COVERED CALIFORNIA POLICY ITEMS

January 15, 2015

RECOMMENDED QUALIFIED HEALTH PLAN RECERTIFICATION AND NEW ENTRANT 2016

Anne Price, Director of Plan Management

2016 QHP INDIVIDUAL APPLICATION POLICY RECOMMENDATION

- Covered California would consider for inclusion in the Covered California marketplace new carrier entrants that are either Medi-Cal managed care plans or newly licensed plans since August 2012. These carriers may apply for inclusion Regions 1 – 19. Final selection will be based on the following:
    - Increase in consumer choice relative to provider network, product offered, enrollment projections, and the plan's administrative capacity and premium
- New carrier entrants that are <u>not</u> Medi-Cal Managed care plans or new licensed plans may apply for inclusion in the Covered California marketplace in Regions 1, 9, 11,12, and 13 where currently members have limited plan choice. Based on the intention of existing carriers to expand for complete coverage in regions 3 and 6, increasing carrier choice to at least 3 plans, these regions were removed from previous discussion in December.
- Final selection will be based on the following:
    - Covered California will give first consideration to 2015 contracted QHPs who propose to expand coverage to the same counties/regions where there are less than three carriers before accepting new entrants
    - Increase in plan choice related to specified zip codes in the application
    - Increase in consumer choice relative to provider network, product offered, enrollment projections, and the plan's administrative capacity and premium.

POLICIES FOR 2016 CERTIFICATION AND RECERTIFICATION - INDIVIDUAL

New Entrant Applications

- Applicants who qualify based on approved criteria would complete new 2015 application

Recertification Applications

- QHPS certified for 2015 would complete abridged recertification application

Benefit Designs

- 2016 benefit designs would apply to all participating plans (building on and reaffirming the value of standard benefit designs for consumers)
- Carriers would not be permitted to offer “alternate benefit designs”

Product Changes (e.g., from PPO to HMO)

- Product changes for existing carriers would be considered with Covered California applying the factors it considers for new plan selection when allowing such changes

Network Changes

- Expansion of networks would be considered and expressly encouraged in some regions

ADDITIONAL PROPOSED POLICIES FOR 2016 CERTIFICATION AND RECERTIFICATION - SHOP

New Entrant Applications

- New applicants will be considered (revised 2015 application)
- New applicants will be considered for an effective date of 10/15 – 12/15 or 01/16

Recertification Applications

- QHPs certified for 2015 would complete abridged recertification application

Benefit Designs

- 2016 benefit designs would apply to all participating plans (building on and reaffirming the value of standard benefit designs for consumers)
- Alternate benefit designs would be considered

Product Changes (e.g., from PPO to HMO)

- Product changes would be considered with Covered California similarly applying the factors it considers for new plan selection when allowing such changes

Network Changes

- Expansion of networks would be considered

ADDITIONAL PROPOSED POLICIES FOR 2016 CERTIFICATION AND RECERTIFICATION - DENTAL

New Entrant Applications

- No new applicants for entry

Recertification Applications

- QDPs certified for 2015 would complete abridged recertification application

Benefit Designs

- Standard benefit changes unlikely

Product Changes (e.g., from PPO to HMO)

- Product changes would be considered

Network Changes

- Expansion of networks would be considered

RECOMMENDED INDIVIDUAL AND SHOP STANDARD BENEFIT DESIGNS 2016

Anne Price, Director on Plan Management

KEY CONSIDERATIONS IN DESIGNS OFFERED

The plan designs on the following pages represent an aggregation of workgroup, plan, and committee input. Primary considerations to the recommendations are:

- Design meets Target Actuarial Value (AV) as computed with the 2016 Proposed AV Calculator
  - Ideally, allow margin in the 2016 AV for each metal tier to allow for future year flexibility
- Generally increases transparency in cost and allows for easier comparison by benefit line across all metal tiers
- Lessen barriers to general care needs in Bronze plan
- Maintains aligned incentives between members, provider, and plans on quality and cost for benefits that generally have a wide variation in cost for the service
- Are operationally feasible for both Covered California and Qualified Health Plans (QHPs) to implement
- As medical treatments, services, and cost/quality tools evolve over the coming years, we have the ability to further refine benefit offerings

RECOMMENDED DESIGN CHANGES FOR 2016

Bronze

- Benefit sets both Deductible and Max Out of Pocket (MOOP) at $6,500
  - Implication: With exception of next two bullets, all other services are paid by enrollee until MOOP is hit (no coinsurance or copays will apply)
    - Added Specialist Visit to services where cumulative first three visits do not apply to the deductible (in addition to PCP, Mental Health Outpatient, and Urgent Care)
    - Removed deductible application to Lab and OP Rehab/Speech/OP Occ

