



COVERED
CALIFORNIA

PLAN MANAGEMENT ADVISORY GROUP

January 11, 2018

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, January 11, 2018, 10:00 a.m. to 12:00 p.m.

Webinar link: <https://register.gotowebinar.com/register/407690502354527234>

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|--|-------------------------|
| I. Welcome and Agenda Review | 10:00 - 10:05 (5 min.) |
| II. 2018 Plan Advisory Membership | 10:05 - 10:15 (10 min.) |
| III. 2019 Health and Dental Benefit Design | 10:15 - 10:50 (35 min.) |
| IV. Anthem Transition Update | 10:50 - 11:30 (40 min.) |
| V. 2019 Certification | 11:30 – 11:50 (20 min.) |
| VI. Open Forum | 11:50 – 12:00 (10 min.) |

2018 PLAN ADVISORY MEMBERSHIP

LINDSAY PETERSEN, SENIOR QUALITY ANALYST
PLAN MANAGEMENT DIVISION

PLAN MANAGEMENT ADVISORY GROUP

2018 MEMBERSHIP

David Brabender

Independent Health Insurance Agent
Legislative Chair, Sacramento Association of Health Underwriters

Douglas Brosnan

Emergency Room Physician
Sutter Roseville Medical Center
Director of Provider Relations, CEP America

Mary June Flores

Policy and Legislative Advocate
Health Access California

Emalie Huriaux

Director of Federal and State Affairs
Project Inform

Betsy Imholz

Special Projects Director
Consumers Union

Richard Kronick

Professor, Division of Health Care
Department of Family and Preventive Medicine
School of Medicine
University of California, San Diego

April Martin

Director, Managed Care
Dignity Health

James Mullen

Director, Public & Government Affairs
Delta Dental of California

Robert Oreilly

Director of Policy
Molina Health Plan

Bill Phelps

Chief of Program Services
Clinica Sierra Vista

Cary Sanders

Director, Policy Analysis & Having Our Say Coalition
California Pan-Ethnic Health Network

Robert Spector

Area Vice President, Covered California Health Insurance Exchanges
Blue Shield of California

Bill Wehrle

Vice President, Health Insurance Exchanges
Kaiser Permanente

2019 BENEFIT DESIGN

ALLIE MANGIARACINO, SENIOR QUALITY ANALYST
PLAN MANAGEMENT DIVISION

2018 PLANS IN THE 2019 AV CALCULATOR

Due to AV requirements, the benefit workgroup considered a number of potential changes to cost shares for the 2019 benefit plan designs.

	Bronze		Silver				CCSB Silver		
	HDHP	Standard	Silver	Silver 73	Silver 87	Silver 94	Copay	Coins	HDHP
AV Target	60	60	70	73	87	94	70	70	70
Deviation Allowance	+/-2.0%	+/-2.0%	+/-2.0%	+/-1.0%	+/-1.0%	+/-1.0%	+/-2.0%	+/-2.0%	+/-2.0%
2018 AV	61.38	60.75	71.90*	73.88*	87.98*	93.94	71.42*	71.85*	71.66
2019 AV	62.62	62.14	72.79	74.68	88.42	94.21	72.33	72.67	72.63

	Gold		Platinum	
	Copay	Coins	Copay	Coins
AV Target	80	80	90	90
Deviation Allowance	+/-2.0%	+/-2.0%	+/-2.0%	+/-2.0%
2018 AV	78.40	81.85	88.11	91.23
2019 AV	79.62	82.84	88.90	91.73

Red text: AV is outside de minimis range

Blue text: AV is within de minimis range

*Final AV includes additive adjustment for drug copay accumulation

SUMMARY OF PROPOSED COST SHARE CHANGES IN 2019

See documents “2019 Proposed Plan Designs_2018 01 11_for discussion.pdf” and “DRAFT 2019 Patient-Centered Benefit Plan Designs_2018 01 11_for discussion.pdf”. **Note that final plan designs and AV are tentative pending review by Milliman.**

Platinum Coinsurance and Copay Plans: No changes (AV increases by 0.5-0.8%)

Gold Coinsurance and Copay Plans:

- Increase MOOP from \$6,000 to \$7,200
- Increase primary care office visits from \$25 to \$30

Silver Plans (Standard, CSR plans, CCSB):

