WELCOME AND AGENDA REVIEW

JAMES DEBENEDETTI, DIRECTOR
PLAN MANAGEMENT DIVISION
<table>
<thead>
<tr>
<th>Topic</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome and Agenda Review</td>
<td>10:00 - 10:05 (5 min.)</td>
</tr>
<tr>
<td>2018 Marketplace Stabilization Regulations</td>
<td>10:05 – 10:35 (30 min.)</td>
</tr>
<tr>
<td>2018 Certification Update</td>
<td>10:35 – 10:40 (5 min.)</td>
</tr>
<tr>
<td>Consumer Experience Project Overview</td>
<td>10:40 – 10:50 (10 min.)</td>
</tr>
<tr>
<td>Provider Directory Launch</td>
<td>10:50 – 11:10 (20 min.)</td>
</tr>
<tr>
<td>Health Savings Accounts and other Account Based Health Plans</td>
<td>11:10 – 11:55 (45 min.)</td>
</tr>
<tr>
<td>Open Forum and Next Steps</td>
<td>11:55 – 12:00 (5 min.)</td>
</tr>
</tbody>
</table>
2018 MARKET STABILIZATION REGULATIONS

PETER V. LEE, EXECUTIVE DIRECTOR
KATIE RAVEL, DIRECTOR, POLICY, PROGRAM INTEGRITY AND RESEARCH
The Department on Health and Human Services (HHS) released final Market Stabilization regulations on April 18, 2017.

Below is an overview of the final provisions that Covered California commented on.

**Open Enrollment (OE) Period:** HHS will shorten the OE period to 45 days (Nov. 1 – Dec. 15) beginning plan year 2018 with the possibility of beginning OE in October in future years.

- Under existing regulatory authority, SBMs may elect to supplement the OE with a SEP to account for operational difficulties in implementing a shorter OE.

**Special Enrollment Period:** HHS made several changes to the special enrollment process.

- Covered California notified HHS of existing SEP pre-enrollment verification efforts to leverage electronic verifications.
- While final regulations do not require SBMs to conduct pre-enrollment verification, Exchanges are encouraged to adopt the FFM process.

**Changes to Actuarial Value Ranges:** HHS will allow plans to have -4/+2% instead of current -/+2%.

- Certain Bronze level plans will be allowed to have a variation of -4/+5.
2018 CERTIFICATION UPDATE
TAYLOR PRIESTLY, CERTIFICATION PROGRAM MANAGER
PLAN MANAGEMENT DIVISION
CONSUMER EXPERIENCE

GWYN JACKSON, CONSULTANT
PROGRAM COMPLIANCE AND ACCOUNTABILITY
CONSUMER EXPERIENCE - AGENDA

• Goal and Objectives
• Initiatives
• Approach and Focus
• Next Steps
CONSUMER EXPERIENCE – GOAL AND OBJECTIVES

Improve the Consumer Experience throughout their journey.

1. Improve how WE (Covered CA = Agents, CECs, QHPs, CalHEERS) interact with the Consumer Experience lifecycle, as well as improve:
   i. How the consumer self serves
   ii. How the consumer receives access
   iii. How the consumer makes use of tools
   iv. How the consumer utilizes their coverage
2. Ensure the Consumer Experience is anchored by experiences and analytics.
3. Establish the Consumer Experience as a ‘lifetime’ work group for Covered CA.
4. Institutionalize the Consumer Experience as lifecycle centric.
CONSUMER EXPERIENCE – INITIATIVES

1. Create The Consumer Experience workgroup.
   1. Examine the Consumer Experience from a holistic perspective:
      a. Covered CA = Agents, CECs, QHPs, CalHEERS
      b. Include stakeholder groups when possible
   2. Identify areas of potential constraints.
   3. Prioritize constraint efforts, and if needed, formulate small workgroups to perform appropriate research.
   4. Categorize short term, near term, and long term mitigations/opportunities to improve any identified constraints.
   5. Develop ongoing method for revolving examination of the Consumer Experience.
CONSUMER EXPERIENCE – APPROACH AND FOCUS

