PLAN MANAGEMENT ADVISORY GROUP

January 19, 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, January 19, 2017, 10:00 a.m. to 12:00 p.m.

Webinar link: https://attendee.gotowebinar.com/register/6691110276636113154

January Agenda Items	Suggested Time
Welcome and Agenda Review	10:00 - 10:05 (5 min.)
Membership Transition	10:05 – 10:20 (15 min.)
2018 Certification Application Comment Review	10:20 – 11:00 (40 min.)
2018 Benefit Design	11:00 – 11:20 (20 min.)
Special Enrollment Period RFP for Electronic Verification	11:20 – 11:45 (25 min.)
Future Topics and Open Forum	11:45 – 11:55 (10 min.)
Wrap-Up and Next Steps	11:55 – 12:00 (5 min.)

PLAN MANAGEMENT ADVISORY GROUP MEMBERSHIP TRANSITION

JAMES DEBENEDETTI, DIRECTOR
LINDSAY PETERSEN, SENIOR QUALITY ANALYST
PLAN MANAGEMENT DIVISION

PLAN MANAGEMENT ADVISORY GROUP
NEW 2017 MEMBERSHIP

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 Sciences
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

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

Two additions likely in February

PLAN MANAGEMENT ADVISORY GROUP 2016 MEMBERSHIP SURVEY: KEY TAKEAWAYS

- Satisfaction:
  - 75% of respondents indicated being either “Very Satisfied” or “Satisfied” with participating in the Plan Management Advisory Group and thought it was a valuable use of their time. (Other 25% was neutral.)
  - All respondents were heavy participators (7 or more meetings attended).
- Improvement suggestions:
  - Distribute materials with enough lead time to review with colleagues.
  - Provide avenue for follow-up comments.
  - Announce members in the room and on the phone at the start of each meeting.
  - Meeting frequency: 50% thought bi-monthly is better, rest of members either liked mirroring the Board or preferred the flexibility of scheduling monthly and canceling if needed (due to the dynamic 2017 environment). Members noted some meetings do not need the full two hours.

2018 CERTIFICATION APPLICATION COMMENT REVIEW

TAYLOR PRIESTLEY, CERTIFICATION PROGRAM MANAGER
PLAN MANAGEMENT DIVISION

PROPOSED 2018 QHP CERTIFICATION MILESTONES

Release draft 2018 QHP & QDP Certification Applications	December 22, 2016
Draft application comment periods end	January 13, 2017
Plan Management Advisory: Benefit Design & Certification Policy recommendation	January 19, 2017
January Board Meeting: discussion of benefit design & certification policy recommendation	January 26, 2017
Letters of Intent Accepted	February 1 – 15, 2017
Final AV Calculator Released*	February 2017
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 22-24, 2017
March Board Meeting: anticipated approval of 2018 Standard Benefit Plan Designs & Certification Policy	March 2, 2017
QHP & QDP Applications Open	March 3, 2017
QDP Application Responses (Individual and CCSB) Due	April 3, 2017
Evaluation of QDP Responses & Negotiation Prep	April 2017
QDP Negotiations	April 2017
QHP Application Responses (Individual and CCSB) Due	May 1, 2017
Evaluation of QHP Responses & Negotiation Prep	May - June 2017
QHP Negotiations	June 2017
QHP Preliminary Rates Announcement	July 2017
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2017
CCSB QHP Rates Due	TBD
QDP Rates Announcement (no regulatory rate review)	August 2017
Public posting of proposed rates	TBD
Public posting of final rates	TBD

*Final AV Calculator and final SERFF Templates availability dependent on CMS release
TBD = dependent on CCIIO rate filing timeline requirements

