PLAN MANAGEMENT ADVISORY GROUP

September 17, 2015

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
https://attendee.gotowebinar.com/register/3700058205961202433
Thursday, September 17, 2015, 10:00 a.m. to 11:00 p.m.

	September Agenda Items	Suggested Time
I.	Welcome and Agenda Review	10:00 - 10:05 (5 min.)
II.	Covered California Health Plan Quality Reporting 2015	10:05 - 10:20 (15 min.)
III.	Member Communications on Benefits	10:20 – 10:40 (20 min.)
IV.	Overview: Subcommittees for 2017 Certification/Recertification	10:40 - 10:45 (5 min.)
V.	Wrap-Up and Next Steps	10:45 – 10:50 (5 min.)

COVERED CALIFORNIA HEALTH PLAN QUALITY REPORTING, OPEN ENROLLMENT 2016

DR. LANCE LANG, CHIEF MEDICAL OFFICER
TED VON GLAHN, CONSULTANT

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Covered California Quality Ratings Overview

1. Covered California is the first Exchange in the nation to report health plan quality ratings and for Open Enrollment 3 (OE3), the quality ratings will be based on the experience of *Exchange* enrollees. No other marketplace is reporting Exchange specific quality ratings this year.

2. California consumers have more information to help them choose a health plan. Enrollees and prospective consumers, using a single performance rating, can compare quality across 11 individual market products and 6 small business products.

3. Covered California quality ratings capture consumer's overall experience with their health plan and their experiences with doctors, hospitals and other healthcare providers. Ideally, Covered California will expand the quality ratings to a larger number of topics in future years.

4. Quality, based on enrollee survey results, varies across plans. The top Covered California-performing plans are among the best nationwide. The lower performing plan is in the lowest quarter of all plans.

5. Covered California is working with plans whose quality rating score lags.

Recommended Quality Rating for 2016 Open Enrollment

- Report a single summary rating that is a roll-up of two CAHPS questions from the Enrollee Satisfaction Survey (ESS)
  1. global rating of health plan
  2. global rating of healthcare
- CMS linear mean scoring (1-10 scale) for the global ratings questions
- CMS case-mix adjustment formula
- All product type benchmarks (PPO, HMO, EPO, POS)
- Western region benchmarks to categorize performance
- 1-4-star performance ratings
- Confirmed that the final quality rating scores are accurately categorized

Quality Rating Based on Two Questions: Global Rating of Health Plan and Global Rating of Healthcare

- **Covered California did not use results from eight of the ten survey questions due to the following factors:**
  - Very low plan-level reliability due to smaller differences among plans
  - Low plan-level reliability due to small sample sizes
  - Low response rate for some products
- **The two global ratings questions distinguish plan performance with high reliability (low likelihood of error)**
  - Plan level reliability is very high for all plans for both of these questions
  - The completed sample size is above or slightly below 100 respondents for all plans except for one plan
- **The two questions capture more enrollee experience information than the single rating of plan item**
  - Enrollee's health plan and healthcare experiences overlap but these two dimensions also represent distinct aspects of overall experience

Quality Ratings Performance Distribution: Open Enrollment 2016 Compared to Open Enrollment 2015

Covered California Quality Rating Global Star Results	# Products	1 Star < 25th PCT	2 Star 25th-49th PCT	3 Star 50th-74th PCT	4 Star >74th PCT
Open Enrollment 2016 (10/15)	12[1, 2]	1	5	3	3
Open Enrollment 2015 (10/14)	10	0	3	3	4

Notes to Table:

[1] Includes 11 individual products and one CCSB-only product

[2] Two Health Net products and two New Entrant products do not have star ratings and are not included here

Implications for Quality Rating System Reporting Beginning October 2015

California plans performance is low relative to national benchmarks

- CMS plan is to use national benchmarks in QRS scoring for Fall 2016
- CMS to announce QRS roll-up scoring approach this fall – combines clinical and member experience measures