Standard Silver and Cost Share Reduction (CSR) Silver plans

- Combined the Copay and Coinsurance plan designs into a single Silver offering (similar to Bronze)
  - Prior to this change, there are only five benefit categories with different cost sharing between the coinsurance and copay Silver plan
  - Reduces Cost Sharing Reduction (CSR) Silver plans from six to three
- Moderate increases in Deductible, MOOP, Primary Care, and Specialist cost sharing as needed to meet AV calculations
- Facility and Physician/Surgeon fees now have a consistent application for the Deductible and Coinsurance
- Imaging coinsurance was replaced with a $250 copay for CT, MRI, and PET Scans

RECOMMENDED DESIGN CHANGES FOR 2016

Gold

- Reduction in Max Out of Pocket from $6,250 to $6,200
- Increased office visit copays for primary care and specialist visits by $5
- Increased lab by $5

Platinum

- No benefit changes recommended from 2015 benefit design

Changes in AV are outlined below:

	Bronze	Silver 70 Copay	Silver 70 Coinsurance	Gold Copay	Gold Coinsurance	Platinum Copay [2]	Platinum Coinsurance [2]
Target +/- 2.0%	60.0	70.0	70.0	80.0	80.0	90.0	90.0
Current 2015 AV	60.6	69.9	70.3	78.6	78.8	88.0	88.1
2016 AV	63.7	71.0	71.3	81.4	81.2	88.9	88.6
With Recommended Benefit Changes	61.2	Combined Silver [1] 70.5		81.0	80.3	89.9	88.6

Notes:
1. Recommendation is to combine Silver plans into one Silver plan in 2016
2. No Change is being recommended for the two Platinum plans

RECOMMENDED DESIGN CHANGES FOR 2016

Specialty Drugs

- Covered California will work with regulators, health plans, and advocates through an ad hoc committee to review the current specialty drug designs across all metal plans to insure consumer access for appropriate pharmacy treatment for chronic conditions

- Staff recommends approving the 2016 benefit design as presented. If further changes are recommended to the specialty drug benefit design, regulations may be amended and plans will be asked to adjust pricing as appropriate

KEY UPDATES TO 2016 BENEFIT DESIGNS FOR CONSUMER AND QHP CLARITY

Increased Standardization

- **Definitions**: Enhanced endnote definitions to expand/include: “Specialist”, “Other Practitioner Visit”, new “Outpatient Services Visit”, and “Residential Substance Use Disorder Treatment”
- **Different terms**: Changed “Brand drug deductible” to “Pharmacy Deductible”

Increased Clarity

- **ER**: ER Services fee clarified to be ER Facility Fee, and added a separate line item for ER physician fee
- **Deductibles**: Added Family Deductibles and Family MOOPs to design documents so they are clearly stated for each plan**.** All plan designs continue to have an embedded deductible which is consistent with 2015 designs.
- **Hospice**: Clarity that there is no charge for Hospice services in any non-HSA plan design by removing the application of deductible “check mark”

UPDATES TO BENEFIT DESIGNS SINCE DECEMBER DISCUSSION (NO CHANGE TO AV)

Mental Health Parity

- Mental Health Substance Use Disorder (MH/SUD) inpatient stay deductibles for facility and physician fees are now aligned with medical/surgical inpatient stay deductibles
- Created MH/SUD outpatient sub-classification to allow for compliance with federal mental health parity financial analysis
- Office Visits separated from Other Outpatient Items and Services
- Added endnote describing possibility of non-standardized MH/SUD benefits based on individual plans' financial analysis calculations as required by the Mental Health Parity regulations

SHOP 2016 BENEFIT DESIGN UPDATE

SHOP

- SHOP Silver coinsurance and copay plan designs are not combined as with Individual

To achieve SHOP Silver AV requirements and comply with state law:

- SHOP Silver medical deductible set to $1500 and pharmacy deductible set to $500 to comply with state law ($2000 maximum small group individual deductible)
- Increased out-of-pocket maximum to $6500 (allows for purchase of pediatric dental with $350 MOOP)
- Increased preferred brand drugs from $50 to $55
- Increased non-preferred brand drugs from $70 to $75
- SHOP Silver HSA plan - increased deductible from $1500 to $2000

