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# Covered California

## Plan Management and Delivery System Reform Advisory Group

January 9, 2013

# Covered California's Vision and Mission

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## **Vision**

The vision of Covered California is to improve the health of all Californians by assuring their access to affordable, high quality care.

## **Mission**

The mission of the Covered California is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.



# Covered California's Values

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## **Consumer-focused**

At the center of the Exchange's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those we serve.

## **Affordability**

The Exchange will provide affordable health insurance while assuring quality and access.

## **Catalyst**

The Exchange 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.

## **Integrity**

The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.

## **Partnership**

The Exchange welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners, and other stakeholders.

## **Results**

The impact of the Exchange will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians.



# Covered California Governance

## Independent Public Entity with Qualified Board

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**Diana Dooley**, Board Chair and Secretary of the California Health and Human Services Agency, which provides a range of health care services, social services, mental health services, alcohol and drug treatment services, income assistance and public health services to Californians

**Kim Belshé**, Senior Policy Advisor of the Public Policy Institute of California, former Secretary of California Health and Human Services Agency, and former Director of the California Department of Health Services

**Paul Fearer**, Senior Executive Vice President and Director of Human Resources of UnionBanCalCorporation and its primary subsidiary, Union Bank N.A., Board Chair of Pacific Business Group on Health, and former board chair of Pacific Health Advantage

**Robert Ross, M.D.**, President and Chief Executive Officer of The California Endowment, previous director of the San Diego County Health and Human Services Agency from 1993 to 2000, and previous Commissioner of Public Health for the City of Philadelphia from 1990 to 1993

**Susan Kennedy**, Nationally-recognized policy consultant, former Deputy Chief of Staff and Cabinet Secretary to Governor Gray Davis, former Chief of Staff to Governor Arnold Schwarzenegger, former Communications Director for U.S. Senator Dianne Feinstein, and former Executive Director of the California Democratic Party