1. Identify and research touchpoints where the consumer engages with Covered CA.

2. Group the touchpoints and identify areas of focus:
   - Engagement – prior and initial engagement with Covered CA
   - Enter Case & Family Info – focus on ease of use, barrier points
   - Eligibility Determination – subsidy and/or dual eligibility, along with appeals
   - Plan Selection - rate consideration, assistance regarding plan questions
   - Effectuation – 834 processing, carrier payment, effectuation timing
   - Coverage Experience – experience while they are receiving coverage
   - Renewal Coverage or Continuity of Care – survey and reasonable opportunity coverage

3. Review consumer experiences that run across all of the consumer engagement:
   - Consumer Survey
   - Service Center Operations
   - Covered CA University (CCU)
   - CalHEERS Changes
   - Help Desk Processing
   - Data Integrity and Exchange
CONSUMER EXPERIENCE – NEXT STEPS

1. Completed - Create and staff workgroups.

2. Completed - Meet with Executive Chiefs and Directors to review. Consumer Experience information

3. In Process - Define the following holistic phases and define Covered CA expectations at each phase, which includes:
   i. Completed - Catalog current analytical information
   ii. Completed - Review analytical results and identify impact areas
   iii. Completed - Compare service for impacted areas to industry standards
   iv. Completed - Define measure of success and define service levels
   v. Define business process for identified areas
   vi. Validate success

4. In Process - Identify existing, short term (w/in 90 days), near term (w/in 6 months), and long term (FY 17/18) improvement opportunities.
COVERED CALIFORNIA PROVIDER DIRECTORY

LANCE LANG, CHIEF MEDICAL OFFICER
MARGARETA BRANDT, PROVIDER DIRECTORY PROJECT MANAGER
PLAN MANAGEMENT DIVISION
PROVIDER DIRECTORY OVERVIEW

• Covered California will implement a consolidated online provider directory during the 2017 Special Enrollment Period to enable consumers to conduct a search for their doctor, a dentist for their children, or hospital prior to selecting a health plan.

• The purpose of the Covered California provider directory is to support consumers in selecting a health plan, not to make an appointment with a provider or to use for seeking care.

• Covered California will direct consumers to check the provider directory of the health plan they select before seeking care.

• Covered California is planning to build on the provider directory by enabling consumers to select a primary care provider (PCP) after selecting a health plan during the 2018 Special Enrollment Period.
HISTORY AND LESSONS LEARNED

• The launch of the Covered California provider directory in 2014 didn’t go well
  o Data unreliable
  o Lack of standards and validation
  o Led to passage of SB 137

• It is imperative that accurate provider information be displayed online to correctly inform the consumer as he/she selects a health plan

• To support QHP’s ongoing efforts to improve provider data accuracy, Covered California implemented
  o Standards for all data elements
  o A validation and error reporting process to identify possible critical errors for the QHP to verify and correct, as needed, in their provider data system

• Covered California will exclude:
  o A QHP’s entire list of providers if the list doesn’t meet standards for data and
  o Any individual providers for whom critical data errors have not been corrected

• The Covered California provider directory will not include phone numbers
## PROVIDER DIRECTORY TIMELINE

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2016</td>
<td>Covered California provider directory project announced to all QHPs</td>
</tr>
<tr>
<td>July 2016</td>
<td>Onsite implementation meetings with all QHPs to review feedback process for addressing data errors and validating data</td>
</tr>
<tr>
<td>August 2016</td>
<td>Started data feedback process with QHPs; began hosting biweekly meetings with QHPs to review results of feedback process</td>
</tr>
<tr>
<td>September 23, 2016</td>
<td>DMHC ruling to exclude Covered CA from SB 137 Section 1367.27: Requirements to correct provider directory inaccuracies within 30 days of receiving notification and contact affected providers within 5 business days of receiving notice of an inaccuracy</td>
</tr>
<tr>
<td>January 2017</td>
<td>Distributed updated Provider Directory Data Submission Guide to QHPs</td>
</tr>
<tr>
<td>June 2017</td>
<td>Expected CalHEERS UAT testing with QHPs of provider directory search functionality</td>
</tr>
<tr>
<td>June 30, 2017</td>
<td>QHPs will extract provider data for the first production file for the provider directory search</td>
</tr>
<tr>
<td>July 12, 2017</td>
<td>Covered California will generate first production file for the provider directory search and provide to CalHEERS</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>Launch of provider directory search functionality through CalHEERS</td>
</tr>
<tr>
<td>February 2018</td>
<td>Tentative launch of PCP selection functionality through CalHEERS</td>
</tr>
</tbody>
</table>
CURRENT PROVIDER DIRECTORY PROCESS

