



COVERED
CALIFORNIA

COVERED CALIFORNIA POLICY AND ACTION ITEMS

March 5, 2015

COVERED CALIFORNIA BUDGET PLANNING 2014/15 BUDGET STATUS AND 2015/16 BUDGET PLANNING

Jim Lombard, Director of Financial Management Division

MAJOR TOPICS

- Financial Guiding Principles
- FY 2014-15 Expenditure Update
- Enrollment Forecast Assumptions & Scenario's
- 2016 PMPM Recommendation

COVERED CALIFORNIA: FINANCIAL GUIDING PRINCIPLES

Controlling Costs: In keeping with our value of affordability, Covered California aims to limit its cost of operations in order to deliver products and services that offer high value to our consumers. This includes consideration of the amount of participation fees on the cost of coverage, balanced with the need to support fulfilling our mission, including enrolling and retaining members and establishing adequate reserves.

Stability: Provide a reliable and predictable level of resources to support ongoing cost effective operations and provide consumers and health plans with stable rates.

Flexibility: Financial plans need to be flexible to accommodate both changing business priorities and adjustments to match service demands.

Accountability: Covered California is responsible for careful stewardship of public resources. Financial activities are monitored and controlled by Financial Management staff, and will also be independently audited.

Transparency: Covered California has a responsibility to provide transparency into the management of its finances. Annual budget presentations and other financial information presented to the Board will be posted to our website.

Reserve: Covered California's reserve should be sufficient to cover financial obligations and allow for time to adjust revenue and expenditures in the event of an unanticipated fiscal event.

COVERED CALIFORNIA BUDGET DEVELOPMENT:

Applying Financial Principles & Budget Realities

- Covered California will transition from Federal Establishment funding to ongoing PMPM funded operations over multiple years to assure it can meet its mission in a fiscally sound matter. (FY 2015-16 will be the final year of using federal establishment funds).
- Government code section 100503 states that the Exchange Board must maintain enrollment and expenditures to ensure that expenditures do not exceed the amount of revenue in the fund, and if sufficient revenue is not available to pay estimated expenditures, institute appropriate measures to ensure fiscal solvency.
- Forecasts indicate that revenue will equal expenditures as early as FY 2017-18.
- The key criteria in budget planning are (1) Revenue, which factors enrollment and PMPM; (2) Expenditures and (3) Reserves.
- The forecast is primarily based upon the enrollment experience and estimates of the subsidy eligible population, and will be frequently updated.
- It takes nine to eighteen months for adjustments in PMPM rates to have an impact on PMPM revenue.
- Covered California's reserve should be sufficient to assure an adequate cushion in the movement to financial alignment and allow for timing lags needed to adjust revenue and expenditures. A prudent reserve position should be a minimum of three months.

FY 2014-15 EXPENDITURES AND BUDGET ADJUSTMENT RECOMMENDATION

Jim Lombard, Director of Financial Management Division

COVERED CALIFORNIA: FY 2014-15 EXPENDITURES

- Current expectation is for FY 2014-15 expenditures to be within board approved total budget amount.
- Although the Board authorized additional contracts totaling \$43 million for Service Center surge capacity, savings and contingency will offset these costs.
- Anticipate over \$20 million in salary savings.
- Anticipate additional \$15 million in contract savings.
- Due to a natural lag in the billing process, combined with the timing of certain expenditures, year-to-date expenditures are weighted towards the end of the fiscal year.
- As the end of the federal establishment funding approaches, anticipated expenditures and balances are being closely monitored for any need to request reallocation across federal budget categories

FY 2014-15 PROJECTED EXPENDITURES

Current projections for FY 2014-15 expenditures do not indicate that a budget adjustment is necessary at this time.

	Adopted 2014-15	Year-to-Date Through 1/31/15 2014-15	Projected March 2015 2014-15
Service Center	\$ 97,022,224	\$ 37,496,787	\$ 105,177,829
CalHEERS	\$ 88,177,616	\$ 35,371,084	\$ 77,280,313
Sales, Enrollment Activities & SHOP	\$ 189,831,459	\$ 64,746,132	\$ 182,516,026
Plan Management & Evaluation	\$ 17,334,578	\$ 4,649,475	\$ 12,587,038
Administration	\$ 50,385,749	\$ 18,568,729	\$ 40,396,739
Total Expenses	\$ 442,751,626	\$ 160,832,207	\$ 417,957,945
Reimbursement/Cost Sharing	\$ (31,058,183)	\$ (4,899,928)	\$ (25,283,437)
Total Operating Costs	\$ 411,693,443	\$ 155,932,279	\$ 392,674,508