- Increase MOOP from \$7,000 to \$7,550
- Increase cost shares (office visits, x-rays) by \$5-\$10
- Removed deductible for inpatient physician fees on Silver plans and CCSB Silver Copay plan
- No cost-share changes to Silver 94

Bronze Plan:

- Increase MOOP from \$7,000 to \$7,550

HDHP Plans:

- Increased deductibles \$500-\$1,200
- Set the MOOP at the 2018 allowed amount of \$6,650 (\$100 increase from 2017)

SUMMARY OF POLICY ITEMS CONSIDERED BY WORKGROUP

Mental Health/Substance Use “other outpatient items and services” change to coinsurance: **No.** Covered California is researching how to address instances where this benefit must be offered at \$0 to the member due to parity requirements.

Set different copay amounts for freestanding ASCs vs. Outpatient Facilities: **No**

Clarify cost share for medical transportation (both emergency and non-emergency): **Yes.** See revised language in draft 2019 plan designs

“COPAY-ONLY, NO-DEDUCTIBLE” SILVER PLAN

In mid-December, the benefits workgroup received a proposal from Anthem to include a Silver plan with no deductible and copays only in its Standard Benefit Plan Designs. Covered California and the workgroup considered two options for this type of plan design:

- Offering the design as an alternative to the current standard Silver (i.e. carriers could offer either plan)
- Replacing the current standard Silver with the “copay only, no deductible” Silver

The plan would have the following cost shares:

COPAY-ONLY, NO-DEDUCTIBLE SILVER PLAN			
Service	Cost Share	Service	Cost Share
Medical deductible	\$0	Imaging	\$350
Drug deductible	\$250	Outpatient facility / physician	\$350 / \$100
Maximum out of pocket	\$7,550	Emergency Room	\$450
Office visits (primary care, etc.)	\$45	Inpatient facility / physician	\$1400/day / no charge
Specialist visit	\$85	Outpatient rehab / hab	\$45
Lab tests	\$45	Skilled Nursing Facility	\$250/day
X-rays	\$80		

“COPAY-ONLY, NO-DEDUCTIBLE” SILVER PLAN (CONT.)

Covered California would like to consider this proposal for a future plan year (2020) but has deferred it for 2019 due largely to timing concerns:

- Unknown consumer preferences for cost shares and potential confusion on plan value among renewing Silver enrollees
- Potential rate changes among carriers opting to offer the copay plan and impact to APTC
- Product discontinuance among carriers opting to offer the copay plan and downstream effects (plan filings, consumer notification and education, CalHEERS plan choice display, etc.)
- Regulatory review of cost shares to rule out potential illusory benefits
- Compressed timeline for 2019 filings (due to earlier open enrollment)

“COPAY-ONLY, NO-DEDUCTIBLE” SILVER PLAN (CONT.)

- Covered California modeled the design based on input from one carrier and known maximum limits for certain cost shares (MOOP, imaging, x-rays).
- The minimum charge possible in the AV Calculator for inpatient services is \$1,400 per day.
- On average, 5-6% of Silver members will use inpatient services.

Hypothetical Inpatient Stay	
<i>Allowed cost per day: \$5,000</i>	
<i>Number of days: 3 days</i>	
2019 Proposed Silver	Copay-only, No-deductible Silver Plan
<i>Inpatient member cost share:</i> \$2,500 deductible and 20% coinsurance	<i>Inpatient member cost share:</i> \$1,400 per day (maximum 5 days)
<i>Allowed amount:</i> \$15,000 bill	<i>Allowed amount:</i> \$15,000 bill
<i>Member pays:</i> \$2,500 deductible + (\$12,500 * 20% coinsurance) = \$5,000	<i>Member pays:</i> \$1,400 per day * 3 days = \$4,200

- Covered California needs more time to model options for the Copay-only, No-deductible Silver Plan to understand consumer impacts, ensure cost shares are not illusory, and model potential APTC changes.

2020 BENEFIT DESIGN TOPICS FOR CONSIDERATION

- Copay-only, No-deductible Silver Plan
- 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

2019 DENTAL BENEFIT DESIGN

DIANNE EHRKE, SENIOR DENTAL SPECIALIST
PLAN MANAGEMENT DIVISION

PEDIATRIC DENTAL COINSURANCE ACTUARIAL VALUE OPTIONS

- Covered California will maintain an 85% AV (+/- 2%) requirement for the pediatric dental EHB consistent with prior years, regardless of final federal decision.
- The following options are proposed as potential approaches to decrease the actuarial value in the 2019 Dental Coinsurance Benefit Design.
- These options have been shared with the Dental Technical Workgroup.
- Please email comments to Dianne.Ehrke@covered.ca.gov.

