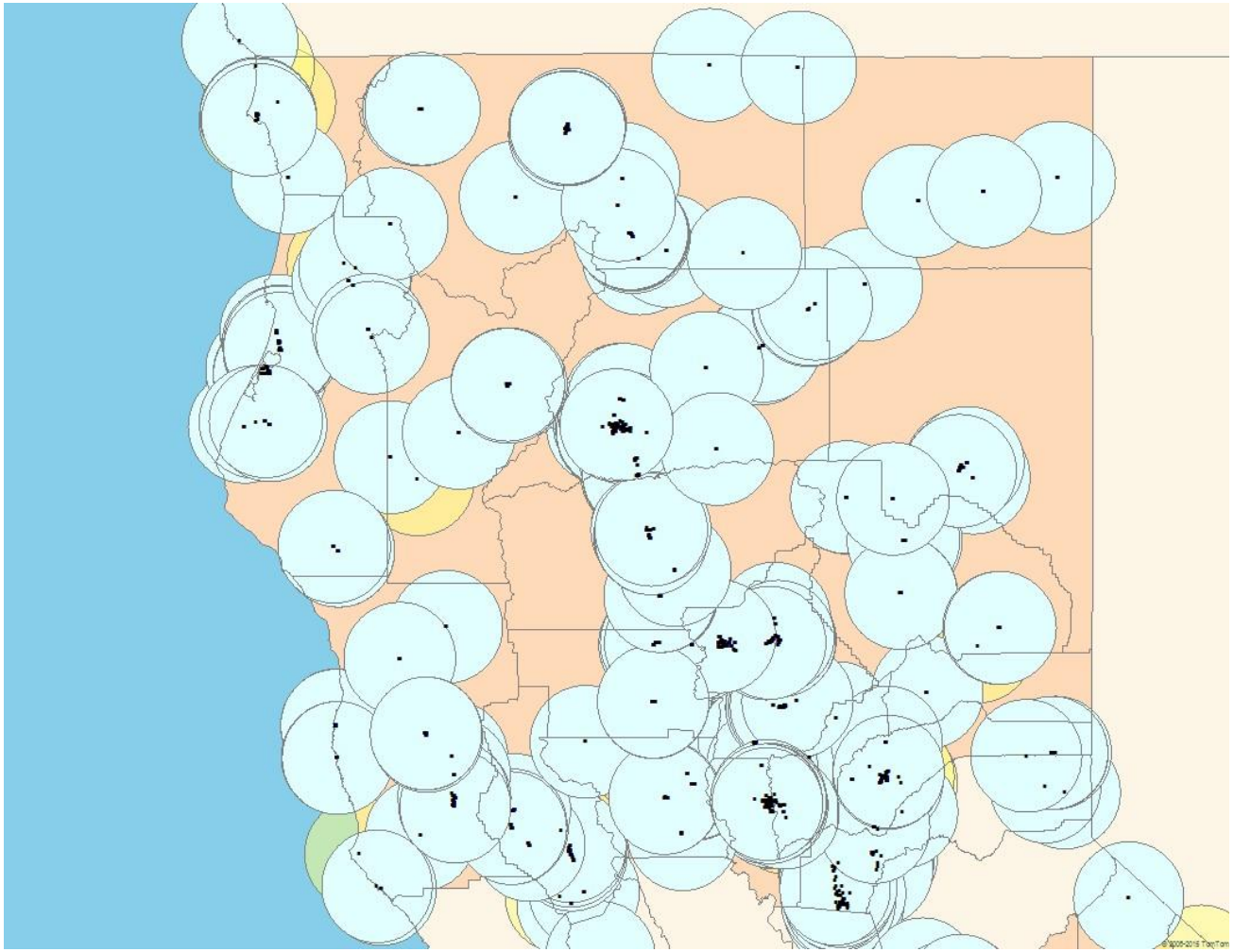
Provider Distributions

All PCPs in Region 1 Contracted with DMHC plans (2013)



