Covered California
Health Plan Contracting

Board of Directors

April 23, 2013

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Factors Affecting Individual Premium Rates in 2014 for California

Prepared for:

Covered California

Prepared by:

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Principal and Consulting Actuary

March 28, 2013

Report available at www.hbex.ca.gov

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Total 2014 Impact of Affordable Care Act on California's Individual Health Insurance

Presently Insured	Less than 400% FPL	Greater than 400% FPL
Californians Impacted	600,000	1,300,000
Eligible for federal tax credit	YES	NO
Change in total cost (Premium + out-of-pocket)	Down 40% to 76%	Up 20%

Presently Uninsured	Less than 400% FPL	Greater than 400% FPL
Californians Impacted	1,600,000	1,400,000
Eligible for federal tax credit	YES	NO
Change in total cost (Premium + out-of-pocket*)	Down 55% to 91%	Down 0 - 1%

* Assumes uninsured have been receiving all the health care they would have had they actually purchased insurance.

Data source: Factors Affecting Individual Premium Rates in 2014, Milliman, San Diego, CA, March 28, 2013

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Premium Rate Adjustments due to Affordable Care Act Market Changes

Affordable Care Act Market Changes	Low	Best Estimate	High
Health Status	15%	26.5%	40%
Provider Contracting Changes	-9.0%	-6.0%	1.0%
Benefit Coverage Adverse Selection	1.0%	1.9%	2.9%
Cost Sharing Induced Utilization	3.7%	4.1%	5.0%
Reinsurance Protection	-12.0%	-9.1%	-8.0%
Increased Taxes and Fees	2.3%	4.1%	7.2%
Pent-up Demand	0.0%	2.1%	2.2%
Change in Administrative Expenses	-7.0%	-4.5%	0.0%
Composite – Affordable Care Act Market Changes	See note.	14.0%	See note.

Note:

Some of these factors are not independent, so the reader should use judgment in using these factors to estimate the low or high composite values.

Note: Covered California can make a big difference in outlined areas.

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Covered California Plan Model Contract: Options and Recommendations

Andrea Rosen

Interim Health Plan Management Director

Board Meeting
April 23, 2013

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Contract Development / Review Process

- Broad engagement with plans and other stakeholders during 2012 re: expectations for plans in Exchange
- Board Adopted Health Plan Contracting Policies – August 2012 including 7 key active purchaser principles which were implemented in Solicitation and in Model Contract
- Draft Contract Version 2.0 Released: 4/1/13
- Draft Contract Version 3.0 Released : 4/19/13 and further revised on 4/22/2013

Qualified Health Plan Selection and Contracting Timeline

(as of April 23, 2013, subject to revision)

Activity	Date
Third Draft Model Contract Released	April 19, 2013 and April 22, 2013 revised
Model Contract Attachments Released	April 19, 2013 and April 22, 2013 revised
Public Comments Due on Third Draft Model Contract	April 26, 2013
Board Action on Staff Final Recommendations	May 7, 2013
Model Contract – Final	May 8, 2013 (tentative)
Tentative QHP Certifications and Initial Contract Agreement	May 15, 2013
Reasonableness Rate Review by Regulators	May 15 - June 2013
Final Contracts Signed and Certification of Covered California Plans	June 30, 2013
Covered California Plans Loaded into CalHEERS	Beginning July 1, 2013

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Comments Received on Contract To Version 2.0

- California Association of Health Plans
- Confidential Comments from five potential Bidders
- Health Insurance Alignment Project
- Pacific Business Group on Health
- March of Dimes Foundation
- California Pan-Ethnic Health Network, Consumers Union, Health Access
- California Primary Care Association
- California Hospital Association
- California Medical Association
- California Association of Physician Groups
- California Medical Association, California Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, District IX, California Academy of Eye Physicians and Surgeons, California Hospital Association, California ACEP, Medical Oncology Association of Southern California, Inc., Association of Northern California Oncologists

Covered California: Model Contract Version 2.0 Major Issues

1. Active Purchaser Versus “Third Regulator”
2. Plans’ Legal Obligations Are Reinforced
3. Contract Should be More Balanced
4. Phase in Covered California As a Catalyst for Delivery System Reform
5. Assuring Language Access
6. Promoting Primary Care
7. Collecting Information to Address Health Disparities
8. The Agreement Needs to Define Core Terms
9. Promoting Transparency at the Provider Level
10. Assuring High Quality Care for At-Risk Population
11. Performance Accountability – For Both Contractors and Covered California
12. Allow for the Potential for Additional Public Subsidies

1. Covered California: Active Purchaser Versus "Third Regulator"

Issue	Discussion
Plans are concerned that Covered California is acting as a "third regulator."	Areas of Concern: • Network Adequacy • Provider credentialing • Marketing materials review • Provider Credentialing • Utilization Review • Financial Solvency • Formulary Changes

Recommendations

- Defer to regulator on areas such as financial solvency, credentialing and utilization review.
- Keep in contract those areas where Exchange is concerned with direct consumer impacts as an active purchaser (e.g., require Contractor to consult with Exchange on changes to service area, drug formulary and network capacity issues where Exchange enrollee's experience could be immediately and dramatically affected).
- Revise language related to marketing materials to reflect Exchange's position as a marketing partner.

