COVERED CALIFORNIA POLICY AND ACTION ITEMS

March 20, 2014

PROPOSED STANDARDIZED PLAN DESIGNS

Tim von Herrmann, Advisor, Plan Management

CRITERIA FOR UPDATES IN BENEFIT DESIGN

1. Limited Changes from 2014 benefit designs
   - 2015 Actuarial Value (AV) Calculator
   - Embedded dental
   - Family dental
2. Portfolio price stability year to year
3. Create an affordable Family Dental Plan
   - Pricing appeal to consumer
   - Familiarity to consumer
   - Ease of Family Plan administration for dental plans

OVERVIEW OF CHANGES IN FINAL 2015 BENEFIT DESIGNS

1. Entered all proposed 2015 health plan benefit designs in 2015 AV Calculator; adjusted plan designs as needed to meet actuarial value requirements
2. Reduced health plan out of pocket maximum to comply with Senate Bill 639 out of pocket maximum requirements
3. Conducted independent actuarial analysis of dental plan designs

PROPOSED STANDARD BENEFIT PLAN DESIGN: EMBEDDED DENTAL

	Approach
10.0 – Standard Benefit Plan	• Lowered generic drug copay to $15 from $19 • Lowered out of pocket maximum to $6250 • Set dental deductible at $0 • No dental-specific out of pocket maximum

OVERVIEW OF CHANGES IN BENEFIT DESIGN BY METAL TIER

Metal Tier	Proposed Design Change
Bronze	• Lowered generic drug copay • Lowered out-of-pocket maximum
Silver	• Lowered generic drug copay • Lowered out-of-pocket maximum
Silver Enhanced	• Lowered generic drug copay • Imaging cost-share increased to 30% (Coinsurance Silver 73) • Medical deductible increased $100 (Copay Silver 73)
Gold	• Lowered generic drug copay • Lowered out-of-pocket maximum
Platinum	• No changes

STANDARD BENEFIT PLAN DESIGN
FAMILY AND PEDIATRIC DENTAL BENEFIT

	Approach
Stand Alone Dental Plan (Pediatric Dental Essential Health Benefit)	• $65 deductible for children in coinsurance design • $350 pediatric out of pocket maximum • Compliance with 85% actuarial value requirement per federal rules • Copay and coinsurance options • No-cost diagnostic and preventive services

Family Dental (Pediatric Dental EHB + Family)	• Same pediatric EHB benefit as Stand Alone Dental Plan, plus:
	  ○ $50 deductible for adults in coinsurance design
	  ○ Annual benefit limit and lifetime maximum for adults
	  ○ Adult copay and coinsurance options
	  ○ Adult no-cost diagnostic and preventive services

STATUS OF PROPOSED BENEFIT DESIGN CHANGES

Proposed Benefit Design Changes*	Planned for 2015	To be considered for 2016
Reduce annual out-of-pocket maximum for Standalone Dental Plans	✔	
Embed pediatric dental benefit	✔	
Offer family dental benefit	✔	✔
Consider alternate benefit designs in SHOP	✔	✔
Consider alternate benefit designs in individual market		✔
Reconsideration of application of deductible		✔
Minimize use of coinsurance		✔
Reconsideration of cost sharing amounts for enhanced silver products		✔

*List not exhaustive

READOPTION OF EMERGENCY REGULATIONS

Katie Ravel, Director of Program Policy

REGULATION READOPTION PROCESS

- Regulations needing readoption today were originally adopted in September for 180 days
  - Eligibility and Enrollment Process for the Individual Exchange
  - Certified Plan-Based Enrollment Program
  - SHOP Eligibility and Enrollment Process
  - Certified Insurance Agents
- Today staff is requesting readoption for 90 days. An additional extension will be requested.
- Staff are working with stakeholders on a parallel track to make these regulations permanent.

KEY CHANGES SINCE INITIAL ADOPTION OF REGULATIONS

- Eligibility and Enrollment Process for the Individual Exchange
  - Clarifying changes to definitions
  - Clarifying changes to application
  - Clarifying changes to appeals process
- Certified Plan-Based Enrollment Program
- SHOP Eligibility and Enrollment Process
- Certified Insurance Agents

KEY CHANGES SINCE INITIAL ADOPTION OF REGULATIONS

- Eligibility and Enrollment Process for the Individual Exchange
- Certified Plan-Based Enrollment Program
  - Minor changes made to program application, roles and responsibilities, and conflict of interest standards
- SHOP Eligibility and Enrollment Process
- Certified Insurance Agents

