## AGENDA

Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar

[https://attendee.gotowebinar.com/register/3700058205961202433](https://attendee.gotowebinar.com/register/3700058205961202433)
Thursday, October 15, 2015, 10:00 a.m. to 12:00 p.m.

<table>
<thead>
<tr>
<th>October Agenda Items</th>
<th>Suggested Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Welcome and Agenda Review</td>
<td>10:00 - 10:05 (5 min.)</td>
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<tr>
<td>II. 2017 Certification Discussion</td>
<td>10:05 - 10:50 (45 min.)</td>
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<tr>
<td>III. Benefits and Networks Subcommittee update</td>
<td>10:50 – 11:20 (30 min.)</td>
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<tr>
<td>IV. Quality and Contracting Subcommittee update</td>
<td>11:20 - 10:50 (30 min.)</td>
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<tr>
<td>V. Wrap-Up and Next Steps</td>
<td>11:50 – 12:00 (5 min.)</td>
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2017 CERTIFICATION DISCUSSION

ANNE PRICE, DIRECTOR
PLAN MANAGEMENT DIVISION
2017 QHP CERTIFICATION FOR COVERED CALIFORNIA INDIVIDUAL MARKET

Guiding Principals

- Portfolio stability with flexibility for new plan and product offerings
  - Continued growth and implementation of integrated models of care such as Accountable Care Organizations (ACO) or Medical Homes
  - Support of new payment models in concert with other Payors
  - Consider changes over-time to promote Value Based Insurance Designs (VBID) either as part of standard design or allow alternatives
  - Consider implementation of new networks

- Focus on carrier performance
  - Requirement of carrier participation in targeted statewide quality initiatives
  - Improvement in consumer satisfaction
  - Reduction Racial/Ethnic disparities in health outcomes
  - Further support and development of decision support for treatment/provider selection

- Focus on policies/service that promote retention and new enrollment

- Seek to reduce administrative cost of Covered California and carriers which impacts affordability

- Certification policy will continue to be recommended and approved by board, but application documents themselves do not require board approval and are no longer required in state regulations
PROPOSED APPROACH FOR 2017 INDIVIDUAL PLAN CERTIFICATION

• For 2017, recommend one QHP Certification application that is open to all licensed health insurers

• Consider multi-year contract term (2017 – 2019) with annual plan certification that includes:
  • Contract compliance and performance review
  • Rates
  • Benefits
  • Networks
  • New products
  • Expanded expectations on delivery reform

• Consider limits on new health insurer entrants through 2019
  • Consider if this rule should also apply to Medi-Cal managed care plans and newly licensed entrants

• Consider changing (and timing) of exchange participation fee to a percent of premium
  • Addresses concern from carriers with a higher proportion of Bronze members
PROPOSED APPROACH FOR 2017 DENTAL PLAN CERTIFICATION

- One Qualified Dental Plan (QDP) application, open to all licensed dental issuers

- Multi-year contract term (2017 – 2019) with annual plan certification that includes:
  - Contract compliance and performance review
  - Rates
  - Benefits
  - Networks
  - New products

- No new dental insurer entrants through 2019 except potentially newly licensed

- Consider changing (and timing) of exchange participation fee to a percent of premium to have exchange fee be a more consistent percentage of premium for HMO and PPO dental plans

- Timeline for recommendation and approval by Covered California board will be consistent with the Individual proposal
2017 QHP CERTIFICATION FOR COVERED CALIFORNIA SMALL BUSINESS

Guiding Principals

• Flexibility to respond to small business market environment
• Focus on carrier performance
• Reduction in administration cost to Covered California and carriers which impacts affordability

Proposed Approach

• Covered California for Small Business QHP certification application, open to all licensed health insurers and not limited to carriers who are QHPs for Individual
• Multi-year contract term (2017 – 2019) with annual plan certification that includes review of performance and compliance with QHP contract requirements
• Allowance for either monthly or quarterly change in rates, products, plans and networks (subject to Covered California approval)
  • Consider if new entrants could come on Exchange outside certification if the carrier is already a Qualified Health Plan for Individual
• Timeline for recommendation and approval by Covered California board will be consistent with the Individual proposal
# DECISION PROCESS AND SUBCOMMITTEE TIMELINE

