PLAN MANAGEMENT ADVISORY GROUP

May 11, 2017

WELCOME AND AGENDA REVIEW

JAMES DEBENEDETTI, DIRECTOR
PLAN MANAGEMENT DIVISION

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
Thursday, May 11 , 2017, 10:00 a.m. to 12:00 p.m.

Webinar link: https://attendee.gotowebinar.com/register/7768186369647706370

Welcome and Agenda Review	**10:00 - 10:05 (5 min.)**
2018 Marketplace Stabilization Regulations	**10:05 – 10:35 (30 min.)**
2018 Certification Update	**10:35 – 10:40 (5 min.)**
Consumer Experience Project Overview	**10:40 – 10:50 (10 min.)**
Provider Directory Launch	**10:50 – 11:10 (20 min.)**
Health Savings Accounts and other Account Based Health Plans	**11:10 – 11:55 (45 min.)**
Open Forum and Next Steps	**11:55 – 12:00 (5 min.)**

2018 MARKET STABILIZATION REGULATIONS

PETER V. LEE, EXECUTIVE DIRECTOR
KATIE RAVEL, DIRECTOR, POLICY, PROGRAM INTEGRITY AND RESEARCH

COVERED CALIFORNIA ANALYSIS OF MARKET STABILIZATION REGULATIONS

- The Department on Health and Human Services (HHS) released final Market Stabilization regulations on April 18, 2017.
- Below is an overview of the final provisions that Covered California commented on.
- **Open Enrollment (OE) Period:** HHS will shorten the OE period to 45 days (Nov. 1 – Dec. 15) beginning plan year 2018 with the possibility of beginning OE in October in future years.
  - Under existing regulatory authority, SBMs may elect to supplement the OE with a SEP to account for operational difficulties in implementing a shorter OE.
- **Special Enrollment Period:** HHS made several changes to the special enrollment process.
  - Covered California notified HHS of existing SEP pre-enrollment verification efforts to leverage electronic verifications.
  - While final regulations do not require SBMs to conduct pre-enrollment verification, Exchanges are encouraged to adopt the FFM process.
- **Changes to Actuarial Value Ranges:** HHS will allow plans to have -4/+2% instead of current -/+2%.
  - Certain Bronze level plans will be allowed to have a variation of -4/+5.

2018 CERTIFICATION UPDATE

TAYLOR PRIESTLY, CERTIFICATION PROGRAM MANAGER
PLAN MANAGEMENT DIVISION

CONSUMER EXPERIENCE

GWYN JACKSON, CONSULTANT
PROGRAM COMPLIANCE AND ACCOUNTABILITY

CONSUMER EXPERIENCE - AGENDA

- Goal and Objectives
- Initiatives
- Approach and Focus
- 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.

CONSUMER EXPERIENCE – INITIATIVES

1. Create The Consumer Experience workgroup.
    1. Examine the Consumer Experience from a holistic perspective:
        a. Covered CA = Agents, CECs, QHPs, CalHEERS
        b. Include stakeholder groups when possible
    2. Identify areas of potential constraints.
    3. Prioritize constraint efforts, and if needed, formulate small workgroups to perform appropriate research.
    4. Categorize short term, near term, and long term mitigations/opportunities to improve any identified constraints.
    5. Develop ongoing method for revolving examination of the Consumer Experience.

CONSUMER EXPERIENCE – APPROACH AND FOCUS

1. Identify and research touchpoints where the consumer engages with Covered CA.
2. Group the touchpoints and identify areas of focus:
   - Engagement – prior and initial engagement with Covered CA
   - Enter Case & Family Info – focus on ease of use, barrier points
   - Eligibility Determination – subsidy and/or dual eligibility, along with appeals
   - Plan Selection - rate consideration, assistance regarding plan questions
   - Effectuation – 834 processing, carrier payment, effectuation timing
   - Coverage Experience – experience while they are receiving coverage
   - Renewal Coverage or Continuity of Care – survey and reasonable opportunity coverage
3. Review consumer experiences that run across all of the consumer engagement:
   - Consumer Survey
   - Service Center Operations
   - Covered CA University (CCU)
   - CalHEERS Changes
   - Help Desk Processing
   - Data Integrity and Exchange

CONSUMER EXPERIENCE – NEXT STEPS

1. Completed - Create and staff workgroups.
2. Completed - Meet with Executive Chiefs and Directors to review. Consumer Experience information
3. In Process - Define the following holistic phases and define Covered CA expectations at each phase, which includes:
    i. Completed - Catalog current analytical information
    ii. Completed - Review analytical results and identify impact areas
    iii. Completed - Compare service for impacted areas to industry standards
    iv. Completed - Define measure of success and define service levels
    v. Define business process for identified areas
    vi. Validate success
4. In Process - Identify existing, short term (w/in 90 days), near term (w/in 6 months), and long term (FY 17/18) improvement opportunities .

COVERED CALIFORNIA PROVIDER DIRECTORY

LANCE LANG, CHIEF MEDICAL OFFICER
MARGARETA BRANDT, PROVIDER DIRECTORY PROJECT MANAGER
PLAN MANAGEMENT DIVISION

PROVIDER DIRECTORY OVERVIEW

- Covered California will implement a consolidated online provider directory during the 2017 Special Enrollment Period to enable consumers to conduct a search for their doctor, a dentist for their children, or hospital prior to selecting a health plan
- The purpose of the Covered California provider directory is to support consumers in selecting a health plan, not to make an appointment with a provider or to use for seeking care
- Covered California will direct consumers to check the provider directory of the health plan they select before seeking care
- Covered California is planning to build on the provider directory by enabling consumers to select a primary care provider (PCP) after selecting a health plan during the 2018 Special Enrollment Period