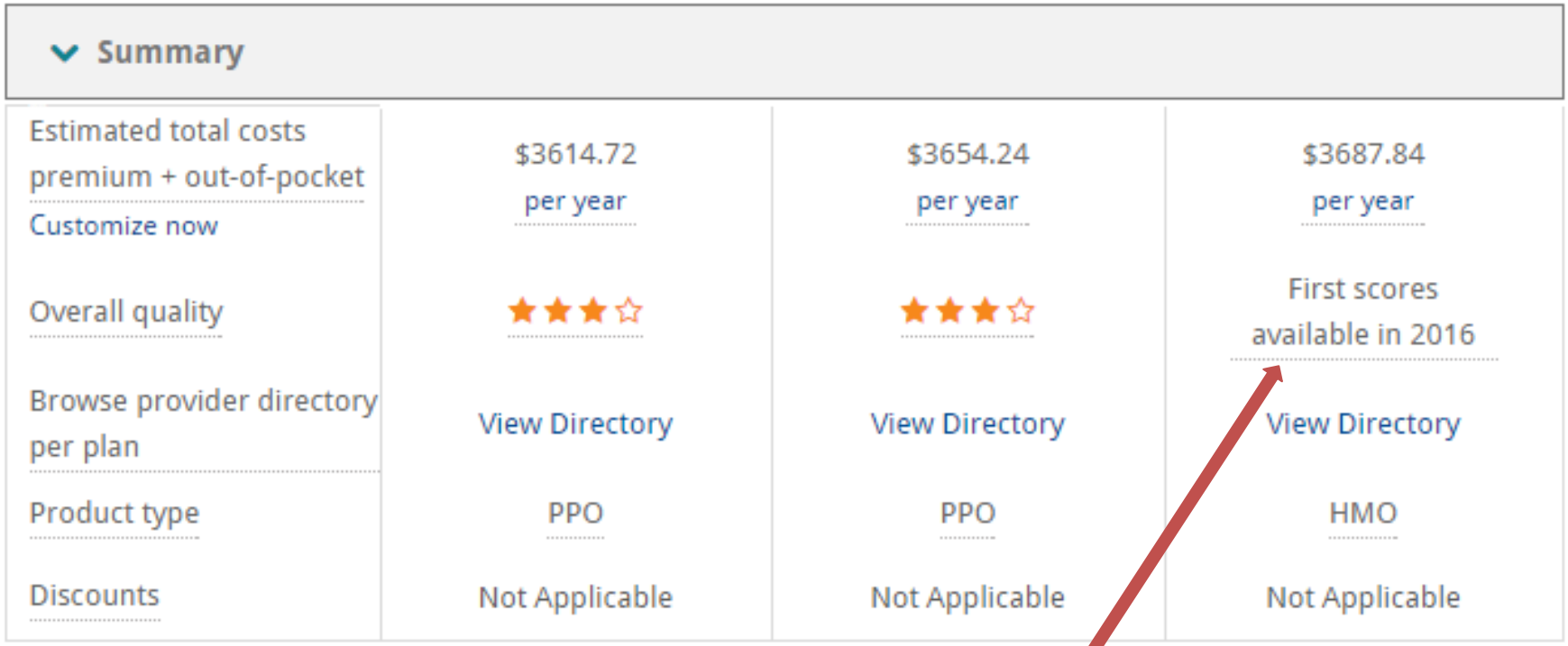
Survey response rates and completed respondent samples

- California response rate similar to national results (21.7% vs. 23.0%)
- Larger completed sample sizes will improve the reliability of the results, so more information can be used, but is unlikely to improve the performance levels

Next Steps

- Covered California will work with CMS and issuers on lessons learned from the 2015 beta test and how to improve methodology
- Consider additional analyses to evaluate if other factors are influencing survey results
- Assess additional survey results: care coordination, cultural competency, etc.
- CMS to provide quality improvement feedback to plans and Covered California in mid-October