FINAL BULLETIN: TIMING OF RATE SUBMISSION AND POSTING

Deadline	November 10 Draft Bulletin	Covered California Recommendation	December 16 Bulletin
Proposed Uniform Submission Deadline "Issuers in a state with an Effective Rate Review Program would be required to submit proposed rate filings for single risk pool coverage (both QHPs and non-QHPs) on a date set by the State, as long as the date is not later than **June 1, 2017.**"	Not later than June 1, 2017	Not later than July 17, 2017	Not later than July 17, 2017
Proposed Rate Increases Subject to Review – Posting by States "The proposed uniform posting deadline for a State with an Effective Rate Review Program to post on the State's website … for proposed rate increases that are subject to review for single risk pool coverage (including both QHPs and non-QHPs) is no later than **June 30, 2017.**"	Not later than June 30, 2017	Not later than August 1, 2017	Not later than August 1, 2017
Final Rate Increases – Posting by States "…a State with an Effective Rate Review Program would be required to post … for all single risk pool coverage final rate increases (including those non subject to review) no later than **November 1, 2017**."	Not later than November 1, 2017	No recommendation to change	Not later than November 1, 2017

COMMENTS RELATED TO DRAFT APPLICATIONS

Comments Received on the Following Topics:

- Requests to Adjust QHP Rate Submission Timeline
  - No change made
- Service Area Requirements
  - Revised language for clarity, no change to requirement to bid full licensed service area
- Quality

  Revised language for clarity; examples and other clarifying information will be provided during Applicant training

  Narrowed scope of some questions to apply to Covered California business only, while retaining a broader scope for other questions where a meaningful reference point is necessary
- Requirements for Returning v. New Entrant Applicants
  - Reduced returning applicant questions in the following sections:
    - Electronic Data Interface
    - Privacy and Security
- Comments and Questions related to clarity of application language
  - Revised language or added definitions in the following sections:
    - Fraud, Waste, and Abuse
    - Sales Channels

2018 BENEFIT DESIGN

ALLIE MANGIARACINO, SENIOR QUALITY ANALYST
TAYLOR PRIESTLEY, CERTIFICATION PROGRAM MANAGER
PLAN MANAGEMENT DIVISION

2018 PATIENT CENTERED BENEFIT DESIGNS

Follow-ups from December:

- **Silver Plans:** In order to meet the AV requirements in the Silver, Silver 73, and CCSB Silver Plans, we will lower the pharmacy deductible from $250 to $100 and apply the pharmacy deductible to Tier 1 (generic) drugs.

- **Preferred pharmacy networks:** Due to minimal premium savings, increased costs for consumers utilizing nonpreferred pharmacies, and the deviation from standard plan designs, we are forgoing the proposal to allow preferred pharmacy networks.

- **Endnotes:** We have made some changes to the endnotes, including the addition of an endnote for removal of tobacco cessation day limits.

- **Gold Plans:** We opted to decrease the copay for primary care/mental health office visits instead of decreasing the copay for specialist visits.

