PLAN MANAGEMENT ADVISORY GROUP

November 30, 2017

WELCOME AND AGENDA REVIEW

ROB SPECTOR, CHAIR
PLAN MANAGEMENT ADVISORY GROUP

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
Thursday, November 30, 2017, 10:30 a.m. to 12:00 p.m.

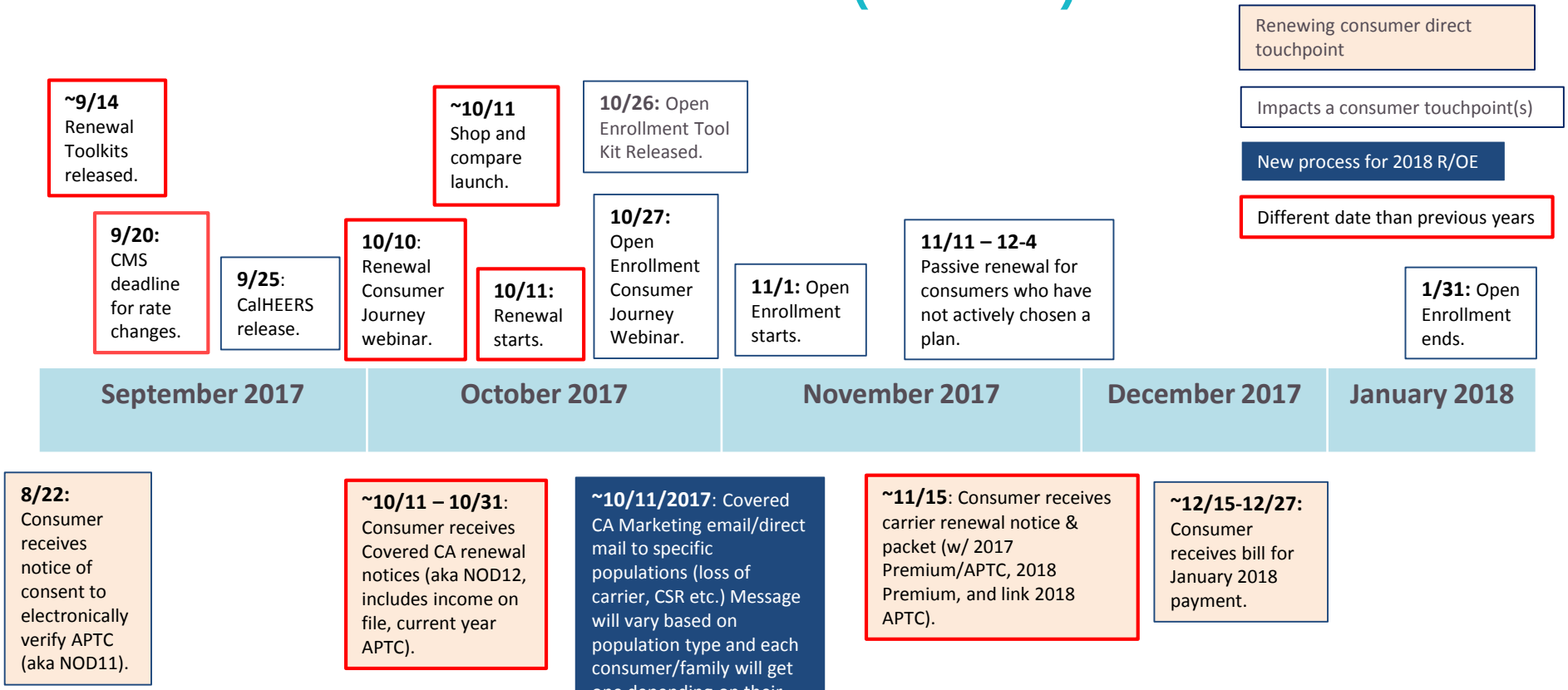
Webinar link: https://register.gotowebinar.com/register/3571310904008477954

November Agenda Items	Suggested Time
I. Welcome and Agenda Review	10:30 - 10:35 (5 min.)
II. 2018 Member Transition Process and Timeframe	10:35 – 11:05 (30 min.)
III. 2019 Benefit Design	11:05 – 11:20 (15 min.)
IV. Proposed 2019 Certification Timeline	11:20 – 11:40 (20 min.)
V. Consumer Journey Project Update	11:40 – 11:55 (15 min.)
VI. Open Forum	11:55 – 12:00 (5 min.)