1. QHPs submit provider data submissions monthly to Covered California
2. Covered California validates the completeness of critical fields in the files
3. If the QHP passes validation, Covered California processes the file for errors
   - QHPs can resubmit a corrected file up for validation until the due date for the particular month
4. Covered California provides QHPs a validation report and an error report
5. QHP verifies errors and corrects errors as needed
6. Covered California excludes un-corrected critical errors from the production file for the online provider directory
   - QHPs can correct critical errors with each monthly provider data submission
7. Covered California provides CalHEERS a production file each month
8. CalHEERS loads the file for the online provider directory search
PROVIDER DIRECTORY SEARCH FUNCTIONALITY

• Consumers will be able to search for their doctor, a dentist for their children or a hospital
  o Name, address and specialty will be displayed for doctors and dentists. (Will display up to two specialties per doctor per location.)
  o Name and address will be displayed for hospitals
• The CalHEERS plan selection pages will indicate whether the provider is in or out of network for each health plan
• The provider directory search will also be available in Shop and Compare
• The provider directory search page will include the following disclaimer language:
  o Paragraph 1: The Covered California provider directory can help you select a health plan. The directory is updated monthly and may not be a current or complete list of the health plan’s providers.
  o Paragraph 2: The health plan you select will have the most current provider directory. You may not have coverage or may have higher costs if you visit a provider who is not in your plan’s network. To avoid this, you must verify with your health plan if the provider is in-network before you seek care.
Tell us about your health care needs

Your answers are used to find the best plan option for you.

Search for a hospital that you may want to use in your health plan

Search by hospital name within 100 miles of

Dr. Basovich Basovich
Family Medicine
916-522-5936
1200 J St
Sacramento, CA

Dr. Gerstein Gerstein
Psychiatry & Neurology Psychiatry
1500 21st St
Sacramento, CA

The health plan’s list of providers changes daily. Call your doctor or provider to be sure they belong to the health plan.

Final disclaimer language will be displayed here.
Tell us about your health care needs

Your answers are used to find the best plan option for you.

Search for a hospital, doctor, dentist, or other healthcare provider that you may want to use in your health plan.

Search by location:
- Doctor
- Dentist for your children
- Hospital

Within 100 miles of 94203

Hospital
- Kaiser Foundation Hospital - South Sacramento
- Washington Hospital - Fremont

The health plan's list of providers changes daily. Call your doctor or provider to be sure they belong to the health plan.

Health plans are responsible for providing up-to-date provider lists to Covered California. Covered California makes no warranties about the accuracy of the provider directory on this website.

Final disclaimer language will be displayed here.
Tell us about your health care needs

Your answers are used to find the best plan option for you.

Search for a **DOCTOR** that you would like to keep in your plan.

1. Dr. Gerstein Gerstein
   Psychiatry & Neurology-Psychiatry
   1500 21st St
   Sacramento CA, 95811

2. Dr. Barger Barger
   Internal Medicine-Rheumatology
   916-733-2033
   3500 Q St, Ste 5
   Sacramento CA, 95816

3. Dr. Emge Emge
   Pediatrics

Within 5 mile radius of 94203

Please note that your doctor or provider must be a Covered California provider to be selected in the plan options. Covered California is not responsible for the accuracy of this provider list. If you choose a provider who is not listed, Covered California will verify that the provider belongs to Covered California.

**VIEW PLANS**
NEXT STEPS

• Launch of Provider Search functionality in July 2017
• Monitor provider search functionality during Special Enrollment Period (SEP) 2017
• Planned launch of PCP selection functionality in February 2018
  o PCP selection functionality will need to support PCP selection for both HMOs and EPOs/PPOs with distinct work flows
HEALTH SAVINGS ACCOUNTS
AND OTHER ACCOUNT BASED HEALTH PLANS

JAMES DEBENEDETTI, DIRECTOR
PLAN MANAGEMENT DIVISION
MARCELLA REEDER, SENIOR ACCOUNT MANAGER
BLUE SHIELD OF CALIFORNIA
PURPOSE FOR REVIEW

• Educate Covered California staff and stakeholders on the basics and mechanics of Health Savings Accounts (HSAs) and other account based health plans (e.g HRAs, FSAs).