2018 PATIENT CENTERED BENEFIT DESIGNS

Benefit	Platinum Coins		Platinum Cop		Gold Coins		Gold Copay		Silver		Silver 73		Silver 87		Silver 94		CCSB Silver Coin		CCSB Silver Cop		Silver HDHP		Bronze		Bronze HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible																						$2,000				$4,800
Medical Deductible										$2,500		$2,200		$650		$75		$2,000		$2,000				$6,300		
Drug Deductible										$100		$100		$50		$0		$100		$100				$500		
Coinsurance (Member)		10%		10%		20%		20%		20%		20%		15%		10%		20%		20%		20%		100%		40%
MOOP		$3,350		$3,350		$6,000		$6,000		$7,000		$5,850		$2,450		$1,000		$6,800		$6,800		$6,550		$7,000		$6,550
ED Facility Fee		$150		$150		$325		$325		$350		$350		$100		$50		$350		$350	X	20%	X	100%	X	40%
Inpatient Facility Fee		10%		$250		20%		$600	X	20%	X	20%	X	15%	X	10%	X	20%	X	20%	X	20%	X	100%	X	40%
Inpatient Physician Fee		10%		---		20%		---	X	20%	X	20%	X	15%	X	10%	X	20%	X	20%	X	20%	X	100%	X	40%
Primary Care Visit		$15		$15		$25		$25		$35		$30		$10		$5		$45		$45	X	20%	X	$75	X	40%
Specialist Visit		$30		$30		$55		$55		$70		$65		$25		$8		$75		$75	X	20%	X	$105	X	40%
MH/SU Outpatient Services		$15		$15		$25		$25		$35		$30		$10		$5		$45		$45	X	20%	X	$75	X	40%
Imaging (CT/PET Scans, MRIs)		10%		$75		20%		$275		$300		$300		$100		$50		20%		20%	X	20%	X	100%	X	40%
Speech Therapy		$15		$15		$25		$25		$35		$30		$10		$5		$45		$45	X	20%		$75	X	40%
Occupational and Physical Therapy		$15		$15		$25		$25		$35		$30		$10		$5		$45		$45	X	20%		$75	X	40%
Laboratory Services		$15		$15		$35		$35		$35		$35		$15		$8		$40		$40	X	20%		$40	X	40%
X-rays and Diagnostic Imaging		$30		$30		$55		$55		$70		$70		$25		$8		$70		$70	X	20%	X	100%	X	40%
Skilled Nursing Facility		10%		$150		20%		$300	X	20%	X	20%	X	15%	X	10%	X	20%	X	20%	X	20%	X	100%	X	40%
Outpatient Facility Fee		10%		$100		20%		$300		20%		20%		15%		10%		20%		20%	X	20%	X	100%	X	40%
Outpatient Physician Fee		10%		$25		20%		$40		20%		20%		15%		10%		20%		20%	X	20%	X	100%	X	40%
Tier 1 (Generics)		$5		$5		$15		$15	X	$15	X	$15		$5		$3	X	$15	X	$15	X	20%	X	100%	X	40%
Tier 2 (Preferred Brand)		$15		$15		$55		$55	X	$55	X	$50	X	$20		$10	X	$55	X	$55	X	20%	X	100%	X	40%
Tier 3 (Nonpreferred Brand)		$25		$25		$75		$75	X	$80	X	$75	X	$35		$15	X	$85	X	$85	X	20%	X	100%	X	40%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%	X	15%		10%	X	20%	X	20%	X	20%	X	100%	X	40%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$150		$150		$250		$250		$250*		$500*		$500
Maximum Days for charging IP copay				5				5																		
Begin PCP deductible after # of copays																								3 visits		
Actuarial Value (2018 AVC)		**91.23**		**88.11**		**81.85**		**78.40**		**71.87**		**73.92**		**87.88**		**93.94**		**71.81**		**71.38**		**71.66**		**60.75**		**61.38**
Baseline AV (2018 AVC)		90.16		85.51		81.02		76.75		73.21		75.65		88.06		90.68		72.89		72.45		71.66		61.19		61.38
Actuarial Value (2017)		89.72		90.28		80.86		81.23		71.53		73.67		87.48		94.12		71.56		71.25		71.31		61.93		61.96

KEY:	
	X — Subject to deductible
	* — Drug cap applies to all drug tiers
	Increase member cost
	Decrease member cost
	Does not meet AV
	Within .5 of de minimis
	Securely within AV

Note: CSR and CCSB Silver plans modeling slides are in the Appendix

COVERED CALIFORNIA DENTAL PLAN DESIGN

2018 Dental Benefit Plan Design Discussion Topics:

- Copay Schedule
  - Alignment with benchmark plan
  - Current Dental Terminology (CDT) Update

- Adult Dental Benefits
  - Waiting Period Waiver
  - Exempt Preventive and Diagnostic Services from Annual Benefit Limit
  - Standardization of Exclusions and Limitations

- Employer-Sponsored Plan
  - Benefit Design
  - Contribution and Participation Requirements

STANDARD COPAY SCHEDULES

Pediatric Copay Schedule

- QDP issuers need to comply with both EHB and standard benefit plan design requirements so the copay schedule must not conflict with the benchmark plan.
- Draft copay schedule posted for comment reflecting update to CDT-17. Inclusion of CDT-17 codes in the pediatric copay schedule based on Dental Technical Workgroup's clinical interpretation of benchmark plan.
- Existing discrepancies in the 2017 copay schedule have been eliminated by adding omitted procedure codes and removing those not in the benchmark plan.