HISTORY AND LESSONS LEARNED

- The launch of the Covered California provider directory in 2014 didn't go well
  - Data unreliable
  - Lack of standards and validation
  - Led to passage of SB 137
- It is imperative that accurate provider information be displayed online to correctly inform the consumer as he/she selects a health plan
- To support QHP's ongoing efforts to improve provider data accuracy, Covered California implemented
  - Standards for all data elements
  - A validation and error reporting process to identify possible critical errors for the QHP to verify and correct, as needed, in their provider data system
- Covered California will exclude:
  - A QHP's entire list of providers if the list doesn't meet standards for data and
  - Any individual providers for whom critical data errors have not been corrected
- The Covered California provider directory will not include phone numbers

PROVIDER DIRECTORY TIMELINE

Date	Milestone
June 2016	Covered California provider directory project announced to all QHPs
July 2016	Onsite implementation meetings with all QHPs to review feedback process for addressing data errors and validating data
August 2016	Started data feedback process with QHPs; began hosting biweekly meetings with QHPs to review results of feedback process
September 23, 2016	DMHC ruling to exclude Covered CA from SB 137 Section 1367.27: Requirements to correct provider directory inaccuracies within 30 days of receiving notification and contact affected providers within 5 business days of receiving notice of an inaccuracy
January 2017	Distributed updated Provider Directory Data Submission Guide to QHPs
June 2017	Expected CalHEERS UAT testing with QHPs of provider directory search functionality
June 30, 2017	QHPs will extract provider data for the first production file for the provider directory search
July 12, 2017	Covered California will generate first production file for the provider directory search and provide to CalHEERS
July 31, 2017	Launch of provider directory search functionality through CalHEERS
February 2018	Tentative launch of PCP selection functionality through CalHEERS

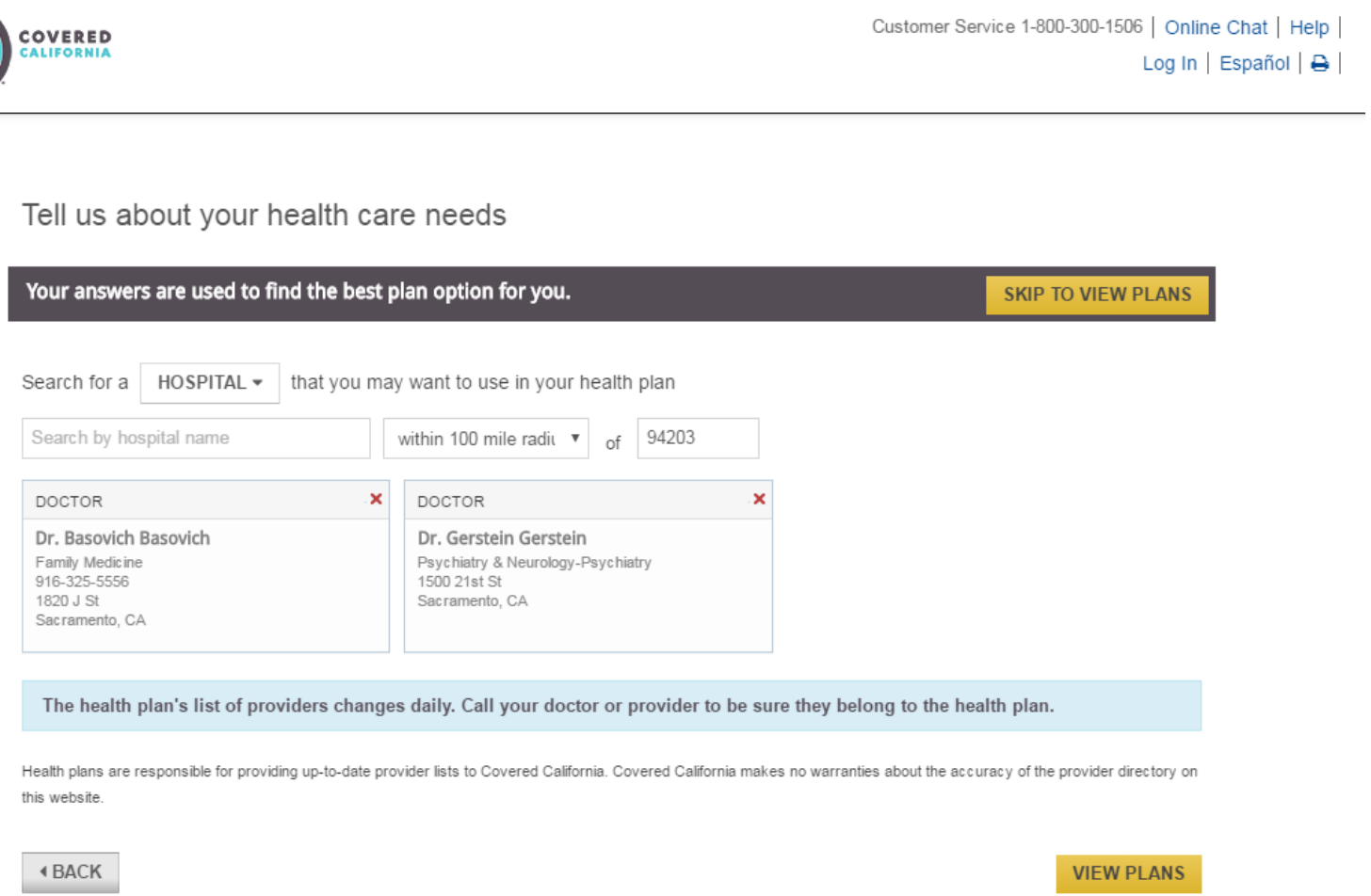
CURRENT PROVIDER DIRECTORY PROCESS

1. QHPs submit provider data submissions monthly to Covered California
2. Covered California validates the completeness of critical fields in the files
3. If the QHP passes validation, Covered California processes the file for errors
   - QHPs can resubmit a corrected file up for validation until the due date for the particular month
4. Covered California provides QHPs a validation report and an error report
5. QHP verifies errors and corrects errors as needed
6. Covered California excludes un-corrected critical errors from the production file for the online provider directory
   - QHPs can correct critical errors with each monthly provider data submission
7. Covered California provides CalHEERS a production file each month
8. CalHEERS loads the file for the online provider directory search