PROPOSED 2016 PORTFOLIO: BRONZE/SILVER/CSRS SIDE-BY-SIDE

		Bronze 60	Silver 70	Silver 73	Silver 87	Silver 94
	Coinsurance (what Enrollee pays)	30%	20%	20%	15%	10%
	Deductible	$6,500 (Integrated)	$2,250	$1,900	$550	$75
	Brand Drug Deductible	N/A	$250	$250	$50	$0
	Max Out of Pocket (MOOP)	$6,500	$6,250	$5,450	$2,250	$2,250
Not Subject to Deductible unless noted otherwise.	Primary Care Visit	$70 Ded waived for 1st 3 visits *	$45	$40	$15	$5
	Specialist Visit	$90 Ded waived for 1st 3 visits *	$70	$55	$25	$8
	Imaging (CT/PET Scans, MRIs)	$0 after Ded	$250	$250	$100	$50
	Laboratory Tests	$40 (DNA)	$35	$35	$15	$8
	MH: Outpatient	$70 Ded waived for 1st 3 visits *	$45	$40	$15	$5
	Home Health Care	$0 after Ded	$45	$40	$15	$3
	OP Rehab/Speech and OP Occ	$70 (DNA)	$45	$40	$15	$5
	Outpatient and OP Professional Serv	$0 after Ded	Coinsurance	Coinsurance	Coinsurance	Coinsurance
	Durable Medical Equipment	$0 after Ded	Coinsurance	Coinsurance	Coinsurance	Coinsurance
	Urgent Care	$120 Ded waived for 1st 3 visits *	$90	$80	$30	$6
	X-rays and Diagnostic Imaging	$0 after Ded	$65	$50	$25	$8
	Generics	$0 after Ded	$15	$15	$5	$3
Subject to Deductible unless noted otherwise.	ER Services	$0 after Ded	Ded + $250	Ded + $250	Ded + $75	Ded + $30
	Inpatient Services: Facility	$0 after Ded	Ded + Coins	Ded + Coins	Ded + Coins	Ded + Coins
	Inpatient Services: Physician/Surgeon	$0 after Ded	Ded + Coins	Ded + Coins	Ded + Coins	Ded + Coins
	MH: Inpatient	$0 after Ded	Ded + Coins	Ded + Coins	Ded + Coins	Ded + Coins
	Skilled Nursing Facility	$0 after Ded	Ded + Coins	Ded + Coins	Ded + Coins	Ded + Coins
	Preferred Brand Drugs	$0 after Ded	Ded + $50	Ded + $45	Ded + $20	Ded + $10
	Non-preferred Brand Drugs	$0 after Ded	Ded + $70	Ded + $70	Ded + $35	Ded + $15
	Specialty Drugs	$0 after Ded	Ded + Coins	Ded + Coins	Ded + Coins	Ded + Coins
	2016 Actuarial Value	**61.19**	**70.53**	**72.91**	**86.89**	**93.93**

DNA = Deductible does not apply.

* Total of three visits cumulative across benefits lines with deductible waived for initial visits.

PROPOSED 2016 PORTFOLIO: ALL STANDARD PLANS SIDE-BY-SIDE

		Bronze 60	Silver 70	Gold Copay [1]	Gold Coins [1]	Platinum Copay [1]	Platinum Coins
	Coinsurance (what Enrollee pays)	30%	20%	20%	20%	10%	10%
	Deductible	$6,500 (Integrated)	$2,250	0	0	$0	$0
	Brand Drug Deductible	N/A	$250	0	0	$0	$0
	Max Out of Pocket (MOOP)	$6,500	$6,250	$6,200	$6,200	$4,000	$4,000
Not Subject to Deductible unless noted otherwise.	Primary Care Visit	$70 Ded waived for 1st 3 visits *	$45	$35	$35	$20	$20
	Specialist Visit	$90 Ded waived for 1st 3 visits *	$70	$55	$55	$40	$40
	Imaging (CT/PET Scans, MRIs)	$0 after Ded	$250	$250	Coinsurance	$150	Coinsurance
	Laboratory Tests	$40 (DNA)	$35	$35	$35	$20	$20
	MH: Outpatient	$70 Ded waived for 1st 3 visits *	$45	$35	$35	$20	$20
	Home Health Care	$0 after Ded	$45	$30	Coinsurance	$20	Coinsurance
	OP Rehab/Speech and OP Occ	$70 (DNA)	$45	$35	$35	$20	$20
	Outpatient and OP Professional Serv	$0 after Ded	Coinsurance	$600	Coinsurance	$250	Coinsurance
	Durable Medical Equipment	$0 after Ded	Coinsurance	Coinsurance	Coinsurance	Coinsurance	Coinsurance
	Urgent Care	$120 Ded waived for 1st 3 visits *	$90	$60	$60	$40	$40
	X-rays and Diagnostic Imaging	$0 after Ded	$65	$50	$50	$40	$40
	Generics	$0 after Ded	$15	$15	$15	$5	$5
Subject to Deductible unless noted otherwise.	ER Services	$0 after Ded	Ded + $250	$250	$250	$150	$150
	Inpatient Services: Facility	$0 after Ded	Ded + Coins	$600/day up to 5 days	Coinsurance	$250/day up to 5 days	Coinsurance
	Inpatient Services: Physician/Surgeon	$0 after Ded	Ded + Coins		Coinsurance		Coinsurance
	MH: Inpatient	$0 after Ded	Ded + Coins	$600/day up to 5 days	Coinsurance	$250/day up to 5 days	Coinsurance
	Skilled Nursing Facility	$0 after Ded	Ded + Coins	$300/day up to 5 days	Coinsurance	$150/day up to 5 days	Coinsurance
	Preferred Brand Drugs	$0 after Ded	Ded + $50	$50	$50	$15	$15
	Non-preferred Brand Drugs	$0 after Ded	Ded + $70	$70	$70	$25	$25
	Specialty Drugs	$0 after Ded	Ded + Coins	Coinsurance	Coinsurance	Coinsurance	Coinsurance
	2016 Actuarial Value	**61.19**	**70.53**	**81.05**	**80.34**	**89.91**	**88.59**

