COVERED CALIFORNIA POLICY AND ACTION ITEMS

October 24, 2013

IDENTITY PROOFING POLICY

David Maxwell-Jolly, Chief Deputy, Executive Director

COVERED CALIFORNIA IDENTITY PROOFING PROCESS KEY ISSUES

Federal Guidance Requires Identity Proofing

- Federal guidance released in June 2013 requires identity verification for all consumers applying for health insurance through the individual and SHOP Marketplaces.
- Identity proofing ensures applicants are who they say they are.
- The Remote Identity Proofing Program is a federally-sponsored service that verifies applicants' identities based on correct answers to security questions, which may pertain to applicants' credit history, residential history, or other identifying attributes.

Covered California's Current Identity Proofing Process

1. Paper: The consumer provides a signature attesting to his/her identity, under the penalty of perjury.
2. Online: The consumer provides an electronic signature attesting to his/her identity, under the penalty of perjury.
3. In-Person: In-person enrollment assistance personnel must provide verification of identity to become certified and must verify applicants' identities.
4. Phone: The consumer provides a recorded verbal attestation that the consumer is who he/she says he/she is, under the penalty of perjury.

COVERED CALIFORNIA PERMANENT IDENTITY PROOFING PROCESS

Permanent Identity Proofing Process

- Covered California will ask online and phone applicants to respond to Remote Identity Proofing ("RIDP")-supplied questions to verify their identities.
- CalHEERS will be equipped to interface with the Federal Data Services Hub for the RIDP.
- Covered California applicants in the individual marketplace will be able to verify their identity via one of the following channels:
  - Paper application: Signature under the penalty of perjury
  - In-person: Verification of identity through review of photo documentation or other acceptable proof.
  - Non-paper application: Federal Data Services Hub Remote Identity Proofing Process **OR** in-person proof of identity **OR** mail or electronic transmission of proof of identity
- SHOP Marketplace identity verification process will remain unchanged

Next Steps

- Covered California staff will request Board approval of identity proofing regulations at the November 21st Board meeting
- Comments on draft regulations can be submitted to info@covered.ca.gov by Friday, November 1, 2013

CONSUMER PROTECTION & ENROLLMENT ASSISTANCE

LaVonne Coen, Deputy Chief Operations Officer

CONSUMER PROTECTION & FRAUD PREVENTION

Covered California Consumer Protection Measures

- Fingerprint-based criminal background checks for certified enrollment personnel
- Office of Consumer Protection housed within the Covered California Service Center
  - Complaint tracking
  - Investigation
  - Referral to law enforcement
  - Consumers can report potential fraud by calling the service center (1-800-300-1506) or emailing consumerprotection@covered.ca.gov
- Collaborations underway with counterparts in state government and local law enforcement

Enterprise-wide Efforts

- Information Technology and Privacy Security
- Financial Audit Unit

CONSUMER PROTECTION & ENROLLMENT: KEY MESSAGES

- **Make sure you're working with a Covered California certified helper**
  - Verify certification by phone or online
- **Enrollment assistance is always free**
- **You pay the health insurance company for coverage**
- **Report any suspected fraud to Covered California**
  - Call (800) 300-1506 or email consumerprotection@covered.ca.gov.
- **Get informed** with Top Tips, FAQ, and resources:
  - https://coveredca.com/consumerprotection/

CONSUMER PROTECTION & ENROLLMENT: KEY MESSAGES

Know the Difference Between Outreach and Enrollment Activities

Outreach and Education		Enrollment Assistance
• Gives consumers information about changes coming to health care.		• Help completing the application for health insurance.
• Provides an opportunity to anonymously shop and compare for available options.	**VS**	• Only individuals certified by Covered California are authorized to help.
• Never includes sharing social security numbers, tax, or payment information.		• Requires sharing limited personal identifying information and protected health information, including social security numbers and tax information.

CONSUMER PROTECTION & ENROLLMENT: WHAT CONSUMERS SHOULD EXPECT

Outreach and Education

- Consumers should expect to encounter Covered California's outreach partners:
  - In person, at community events and through door-to-door education efforts.
  - On the phone, as they call their neighbors and contacts.
  - With a tablet, using the Shop and Compare Tool to show consumers available options and to help them request an appointment for enrollment assistance.