KEY CHANGES SINCE INITIAL ADOPTION OF REGULATIONS

- Eligibility and Enrollment Process for the Individual Exchange
- Certified Plan-Based Enrollment Program
- SHOP Eligibility and Enrollment Process
  - No changes
- Certified Insurance Agents

KEY CHANGES SINCE INITIAL ADOPTION OF REGULATIONS

- Eligibility and Enrollment Process for the Individual Exchange
- Certified Plan-Based Enrollment Program
- SHOP Eligibility and Enrollment Process
- Certified Insurance Agents
  - Minor, non-substantive changes

APPENDIX: ELIGIBILITY AND ENROLLMENT REGULATION CHANGES

ELIGIBILITY & ENROLLMENT STATE REGULATIONS TIMELINES

Activity:	Timeline:
Final Federal Regulations - Final Rule Regarding Eligibility Appeals Released by the Center for Medicare and Medicaid Services	August 30, 2013
Final Comprehensive Eligibility and Enrollment Regulations to the Board ***(for Board Action)***	September 19, 2013
Submission of Board Adopted State Regulations to the Office of Administrative Law	September 20, 2013
1st Stakeholder Meeting to Solicit Public Feedback and Input: Stakeholder Review of Revised Eligibility and Enrollment State Regulations	March 7, 2014
Follow up Stakeholder Meeting: Stakeholder Review of Revised Eligibility and Enrollment State Regulations	March 10, 2014
1st package of revised draft Eligibility and Enrollment State Regulations presented at Board Meeting ***(Action Item)***	March 20, 2014

APPENDIX: ARTICLE 2 - ABBREVIATIONS & DEFINITIONS

State Regulation Section	CHANGES TO SECTION
§ 6410: Definitions.	• Revised definition of Dependent is now included in the State Regulations, in accordance with Section 1357.500(b) of California Health and Safety Code and Section 10753(e) of California Insurance Code. The language now reads, "~~For purposes of I~~n the Individual Exchange: For purposes of eligibility determination for APTC and CSR, a dependent as defined in Section 152 of IRC (26 USC § 152) and the regulations thereunder. For purposes of eligibility determinations ~~and~~ for enrollment in a QHP without requesting APTC or CSR, "dependent" also includes domestic partners. For purposes of enrollment in a QHP, including enrollment during a special enrollment period specified in Section 6504 of Article 5 of this chapter, a dependent as defined in Section 1357.500(b) of California Health and Safety Code and in Section 10753(e) of California Insurance Code, referring to the spouse or registered domestic partner, or child until attainment of age 26 unless the child is disabled (as defined in Section 22775 of the Government Code and subdivisions (n) to (p), inclusive, of Section 599.500 of Title 2 of the California Code of Regulations), of a qualified individual or enrollee." • The definition of "Large Employer" has been removed. • The definition of Taxpayer Identification Number (TIN) has is now included in the State Regulations. The definition of TIN is as follows: "An identification number used by the IRS in the administration of tax laws. It is issued either by the SSA or by the IRS. TINs include SSN, Employer Identification Number (EIN), Individual Taxpayer Identification Number (ITIN), Taxpayer Identification Number for Pending U.S. Adoptions (ATIN), and Preparer Taxpayer Identification Number (PTIN). A SSN is issued by the SSA whereas all other TINs are issued by the IRS."

APPENDIX: ARTICLE 5 - APPLICATION, ELIGIBILITY, AND ENROLLMENT PROCESS FOR THE INDIVIDUAL EXCHANGE

STATE REGULATION SECTION	CHANGES TO SECTION
§ 6470(c)(7): Application.	• Language has been modified and now reads, "The applicant's ~~citizenship~~ status as a U.S. Citizen or U.S. National, or the applicant's immigration status, if the applicant is not a U.S. Citizen or U.S. National and attests to having satisfactory immigration status."
§ 6470(c)(12)(B): Application	• Language has been included to identify whether American Indian or Alaska Natives are receiving services from an Indian health program and if not, whether they are eligible for such services. • The included language is as follows: "Whether the applicant has ever received a service from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs, and if not, whether he or she is eligible to receive such services."