PROVIDER DIRECTORY SEARCH FUNCTIONALITY

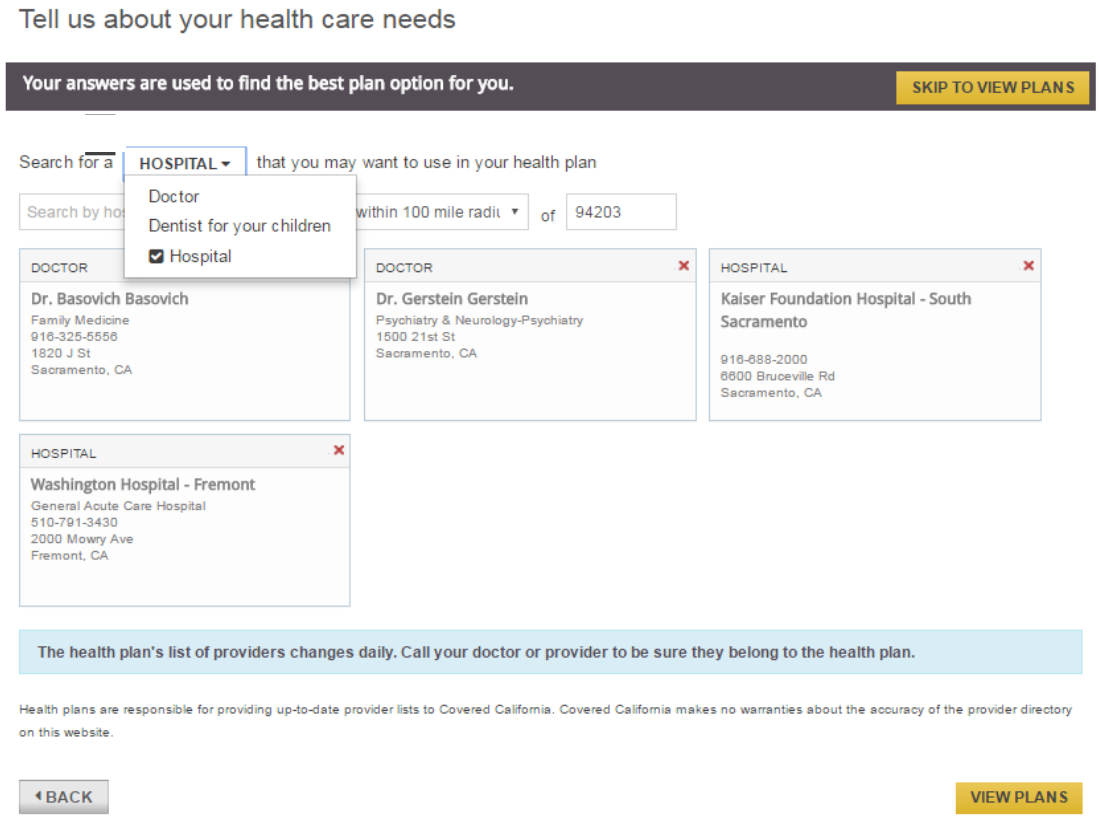
- Consumers will be able to search for their doctor, a dentist for their children or a hospital
  - Name, address and specialty will be displayed for doctors and dentists. (Will display up to two specialties per doctor per location.)
  - Name and address will be displayed for hospitals
- The CalHEERS plan selection pages will indicate whether the provider is in or out of network for each health plan
- The provider directory search will also be available in Shop and Compare
- The provider directory search page will include the following disclaimer language:
  - Paragraph 1: *The Covered California provider directory can help you select a health plan. The directory is updated monthly and may not be a current or complete list of the health plan's providers*.
  - Paragraph 2: *The health plan you select will have the most current provider directory. You may not have coverage or may have higher costs if you visit a provider who is not in your plan's network. To avoid this, you must verify with your health plan if the provider is in-network before you seek care.*

PROVIDER SEARCH SCREENSHOT



Final disclaimer language will be displayed here.