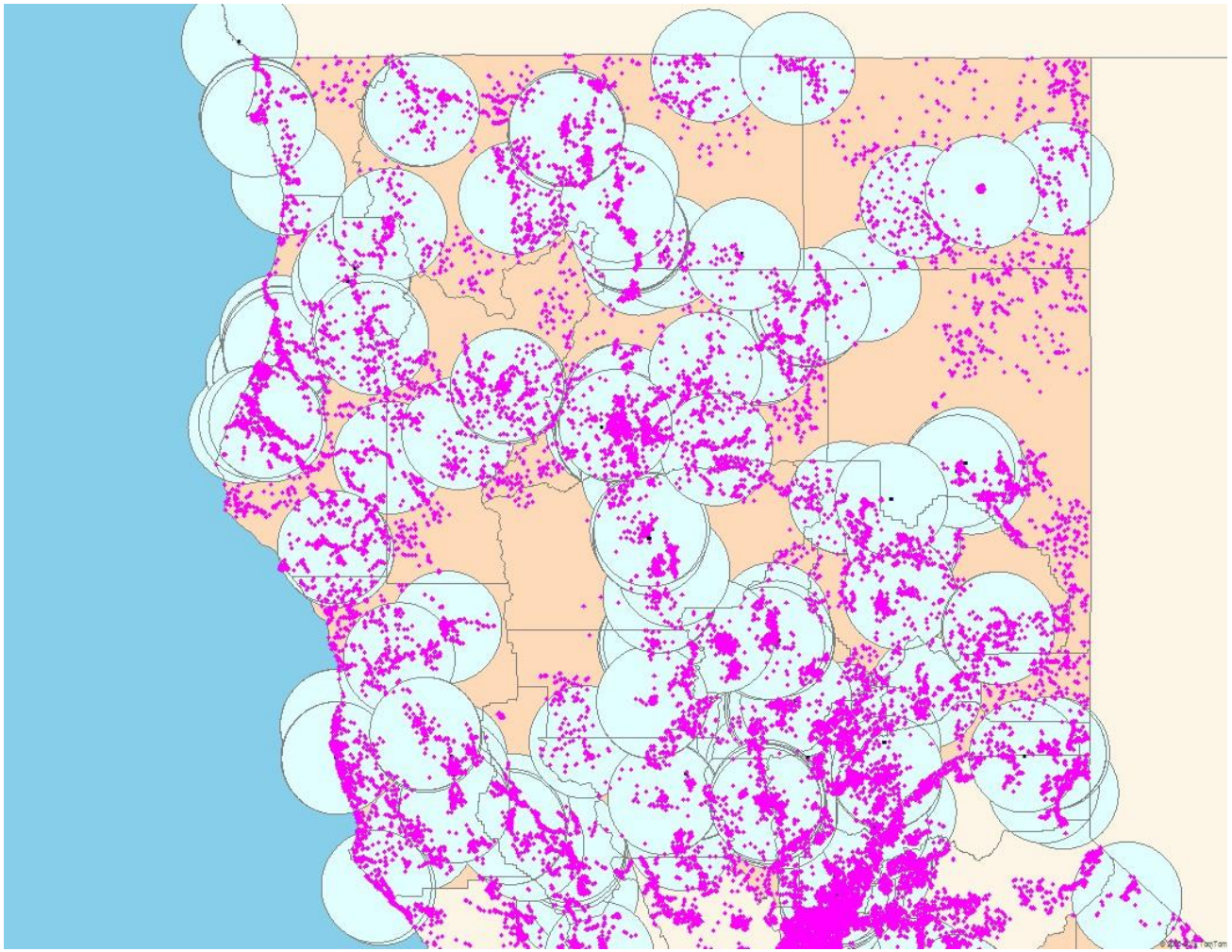
Provider Distributions

All PCPs in QHP Plans in Region 1 (2015)



