PLAN MANAGEMENT ADVISORY GROUP

October 15, 2015

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
https://attendee.gotowebinar.com/register/3700058205961202433
Thursday, October 15, 2015, 10:00 a.m. to 12:00 p.m.

	October Agenda Items	Suggested Time
I.	Welcome and Agenda Review	10:00 - 10:05 (5 min.)
II.	2017 Certification Discussion	10:05 - 10:50 (45 min.)
III.	Benefits and Networks Subcommittee update	10:50 – 11:20 (30 min.)
IV.	Quality and Contracting Subcommittee update	11:20 - 10:50 (30 min.)
V.	Wrap-Up and Next Steps	11:50 – 12:00 (5 min.)

2017 CERTIFICATION DISCUSSION

ANNE PRICE, DIRECTOR
PLAN MANAGEMENT DIVISION

2017 QHP CERTIFICATION FOR COVERED CALIFORNIA INDIVIDUAL MARKET

Guiding Principals

- Portfolio stability with flexibility for new plan and product offerings
  - Continued growth and implementation of integrated models of care such as Accountable Care Organizations (ACO) or Medical Homes
  - Support of new payment models in concert with other Payors
  - Consider changes over-time to promote Value Based Insurance Designs (VBIDs) either as part of standard design or allow alternatives
  - Consider implementation of new networks

- Focus on carrier performance
  - Requirement of carrier participation in targeted statewide quality initiatives
  - Improvement in consumer satisfaction
  - Reduction Racial/Ethnic disparities in health outcomes
  - Further support and development of decision support for treatment/provider selection

- Focus on policies/service that promote retention and new enrollment

- Seek to reduce administrative cost of Covered California and carriers which impacts affordability

- Certification policy will continue to be recommended and approved by board, but application documents themselves do not require board approval and are no longer required in state regulations

PROPOSED APPROACH FOR 2017 INDIVIDUAL PLAN CERTIFICATION

- For 2017, recommend one QHP Certification application that is open to all licensed health insurers

- Consider multi-year contract term (2017 – 2019) with annual plan certification that includes:
  - Contract compliance and performance review
  - Rates
  - Benefits
  - Networks
  - New products
  - Expanded expectations on delivery reform

- Consider limits on new health insurer entrants through 2019
  - Consider if this rule should also apply to Medi-Cal managed care plans and newly licensed entrants

- Consider changing (and timing) of exchange participation fee to a percent of premium
  - Addresses concern from carriers with a higher proportion of Bronze members

PROPOSED APPROACH FOR 2017 DENTAL PLAN CERTIFICATION

- One Qualified Dental Plan (QDP) application, open to all licensed dental issuers
- Multi-year contract term (2017 – 2019) with annual plan certification that includes:
  - Contract compliance and performance review
  - Rates
  - Benefits
  - Networks
  - New products
- No new dental insurer entrants through 2019 except potentially newly licensed
- Consider changing (and timing) of exchange participation fee to a percent of premium to have exchange fee be a more consistent percentage of premium for HMO and PPO dental plans
- Timeline for recommendation and approval by Covered California board will be consistent with the Individual proposal

2017 QHP CERTIFICATION FOR COVERED CALIFORNIA SMALL BUSINESS

Guiding Principals

- Flexibility to respond to small business market environment
- Focus on carrier performance
- Reduction in administration cost to Covered California and carriers which impacts affordability

Proposed Approach

- Covered California for Small Business QHP certification application, open to all licensed health insurers and not limited to carriers who are QHPs for Individual
- Multi-year contract term (2017 – 2019) with annual plan certification that includes review of performance and compliance with QHP contract requirements
- Allowance for either monthly or quarterly change in rates, products, plans and networks (subject to Covered California approval)
    - Consider if new entrants could come on Exchange outside certification if the carrier is already a Qualified Health Plan for Individual
- Timeline for recommendation and approval by Covered California board will be consistent with the Individual proposal

