



**COVERED**  
**CALIFORNIA**

**Plan Management and Delivery System Reform Advisory Group**

November 15, 2013

# AGENDA 1

*Public comment will be taken after each agenda item*

- |      |   |                     |
|------|---|---------------------|
| I.   | Welcome and Agenda Review (Ellen Wu)  | 1:30-1:40(10 min.)  |
| II.  | 2015 Benefit Design and Recertification (Ellen Wu)  | 1:40-2:40 (60 min.) |
|      | <ul style="list-style-type: none"><li>• Certification and Recertification</li><li>• Network adequacy standards to CDI products</li><li>• Member-level benefits</li><li>• Deductibles</li><li>• Coinsurance</li><li>• Alternative benefit design</li></ul> |                     |
| III. | Update on pediatric dental  | 3:00-3:10 (10 min.) |
| IV.  | Plan Management Advisory Committee Membership   | 3:10-3:30 (20 min.) |
- Send public comments to [qhp@hbex.ca.gov](mailto:qhp@hbex.ca.gov)

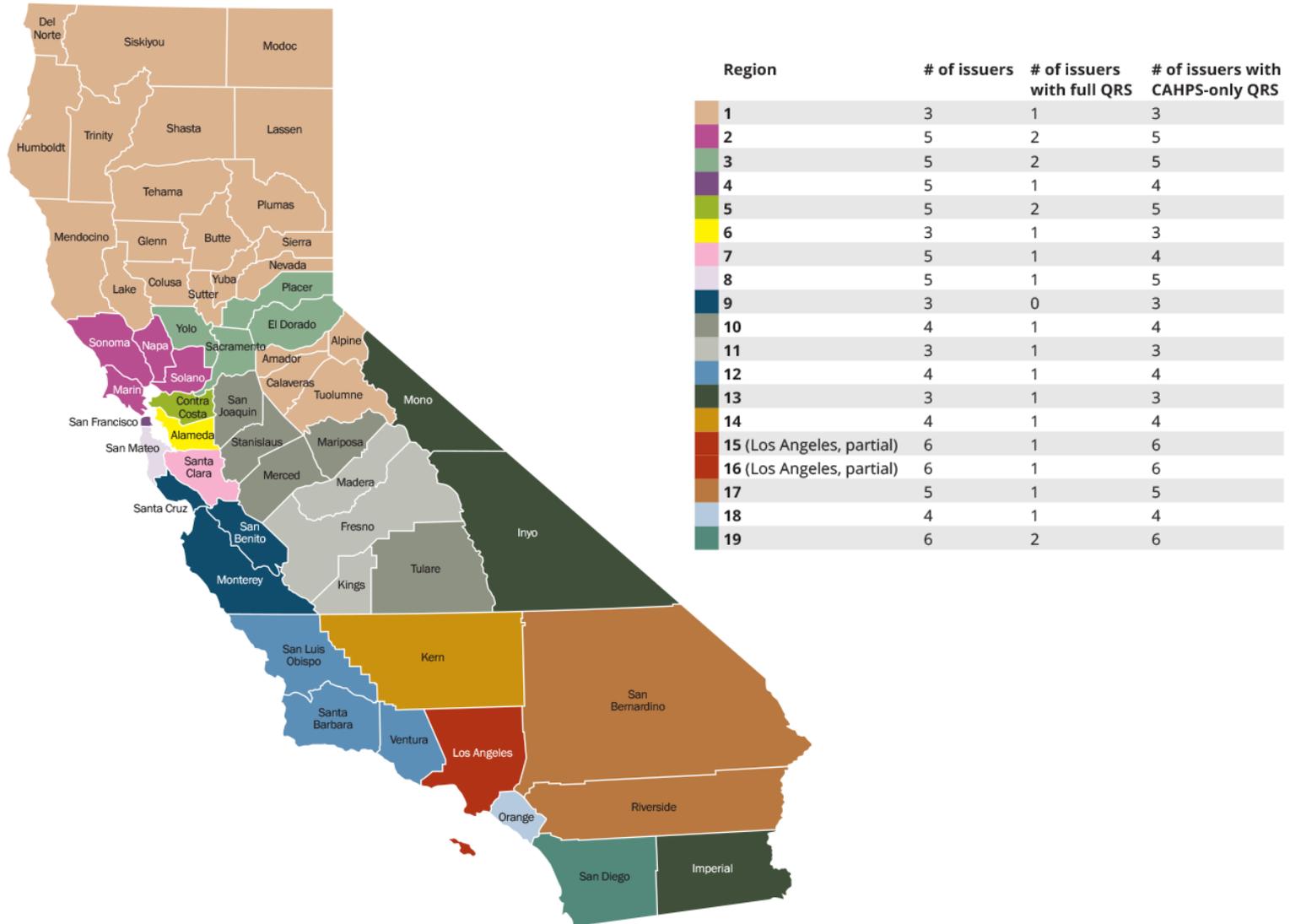
# QUALITY RATING SYSTEM (QRS) UPDATE FOR PLAN ADVISORY COMMITTEE

Jeff Rideout, Senior Medical Advisor  
11-15-2013

# 10-24: MANAGEMENT INSTRUCTED TO RECOMMEND A QRS USING HISTORIC CAHPS INFORMATION

- CAHPS information available for 9 of 11 issuers and 11 of 13 plans
  - No scores available for Chinese Community or Valley Health Plan
  - No score to be posted for Alameda Alliance
- Information available for all plans offered in 17 of 19 regions
- 10 measures available across commercial HMO, PPO & MediCal plans
  - Access to Care(4)- getting needed care (2), getting care quickly (2)
  - Doctors and Care (3)- all health care (1), personal doctor (1), specialist (1)
  - Plan Service (3)- rating of health plan (1), customer service (2)
- 4 measures excluded- not used in MediCal- plan information on costs (2); claims processing (2)
- Underway: comparison of HEDIS/CAHPS scores and distribution vs. CAHPS only

# WHAT WOULD CALIFORNIA LOOK LIKE FOR CONSUMERS USING HISTORICAL DATA FOR SOME PLANS?



# Results of CAHPS Scenario Testing

	1 Star	2 Star	3 Star	4 Star
Using Regional PPO Benchmark	0	4	5	2
Using National PPO Benchmark	2	5	3	1
Using California PPO Benchmark	No meaningful performance distribution benchmarks is possible given only 6 plans			