Provider Distributions

All PCPs in QHP Plans in Region 1 with population (2015)



Provider Distributions

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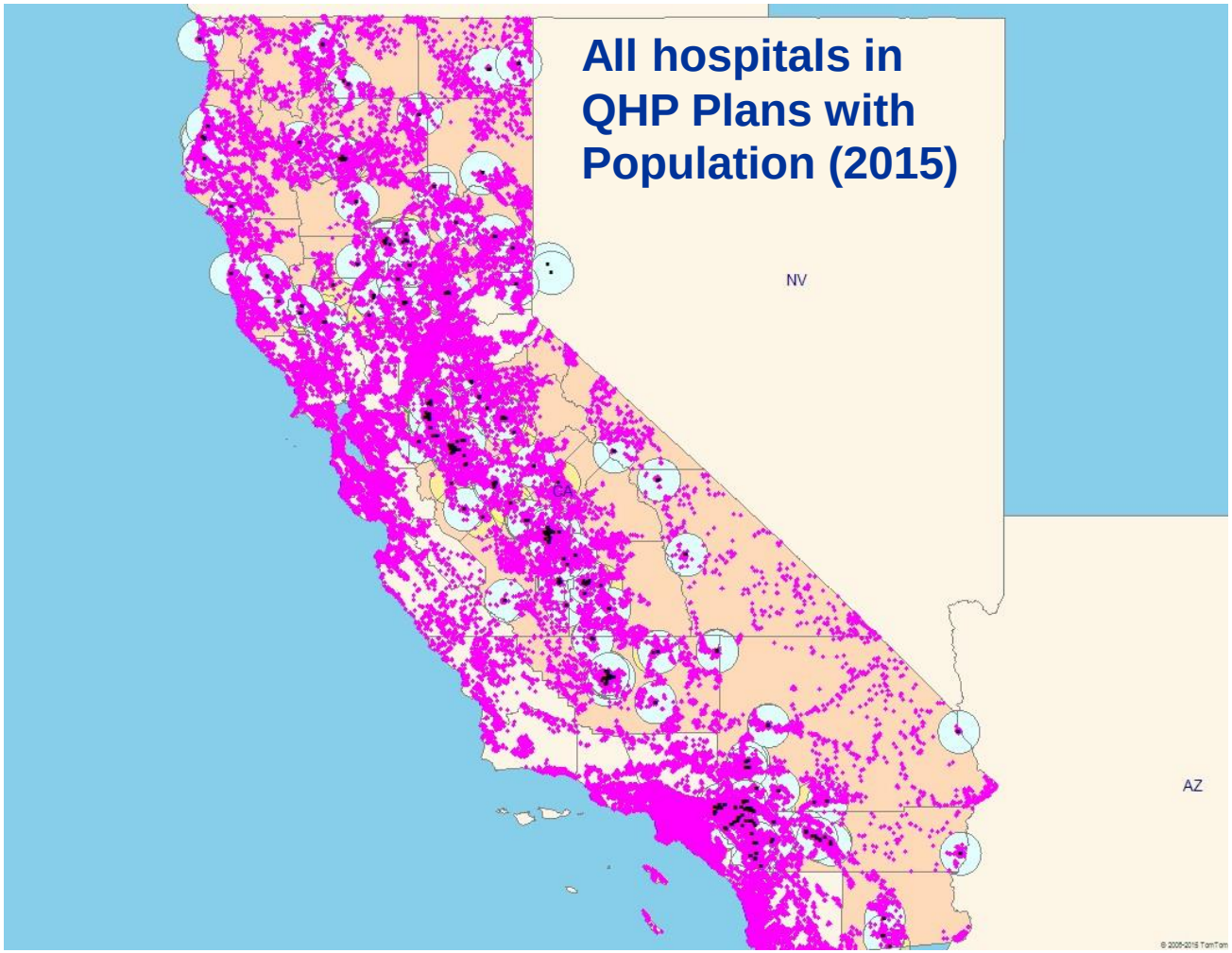
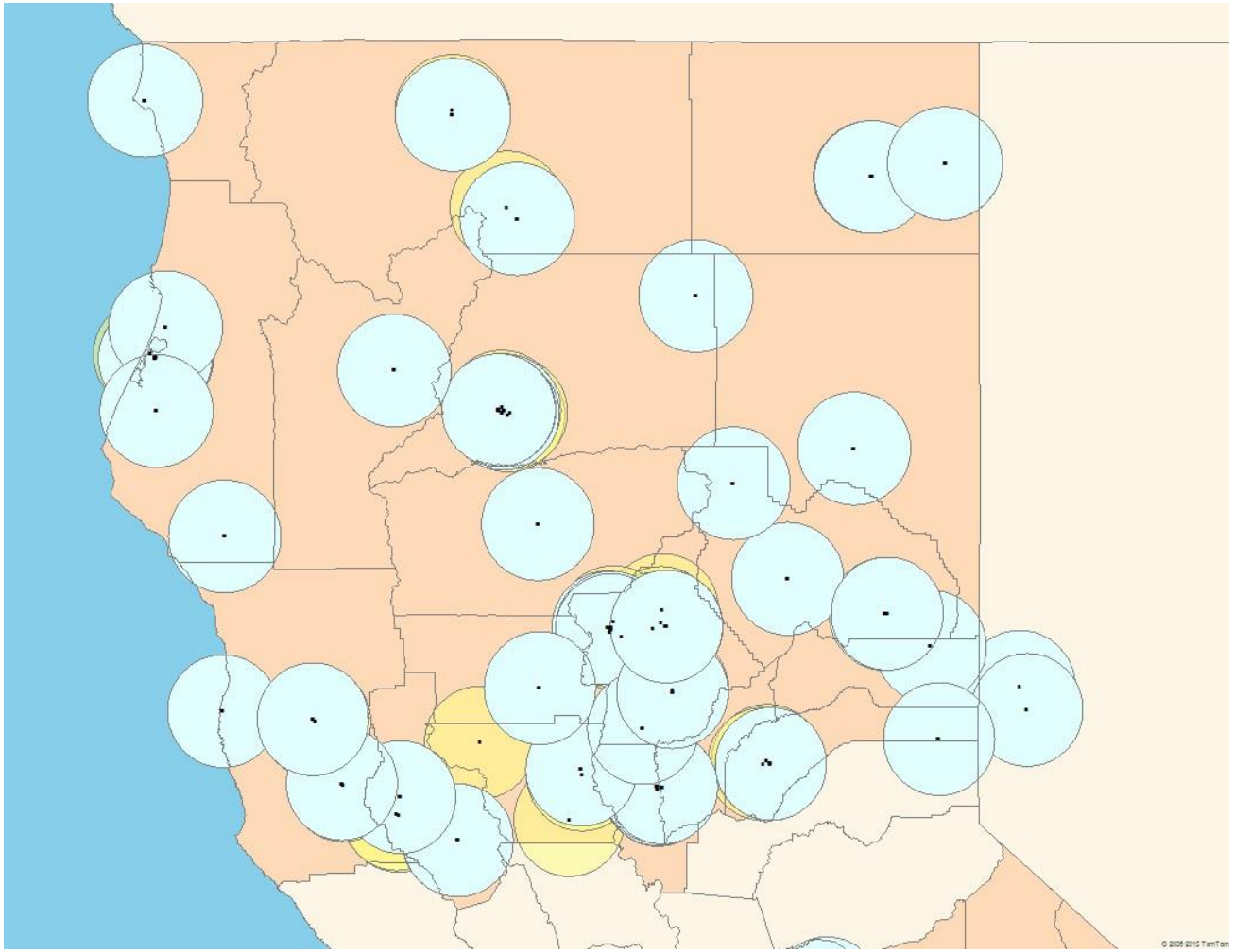


