COVERED CALIFORNIA POLICY AND ACTION ITEMS

January 18, 2018 Board Meeting

2019 PROPOSED PATIENT CENTERED BENEFIT DESIGN

James DeBenedetti, Director, Plan Management Division

Discussion

2018 HEALTH BENEFITS WITH THE 2019 AV CALCULATOR

Each year, benefits need to be adjusted to make sure they continue to meet the actuarial value (AV) requirements of the affordable care act. Due to actuarial value (AV) requirements, the benefit workgroup needed to consider changes to cost sharing for the 2019 benefit plan designs.

	Bronze		Silver				CCSB Silver		
	HDHP	Standard	Silver	Silver 73	Silver 87	Silver 94	Copay	Coins	HDHP
AV Target	60	60	70	73	87	94	70	70	70
Deviation Allowance	+/-2.0%	+/-2.0%	+/-2.0%	+/-1.0%	+/-1.0%	+/-1.0%	+/-2.0%	+/-2.0%	+/-2.0%
2018 AV	**61.38**	**60.75**	**71.90***	**73.88***	**87.98***	**93.94**	**71.42***	**71.85***	**71.66**
2019 AV	**62.62**	**62.14**	**72.79**	**74.68**	**88.42**	**94.21**	**72.33**	**72.67**	**72.63**

	Gold		Platinum	
	Copay	Coins	Copay	Coins
AV Target	80	80	90	90
Deviation Allowance	+/-2.0%	+/-2.0%	+/-2.0%	+/-2.0%
2018 AV	**78.40**	**81.85**	**88.11**	**91.23**
2019 AV	**79.62**	**82.84**	**88.90**	**91.73**

Red text: AV is outside de minimis range

Blue text: AV is within de minimis range

*Final AV includes additive adjustment for drug copay accumulation

SUMMARY OF PROPOSED COST SHARE CHANGES IN 2019

Platinum Coinsurance and Copay Plans: No changes (AV increases by 0.5-0.8%)

Gold Coinsurance and Copay Plans:
- Increase Maximum Out-of-Pocket (MOOP) from $6,000 to $7,200
- Increase primary care office visits from $25 to $30

Silver Plans (Standard, CSR plans, CCSB):
- Increase MOOP from $7,000 to $7,550 (smaller increases for CSR plans, which have lower MOOPs)
- Increase cost shares (office visits, x-rays) by $5 (final amounts differ by service type and metal tier; see following slides)
- Removed deductible for inpatient physician fees on Silver plans and CCSB Silver Copay plan

Bronze Plan:
- Increase MOOP from $7,000 to $7,550

HDHP Plans:
- Increased deductibles $500 (Silver) $1,200 (Bronze)
- Set the MOOP at the 2018 IRS allowed amount of $6,650 ($100 increase from 2017)

All Plan Designs:
- Clarify the cost share for medical transportation (i.e. applies to both emergency and non-emergency)

COMPARISON OF PROPOSED COST SHARE CHANGES IN 2019

Metal Tier	Service Type	2018 Cost Share	Proposed 2019 Cost Share
Gold *(Copay and Coinsurance Plans)*	Maximum Out of Pocket	$6,000	$7,200
	Primary care / mental health / rehab office visits	$25	$30
Silver	Maximum Out of Pocket	$7,000	$7,550
	Pharmacy Deductible	$130	$200
	Primary care / mental health / rehab office visits	$35	$40
	Specialist visit	$75	$80
	Inpatient physician fee	Deductible / 20% Coinsurance	20% Coinsurance
Silver 94	Inpatient physician fee	Deductible / 10% Coinsurance	10% Coinsurance
Silver 87	Maximum Out of Pocket	$2,450	$2,600
	Primary care / mental health / rehab office visits	$10	$15
	X-rays	$25	$30
	Inpatient physician fee	Deductible / 15% Coinsurance	15% Coinsurance

COMPARISON OF PROPOSED COST SHARE CHANGES IN 2019

Metal Tier	Service Type	2018 Cost Share	Proposed 2019 Cost Share
Silver 73	Maximum Out of Pocket	$5,850	$6,300
	Pharmacy Deductible	$130	$175
	Primary care / mental health / rehab office visits	$30	$35
	Inpatient physician fee	Deductible / 20% Coinsurance	20% Coinsurance
CCSB Silver Copay Plan	Maximum Out of Pocket	$7,000	$7,550
	Pharmacy Deductible	$125	$200
	Specialist visit	$75	$80
	X-rays	$70	$75
	Inpatient physician fee	Deductible / 20% Coinsurance	20% Coinsurance
CCSB Silver Coinsurance Plan	Maximum Out of Pocket	$7,000	$7,550
	Pharmacy Deductible	$125	$200
	Specialist visit	$75	$80
	X-rays	$70	$75
CCSB Silver HDHP	Deductible	$2,000	$2,500
	Maximum Out of Pocket	$6,550	$6,650

COMPARISON OF PROPOSED COST SHARE CHANGES IN 2019

Metal Tier	Service Type	2018 Cost Share	Proposed 2019 Cost Share
Bronze	Maximum Out of Pocket	$7,000	$7,550
Bronze HDHP	Deductible	$4,800	$6,000
	Maximum Out of Pocket	$6,550	$6,650
Catastrophic	Maximum Out of Pocket	$7,350	$7,900

POTENTIAL DESIGNS FOR 2020 AND BEYOND

- Copay-only, no-deductible Silver plan
- Value-Based Insurance Design
- “High AV” Bronze plans
- Funded HSA accounts for Cost-Sharing Reduction (CSR)-eligible members who select Bronze plans

