Qualified Health Plan Update: Standardized Benefit Plan Designs, Out of Network Benefit Policies and QHP Model Contract Outline

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Major Issues

- Standardized Benefit Design
  - Overview of current status of standardized design
  - Board Action on Recommendation to change Out-of-Network Policy
- Overview of Model Contract Provisions
  - Review decision issues for January (e.g., fee structure)
- Plan Management Next Steps and Timeline
  - File revised regulation package

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What's New in Plan Design Issues

- Federal Actuarial Value calculator released in draft form on November 20, 2012 required changes to cost-sharing in earlier draft standardized plans as expected.
  - Impact of federal calculator was to raise cost-sharing requirements;
  - Standardized benefit plan designs have been revised to conform; may need to be revised again once calculator is final.
- Continued efforts to move co-insurance to co-pay when possible to improve consumer comparison.

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Standardized Benefit Plan Designs: Key Changes (12/12/12 Version)

- Using Federal calculator, most per visit co-pays increased (e.g. silver co-pay plan went from $40 to $45).
- Out of pocket expense limits increased across the board.
  - Co-pays for all items in co-pay plan would increase dramatically if out of pocket limits were not increased.
- Most enrollees do not reach out of pocket limits unless they are hospitalized.
- Retained “stair-step” approach to standard co-pay and co-insurance changes across coverage tiers (metals) (PCP visit co-pays are $80, $45,$35,$25 from lowest to highest coverage tier)
- Move from two to one the deductible-waived non-preventive office visits to reduce other cost-sharing.
- Converted imaging from co-insurance to co-pay in co-pay plans.

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Proposed Change in Standardization of Out-of-Network Benefits

- Board policy adopted last August applied exclusively to non-emergent covered services; PPO plans only.
- Board policy had three components; staff recommends change to one component of the policy adopted by the Board.
- Policy components:
  - Require plans to inform its member *prior* to the use of non-emergent care of the amount that the plan will pay for the out of network care.
  - Require the plan to require its network providers to disclose the cost and the use of non-network providers to its members in advance of a member's decision to use out of network services.
  - Established that the *basis* for a plan's out of network benefit amount would be the 50th percentile of the Fair Health Database.
- Staff recommends eliminating the use of the 50th percentile of the Fair Health Database as the basis for calculating out of network benefits and that Covered California monitor and report back 2014 experience relative to Fair Health data base and reconsider for 2015.

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Reasons for Change in Recommendation: Out of Network Benefit Payments

- Policy could inadvertently induce use of out of network providers and undermine incentives to use in-network providers.
- Policy could negatively affect affordability of Exchange plans.
- Change in policy is limited and leaves consumer notice requirements intact.
- Policy didn't affect or reduce consumer responsibility for balance billed charges by non-network providers, creating potential bad debt problems for hospitals in particular.

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Qualified Health Plan Model Contract: Sources of Model Contract Provisions

- State law and regulations
- Federal law and regulations
- Board policies (e.g. August 2012)
- QHP Solicitation
- Standard contracting requirements

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Qualified Health Plan Model Contract: Major Subject Areas

1. State and federal requirements
2. Administrative and Operational Requirements
   a) Agent Policies
   b) Customer Service Requirements
   c) American Indian & Alaska Native Requirements
   d) Complaints, Grievances and Appeals
3. CalHEERS Interfaces
4. Network and Essential Community Provider Adequacy
5. Financial Management
6. Eligibility and Enrollment
7. Quality Improvement and Delivery System Reform
8. Marketing requirements and plan partnership
9. SHOP-Specific Requirements
10. Data Reporting Requirements
11. Recertification and Decertification
12. **Plan Participation Fees (see following slides)**
13. Definitions

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Planned Enrollment & Operating Budget

	2013	2014	2015	2016	2017
Key Variables					
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
Revenue					
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
Total Revenue	**$ 364,971,379**	**$ 522,394,940**	**$ 258,186,923**	**$ 301,960,074**	**$ 307,398,061**
Plan Assessment %	-	**3.00%**	**3.00%**	**2.50%**	**2.00%**
Total Expenses					
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
Subtotal Expenses	**390,817,627**	**403,680,677**	**336,081,251**	**322,382,621**	**313,697,479**
Allocated Cost Offsets	(25,846,247)	(14,094,819)	(20,739,715)	(17,121,581)	(14,735,341)
Total Operating Cost	**$ 364,971,379**	**$ 389,585,858**	**$ 315,341,536**	**$ 305,261,039**	**$ 298,962,137**
Expense PMPM			**17.65**	**13.07**	**10.79**
Net Income	**$ -**	**$ 132,809,082**	**$ (57,154,613)**	**$ (3,300,965)**	**$ 8,435,924**
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
Difference - Surplus (Gap from 3 month minimum)	**$ -**	**$ 55,809,082**	**$ (1,345,531)**	**$ (4,646,496)**	**$ 3,789,428**