CalHEERS Display



Summary

Estimated total costs premium + out-of-pocket Customize now	$3614.72 per year	$3654.24 per year	$3687.84 per year
Overall quality	★★★☆	★★★☆	First scores available in 2016
Browse provider directory per plan	View Directory	View Directory	View Directory
Product type	PPO	PPO	HMO
Discounts	Not Applicable	Not Applicable	Not Applicable

Display for products without a star rating

Timeline: Covered California Quality Reporting October 2016

Reporting Step	Date
Preliminary Findings Review	
Advisory Group	August 13
Board Meeting	August 20
OE 2016 Quality Star Ratings Results Review	
Health Plans	August 27
Advisory Group	September 17
Presentation to Board *(Carrier Specific Results)*	
October Board Meeting	October 8
Public Release	
Fact Sheets on www.hbex.coveredca.com	October 8
CalHEERS Release	October 12
Shop & Compare Release	October 12

APPENDIX

Evaluated ten questions: reliability & sample size

CAHPS Question	Reliability	N>100
Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to **rate your health plan** in the last 6 months?	↑	↑
Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to **rate the specialist**?	↓	↓
Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to **rate all your health care** in the last 6 months?	↑	↑
Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to **rate your personal doctor**?	↓	↓
In the last 6 months, when you needed care right away, how often did you **get care as soon as you needed**?	↓	↓
In the last 6 months, how often did you get an appointment for a **check-up or routine care** at a doctor's office or clinic as soon as you needed?	↑	↑
In the last 6 months, how often did you get an appointment to **see a specialist as soon as you needed**?	↓	↓
In the last 6 months, how often was it easy to get the **care, tests, or treatment** you needed?	↑	↑
In the last 6 months, how often did your health plan's **customer service** staff treat you with **courtesy and respect**?	↑	↓
In the last 6 months, how often did your health plan's **customer service** give you the **information or help you needed**?	↓	↓

Very low reliability due to smaller differences among plans and smaller sample sizes
Lower plan-level reliability due to smaller samples sizes

MEMBER COMMUNICATIONS ON BENEFITS

ALLISON MANGIARACINO & LINDSAY PETERSEN
HEALTH PROGRAM SPECIALIST II

Changes to 2016 Rate Book Based on Feedback

2016 STANDARD BENEFIT DESIGNS BY METAL TIER

MEDICAL COST SHARES				
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
Annual Wellness Exam	$0	$0	$0	$0
Primary Care Visit	$70*	$45	$35	$20
Specialty Care Visit	$90*	$70	$55	$40
Urgent Care Visit	$120*	$90	$60	$40
Emergency Room Facility	Full cost until out-of-pocket maximum is met	$250 once medical deductible is met	$250	$150
Laboratory Tests	$40	$35	$35	$20
X-Ray and Diagnostics	Full cost until out-of-pocket maximum is met	$65	$50	$40
Deductible	Individual: $6,000 medical $500 drug Family: $12,000 medical $1,000 drug	Individual: $2,250 medical $250 drug Family: $4,500 medical $500 drug	N/A	N/A
Annual Out-of-Pocket Maximum	$6,500 individual and $13,000 family	$6,250 individual and $12,500 family	$6,200 individual and $12,400 family	$4,000 individual and $8,000 family

Benefits shown in blue are not subject to a deductible.

**Copay is for any combination of the first three visits. After three visits, they will be at full cost until the out-pocket-maximum is met.*

DRUG COST SHARES — 30 DAY SUPPLY				
Generic Drugs (Tier 1)	up to $500, after deductible is met	$15 or less	$15 or less	$5 or less
Preferred Drugs (Tier 2)	up to $500, after deductible is met	$50 after drug deductible	$50 or less	$15 or less
Non-preferred Drugs (Tier 3)	up to $500, after deductible is met	$70 after drug deductible	$70 or less	$25 or less
Specialty Drugs (Tier 4)	up to $500, after deductible is met	20% up to $250 after drug deductible	20% up to $250	10% up to $250