• Explore the ways in which account based health plans can better meet the needs of low to moderate income consumers.

• Covered California currently has a Bronze High Deductible Health Plan (HDHP) in the Individual market, which represents ~6.03% of total enrollment. (~4.7% subsidized and ~1.38% unsubsidized).
PURPOSE FOR REVIEW

Review Phase

- How health savings accounts (HSA) and other account based health plans (e.g. HRS, FSAs) work
- Member experience
- Latest developments (both public and commercial)

Consider Options / Feasibility / Implications

Plan Management Advisory Committee Recommendations

Spring/Summer 2017

Summer/Fall 2017

Winter 2017/2018
At the national level, there has been a five-fold growth in high deductible health plans paired with a savings account option. In California, growth is slower, growing from 4% of workers in 2007 to nearly a tenth (9%) in 2015. A likely reason for the slower growth is California’s extensive experience with HMO-based managed care.

This chart is from slide 29 in the following California HealthCare Foundation report: California Employer Health Benefits: Workers Pay the Price.
Account Based Health Plans

Overview for Plan Management Advisory Committee
5/11/2017
# Types of employer based health financial accounts

<table>
<thead>
<tr>
<th>Plan Type Comparison</th>
<th>Health Savings Account (HSA)</th>
<th>Health Reimbursement Arrangement (HRA)</th>
<th>Flexible Spending Account (FSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Account Definitions</strong></td>
<td>A tax-advantaged account funded with either employee payroll pre-tax dollars, employer matching or after tax deposits which is used to pay for qualified medical expenses of the account holder, spouse, and/or dependents. Employees can keep their dollars in an HSA if they change employers. Dollars can be used until exhausted</td>
<td>An employer funded arrangement. The employer sets the parameters for the Health Reimbursement Accounts, and unused dollars remain with the employer - they do not follow the employee to new employment. Employees use the available amounts for incurred qualified medical expenses.</td>
<td>An employer-established, tax-advantaged account funded by employee pre-tax dollars to pay for qualified expenses. These dollars are capped and have a “use it or lose it” policy</td>
</tr>
<tr>
<td>Who can open the account?</td>
<td>Individual, employee or employer as long as enrolled in a qualified high-deductible health plan</td>
<td>The employer</td>
<td>Offered through employers, and employees choose whether or not to enroll in the plan on an annual basis</td>
</tr>
<tr>
<td>Who can contribute?</td>
<td>Individual, employers, employee/account holder, or any third party</td>
<td>The employer</td>
<td>The employee</td>
</tr>
<tr>
<td>Who owns the account?</td>
<td>The account holder</td>
<td>The employer</td>
<td>Unused account balances forfeit to the employer at the end of the plan year plus runout (excluding rollover amount of $500)</td>
</tr>
<tr>
<td>Is there an annual contribution limit?</td>
<td>Yes, as determined by the IRS rules</td>
<td>Yes, as determined by the HRA plan design</td>
<td>Yes, as determined by the employer’s plan design and IRS rules</td>
</tr>
<tr>
<td>Can the account earn interest?</td>
<td>Yes, as determined by HSA administrator / bank</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Do unused funds carry over to the next year?</td>
<td>Yes</td>
<td>Possibly, as determined by the HRA plan design</td>
<td>Typically, no, but employers may allow up to $500 to roll over to the next plan year</td>
</tr>
</tbody>
</table>
Opening and funding an HSA

Must be enrolled in an HSA qualified high deductible medical plan. The only services allowed before the deductible are preventative.