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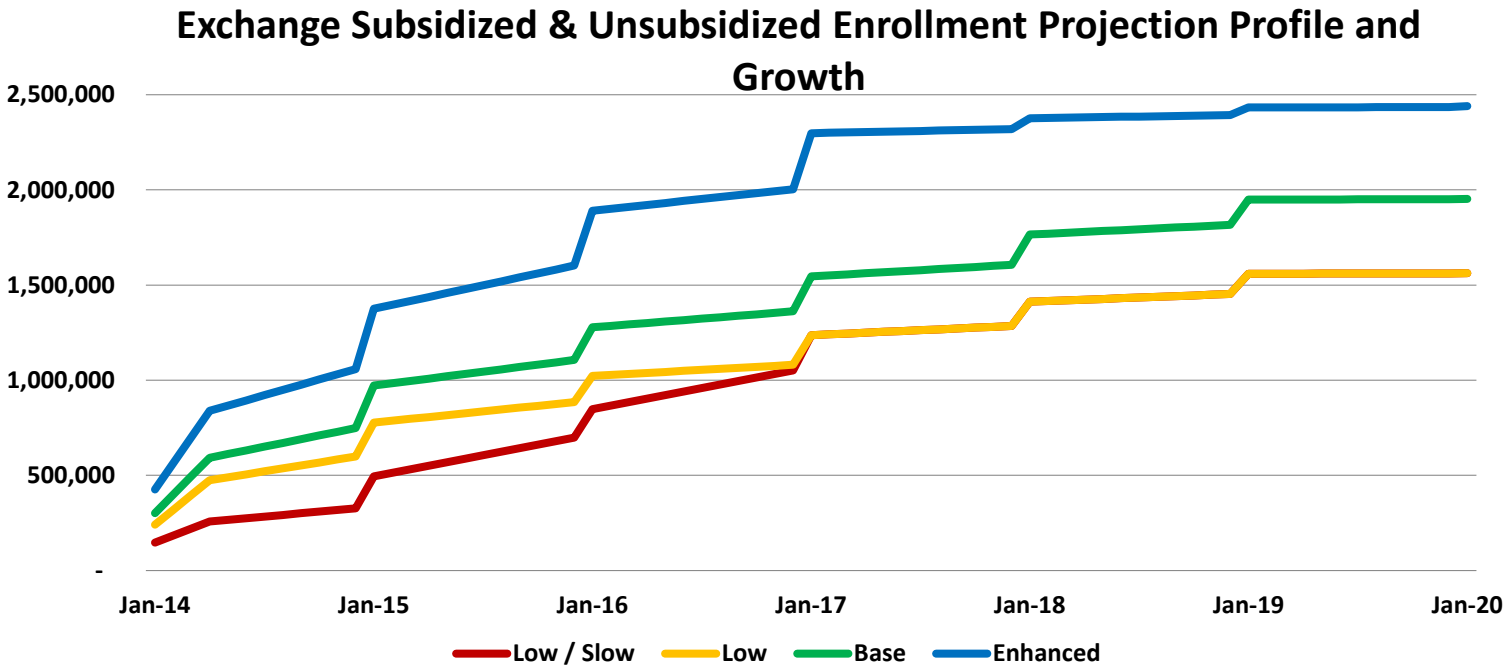
“Aim High” and Plan for Uncertainty



	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.

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Qualified Health Plan Model Contract: Participation Fees

As Covered California considers plan participation fee structures and plans, it welcomes comments on major elements that will be brought to the board for action in January. Initial recommendations include:

- Calculate payment on percentage of average premium, but charge based on standard per member/per month assessment

2014 Fee:

- Assessment level 3% (set for entire year and adjust for 2015)
- Assess fee at same level on standalone or supplemental dental and vision products
- Assess fee on QHP enrollment outside of Covered California at 50% of standard rate (e.g., at 1.5% for 2014)

2015 Fee:

- Adjust fee based on enrollment and revised evaluation of Exchange finances
- Consider implementing mechanisms for discounting fee to plans based on "in-kind" services or reducing burden on CoveredCA (planning in 2014)

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Next steps for Plan Management

- We continue to support the bid submission process by QHP bidders
- Respond to and incorporate changes in state statute and federal rules as they impact QHPs.
- Prepare for Evaluation, Selection and Certification of QHPs in order to meet timeline requirements.
- Run dental and vision RFP processes in coordination with QHP timeline.
- Administrative provisions for QHPs that are not appropriate for inclusion in model contract will be included in a Plan Administrative Manual
- Potential adjustments to timelines for affordability/Medi-Cal plan contracting

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Health Plan Contracting Timeline

Contracting Activity	Date
Overview of Key Elements of QHP Model Contract	December 18, 2012
Draft QHP Model Contract Released	January 4, 2012
Issue Final Dental and Vision Benefits Solicitation	January 7, 2013
Comments due on QHP Model Contract	January 10, 2013
Notice of Intent to Bid: Dental and Vision Benefits-Responses Due	January 14, 2013
Questions from Bidders on Dental and Vision Benefits Solicitation Due	January 14, 2013
QHP Solicitation Response - Phase 1	January 15, 2013
QHP Model Contract to Covered California Board	January 17, 2013
Final QHP Model Contract - posting	January 18, 2013

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Health Plan Contracting Timeline

Contracting Activity	Date
Essential Community Provider Network maps and lists due to Exchange - Phase 1a	February 15, 2013
Provider networks to Regulators - Phase 2	February 28, 2013
Dental and Vision Benefits - Bids due	March 1, 2013
QHP Solicitation - Phase 3 (bids including premium rates due)	March 31, 2013
Evaluation/negotiation period	April 1 - May 15, 2013
Plan administration manual draft released	April 30, 2013

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Health Plan Contracting Timeline

Contracting Activity	Date
Tentative certification notices sent to bidders contingent on regulator Rate Review and QHP or QDP Contract Negotiations	May 15, 2013
Rate filing with regulators for selected QHPs (rates will become public)	May 15, 2013
QHP Model contract – negotiations	May 15-June 30, 2013
Rate review by regulators	May 15-June 30, 2013
Plan administration manual (Version 1) - released	May 30, 2013
QHP contracts signed – Participating plans announced	June 30, 2013
Plan enrollment begins	October 1, 2013

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Providing Input

Input is welcome on Covered California's Benefit Design and Model Contract Provisions

Please send input to qhp@hbex.ca.gov

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