2. Plans' Legal Obligations Are Reinforced

Issue	Discussion
Plans are concerned that contract terms duplicate existing legal requirements; consumer and provider groups support reinforcing requirements.	Plans are concerned that references to their need to comply with state and federal laws, rules and regulations duplicates existing requirements. The Exchange calls out certain existing requirements, such as non discrimination, language assistance and others that have a direct impact on consumers.

Recommendation:

- Selectively omit references to certain current State or Federal requirements that require Contractor compliance.
- Emphasize consumer-facing legal requirements that may be federal or state law, that relate to core expectations which, in the absence of the law Covered California would likely have contract requirements (e.g., non-discrimination and language access).

3. Contract Should Be More Balanced

Issue	Discussion
Plans consider the model contract as too “one-sided” and lacking mutuality	The Exchange and Contractor are essentially interdependent to ensure that enrollment is attractive and people get the coverage in year one they need and deserve. Terms of the agreement between the parties have been changed to reflect more balance between expectations of each party.

Recommendation:

- Revise language to reflect greater collaboration between the parties and remove some requirements that are viewed as too “prescriptive”. Examples of these areas include:
  - Requiring prior approval of marketing and collateral material.
  - Exchange to adopt specific customer service requirements and responsibilities,
  - Exchange to assume statutory enrollment requirements such as agent attestation.
  - Exchange to collect and transmit first month of Individual premium fees to Contractor
  - Relaxation of logo co-branding requirements to ID cards, premium invoices and enrollee termination letters; recognize Exchange need to control use of Exchange logo.
  - Setting quality, network management and delivery system standards
  - Enrollee data collection requirements and provider data on cost and quality

4. Phase In Covered California As a Catalyst for Delivery System Reform

Issue	Discussion
Plans expressed concern that the Quality, Network Management and Delivery System Standards were too aggressive for year one; while others (purchasers, consumers and some providers) generally applauded the more proactive approach.	The Exchange focus on gathering reports and information from its contracted plans on quality improvement initiatives. Increase focus on Triple Aim initiatives through collaboration in year two and beyond.

Recommendation:

- Adjust terms to focus 2014 on requiring Contractor to inform and report to Exchange on current network and delivery system quality improvement projects.
- Develop plans for collecting claims and encounter data while protecting all PHI and using to enhance quality of care and efficiency of delivery systems.
- For 2015 work to identify additional quality requirements and metrics.

5. Assuring Language Access

Issue	Discussion
Plans expressed concerns about imposing language requirements beyond current state law; consumer advocates proposed clarifications to proposed “Medi-Cal-like” standards.	Plans noted that they had invested heavily in meeting language requirements within the last few years; object to expanding requirements at this very busy time. Asked to eliminate “Medi-Cal” requirements regarding “threshold” languages.

Recommendation:

- Revise contract terms to limit language requirements to current State and Federal requirement, with the exception that all key Enrollee communications and web-site information shall be available in both English and Spanish. This exception recognizes projected Exchange enrollment will include a substantial enrollment of Spanish language speakers.

6. Covered California Promoting Primary Care

Issue	Discussion
Plans expressed concern related to the proposal to require that all patients have a known primary care provider or have one assigned, especially PPO and EPO product designs.	Non-HMO models do not require PCP assignment and current provider contracts in non-HMO products do not have provisions for PCP assignment, nor do they create PCP responsibilities for providers. Covered California sees consumers having a known primary provider or clinic as an important move towards more coordinated care models. System changes may be needed to accommodate PCP assignment by non HMOs.

Recommendation:

- Revise terms to encourage and measure primary care selection or assignment where applicable (or required under the benefit plan).
- Encourage and assist enrollees in selecting a primary provider, Federally Qualified Health Center or Patient Centered Medical Home. Auto-assignment of PCP or FQHC or Patient Centered Medical Home should be based on Enrollee stated preference for provider gender, language, ethnic or cultural diversity.
- Plan must report percentage of enrollees that have selected or been assigned a primary provider within 120 days of enrollment for future evaluation of this provision, and propose plans to implement such provisions.