2016 STANDARD BENEFIT DESIGNS BY INCOME

MEDICAL COST SHARES			
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 $17,655 (≤150% FPL)**	**$17,656 to $23,450 (>150% to ≤200% FPL)**	**$23,451 to $29,425 (>200% to ≤250% FPL)**
Annual Wellness Exam	$0	$0	$0
Primary Care Vist	$5	$15	$40
Specialist Visit	$8	$25	$55
Urgent Care Visit	$6	$30	$80
Laboratory Tests	$8	$15	$35
X-Rays and Diagnostics	$8	$25	$50
Imaging	$50	$100	$250
Deductible	Individual: $75 medical Family: $150 medical	Individual: $550 medical $50 drug Family: $1,100 medical $100 drug	Ind.: $1,900 medical $250 drug Family: $3,800 medical $500 drug
Annual Out-of-Pocket Maximum	$2,250 individual and $4,500 family	$2,250 individual and $4,500 family	$5,450 individual and $10,900 family
DRUG COST SHARES — 30 DAY SUPPLY			
Generic Drugs (Tier 1)	$3 or less	$5 or less	$15 or less
Preferred Drugs (Tier 2)	$10 or less	$20 after drug deductible	$45 after drug deductible
Non-preferred Drugs (Tier 3)	$15 or less	$35 after drug deductible	$70 after drug deductible
Specialty Drugs (Tier 4)	10% up to $150	15% up to $150 after drug deductible	20% up to $250 after drug deductible

Benefits shown in blue are not subject to any deductible.

- *Deductible added*
- *Separate table for prescription drugs*
- *All drug tiers shown and labeled with 2015 and 2016 names to avoid confusion*
- *Caps represented on tier 4 boxes as "up to $XXX"*
- *Bronze benefits that do not apply to deducible for first three visits are called out*

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http://www.coveredca.com/PDFs/7-27-CoveredCA-2016PlanRates-prelim.pdf

Changes to 2016 Shop and Compare Tool

Based on stakeholder feedback

- All drug tiers shown in benefits display with detailed labeling. Example: Tier 1 (Most Generics); Tier 2 (Preferred Brand).
- Cap represented (Platinum example: “10% up to $250 per script”).
- Text at the top of the plan and benefits details page reminds consumers to always confirm details by checking EOC.

Other changes effective 10/12/15

- Embedded pediatric dental benefits provider name added to QHP Plan Details page. For example, page will now say that Kaiser products include children’s dental benefits from Delta Dental.
- Add family dental plans: allow consumers to see customized plan selection and rate quotes by zip code and age.

All changes are in English and Spanish
Consumers can view 2014, 2015, and 2016 rates

Sample Changes to 2016 Shop and Compare Tool

STANDARD BENEFITS FOR INDIVIDUALS

Key benefits	Bronze 60
Individual Deductible	$6,000 medical deductible $500 pharmacy deductible
Family Deductible	$12,000 medical deductible $1,000 pharmacy deductible
Preventative Care Copay[1]	no cost
Primary Care Visit Copay	$70 [2]
Specialty Care Visit Copay	$90 [2]
Urgent Care Visit Copay	$120 [2]
Tier 1 (most generics) Drug Copay	100% up to $500 per script after deductible
Lab Testing Copay	$40
X-Ray Copay	100% of your plan's negotiated rate
Emergency Room Facility Copay	100% of your plan's negotiated rate
High cost and infrequent services (e.g. Hospital Stay)	100% of your plan's negotiated rate
Hospital Stay Physician Fee	100%
Tier 2 (preferred brand) Drug Copay after Pharmacy Deductible (if any)	100% up to $500 per script after deductible
Tier 3 (non-preferred brand) Drug Copay after Pharmacy Deductible (if any)	100% up to $500 per script after deductible
Tier 4 (specialty drugs) cost-share after Pharmacy Deductible (if any)	100% up to $500 per script after deductible
Maximum Out-of-Pocket For One	$6,500
Maximum Out-of-Pocket For Family	$13,000