ENROLLMENT FORECAST, FINANCIAL OUTLOOK AND 2016 PMPM RECOMMENDATION

Jim Lombard, Director of Financial Management Division

ENROLLMENT FORECAST FOR 2014-15 AND BEYOND

- Compared to the May 2014 forecast:
 - Total enrollment at the end of the second open enrollment is now projected at 1.3 million versus the 1.7 (medium) and 1.3 (low) million projected in the original forecast
 - The differences from forecast were largely due to (1) somewhat lower effectuation rate (80% instead of 85%) and (2) lower Special Enrollment Period monthly new enrollment from consumers' loss of ESI and Medi-Cal coverage
 - Renewal rates were close to projected and monthly disenrollment rates were lower than forecast (meaning higher retention)
- For 2015-16 multi-year budget planning, three scenario's were modeled, based upon 70%, 75% and 80% enrollment of the subsidy eligible population by the end of 2018.
- Scenario's were based on review of existing programs and independent estimates:
 - Participation in the Healthy Families program reached 75% at the end of its first 5 years
 - Over 80% of those eligible currently participate in the Women Infants & Children program
 - The latest version of CalSIM estimates enrollment through the Exchange at 78% to 81% of the subsidy eligible population (Base vs. Enhanced) in 2019 (when adjusted to exclude those with unaffordable employer-sponsored coverage)

ENROLLMENT FORECAST FOR 2014-15 AND BEYOND

- The preliminary forecast reflects the following major assumptions based on current enrollment trends:
 - 80 percent of those who enroll during Open Enrollment will pay their premium
 - 75 percent of those who enroll in Special Enrollment will pay their premium
 - Approximately 1.5 percent of enrollees will leave the program every month and 12 percent of enrollees will leave the program at annual renewal
 - Approximately 25,000 new enrollments per month will occur on average during Special Enrollment
 - 85 percent of Covered California enrollees receive subsidies
- The medium enrollment scenario is recommended for forecasting.
- Staff performed sensitivity analysis on different retention and Medi-Cal enrollment rates and the results remained within the parameters of the three scenario's.
- Revenue projections assume that the Individual and SHOP PMPMs are held steady at \$13.95 and \$18.60 respectively.

MULTIYEAR OUTLOOK – ENROLLMENT SCENARIO'S

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Effectuated Enrollment <i>(at fiscal year end)</i>	1,300,000	1,366,000	1,548,000	1,689,000	1,854,000
Revenue <i>(cash basis)</i>	\$ 197.4	\$ 227.8	\$ 250.1	\$ 283.5	\$ 308.7

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Effectuated Enrollment <i>(at fiscal year end)</i>	1,300,000	1,476,000	1,667,000	1,809,000	1,978,000
Revenue <i>(cash basis)</i>	\$ 197.4	\$ 234.4	\$ 269.2	\$ 303.6	\$ 329.2

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Effectuated Enrollment <i>(at fiscal year end)</i>	1,300,000	1,542,000	1,807,000	1,953,000	2,102,000
Revenue <i>(cash basis)</i>	\$ 197.4	\$ 238.3	\$ 284.8	\$ 327.5	\$ 352.3

Revenue dollars in millions

WHAT CAN WE ADJUST IF ENROLLMENT IS LOWER THAN FORECAST?

- Reduce Expenditures
- Spend more from Reserves (while maintaining adequate cushion)
- Increase PMPM

MULTIYEAR FINANCIAL OUTLOOK – BASED UPON MEDIUM SCENARIO

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Effectuated Enrollment <i>(at fiscal year end)</i>	1,300,000	1,476,000	1,667,000	1,809,000	1,978,000
Opening Balance	\$ 485.2	\$ 289.6	\$ 184.0	\$ 143.2	\$ 146.7
Revenue <i>(cash basis)</i>	\$ 197.4	\$ 234.4	\$ 269.2	\$ 303.6	\$ 329.2
Expenditures	\$ 393.0	\$ 340.0	\$ 310.0	\$ 300.0	\$ 300.0
Year-End Operating Reserve	\$ 289.6	\$ 184.0	\$ 143.2	\$ 146.7	\$ 175.9
<i>Minimum number of months expenditures covered by reserve</i>	<i>8.8</i>	<i>6.5</i>	<i>5.1</i>	<i>4.9</i>	<i>5.6</i>

Revenue, Expenditure & Reserve dollars in millions

- The latest forecast assumes up to a \$340 million budget in FY 2015-16. The multi-year outlook assumes a \$310 million budget in 2016-17 and a \$300 million budget ongoing beginning in 2017-18. Actual budget amounts are subject to the board annual budget processes.
- The multi-year plan is designed to balance revenues and expenditures by FY 2017-18.
- Forecasts increasing reserve and/or decisions to lower PMPM possible in FY 2017-18.
- Provides a 6 month operating reserve throughout FY 2015-16 with a fiscal year-end position of \$184 million.

PER MEMBER PER MONTH RECOMMENDATION FOR 2016

- Government Code Section 100503(n), authorizes the Board to charge per member per month fees to fund its operation.
- A Board action will be requested at the April meeting.
- At this point, staff plans to recommend that the PMPM for both the individual and SHOP markets be maintained at their current levels through December 31, 2016 (\$13.95 and \$18.60 respectively).