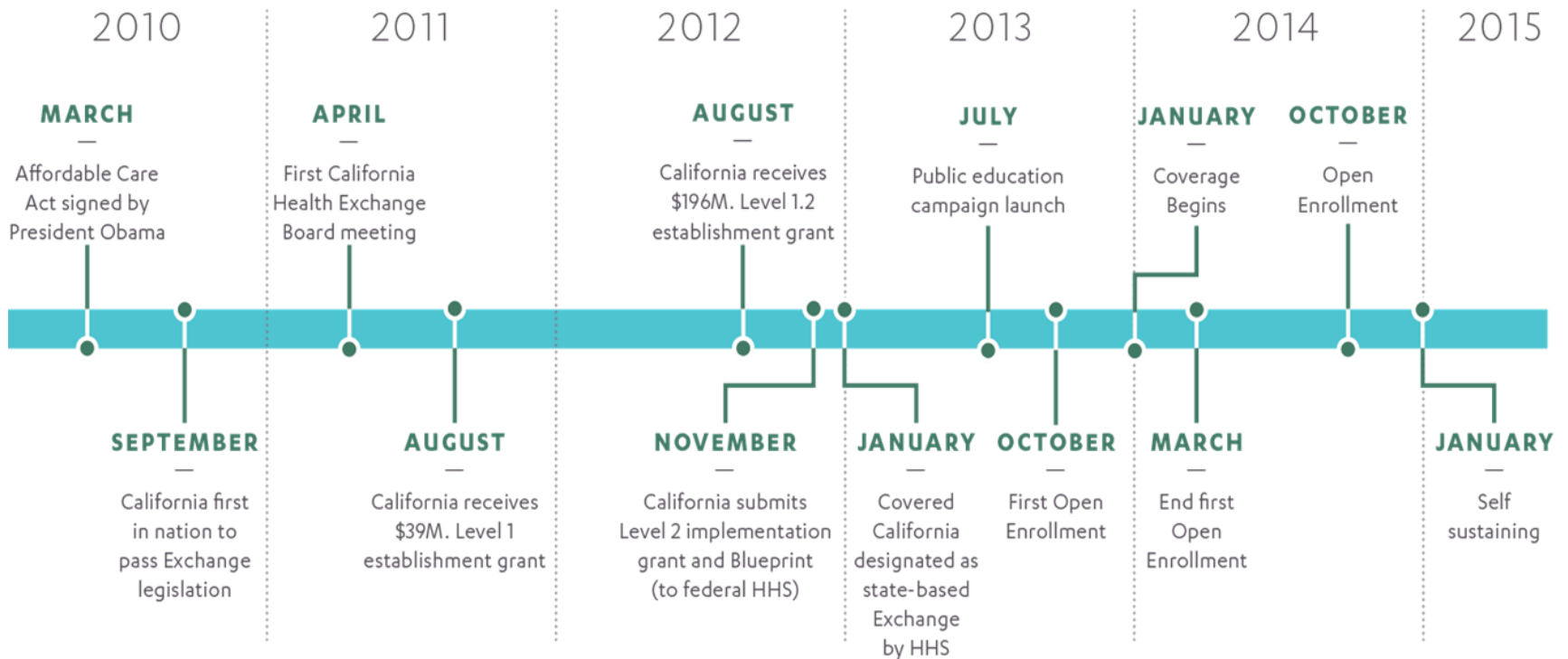


# Foundations of Covered California's Success

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# Covered California's Milestones



# Plan Management and Delivery System Reform Advisory Group Composition

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**Irma Cota**

North County Health Service

**Jerry Fleming**

Kaiser Permanente

**Brad Gilbert, MD**

Inland Empire Health Plan

**Elizabeth Gilbertson**

Unite Here Health

**Dana Goldman, Ph.D.**

USC Leonard D. Schaeffer  
Center for Health Policy & Economics

**Shelley Horwitz**

Bay Valley Medical Group

**Abdul Kassir**

Community Medical Centers

**Deborah Kelch**

Kelch Policy Group

**Alana Ketchel**

Pacific Business Group and Health

**Steven Larson, MD**

Riverside Medical Clinic,  
California Medical Association

**Ruth Liu**

Blue Shield of California

**Lynn Quincy**

Consumers Union

**Lisa A. Rubino**

Western Region & Medicare  
Molina Healthcare, Inc.

**Victoria Sorlie-Aguilar, MD**

California Academy of Family  
Physicians, National Hispanic Medical  
Association

**Valerie Yv. Woolsey**

Bay Area Addiction Research and  
Treatment

**Ellen Wu (Chair)**

California Pan-Ethnic Health Network

**Board Participants**

**Kim Belshé**

**Paul Fearer**



# Plan Management and Delivery System Reform Advisory Group Charter

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- **Purpose:** To provide advice and recommendations and serve as a sounding board to Covered California to assist in the continual refinement of policies and strategies.
- **Scope:** The provide **input on qualified health plan contracting strategies\***, ongoing benefit design issues, and strategies to promote health care value and drive delivery system reform.
- **Structure:** Advisory Group members are selected for an initial two-year term and meet quarterly.

\*today's focus



# Commitment to Transparency

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- We are very public:
  - Public Records Act: The Public has the right to inspect and/or obtain copies of public records maintained by Covered California.
  - Assume all emails will be in the LA Times
  - Meetings are public
  - Advisory group discussions – individuals’ comments will NOT be treated as “positions” of the organizations they represent, but press and the public will be at quarterly meetings
- Advisory Group members may be contacted by media organizations, but do not “represent” Covered California
- Covered California may informally reach out to some or all of the Advisory Group for input between meetings.