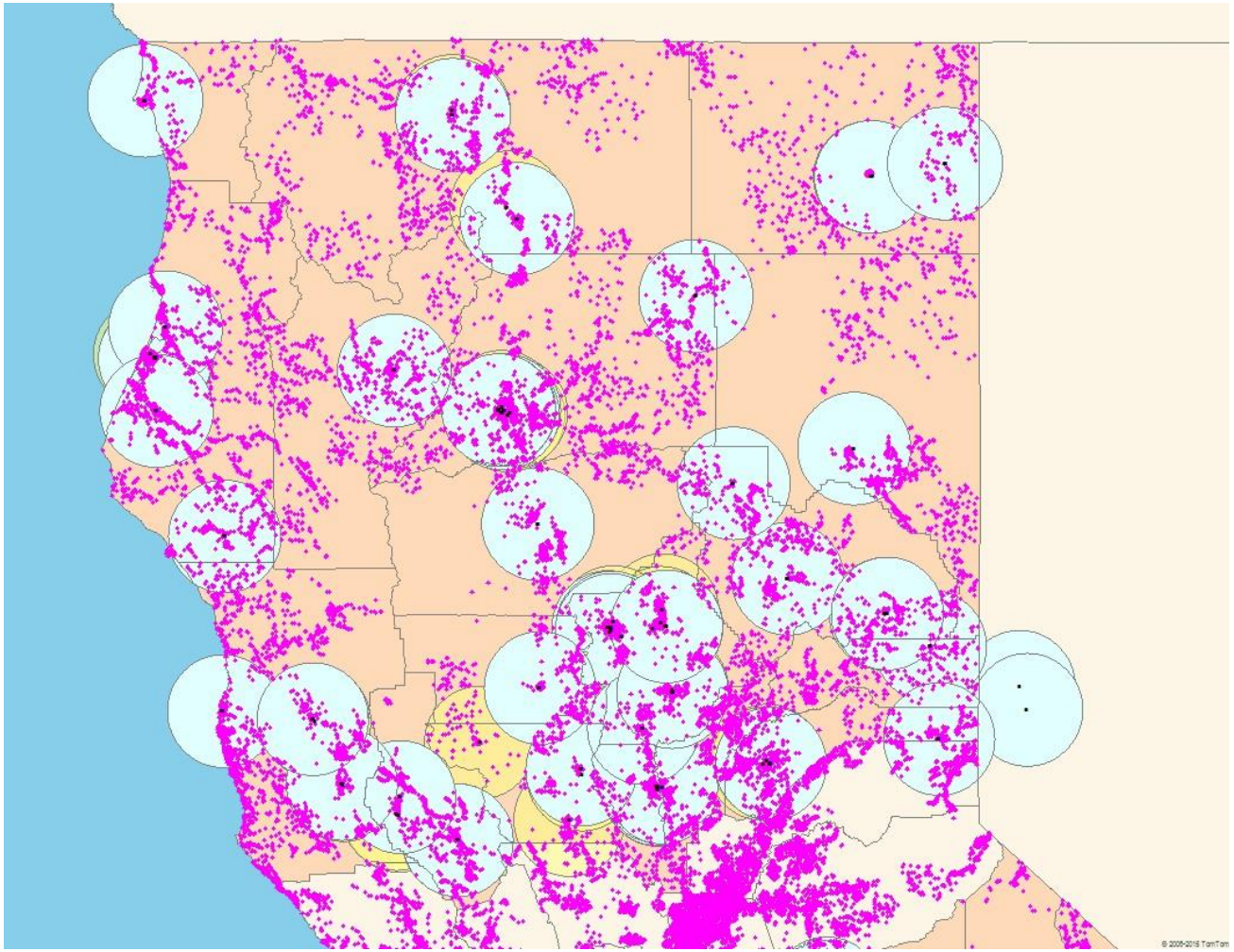
Provider Distributions

All Hospitals in QHP Plans in Region 1 (2015)



Provider Distributions

All Hospitals in QHP Plans in Region 1 with population (2015)



Provider Directories

- Health & Safety Code § 1367.26:
  - Provide provider listing to enrollee upon request
  - Identify open practices
  - Update quarterly
- SB 137 – proposed legislation

Questions?

