PLAN MANAGEMENT ADVISORY GROUP

July 23rd, 2015

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
https://attendee.gotowebinar.com/register/3700058205961202433
Thursday, July 23rd, 2015, 10:00 a.m. to 12:00 p.m.

July Agenda Items	Suggested Time
I. Welcome and Agenda Review	10:00 – 10:05 (5 min.)
II. 2016 Contract Update	10:05 – 10:25 (20 min.)
III. Vision Offering	10:25 – 10:45 (20 min.)
IV. Analytics/EAS	10:45 – 11:15 (30 min.)
I. Reinsurance and Risk Adjustment	11:15 – 11:55 (40 min.)
II. Wrap-Up and Next Steps	11:55 – 12:00 (5 min.)

2016 CONTRACT UPDATE

ELISE DICKENSON, CONTRACT ANALYST
ALLISON MANGIARACINO, QUALITY ANALYST
COVERED CALIFORNIA PLAN MANAGEMENT DIVISION

2016 Contract – Overview of Changes

Recommended changes in the 2016 contract will not include major revisions to Qualified Health Plan requirements, but will include a re-organization of the contract to allow for more substantial changes in 2017 and the future

- Areas of focus for the contract reorganization include the following:
  - Contract was reorganized to make the provisions more readable and accessible and move requirements that will generally be updated annually to attachments to the contract
  - Make necessary updates such as year references, changes in federal or state regulations, correction of inaccuracies, and removal of any redundant language to provide better clarity
  - Identification of changes/improvements to be included in the 2017 contract
- Attachments 7 and 14 will have minor changes related to changes in Quality Rating Score (QRS) methodology, potential measurement and penalty/credit assessment of eValue8

2016 Contract Revisions Summary

- Formalized requirements of quarterly meetings between QHPs and Plan Management to review plan performance (Section 1.5)
- Updated contract provision related to enrollee notification of subsidy eligibility (Section 1.17)
- Formalized Issuer enrollment reconciliation process and timelines (Section 2.1.2)
- Formalized Agent of Record reconciliation process and timelines (Section 2.2.6)
- Marketing Sections updated for clarity; due dates (Section 2.4 and 2.5)

2016 Contract - Reorganize and Restructure

Highlights of Revisions (continued):

- Updated Section on Prescription Drugs based on 2016 approved Benefit Design (Section 3.2.6)
  - *Issuer shall post drug formularies on their website*
  - *Opt-out retail option for mail order drugs to allow consumers to receive in-person assistance at no additional cost*
  - *Issuer shall provide consumers with an estimate of range of costs for specific drugs*
  - *Issuer shall have a dedicated pharmacy customer service line for consumers and advocates to obtain clarification on formularies and consumer cost shares for drug benefits*
- Notice for Network Change modified for clarity (Section 3.3.2)
  - *Issuer shall notify the Exchange of any pending **material** change at least 60 days **prior** to any change or immediately upon Contractor's knowledge*
  - *Issuer shall ensure that Exchange enrollees have access to care when there are changes in the provider network*
- Definitions Section updated for consistency and clarity (Article 13)
- Moved list of Required Reports from Attachment 7 to new Attachment 13 – Required Reports

Covered California Holding Plans Accountable for Quality and System Reform: Attachments 7 and 14

- Attachment 7 in the Covered California QHP Contract sets forth the quality and performance requirements QHPs must satisfy to be a contracted health plan on the Exchange.

- Through the quality and delivery system standards in Attachment 7, Covered California aims to insure that consumers are enrolled in plans that are currently promoting, developing, and actively engaged in practices that meet the Exchange's "Triple Aim" framework of improving the care patients receive, improving population health, and reducing costs.

- Additionally, Attachment 7 identifies reporting requirements for quality and delivery system standards and specifies the data reporting requirements for the Enterprise Analytic System that will allow Covered California to use data to inform future policy changes

- Attachment 14 is the vehicle to hold QHPs accountable by setting targets and establishing penalty and/or credit assessments for the various performance and quality measures required in Attachment 7

Quality and Delivery System Reporting, 2012-2016

Covered California adopted the Pacific Business Group on Health (PBGH) eValue8™ survey for the initial assessment of health plan quality in the 2012 Solicitation and continues to use the tool for contract compliance reporting:

Assessment Type	Reporting Period	Reporting Tool	Scope	Performance Guarantee
2012 QHP Solicitation	2012	PBGH eValue8™	Full set of questions included in the PBGH eValue8™	N/A
2015 QHP Recertification	2014	PBGH eValue8™	Plans responded to a subset of questions related to accreditation, health disparities, and price transparency.	N/A
2014 QHP Contract	2015	Covered California-PBGH eValue8™ RFI	PBGH tailored the eValue8 survey to Covered California-specific quality and delivery system reform requirements in Attachment 7.	No
2015 QHP Contract	2016	Covered California-PBGH eValue8™ RFI	PBGH tailored the eValue8 survey to Covered California-specific quality and delivery system reform requirements in Attachment 7.	Yes
2016 QHP Contract	2017	Covered California-PBGH eValue8™ RFI	Plans to submit a subset of questions representing the identified areas of improvement mutually agreed upon between Covered California and each QHP.	Yes

Covered California Promoting Quality and Innovation

- The current requirements in Attachment 7 will not be changed in 2016 with the exception of methodology changes to the QRS scoring and moving the required reporting currently outlined in Attachment 7 to a new and separate Attachment that solely sets provisions for required reporting
- For Contract Year 2016, QHPs will be assigned a subset of eValue8 questions representing mutually-agreed upon areas of improvement.
- At a high-level, the quality and innovations requirements currently in Attachment 7 are the following:

    - Participation in collaborative quality initiatives
    - Accreditation by national quality assurance organization
    - **Reducing Racial/Ethnic disparities in health outcomes***
    - Use of data for quality improvement
    - Support for Health and Wellness
    - Ensure access and coordination of care including focus on those at high risk
    - **Support members with cost and quality information***
    - Promote new models of care such as medical homes and accountable care organizations
    - Support new payment models that promote value

- Attachment 14 measures will be updated as appropriate to account for the minor changes noted above to QRS and eValue8

*Targeted areas of improvement for 2016 for *all* plans

2016 and Beyond: Covered California Moving from Assessment to Improvement for Holding Plans Accountable

For 2017, Covered California will be updating Attachment 7 in ways that may be more prescriptive and focus effort in targeted areas of improvement and alignment in similar innovations of other large purchasers. Covered California is considering the following changes and will engage in discussion in the coming months

- Continuing a targeted focus on QHP-specific areas of improvement and using eValue8 as the reporting mechanism

- Two targeted areas of improvement for *all* QHPs:
  - Reducing Racial/Ethnic disparities in health outcomes
    - Consider making NCQA recognition for MultiCultural Health Care a requirement
    - Track select HEDIS Scores by racial/ethnic group
    - Demonstrate narrowed disparity in scores
    - Continue to develop Essential Community Provider networks

  - Decision Support for Treatment/Provider Selection
    - Use of benefit information to support member estimate of cost sharing
    - Price transparency for procedures and episodes of care
    - Variation in quality outcomes

Please send comments, reactions, and suggestions to:
Allison.Mangiaracino@covered.ca.gov

Covered California: Promoting Collaboration to Improve Care for all Californians

The following are some core principles for “Raising the Bar” on collaborative performance improvement and some examples of specific projects that Covered California is considering encouraging or requiring health plans to participate in

- Select a narrow number of initiatives to drive more focused and concentrated effort to support change of healthcare delivery that benefits all California consumers

- Participate in projects that align with improvement sponsored by other purchasers
  - California State Innovation Model (CalSIM)
  - CalPERS, Medi-Cal, and PBGH
  - Center for Medicare and Medicaid Innovation (CMMI)

- Examples of current projects where Covered California can potentially promote and align carrier participation in 2016 and beyond:
  - Reduce Overuse through “Choosing Wisely”
  - CalSIM Maternity Project
  - Payment Reform Models from CMMI
  - Hospital Safety, Partnership for Patients
  - Clinical Practice Transformation (CMMI Awards July 2015)

Please send comments, reactions, and suggestions to: Allison.Mangiaracino@covered.ca.gov

Covered California Health Plan 2016 Contract Timeline

ACTIVITY	DATE
Reorganize 2016 Contract	APRIL 2015
2016 Contracting Strategy Shared at Plan Advisory Meeting	MAY 2015
Qualified Health Plan Contract Review and Comments	MAY 2015
Stakeholder opportunity to provide comments on 2015 Contract	MAY 2015
Covered California Internal Review and Comments	JUNE 2015
2nd Plan Advisory Meeting - Update	JULY 2015
Health Plan and Stakeholder Review and Comments	JULY 2015
2016 Contract Update and Highlight of Revisions to the Covered CA Board	AUGUST 2015
2016 Final Contract to Health Plans for signature	SEPTEMBER 2015

Covered California Health Plan 2017 Contract Timeline – Quality Revisions

ACTIVITY	DATE
2017 Contracting Strategy Shared with Plan Advisory – Solicit Comments and Suggestions	JULY 2015
Covered California Meetings with Qualified Health Plans	AUGUST 2015
Develop Potential Recommendations for 2017 Contract	SEPTEMBER – OCTOBER 2015
Plan Advisory Meeting to Share Potential Recommendation – Solicit additional Input and Comments	OCTOBER 2015
2017 Contract Recommendation to the Covered CA Board	OCTOBER 2015
2017 Contract Approval from the Covered CA Board	NOVEMBER 2015
2017 Contract Requirments incorporated into 2017 Certification/Recertification	DECEMBER 2015 – JANUARY 2016

VISION OFFERING

JAMES DEBENEDETTI, DEPUTY DIRECTOR
COVERED CALIFORNIA PLAN MANAGEMENT DIVISION

Vision Offering - Overview

- Adult vision plans are not Essential Health Benefits (EHB), and therefore not Qualified Health Plans (QHP) under the Affordable Care Act (ACA)

- Revenue generated from QHPs cannot be used for non-QHP programs

- This prevents the use of Covered California resources (staff, consultants, etc.) to manage a vision plan program

Proposal For Discussion Purposes

- Covered California's Role
  - Provide link(s) to vendor's website
  - Limited oversight
  - No standardized benefits
  - No enrollee assistance from Covered California
- Request For Proposal (RFP) Criteria
  - Licensed in good standing
  - Minimum size (enrollment)
  - Minimal contract terms
- Implementation Steps
  - Link to vision plan website(s) from CoveredCA.com (no CalHEERS integration)
  - Potential revenue generation – for program development in future years
    - RFP application fee
    - Commissions for enrollment generated by CoveredCA.com

Implementation Timeline

This timeline is subject to change, depending on competing priorities

- August Board meeting – seek approval to conduct an RFP
- September – release RFP
- October – evaluate RFP responses
- November – link to approved vendors from CoveredCA.com

ANALYTICS/EAS

KATIE RAVEL

DIRECTOR, POLICY, EVALUATION & RESEARCH

COVERED CALIFORNIA HEALTHCARE EVIDENCE INITIATIVE:

Leveraging data to lower costs, expand access and improve care

HEALTHCARE EVIDENCE INITIATIVE: DISCUSSION ITEMS

- Introduction to Covered California
- The Covered California Healthcare Evidence Initiative
- Consumer privacy
- Data and tools
- Key areas of focus
- Continuous improvement timeline
- Feedback