Enrollment Assistance

Consumers should *always* be cautious with their confidential personal information:

- Never begin an enrollment session based on an unsolicited, door-to-door contact.
- Never begin an enrollment session based on a cold-call from someone you do not know.
- Never pay cash at an enrollment session.
  - Payment is between you and your health plan. Payment is *never required* at your initial enrollment session, but coverage doesn't begin until you make your first payment.
- Look for the Covered California photo ID badge when getting help in-person.

CONSUMER PROTECTION & ENROLLMENT: WHAT CONSUMERS SHOULD EXPECT

Email comments on consumer protection,
including door-to-door and cold-calling policies,
by November 1, 2013 to
info@covered.ca.gov.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) DRAFT PROPOSED APPEALS REGULATIONS

Anne Gezi, SHOP Manager

SHOP APPEALS OVERVIEW

Eligibility determination denial or untimely determination of eligibility.

SHOP receives appeal and forwards to Department of Social Services (DSS) to start the 90 day appeal window.

Appeal is received at DSS, hearing date is scheduled, and acknowledgement is sent to appellant.

SHOP begins the informal resolution process (30 day period).

If not resolved, hearing is handled by DSS/State Hearings Division.

SHOP DRAFT PROPOSED APPEALS REGULATIONS

Article 6. Application, Eligibility, and Enrollment Process for the SHOP	
Sections:	**Table of Contents:**
§ 6540	Definitions
§ 6542	General Eligibility Appeals Requirements for SHOP
§ 6544	Informal Resolution
§ 6546	Hearing Requirements
§ 6548	Dismissal of Appeals
§ 6550	Expedited Appeals Process
§ 6552	Appeals Decisions

SHOP DRAFT PROPOSED APPEALS REGULATION HIGHLIGHTS

- An employer/employee may appeal:
  - A notice of denial of eligibility; and
  - A failure of the SHOP to make timely eligibility determination
- An employer/employee has 90 days to request an appeal.
- An employer/employee shall have a 30 day period for informal resolution.
- Appeals not resolved by informal resolution will go to a formal hearing with DSS.
- The hearing shall be conducted within 90 days from the appeal date.

SHOP APPEALS REGULATION TIMELINE

Activity	Proposed Timeline
Fourth Quarter Advisory Group Meeting	October 16
Stakeholder Review of Draft Proposed Dispute & Appeals Regulations	October 15 – October 18
Board Meeting – Discussion of Proposed Regulations	October 24
Further Stakeholder Review if needed	October 25 – November 12
Board Meeting – Approval of Proposed Regulations	November 21
Submit to Office of Administrative Law for Approval	November 22

COVERED CALIFORNIA BOARD OF DIRECTORS RECOMMENDATION REGARDING THE QUALITY RATING SYSTEM (QRS)

Jeff Rideout, Senior Medical Advisor

CONTEXT FOR CONSIDERING QUALITY REPORTING OPTIONS

- Since physicians and other providers are the most essential factor in determining quality, Covered California in the past month performed an assessment of "network similarity," which measured whether the scores currently available in the public domain are a good way to compare insurance companies in the exchange.

- Only four of the 12 insurers were found to have highly similar or identical networks, or 80 percent similarity or above, a threshold for scoring. Only one of those issuers offered products in both Northern and Southern California and only two of those insurers offered products in more than one region.

CONTEXT FOR CONSIDERING QUALITY REPORTING OPTIONS (continued)

- From participating health plans, strong arguments have been made both for and against using historical information and reporting on some plans for 2014 enrollment.
- From a consumer perspective:
  - It could be argued that's not a fair, useful or reliable "quality" indicator of performance of carriers in the exchange when more than 70 percent of the issuers wouldn't have a rating. Consumers would be asked to compare scores from just three plans and potentially presume that other plans are "poor quality." In many regions, there would be only one score available. (See Map)
  - It could also be argued that "some information is better than no information," even at the risk of mistakenly implying some plans are of poor quality.