# RECOMMENDATION ON QUALITY RATING SYSTEM (QRS)

Management recommends that Covered California implement a Quality Rating System using: i) 10 CAHPS measures common to both commercial and Medi-Cal plans, ii) a single summary score for each plan compared to the regional PPO benchmark and iii) a 1-4 star rating system.

The earliest anticipated presentation of QRS information is January 2014 and will include all plans that have scores available. Plans for which no CAHPS information is available will be noted as “first information available in 2015”.

The implications of this decision on the “Group 3” plan performance assessment of attachment 14 of the model contract have not been determined.

Considered: single measure of overall rating of plan (used by CO Exchange)

- no reasonable distribution of plan scores-all very high or low
- measure is very sensitive to product type (HMO, PPO, Medi-Cal)
- results of this single measure diverged from the 10 measure set results

Considered: subset that excluded 3 care/physician related questions

- no meaningful difference in distribution; implied policy decision

# PROVIDER DIRECTORY UPDATE

Jeff Rideout, Senior Medical Advisor

# Provider Information and Provider Directory Update Week of 11-11

Key Task	Goal	Target Date	Comments	Status
create single CCA PM point of contact	Ensure comprehensive cataloging for all identified issues regardless of source	October 31		
Physician search accuracy	Ensure X% accuracy of cross plan search (X TBD- recommend >80% all cause); "machine" process to assess	November 6 (done)	CMA rerunning cases; anticipating >80% accuracy with remaining being submission errors	
Add Physician Specialty Codes	Improve Provider Search Information	Nov 19	Plan call 10-30 to explain intent	
Multi plan directory	Physician and Hospital (only) composite information for external parties	November 15	Difficulty with pre-scrub data; CCA doing the work directly; QA loop with plans needed	
Plan and Exchange product specific URLs from plan information	Allow consumers direct path from enrollment site to plan specific provider directory information	Nov 6 (done)		
"Medical group" identification	Allow enrollees to search via key organizational names	1X Nov 6(done); roll out Nov 19 refresh version	Longer term process improvements for "top down" lists being recommended	
"Re Boot"	Create a new end/end process with full QA and testing; new data submission template	Aug 2014	All Plan kick off on 11-19	