[1] in-network only

[2] First 3 visits each year are not subject to the deductible

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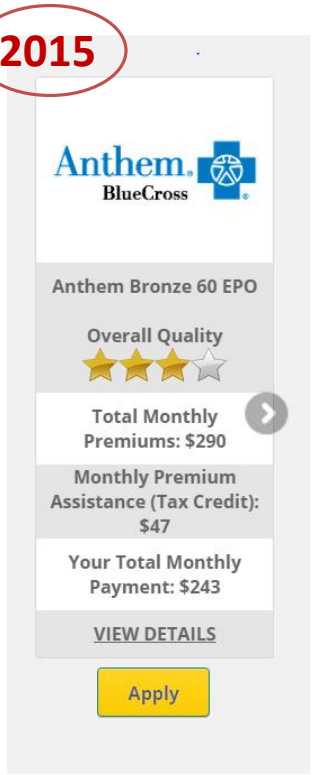
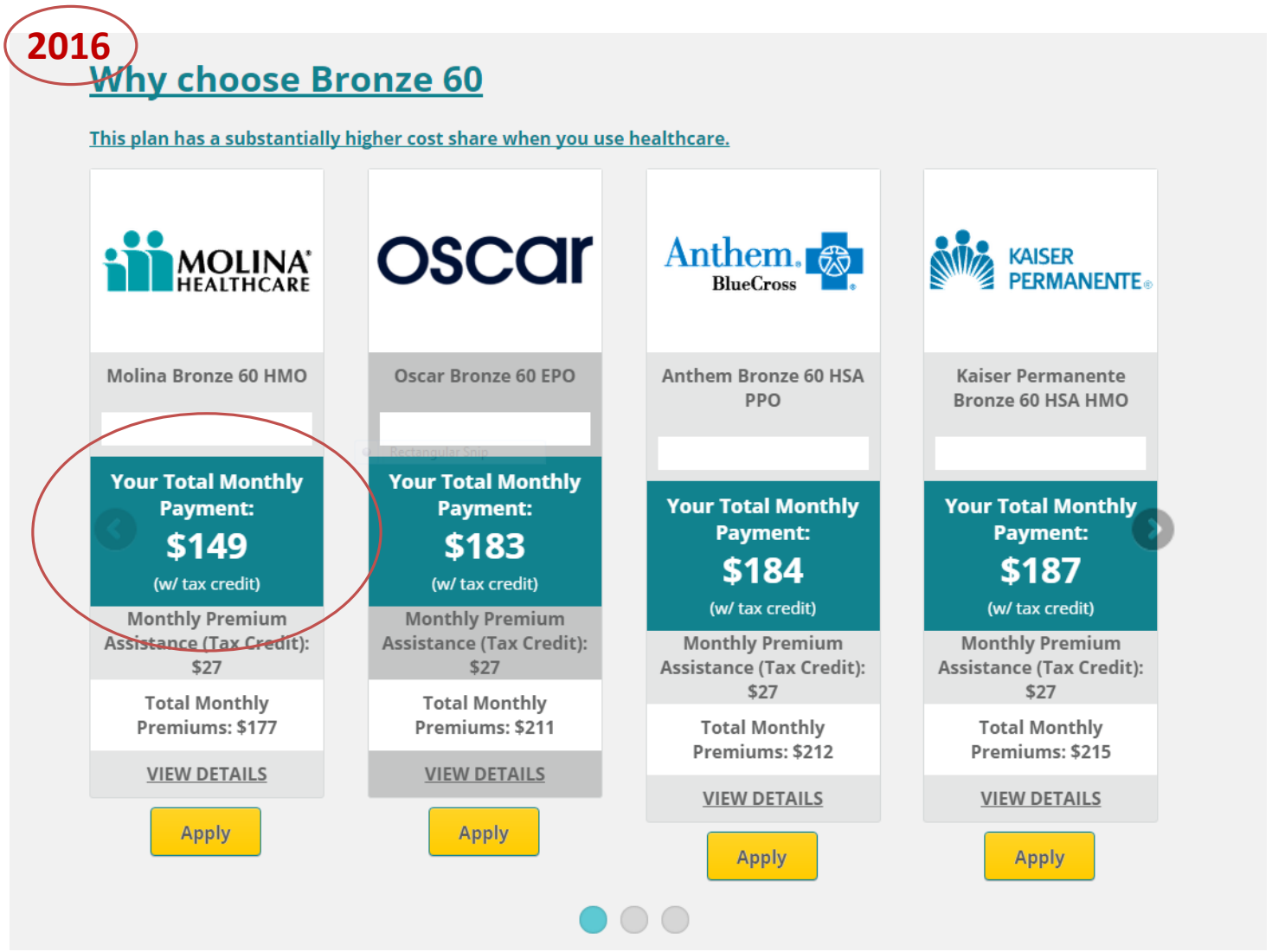
Sample Changes to 2016 Shop and Compare Tool