# Qualified Health Plan Timeline

	Activity	Date
<b>TODAY</b> →	<b>Plan Management and Delivery System Reform Advisory Group – Input</b>	<b>January 9, 2013</b>
	Phase one responses due from QHP bidders	January 15, 2013
	Final model contract-posting	January 17, 2013
	Essential Community Provider Network maps and lists due to Exchange-phase 1a	February 15, 2013
	Provider networks to regulators-phase 2	February 28, 2013
	Solicitation phase 3-due (bids including premium rates)	March 31, 2013
	Evaluation/negotiation period	April 1-May 15, 2013
	Tentative certification notices sent to bidders contingent on Regulator Rate Review and QHP Contract Negotiations	May 15, 2013
	Rate filing with regulators for selected QHP's (rates will become public)	May 15, 2013
	<b>120 Days</b> →	<b>Contract-negotiation completed by May 15, 2013</b>
Rate review by regulators		May 15-June 30, 2013
Plan administration manual (version 1)- released		May 30, 2013
Model contract-final executed		June 30, 2013
QHPs loaded into CalHEERS		July 1, 2013



# Delivering on Covered California's Mission

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## **Transforming the individual and small employer market place**

- Fully embraced the Affordable Care Act and California Affordable Care Act
- Be leading exchange in country
- Broad participation of all types of Qualified Health Plans

## **Constructive partnership with Qualified Health Plans**

- Seek multi-year collaboration to build a better system
- Maximize funds going to health care

## **Clear consumer protections**

- Access standards for getting Primary Care assignment and annual wellness visit
- Protection for hidden “non-participating” provider – member only pays standard copayment
- Live telephone support in English and Spanish
- Native American <300% FPL have no costs (either premium or copayment)



# Delivering on Covered California's Mission

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## **Continually improve quality of care and access to care**

- Expect and reward continuous improvement with penalties for substandard performance
- Collaborate with like-minded organizations to support delivery system reform

## **Transparency and meaningful reporting**

- Full disclosure of financials and plan performance to Covered California
- Meaningful dashboards that produce actionable insights

## ***Advisory Group Input:***

- *What other areas need focus?*



# How will we evaluate and select QHPs?

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- Develop an overall value of bids based on **quality, service** and **price** .
- Offer a healthy **mix of HMO and PPO products in each region** by requiring bidders to use one of the two standardized benefit plan designs and carefully consider alternate non-standard plan designs.
- Encourage issuers to cover as much of the State as possible to **stimulate competition and increase consumer choice**; recognize health care is local.
- Give **preference to bidders who include more Essential Community Providers** in their provider networks to achieve alignment with goal of serving the low-income population.

# How will we evaluate and select QHPs?

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- Give greater weight to responders who **demonstrate commitment to serving the cultural, linguistic and health care needs of the low-income uninsured population**, by contracting with Federally Qualified Health Centers as one example.
- Evaluate and prioritize demonstrated **innovations in health care delivery that emphasize quality initiatives, increase patient safety and alter payment approaches**.

## *Advisory Group Input:*

- *Are there other criteria we should consider?*

# Model Contract - Key QHP Provisions

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- 1. Quality Improvement and Delivery System Reforms**
  - Addressing Enrollees with Existing Health Needs
  - Reporting on Quality of Care
  
- 2. Effective Consumer Communication**
  - Ensuring Culturally Competent Care and Linguistically Appropriate Care
  
- 3. Fee Structure for Health Plans**
  - Planned Enrollment & Operating Budget
  
- 4. Plan Partnerships and Marketing**

# Key QHP Contract Provisions

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## 1. Quality Improvement and Delivery System Reforms

### Primary Care and Preventive Services

- Contractor shall demonstrate to the Exchange that all new Enrollees are assigned to Primary Care Providers or a Patient-Centered Medical Home within 45 days of enrollment. Contractor may offer an alternative approach to achieving this goal.
- Contractor shall demonstrate to the Exchange that at least XX% of new Enrollees receive a preventive services visit within 120 days

### Motivating and rewarding innovations that work

- Collecting information on Patient Centered Medical Homes, telemedicine, provider payment approaches which incentivize patient- centered decision making.

### *Advisory Group Input*





# Key QHP Contract Provisions

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## 1a. Addressing Enrollees with Existing Health Needs

- Contractor shall identify Enrollees with chronic conditions and/or significant health needs and pro-actively arrange for these Enrollees to get needed care in a timely fashion.
- Contractor shall demonstrate to the Exchange its use of health assessment tools, data analytics and member self-identification to identify Enrollees most in need of timely treatment plans.
- Contractor must demonstrate its ability and mechanisms to pre-identify all Enrollees with existing chronic conditions and significant health needs within 120 days of enrollment.
- Once such Enrollees are identified, Contractor must demonstrate that XX % of identified enrollees with chronic conditions or significant health needs are in a treatment plan within 60 days of identification.