APPENDIX: ARTICLE 5 - APPLICATION, ELIGIBILITY, AND ENROLLMENT PROCESS FOR THE INDIVIDUAL EXCHANGE

STATE REGULATION SECTION	CHANGES TO SECTION
§ 6470(d)(4)(5): Application.	• The included language is as follows : "An applicant or an application filer shall declare under penalty of perjury that he or she: (4) Agrees to notify the Exchange if any information in the application for any person applying for health insurance changes, which may affect the person's eligibility; and (5) Understands that if he or she selects a health plan in the application and is determined eligible by the Exchange to enroll in his or her selected plan: (A) By signing the application and making timely payment of the initial premium, if applicable, he or she is entering into a contract with the issuer of that plan; and (B) The applicant or responsible party signing the application is at least 18 years of age or an emancipated minor, and mentally competent to sign a contract."
§ 6470(d)(7): Application.	• Language has been modified to clarify the circumstances when the applicant or an applicant filer can be included in the application if he or she is incarcerated. The language now reads "The applicant understands that, except for purposes of applying for Medi-Cal, ~~Neither~~ the applicant ~~nor~~ and any other person(s) the applicant has included in the application ~~is~~ shall not be confined, after the disposition of charges (judgment), in a jail, prison, or similar penal institution or correctional facility."

APPENDIX: ARTICLE 5 - APPLICATION, ELIGIBILITY, AND ENROLLMENT PROCESS FOR THE INDIVIDUAL EXCHANGE

STATE REGULATION SECTION	CHANGES TO SECTION
§ 6470(f): Application.	• The added language is as follows: "If an applicant or an application filer selects a health insurance plan or a pediatric dental plan, as applicable, in the application: (1) He or she shall provide: (A) The name of the applicant and each family member who is enrolling in a plan; and (B) The plan information, including plan name, metal tier, metal number, coverage level and plan type, as applicable; and (2) All individuals, responsible parties, or authorized representatives, age 18 or older who are selecting and enrolling into a health insurance plan shall agree to, sign, and date the agreement for binding arbitration, as set forth below: (A) For an Exchange Plan: "I understand that every participating health plan has its own rules for resolving disputes or claims, including, but not limited to, any claim asserted by me, my enrolled dependents, heirs, or authorized representatives against a health plan, any contracted health care providers, administrators, or other associated parties, about the membership in the health plan, the coverage for, or the delivery of, services or items, medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), or premises liability. I understand that, if I select a health plan that requires binding arbitration to resolve disputes, I accept, and agree to, the use of binding arbitration to resolve disputes or claims (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law) and give up my right to a jury trial and cannot have the dispute decided in court, except as applicable law provides for judicial review of arbitration proceedings. I understand that the full arbitration provision for each participating health plan, if they have one, is in the health plan's coverage document, which is available online at CoveredCA.com for my review, or, I can call Covered California at 1-800-300-1506 (TTY: 1-888-889-4500) for more information."

APPENDIX: ARTICLE 5 - APPLICATION, ELIGIBILITY, AND ENROLLMENT PROCESS FOR THE INDIVIDUAL EXCHANGE

STATE REGULATION SECTION	CHANGES TO SECTION
§ 6470(f): Application. (cont.)	"(B) For a Kaiser Medi-Cal health plan: "I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services, including whether any medical services provided were unnecessary or unauthorized, or were improperly, negligently, or incompetently rendered. If I pick Kaiser as my Medi-Cal health plan, I give up my constitutional right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a state hearing of any issue, which is subject to the state hearing process."
§ 6470(i): Application.	• Language has been added to clarify that the applicant or the applicant filer shall submit all information, documentation and declarations as required for the he or she and each person applying for health insurance coverage. The language now reads, "To apply for an eligibility determination and enrollment in QHP through the Exchange without requesting any APTC or CSR, an applicant or an application filer shall, for the applicant and each person for whom the applicant is applying for coverage, submit all information, documentation, and declarations required."

APPENDIX: ARTICLE 5 - APPLICATION, ELIGIBILITY, AND ENROLLMENT PROCESS FOR THE INDIVIDUAL EXCHANGE

STATE REGULATION SECTION	CHANGES TO SECTION
§ 6496(L): Eligibility Redetermination during a Benefit Year.	• Language has been modified to clarify the action Covered California shall implement when notified of a change effecting enrollment or premiums only. The language now reads, "Except as specified in subdivisions (m) and (n) of this section, the Exchange shall implement a change described in subdivision (k) of this section that results in a decreased amount of APTC, or a change in the level of CSR, and for which the date of the notice of eligibility redetermination described in subdivision (h)(2) of this section, or the date specified in the appeal decision described in subdivision (k)(2) of this section, or the date on which the Exchange is notified in accordance with subdivision (k)(3) of this section is after the 15th of the month, on the first day of the ~~second~~ month ~~following the date of the redetermination notice~~ after the month specified ~~described~~ in subdivision ~~(h)(2)~~ (k) of this section.
§ 6500(I): Enrollment of Qualified Individuals into QHPs.	• Language has been added to address if individuals in the tax filers' tax households are enrolled in more than one QHP or stand-alone dental plan, and one or more APTC are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)). The language added is as follows: "(i) If individuals in the tax filers' tax households are enrolled in more than one QHP or stand-alone dental plan, and one or more APTC are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)):