PROPOSED ADDITIONAL CHANGES TO QUALIFIED HEALTH PLAN RECERTIFICATION AND NEW ENTRANT 2016 (ACTION)

Anne Price, Director of Plan Management Division

POLICIES FOR 2016 CERTIFICATION AND RECERTIFICATION - SHOP

Staff is seeking approval of the following modifications to the 2016 Certification and Recertification regulations as indicated below in red font. The changes are needed to clarify the different due dates for a 10/01/2015 effective date and a 01/01/2016 effective date and to apply the 10/01/2015 effective date to recertifying plans who wish to propose new products

New Entrant Applications

- New applicants will be considered (revised 2015 application **timeline**)
- New applicants will be considered for an effective date of 10/15 ~~—12/15~~ or 01/16.
- **Products for a 10/15/2015 effective date must be using 2015 Standard Benefit Designs**

Recertification Applications

- QHPs certified for 2015 would complete abridged recertification application (**revised timeline**)
- **QHPs may introduce new products with an effective date of 10/15 ~~—12/15~~ or 01/16.**
- **Products for a 10/15/2015 effective date must be using 2015 Standard Benefit Designs**

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

POLICIES FOR 2016 CERTIFICATION AND RECERTIFICATION – DENTAL

Staff is seeking approval of the following modification to the 2016 Certification and Recertification regulations as indicated below in red font. The change is clarifying that the no new benefit designs will be considered.

New Entrant Applications

- No new applicants for entry

Recertification Applications

- QDPs certified for 2015 would complete abridged recertification application

Benefit Designs

- No 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
- Resolution 2015-21

COVERED CALIFORNIA 2016 BENEFIT RECOMMENDATION

Anne Price, Director of Plan Management Division

PROPOSED UPDATES 2016 APPROVED BENEFIT DESIGNS – NON-RX

Emergency Room Physician Cost Sharing Silver Plans

- The new Silver plan has inconsistent cost sharing for Emergency Room visits for facility and physician. The facility cost sharing is currently set at a copay and the physician cost sharing is set at a co-insurance amount. The inconsistency is difficult to administer for some qualified health plans. Staff is recommending that the Silver plans be modified to have a physician copay. The impact to the AV is negligible.

Benefit	Ind. Silver	SHOP Silver Coinsurance	SHOP Silver Copay	CSR 73	CSR 87	CSR 94
ER Facility Fee	\$250	\$250	\$250	\$250	\$75	\$30
ER Physician Fee	\$50	\$50	\$50	\$50	\$40	\$25

Updated End Notes

- Staff is recommending a modification to the end notes to clarify the cost share for laboratory. The statement regarding illusory benefits was removed from endnote #6.

PROPOSED UPDATES 2016 APPROVED BENEFIT DESIGNS PHARMACY (ACTION)

Anne Price, Director of Plan Management Division

SPECIALTY DRUG WORK GROUP

Covered California would like to acknowledge the participants of this workgroup and express our appreciation for their thoughtful input and productive discussion over the last month.

Earl Nelson, Colleen Haines
and other representatives
Anthem

Don Hufford
Western Health Advantage

Athena Chapman
California Association of Health Plans

Salina Wong, Nancy Stalker,
Jeff Smith, and other representatives
Blue Shield

Janice Rocco, Bruce Hinze
California Department of Insurance

Anne Donnelly
Project Inform

Alan Jacobs, Linda Brown,
and other representatives
Health Net

Sonia Fernandes, Sandra Gallardo
Department of Managed Health Care

Beth Capell and other representatives
Health Access California

Jerry Fleming
Kaiser Permanente

Jerry Jeffe and Liz Helms
California Chronic Care Coalition

Betsy Imholz
Consumers Union

The information gathering for this workgroup required numerous email requests with quick turnarounds to advocates, regulators, and all 10 Qualified Health Plans (QHPs). Thank you for your hard work and collaboration to help move the conversation forward with the goal of a solution for Covered California and stakeholders.

COVERED CALIFORNIA'S PRINCIPLES FOR ACTION

As part of its consideration of how to meet consumers' needs regarding specialty drug coverage and access, Covered California has solicited suggestions and proposals from health plans, advocates and others on how to best address specialty drug issues in 2016 and future years. The issue is multifaceted, involving many future unpredictable variables. Covered California believes that its decisions need to reflect the balancing of core principles:

- As with all benefits, drug benefit designs should foster consumers getting the right care at the right time. Benefits should steer patients to the most appropriate and cost effective drugs and not result in undue financial barriers for category of members with particular conditions
- At the same time we need to assure overall affordability of premiums including drug costs that are increasingly becoming a larger component of the total cost of healthcare, primarily driven by the introduction and continued development of high cost specialty drugs
- Preserving the plan's ability to maximize savings and control drug costs through preferred formulary tier placement, cost-sharing, and manufacturer negotiations is an important factor in long term affordability

COVERED CALIFORNIA'S PRINCIPLES FOR ACTION (CONT.)