Proposed Changes to CoveredCA.com Glossary

Deductible: Typically, the amount of money you have to pay for your health care before your health insurance company will pay for the costs. In general, **premiums (monthly payments to your health plan) do not count toward the deductible. Some health plans cover certain services, like a doctor visit, before you fulfill the deductible. In this case, you would pay the copay amount for that service, and that copay does not count toward your deductible.**

Out of Pocket Maximum: The most money you will pay for your health care over an entire year. This amount includes deductible and costs of all health care. In general, **premiums (monthly payments to your health plan) do not count toward the Out of Pocket Maximum. Payment for services received out of your health plan network, or payment for services your plan does not cover, do not count toward the Out of Pocket Maximum. After you've paid the Out of Pocket Maximum, your health plan will cover all of your costs.** (Also referred to as Annual Out of Pocket Maximum, Maximum Out of Pocket, or Out of Pocket Limit.)

*Bold text represents common feedback

http://www.coveredca.com/glossary/

Please send additional suggestions for glossary updates or additions to ghp@covered.ca.gov and copy Hugh James at Hugh.James@covered.ca.gov

New Display on Covered California Prescription Drug Page

PRESCRIPTION DRUG COST SHARES									
Coverage Category	Bronze	Bronze HSA	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum	Catastrophic
	Covers 60% average annual cost	*Covers 60% average annual cost*	*Covers 70% average annual cost*	*Covers 73% average annual cost. Eligibility based on income and premium assistance.*	*Covers 87% average annual cost. Eligibility based on income and premium assistance.*	*Covers 94% average annual cost. Eligibility based on income and premium assistance.*	*Covers 80% average annual cost*	*Covers 90% average annual cost*	
Generic Drugs (Tier 1)	100% up to $500 per script	40%	$15	$15	$5	$3	$15	$5	0%
Preferred Drugs (Tier 2)	100% up to $500 per script	40%	$50	$45	$20	$10	$50	$15	0%
Nonpreferred Drugs (Tier 3)	100% up to $500 per script	40%	$70	$70	$35	$15	$70	$25	0%
Specialty Drugs (Tier 4)	100% up to $500 per script	40%	20% up to $250 per script	20% up to $250 per script	15% up to $150 per script	10% up to $150 per script	20% up to $250 per script	10% up to $250 per script	0%
PLAN FEATURES WHICH MAY APPLY									
Pharmacy Deductible	$500	N/A	$250	$250	$50	$0	N/A	N/A	N/A
Integrated Medical/Pharmacy Deductible	N/A	$4,500	N/A	N/A	N/A	N/A	N/A	N/A	$6,850
Medical Deductible	$6,000	N/A	$2,250	$1,900	$550	$75	N/A	N/A	N/A
Out-of-Pocket Maximum	$6,500	$6,500	$6,250	$5,450	$2,250	$2,250	$6,250	$4,000	$6,850