Adult Copay Schedule

- Updating "Not Covered" with copay amount
- Adult Copay Schedule not intended to standardize adult dental benefits

ADULT DENTAL BENEFITS

Waiting Period Waiver Staff Recommendation

The following conditions will be standardized:

- Any prior coverage will be accepted: Group/Individual/Medi-Cal, On/Off-Exchange, Any issuer
- No required minimum duration of prior coverage allowed; dental plans must reduce the six month waiting period for each month of prior coverage

The following conditions will not be standardized in the plan design:

- Maximum allowed lapse in coverage
- Acceptable documents to provide proof of prior coverage

Rationale: Support continuous enrollment in dental insurance in an environment where plan choices can change.

Standard Exclusions Staff Recommendation

Continue 2017 standard exclusions in 2018 and add exclusion of veneers:

- Tooth Whitening
- Adult Orthodontia
- Implants
- Veneers

Rationale: Continued progress towards standardization of adult dental exclusions, utilizing guiding principle of excluding services without oral health benefit.

EMPLOYER-SPONSORED DENTAL PLAN

Component	Staff Recommendation
Plan Design	• No waiting period for Major Services
Employer Contribution & Participation Requirements	• Employer must select a specific Group Dental Plan and contribute minimum 50% of premium • Minimum 70% employee participation, defined as enrollment • Employees remain free to select any dental plan for which they are eligible
Dependent Coverage	• Dependent coverage completely voluntary

Employer-sponsored Dental Plan program requirements still being finalized based on workgroup feedback

SPECIAL ENROLLMENT PERIOD
RFP FOR ELECTRONIC VERIFICATION

JAMES DEBENEDETTI, DIRECTOR
PLAN MANAGEMENT DIVISION

BACKGROUND AND PURPOSE

- Special enrollment periods allow consumers experiencing expected or unanticipated life changes (qualifying life events – QLEs) to obtain new coverage or change their insurance plan.

- Covered California and Qualified Health Plan (QHP) issuers have a common goal of quickly and accurately performing verifications of qualifying life events prior to effectuating coverage.

- Therefore, Covered California will be issuing a Request for Proposal (RFP) with an emphasis on electronic verification of the QLE loss of minimum essential coverage (MEC), while also exploring expedited verification of additional QLEs including permanently moved to / within California, had a baby or adopted a child, etc.

- Guiding principles during Covered California's initiative to improve SEP QLE verification processes and systems include:

    - While conducting pre-enrollment verification of QLEs, limit delays in consumers obtaining coverage.
    - Maximize the number of verifications that can be completed electronically in real time.
    - Guide and support consumers in their effort to provide required information and documentation.

RECENT ACTIVITIES

- Conducted SEP verification Request for Information (RFI) September through November 2016.
- Six companies responded to the RFI – including application and system integration companies with experience in the health care marketplace.
- We learned that companies:
  - can use existing industry standard electronic data interchange (EDI) 270/271 transactions to verify loss of MEC.
  - already have or could establish existing nationwide interfaces to insurance carriers.

NEXT STEP AND TIME FRAME

- Develop and release SEP Verification RFP no later than March 2017.
- Select vendor / system integrator and initiate development no later than August 2017.
- Draft regulations in coordination with system and process development.
- Finalize regulations and put the system into production by the start of the 2018 SEP period (February 2018).

WRAP UP AND NEXT STEPS

JAMES DEBENEDETTI, DIRECTOR
PLAN MANAGEMENT DIVISION