DNA = Deductible does not apply.

* Total of three visits cumulative across benefits lines with deductible waived for initial visits.

[1] Items in Red denote changes made after detailed actuarial review completed 1-9-15.

REVISION OF NAVIGATOR PAYMENT POLICY

Mary Watanabe, Acting Deputy Director, Sales Division

BACKGROUND

- Covered California awarded Navigator Grants to 65 organizations in the amount of $14.65 million with an additional $2.25 million allocated to a bonus pool to perform outreach, education, enrollment assistance and post enrollment support

- Total Navigator enrollment goal of 92,817 effectuated enrollments from October 1, 2014 – June 30, 2015

- Performance and payment based on new Covered California effectuations

UNANTICIPATED EFFORTS TO SUPPORT RETENTION

Navigator Grantees are anxious about meeting enrollment goals and receiving their next payment. Some unanticipated challenges include:

- Providing substantially more assistance with activities that can't be quantified, including renewals and explaining notices in the first months of the grant program. We anticipate that this will continue over the next few months once 1095's are sent out
- Increased number of consumers who are self-enrolling this year, which is leading to more calls from consumers who want assistance over the phone with plan selection, explaining metal tiers, binder payments, etc. In most cases, this assistance is not counted towards the enrollment goals
- Continued need to support the "no wrong door" by enrolling into Medi-Cal, but this assistance is not counted towards the enrollment goals
- Time frame for receiving confirmation of effectuations is delaying payments even for those that may reach their enrollment milestones

RECOMMENDED CHANGE TO NAVIGATOR PAYMENT POLICY

To support the critical work that our Navigator Grantees are doing to support our culturally and linguistically diverse communities, we are recommending the following changes to the Navigator Payment Policy:

- Count assisted applications through plan selection towards enrollment goals instead of effectuations. This change should allow many of the Grantees to be eligible for their next 25% payment.

- For organizations that do not meet 25% of enrollment goal, we are recommending that we process the next payment upon satisfactory demonstration of their readiness and efforts to implement their campaign strategy.

CERTIFIED APPLICATION COUNSELOR PROGRAM REGULATIONS (DISCUSSION)

Mary Watanabe, Acting Deputy Director, Sales Division

CONSUMER ASSISTANCE EFFORTS

Role and Responsibility	Funding Source	Federal or State
Certified Insurance Agents: Licensed by the CA Dept. of Insurance. Sell Covered California Health Insurance Plans in the individual and small business markets.	Health Insurance Company (Qualified Health Plan)	No Federal Requirement. State Regulation.
Plan Based Enroller: Employee of a Covered California Qualified Health Plan. Assists plan members in enrolling into Covered California.	Health Insurance Company (Qualified Health Plan)	No Federal Requirement. State Regulation.
Medi-Cal Managed Care Plan Enroller: Employee of a Medi-Cal Managed Care Plan. Assists plan members in enrolling in a Covered California plan and Medi-Cal.	Covered California does not compensate for enrollment assistance work.	No Federal Requirement. State Regulation.
Certified Educator: Work for a Covered California Outreach and Education Grant Recipient. Do not provide assistance with filling out the application. Grant period is July 2013 – February 2015.	Covered California $40 million Outreach and Education Grant (Federal Grant)	No Federal or State Requirement.