- Policies for drugs treating those facing ongoing maintenance of chronic illnesses raise different issues and need to reflect different strategies than for drugs that have more time limited treatment
- Given the complexity and importance of this area, Covered California should take steps informed by data, regulatory, and other factors as we learn about potential impacts on consumers and the near and long-term impact to premiums

COVERED CALIFORNIA'S PROPOSED 2016 ACTIONS

Recognizing the complexity and importance of this area, Covered California proposes to take measured, incremental steps for 2016, while analyzing data, regulatory and other factors to consider potential modifications and changes for 2017 plan years and beyond. Proposals are to:

1. Significantly expand the transparency requirements on Qualified Health Plans regarding formulary information and access to that information
2. Standardized definitions for formulary tiers
3. Establish requirements such that where multiple treatments are available for the ongoing maintenance care for chronic conditions, there are treatments available outside of Tier 4 with the highest cost sharing
4. Covered California is requesting plans submit premium impacts of implementing specialty drug caps for 2016 through 2019 as well as commenting on their administrative capacity to do so . Based on this information, staff will bring recommendations to the May board meeting, which could include implementing caps for 2016

COVERED CALIFORNIA'S PROPOSED 2016 ACTIONS

1. Expanded Transparency and Access

A central concern is to assure the consumers have clear information about what drugs are covered at what tier. Under SB 1052 there will be new requirements on plans to have standard formulary information posted in 2017. Covered California proposes to impose additional requirements on its QHPs in 2016, including:

- Plans to have an opt out retail option for mail order (allowing consumers that want/need in-person assistance to get such service at no additional cost)
- Plans to provide estimate of enrolled consumer range of costs for specific drugs
- Include statement on the availability of drugs not listed on the formulary
- In tiers 1-4, the plans must include all of their formulary covered drugs used to treat HIV/AIDS, Hepatitis C, Rheumatoid Arthritis, Multiple Sclerosis, Systemic Lupus Erythematosus
- Exception process written clearly on formulary
- All drugs that are covered in Tier 4 must be listed on the formulary (not just the Top 50 or highest use drugs)
- Dedicated pharmacy customer service line where advocates and prospective consumers can call for clarification

COVERED CALIFORNIA'S PROPOSED 2016 ACTIONS

2. Standardized Formulary Tier Definitions

Tier	Definition
1	1) Most generic drugs and low cost preferred brands
2	1) Generic drugs - non-preferred
	2) Brand name drugs - preferred
	3) Recommended by the plan's P&T committee based on drug safety, efficacy and cost
3	1) Brand name drugs - non-preferred
	2) Recommended by P&T committee based on drug safety, efficacy and cost
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier
4	1) Drugs that are: a) FDA or drug manufacturer limits distribution to specialty pharmacies or; b) Self administration requires training, clinical monitoring or; c) Drug manufactured using biotechnology
	2) More costly than other drugs (minimum baseline for cost is >\$600)

COVERED CALIFORNIA'S PROPOSED 2016 ACTIONS

3. Establish Clear Requirements for Access to Chronic Care Drugs Across Tiers

- If a drug would otherwise qualify for placement on tier 4 and at least 3 treatment options are available for that particular condition as determined by either a plan's pharmaceutical and therapeutics (P&T) committee or indicated by the Food and Drug Administration (FDA) or according to applicable treatment guidelines for that condition, at least one drug for that condition must be placed on either tier 1,2 or 3
- This new requirement aims to alleviate the cost burden for the ongoing care needs consumers with chronic conditions, including HIV/AIDS, Hepatitis C, Rheumatoid Arthritis, Multiple Sclerosis, and Lupus.

COVERED CALIFORNIA'S PROPOSED 2016 ACTIONS

4. Assess Implementation of Caps or Spreading of Maximum Out-of-Pocket Throughout the Year

- Covered California recognizes that for some consumers with high-cost maintenance drugs for chronic conditions, one way to address the costs is to spread the Maximum Out-of-Pocket on a script or per-month basis. The advantages for consumers would be that they may be able to more easily budget for their expenses.
- Plans can generally administer a “per script” cap, but are challenged administratively to apply a per month cap. There are a range of issues regarding the actuarial impact, consumer drug taking patterns and cost of drugs where consumers are taking multiple scripts.
- Covered California recommends that to fully understand the impact of the cap to both immediate and long-term premiums, we will be requesting plans to provide both 2016 and future premium impacts to three scenarios in the following slide by May 1, 2015. In addition, plans are requested to clearly note administrative issues with implementing each scenario. Covered California staff will bring forward a recommendation to the May board meeting, which could include implementing some form of cap for plan year 2016.

