Partner Plan Model Contract: Key Provisions

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Qualified Health Plan Timeline

Activity	Date
Plan Management and Delivery System Reform Advisory Group – Input	January 9, 2013
Draft Partner Plan Contract Released for Comments	January 11, 2013
Update Covered California Board	**January 17, 2013**
Phase one responses due from Partner Plan bidders	January 23, 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 contingent on Rate Review and Partner Plan Contract Negotiations	May 15, 2013
Rate filing with regulators for selected Partner Plans (rates will become public)	May 15, 2013
Contract-negotiation completed by May 15, 2013	**May 15, 2013**
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
Partner Plans loaded into CalHEERS	July 1, 2013

Today

118 Days

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Objectives of *Partner Plan* Model Contract

1. Implement the Affordable Care Act and the California Affordable Care Act.
2. Build strong, multi-year partnerships with ***Partner Plans*** to improve quality, lower cost and improve health for Californians.
3. Deliver on consumer protections through Partner Plans contract with Covered California.
4. Define our commitment to ***Partner Plans*** in marketing, enrollment, communications and operations.
5. Execute Board decisions through ***Partner Plan*** contracts to meet Covered California's policy and program objectives.
6. Achieve financial sustainability by 2015.

Key *Partner Plan* Contract Provisions

- Quality Improvement and Delivery System Reforms
  - Addressing Enrollees with Existing Health Needs
  - Reporting on Quality of Care

- Effective Consumer Communication
  - Ensuring Culturally Competent Care and Linguistically Appropriate Care

- ***Partner Plan*** Joint Marketing
  - “Rollover” Strategy

- Fee Structure for ***Partner Plans***
  - Planned Enrollment & Operating Budget

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Contract: Delivery System Reforms

Primary Care and Preventive Services (Section 88)

- ***Partner Plans*** 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. ***Partner Plans*** may offer an alternative approach to achieving this goal.

- ***Partner Plans*** 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 (91 &92**)**

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

Contract: Meeting Urgent Health Needs

- ***Partner Plans*** 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.
- ***Partner Plans*** shall demonstrate to the Exchange how it uses health assessment tools, data analytics and member self-identification to find Enrollees most in need of timely treatment plans.
- ***Partner Plans*** must demonstrate how it identifies all Enrollees with existing chronic conditions and significant health needs within 120 days of enrollment.
- Once such Enrollees are identified, ***Partner Plans*** must demonstrate that XX % of identified enrollees with chronic conditions or significant health needs are in a treatment plan within 60 days of identification. (Section 89)

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Contract: Reporting on Quality of Care

- ***Partner Plans*** shall provide periodic reports that describe the types of care provided to Enrollees. Report requirements and formats will be outlined in the Administrative Manual but include:
  - 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 (Section 90)

- ***Partner Plans*** shall collect and compile National Committee on Quality Assurance (NCQA)-approved Health Plan Employer Data and Information Set (HEDIS) Effectiveness of Care measure performance rates for its Exchange population.(Section 90)

Contract: Effective Consumer Communication

- ***Partner Plans*** 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. (Section 91)
- ***Partner Plans*** 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.
- ***Partner Plans*** shall use a clear and consumer-friendly explanation of benefits.
- ***Partner Plans*** 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.

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Contract: Cultural & Linguistic Competency

- ***Partner Plans*** provide or make arrangements for language interpretation and translation services for its Enrollees at:
  - Point of care
  - Contacting the Partner Plan
  - Accessing Partner Plan providers.
- ***Partner Plans*** shall develop and deploy internal systems to ensure the availability of appropriate language proficiency at point of care and Enrollee support/services. (Sections 46 and 91)

Contract: Customer Service Guarantees

- Superior customer service is an Exchange priority. The Exchange and ***Partner Plans*** shall work closely together to ensure the needs of Exchange Enrollees are met. ***Partner Plans*** shall provide and maintain all systems to ensure record protection and uninterrupted service to the Exchange and its Enrollees. (Sections 46 and 104)

- ***Partner Plans*** agrees to Customer Service Performance Guarantees including an annual compliance review and operational performance, by an independent, third-party reviewer designated by the Exchange. ***Partner Plans*** and the Exchange shall share in the cost of these annual audits equally. (Attachment 3)

Contract: Plan Partnership Elements

- ***Partner Plans*** will agree to prominently display the Subsidy Calculator on its website and on all appropriate web pages related to individual health insurance coverage. (Section 103 and 104)

- ***Partner Plans*** will 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 ***Partner Plans*** also offer Qualified Health Plans through the Exchange. (Section 47 and 48)

- 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. (Section 104)

Contract: Rollover Strategy

- Approximately 600,000 of the individuals currently covered under individual policies are eligible for subsidies. It is in both Covered California and the ***Partner Plans'*** interest to insure that these individuals rollover into the Exchange.

- We will work with the ***Partner 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 ***Partner Plan*** 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. (Section 116)

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Contract: Major Fee Components

Base Fee Proposal-Individual Market (Section 114)

- Set initial fee based on 3% of premium, but assess on PMPM basis
- Assess fee on non-Covered California ***Partner Plans'*** enrollment at 50% of Covered California plans.
- 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

Base Fee Proposal-SHOP Market (Section 115)

- For products sold in the SHOP Exchange, the Fee is consists of two components:
  - A fee of 4% of premium to support ongoing operations
  - An additional component to cover the estimated cost of agent commissions
- Assess fee on non-Covered California ***Partner Plans'*** enrollment at 50% of Covered California plans' fee component supporting ongoing operations
- Fees for Supplemental Plans (Dental and Vision) at same rate as for SHOP products and adjusted as required.

Contract: Proposed Performance-based Adjustments

- Allow potential for ***Partner Plans*** to receive a discount off of their Covered California fee for those lives that they convert from existing insurance coverage (Section 116)
  - 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

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Critical Path for Partner Plans Strategic Relationship

1. Basis for marketplace by July 1

- Competitive choices in all 19 regions
- Realistic pricing that incorporates transitional support for adverse health risk in the uninsured populations
- Successful negotiation of plans, prices, quality programs, and Covered California revenue
- All needed regulatory approvals and/or reviews
- Executed Partner Plan contracts by July 1, 2013
- Multi-state plans incorporated if required

2. Awareness building by August 1

- Community outreach focusing on awareness
- Marketing/communication program focusing on awareness
- Call center(s) live and scaling
- Covered California internet portal

3. Distribution platform live by September 1

- CALHEERS + Federal Hub for eligibility and quoting
- Assisters trained (including community, business, and government)
- Agents/Brokers trained (both individual and SHOP)
- Plans trained for sales, support, and administration

BROWN = Major IT Contingency

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Critical Path for Partner Plans Strategic Relationship

4. Enrollment platform live by October 1

- Marketing/communication focusing on driving enrollment
- Full deployment of all enrollment resources (assisters, agent/brokers, and plans)
- CALHEERS + Partner PlanS for enrollment and premium collection fully functional and scalable

5. Full administrative platform live by January 1

- Marketing/communications continues focus on driving enrollment for additional 90 days
- Distribution resources continue for an additional 90 days
- CALHEERS + Partner Plans + Federal Funds for full administration – fully functional and scalable

BROWN = Major IT Contingency

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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