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-Sep</td>
<td>Project Start</td>
<td>Kick Off Communication</td>
</tr>
<tr>
<td>17-Sep</td>
<td>Plan Advisory Meeting</td>
<td>Kick Off meeting</td>
</tr>
<tr>
<td>17-Sep</td>
<td>Quality Subcommittee Meeting</td>
<td>Kick Off meeting</td>
</tr>
<tr>
<td>22-Sep</td>
<td>Benefits &amp; Networks Meeting</td>
<td>Kick Off Meeting</td>
</tr>
<tr>
<td>7-Oct</td>
<td>Benefits &amp; Networks Meeting</td>
<td>Subcommittee meeting</td>
</tr>
<tr>
<td>15-Oct</td>
<td>Plan Advisory Meeting</td>
<td>Workgroup Status Provided to Advisory</td>
</tr>
<tr>
<td>29-Oct</td>
<td>Dental Technical Work Group</td>
<td>Kickoff meeting to discuss 2017 benefit design</td>
</tr>
<tr>
<td>4-Nov</td>
<td>Benefits &amp; Networks Meeting</td>
<td>Subcommittee meeting</td>
</tr>
<tr>
<td>5-Nov</td>
<td>Dental Technical Work Group</td>
<td>Discuss 2017 benefit design</td>
</tr>
<tr>
<td>10-Nov</td>
<td>Quality Subcommittee Meeting</td>
<td>Subcommittee meeting</td>
</tr>
<tr>
<td>12-Nov</td>
<td>Plan Advisory Meeting</td>
<td>Recommendations Provided to Advisory for Feedback</td>
</tr>
<tr>
<td>Mid-Nov</td>
<td>Draft AV Calculator Release</td>
<td>Draft CMS rules and AV Calculator expected</td>
</tr>
<tr>
<td>19-Nov</td>
<td>Board Meeting</td>
<td>Recommendation to Board (pending AV requirements)</td>
</tr>
<tr>
<td>2-Dec</td>
<td>Benefits &amp; Networks Meeting</td>
<td>Subcommittee meeting to make necessary changes for AV requirements and finalize benefits, as needed</td>
</tr>
<tr>
<td>9-Dec</td>
<td>Benefits &amp; Networks Meeting</td>
<td>Subcommittee meeting to make necessary changes for AV requirements and finalize benefits, as needed</td>
</tr>
<tr>
<td>Dec TBD</td>
<td>Board Meeting</td>
<td>Board meeting in December is TBD</td>
</tr>
<tr>
<td>Jan TBD</td>
<td>Board Meeting - Decision</td>
<td>Approval by Board (Pending Final Actuarial Value Calculator)</td>
</tr>
<tr>
<td>Late Feb</td>
<td>Final AV Calculator Release</td>
<td>Final CMS rules and AV Calculator expected (based on prior year experience)</td>
</tr>
<tr>
<td>Feb TBD</td>
<td>Board Meeting</td>
<td>Approval by Board of final adjustments to SBPD if necessary</td>
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BENEFITS AND NETWORKS SUBCOMMITTEE UPDATE

JAMES DEBENEDETTI, DEPUTY DIRECTOR
PLAN MANAGEMENT DIVISION
STRATEGY FOR 2017 BENEFIT DESIGN

Organizational Goal
Covered California should have benefit designs that are standardized, promote access to care, and are easy for consumers to understand.

Subcommittee Goal
Provide input to Covered California staff as we develop recommendations for the 2017 Standard Benefit Plan Design that are consistent with a multi-year progressive strategy with consideration for market dynamics.

Subcommittee Objectives
1. Address benefit design priority areas and make minimal changes as necessary to meet AV requirements
2. Consider benefit changes that align with market dynamics:
   - Non-standard benefits
   - Non-essential health benefits
   - Alternative Benefit Designs (ABDs)
   - Value-Based Insurance Design (VBID)
3. Discuss tiered networks and product requirements
## INDIVIDUAL MARKET BENEFIT REDESIGN LANDSCAPE

**Text in red indicates updates to multi-year strategy since October 2014**

<table>
<thead>
<tr>
<th>Year</th>
<th>Statutory</th>
<th>Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>Actuarial Value (AV) baseline</td>
<td>Baseline: standard benefit design</td>
</tr>
<tr>
<td></td>
<td>No change</td>
<td>No change</td>
</tr>
<tr>
<td>2015</td>
<td>Essential Health Benefits (EHB) baseline</td>
<td>Baseline products/plans established</td>
</tr>
<tr>
<td></td>
<td>No change</td>
<td>No change¹</td>
</tr>
<tr>
<td>2016</td>
<td>Reinsurance and Risk Corridor protection to plans</td>
<td>Standalone pediatric dental</td>
</tr>
<tr>
<td></td>
<td>Reinsurance and Risk Corridor protection to plans (reduction in available dollars)</td>
<td>Embedded pediatric dental benefit</td>
</tr>
<tr>
<td>2017</td>
<td>AV updated</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td>Possible slight changes</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td>Reinsurance and Risk Corridors expire</td>
<td>Minimal benefit changes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All-applicant certification and potential product/plan changes</td>
</tr>
</tbody>
</table>