COVERED CALIFORNIA'S PROPOSED 2016 ACTIONS

4. Assess Implementation of Caps for 2016 and future Plan Years

Pharmacy Tier 4 Options for 2016 Certification Pricing

Scenario 1: Tier 4 maintenance drugs ONLY. Maintenance drugs are defined as medications taken for a long-term duration of 12 months or more to stabilize a chronic condition or the symptoms of chronic condition.

Option A: Tier 4 cost sharing to member will not exceed per script/per month \$ value of:

Option B: Tier 4 cost sharing to member will not exceed per script/per month \$ value of:

Bronze	Silver	Gold	Platinum	Silver 100-150	Silver 150-200	Silver 200-250
na	\$500	\$500	\$300	\$200	\$200	\$500
na	\$200	\$200	\$200	\$100	\$100	\$200

Scenario 2: All Tier 4 drugs

Option A: Tier 4 cost sharing to member will not exceed per script/per month \$ value of:

Option B: Tier 4 cost sharing to member will not exceed per script/per month \$ value of:

Bronze	Silver	Gold	Platinum	Silver 100-150	Silver 150-200	Silver 200-250
na	\$500	\$500	\$300	\$200	\$200	\$500
na	\$200	\$200	\$200	\$100	\$100	\$200

Scenario 3: Cost differentiation between maintenance drugs and all other specialty drugs

For maintenance drugs (defined as medications taken for a long-term duration of 12 months or more to stabilize a chronic condition or the symptoms of chronic condition), Tier 4 cost sharing to member will not exceed per script/per month \$ value of:

For all other specialty drugs, Tier 4 cost sharing to member will not exceed per script/per month \$ value of:

Bronze	Silver	Gold	Platinum	Silver 100-150	Silver 150-200	Silver 200-250
na	\$200	\$200	\$200	\$100	\$100	\$200
na	\$500	\$500	\$300	\$200	\$200	\$500

NOTE: Scenario 3 does not include two options (A & B). It is ONE scenario with cost differentiation based on the type of specialty drug - maintenance vs. all other specialty drugs

In addition to pricing premium impact for 2016, please project 2017, 2018, and 2019 projected premium impact for Scenarios 1-3.

ISSUES FOR ONGOING CONSIDERATION

Covered California is seeking to take deliberate steps that address classes of chronic conditions and recognizes that there continue to be major issues that warrant further close monitoring for potential action. Examples include:

1. Appropriate standards for coverage of single dose combination drugs and placement in formulary tiers. Standard should include consideration of improvement in adherence, reduction in medical cost and consumer access.
 2. Where a drug in a higher cost tier is determined to be medically necessary (through either an exception process or IMR), to what extent and on what basis should the consumer be responsible for the higher share of costs or the lower-cost sharing.
 3. How to address expensive “Time-Limited” treatments where the treatment is not unlike a hospital stay where members are also faced with the expense of the whole maximum out of pockets in a short duration of time
 4. The scope and treatment of biosimilars with regards to formulary placement and cost
- Resolution 2015-22

APPENDIX: WORKGROUP DOCUMENTS

Letter to Covered California, “2016 Benefit Design Option: Specialty Drugs.” *Health Access, Consumers Union, Project Inform*
[http://board.coveredca.com/meetings/2015/3-15/Comments%20to%20the%20Board%20-%20Master_March%205%202015%20\(External\).pdf](http://board.coveredca.com/meetings/2015/3-15/Comments%20to%20the%20Board%20-%20Master_March%205%202015%20(External).pdf)

Letter to Covered California, “Recommended Options for Covered CA Specialty Drug Benefits.” *California Chronic Care Coalition*
[http://board.coveredca.com/meetings/2015/3-15/Comments%20to%20the%20Board%20-%20Master_March%205%202015%20\(External\).pdf](http://board.coveredca.com/meetings/2015/3-15/Comments%20to%20the%20Board%20-%20Master_March%205%202015%20(External).pdf)

Letter to the California Department of Insurance, “Discrimination in Benefit Design: Prescription Drug Formularies.” *Health Access*
[http://board.coveredca.com/meetings/2015/1-15/Comments%20to%20the%20Board%20-%20Master_January%2015%202015%20\(External\).pdf](http://board.coveredca.com/meetings/2015/1-15/Comments%20to%20the%20Board%20-%20Master_January%2015%202015%20(External).pdf)

“Covered California’s 2015 Formularies: An analysis of the drugs per tier in all 10 health plans that are available for treating and preventing HIV (pp 1–20) and for treating hepatitis C (pp 22–31).” *Project Inform, APLA Health & Wellness, San Francisco AIDS Foundation, AIDS Services Foundation Orange County, CNE Media, Los Angeles LGBT Center, Public Law Center, San Luis Obispo Co. AIDS Support Network, The Thrive Tribe Foundation* <http://www.projectinform.org/pdf/CCformularies.pdf>

“Disease Matters: Comparing Prescription Drug Benefits in Covered California Plans.” *California HealthCare Foundation / Avalere Health*
<http://www.chcf.org/publications/2015/02/drug-benefits-covered-ca>