PROVIDER SEARCH SCREENSHOT



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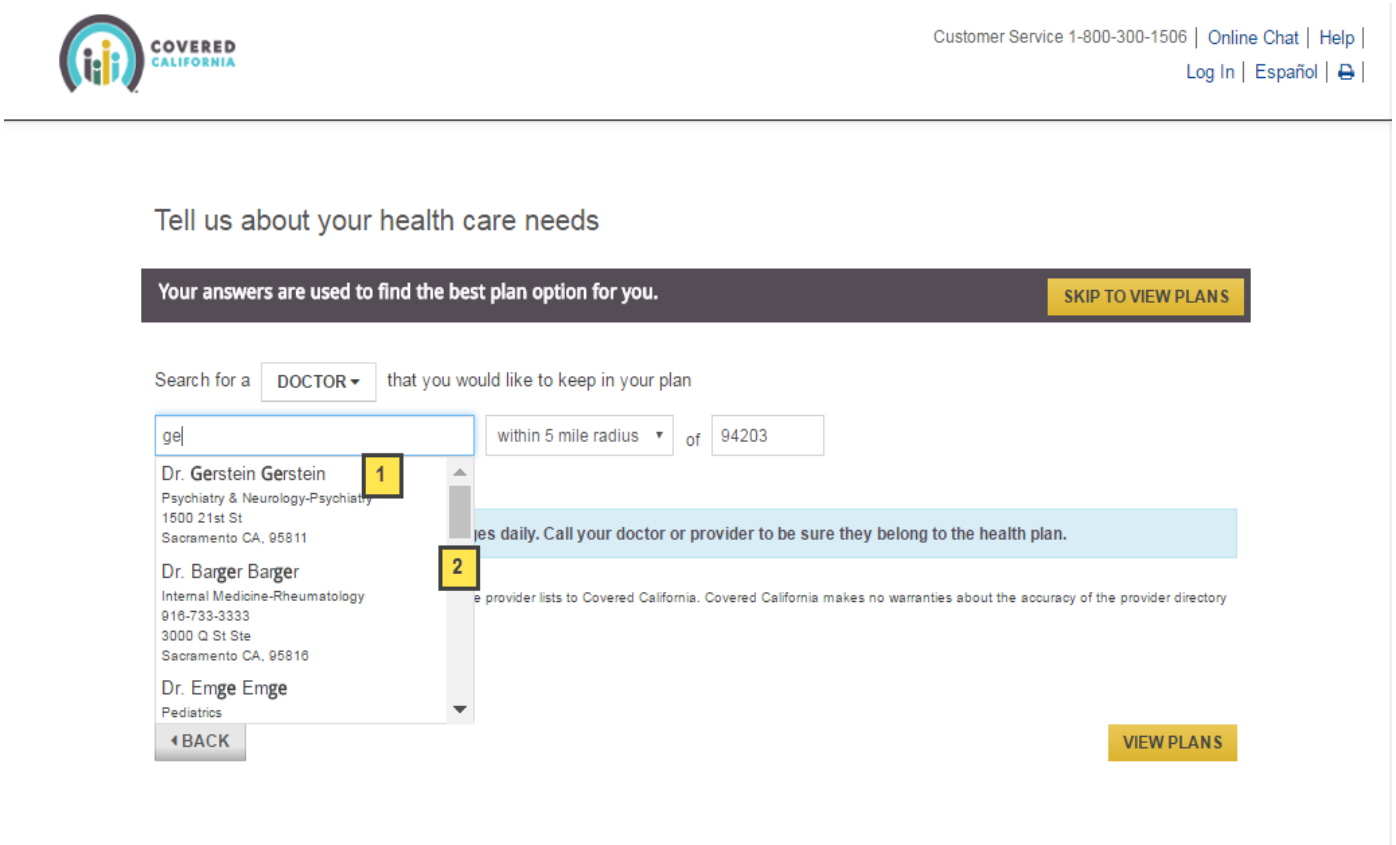
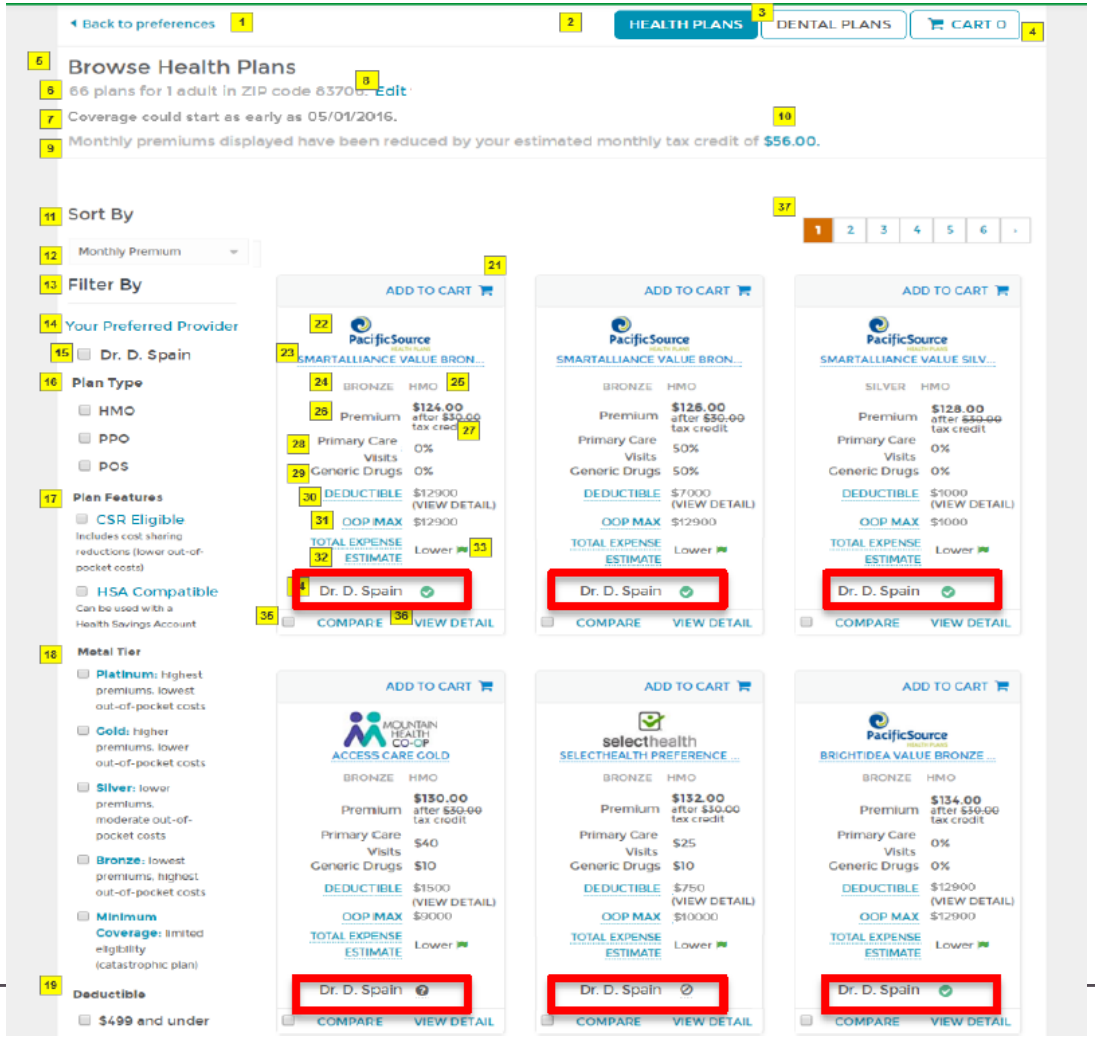