DECISION PROCESS AND SUBCOMMITTEE TIMELINE

Date	Event	Description
14-Sep	Project Start	Kick Off Communication
17-Sep	**Plan Advisory Meeting** Quality Subcommittee Meeting	 Kick Off meeting
22-Sep	Benefits & Networks Meeting	Kick Off Meeting
7-Oct	Benefits & Networks Meeting	Subcommittee meeting
15-Oct	**Plan Advisory Meeting**	Workgroup Status Provided to Advisory
29-Oct	Dental Technical Work Group	Kickoff meeting to discuss 2017 benefit design
4-Nov	Benefits & Networks Meeting	Subcommittee meeting
5-Nov	Dental Technical Work Group	Discuss 2017 benefit design
10- Nov	Quality Subcommittee Meeting	Subcommittee meeting
12-Nov	**Plan Advisory Meeting**	Recommendations Provided to Advisory for Feedback
Mid-Nov	Draft AV Calculator Release	Draft CMS rules and AV Calculator expected
19-Nov	**Board Meeting**	Recommendation to Board (pending AV requirements)
2-Dec	Benefits & Networks Meeting	Subcommittee meeting to make necessary changes for AV requirements and finalize benefits, as needed
9-Dec	Benefits & Networks Meeting	Subcommittee meeting to make necessary changes for AV requirements and finalize benefits, as needed
Dec TBD	**Board Meeting**	**Board meeting in December is TBD**
Jan TBD	**Board Meeting - Decision**	Approval by Board (Pending Final Actuarial Value Calculator)
Late Feb	Final AV Calculator Release	Final CMS rules and AV Calculator expected (based on prior year experience)
Feb TBD	**Board Meeting**	**Approval by Board of final adjustments to SBPD if necessary**

BENEFITS AND NETWORKS SUBCOMMITTEE UPDATE

JAMES DEBENEDETTI, DEPUTY DIRECTOR
PLAN MANAGEMENT DIVISION

STRATEGY FOR 2017 BENEFIT DESIGN

Organizational Goal

Covered California should have benefit designs that are standardized, promote access to care, and are easy for consumers to understand.

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

Subcommittee Objectives

1. Address benefit design priority areas and make minimal changes as necessary to meet AV requirements
2. Consider benefit changes that align with market dynamics:
   - Non-standard benefits
   - Non-essential health benefits
   - Alternative Benefit Designs (ABDs)
   - Value-Based Insurance Design (VBID)
3. Discuss tiered networks and product requirements

INDIVIDUAL MARKET BENEFIT REDESIGN LANDSCAPE

Text in **red** indicates updates to multi-year strategy since October 2014

	2014	2015	2016	2017
	Year 1: coverage begins	***Year 2: consistency and stability***	***Year 3: redesign improvements considered for access and cost***	***Year 4: progression of improvements considered for access and cost (will be limited to AV changes)***
Statutory	Actuarial Value (AV) baseline	No change	**AV updated**	**AV updated**
Statutory	Essential Health Benefits (EHB) baseline	No change	No change	Possible slight changes
Statutory	Reinsurance and Risk Corridor protection to plans	Reinsurance and Risk Corridor protection to plans (reduction in available dollars)	Reinsurance and Risk Corridor protection to plans (reduction in available dollars)	Reinsurance and Risk Corridors expire
Optional	Baseline: standard benefit design	No change	Incremental benefit changes	**Minimal** benefit changes
Optional	Baseline products/plans established	No change[1]	Product and plan changes[2]	**All-applicant certification and potential** product/plan changes
Optional	Standalone pediatric dental	Embedded pediatric dental benefit	No change	No change
Optional	No adult dental coverage	No adult dental coverage	Family dental offerred	No change

1. Health Net changed PPO product to EPO product due to regulatory requirement
2. Oscar Health Plan and UnitedHealthcare added to Covered California QHPs

Benefit & Networks Subcommittee Focus

EXAMPLES OF 2016 PLAN DESIGN CHANGES

GLOBAL CHANGES TO ALL PLAN DESIGNS IN 2016

Global Changes to Service Type	Common Medical Event	2016 Changes
Other practitioner office visit	Health care provider's office or clinic visit	Added this benefit to the SBPD. See line item under each metal level for the cost share.
All drug tiers	Drugs to treat illness or condition	Changed names: Generic drugs, now Tier 1; Preferred brand drugs, now Tier 2; Non-preferred brand drugs, now Tier 3; Specialty drugs, now Tier 4
Pharmacy deductible	Drugs to treat illness or condition	For plans with a non-integrated deductible (i.e. the Silver and Bronze tiers), "Brand Drugs Deductible" has been changed to "Pharmacy Deductible"
Specialty Drug Cap	Drugs to treat illness or condition	All Tier 4 prescriptions now have a maximum charge per script which varies by metal tier. Note that the HSA plans and Catastrophic plans do not have a cap on Tier 4 drugs.
Outpatient visit	Outpatient Services	Added the "outpatient visit" benefit to the outpatient services category (see details in the SBPD regulations text endnotes); changed the 2015 name, "Outpatient Surgery" to "Outpatient Services." See line item under each metal level for the cost share.
Emergency services	Needs immediate attention	Split "Emergency room services" into "Emergency room facility fee" and "Emergency room physician fee". See metal tier plan designs for the physician fee cost-share.
Mental Health Outpatient Services	Mental health, Behavioral Health, or Substance Abuse Needs	Split "Mental Health Outpatient Services" into "Mental/Behavioral Health Outpatient Office Visits" and "Mental/Behavioral Health Outpatient Items and Services." See endnote #13 in the SBPD regulations text for an explanation of Items and Services.
Substance Use Outpatient Services	Mental health, Behavioral Health, or Substance Abuse Needs	Split "Substance Use Outpatient Services" into "Substance Use Outpatient Office Visits" and "Substance Use Outpatient Items and Services." See endnote #13 in the SBPD regulations text for explanation of Items and Services.
Mental Health Inpatient Services	Mental health, Behavioral Health, or Substance Abuse Needs	Split "Mental Health Inpatient Services" into "Mental/Behavioral Health Inpatient Facility Fee" and "Mental/Behavioral Health Inpatient Physician/Surgeon Fee."
Substance Use Inpatient Services	Mental health, Behavioral Health, or Substance Abuse Needs	Split "Substance Use Inpatient Services" into "Substance Use Inpatient Facility Fee" and "Substance Use Inpatient Physician/Surgeon Fee."