WHAT WOULD CALIFORNIA LOOK LIKE FOR CONSUMERS USING HISTORICAL DATA FOR SOME PLANS?

Region	# of Issuers	# of Issuers w/QRS
1	3	1
2	5	2
3	5	2
4	5	1
5	5	2
6	4	1
7	5	1
8	5	1
9	3	0
10	4	1
11	3	1
12	4	1
13	3	1
14	4	1
15 (Los Angeles, partial)	6	1
16 (Los Angeles, partial)	6	1
17	5	1
18	4	1
19	6	2

Covered California Plans with QRS:

- **Contra Costa:** Rating Region 5
- **Kaiser:** All Rating Regions, except 9
- **Western Health Advantage:** Rating Region 2 and 3
- **SHARP:** Rating Region 19

EXCHANGES NATIONWIDE: QUALITY RATINGS

- Federal Exchange does not provide quality ratings
- Among the states that provide meaningful quality ratings are: Oregon, Maryland, Colorado, Connecticut, and Massachusetts
- Among the states that do not provide meaningful quality ratings for 2014 are: Minnesota, Washington, Rhode Island, Vermont, Nevada, Kentucky, Idaho*, Hawaii, and Washington DC
- Status of quality ratings for other state exchanges is unknown today: New York and New Mexico

* Idaho is a different composition of a state-based exchange

COLORADO EXCHANGE QUALITY RATINGS

Premium	Carrier / Rating	Plan	Deductible	Costs
$309^61	KAISER PERMANENTE. ★★★★★ ☐Select to compare	KP CO Bronze 4500/50/HSA Preferred Drug List HMO/BRONZE	$4,500^00 / Person $9,000^00 / Family	Annual Max. Costs $6,350^00 / Person $12,700^00 / Family Est. Costs based on Use N/A
$324^70	Colorado Healthop Making Healthcare Better. Together. Rating in progress ☐Select to compare	HealthOp Bear EPO Preferred Drug List EPO/BRONZE	$5,500^00 / Person $11,000^00 / Family	Annual Max. Costs $6,350^00 / Person $12,700^00 / Family Est. Costs based on Use N/A
$352^42	Humana ★☆☆☆☆ ☐Select to compare	Humana Connect Bronze 6300/6300 Plan Preferred Drug List HMO/BRONZE	$6,300^00 / Person $12,600^00 / Family	Annual Max. Costs $6,300^00 / Person $12,600^00 / Family Est. Costs based on Use N/A

- Rates 5 of 8 health plans – those with historical data
- A single, member experience with plan global rating only
  - Member overall rating of health plan (CAHPS) is sole measure
- Global member experience rating represented 1-5 stars
- Presents global member experience rating as part of content in the online, side-by-side plan comparison

MARYLAND EXCHANGE QUALITY RATINGS

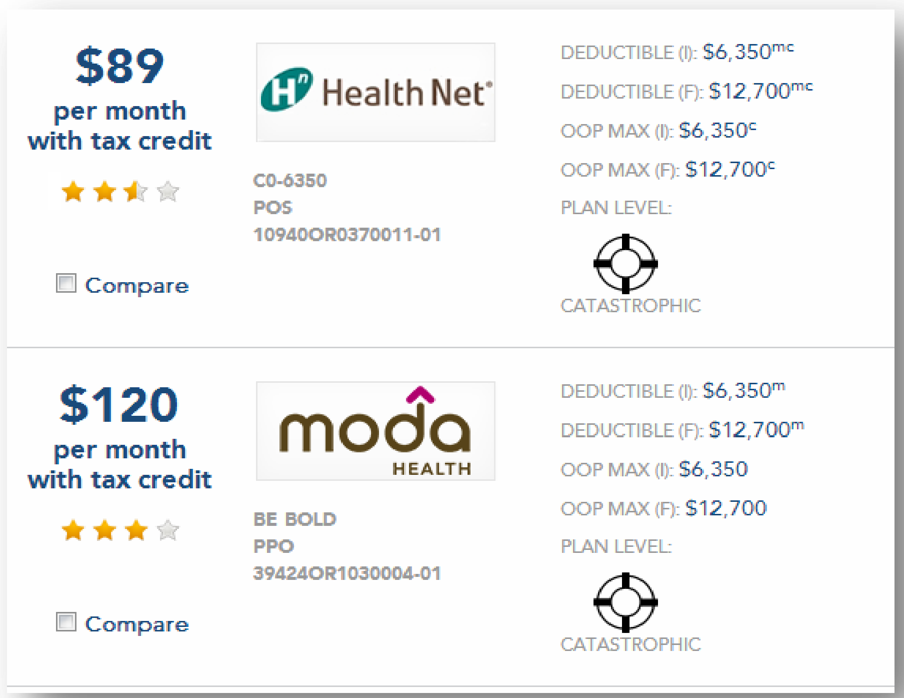
PERFORMANCE RATING TABLE FOR MARYLAND CARRIERS OFFERING PLANS TO SMALL BUSINESSES