CONSUMER ASSISTANCE EFFORTS (CONTINUED)

Role and Responsibility	Funding Source	Federal or State
Certified Enrollment Counselor: Work for an Enrollment Entity. Provide In-person enrollment assistance. $58 payment per application that results in effectuation of coverage; $25 renewal. $58 new Medi-Cal enrollment.	$21 million Consumer Assistance Initiative (Federal Grant). Medi-Cal payment from DHCS.	No Federal Requirement. State Regulation.
Navigator (Certified Enrollment Counselor): Work for a Covered California Navigator Grant Recipient. Conduct outreach, education, enrollment assistance, and post-enrollment support. Grant period is October 2014 – June 2015.	$14.65 million Navigator Grant plus $2.25 million in bonus pool. Self-sustainable budget.	Federal Requirement. State Regulation.
Certified Application Counselor: Work for an Enrollment Entity that has an economic incentive to enroll consumers. Provide non-compensated enrollment assistance and must disclose their conflict of interest to the consumer in writing prior to enrollment assistance.	Covered California does not compensate for enrollment assistance work.	Federal Requirement. State Regulation.

CERTIFIED APPLICATION COUNSELOR PROGRAM REGULATIONS

Article 11 – Certified Application Counselor Program

§ 6854 – Certified Application Entity Application

- Requires identification of status as non-profit, for profit, or governmental organization, and provide supporting documentation
- Requires identification of the type of organization and to provide applicable license or certification
- Requires indication of the type of disability(ies) of individuals served, if applicable
- Requires disclosure of all federal and/or state grants received, not only from Covered California or DHCS

CERTIFIED APPLICATION COUNSELOR PROGRAM REGULATIONS

Article 11 – Certified Application Counselor Program

§ 6856 – Certified Application Counselor Application

- Adds “have no administrative actions taken against them” to qualifications of applicants

§ 6858 – Certified Application Counselor Fingerprinting and Criminal Record Checks

- Adds a two-year prohibition on reapplying for certification after receipt of a negative final determination
- Adds that the Exchange will cover the fingerprinting background check costs for individuals seeking certification until December 31, 2015

§ 6860 – Training Standards

- Clarifies that all entities are required to undergo training in voter registration assistance procedures, not only governmental agencies

CERTIFIED APPLICATION COUNSELOR PROGRAM REGULATIONS

Article 11 – Certified Application Counselor Program

§ 6864 – Roles and Responsibilities

- Requires Certified Application Entities to:
  - Maintain a physical presence in the Exchange Service area
  - Ensure that Consumer Assistance information that is culturally and linguistically appropriate to the populations served
  - Ensure that Consumer Assistance is accessible to people with disabilities
- Prohibits gifts, including cards or cash, to applicants or potential enrollees as an inducement for enrollment
- Prohibits using Exchange funds to purchase gifts, gift cards, or promotional items that would be provided to any applicant or potential enrollee

CERTIFIED APPLICATION COUNSELOR PROGRAM REGULATIONS

Article 11 – Certified Application Counselor Program

§ 6864 – Roles and Responsibilities, Cont.

- Prohibits solicitation of consumers for enrollment assistance by going door-to-door or through other unsolicited means of direct contact
- Prohibits calling a consumer using an automatic telephone dialing system or prerecorded voice (robocalls)
- Requires Certified Application Counselors to report subsequent arrests for which Certified Application Counselors have been released on bail or personal recognizance
- Requires Certified Application Counselors to:
  - Inform individuals that they must obtain his or her authorization prior to accessing any personally identifiable information
  - Maintain records of such authorization for a minimum of six years

CERTIFIED APPLICATION COUNSELOR PROGRAM REGULATIONS

Article 11 – Certified Application Counselor Program

§ 6868 – Suspension and Revocation

- Adds administrative action to the list of potentially disqualifying events for which certification could be suspended or revoked
- Adds a two year prohibition on reapplying for certification following a final determination of revocation or suspension

MEDI-CAL MANAGED CARE ENROLLMENT PROGRAM REGULATIONS (DISCUSSION)

Mary Watanabe, Acting Deputy Director, Sales Division

MEDI-CAL MANAGED CARE PLAN PROGRAM REGULATIONS

Article 12 – Medi-Cal Managed Care Plan Enrollment Assistance

- Allows Medi-Cal Managed Care Plans to provide enrollment assistance in Covered California's affordable health plans
- Most individuals and families that received enrollment assistance were either individually or part of a family with Medi-Cal or Covered California eligibility
- Medi-Cal Managed Care Plan staff brings:
  - Multilingual, culturally competent, collaborative enrollment experience
  - Significant expert enrollment experience serving low and moderate income families in County health insurance programs and the Healthy Families Program