Covered California's Promise:

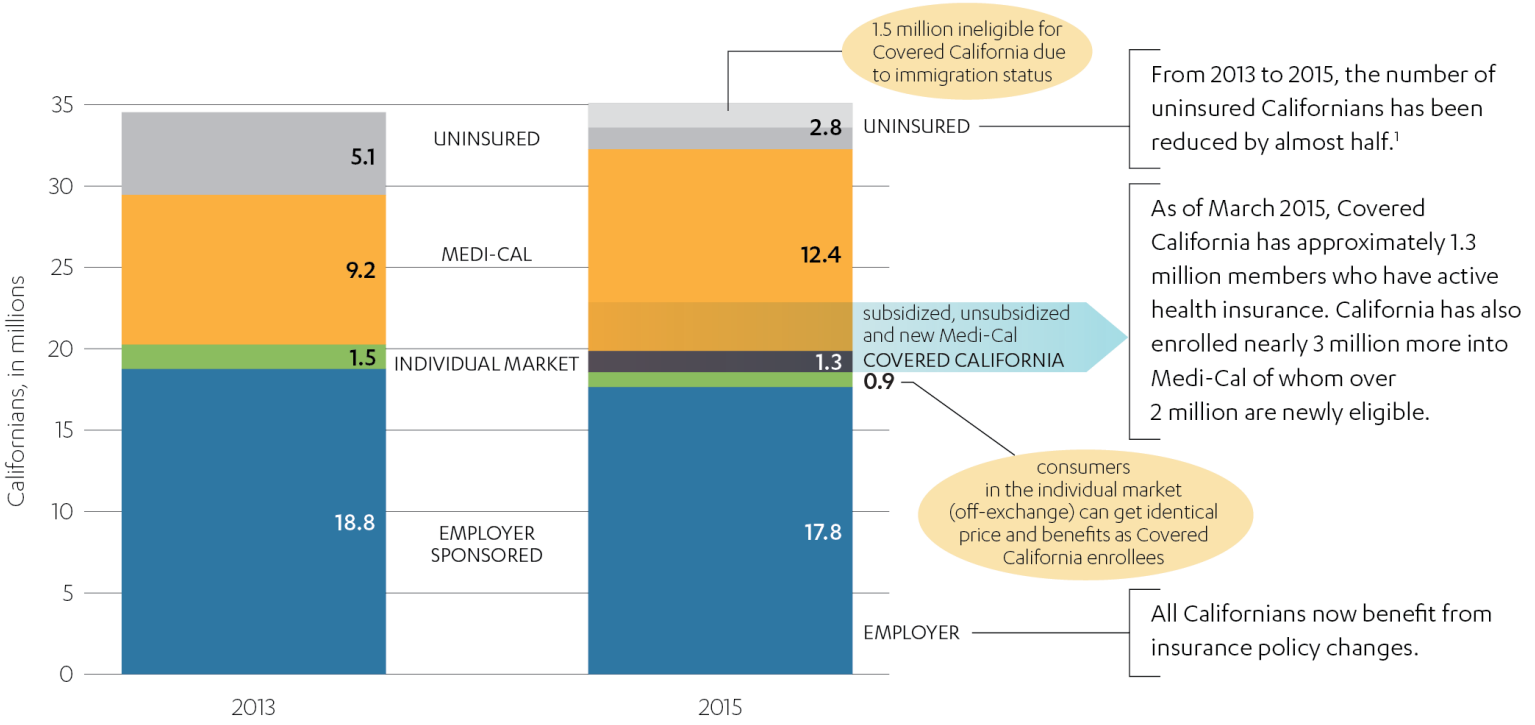
- Better Care
- Healthier People
- Lower Cost

How Covered California Makes the Promise Real:

BEING AN **ACTIVE PURCHASER**	OFFERING **AFFORDABLE PRODUCTS**	EFFECTIVELY **REACHING AND ENROLLING CONSUMERS**	ENCOURAGING **THE RIGHT CARE AT THE RIGHT TIME**

The Affordable Care Act Has Changed Health Care in California

The Affordable Care Act has dramatically changed the health insurance landscape in California with the expansion of Medicaid, Covered California and new protections for all Californians.



Source: Data shown in above graph is from: California Health Benefits Review Program, Center for Medicare and Medicaid Services, California Healthcare Foundation and Covered California (May 2015).

Notes: Medicare recipients and other publicly funded insured are not included in the graph.