<table>
<thead>
<tr>
<th>2017 amounts for HSA qualified high deductible health plans</th>
<th>Self Only Coverage</th>
<th>Family Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Annual Deductible</td>
<td>$1,300</td>
<td>$2,600</td>
</tr>
<tr>
<td>Maximum Out of Pocket (in network)</td>
<td>$6,550</td>
<td>$13,100</td>
</tr>
</tbody>
</table>

Individual can open and contribute to an HSA account as long as:

- Only covered by the HSA-qualified plan – can not have additional coverage (e.g. spouse’s plan) or Medicare, TRICARE or VA
- Not claimed as a dependent on another person's tax return
- Can not have a flexible spending account (FSA) or health reimbursement account (HRA)

Maximum contribution limit for 2017 (including employer contributions for employer sponsored coverage)

- Individual $3,400 / Family $6,750 / 55+ can contribute an additional $1,000

Contributions by individual and family members are tax deductible
HSA account custodians / account administrators

**Set up and Funding**
- HSA account must be with a HSA account custodian or administrator – typically via banks, brokers, credit unions and health plans
- Not all financial institutions offer an HSA account
- Fees can include monthly, opening/closing, transaction and minimum balance

**Investment Options**
- Account balances can earn interest and be invested
- Investment earnings accrue tax-free
- Fees, interest rates, investment options, requirements and capabilities vary by account administrator

**Accessing Funds**
- HSA balances typically available via debit card, checks, withdrawal at administrator and/or on-line bill pay
- The money in an HSA belongs to the account holder, no matter who deposited it
- There’s no “use it or lose it” rule, meaning deposits can earn interest and funds could grow over time
- HSA funds roll over from year to year and accumulate in the account. Funds can be rolled over into another HSA
Using funds for qualified expenses

HRA and HSA funds can be used for qualified medical expenses - medical care as defined by Internal Revenue Code Section 213(d) – includes dental and vision.

HSA funds can be used to pay for qualified expenses for the account holder, spouse and other tax dependents (even if they are not covered on the account holders’ health plan).

HRA funds can be used for premium payments; HSA funds cannot generally be used to pay insurance premiums, except:

• Qualified long-term care insurance
• Health insurance while receiving federal or state unemployment compensation
• Continuation of coverage plans, e.g. COBRA
• Medicare premiums

HSA non qualified distributions subject to income tax + 20% penalty

HSA account holder must track and report all expenses.
**Example of using an HSA with the 2017 Covered California Bronze 60 HDHP PPO**

**Medical plan:** Bronze 60 HDHP  
**HSA Balance:** $2000  
**Individual deductible:** $4,800 (in-network)  
**Out-of-pocket maximum:** $6,550 (In-network)  
**Benefits:** 40% co-insurance after deductible is met (up to the MOOP)

<table>
<thead>
<tr>
<th>Service</th>
<th>Allowed Amount (Cost)</th>
<th>Payments to Provider</th>
<th>Member Balances</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>From Mbr’s HSA</td>
<td>From Mbr</td>
<td>From QHP</td>
</tr>
<tr>
<td><strong>Jan</strong></td>
<td>Preventive</td>
<td>$150</td>
<td>-</td>
</tr>
<tr>
<td><strong>Feb</strong></td>
<td>RX</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td><strong>April</strong></td>
<td>Specialist</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td><strong>May</strong></td>
<td>Surgery</td>
<td>$5,000</td>
<td>$1,700</td>
</tr>
<tr>
<td><strong>Jun</strong></td>
<td>Specialist</td>
<td>$100</td>
<td>-</td>
</tr>
<tr>
<td><strong>Jul</strong></td>
<td>Surgery</td>
<td>$5,000</td>
<td>-</td>
</tr>
<tr>
<td><strong>Aug</strong></td>
<td>RX</td>
<td>$100</td>
<td>-</td>
</tr>
</tbody>
</table>

*As deductible will be satisfied during this service - 40% coinsurance on $500 (difference between cost $5000 and remaining deductible $4500)  
**Deductible satisfied - 40% coinsurance of $5000, up to remaining MOOP ($1,510)  
***MOOP satisfied - plan pays 100%
Using a health debit card to pay for healthcare