APPENDIX: ARTICLE 5 - APPLICATION, ELIGIBILITY, AND ENROLLMENT PROCESS FOR THE INDIVIDUAL EXCHANGE

State Regulation Section	CHANGES TO SECTION
§ 6500(l): Enrollment of Qualified Individuals into QHPs. (cont.)	(1) That portion of the APTC that is less than or equal to the aggregate adjusted monthly premiums, as defined in 26 CFR Section 1.36B-3(e), properly allocated to the essential health benefits (EHB) for the QHP policies, shall be allocated among the QHP policies as follows: (A) The APTC shall be apportioned based on the number of enrollees covered under the QHP, weighted by the age of the enrollees, using the default uniform age rating curve established by the Secretary of HHS under 45 CFR Section 147.102(e); (B) The portion allocated to any single QHP policy shall not exceed the portion of the QHP's adjusted monthly premium properly allocated to EHB; and (C) If the portion of the APTC allocated to a QHP under this subdivision exceeds the portion of the same QHP's adjusted monthly premium properly allocated to EHB, the remainder shall be allocated evenly among all other QHPs in which individuals in the tax filers' tax households are enrolled."

APPENDIX: ARTICLE 5 - APPLICATION, ELIGIBILITY, AND ENROLLMENT PROCESS FOR THE INDIVIDUAL EXCHANGE

STATE REGULATION SECTION	CHANGES TO SECTION
§ 6500(I): Enrollment of Qualified Individuals into QHPs. (cont.)	"(2) Any remaining APTC shall be allocated among the stand-alone dental policies as follows: (A) The APTC shall be apportioned based on the number of enrollees covered under the stand-alone dental policy, weighted by the age of the enrollees, using the default uniform age rating curve established by the Secretary of HHS under 45 CFR Section 147.102(e); (B) The portion allocated to any single stand-alone dental policy shall not exceed the portion of the stand-alone dental policy premium properly allocated to EHB; and (C) If the portion of the APTC allocated to a stand-alone dental policy under this subdivision exceeds the portion of the same policy's premium properly allocated to EHB, the remainder shall be allocated evenly among all other stand-alone dental policies in which individuals in the tax filers' tax households are enrolled."
§ 6502: Initial and Annual Open Enrollment Periods.	• Language has been modified to Language now reads, "(c) Regular coverage effective dates for initial open enrollment period for a QHP selection received by the Exchange from a qualified individual: (1) On or before December ~~15~~23, 2013, shall be January 1, 2014;.. (3) Between the sixteenth and last day of the month for any month between ~~December 2013~~ January 2014 and March 31, 2014, shall be the first day of the second following month. (g) A qualified individual's coverage shall be effectuated in accordance with the coverage effective dates specified in subdivisions (c) and (f) of this section if: (1) The individual makes his or her initial premium payment in full, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the premium payment due date, as defined in Section 6410 of Article 2 of this chapter; …"

APPENDIX: ARTICLE 5 - APPLICATION, ELIGIBILITY, AND ENROLLMENT PROCESS FOR THE INDIVIDUAL EXCHANGE

STATE REGULATION SECTION	CHANGES TO SECTION
§ 6504: Special Enrollment Periods.	"(a) A qualified individual may enroll in a QHP, or an enrollee may change from one QHP to another, during special enrollment periods only if one of the following triggering events occurs:… (2) A qualified individual gains a dependent or becomes a dependent through marriage or entry into domestic partnership, birth, adoption, placement for adoption, or placement in foster care. (3) The Exchange determines on a case-by-case basis that a qualified individual or enrollee, or his or her dependent(s) was not enrolled in QHP coverage; was not enrolled in the QHP selected by the qualified individual or enrollee; or is eligible for but is not receiving APTC or CSR as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. For purposes of this provision, misconduct includes, but is not limited to, the failure of the non-Exchange entity to comply with applicable standards under this title, or other applicable Federal or State laws, as determined by the Exchange. (b) Loss of MEC, as specified in subdivision (a)(1) of this section, includes (A) Loss of eligibility for coverage as a result of: (2) Divorce or dissolution of domestic partnership, (i) A qualified individual's coverage shall be effectuated in accordance with the coverage effective dates specified in subdivisions (g) and (h) of this section if: (1) The individual makes his or her initial premium payment in full, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the premium payment due date, as defined in Section 6410 of Article 2 of this chapter; …"