Plan	MHCC Report-Level Name	Legacy Quality Rating
(UnitedHealthcare) MAMSI Life and Health Insurance Company	MAMSI Marketplace PPO	★★★★
Aetna Health, Inc. (Pennsylvania)- Maryland	Aetna Marketplace HMO	★★★½
Aetna Life Insurance Company (MD/DC)	Aetna Marketplace PPO	★★★★
All Savers Insurance Company EPO (a United Healthcare plan for inside the Exchange)	All Savers Marketplace EPO	New Entrant 2014

- Rates 3 of 6 health plans – those with historical data*
- Combines a large number of HEDIS and CAHPS quality measures to produce a single, global rating of the plan
- Global plan rating represented 1-5 stars
- Presents plan global rating in PDFs available via links (unclear if also presented in the online, side-by-side plan comparison)

*SHOP plan mix differs

OREGON EXCHANGE QUALITY RATINGS



- Rates 11 of 11 health plans
- Combines a small number of HEDIS and CAHPS quality measures to produce a single, global rating of the plan
- Global plan rating represented 1-4 stars
- Presents plan global rating as part of content in the online, side-by-side plan comparison

RECOMMENDATION ON QUALITY RATING SYSTEM (QRS)

Staff recommend that Covered California implement a Quality Rating System (QRS) as soon as it can be done using HEDIS and CAHPS performance information for Exchange members. The earliest anticipated presentation of QRS information is open enrollment of 2015 and will include all plans offered on the Exchange. The implications of this decision on the “Group 3” plan performance assessment of attachment 14 of the model contract have not been determined.

Other options considered by not recommended:

Report QRS scores for those plans that meet the network similarity criteria using historical HEDIS/CAHPS performance

- Only 5/17 plans offered meet the network similarity threshold (4 of 12 issuers)
- The absence of 70% of the plans creates a challenge for enrollees in their efforts to use quality information and may create an unintended perception of poor quality or lack of commitment to quality transparency

Voluntary reporting of QRS results based on historic HEDIS/CAHPs scores

- Plans and Stakeholders strongly encouraged Covered California to make a policy decision
- Does not alter the absence of scores for most plans

Administer CAHPS (only) in time for 2014 open enrollment

- Would largely measure only the enrollment experience and not access or clinical care
- Continuous enrollment and sampling requirements would mean information available no sooner than Dec 2014
- Would require a single cross plan vendor contract and commitment

NOTE: *Plan CAHPS process to begin in 2014 with results available for open enrollment 2015*

Administer a non-CAHPS/HEDIS measure set for 2014 open enrollment

- No such survey exists or would likely be acceptable to the Federal government
- Would largely measure only the enrollment experience and not access or clinical care

CORE ELEMENTS OF RECOMMENDATION TO THE BOARD

- Not to include Quality Rating System scores for 2014.
- Covered California would include ratings during the 2015 enrollment period (for plan year 2016), after we have the opportunity to collect HEDIS and CAHPS data from enrollees actually using the plans and providers in the exchange environment.
- The target date of providing ratings in Oct. 2015 for coverage beginning in 2016 (one year before the federal government has targeted states to provide ratings).
- CoveredCA.Com include a link to the state Office of Patient Advocate on the enrollment website, allowing consumers to search for information on each insurance plan.