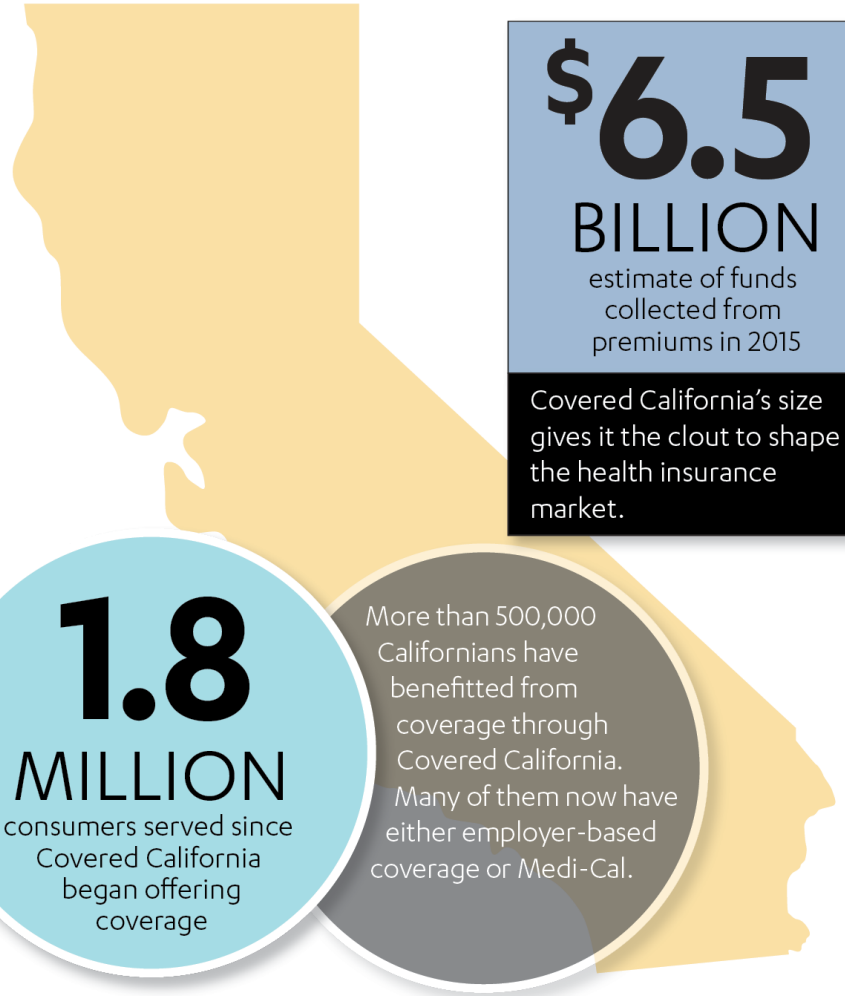
[1] http://www.commonwealthfund.org/publications/press-releases/2014/jul/after-first-aca-enrollment-period

Covered California is Big and Having Big Impacts

It is now one of the largest purchasers of health insurance in California and the nation.

1.3 MILLION
consumers have active health insurance as of March 2015

Covered California is now the second largest purchaser of health insurance in the state for those under 65.



$6.5 BILLION
estimate of funds collected from premiums in 2015

Covered California's size gives it the clout to shape the health insurance market.

1.8 MILLION
consumers served since Covered California began offering coverage

More than 500,000 Californians have benefitted from coverage through Covered California. Many of them now have either employer-based coverage or Medi-Cal.

Covered California Health Plan Offerings for 2015: Broad Choice, Local Options and Good Trend

PRICING REGION	ANTHEM	BLUE SHIELD	CHINESE COMMUNITY HEALTH PLAN	HEALTH NET	KAISER PERMANENTE	L.A. CARE HEALTH PLAN	MOLINA HEALTHCARE	SHARP HEALTH PLAN	VALLEY HEALTH PLAN	WESTERN HEALTH ADVANTAGE
1 Northern counties	●	●			●					
2 North Bay Area	●	●		●	●					●
3 Greater Sacramento	●	●			●					●
4 San Francisco County	●	●	●	●	●					
5 Contra Costa County	●	●		●	●					
6 Alameda County	●	●			●					
7 Santa Clara County	●	●		●	●				●	
8 San Mateo County	●	●	●	●	●					
9 Santa Cruz, San Benito, Monterey	●	●		●						
10 Central Valley	●	●		●	●					
11 Fresno, Kings, Madera counties	●	●			●					
12 Central Coast	●	●			●					
13 Eastern counties	●	●			●					
14 Kern County	●	●		●	●					
15 Los Angeles County, partial	●	●		●	●	●	●			
16 Los Angeles County , partial	●	●		●	●	●	●			
17 Inland Empire	●	●		●	●		●			
18 Orange County	●	●		●	●					
19 San Diego County	●	●		●	●		●	●		

2015 AVERAGE RATE INCREASE OF 4.2%

Covered California 2015 Standard Benefit Designs

In California, standard benefits allow apples-to-apples plan comparisons and seek to **encourage** utilization of the right care at the right time with many services that are not subject to a deductible.

Benefits below shown in blue are not subject to any deductible.

2015 STANDARD BENEFIT DESIGN BY METAL TIER								
Coverage Category	Minimum Coverage	Bronze	Enhanced Silver **94**	Enhanced Silver **87**	Enhanced Silver **73**	Silver	Gold	Platinum
Percent of cost coverage changes	Covers **0%** until out-of-pocket maximum is met	Covers **60%** average annual cost	Covers **94%** average annual cost	Covers **87%** average annual cost	Covers **73%** average annual cost	Covers **70%** average annual cost	Covers **80%** average annual cost	Covers **90%** average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	**up to $17,235** (100% to ≤150% FPL)	**17,236 to $22,980** (>150% to ≤200% FPL	**$22,981 to $28,725** (>200% to ≤250% FPL)	N/A	N/A	N/A
Annual Wellness Exam	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Vist	after first 3 non-preventive visits, pay negotiated carrier rate per instance until out-of-pocket maximum is met	$60 for first 3 non-preventive visits	$3	$15	$40	$45	$30	$20
Specialist Visit	pay negotiated carrier rate per service until out-of-pocket maximum is met	$70 after deductible is met	$5	$20	$50	$65	$50	$40
Laboratory Tests		30% after deductible is met	$3	$15	$40	$45	$30	$20
X-Rays and Diagnostics		30% after deductible is met	$5	$20	$50	$65	$50	$40
Generic Drugs		$15 or less after deductible is met	$3	$5	$15 or less	$15 or less	$15 or less	$5 or less
Preferred Drugs		$50 after deductible is met	$5	$15	$35	$50	$50	$15
Emergency Room		$300 after deductible is met	$25	$75	$250	$250	$250	$150
Imaging		30% after deductible is met	10%	15%	20%	20%	20%	10%
Deductible	N/A	$5,000	$0	$500 medical $50 brand drugs	$1,600 medical $250 brand drugs	$2,000 medical $250 brand drugs	$0	$0
Annual Out-of-Pocket Maximum Individual and Family	$6,600 individual only	$6,250 individual $12,500 family	$2,250 individual $4,500 family	$2,250 individual $4,500 family	$5,200 individual $10,400 family	$6,250 individual $12,500 family	$6,250 individual $12,500 family	$4,000 individual $8,000 family