# Key QHP Contract Provisions

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## 1b. Reporting on Quality of Care

Contractor shall provide periodic reports that describe the types of care provided to Enrollees. Report requirements and formats will be outlined in the Administrative Manual.

- Claims and encounter data provided for all-payer or other analytics
- Volume by type of provider
- High-cost Enrollee
- Health Assessment Completion Preventive Services Visits
- Reports on episodes of care eligible for reinsurance reimbursement
- Out of Network Paid Claims

### *Advisory Group Input*

- *Other key data elements we should be gathering?*



# Key QHP Contract Provisions

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## 2. Effective Consumer Communication

- Contractor must provide Enrollees with current and real-time information on costs and quality of treatment provided (region-specific and provider-specific) including cost sharing incurred and remaining cost sharing.
- Contractor shall regularly communicate specific customized cost information to its enrollees which include out-of-pocket costs incurred or care used to date and progress towards satisfaction of deductible.
- Contractor shall use a clear and consumer-friendly explanation of benefits
- Contactor shall adopt shared-decision-making practices for preference-sensitive conditions, including but not limited to breast cancer, prostate cancer, and knee and hip replacements, that feature patient-decision-making aids in addition to physician opinions and present trade-offs regarding quality or length of life.



# Demonstrated Cultural and Linguistic Competency

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## 2b. Ensuring Culturally Competent Care and Linguistically Appropriate Care

- Contractor provide or make arrangements for language interpretation and translation services for its Enrollees at:
  1. Point of care
  2. Contacting the QHP
  3. Accessing QHP providers.
- Contractor shall develop and deploy internal systems to ensure the availability of appropriate language proficiency at point of care and Enrollee support/services.