FEDERAL ESTABLISHMENT SUPPORT AND BLUEPRINT APPLICATION

Peter V. Lee, Covered California Executive Director

TRANSITIONING FROM PLANNING TO OPERATIONS

- Covered California opened for business on October 1.

- Much has been learned during the planning and implementation process about the required tasks and actual costs of establishing the Exchange.
  - Covered California is ready to request final federal certification as a state-based exchange.
  - Current grants funds will not fully cover all requirements as originally budgeted in the Level 2 grant.

FEDERAL OPTIONS FOR EXCHANGES

Health & Human Services has developed a program that offers multiple Exchange models as well as a number of design alternatives within each model. California has chosen the State-based Exchange model.

State-based Exchange

State operates all Exchange activities; however, State may use Federal government services for the following activities:

- Premium tax credit and cost sharing reduction determination
- Exemptions
- Risk adjustment program
- Reinsurance program

State Partnership Exchange

State operates activities for:

- Plan Management
- Consumer Assistance
- Both

State may elect to perform or can use Federal government services for the following activities:

- Reinsurance program
- Medicaid and CHIP eligibility: assessment or determination*

Federally-facilitated Exchange

HHS operates; however, State may elect to perform or can use Federal government services for the following activities:

- Reinsurance program
- Medicaid and CHIP eligibility: assessment or determination*

*Coordinate with Medicaid and CHIP Services (CMCS) on decisions and protocols

FEDERAL CERTIFICATION REQUIREMENTS AND COVERED CALIFORNIA PROGRESS TO DATE

- Federal certification of a state-based exchange is granted based on federal review of a state in the following areas:

Legal Authority and Governance	Organization and Human Resources
Consumer and Stakeholder Engagement	Finance and Accounting
Eligibility and Enrollment	Technology
Plan Management	Privacy and Security
Risk Adjustment and Reinsurance	Oversight and Monitoring
Small Business Health Options Program	Contracting, Outsourcing and Agreements

- In January 2013, Covered California received conditional certification to operate a state-based exchange based on the Blueprint application submitted in December 2012.
- Throughout 2013, Covered California has continued to make progress on achieving full certification through federal reviews.
- Covered California is now in a position to request final federal certification as a state-based exchange.

LEVEL 2.0 ESTABLISHMENT SUPPORT PLANNING PRINCIPLES

- Seek the highest value for the lowest cost
- Distinguish one-time development efforts and costs from ongoing costs
- Plan for variances
- Embrace interdependence and partnerships
- Evidence-based planning: test, verify and adjust

COVERED CALIFORNIA IS CONSIDERING MODIFICATIONS TO SUPPLEMENT THE LEVEL 2.0 FUNDING REQUEST

- In January 2013, Covered California was awarded a Level 2.0 establishment grant of $673,705,358.
- The following areas have been identified as potentially needing supplemental funding beyond what was requested in the Level 2.0 grant to meet grant milestones and ensure compliance with federal requirements:
    - Information technology
    - Marketing and Sales
    - Business Services
    - Appeals
    - Clinical Analytics
    - Consumer Protection

REQUESTING A SUPPLEMENT TO AN ESTABLISHMENT GRANT

- Supplemental funding for existing establishment grants is available from the Department of Health and Human Services to fund budget needs that have arisen or were not anticipated when the grants were awarded.
- Grantees can request supplemental funding up to 25 percent of a grant's original award amount.
- Covered California could submit a supplemental request to coincide with the next establishment grant due date on November 15, 2013, to ensure rapid review.
- Supplemental funding could be approved within 45 days of a grantee submitting the request.

RECOMMENDATION FOR APPROVAL

Designate a subcommittee of the Board to work with the Executive Director to (1) develop and seek approval of a Level 2.0 supplemental funding request to be submitted to HHS by November 15, 2013 and (2) to participate in any necessary activities to complete the federal Blueprint approval process to operate as a state-based exchange.