PEDIATRIC DENTAL COINSURANCE ACTUARIAL VALUE OPTIONS

Due to AV requirements, there are a number of potential changes to cost shares for the 2019 benefit plan designs.

Benefit Plan Year Options	2018		#1 2019		#2 2019		#3 2019		#4 2019		#5 2019		#6 2019		#7 2019	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Pediatric Individual Deductible		\$65		\$75		\$80		\$85		\$65		\$65		\$65		\$65
Diagnosis & Preventive - Coinsurance (Member) Oral Exam, Preventive Cleaning/Xray, Sealants, Topical Fluoride, Space Maintainers		0%		0%		0%		0%		0%		0%		0%	X	0%
Basic Services - Coinsurance (Member) Restorative Procedures, Periodontal Maintenance Services	X	20%	X	20%	X	20%	X	20%	X	30%	X	30%	X	50%	X	20%
Major Services - Coinsurance (Member) Periodontics, Endodontics, Crowns & Casts, Prosthodontics, Oral Surgery	X	50%	X	50%	X	50%	X	50%	X	50%	X	60%	X	50%	X	50%
2019 AV (FINAL 2019 AVC)	87.36		86.93		86.71		86.49		86.83		86.34		86.03		85.30	
Actuarial Value (2018)	86.98															
Actuarial Value Difference from 2018 SBD			-0.05%		-0.27%		-0.87%		-0.15%		-1.02		-0.95		-2.06	

KEY:	X	Subject to deductible
		Increased member cost from 2018
		Does not meet AV
		Within .5 of de minimis
		Securely within AV

PEDIATRIC DENTAL COINSURANCE ACTUARIAL VALUE OPTIONS

Plan Design	Options	2019 Actuarial Value
2018 Standard Plan Design AV 86.98%		87.36%
Increase Pediatric Individual deductible from \$65 to \$75	Option #1	86.93%
Increase Pediatric Individual deductible from \$65 to \$80	Option #2	86.71%
Increase Pediatric Individual deductible from \$65 to \$85	Option #3	86.49%
Increase non-surgical Basic Services (restoration procedures, periodontal maintenance services, and periodontics) coinsurance from 20% to 30%	Option #4	86.83%

PEDIATRIC DENTAL COINSURANCE ACTUARIAL VALUE OPTIONS

Plan Design	Options	2019 Actuarial Value
Increase non-surgical Basic Services (restoration procedures, periodontal maintenance services, and periodontics) coinsurance from 20% to 30% and increase Major Services (periodontics, endodontics, crowns & casts, prosthodontics, oral surgery) coinsurance from 50% to 60%	Option #5	86.34%
Increase non-surgical Basic Services (restoration procedures, periodontal maintenance services, and periodontics) coinsurance from 20% to 50%	Option #6	86.03%
Add deductible to Diagnostic & Preventive Category (oral exam, preventive cleaning/x-ray, sealants, topical fluoride, space maintainers)	Option #7	85.30%

COPAY AND ADULT DENTAL COINSURANCE BENEFIT REVIEW

Copay Plan Design

- Draft Pediatric and Adult Copay Schedule updated deleting obsolete Dental Procedures and Nomenclature (CDT-19) 2017 codes
- CDT-19 will be available in May 2019 and final Copayment Schedule will be presented in November 2018

Adult Coinsurance Plan Design (No change except Endnote 14)

- Continue 2018 standard exclusions in 2019:
 - Tooth Whitening, Adult Orthodontia, Implants, Veneers
- Six Month Waiting Period for Major Services
 - Any prior coverage must be accepted: Group/Individual/Medi-Cal, On/Off-Exchange, Any Dental Plan Issuer
 - Dental plan issuers must reduce the six month waiting period for each month of prior coverage, no required minimum duration of prior coverage allowed
 - Dental plan issuers may set the maximum allowed lapse in coverage when waiving waiting period
 - Dental plan issuers may determine which documents are acceptable to provide proof of prior coverage