2018 MEMBER TRANSITION PROCESS AND TIMEFRAME

JEN JACOBS, DEPUTY DIRECTOR
PLAN MANAGEMENT DIVISION

RENEWING CONSUMER JOURNEY (REVIEW)



TRANSITIONING CONSUMER JOURNEY UPDATE

Transitioning consumer direct touchpoint

New process for 2018 renewal

New process for 2018 renewal and transitioning consumer direct touchpoint

Different date than previous years

~10/13 Shop and compare launch.

10/13: Renewal starts.

11/1: Open Enrollment starts.

~11/13: Passive renewal of transitioning members into lowest cost option in zip code (same metal tier).

~11/17 Issuers receive lists of Anthem members who have been auto-enrolled with them.

~12/27-12/28: Issuers receive data from Anthem for members who have effectuated in order to smooth the transition of care (open auths, CM/DM, Rx, PCP). A follow-up round will occur in January.

1/31: OE ends.

October 2017

~10/13 – 10/31: Consumer receives Covered CA renewal notices & packet (aka NOD12, includes income on file, current year APTC).

November 2017

~10/11: Covered CA Marketing email/direct mail to specific populations (loss of carrier, CSR etc.) Message will vary based on population type and each consumer/family will get one depending on their situation.

Late November: Anthem sending letters to transitioning members with open authorizations for services. Will remind member of change in issuer and suggest talking with doctor about best course of action.

December 2017

Early December: Ad Hoc Policy Notice to transitioning consumers, tells which plan the consumer has been auto-enrolled into. Will include transition of coverage information.

~12/15: Anthem sending letters to members with open auths and those in CM/DM. Will remind member of change in issuer and suggest talking with doctor about best course of action.

~12/15-12/27: Consumer receives application acknowledgment and reminder to make binder payment.

12/2017: QHP outreach to transitioning members

January 2018

~Early January/ within 10 days of initial payment: Consumer receives welcome packet from 2018 carrier, if new.

COVERED CALIFORNIA

CURRENT AS OF 11/28/2017

2018 MEMBER TRANSITIONS OF COVERAGE UPDATE

- Anthem, Covered California, and receiving carriers have arranged a process for data transfer to ensure smooth the transition of member care.
- Issuers will receive relevant info on effectuated members via FTP in late December with a follow-up round in January.
- Anthem is also:
  - Sending two waves of letters to impacted Covered California members with HIPPA authorization:
    - Late November letter to members with prior authorizations notifying of end of coverage, their options and advising discussion with doctor,
    - Mid December letter to members with prior authorization and CM/DM program members with same information.
  - Sending off-exchange impacted members letters with HIPPA authorization for smooth transition.
  - Reaching out to providers and hospitals in impacted regions.

2019 BENEFIT DESIGN

ALLIE MANGIARACINO, SENIOR QUALITY ANALYST
PLAN MANAGEMENT DIVISION

BENEFIT DESIGN WORKGROUP UPDATE

Plan design cost share changes by metal level:

- **Bronze:** Considering changes to make office visits more affordable. Options include:
  - Unlimited PCP/MH/Urgent Care Visits at the copay amount (no deductible) and a 3-visit rule for specialist visits
  - Increasing the 3-visit rule to 4-5 visits
  - Keep 3-visit rule and decrease copay amounts
  - ***Alternatively,*** leave cost shares unchanged from 2018 to maintain stability and avoid major changes next year, and make adjustments to the MOOP to meet AV requirements
- **Silver:** Changes to cost shares necessary to meet AV requirements. Options include:
  - Increase copays by $5 for office visits and other services, as well as increase the drug deductible to $200
  - Apply the deductible to outpatient facility and increase other cost shares as necessary to meet AV requirements

BENEFIT DESIGN WORKGROUP UPDATE

Policy items under consideration:

- Change the cost share for Mental Health/Substance Use “other outpatient items and services” from a copay to coinsurance: Due to mental health parity requirements, some carriers must offer this service at the coinsurance amount (10-20%) up to a cap. This design cannot be administered due to operational limitations, so some carriers are required to offer the service at $0 to the member.
- Differentiate cost shares for Ambulatory Surgery Centers (ASCs) vs. Outpatient Facilities to reflect the price differential between freestanding ASCs and hospital-based OP facilities
- Standardize the cost share for non-emergency transportation, i.e. remove “emergency” from “emergency medical transportation” in the plan design to clarify that the cost share applies to both emergency and non-emergency transportation