<table>
<thead>
<tr>
<th>Provider's office (check-in or check-out)</th>
<th>Co-Pay Services</th>
<th>Deductible / Co-Insurance Services</th>
<th>RX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider looks up cost-share &amp; deductible status from QHP</td>
<td>Member pays with card at point of care</td>
<td>Provider looks up cost-share &amp; deductible status from QHP</td>
<td>Provider looks up cost-share &amp; deductible status from QHP</td>
</tr>
<tr>
<td>Health Plan</td>
<td>N/A</td>
<td>Plan processes claim &amp; determines member cost-share and applies any deposits</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan sends EOB to member &amp; provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Some integrated models allow plans to auto-pay provider from funds)</td>
<td></td>
</tr>
<tr>
<td>Provider’s billing (after care delivery &amp; claim adjudication)</td>
<td>N/A</td>
<td>Provider sends invoice to member</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member pays balance using funds/card (or can be reimbursed from HSA if already paid)</td>
<td></td>
</tr>
</tbody>
</table>
How health debit cards are used to pay for out health plan out of pocket costs

Most administrators’ cards use Merchant Category Codes to limit use to qualified merchants and to auto-substantiate (not require any further receipts/EOB to confirm it is a qualified expense)

- e.g. decline retail; allow pharmacy and providers
- Some merchant cash registers classify qualified expenses products at the item level – individual items at the pharmacy could be declined if not qualified expenses (inventory information approval system)
- Some HSA cards can be used at ATMs, allowing members to “reimburse themselves” for healthcare expenses that are paid out-of-pocket
- Card capabilities can vary by administrator

HSA’s are member owned accounts – if the account has funds, there are no requirements that a merchant prevent a member from purchasing any item with the card.

The issue of documenting legitimate expenses and/or qualifying for the account with an HDHP is between the member and the IRS. It is ultimately the members responsibility to ensure they are using the HSA funds for an IRS qualified healthcare services.
Different types of integration between a health plan and an HSA administrator

<table>
<thead>
<tr>
<th>Opening Account</th>
<th>No Integration</th>
<th>Partial Integration</th>
<th>Full Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manually open account</td>
<td>Manual or automatically opened (may still need wet signatures / forms, etc completed)</td>
<td>Automatically opened (may still need wet signatures / forms, etc completed)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capabilities</th>
<th>No Integration</th>
<th>Partial Integration</th>
<th>Full Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Card/check to pay at point of care/service</td>
<td>Card/check to pay at point of care/service</td>
<td>Card/check to pay at point of care/service</td>
<td></td>
</tr>
<tr>
<td>Pays out of pocket and is reimbursed</td>
<td>Pays out of pocket and is reimbursed</td>
<td>Pays out of pocket and is reimbursed</td>
<td></td>
</tr>
<tr>
<td>Bill pay like service</td>
<td>Bill pay like service</td>
<td>Bill pay – but may enables direct payment to provider from claims adjudication</td>
<td></td>
</tr>
<tr>
<td>Separate web/applications for plan and HSA</td>
<td>Separate web/applications for plan and HSA</td>
<td>Integrated web/applications and capabilities for plan and account balances</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Plan / Exchange Integration Requirements</th>
<th>No Integration</th>
<th>Partial Integration</th>
<th>Full Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing</td>
<td>Sends eligibility files to facilitate enrollment</td>
<td>Send claims files, eligibility files; integrates account balances into plan tools (single sign on)</td>
<td></td>
</tr>
<tr>
<td>Single sign on / links between portals</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HSA: Tax reporting

The IRS mandates what HSA dollars can be spent on, not the health plan or the HSA administrator

HSA administrator may provide records retention (receipt storage) and summarize transactions for tax reporting purposes

The account owner is responsible to:
• ensure HSA dollars are only spent on qualified medical expenses
• retain and provide proof of expenses to the IRS if they are audited
• account for HSA contributions and withdrawals on income tax returns (form 8889)
• If audited, may be required to provide documentation of medical expenses – such as receipts, invoices, EOBs, written RXs, and other official documentation
Unlike a FSA - HSA administrators are not required to keep track of an account holder’s expenses. The account holder must track and report all expenses.

If spent on nonqualified expense, income tax and an additional 20% penalty may apply.

Form 8889 – reports all contributions / withdrawals associated with HSA

1099-SA – from HSA administrator reporting withdrawals

No longer file form 1040-EZ
NEXT STEPS

• Identify and examine existing account based programs for low income individuals such as the Healthy Indiana Plan (HIP).