COPAY AND ADULT DENTAL COINSURANCE BENEFIT REVIEW

Endnotes

- Delete Endnote 14 from Dental Standard Benefit Design. These non-covered adult codes are already noted as not covered in the Copayment Schedule.
 - 14) The following CDT codes are not covered adult dental benefits: D0145, D0251, D0310, D0320, D0322, D0340, D0350, D0351, D0601, D0602, D0603, D1120, D1206, D1208, D1310, D1320, D1352, D1520, D1525, D1575, D2929, D2930, D2932, D2933, D2941, D2949, D2955, D2971, D3230, D3240, D3353, D4920, D5911, D5912, D5913, D5914, D5915, D5916, D5919, D5922, D5923, D5924, D5925, D5926, D5927, D5928, D5929, D5931, D5932, D5933, D5934, D5935, D5936, D5937, D5951, D5952, D5953, D5954, D5955, D5958, D5959, D5960, D5982, D5983, D5984, D5985, D5986, D5987, D5988, D5991, D6010, D6011, D6013, D6040, D6050, D6052, D6055, D6056, D6057, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6080, D6081, D6085, D6090, D6091, D6092, D6093, D6094, D6095, D6100, D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117, D6190, D6194, D6199, D7920, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7951, D7952, D7955, D7972, D7990, D7991, D7995, D7997, D8080, D9230, D9248, D9410, D9420, D9610, D9612, D9950

ANTHEM TRANSITION UPDATE

RICK KRUM, EXCHANGE DIRECTOR
ANTHEM BLUE CROSS

JEN JACOBS, DEPUTY DIRECTOR
PLAN MANAGEMENT DIVISION

Transition Assistance – Update as of 1/8



Summary

- Anthem reduced the footprint for on/off exchange plans from 19 rating regions to 3 rating regions effective January 1, 2018.
- Covered California requested that Anthem provide data files to other carriers for transition assistance / continuity of care. Information sharing included Medical Management authorizations, Case Management/Disease Management, Pharmacy authorizations, and PCP information.
- To Anthem's knowledge the sharing of this data was never performed in the Individual fully insured market before this effort. Anthem discussed these efforts with our Medical Management team to understand Group processes and data files.
- This was a short term unplanned initiative that took considerable time to develop and deploy. Anthem had 2 primary points of contact dedicated to this effort (Rick Krum and Susan Schmidt).
- Initial discussion between Covered California and Anthem kicked off in August. In depth discussions began in October.
- Anthem completed the first of two data exchanges on 12/29. The second data exchange is being performed the week of 1/8.

Member Communication

- Letter campaigns began in late November and were completed in early January.
- Due to letter content, between outreach to members and providers there were 13 different letter variations that were sent.
- While most had minor modifications to baseline templates, each needed special handling.
- Anthem conducted outreach for Medical Management authorizations (4 batches), Rx authorizations, Case Management/Disease management, and an off-exchange education letter. Over 115,000 letters were sent.
- The letters sent to members regarding their authorizations included prepaid envelopes and HIPAA authorization forms so Anthem could share sensitive diagnosis information with other carriers. The mailing address for the return envelopes went to a special address so we could identify and keep track of these special cases. We received 160 responses (1% response rate for this specific type of letter).

Addressing Privacy Concerns

- 9 carriers completed agreements for the data sharing with Anthem.
- Each carrier attested that their effectuation data sent to CalHEERS is accurate.
- Anthem provided each carrier a statistically accurate random sampling of data to confirm effectuations. A total of 2,029 cases were sampled. This was at 95% +/- 5% confidence level.
- Carriers needed to confirm accuracy of the sampling effectuations before production data was uploaded to the carriers.
- New process established for this initiative to share data with carriers via a FTP site. Each carrier had their own login with access only to their data files.
- Anthem scrubbed various data files to prevent release of sensitive diagnosis information when no HIPAA authorization was received from the member.