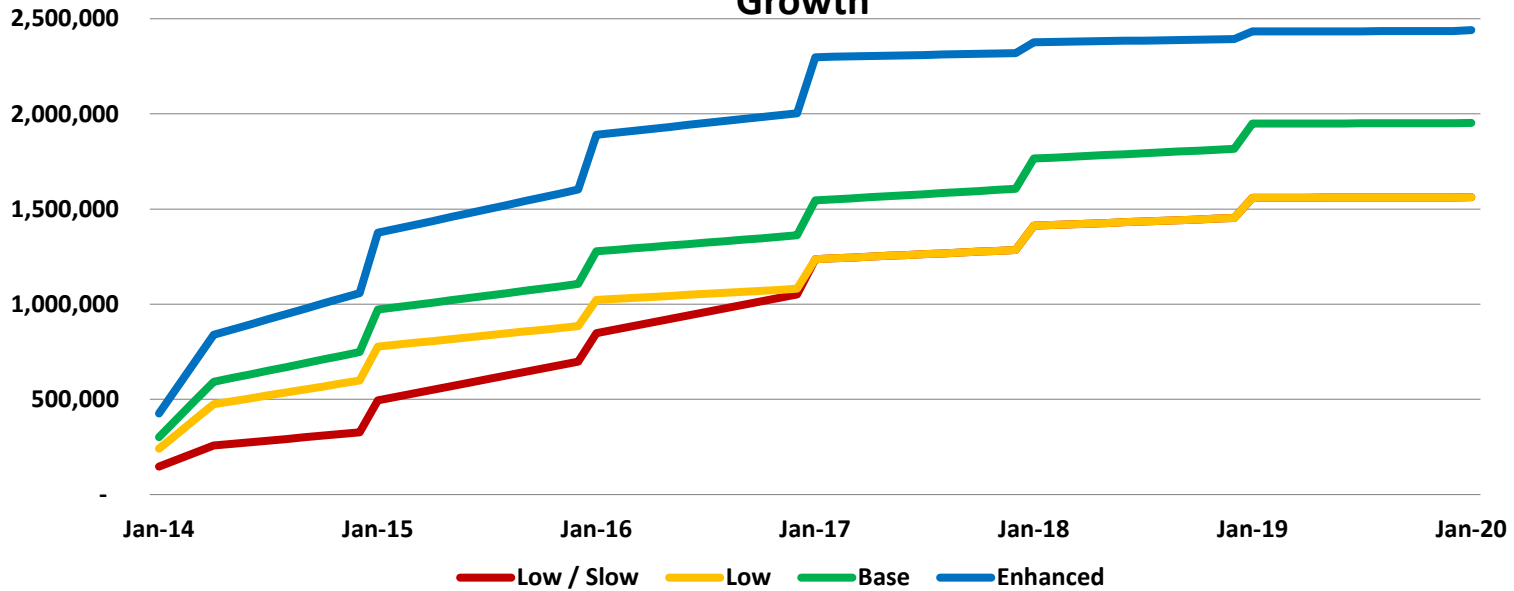
### *Advisory Group Input*

- *Other key data elements we should be gathering?*



# “Aim High” and Plan for Uncertainty

## Exchange Subsidized & Unsubsidized Enrollment Projection Profile and Growth



	Jan-14	Jan-15	Jan-16	Jan-17	Jan-18	Jan-19	Jan-20
Low / Slow	150,000	490,000	850,000	1,240,000	1,410,000	1,560,000	1,560,000
Low	240,000	780,000	1,020,000	1,240,000	1,410,000	1,560,000	1,560,000
Base	300,000	970,000	1,280,000	1,550,000	1,770,000	1,950,000	1,950,000
Enhanced	430,000	1,380,000	1,890,000	2,300,000	2,380,000	2,430,000	2,440,000

Covered California is seeking to enroll as many Californians as possible. Covered California is working to meet and exceed its goals, while at the same time planning for lower enrollment by developing budgets that can be adjusted and constantly adjusting its marketing, outreach and operations as needed based on new information and experience.



# Major Fee Components

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## Base Fee Proposal

- Set initial fee based on 3% of premium, but assess on PM/PM basis
- Assess fee at on non-Covered California QHP enrollment at 50% of QHP
- Charge fee on Supplemental Plans (Dental and Vision) at same rate (3%) and charge on converted PMPM basis
- Fee charged for entire 2014 year; adjusted downward (or upward) as needed for 2015

## Comment solicited on variations on Fee:

- Allow for potential for plans to receive a discount off of their Covered California fee for those lives that they convert from existing insurance coverage
  - Discount of up to 10% reduction in the fee (e.g., total fee for those lives could be 2.7%)
  - Must be based on approved conversion plan
  - Discount for either roll-over of existing covered lives (currently insured or about to lose coverage to go on COBRA)
- Provide for Performance Guarantees for meeting service standards
  - Provide payment of up to 10% of fee on top of existing fee base if service standards not met (e.g., total fee could be 3.3%)
  - Allow very good performance to offset poor performance
  - Provide for three-month baseline determination
  - Consider new elements and changed standards for 2015