Benefit design topics for 2020 and Beyond:

- Value-Based Insurance Design, in alignment with CalPERS
- Benefits of adding a “High AV” Bronze products
- Funded HSA accounts for Cost-Sharing Reduction (CSR)-eligible members who select Bronze

PROPOSED 2019 QHP/QDP CERTIFICATION TIMELINE

JEN JACOBS, DEPUTY DIRECTOR
PLAN MANAGEMENT DIVISION

PROPOSED 2019 QHP/QDP CERTIFICATION TIMELINE

Release draft 2019 QHP & QDP Certification Applications	~ December 15, 2017
Draft application comment periods end	January 5, 2018
Plan Management Advisory: Benefit Design & Certification Policy recommendation	January 11, 2018
January Board Meeting: discussion of benefit design & certification policy recommendation	January 15, 2018
Letters of Intent Accepted	February 1 – 15, 2018
Final AV Calculator Released*	February 2018
February Board Meeting: anticipated approval of 2019 Patient-Centered Benefit Plan Designs & Certification Policy	February 15, 2018
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 16 – 28, 2018
QHP & QDP Applications Open	March 1, 2018
QHP Application Responses (Individual and CCSB) Due	May 1, 2018
Evaluation of QHP Responses & Negotiation Prep	May - June 2018
QHP Negotiations	June 2018
QHP Preliminary Rates Announcement	July 2018/TBD
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2018/TBD
QDP Application Responses (Individual and CCSB) Due	June 1, 2018
Evaluation of QDP Responses & Negotiation Prep	June – July 2018
QDP Negotiations	July 2018
CCSB QHP Rates Due	TBD
QDP Rates Announcement (no regulatory rate review)	August 2018
Public posting of proposed rates	TBD
Public posting of final rates	TBD
Open Enrollment Begins	October 15, 2018

*Final AV Calculator and final SERFF Templates availability dependent on CMS release
TBD = dependent on CCIIO rate filing timeline requirements

CONSUMER JOURNEY PROJECT UPDATE

GWYN JACKSON, CONSULTANT
COVERED CALIFORNIA

CONSUMER EXPERIENCE - AGENDA

- **Goals and Objectives**
- **Health Plan Workgroup Goals, Measures and Validations**
- **Next Steps**

CONSUMER EXPERIENCE – GOAL AND OBJECTIVES

Improve the Consumer Experience throughout their journey.

1. Improve how WE (Covered CA = Agents, CECs, QHPs, CalHEERS) interact with the Consumer Experience lifecycle, as well as improve:
    i. How the consumer self serves
    ii. How the consumer receives access
    iii. How the consumer makes use of tools
    iv. How the consumer utilizes their coverage
2. Ensure the Consumer Experience is anchored by experiences and analytics.
3. Establish the Consumer Experience as a ‘lifetime’ work group for Covered CA.
4. Institutionalize the Consumer Experience as lifecycle centric.

HEALTH PLAN SHORT TERM (OPEN ENROLLMENT 5)

Goal	Objective	Measure(s)	Validation Date/Status
Goal I – Implement plan to ensure maximum number of valid enrollments	Develop, adapt, and deploy Data Integrity tools that address enrollment accuracy	• Reduce volume of cases pending >60 days by 25%	• 01/03/2018 • As of 09/17: 98% reduction

Goal II – Reconciliation: Reduce volume of financial differences with issuers	Reconcile enrollment data with issuers while identifying improvements to the 834 transaction process	• Yes/No: Develop strategy to enhance the data fields reconciled to include eligibility and financial information (e.g., premium amount, APTC start and end dates, CSR)
		• Reduce volume of financial discrepancy cases by 40%
		• Yes/No: Implement 834 enhancements to communicate monthly financial values on outbound transactions
			• 10/01/2017
			  • Yes
			• 01/03/2018
			  • As of 09/17: 78% reduction
			• 01/03/2018
			  • Yes

HEALTH PLAN SHORT TERM (OPEN ENROLLMENT 5)

Goal	Objective	Measure(s)	Validation Date/Status
Goal III – Improve federal and issuer reporting consistency	Enhance exception reporting and monitoring processes of internal database systems (e.g., HBEX, GI and ABE)	• Yes/No: Architect actionable exception report for interfaces between HBEX, GI, & ABE to help ensure core system inconsistencies do not exceed 1% for any field • Yes/No: Expand proactive monitoring tools for internal systems to measure invalid financial & enrollment scenarios • Reduce 1095 dispute calls by 10%	• 07/01/2017 • Yes • 12/01/2017 • 01/03/2018