- Please feel free to contact us

Kacey Kamrin
Senior Attorney, Office of Plan Licensing
Kacey.Kamrin@dmhc.ca.gov
916-324-9028

John Boskovich
Assistant Chief Counsel, Office of Plan Licensing
John.Boskovich@dmhc.ca.gov
916-255-5245

Rural Access Discussion

Recap from April 9th Meeting: Possible Solutions to Address Network Adequacy

Easy

- Update Directories
- Use of Social Networking to Promote Covered CA
- More Marketing of Silver Plan
- Promote local collaboration between health plans and providers

Not so Easy

- Align Covered CA and Medi-Cal Standards for Rural Networks
- Change the Model
- Reimbursement
- Pay for Performance

2016 CONTRACT UPDATE

BECKY THOMAS
MANAGER, CONTRACTS AND PLAN MANAGEMENT
COVERED CALIFORNIA PLAN MANAGEMENT DIVISON

2016 Contract - Reorganize and Restructure

Reorganize and Restructure in order to:

- *Allow provisions to be more readable and accessible*
- *Make necessary updates, limit substantive changes to those related to Covered CA policy, state and federal laws, requirements and clarifications*
- *Change contract metrics to match data and reporting requirement of the Enterprise Analytics System (EAS)*
- *Identify changes/improvements to be included in 2017 contract*
- *Finalize a revised 2016 contract by July 2015*

2016 CERTIFICATION AND RECERTIFICATION UPDATE

TAYLOR PRIESTLEY, PROGRAM ANALYST
COVERED CALIFORNIA PLAN MANAGEMENT DIVISON

Certification and Recertification Update

Proposed Recertification/Certification Timeline for Plan Year 2016 – INDIVIDUAL & SHOP	
ACTIVITY	PLAN YEAR 2016 DATE
Applications due: New Entrant QHPs and Recertifying QHPs and QDPs • Proposed rates due (Individual QHP effective 1/1/2016 & SHOP QHP effective 10/1/2015) • Networks due • SERFF Templates (5) & Supporting documentation due	MAY 1, 2015
Evaluation of New Entrant QHPs and Recertifying QHPs and QDP Applications and data (rates, networks, quality, contract compliance, reporting, analytics, enrollment)	MAY - JUNE 2015
Regulatory Review (non-rate)	MAY - SEPTEMBER 2015
Recertifying QHP Optional 4th Quarter SHOP Rate Updates Due	JUNE 1, 2015
QHP Negotiations	JUNE, 2015
QHP Rate Submissions 2ND Round	JUNE, 2015
Evaluation of SHOP QHP Alternate Benefit Designs	MAY-JUNE 2015
QDP Negotiations	JULY 6-10, 2015
Contingent QHP & QDP Recertification and New Entrant Certification complete (subject to regulatory review) & Public Announcement	JULY 2015
SHOP QHP Rates effective 1/1/2016 due	AUGUST 3, 2015
CalHEERS Load and Test QHP/QDP Plan Data	JUNE - SEPTEMBER 2015
Regulatory Rate Review – Individual QHP	AUGUST 1- SEPTEMBER 30, 2015
Final QHP/QDP Certification	SEPTEMBER 2015
QHP/QDP Contract Execution	SEPTEMBER 2015
Open Enrollment Period for 2016 Plan Year begins	NOVEMBER 1, 2015
SHOP QHP Rates filed with Regulators	OCTOBER 30, 2015

QUESTIONS, WRAP-UP, AND NEXT STEPS

JAMES DEBENEDETTI, DEPUTY DIRECTOR
COVERED CALIFORNIA PLAN MANAGEMENT DIVISION