# Planned Enrollment & Operating Budget

	2013	2014	2015	2016	2017
<b>Key Variables</b>					
Premium Collected	\$ -	\$ 4,593,636,060	\$ 8,606,230,770	\$ 12,078,402,954	\$ 15,369,903,069
Members	0	1,058,791	1,602,078	2,002,972	2,319,902
FTEs - Program Operations (Ex. Service Center)	272	293	293	293	293
FTEs - Service Center	530	860	761	761	761
<b>Revenue</b>					
HHS Establishment Grant 1.1-1.2 Funds	\$ 79,850,010	\$ -	\$ -	\$ -	\$ -
HHS Establishment Grant 2.0 Funds	285,121,369	384,585,858	-	-	-
Plan Assessment Revenue	-	137,809,082	258,186,923	301,960,074	307,398,061
<b>Total Revenue</b>	<b>\$ 364,971,379</b>	<b>\$ 522,394,940</b>	<b>\$ 258,186,923</b>	<b>\$ 301,960,074</b>	<b>\$ 307,398,061</b>
Plan Assessment %	-	3.00%	3.00%	2.50%	2.00%
<b>Total Expenses</b>					
Program Operations	54,146,282	57,032,843	47,675,385	49,585,457	50,728,010
Outreach, Education, & Grants	88,715,463	129,884,207	100,217,447	98,695,760	98,695,760
In-Person Assistance	17,522,532	36,738,170	24,700,929	25,346,554	25,346,554
Customer Service Center	87,812,637	102,100,905	91,890,815	91,890,815	91,890,815
CalHEERs System Development & Support	142,620,714	77,924,552	71,596,676	56,864,035	47,036,340
<b>Subtotal Expenses</b>	<b>390,817,627</b>	<b>403,680,677</b>	<b>336,081,251</b>	<b>322,382,621</b>	<b>313,697,479</b>
Allocated Cost Offsets	(25,846,247)	(14,094,819)	(20,739,715)	(17,121,581)	(14,735,341)
<b>Total Operating Cost</b>	<b>\$ 364,971,379</b>	<b>\$ 389,585,858</b>	<b>\$ 315,341,536</b>	<b>\$ 305,261,039</b>	<b>\$ 298,962,137</b>
Expense PMPM			17.65	13.07	10.79
<b>Net Income</b>	<b>\$ -</b>	<b>\$ 132,809,082</b>	<b>\$ (57,154,613)</b>	<b>\$ (3,300,965)</b>	<b>\$ 8,435,924</b>
Year-end Reserve Balance	\$ -	\$ 132,809,082	\$ 75,654,469	\$ 72,353,504	\$ 80,789,428
Minimum Target Year-End Balance (3 months)	\$ -	\$ 77,000,000	\$ 77,000,000	\$ 77,000,000	\$ 77,000,000
<b>Difference - Surplus (Gap from 3 month minimum)</b>	<b>\$ -</b>	<b>\$ 55,809,082</b>	<b>\$ (1,345,531)</b>	<b>\$ (4,646,496)</b>	<b>\$ 3,789,428</b>



# QHP Partnership and Marketing Elements

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To support the collaborative marketing and enrollment effort, plans must agree to:

- Agree to prominently display the Subsidy Calculator on its website and on all appropriate pages related to individual health insurance coverage;
- Agree to have its inside sales staff certified as Exchange agents and have those agents use the Exchange's quoting and enrollment system for those individuals who are eligible for subsidized coverage. In offering Exchange-based coverage, those agents shall disclose that Issuers other than Contractor also offer Qualified Health Plans through the Exchange;
- Agree to educate its agents that part of being an Exchange agent is to strive for annual recertification and that a prospective Enrollee's health status is irrelevant to advice provided with respect to health plan selection other than as it informs out-of-pocket calculation estimates;





# QHP Partnership and Marketing Elements

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To support the collaborative marketing and enrollment effort, plans must agree to:

- Agree to work with the Exchange to efficiently educate its agents and brokers about the Exchange's individual and small group marketplaces; and
- Agree to provide a financial interface at its own cost that allows an Exchange-certified agent to transfer binding premiums directly into Contractor's account.
- Cooperate with the Exchange to develop and implement an Enrollee retention plan. Contractor shall submit an Enrollee retention plan to the Exchange no later than March 1, 2014. Contractor shall coordinate its communications with respect to its obligations related to premium tax credits and related issues .



# Rollover Strategy

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- Approximately 600,000 of the individuals currently covered under individual policies are eligible for subsidies. It is in both Covered California and the QHP's interest to insure that these individuals rollover into the Exchange.
- We will work with the plans to ensure that individuals know that they have the option to look at all available plans and issuers.
- With a focused marketing effort, these 600,000 individuals become the core membership in Covered California effective January 2014 which helps to solidify the business plan.
- In our draft QHP contract, we are exploring an incentive mechanism where the plans would be eligible for a reduced administrative fee for these rollover members in 2014 based on the success of their rollover campaign.

## ***Advisory Group Input***

- *Does this rollover focus make sense?*