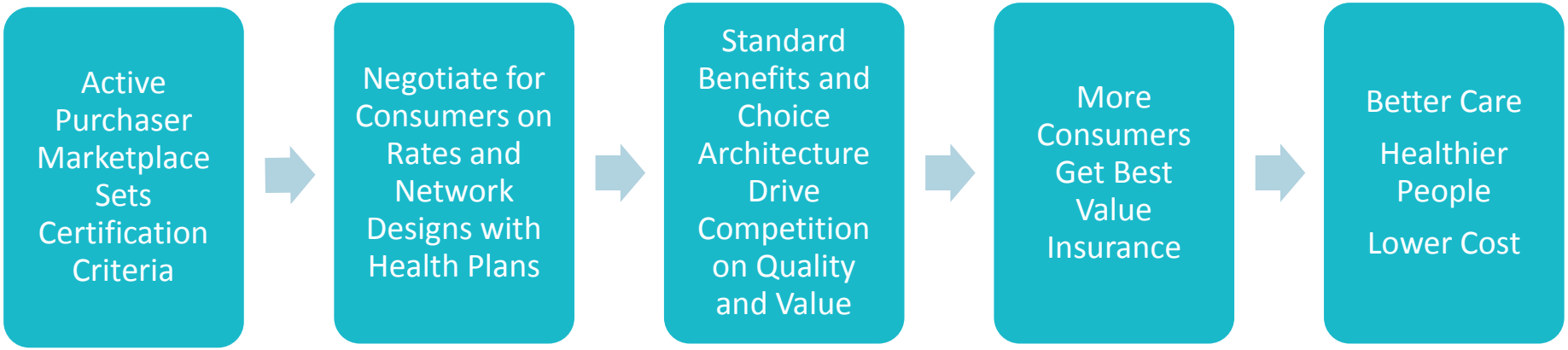
HEALTHCARE EVIDENCE INITIATIVE: PURPOSE

The Healthcare Evidence Initiative will use utilization and claims data to:

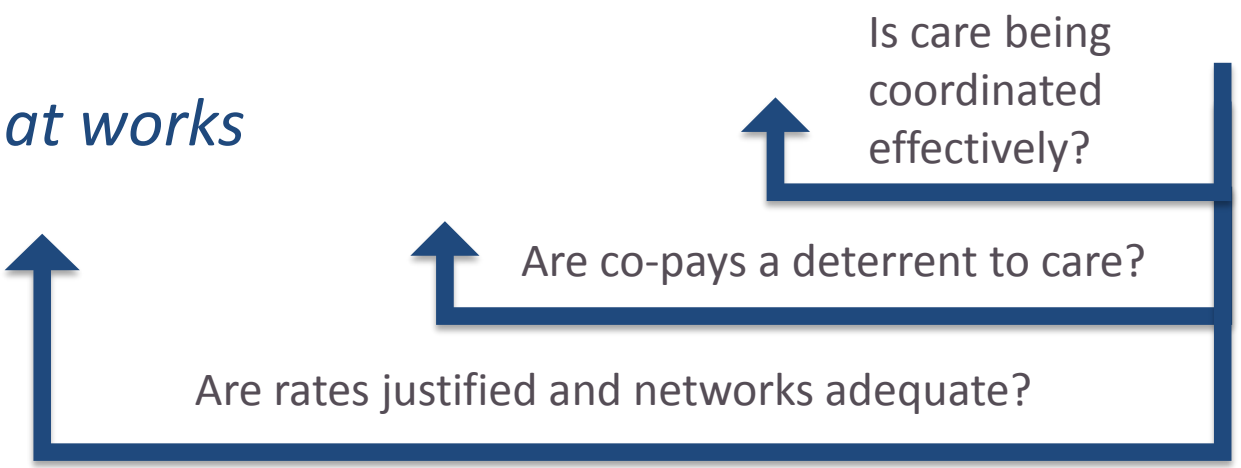
1. Provide actionable information supporting Covered California's operations and policy – improving care, lowering costs, and improving health.
2. Provide evidence to inform public and private policies so that purchasing strategies and benefit designs can improve quality, access, and value throughout the health care delivery system.