“Executive Summary: Analysis of Assembly Bill 1917: Outpatient Prescription Drugs: Cost Sharing” *California Health Benefits Review Program*
http://chbrp.ucop.edu/index.php?action=read&bill_id=159&doc_type=2

“The Impact Of Specialty Pharmaceuticals As Drivers Of Health Care Costs.” *Health Affairs*
<http://content.healthaffairs.org/content/33/10/1714.abstract>

“Despite High Costs, Specialty Drugs May Offer Value For Money Comparable To That Of Traditional Drugs” *Health Affairs*
<http://content.healthaffairs.org/content/33/10/1751.abstract>

Senate Bill 1052 (passed in 2014): http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB1052

Assembly Bill 339 (2015 cycle): http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0301-0350/ab_339_bill_20150213_introduced.pdf

ENROLLMENT ASSISTANCE POLICY CONSIDERATIONS

Mary Watanabe, Deputy Director, Sales Division

OUTREACH & ENROLLMENT ASSISTANCE PROGRAMS

Program	Program Term	Compensation in 2015/16	Scope of Services		
			Outreach & Education	Enrollment Assistance	Renewal Assistance
Navigator Grant Program	On-going	Grants	✓	✓	✓
In-Person Assistance (IPA) Program	Ends June 30, 2015. Transition to CAC Program.	N/A	✓	✓	✓
Certified Application Counselor (CAC) Program	Begins July 1, 2015	None	✓	✓	✓
Plan Based Enroller (PBE) Program	On-going	None	✓	✓	✓
Medi-Cal Managed Care Plan (MMCP) Program	On-going	None	✓	✓	✓
Outreach and Education Grant Program	Ended February 2015	N/A	✓		
Community Outreach Network	On-going	None	✓		

IN-PERSON ASSISTANCE PROGRAM

- Contracts expire June 30, 2015.
- Recommending that we continue \$58 compensation for QHP and Medi-Cal assisted applications through the end of the contract term on June 30, 2015.
- Organizations who do not receive a Navigator Grant and who wish to continue to provide enrollment assistance will transition to the non-compensated Certified Application Counselor (CAC) Program beginning July 1, 2015.

NAVIGATOR GRANT PROGRAM

- Contracts expire June 30, 2015.
- We are not seeking further changes to the Navigator payment policy or to recover funds that have been paid if goals are not met.
- Holding debrief meetings with Navigator Grantees and stakeholders and will be looking at the performance data to inform recommended approach and compensation model at April Board meeting.
- Initial recommendations for 2015/16:
 - Block grant compensation model with a small portion of funding based on performance.
 - Focus on target communities with a high number of remaining uninsured to provide outreach & education, enrollment assistance, renewal and post enrollment support.
 - Priority given to organizations that have demonstrated their ability to enroll QHP eligible consumers.

ENROLLMENT ASSISTANCE PROGRAM REGULATIONS PERMANENT ADOPTION (ACTION)

Mary Watanabe, Deputy Director, Sales Division

ENROLLMENT ASSISTANCE PROGRAM REGULATIONS

Title 10, Chapter 12, Article – Enrollment Assistance
(Section 6650 et seq.)

- Removes references to the In-Person Assistance (IPA) Program and Certified Enrollment Entities (CEEs) for the following reasons:
 - In-Person Assistance Program is not federally required and has been paid with Federal grant funds;
 - Compensation for QHP enrollments will be through the Navigator Program; and
 - Organizations interested in providing non-compensated enrollment assistance will transition to the Certified Application Counselor (CAC) Program, a federally required program, beginning July 1, 2015.
- There were no substantive changes made to the regulations related to the Navigator Program.
- Resolution 2015-16

PLAN-BASED ENROLLMENT PROGRAM REGULATIONS (ACTION)

Mary Watanabe, Deputy Director, Sales Division

CERTIFIED PLAN-BASED ENROLLMENT PROGRAM REGULATIONS

- Title 10, Chapter 12, Article 9 – Plan-Based Enrollers
 - § 6700 – Definitions
 - § 6702 –Eligibility Requirements
 - § 6704 – Program Application
 - § 6706 – Training and Certification Standards

CERTIFIED PLAN-BASED ENROLLMENT PROGRAM REGULATIONS

Continued

- Title 10, Chapter 12, Article 9 – Plan-Based Enrollers
 - § 6708 – Fingerprinting and Criminal Record Checks
 - § 6710 – Roles and Responsibilities
 - § 6712 – Conflict of Interest Standards
 - § 6714 – Compensation
 - § 6716 – Suspension and Revocation
 - § 6718 – Appeal Process

CERTIFIED PLAN-BASED ENROLLMENT PROGRAM REGULATIONS

Continued

- Title 10, Chapter 12, Article 9 – Plan-Based Enrollers
- Federal law requires annual training on voter registration. Covered California did not incorporate the request from one PBE to exempt Plan Based Enrollers from the annual recertification requirement.
- Resolution 2015-17