1. Health Net changed PPO product to EPO product due to regulatory requirement
2. Oscar Health Plan and UnitedHealthcare added to Covered California QHPs

**Benefit & Networks Subcommittee Focus**

- **AV updated**
- **Minimal benefit changes**
- **All-applicant certification and potential product/plan changes**

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**2014**

- **Year 1: coverage begins**
  - Actuarial Value (AV) baseline
  - Essential Health Benefits (EHB) baseline
  - Reinsurance and Risk Corridor protection to plans

**2015**

- **Year 2: consistency and stability**
  - Actuarial Value (AV) baseline
  - Essential Health Benefits (EHB) baseline
  - Reinsurance and Risk Corridor protection to plans

**2016**

- **Year 3: redesign improvements considered for access and cost**
  - Actuarial Value (AV) baseline
  - Essential Health Benefits (EHB) baseline
  - Reinsurance and Risk Corridor protection to plans

**2017**

- **Year 4: progression of improvements considered for access and cost (will be limited to AV changes)**
  - Actuarial Value (AV) baseline
  - Essential Health Benefits (EHB) baseline
  - Reinsurance and Risk Corridor protection to plans
## EXAMPLES OF 2016 PLAN DESIGN CHANGES

### GLOBAL CHANGES TO ALL PLAN DESIGNS IN 2016

<table>
<thead>
<tr>
<th>Global Changes to Service Type</th>
<th>Common Medical Event</th>
<th>2016 Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other practitioner office visit</td>
<td>Health care provider's office or clinic visit</td>
<td>Added this benefit to the SBPD. See line item under each metal level for the cost share.</td>
</tr>
<tr>
<td>All drug tiers</td>
<td>Drugs to treat illness or condition</td>
<td>Changed names: Generic drugs, now Tier 1; Preferred brand drugs, now Tier 2; Non-preferred brand drugs, now Tier 3; Specialty drugs, now Tier 4</td>
</tr>
<tr>
<td>Pharmacy deductible</td>
<td>Drugs to treat illness or condition</td>
<td>For plans with a non-integrated deductible (i.e. the Silver and Bronze tiers), &quot;Brand Drugs Deductible&quot; has been changed to &quot;Pharmacy Deductible&quot;</td>
</tr>
<tr>
<td>Specialty Drug Cap</td>
<td>Drugs to treat illness or condition</td>
<td>All Tier 4 prescriptions now have a maximum charge per script which varies by metal tier. Note that the HSA plans and Catastrophic plans do not have a cap on Tier 4 drugs.</td>
</tr>
<tr>
<td>Outpatient visit</td>
<td>Outpatient Services</td>
<td>Added the &quot;outpatient visit&quot; benefit to the outpatient services category (see details in the SBPD regulations text endnotes); changed the 2015 name, &quot;Outpatient Surgery&quot; to &quot;Outpatient Services.&quot; See line item under each metal level for the cost share.</td>
</tr>
<tr>
<td>Emergency services</td>
<td>Needs immediate attention</td>
<td>Split &quot;Emergency room services&quot; into &quot;Emergency room facility fee&quot; and &quot;Emergency room physician fee.&quot; See metal tier plan designs for the physician fee cost-share.</td>
</tr>
<tr>
<td>Mental Health Outpatient Services</td>
<td>Mental health, Behavioral Health, or Substance Abuse Needs</td>
<td>Split &quot;Mental Health Outpatient Services&quot; into &quot;Mental/Behavioral Health Outpatient Office Visits&quot; and &quot;Mental/Behavioral Health Outpatient Items and Services.&quot; See endnote #13 in the SBPD regulations text for an explanation of Items and Services.</td>
</tr>
<tr>
<td>Substance Use Outpatient Services</td>
<td>Mental health, Behavioral Health, or Substance Abuse Needs</td>
<td>Split &quot;Substance Use Outpatient Services&quot; into &quot;Substance Use Outpatient Office Visits&quot; and &quot;Substance Use Outpatient Items and Services.&quot; See endnote #13 in the SBPD regulations text for explanation of Items and Services.</td>
</tr>
<tr>
<td>Mental Health Inpatient Services</td>
<td>Mental health, Behavioral Health, or Substance Abuse Needs</td>
<td>Split &quot;Mental Health Inpatient Services&quot; into &quot;Mental/Behavioral Health Inpatient Facility Fee&quot; and &quot;Mental/Behavioral Health Inpatient Physician/Surgeon Fee.&quot;</td>
</tr>
<tr>
<td>Substance Use Inpatient Services</td>
<td>Mental health, Behavioral Health, or Substance Abuse Needs</td>
<td>Split &quot;Substance Use Inpatient Services&quot; into &quot;Substance Use Inpatient Facility Fee&quot; and &quot;Substance Use Inpatient Physician/Surgeon Fee.&quot;</td>
</tr>
</tbody>
</table>
POTENTIAL BENEFIT CHANGES WITH MINIMAL INTEREST