PLAN SELECTION SCREENSHOT



NEXT STEPS

- Launch of Provider Search functionality in July 2017
- Monitor provider search functionality during Special Enrollment Period (SEP) 2017
- Planned launch of PCP selection functionality in February 2018
  - PCP selection functionality will need to support PCP selection for both HMOs and EPOs/PPOs with distinct work flows

HEALTH SAVINGS ACCOUNTS AND OTHER ACCOUNT BASED HEALTH PLANS

JAMES DEBENEDETTI, DIRECTOR
PLAN MANAGEMENT DIVISION
MARCELLA REEDER, SENIOR ACCOUNT MANAGER
BLUE SHIELD OF CALIFORNIA

PURPOSE FOR REVIEW

- Educate Covered California staff and stakeholders on the basics and mechanics of Health Savings Accounts (HSAs) and other account based health plans (e.g HRAs, FSAs).

- Explore the ways in which account based health plans can better meet the needs of low to moderate income consumers.

- Covered California currently has a Bronze High Deductible Health Plan (HDHP) in the Individual market, which represents ~6.03% of total enrollment. (~4.7% subsidized and ~1.38% unsubsidized).

PURPOSE FOR REVIEW

Spring/Summer 2017

Review Phase

- How health savings accounts (HSA) and other account based health plans (e.g. HRS, FSAs) work
- Member experience
- Latest developments (both public and commercial)

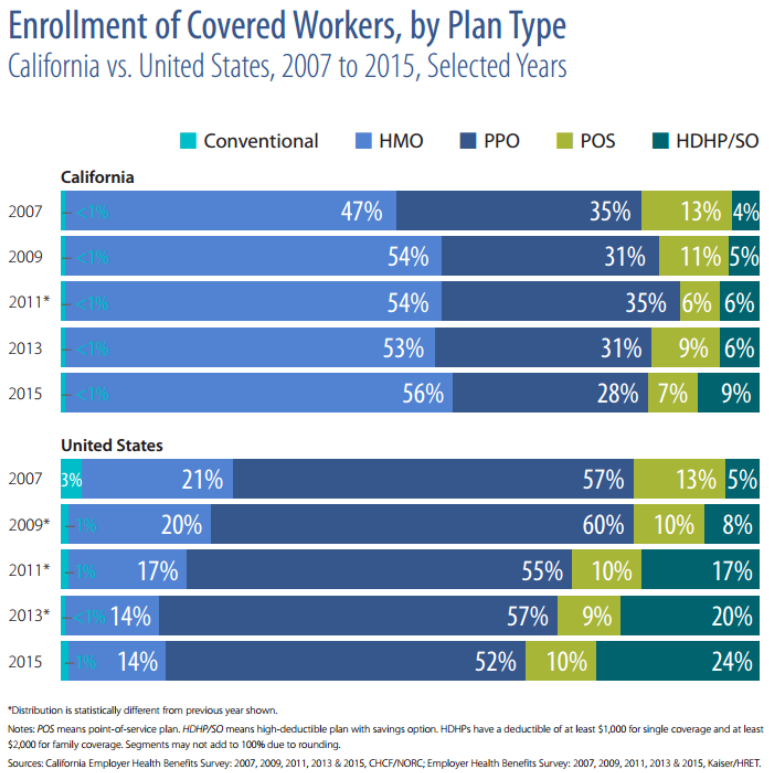
Summer/Fall 2017

Consider Options / Feasibility / Implications

Winter 2017/2018

Plan Management Advisory Committee Recommendations

ENROLLMENT OF COVERED WORKERS BY PLAN TYPE CALIFORNIA VS. UNITED STATES, 2007 TO 2015



At the national level, there has been a five-fold growth in high deductible health plans paired with a savings account option. In California, growth is slower, growing from 4% of workers in 2007 to nearly a tenth (9%) in 2015. A likely reason for the slower growth is California' extensive experience with HMO-based managed care.

COVERED CALIFORNIA

This chart is from slide 29 in the following California HealthCare Foundation report: California Employer Health Benefits: Workers Pay the Price.

Account Based Health Plans

Overview for Plan Management Advisory Committee

5/11/2017

Types of employer based health financial accounts

Plan Type Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)	Flexible Spending Account (FSA)
Account Definitions	A tax-advantaged account funded with either employee payroll pre-tax dollars, employer matching or after tax deposits which is used to pay for qualified medical expenses of the account holder, spouse, and/or dependents. Employees can keep their dollars in an HSA if they change employers. Dollars can be used until exhausted	An employer funded arrangement. The employer sets the parameters for the Health Reimbursement Accounts, and unused dollars remain with the employer - they do not follow the employee to new employment. Employees use the available amounts for incurred qualified medical expenses.	An employer-established, tax-advantaged account funded by employee pre-tax dollars to pay for qualified expenses. These dollars are capped and have a "use it or lose it" policy
Who can open the account?	Individual, employee or employer as long as enrolled in a qualified high-deductible health plan	The employer	Offered through employers, and employees choose whether or not to enroll in the plan on an annual basis
Who can contribute?	Individual, employers, employee/account holder, or any third party	The employer	The employee
Who owns the account?	The account holder	The employer	Unused account balances forfeit to the employer at the end of the plan year plus runout (excluding rollover amount of $500)
Is there an annual contribution limit?	Yes, as determined by the IRS rules	Yes, as determined by the HRA plan design	Yes, as determined by the employer's plan design and IRS rules
Can the account earn interest?	Yes, as determined by HSA administrator / bank	No	No
Do unused funds carry over to the next year?	Yes	Possibly, as determined by the HRA plan design	Typically, no, but employers may allow up to $500 to roll over to the next plan year

Opening and funding an HSA

Must be enrolled in an HSA **qualified high deductible medical plan**. The only services allowed before the deductible are preventative.