HEALTHCARE EVIDENCE INITIATIVE: ACTIVE PURCHASER MODEL

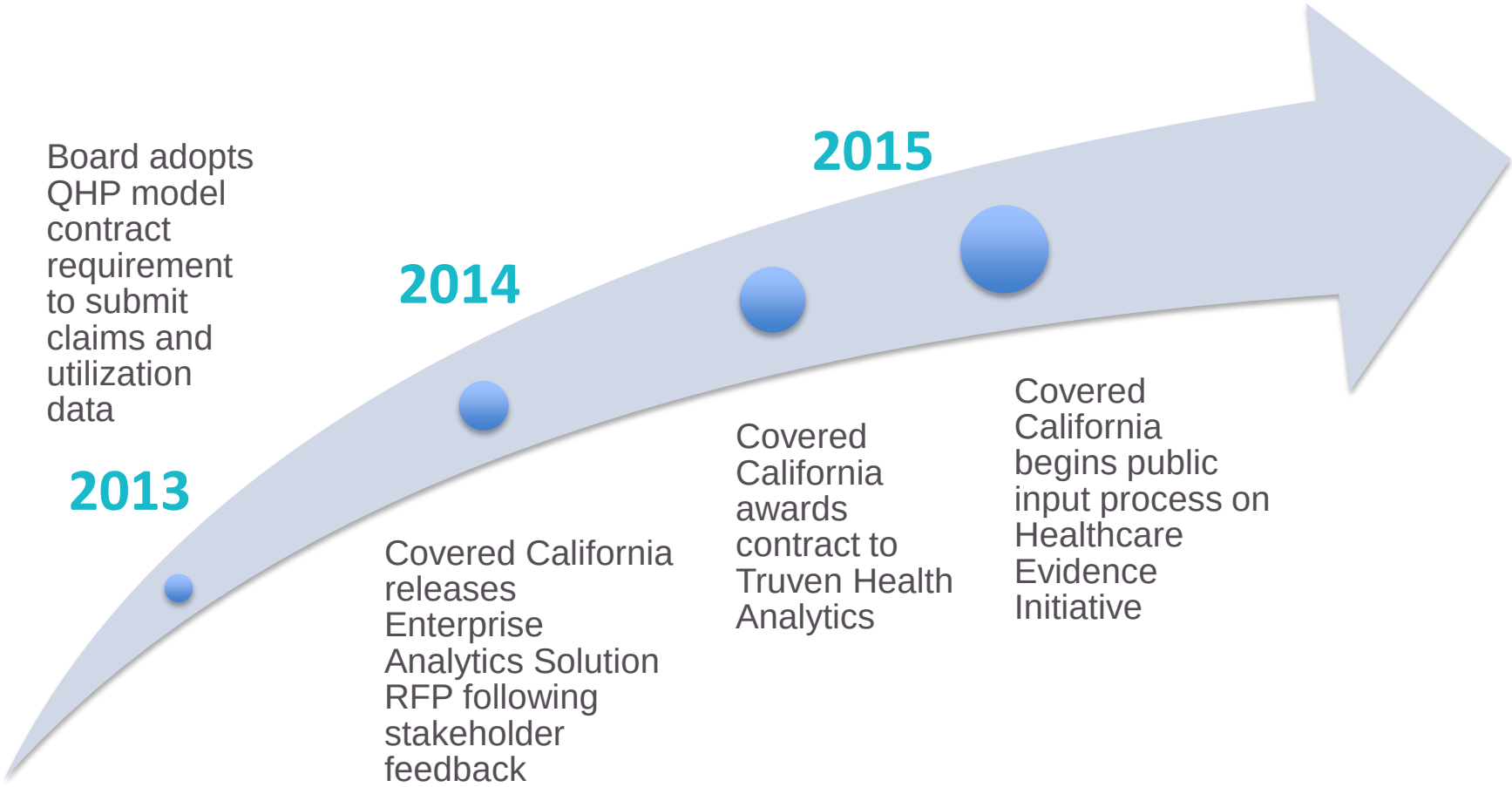
Covered California is not simply a place to enroll in coverage, but an active purchaser with a mission to improve quality, access and value for all consumers.



Evidence for *what works*



HEALTHCARE EVIDENCE INITIATIVE: RECAP OF MILESTONES TO DATE

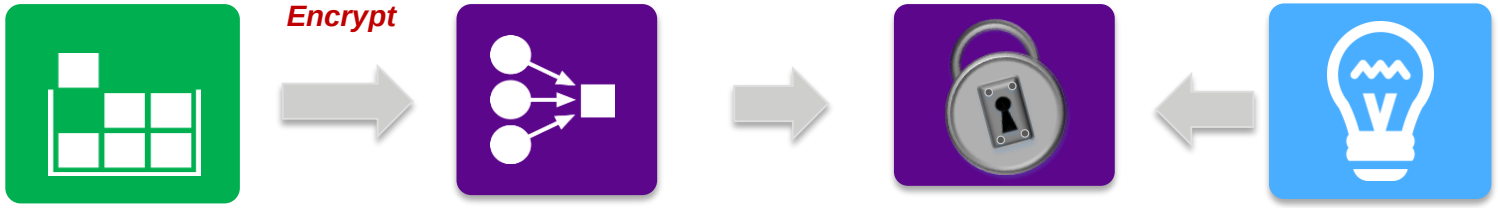


HEALTHCARE EVIDENCE INITIATIVE: ENSURING CONSUMER PRIVACY

- **Consumer privacy:** Health plan claims and utilization data provided to Covered California will be encrypted by Truven and will not reveal the identity of any individual consumer.
- **Protecting consumer information:** Consistent with any Covered California contractor, Truven is required to abide by all state and federal laws and requirements to protect consumer information.
- **Consumer opt-out:** Today, consumers have a right to request restrictions on how their information is shared by their health plan. Covered California is working with health plans to assess implementation options for this initiative.

Feedback requested

HEALTHCARE EVIDENCE INITIATIVE: DATA AND TOOLS



Data Collection from QHPs

- Claim / Encounters
- Enrollment
- Capitation
- Provider
- Plan / Product

Data Aggregation by Truven

- Standardize
- Normalize
- Quality & Performance Measures
- Benchmarks
- Episodes of Care

Data Tools Built by Truven

Identifying information removed

Secured Access

Covered California Evidence Initiative Analysts

Actionable Intelligence:

- Are members getting the right care at the right time?
- Are we negotiating competitive rates for members?
- Are members selecting the best plan to meet their health needs?
- Are all members getting the right care at the right time?

HEALTHCARE EVIDENCE INITIATIVE: PUTTING MEMBERS FIRST

Covered California has always used available data to support evidence-based policy making with a focus on our members. The Healthcare Evidence Initiative will take it to the next level with utilization and claims data. Here are a few examples:

- **Are members getting the right care at the right time?** Covered California has estimated the number of members who have been newly diagnosed with certain diseases. The Evidence Initiative will help us make this concrete, for example, assessing what percentage of Covered California members are getting recommended cancer screenings.

- **Is Covered California negotiating competitive rates?** Covered California used state data on health care usage to help drive down the cost of premiums in 2015. The Evidence Initiative will provide a complete picture of the health status and health care utilization of our members so Covered California can make sure rates are reasonable.