Round 1 Data Exchange: CalHEERS File 12/26

- CalHEERS file sent to Anthem on 12/26.
- Anthem sent sampling to carriers on 12/26.
- Anthem received confirmation of sampling accuracy between 12/27-12/29.
- Anthem uploaded files for the 9 carriers on 12/29.
- Each carrier received 4 tabs of information (as it was available). Total of 36 tabs across the 9 files. Tabs of data included:
 - Medical Management authorizations Total*: 1,519
 - Case Management/Disease Management Total*: 52
 - Pharmacy authorizations Total*: 2,086
 - PCP information Total: 23,982
- During the analysis process Anthem compared data across 19 data files totaling over 2.5 million rows of data. Examples of large data sets:
 - Covered California (CalHEERS) enrollment information
 - Anthem enrollment information
 - Anthem claims data
 - Anthem provider data
 - Anthem pharmacy authorization data
 - Anthem Medical Management authorization data

* The “Total” is not a member level count. Members may have been listed multiple times due to type of authorization or program they were participating in.

Round 2 Data Exchange: CalHEERS File 1/8

- At time presentation prepared Anthem was awaiting confirmation that file was complete from Covered California / CalHEERS.
- Many of the files used to develop Round 1 will be able to be leveraged for Round 2.

2019 CERTIFICATION

JEN JACOBS, DEPUTY DIRECTOR
PLAN MANAGEMENT DIVISION

2019 Certification Application Strategy – Contracted Issuers

Plan Management recently performed an extensive review of the Individual QHP Application template with a goal of validating questions posed were still appropriate and to ensure consistency in speech, format and approach.

Impact:

- Removal of questions or sections cared for via Issuer contract compliance, performance guarantees, contractual reporting, and Attachment 7 ongoing work and initiatives not required to be addressed in the Application.
- Removal of questions or sections not relevant to currently contracted Issuers.

Benefit:

- Reduce resources used to review already established, monitored and/or reported according to the Issuer contract.
- Increase collaboration on quality initiatives and proposed product and/or network strategies.
- Emphasis on areas that “really matter” to the Consumer experience and align with the Triple Aim.

Sample explanation legend

Section	Category Information	Comments
3. Licensed & Good Standing (Full Section)	<ul style="list-style-type: none">○ 3.1: DMHC or DOI license.○ 3.2: Material fines related to good standing.○ 3.3: Material fines in CA.	Included in Issuer contract section 8.1. Remove full section.
15. Marketing & Outreach (Partial Section)	<ul style="list-style-type: none">○ 15.1: Marketing org chart.○ 15.2 Adhere to Exchange branding.○ 15.3: Submit materials per deadline.○ 15.4: Submit Member communication calendar.○ 15.5: Submit proposed marketing plan.	Items 15.1 – 15.3 established and/or included in Issuer contract. Remove. Items 15.4 – 15.5 required.

2019 Certification Application Strategy – New Entrant Applicants

New for 2019: Clearly defining minimum qualifications for new entrant Applicants to include:

- Currently licensed by DMHC or CDI and in Good Standing.
- (2) year minimum experience operating as a health issuer.
- (2) year minimum experience operating in the California marketplace (exchange or other market segments).

Benefit:

- Ensures Covered California is providing the highest level of quality, cost-effectiveness, and operational efficiency to consumer.
- Reduces resources required to review plans not meeting minimum threshold of service.

PROPOSED CERTIFICATION MILESTONES

Final AV Calculator Released	December 28, 2017
Release draft 2019 QHP & QDP Certification Applications	January 12, 2018
Draft application comment period	January 12-26, 2018
January Board Meeting: discussion of benefit design & certification policy recommendation	January 18, 2018
Letters of Intent Accepted	February 1 – 15, 2018
February Board Meeting: anticipated approval of 2019 Standard Benefit Plan Designs & Certification Policy	February 15, 2018
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 20-28, 2018
QHP & QDP Applications Open	March 1, 2018
March Board Meeting: approval of 2019 Standard Benefit Plan Designs & Certification Policy (if Feb meeting cancelled)	March 15, 2018
QHP Application Responses (Individual and CCSB) Due	May 1, 2018
Evaluation of QHP Responses & Negotiation Prep	May - June 2018
QHP Negotiations	June 25, 2018
QHP Preliminary Rates Announcement	July 2018
Regulatory Rate Review Begins (QHP Individual Marketplace**)	July 25, 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	July 25, 2018
QDP Rates Announcement (no regulatory rate review)	August 2018
Public posting of proposed rates**	July 25, 2018
Public posting of final rates**	November 1, 2018

* Final SERFF template dependent on CMS release

** TBD = dependent on CCIIO rate filing timeline requirements

OPEN FORUM AND NEXT STEPS

ROB SPECTOR, CHAIR
PLAN MANAGEMENT ADVISORY GROUP