Must meet deductible first

Plan feature does not apply to the metal tier

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OVERVIEW: SUBCOMMITEES FOR 2017 CERTIFICATION AND RECERTIFICATION

JAMES DEBENEDETTI, DEPUTY DIRECTOR
COVERED CALIFORNIA PLAN MANAGEMENT DIVISION

QUALITY SUBCOMMITTEE WORK GROUP MEMBERS

Name	Representation	E-Mail
Stakeholder Members		
Beth Capell	Health Access California	bcapell@jps.net
Athena Chapman	California Association of Health Plans	achapman@calhealthplans.org
Betsy Imholz	Consumers Union	bimholz@consumer.org
Liz Helms	Chronic Care Coalition	lizhelms@chroniccareca.org
Tam Ma	Health Access California	tma@health-access.org
Cary Sanders	California Pan-Ethnic Health Network	CSanders@cpehn.org
Brent Barnhart	DMHC (former)	culver43@ymail.com
Health Plan Members		
Rosemary Jordan	Blue Shield	Rosemary.Jordan@blueshieldca.com
Francene Mori or designee	Anthem	francene.mori@anthem.com
Elaine Robinson-Frank	Health Net	Elaine.X.Robinson-Frank@healthnet.com
Sarah Summer	Blue Shield	Sarah.Summer@blueshieldca.com
Bill Wehrle	Kaiser	Bill.S.Wehrle@kp.org

Subcommittee Goal: Gain stakeholder input on how to integrate the following initiatives and areas into the 2017 QHP contract, with an eye for targeted improvements by 2020:

- State Workgroup on Reducing Overuse – Choosing Wisely
- CalSIM Maternity Care Initiative/California Maternal Quality Care Collaborative
- CMS Innovation Center: Payment Reform Models
- Tracking Hospital Safety – Partnership for Patients
- Transforming Clinical Practices - CMS Innovation Center
- Other areas: measure and reduce health disparities; decision support tools; support new integrated, coordinated care delivery models

BENEFITS AND NETWORKS WORK GROUP MEMBERS

Name	Representation	E-Mail
Stakeholder Members		
Beth Capell	Health Access California	bcapell@jps.net
Betsy Imholz	Consumers Union	bimholz@consumer.org
Jerry Jeffe	Chronic Care Coalition	jerry.jeffe@gmail.com
Jen Flory	Western Center on Law and Poverty	jflory@wclp.org
Michelle Lilienfeld	National Health Law Program	lilienfeld@healthlaw.org
Valerie Woolsey	BAART Programs	vwoolsey@baartprograms.com
Cary Sanders	California Pan-Ethnic Health Network	CSanders@cpehn.org
Brent Barnhart	DMHC (former)	culver43@ymail.com
Health Plan Members		
Francene Mori or designee	Anthem	francene.mori@anthem.com
Marcella Reeder	Blue Shield	Marcella.Reeder@blueshieldca.com
Amy Frith	Health Net	amy.m.frith@healthnet.com
Bill Wehrle	Kaiser	Bill.S.Wehrle@kp.org
Tim Rhatigan	United Healthcare	Tim.Rhatigan@uhc.com

Subcommittee Goal: Provide input to Covered California staff as we develop recommendations for the 2017 Standard Benefit Plan Design that are consistent with a multi-year progressive strategy with consideration for market dynamics

COVERED CALIFORNIA WORK GROUP MEMBERS

Name	Representation	E-Mail
Covered California Staff		
Anne Price*	Covered California	anne.price@covered.ca.gov
James DeBenedetti*	Covered California	james.debenedetti@covered.ca.gov
John Bertko	Covered California	john.bertko@covered.ca.gov
Lance Lang	Covered California	lance.lang@covered.ca.gov
Ahmed Al-Dulaimi	Covered California	ahmed.al-dulaimi@covered.ca.gov
Allison Mangiaracino	Covered California	allison.mangiaracino@covered.ca.gov
Lindsay Petersen	Covered California	lindsay.Petersen@covered.ca.gov
Taylor Priestley	Covered California	taylor.priestley@covered.ca.gov
**co-facilitators*		
Additional Resources		
Andrea Rosen	Covered California	andrea.rosen@covered.ca.gov
Barbara Brock	Covered California	barbara.brock@covered.ca.gov

WRAP UP AND NEXT STEPS

BRENT BARNHART, CHAIR

COVERED CALIFORNIA PLAN MANAGEMENT ADVISORY GROUP