# COPAY-ONLY PLAN DESIGNS

Ken Wood, Senior Advisor

# 2015 BENEFIT DESIGN – CONTEXT

- Covered California standard benefits were designed based on extensive stakeholder input, broad transparency, and a commitment to maximize the use of copays
- Our standardized benefits are allowing “apples to apples” consumer comparisons, simplifying training and neutralizing benefit differences between HMO, EPO, and PPO. We believe the standard designs are helping with our superior enrollment results relative to states with complex portfolios
  - Colorado –150 different plans with 3,736 individuals enrolled in October
  - New York – 533 different plans with 16,404 individuals enrolled in October

# 2015 BENEFIT DESIGN – CONTEXT (cont'd)

- 2015 timeline means . . . .
  - No performance information about 2014 standard plans
  - No consumer satisfaction information
  - Dependent on CMS releasing 2015 version of the Actuarial Value Calculator
  - Bias to “stay the course” with minimal changes so that we can gather full data set on the performance of these plans
- **Today’s goal is to get input from advisory group on priorities for 2015 benefit plans**

# 2015 BENEFIT DESIGN

Is it possible to have “copay only” Silver and Bronze plans?

**Covered California's Benefit design goal has always been to maximize the use of copayments and to minimize the use of deductibles and coinsurance.**

**Many consumer advocates have asked us to evaluate plan designs that only use copayments.**

**Is it possible? – yes**

**is it consumer friendly? -- no for bronze, maybe for silver**

# ACTUARIAL VALUE DRIVES ACA COMPLIANT DESIGNS

Actuarial Value (or AV) is the percent of covered services paid by the insurance plan for a large population over a long period of time. CMS mandates the use of an AV Calculator that is developed by the CMS actuaries and used across the country. Each metal tier has a target AV with a +/- 2% variation allowed.

Plan	Target Actuarial Value
Platinum	90%
Gold	80%
Silver	70%
Bronze	60%

# GENEROUS \$6,350 ANNUAL OUT-OF-POCKET MAXIMUM HAS MAJOR IMPACT ON AV CALCULATION

A plan design with a deductible that equals the required maximum out-of-pocket of \$6,350 has an Actuarial Value of 58.0% and qualifies as a Bronze plan.

Plan Feature	Value
Annual Deductible	\$6,350
Coinsurance	100%
Annual Out-of-Pocket Maximum	\$6,350
Actuarial Value	58.0%
Metal Tier	Bronze

# BRONZE COPAY ONLY PLAN

It is mathematically possible to have a Bronze Plan that only uses Copays but this forces all consumers to pay very high prices for every service, at times more than the actual cost of the service.

Category of Care	Copay
Primary Care	\$75
Specialty Care	\$125
Emergency Room	\$750
Hospital per Day	\$1,250/day
Lab	\$250
X-Ray and Imaging	\$500
Imaging (CT, MRI and PET)	\$1,000
Generic Medication*	\$19*
Preferred Brand	\$150
Non-Preferred Brand	\$300
Specialty Drug	\$1,000
<b>Actuarial Value</b>	<b>61.9%</b>

# SILVER COPAY ONLY PLAN

The Silver Copay Only plan is more attractive than the Bronze but results in high copays for many services.