• Survey of Anthem plans on other exchanges did not result in new designs to consider

• Little interest in alternate (non-standard) benefit designs for 2017

• Little interest in non-Essential Health Benefits until 1095 reporting systems can support this function
POTENTIAL BENEFIT CHANGES AREAS WITH NO CONSENSUS

• Two tier hospital networks
  o Member confusion vs. lower cost for Tier 2 hospitals (compared to non-network hospitals)
  o Anthem to follow up with actual utilization of Tier 2 hospitals

• Value Based Insurance Design
  o Member confusion and limited utilization by Covered California population vs. easy to deploy copies of existing designs (e.g., hip & knee replacement reference pricing)
  o Free / low cost maintenance drugs for specific chronic conditions resulting in higher costs for other drugs and/or benefits to meet AV requirements

• Consolidation of copay and coinsurance plans for both Gold and Platinum plans
  o Small enrollment in these plans makes it a lower priority
POTENTIAL BENEFIT CHANGES WITH LIKELY AGREEMENT

• Cost-sharing changes
  o Reduce urgent care copay to standard office visit copay amount
  o Remove physician cost sharing for ER visits
  o Combine medical and pharmacy deductible for Bronze plans

• Thorough review of EOCs, SERFF template requirements, and Knox-Keene requirements to standardize benefits that are not currently standardized - likely a multi-year process.
Dental Standard Benefit Design Review for 2017

Discussion Topics

• Adult waiting period for major services

• Adult annual limit

• Degree of standardization in copay design

• Potential new plan design for employer-sponsored purchase only
QUALITY SUBCOMMITTEE UPDATE

LANCE LANG, CHIEF MEDICAL OFFICER
PLAN MANAGEMENT DIVISION
ORGANIZATIONAL GOAL

Covered California 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.

SUBCOMMITTEE GOAL

- Provide input to Covered California staff as we develop recommendations for 2017 contract requirements that will target further improvements for the quality and delivery of care to consumers and align efforts for participation with other State and Federal initiatives.
- Provide feedback on goal-setting with an eye for targeted improvements by 2020.
2017 DELIVERY REFORM CONTRACTUAL ISSUES UPDATE (1/2)

- Covered California will be raising the bar for carrier requirements to align efforts to improve the delivery of services unique to our population and positively impact healthcare outcomes in California. Areas to be addressed include the following:

  - Reducing Racial/Ethnic disparities in health outcomes
    - Consider NCQA recognition for MultiCultural Health Care
    - Track select HEDIS Scores by racial/ethnic group
    - Demonstrate narrowed disparity in scores
    - Continue to develop Essential Community Provider networks

  - Increasing availability of Decision Support for Treatment/Provider Selection
    - Use of benefit information to support member estimate of cost sharing
    - Price transparency for procedures and episodes of care
    - Variation in quality outcomes
    - Support of integrated provider directory

  - Increase the number of member enrolled in Accountable Care Organizations (ACO) and Patient Centered Medical Homes (PCMH)

  - Sub-committee meetings have started to vet 2017 QHP requirements that includes carrier participation in Quality Initiatives, Performance Measures, and Service Level Standards

  - Sub-committee members include carriers and consumer advocates
2017 DELIVERY REFORM CONTRACTUAL ISSUES UPDATE (2/2)

• Narrow the number of statewide initiatives to drive more focused and concentrated effort by aligning with improvement initiatives sponsored and/or supported by other purchasers
  
  o California State Innovation Model/CalSIM (Appropriate use of C-Sections)
  o CalPERS, California Medicaid and PBGH
  o CMS Innovation Center (Payment reform opportunities, Clinical Transformation grant program (Partnership for Patients/Promoting Hospital Safety)
  o Statewide Workgroup on Overuse and Misuse (“Choosing Wisely” Initiative)

• Sub-committee meetings focused on changes to the 2017 contract related to delivery reform have started and includes carriers and advocates
WRAP UP AND NEXT STEPS

BRENT BARNHART, CHAIR
COVERED CALIFORNIA PLAN MANAGEMENT ADVISORY GROUP