7. Collecting Information to Address Health Disparities

Issue	Discussion
Plans are concerned about the system for and sensitivity about collecting enrollee information such as race, ethnicity, sexual orientation, gender identity and disability status; consumer advocates want information collected and used.	Covered California proposed data collection as reducing health disparities is a key goal. Concerns were expressed about the difficulty of collecting this information privacy and confidentiality of such data. Exchange is concerned about how Plans can reduce health disparities without this type of enrollee data which would inform interventions and changes to service delivery.

Recommendation:

- The Exchange may collect Enrollee data related to sensitive categories, on a voluntary basis to the consumer including race, gender, gender preference, sexual orientation, language and ethnicity (Note: Covered California and DHCS have not yet completed their review of data elements for the single stream-lined application.)
- To the extent the Exchange collects such data, it will be maintained confidentially at the Exchange, in accordance with State and Federal rules or regulations. Covered California will research its ability to provide contractors with this information (subject to agreement by enrollees).

8. The Agreement Needs to Define Core Terms

Issue	Discussion
Plans expressed concern about references to an "Administrative Manual" which is not available for review.	Contractors expressed concerns about agreeing to comply with a document they have not yet seen.

Recommendation:

- Defer creation of an Administrative Manual at this time and build into the contract better.
- Collaborate with QHPs to develop business rules together on operational interfaces and other requirements. These business rules along with operational interface requirements will form the basis of a future Administrative Manual or Business Policies.

9. Promoting Transparency at the Provider Level

Issue	Discussion
Plans and Providers expressed concerns about sharing confidential rate and contract information with the Exchange, and the level of requirements to report provider-level performance; Purchaser and consumer advocates strongly supported increased transparency.	The Exchange's mission includes creating provider cost and quality transparency for consumers and cost data is essential to achieve this type of consumer information at the point of service.

Recommendation:

- Remove requirement to submit provider contracts or rates, but require Plans to inform Covered California of contractual restrictions on sharing data.
- Contractors are required to describe how they collect and make available to enrollees provider cost and quality data and use it to improve care.
- At a minimum, Contractors are required to provide enrollees with information from CMS' hospital and physician programs.
- Contractors to describe plans to create transparency to enhance consumer information at the point-of-service and to keep enrollees current on their cost-sharing contributions.

10. Assuring High Quality Care for At-Risk Population

Issue	Discussion
Plans expressed concerns about a prescriptive approach to identification and management of "at-risk" Enrollees.	At-risk Enrollees are described as those with existing or newly diagnosed chronic conditions who are most likely to benefit from coordinated care. The Exchange is extremely concerned that the individuals who need care the most are identified and well managed. Targeting of Enrollees with diabetes, asthma, heart disease or hypertension, or other chronic or acute conditions is a strategy to better manage care. Contractors expressed concerns with prescriptive instructions on care coordination.

Recommendation:

- Revise terms to allow Contractors to define their "at risk" enrollees and to describe how they identify and proactively manage such Enrollees.
- While there are state law requirements for continuity of care, Covered California believes this issue is of heightened import and Contractors must describe their plan to manage Enrollees transitioning from other high risk, chronic care programs (MRMIP, CPIP,ADAP).
- Contractors are required to document their strategy for collecting information on their enrollees' health status and using it to improve care.

11. Performance Accountability – For Both Contractors and Covered California

Issue	Discussion
Plans expressed concern about the performance expectations.	Contractors expressed concerns that the initial priority of Covered California ought to be enrollment and program launch. Efforts to improve the market and meet the Triple Aim should be phased in constructively to support successful outcomes

Recommendation:

- Maintain the concept of contractors being financially "at-risk" for their performance. Revise contract terms to allow more phased in efforts related to Delivery System Reform, Value Based Purchasing, Provider Transparency, Cost and Quality improvement and collection of Enrollee data to reduce health disparities.
- Add provisions by which Covered California's performance could lead to "credits" for Contractors.
- Work with Contractors and other Stakeholders to agree on initial benchmarks.

12. Allow for the Potential for Additional Public Subsidies

Issue	Discussion
DHCS has informed the Exchange that it might want to partner to address the needs of special populations who will be enrolling in QHPS such as pregnant women and newly qualified immigrants. The model contract needs to prepare QHPs for these possibilities.	Certain pregnant women may be eligible for both an Exchange subsidy and expanded services through the Medi-Cal Program. Also, newly Qualified Immigrant Citizens may be eligible for Exchange subsidy products

Recommendation:

- Add placeholder language that will require the Contractor to cooperate with other Exchange partners where additional premium and cost-sharing subsidies may be available to certain populations.