APPENDIX: ARTICLE 7 - APPEALS PROCESS

STATE REGULATIONS SECTION	CHANGES TO SECTION
§ 6606. Appeal Requests.	(c) The Exchange and the appeals entity shall allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of eligibility determination, unless the appeals entity determines, in accordance with Section 6602(c), that there is good cause, as defined in Section 10951 of the Welfare and Institution Code, for filing the appeals request beyond the 90-day period. No ~~Any~~ appeal ~~requests filed~~ filing timeline shall be extended for good cause for more than 180 days after the date of the notice of eligibility determination ~~shall not be accepted~~. For purposes of this subdivision, if the last day of the filing period falls on a Saturday, Sunday, or holiday, as defined in Government Code Section 6700, the filing period shall be extended to the next business day, in accordance with Government Code Section 6707.
§ 6608. Eligibility Pending Appeal.	(b) If the tax filer or appellant, as applicable, accepts eligibility pending an appeal and agrees to make his or her premium payments in full, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the applicable payment due dates, the Exchange shall continue, or reinstate within five business days, the appellant's eligibility for enrollment in a QHP, APTC, and CSR, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.

APPENDIX: ARTICLE 7 - APPEALS PROCESS

STATE REGULATIONS SECTION	CHANGES TO SECTION
§ 6610. Dismissals.	(C) If the withdrawal is conditional: 1. The withdrawal shall be accompanied by an agreement signed by the appellant and by the Exchange as part of the informal resolution process specified in Section 6612; 2. Upon receipt of the signed conditional withdrawal, the hearing date, if any, shall be vacated; 3. The actions of both parties under the agreement specified in subdivision (a)(1)(C)1 of this section shall be completed prior to the hearing date within 30 calendar days of the date on the agreement; and
§ 6610. Dismissals. (Continued)	(a) The appeals entity shall dismiss an appeal if the appellant: (4) Dies while the appeal is pending, unless the appeal affects the remaining member(s) of the deceased appellant's household, or the appeal can be carried forward by a representative of the deceased appellant's estate, or by an heir of the deceased appellant if the decedent's estate is not in probate, in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-004.4.

APPENDIX: ARTICLE 7 - APPEALS PROCESS

STATE REGULATIONS SECTION	CHANGES TO SECTION
§ 6618. Appeal Decisions.	(b) The appeals entity shall: (1) Issue written notice of the appeal decision to the appellant within 90 days of the date on which a valid appeal request is received ~~, unless the 90-day timeline is extended due to good cause, as provided in Section 6602(c), in which case, the notice of the appeal decision shall be issued within the applicable extended timeline~~; (2) If an appeal request submitted under Section 6616 is determined by the appeals entity to meet the criteria for an expedited appeal, issue the notice of the appeal decision as expeditiously as reasonably possible, but no later than ~~10 calendar~~ five business days from the date of the record closure ~~after the appeals entity receives the request for an expedited appeal~~, unless a shorter timeframe is established by HHS; and

APPENDIX: PLAN-BASED ENROLLMENT REGULATION CHANGES

CHANGES TO PLAN-BASED ENROLLMENT REGULATIONS

Article and Sections of the Emergency Plan-Based Enrollment Regulations:

Article 9. Plan-Based Enrollers		
Sections:	Table of Contents:	Changes:
§ 6700	Definitions	None
§ 6702	Certified Plan-Based Enrollment Program Eligibility Requirements	None
§ 6704	Program Application	Added: Does the PBE hold a different certification with the Exchange Deleted: Entity number from the individual Plan-Based Enroller application
§ 6706	Training and Certification Standards	None
§ 6708	Certified Plan-Based Enroller Fingerprinting and Criminal Record Checks	None

CHANGES TO PLAN-BASED ENROLLMENT REGULATIONS

Article and Sections of the Emergency Plan-Based Enrollment Regulations:

Article 9. Plan-Based Enrollers		
Sections:	Table of Contents:	Changes:
§ 6710	Roles & Responsibilities	Added: Language describing the catastrophic plan Deleted: Enrollee Satisfaction Survey (already provided by the Exchange to the plans) and Plan-Based Enrollment Entity number
§ 6712	Conflict of Interest Standards	Deleted: Redundant section was removed and location was referenced Documentation requirement was changed from quarterly basis to by request
§ 6714	Compensation	None
§ 6716	Suspension and Revocation	None
§ 6718	Appeals Process	None