2017 amounts for HSA qualified high deductible health plans	Self Only Coverage	Family Coverage
Minimum Annual Deductible	$1,300	$2,600
Maximum Out of Pocket (in network)	$6,550	$13,100

Individual can open and contribute to an HSA account as long as:

- Only covered by the HSA-qualified plan – can not have additional coverage (e.g. spouse's plan) or Medicare, TRICARE or VA
- Not claimed as a dependent on another person's tax return
- Can not have a flexible spending account (FSA) or health reimbursement account (HRA)

Maximum contribution limit for 2017 (including employer contributions for employer sponsored coverage)

- Individual $3,400 / Family $6,750 / 55+ can contribute an additional $1,000

Contributions by individual and family members are tax deductible

HSA account custodians / account administrators

Set up and Funding

- HSA account must be with a HSA account custodian or administrator – typically via banks, brokers, credit unions and health plans
- Not all financial institutions offer an HSA account
- Fees can include monthly, opening/closing, transaction and minimum balance

Investment Options

- Account balances can earn interest and be invested
- Investment earnings accrue tax-free
- Fees, interest rates, investment options, requirements and capabilities vary by account administrator

Accessing Funds

- HSA balances typically available via debit card, checks, withdrawal at administrator and/or on-line bill pay
- The money in an HSA belongs to the account holder, no matter who deposited it
- There's no "use it or lose it" rule, meaning deposits can earn interest and funds could grow over time
- HSA funds roll over from year to year and accumulate in the account. Funds can be rolled over into another HSA

Using funds for qualified expenses

HRA and HSA funds can be used for qualified medical expenses - medical care as defined by Internal Revenue Code Section 213(d) – includes dental and vision

HSA funds can be used to pay for qualified expenses for the account holder, spouse and other tax dependents (even if they are not covered on the account holders' health plan)

HRA funds can be used for premium payments; HSA funds cannot generally be used to pay insurance premiums, except:

- Qualified long-term care insurance
- Health insurance while receiving federal or state unemployment compensation
- Continuation of coverage plans, e.g. COBRA
- Medicare premiums

HSA non qualified distributions subject to income tax + 20% penalty

HSA account holder must track and report all expenses.

Example of using an HSA with the 2017 Covered California Bronze 60 HDHP PPO

Medical plan: Bronze 60 HDHP **HSA Balance**: $2000
Individual deductible: $4,800 (in-network) **Out-of-pocket maximum**: $6,550 (In-network)
Benefits: 40% co-insurance after deductible is met (up to the MOOP)

	Service	Allowed Amount (Cost)	Payments to Provider			Member Balances		
			From Mbr's HSA	From Mbr	From QHP	OOP	Deduct	HSA
Jan	Preventive	$150	-	-	$150	-	-	$2,000
Feb	RX	$100	$100	-	-	$100	$100	$1,900
April	Specialist	$200	$200	-	-	$300	$300	$1,700
May	Surgery	$5,000	$1,700	$2,800 + *$200**	$300	$5,000	**$4,800**	$0
Jun	Specialist	$100	-	*$40*	$60	$5,040	**$4,800**	$0
Jul	Surgery	$5,000	-	*$1,510***	$3,490	**$6,550**	**$4,800**	$0
Aug	RX	$100	-	$0	$100****	**$6,550**	**$4,800**	$0

*As deductible will be satisfied during this service - 40% coinsurance on $500 (difference between cost $5000 and remaining deductible $4500)

**Deductible satisfied - 40% coinsurance of $5000, up to remaining MOOP ($1,510)

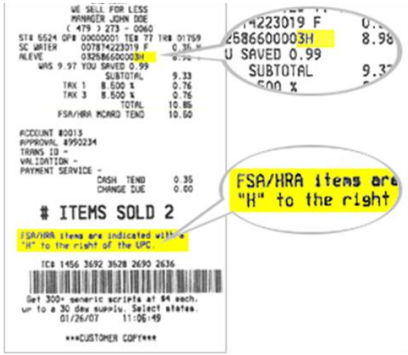
***MOOP satisfied - plan pays 100%

Using a health debit card to pay for healthcare

	Co-Pay Services	Deductible / Co-Insurance Services	RX
Provider's office (check-in or check-out)	Provider looks up cost-share & deductible status from QHP Member pays with card at point of care	Provider looks up cost-share & deductible status from QHP Provider may collect deposit with card or bill member	Provider looks up cost-share & deductible status from QHP Member pays with card at point of sale
Health Plan	N/A	Plan processes claim & determines member cost-share and applies any deposits Plan sends EOB to member & provider (Some integrated models allow plans to auto-pay provider from funds)	N/A
Provider's billing (after care delivery & claim adjudication)	N/A	Provider sends invoice to member Member pays balance using funds/card (or can be reimbursed from HSA if already paid)	N/A

How health debit cards are used to pay for out health plan out of pocket costs

Most administrators' cards use Merchant Category Codes to limit use to qualified merchants and to auto-substantiate (not require any further receipts/EOB to confirm it is a qualified expense)



- e.g. decline retail; allow pharmacy and providers
- Some merchant cash registers classify qualified expenses products at the item level – individual items at the pharmacy could be declined if not qualified expenses (inventory information approval system)
- Some HSA cards can be used at ATMs, allowing members to "reimburse themselves" for healthcare expenses that are paid out-of-pocket
- Card capabilities can vary by administrator