MEDI-CAL MANAGED CARE PROGRAM REGULATIONS (ACTION)

Mary Watanabe, 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 the Children’s Health Insurance and the Healthy Families Programs
- Resolution 2015-18

SHOP ELIGIBILITY AND ENROLLMENT REGULATIONS (ACTION)

Mary Watanabe, Sales Division Acting Deputy Director

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) ELIGIBILITY AND ENROLLMENT REGULATIONS

Title 10, Chapter 12, Article 6 – Application, Eligibility, and Enrollment in the SHOP Exchange

§ 6520 – Employer and Employee Application Requirements

- Removed the requirement for the United States Department of Labor Standard Industrial Code
- Added the information requirement of whether an employer employed 20 or more employees for 20 or more weeks for the current or preceding calendar year.
- Added employer's preferred method of communication.
- Added sex and phone number to the employee application

§ 6526 – Qualified Employer Election of Coverage Periods

- Changed the renewal written notification period from 30 days to 60 days
- Resolution 2015-19

SHOP APPEALS REGULATIONS (ACTION)

Mary Watanabe, Sales Division Acting Deputy Director

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) APPEALS REGULATIONS

Title 10, Chapter 12, Article 6 – General Eligibility Appeals Requirements for SHOP (Section 6540 et seq.)

- There were no changes made to the regulations

- Resolution 2015-20

INDIVIDUAL ELIGIBILITY AND ENROLLMENT REGULATIONS (DISCUSSION)

Thien Lam, Director of Eligibility and Enrollment

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS (FOR DISCUSSION ONLY)

Regulation Section	Summary
§ 6410. Definitions	<p>Added Definitions:</p> <p>“Cancellation of Enrollment” means specific type of termination action that ends a qualified individual’s enrollment on or before the coverage effective date resulting in enrollment through the Exchange never having been effective with the QHP.</p> <p>“Plan” means, with respect to an issuer and a product, the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area. The product comprises all plans offered with those characteristics and the combination of the service areas for all plans offered within a product constitutes the total service area of the product.</p> <p>“Product” means a discrete package of health insurance coverage benefits that a health insurance issuer offers using a particular product network type within a service area.</p> <p>“Reinstatement of Enrollment” means a correction of an erroneous termination of coverage or cancellation of enrollment action and results in restoration of an enrollment with no break in coverage.</p> <p>“Termination of Coverage” means an action taken after a coverage effective date that ends an enrollee's coverage through the Exchange for a date after the original coverage effective date, resulting in a period during which the individual was enrolled in coverage through the Exchange.</p>

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS (FOR DISCUSSION ONLY)

Regulation Section	Summary
<p>§ 6478. Verification Process Related to Eligibility Requirements for Enrollment in a QHP through the Exchange § 6478(b)(2) and (3)</p> <p>§ 6492. Inconsistencies. § 6492(a)(2)(B)</p>	<p>Updated Timeframe:</p> <p>If the Exchange is unable to verify an individual's Social Security Number (SSN) through the Social Security Administration (SSA), the Exchange shall provide the individual with a period of 95 days from the date the inconsistency notice for the applicant to provide satisfactory documentary evidence.</p> <p>If the Exchange is unable to verify an individual's attestation to their SSN, citizenship, status as a national, or lawful presence, through SSA or the U.S. Department of Homeland Security, the Exchange shall provide the individual with a period of 95 days from the date the inconsistency notice for the applicant to provide satisfactory documentary evidence.</p>
<p>§ 6482. Verification of Family Size and Household Income Related to Eligibility Determination for APTC and CSR. § 6482(d)(5) and (e)(4)(B)</p>	<p>Additional Language:</p> <p>The Exchange shall verify that neither Advanced Premium Tax Credit (APTC) nor Cost-Sharing Reductions (CSR) is being provided on behalf of an individual using information obtained by transmitting identifying information specified by Health and Human Services (HHS) to HHS.</p> <p>The tax filer's eligibility for APTC and CSR shall be determined based on the projected household income to which the tax filer attests.</p>
<p>§ 6490. Verifications of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-Sponsored Plan Related to Eligibility Determination for APTC and CSR. § 6490 (e)</p>	<p>Updated Timeframe:</p> <p>For eligibility determinations for APTC and CSR that are effective before January 1, 2016, the Exchange shall accept an applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested without further verification.</p>

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS (FOR DISCUSSION ONLY)

Regulation Section	Summary
<p>§ 6504. Special Enrollment Periods. § 6504. (a)(1)(B), (a)(2)(A) and (B), and (a)(4)</p>	<p>Modified language:</p> <p>A qualified individual may enroll in a Qualified Health Plan (QHP), or an enrollee may change from one QHP to another, during special enrollment periods only if one of the following triggering events occurs:</p> <ul style="list-style-type: none">• A qualified individual or his or her dependent:<ul style="list-style-type: none">Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or his or her dependent has the option to renew such coverage. The date of the loss of coverage shall be the last day of the plan or policy year.• A qualified individual:<ul style="list-style-type: none">Gains a dependent or becomes a dependent through marriage or entry into domestic partnership, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order; orLoses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.• A qualified individual's, or his or her dependent's, enrollment or non-enrollment in a Qualified Health Plan is:<ul style="list-style-type: none">Unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or Health and Human Services, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities For purposes of this provision, misconduct includes the failure to comply with applicable standards under this title, or other applicable Federal or State laws, as determined by the Exchange.