• Background on HIP:
  o HIP Home Page: http://www.in.gov/fssa/hip/index.htm
  o HIP 1115 Waiver Extension Application and related information: http://www.in.gov/fssa/hip/2557.htm

• Explore and discuss potential funding sources and mechanics of account based health plans for low income individuals.
WRAP UP AND NEXT STEPS

JAMES DEBENEDETTI, DIRECTOR
PLAN MANAGEMENT DIVISION
<table>
<thead>
<tr>
<th>Meeting Month</th>
<th>Strategic Topic</th>
<th>Expected Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-Mar2018</td>
<td>Stabilization Regulations</td>
<td>Gather input for Covered California comments on 2018 stabilization regulations and discuss policy change options.</td>
</tr>
<tr>
<td>6-Apr</td>
<td>Cancelled (Account based health plans topic moved to May)</td>
<td>Awareness of the current operational capabilities for account based health plans; Primer on the different types of account based plans; Ideas on operational, policy and member facing impacts on Account Based Health Plans (ABHP) in alignment with potential ACA changes.</td>
</tr>
<tr>
<td>11-May</td>
<td>Account Based Health Plans (HDHP, HSA, HRA)</td>
<td>Covered California is embarking on a long term &quot;lessons learned&quot; project to improve the consumer experience. The initial phase will review how various channels (Covered California, agents, navigators, enrollment system etc.) interact with consumers in efforts to understand weaknesses and gaps to strategize on improvements. Goal is to introduce the project and discuss the potential for Advisory and/or sub work group involvement.</td>
</tr>
<tr>
<td>11-May</td>
<td>Consumer Lifecycle Work Group</td>
<td>Review how Federal and State law cycle overlap with Covered California's certification cycle and major decision points for each. Goal is to set groundwork for understanding when changes for 2019 would likely come and when response actions would need to be taken by Covered California.</td>
</tr>
<tr>
<td>11-May</td>
<td>Covered California Provider Directory (May and June Topics have been swapped)</td>
<td>Demonstrate proposed member functionality for provider look up &amp; PCP selection; Feedback on improving experience and developing readiness plans.</td>
</tr>
<tr>
<td>8-Jun</td>
<td>Integrated Timelines: Federal, State and Covered CA</td>
<td>Review how Federal and State law cycle overlap with Covered California's certification cycle and major decision points for each. Goal is to set groundwork for understanding when changes for 2019 would likely come and when response actions would need to be taken by Covered California.</td>
</tr>
<tr>
<td>13-Jul</td>
<td>Primary Care QIS: PCP for PPO and PCMH update and input gathering session</td>
<td>Gather ideas to improve the assignment and rollout for new members and how to improve awareness and positive acceptance of PCP in the PPO environment.</td>
</tr>
<tr>
<td>10-Aug</td>
<td>Off Exchange Products - Market Scan</td>
<td>Gather ideas on any benefit designs found off exchange (non-mirrored) that should be considered for on-exchange. Understand why members purchase off-exchange with a focus on subsidy eligible (as a mechanism to improve targeting for CC enrollment) Consider variety in telehealth offerings and possibility of best practice encouragement.</td>
</tr>
<tr>
<td>10-Aug</td>
<td>Open Enrollment 2018 User Experience</td>
<td>Preview for stakeholders, no specific outcomes.</td>
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<tr>
<td>28-Sep</td>
<td>Healthcare Evidence Initiative (Truven) Progress</td>
<td>Share a baseline on key metrics in our quality agenda/dashboard based on the data submitted via Truven (disparities, etc.); share top priorities in research queue.</td>
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<tr>
<td>No Oct meeting</td>
<td></td>
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<tr>
<td>9-Nov</td>
<td>Hospital Safety QIS</td>
<td>Goal is to hold an update and input session on network improvements so far and momentum gained (number of hospitals signed up for HIINs and CMQCC, improvement in timing of data flow, annual C-Section Honor Roll etc.) and on payment strategies for quality and for reducing low risk C section.</td>
</tr>
<tr>
<td>14-Dec</td>
<td>Health Disparities QIS</td>
<td>Goal is to hold an input session on plan submissions, efforts to improve rates of data capture, and preliminary work and best practices discussion on projects to improve chronic disease management (Plan Care Management Programs).</td>
</tr>
</tbody>
</table>