HSA's are member owned accounts - if the account has funds, there are **no requirements that a merchant prevent a member from purchasing any item with the card.**

The issue of documenting legitimate expenses and/or qualifying for the account with an HDHP is between the member and the IRS. **It is ultimately the members responsibility to ensure they are using the HSA funds for an IRS qualified healthcare services.**

Different types of integration between a health plan and an HSA administrator

	No Integration Member can select any HSA administrator	Partial Integration Plan has some integration with HSA administrator	Full Integration Plan integrated with HSA administrator
Opening Account	Manually open account	Manual or automatically opened (may still need wet signatures / forms, etc completed)	Automatically opened (may still need wet signatures / forms, etc completed)
Capabilities	Card/check to pay at point of care/service Pays out of pocket and is reimbursed Bill pay like service Separate web/applications for plan and HSA	Card/check to pay at point of care/service Pays out of pocket and is reimbursed Bill pay like service Separate web/applications for plan and HSA	Card/check to pay at point of care/service Pays out of pocket and is reimbursed **Bill pay – but may enables direct payment to provider from claims adjudication** **Integrated web/applications and capabilities for plan and account balances**
Health Plan / Exchange Integration Requirements	Nothing	**Sends eligibility files to facilitate enrollment** **Single sign on / links between portals**	**Send claims files, eligibility files; Integrates account balances into plan tools (single sign on)**

HSA: Tax reporting

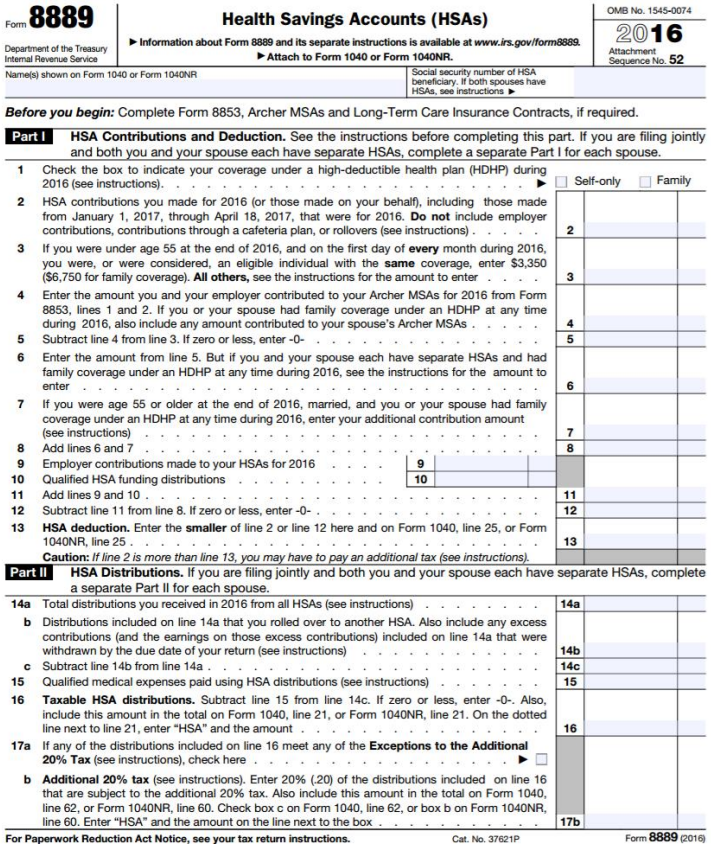
The IRS mandates what HSA dollars can be spent on, not the health plan or the HSA administrator

HSA administrator may provide records retention (receipt storage) and summarize transactions for tax reporting purposes

The account owner is responsible to:

- ensure HSA dollars are only spent on qualified medical expenses
- retain and provide proof of expenses to the IRS if they are audited
- account for HSA contributions and withdrawals on income tax returns (form 8889)
- If audited, may be required to provide documentation of medical expenses – such as receipts, invoices, EOBs, written RXs, and other official documentation

Tax reporting



Form **8889** — Department of the Treasury, Internal Revenue Service

Health Savings Accounts (HSAs)

▶ Information about Form 8889 and its separate instructions is available at *www.irs.gov/form8889*.
▶ Attach to Form 1040 or Form 1040NR.

OMB No. 1545-0074
2016
Attachment Sequence No. 52

Name(s) shown on Form 1040 or Form 1040NR | Social security number of HSA beneficiary. If both spouses have HSAs, see instructions ▶

Before you begin: Complete Form 8853, Archer MSAs and Long-Term Care Insurance Contracts, if required.

Part I **HSA Contributions and Deduction.** See the instructions before completing this part. If you are filing jointly and both you and your spouse each have separate HSAs, complete a separate Part I for each spouse.

1	Check the box to indicate your coverage under a high-deductible health plan (HDHP) during 2016 (see instructions). ▶	☐ Self-only	☐ Family
2	HSA contributions you made for 2016 (or those made on your behalf), including those made from January 1, 2017, through April 18, 2017, that were for 2016. **Do not** include employer contributions, contributions through a cafeteria plan, or rollovers (see instructions)	2	
3	If you were under age 55 at the end of 2016, and on the first day of **every** month during 2016, you were, or were considered, an eligible individual with the **same** coverage, enter $3,350 ($6,750 for family coverage). **All others,** see the instructions for the amount to enter	3	
4	Enter the amount you and your employer contributed to your Archer MSAs for 2016 from Form 8853, lines 1 and 2. If you or your spouse had family coverage under an HDHP at any time during 2016, also include any amount contributed to your spouse's Archer MSAs	4	
5	Subtract line 4 from line 3. If zero or less, enter -0-	5	
6	Enter the amount from line 5. But if you and your spouse each have separate HSAs and had family coverage under an HDHP at any time during 2016, see the instructions for the amount to enter	6	
7	If you were age 55 or older at the end of 2016, married, and you or your spouse had family coverage under an HDHP at any time during 2016, enter your additional contribution amount (see instructions)	7	
8	Add lines 6 and 7	8	
9	Employer contributions made to your HSAs for 2016	9	
10	Qualified HSA funding distributions	10	
11	Add lines 9 and 10	11	
12	Subtract line 11 from line 8. If zero or less, enter -0-	12	
13	**HSA deduction.** Enter the **smaller** of line 2 or line 12 here and on Form 1040, line 25, or Form 1040NR, line 25 **Caution:** *If line 2 is more than line 13, you may have to pay an additional tax (see instructions).*	13	

Part II **HSA Distributions.** If you are filing jointly and both you and your spouse each have separate HSAs, complete a separate Part II for each spouse.