POTENTIAL BENEFIT CHANGES WITH MINIMAL INTEREST

- Survey of Anthem plans on other exchanges did not result in new designs to consider
- Little interest in alternate (non-standard) benefit designs for 2017
- Little interest in non-Essential Health Benefits until 1095 reporting systems can support this function

POTENTIAL BENEFIT CHANGES AREAS WITH NO CONSENSUS

- Two tier hospital networks
  - Member confusion vs. lower cost for Tier 2 hospitals (compared to non-network hospitals)
  - Anthem to follow up with actual utilization of Tier 2 hospitals

- Value Based Insurance Design
  - Member confusion and limited utilization by Covered California population vs. easy to deploy copies of existing designs (e.g., hip & knee replacement reference pricing)
  - Free / low cost maintenance drugs for specific chronic conditions resulting in higher costs for other drugs and/or benefits to meet AV requirements

- Consolidation of copay and coinsurance plans for both Gold and Platinum plans
  - Small enrollment in these plans makes it a lower priority

POTENTIAL BENEFIT CHANGES WITH LIKELY AGREEMENT

- Cost-sharing changes
  - Reduce urgent care copay to standard office visit copay amount
  - Remove physician cost sharing for ER visits
  - Combine medical and pharmacy deductible for Bronze plans
- Thorough review of EOCs, SERFF template requirements, and Knox-Keene requirements to standardize benefits that are not currently standardized - likely a multi-year process.

Dental Standard Benefit Design Review for 2017

Discussion Topics

- Adult waiting period for major services
- Adult annual limit
- Degree of standardization in copay design
- Potential new plan design for employer-sponsored purchase only

QUALITY SUBCOMMITTEE UPDATE

LANCE LANG, CHIEF MEDICAL OFFICER
PLAN MANAGEMENT DIVISION

COMPASS FOR QUALITY CONTRACT CHANGES

Organizational Goal

Covered California will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities

Subcommittee Goal

- Provide input to Covered California staff as we develop recommendations for 2017 contract requirements that will target further improvements for the quality and delivery of care to consumers and align efforts for participation with other State and Federal initiatives
- Provide feedback on goal-setting with an eye for targeted improvements by 2020

2017 DELIVERY REFORM CONTRACTUAL ISSUES UPDATE (1/2)

- Covered California will be raising the bar for carrier requirements to align efforts to improve the delivery of services unique to our population and positively impact healthcare outcomes in California. Areas to be addressed include the following:
  - Reducing Racial/Ethnic disparities in health outcomes
    - Consider NCQA recognition for MultiCultural Health Care
    - Track select HEDIS Scores by racial/ethnic group
    - Demonstrate narrowed disparity in scores
    - Continue to develop Essential Community Provider networks
  - Increasing availability of 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
    - Support of integrated provider directory
  - Increase the number of member enrolled in Accountable Care Organizations (ACO) and Patient Centered Medical Homes (PCMH)
- Sub-committee meetings have started to vet 2017 QHP requirements that includes carrier participation in Quality Initiatives, Performance Measures, and Service Level Standards
- Sub-committee members include carriers and consumer advocates

2017 DELIVERY REFORM CONTRACTUAL ISSUES UPDATE (2/2)

- Narrow the number of statewide initiatives to drive more focused and concentrated effort by aligning with improvement initiatives sponsored and/or supported by other purchasers
    - California State Innovation Model/CalSIM (Appropriate use of C-Sections)
    - CalPERS, California Medicaid and PBGH
    - CMS Innovation Center (Payment reform opportunities, Clinical Transformation grant program (Partnership for Patients/Promoting Hospital Safety)
    - Statewide Workgroup on Overuse and Misuse (“Choosing Wisely” Initiative)
- Sub-committee meetings focused on changes to the 2017 contract related to delivery reform have started and includes carriers and advocates

WRAP UP AND NEXT STEPS

BRENT BARNHART, CHAIR

COVERED CALIFORNIA PLAN MANAGEMENT ADVISORY GROUP