Category of Care	Copay
Primary Care	\$25
Specialty Care	\$75
Emergency Room	\$500
Hospital per Day	\$750/day
Lab	\$50
X-ray and Imaging	\$250
Imaging (CT, MRI and PET)	\$500
Generic Medication*	\$19*
Preferred Brand	\$50
Non-Preferred Brand	\$100
Specialty Drug	\$250
<b>Actuarial Value</b>	<b>72.0%</b>

# **SB639 Hernandez**

Cost Sharing: California Law  
November 12, 2013

## OUT OF POCKET MAXIMUM 2015 PLAN YEAR AND AFTER

- For 2015 plan year and after, SB639 limits the total annual out of pocket maximum to a “total maximum out of pocket limit for all essential health benefits equal to the dollar amounts” allowed under the federal Internal Revenue Code for health savings accounts.
- Applies to all ten essential health benefits, including pediatric dental.
- California law is different than federal guidance. Current federal guidance permits separate out of pocket limits for QHPs and for standalone dental plans which can exceed the IRS limit for QHPs.

# ANNUAL OUT OF POCKET LIMIT

- For 2015 and subsequent plan years
- Multiple out of pocket limits are permitted so long as the total limit does not exceed \$6,350 (or the IRS determined amount).
- A separate limit for pediatric dental is permitted so long as the total annual out of pocket maximum for all ten benefits does not exceed \$6,350( or the IRS determined amount).

## ANNUAL OUT OF POCKET LIMIT: PEDIATRIC DENTAL

- Pediatric dental benefits may be offered as embedded, bundled or standalone plans so long as those plans comply with the total out of pocket limit.
- State law does not specify an amount for the annual out of pocket limit for pediatric dental.
- State law permits separate deductibles for pediatric dental.
- Federal rules permit the Exchange to set a “reasonable” out of pocket limit for pediatric dental benefits.

# OUT OF NETWORK EMERGENCY CARE INCLUDED IN OUT OF POCKET LIMIT

- For 2014 and subsequent plan years, requires Insurance Code products to include cost sharing for out of network emergency care as counting toward the maximum out of pocket limit. Effective 2014.
- Applies to individual, small group and large group products.
- Existing law for Knox-Keene.
- Different than federal law and rules in that federal rules are silent on this question.

# 2014 PLAN YEAR: TRANSITION YEAR

- The 2014 plan year is a transition year. H&SC 1367.0065; Ins Code 10112.285.
  - For individual and small group market, the maximum out of pocket limit included in the Exchange's standard benefit plan designs is the amount set by the IRS for QHPs
  - The Exchange, consistent with federal rules, set a separate out of pocket limit for standalone dental plans that is in addition to the maximum out of pocket limit for other benefits.

# SMALL GROUP RULES

- Consistent with Exchange contracts for 2014, applies annual out of pocket limit to all essential health benefits.
- Adds statute re: limits on deductible for small group consistent with federal law.

# PEDIATRIC DENTAL UPDATE

Casey Morigan, Consultant, Plan Management

# AFTER CONSIDERING A RANGE OF OPTIONS\* TO ACHIEVE OUR POLICY OBJECTIVES, ONE RECOMMENDATION WAS SELECTED FROM THREE FINALISTS.

**A. Change/waiver in CMS regulations to add 2<sup>nd</sup> lowest 70% stand alone dental premium for calculating advanced premium tax credits, and screen for pediatric dental at “check-out,” or**

**B. Work with issuers to offer 10.0 embedded essential health benefits and 0.5 dental plans, or**

**C. Solicit both embedded 10.0 and 9.5 plans, except for the Silver level (10.0 only), and screen for pediatric dental at “check-out.”**

*\* All considered options can be viewed in the full Wakely Report*

# PROPOSED POLICY OBJECTIVES

## *Primary:*

1. Maximize the availability of the advanced premium tax credit for the pediatric dental benefit
2. Ensure the enrollment of all eligible children ( $\leq 18$ ) in the pediatric dental benefit

## *Additional:*

3. Ensure the application of all consumer protections to the dental benefit
4. Fairly spread the cost of the dental benefit across populations with and without children
5. Equalize benefit design (coverage) on and off the Exchange
6. Structure cost sharing to ensure a meaningful dental benefit (OOPM, deductibles)