14a	Total distributions you received in 2016 from all HSAs (see instructions)	14a	
b	Distributions included on line 14a that you rolled over to another HSA. Also include any excess contributions (and the earnings on those excess contributions) included on line 14a that were withdrawn by the due date of your return (see instructions)	14b	
c	Subtract line 14b from line 14a	14c	
15	Qualified medical expenses paid using HSA distributions (see instructions)	15	
16	**Taxable HSA distributions.** Subtract line 15 from line 14c. If zero or less, enter -0-. Also, include this amount in the total on Form 1040, line 21, or Form 1040NR, line 21. On the dotted line next to line 21, enter "HSA" and the amount	16	
17a	If any of the distributions included on line 16 meet any of the **Exceptions to the Additional 20% Tax** (see instructions), check here ▶ ☐		
b	**Additional 20% tax** (see instructions). Enter 20% (.20) of the distributions included on line 16 that are subject to the additional 20% tax. Also include this amount in the total on Form 1040, line 62, or Form 1040NR, line 60. Check box c on Form 1040, line 62, or box b on Form 1040NR, line 60. Enter "HSA" and the amount on the line next to the box	17b	

For Paperwork Reduction Act Notice, see your tax return instructions. Cat. No. 37621P Form **8889** (2016)

Unlike a FSA - HSA administrators are not required to keep track of an account holder's expenses. The account holder must track and report all expenses.

If spent on nonqualified expense, income tax and an additional 20% penalty may apply

Form 8889 – reports all contributions / withdrawals associated with HSA

1099-SA – from HSA administrator reporting withdrawals

No longer file form 1040-EZ

NEXT STEPS

- Identify and examine existing account based programs for low income individuals such as the Healthy Indiana Plan (HIP).

- Background on HIP:
  - HIP Home Page: http://www.in.gov/fssa/hip/index.htm
  - HIP 1115 Waiver Extension Application and related information: http://www.in.gov/fssa/hip/2557.htm
  - HIP 2.0 Interim Evaluation Report: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/in/healthy-indiana-plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf

- Explore and discuss potential funding sources and mechanics of account based health plans for low income individuals.

WRAP UP AND NEXT STEPS

JAMES DEBENEDETTI, DIRECTOR
PLAN MANAGEMENT DIVISION

2017 FUTURE STRATEGIC TOPICS: UPDATED SCHEDULE

Red indicates changes since 3/2

Meeting Month	Strategic Topic	Expected Outcomes
2-Mar	2018 Stabilization Regulations	Gather input for Covered California comments on 2018 stabilization regulations and discuss policy change options.
6-Apr	*Cancelled (Account based health plans topic moved to May)*	Awareness of the current operational capabilities for account based health plans; Primer on the different types of account based plans; Ideas on operational, policy and member facing impacts on Account Based Health Plans (ABHP) in alignment with potential ACA changes.
11-May	Account Based Health Plans (HDHP, HSA, HRA)	
11-May	Consumer Lifecycle Work Group	Covered California is embarking on a long term "lessons learned" project to improve the consumer experience. The initial phase will review how various channels (Covered California, agents, navigators, enrollment system etc.) interact with consumers in efforts to understand weaknesses and gaps to strategize on improvements. Goal is to introduce the project and discuss the potential for Advsiory and/or sub work group involvement.
11-May	Covered California Provider Directory *(May and June Topics have been swapped)*	Demonstrate proposed member functionality for provider look up & PCP selection; Feedback on improving experience and developing readiness plans.
8-Jun	Integrated Timelines: Federal, State and Covered CA	Review how Federal and State law cycle overlap with Covered California's certification cycle and major decision points for each. Goal is to set groundwork for understanding when changes for 2019 would likely come and when response actions would need to be taken by Covered California.
13-Jul	Primary Care QIS: PCP for PPO and PCMH update and input gathering session	Gather ideas to improve the assignment and rollout for new members and how to improve awareness and positive acceptance of PCP in the PPO environment.
10-Aug	Off Exchange Products - Market Scan	Gather ideas on any benefit designs found off exchange (non-mirrored) that should be considered for on-exchange. Understand why members purchase off-exchange with a focus on subsidy eligible (as a mechanism to improve targeting for CC enrollment) Consider variety in telehealth offerings and possibility of best practice encouragement.
10-Aug	Open Enrollment 2018 User Experience	Preview for stakeholders, no specific outcomes.
28-Sep	Healthcare Evidence Initiative (Truven) Progress	Share a baseline on key metrics in our quality agenda/dashboard based on the data submitted via Truven (disparities, etc.); share top priorities in research queue.
No Oct meeting		
9-Nov	Hospital Safety QIS	Goal is to hold an update and input session on network improvements so far and momentum gained (number of hospitals signed up for HIINs and CMQCC, improvement in timing of data flow, annual C-Section Honor Roll etc.) and on payment strategies for quality and for reducing low risk C section.
14-Dec	Health Disparities QIS	Goal is to hold an input session on plan submissions, efforts to improve rates of data capture, and preliminary work and best practices discussion on projects to improve chronic disease management (Plan Care Management Programs).