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS (FOR DISCUSSION ONLY)

Regulation Section	Summary
<p>§ 6504. Special Enrollment Periods. § 6504. (h)(1)(A) and (B),(h)(5)(A) and (B), (h)(6)</p> <p><i>CONTINUED</i></p>	<p>Modified language:</p> <p>In the case of birth, adoption, placement for adoption, or placement in foster care, the coverage shall be effective either:</p> <ul style="list-style-type: none"> • Retroactively, to the date of birth, adoption, placement for adoption, or placement in foster care; or • Prospectively, on the first day of the month following the date of birth, adoption, placement for adoption, or placement in foster care, at the option of the qualified individual or the enrollee. <p>New Language:</p> <p>In the case of a court order, the coverage shall be effective either:</p> <ul style="list-style-type: none"> • On the date the court order is effective; or • During the regular Special Enrollment effective dates at the option of the qualified individual or the enrollee <p>If an enrollee or his or her dependent dies, the coverage shall be effective on the first day of the month following the plan selection.</p>
<p>§ 6506. Termination of Coverage in a QHP. § 6506. (a)(1)-(3)</p>	<p>New Language:</p> <p>Enrollee-initiated terminations shall be conducted in accordance with the following process:</p> <ul style="list-style-type: none"> • An enrollee may choose to remain enrolled in a Qualified Health Plan (QHP) at the time of plan selection if he or she becomes eligible for other Minimum Essential Coverage and the enrollee does not request termination, the Exchange shall initiate termination of his or her enrollment in the QHP upon completion of the redetermination process.

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS (FOR DISCUSSION ONLY)

Regulation Section	Summary
<p>§ 6506. Termination of Coverage in a QHP. § 6506. (a)(1)-(3) and (c)(3)(A) and (C)</p> <p><i>CONTINUED</i></p>	<p>New language:</p> <p>Enrollee-initiated terminations shall be conducted in accordance with the following process:</p> <ul style="list-style-type: none">• An individual, including an enrollee’s authorized representative, shall be permitted to report the death of an enrollee to the Exchange for purposes of initiating termination of the enrollee’s coverage provided that the individual submit satisfactory documentation of the death to the Exchange. <p>Modified language:</p> <p>In the case of termination of enrollee’s coverage due to non-payment of premium, a Qualified Health Plan (QHP) issuer shall:</p> <ul style="list-style-type: none">• Continue to collect Advance Premium Tax Credit on behalf of the enrollee from the Internal Revenue Service <p>New Language:</p> <p>In the case of a enrollee initiated termination, the last day of coverage shall be:</p> <ul style="list-style-type: none">• The retroactive termination date requested by the enrollee, if specified by applicable State laws.

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS (FOR DISCUSSION ONLY)

Regulation Section	Summary
<p>§ 6506. Termination of Coverage in a QHP. § 6506. (d)(9)(A)-(D) and § 6506. (e)(1)(C)</p> <p><i>CONTINUED</i></p>	<p>New language:</p> <p>In cases of retroactive termination dates, the Exchange shall ensure that:</p> <ul style="list-style-type: none">• The enrollee receives the Advanced Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSR) for which he or she is determined eligible;• The enrollee is refunded any excess premiums paid or out-of-pocket payments made by or for the enrollee for covered benefits and services, including prescription drugs, incurred after the retroactive termination date;• The enrollee's premium and cost sharing are adjusted to reflect the enrollee's obligations under the new QHP; and• In the case of a change in the level of CSR under the same QHP issuer during a benefit year, any cost sharing paid by the enrollee under the previous level of CSR for that benefit year is taken into account in the new level of CSR for purposes of calculating cost sharing based on aggregate spending by the individual, such as for deductibles or for the annual limitations on cost sharing. <p>Modified Language:</p> <p>If an enrollee terminates his or her own coverage, fails to pay their premium for coverage, or the enrollee's coverage is rescinded by an QHP, the QHP issuer shall:</p> <ul style="list-style-type: none">• Provide the enrollee, within five business days from the date of the termination, with a written notice of termination of coverage that includes:<ul style="list-style-type: none">○ An description of the issuer's process the enrollee may follow to dispute the termination if the enrollee thinks the information included in the issuer's notice is incorrect.