- **Did members chose the right plan for their health needs?** Today Covered California can tell how many members choose a Bronze plan even though they were eligible for a Silver Cost Sharing Reduction plan. The Evidence Initiative will tell us if those members experience high out-of-pocket costs for their health care (e.g. specialty drugs).

- **Are *all* members getting the right care at the right time?** Today Covered California tracks enrollment by race and ethnicity and other demographics compared to eligibility estimates. The Evidence Initiative will tell us if preventive services are being used at equal rates across demographic groups.

HEALTHCARE EVIDENCE INITIATIVE: KEY AREAS OF FOCUS

1. Right care, right time, right place
2. Standard benefit designs that reduce cost and encourage use of high-value services
3. Opportunities for payment and network design innovation to drive delivery system reform and reward quality
4. Increasing health equity and reducing health disparities

Feedback requested: Are we missing important focus areas?

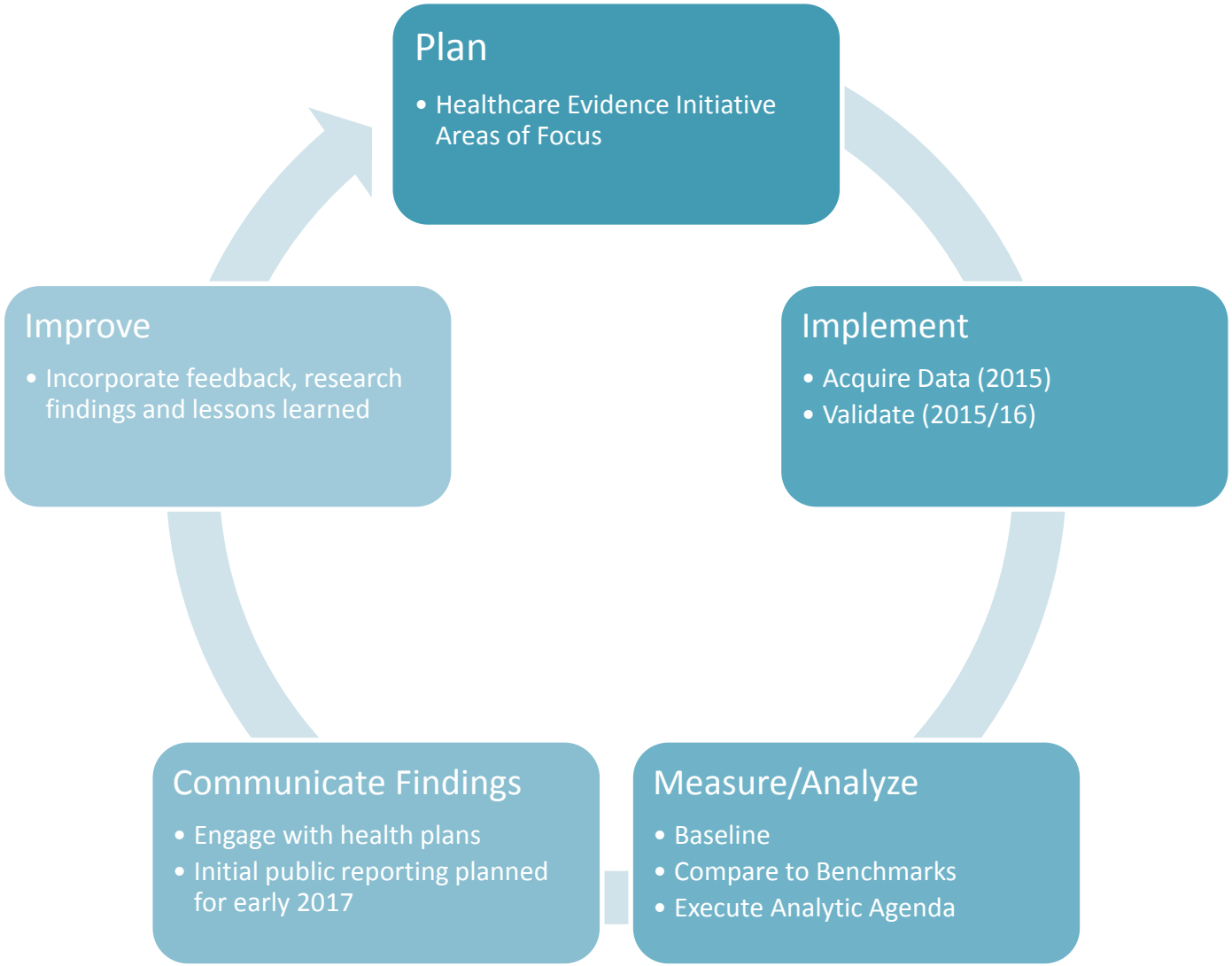
HEALTHCARE EVIDENCE INITIATIVE: ANALYTIC DIMENSIONS

Across all areas of focus, Covered California will assess variations in utilization and cost by:

- Issuer
- Product
- Region
- Race / ethnicity
- Primary language
- Gender
- Age bands
- Income ranges

Feedback requested: Should we consider additional dimensions?