HEALTH PLAN SHORT TERM (OPEN ENROLLMENT 5)

Goal	Objective	Measure(s)	Validation Date/Status
Goal IV – Offer provider search prior to plan selection	Maximize enrollment and reduce consumer confusion around provider access * consumer CANNOT select PCP before OE5	• Yes/No: Determine percent of consumers that used provider search tool prior to plan selection. • Yes/No: Compare effectuation rates of consumers that used provider search tool to those that did not access the tool. • Yes/No: Determine number of consumers who complete enrollment in one sitting before and after implementation • Yes/No: Compare number of consumers who used plan-specific provider directory links before and after implementation • Yes/No: Establish metrics to determine provider access complaints	• 10/01/2017 • 10/01/2017 • 10/01/2017 • 10/01/2017 • 10/01/2017

HEALTH PLAN SHORT TERM (OPEN ENROLLMENT 5)

Goal	Objective	Measure(s)	Validation Date/Status
Goal V – Improve consumer pay now experience	Uniform use of Pay Now WSDL across all health and dental plans to ensure effective performance of the Pay Now WSDL	• Yes/No: Implement Pay Now Web Service Description Language (WSDL) across all health and dental issuers.	• 10/01/2017

HEALTH PLAN NEAR TERM GOALS (SEP 5)

Goal	Objective	Measure(s)	Validation Date/Status
Goal I – Reconciliation: Reduce invalid consumer payment dates	Develop, adapt, and deploy Data Integrity tools that address enrollment accuracy	• Reduce invalid terminations for non-payment and reinstatement by 20%	• 01/03/2018 • As of 09/17: 67% reduction
Goal II – Improve consumer pay now experience	Uniform use of Pay Now WSDL across all health and dental plans to ensure effective performance of the Pay Now WSDL	• Yes/No: Create reports to assess and monitor Pay Now WSDL performance, specifically volume of failed Pay Now transaction and point of failure	• 10/31/2017

HEALTH PLAN LONG TERM GOALS (OPEN ENROLLMENT 6)

Goal	Objective	Measure(s)	Validation Date/Status
Goal I – Reduce number of over age dependents enrolled	Ensure consumers are enrolled in plans for which they are eligible	• Reduction of enrolled over age dependents through manual process by 50% • Reduction of enrolled over age dependents through automated process by 100%	• 10/31/2018 • 10/31/2018
Goal II – Provide pre-enrollment verification for SEP qualifying event	• Discourage fraud • Lower cost of utilization for valid beneficiaries	• Yes/No: Verification completion within 10 days by ___ %	• 09/30/2018
Goal III – Implement provider search enhancements	Enable consumer selection of Primary Care Physician at point of enrollment and transmission of provider selection to health plan	• Increase number using provider search by 15% • Increase enrollment and plan by 10%	• 02/28/2019 • 02/28/2019
Goal IV – Align re-rating with federal guidance	Perform re-rating when appropriate; send accurate rating information to carriers	• Reduce discrepant rate information by _ %	• 05/31/2018

HEALTH PLAN LONG TERM GOALS (OPEN ENROLLMENT 6)

Goal	Objective	Measure(s)	Validation Date/Status
Goal V – Improve consumer Pay Now experience	Uniform use of Pay Now WSDL across all health and dental plans to ensure effective performance of the Pay Now WSDL	• Yes/No: Implement Pay Now WSDL across all health and dental issuers. • Yes/No: Allow Pay Now WSDL to reflect accurate amount due for effectuation (include any past due amounts).	• 02/28/2019 • 02/28/2019
Goal VI – Implement uniform proration	Implement consistent premium proration calculations across all carriers	100% of carriers using premium proration correctly	• 02/28/2019

CONSUMER EXPERIENCE – NEXT STEPS

- **Short Term**
  - Continue ensuring Short Term goal implementations
  - Continue validating Short Term goal measures
- **Near Term**
  - Begin ensuring Near Term goal implementations
  - Begin validating Short Term goal measures
- **Long Term**
  - Finalize Long Term goal volumes and sources

OPEN FORUM AND NEXT STEPS

ROB SPECTOR, CHAIR
PLAN MANAGEMENT ADVISORY GROUP