HEALTHCARE EVIDENCE INITIATIVE: CONTINUOUS IMPROVEMENT TIMELINE



HEALTHCARE EVIDENCE INITIATIVE: FEEDBACK REQUESTED

Covered California welcomes feedback on the Healthcare Evidence Initiative. Please send comments to boardcomments@covered.ca.gov by **August 10, 2015**. We are particularly interested in feedback on the following:

1. Key areas of focus
2. Analytic dimensions
3. Ensuring consumer privacy

Information for consumers

CoveredCA.com

Information on exchange-related activities

hbex.CoveredCA.com

REINSURANCE AND RISK ADJUSTMENT

JOHN BERTKO, FSA, MAAA,
CHIEF ACTURARY
COVERED CALIFORNIA PLAN MANAGEMENT DIVISON

REINSURANCE AND RISK ADJUSTMENT

U.S. Risk Adjustment Implementation Challenges and Early Results for Reinsurance and Risk Adjustment for 2014

REINSURANCE AND RISK ADJUSTMENT

Reinsurance Under the ACA

- Reinsurance is one of the 2Rs that are temporary premium stabilization programs
  - Effective for 2014, 2015 and 2016 only
  - Collect a "belly-button" fee from all PHI enrollees (Large Group (LG) insured, LG self-insured, Small Group insured, Individual market) but not from Medicare/Medicaid plans
  - Reinsurance is paid to all insurers with ACA-compliant Individual market plans
    - $45,000 attachment point, 80% coinsurance, $250K cap
    - More money available, so coinsurance was raised in June to 100%
    - Worth on average about 10-12% premium reduction in 2014 in CA (before the June "bonus")

REINSURANCE AND RISK ADJUSTMENT

Risk Adjustment under the ACA

- Risk Adjustment (RA) is the one permanent “premium stabilization” program for both the Individual and Small Employer (<50 employees) markets
- Focus today is on the Individual insurance market
  - Big changes in the business model for insurers
    - No more underwriting with denial of coverage or limits on pre-existing coverages
    - Age-rating limits of 3:1 premium restriction
    - Some standardization of products into 4 Metal Tiers determined by Actuarial Value (e.g., the Silver Tier has an Actuarial Value of 70%, meaning that, on average, the insurer pays 70% of allowed charges)
  - Competition for enrollees is today based on price (premium) and network
    - A few Quality measures are used today but better Outcome measures will come later

REINSURANCE AND RISK ADJUSTMENT

Choice of Method for Implementation

- The CMS (the U.S. agency responsible for the ACA) chose a data gathering system to:
  - Address privacy and security concerns
    - Partly in response to political concerns
  - Maximize efficiency across two programs – reinsurance payments and risk adjustment
  - Known as a “distributed data approach” (or EDGE Server)
    - Allowed enrollee claims to remain on insurers’ servers
    - Provided insurers with software to calculate results
  - Standardized processes, timing and rules
    - CMS collected only summary reports

REINSURANCE AND RISK ADJUSTMENT

Implementation Challenges of Risk Adjustment for the ACA

- 400+ different insurance companies (by state)
  - Thousands of different products offered
  - Over 750 different External Data Gathering Environment (EDGE) Servers run by the 400+ plans
- 3 risk pools per state
  - Individual (4 Metal Tiers)
  - Catastrophic coverage Individual
  - Small Group

REINSURANCE AND RISK ADJUSTMENT

Issues That Arose

- Delays in software development at CMS
- Lack of familiarity by insurers

Overall Aggregate Results

- Insurers were “dragged across the finish line” with appropriate data
  - Less than 10 (of 750) servers had poor data
  - Many insurers re-submitted data in response to data quality reports and review
  - Timing was essential, since Reinsurance and Risk Adjustment components were large enough to affect financial and regulatory reporting
    - June 30, 2015 was the absolute deadline for 2014 Plan Year reporting

REINSURANCE AND RISK ADJUSTMENT

MORE RESULTS

- Variance of risk adjustment results was much wider than expected:
  - 2014 was a turbulent enrollment year
    - Problems with Healthcare.gov enrollment software meant that only sickest people “fought through” to enroll in some states
    - Some states allowed “transitional policies” to remain outside risk adjustment (Obama’s “You can keep the policy you have” option)
    - Other states had significant late take-up (in CA about 1 million of the 1.4 million enrollees came in after the 1/1/14 start date and before the end of Open Enrollment on 30 April 2014)
  - Thus, healthier enrollees came in late, for partial years (see Covered CA cohort analysis paper)

REINSURANCE AND RISK ADJUSTMENT

MORE RESULTS

- Vast majority (~80%) of enrollees were with insurers that were in a +/-10% range around the statewide normalized average of 1.00
- A significant number of insurers had high risk scores, some explained by:
  - Being the “insurer of choice” for a high risk pool, pre-ACA
  - Having wide provider networks
  - Being in a state with low enrollment and many transitional (i.e., healthy) enrollees who did not enter the new ACA markets
  - Many of these insurers had low enrollment (as few as 5 enrollees) and may have been subject to random events

REINSURANCE AND RISK ADJUSTMENT

MORE RESULTS

- Other plans had very low risk scores
  - Some were as low as about 0.60 normalized
    - Some had very healthy enrollees due to many on Bronze (high deductible plans) who had little or no use of health services
    - Others were unfamiliar with the data collection process and therefore did not provide complete data for the submission process and as a result have incorrect scores
    - Some chose Third Party Vendors who were not able to successfully complete the data submission process
  - Some had capitated provider networks that did not submit adequate data streams
  - Most of these insurers had relative low enrollment

REINSURANCE AND RISK ADJUSTMENT

OVERALL

- Reinsurance/Risk Adjustment was a “success” and results were delivered on June 30, 2015
  - It got (barely) done!
  - Reinsurance delivered MORE than was expected
  - RA is now an established and working part of the ACA markets
  - Some grumbling by insurers:
    - “It is not fair that we have capitated provider networks that don’t report as much data”
    - “This risk adjustor doesn’t pay us enough (still too much) for healthy members”

REINSURANCE AND RISK ADJUSTMENT

CA RESULTS

- CovCA news release: http://news.coveredca.com/2015/07/the-affordable-care-act-is-protecting.html
- Covered CA plans had:
  - More than $1.1 billion in reinsurance payments
  - More than $600 million in risk adjustment transfers

QUESTIONS, WRAP-UP, AND NEXT STEPS

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