POTENTIAL DESIGNS FOR 2020: "COPAY-ONLY, NO-DEDUCTIBLE" SILVER PLAN

- In mid-December, Covered California received a proposal from Anthem to include a Silver plan with no deductible and only copays to its Patient-Centered Benefit Plan Designs. Covered California's Plan Management Advisory Group and the benefits workgroup considered two options for this type of plan design:
  - Offering the design as an alternative to the current standard Silver (i.e. issuers could offer either plan)
  - Replacing the current standard Silver with the "copay only, no deductible" Silver
- The plan would have the following cost sharing:

COPAY ONLY, NO DEDUCTIBLE SILVER PLAN			
Service	**Cost Share**	**Service**	**Cost Share**
Medical deductible	**$0**	Imaging	$350
Drug deductible	**$250**	Outpatient facility / physician	$350 / $100
Maximum out of pocket	**$7,550**	Emergency Room	$450
Office visits (primary care, etc.)	$45	Inpatient facility / physician	$1400/day / no charge
Specialist visit	$85	Outpatient rehab / hab	$45
Lab tests	$45	Skilled Nursing Facility	$250/day
X-rays	$80		

POTENTIAL DESIGNS FOR 2020:"COPAY-ONLY, NO-DEDUCTIBLE" SILVER PLAN (CONT.)

Covered California will consider this proposal for a future plan year (2020) but has deferred it for 2019 to provide additional time to properly review potential impacts, including:

- Consumer preference on cost sharing approaches and potential confusion on plan value among renewing Silver enrollees
- Rate changes among issuers opting to offer only the copay plan and impact to APTC
- Product discontinuance for issuers opting to offer the copay plan and downstream effects (plan filings, consumer notification and education, CalHEERS plan choice display, etc.)
- Regulatory review of cost shares to rule out potential illusory benefits
- Compressed timeline for 2019 filings

DENTAL BENEFIT DESIGNS

PEDIATRIC DENTAL COINSURANCE ACTUARIAL VALUE (AV) OPTIONS

- Covered California will maintain an 85% AV (+/- 2%) requirement for the pediatric dental EHB consistent with prior years
- To maintain this AV, Covered California proposes increasing the pediatric deductible from $65 to $75
- Additional options were considered as potential approaches to decrease the actuarial value in the 2019 Dental Pediatric Coinsurance Benefit Design. These options were shared with the Dental Technical Workgroup and the Plan Management Advisory Workgroup.

PEDIATRIC DENTAL COINSURANCE OPTIONS CONSIDERED

Recommended:

- Increase Pediatric Individual deductible from $65 to $75 – AV 86.93%.

Considered, but not recommended:

- Increase Pediatric Individual deductible from $65 to $80 – AV 86.71%
- Increase Pediatric Individual deductible from $65 to $85 – AV 86.49%
- Increase non-surgical Basic Services (restoration procedures, periodontal maintenance services, and periodontics) coinsurance from 20% to 30% – AV 86.83%
- Increase non-surgical Basic Services (restoration procedures, periodontal maintenance services, and periodontics) coinsurance from 20% to 30% and increase Major Services (periodontics, endodontics, crowns & casts, prosthodontics, oral surgery) coinsurance from 50% to 60% – AV 86.34%8
- Increase non-surgical Basic Services (restoration procedures, periodontal maintenance services, and periodontics) coinsurance from 20% to 50% – AV 86.03%
- Add deductible to Diagnostic & Preventive Category (oral exam, preventive cleaning/x-ray, sealants, topical fluoride, space maintainers) – AV 85.30%

OTHER DENTAL BENEFIT CHANGES

Copay Plan Design

- Obsolete Dental Procedures and Nomenclature (CDT) 2017 codes have been removed from the copay schedule
- CDT-18 Code D9239 (D9239 - Intravenous moderate conscious sedation/analgesia – first 15 minutes) has been added because it was not included in the 2018 Copayment Schedule.
- The proposed copay schedule will remain in draft form until it can be updated with new CDT-19 codes, which will not be available until May 2019; the final copayment schedule will be presented when those codes are available

Adult Coinsurance Plan Design (No change except Endnote 14)

- Delete Endnote 14 from the Dental Standard Benefit Design. These non-covered adult codes are already noted as not covered in the Copayment Schedule.
  - 14) The following CDT codes are not covered adult dental benefits: D0145, D0251, D0310, D0320, D0322, D0340, D0350, D0351, D0601, D0602, D0603, D1120, D1206, D1208, D1310, D1320, D1352, D1520, D1525, D1575, D2929, D2930, D2932, D2933, D2941, D2949, D2955, D2971, D3230, D3240, D3353, D4920, D5911, D5912, D5913, D5914, D5915, D5916, D5919, D5922, D5923, D5924, D5925, D5926, D5927, D5928, D5929, D5931, D5932, D5933, D5934, D5935, D5936, D5937, D5951, D5952, D5953, D5954, D5955, D5958, D5959, D5960, D5982, D5983, D5984, D5985, D5986, D5987, D5988, D5991, D6010, D6011, D6013, D6040, D6050, D6052, D6055, D6056, D6057, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6080, D6081, D6085, D6090, D6091, D6092, D6093, D6094, D6095, D6100, D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117, D6190, D6194, D6199, D7920, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7951, D7952, D7955, D7972, D7990, D7991, D7995, D7997, D8080, D9230, D9248, D9410, D9420, D9610, D9612, D9950

2019 QUALIFIED HEALTH PLAN CERTIFICATION POLICY

James DeBenedetti, Director, Plan Management Division

Discussion

2017-2019 QUALIFIED HEALTH PLAN AND QUALIFIED DENTAL PLAN CERTIFICATION

Plan Year 2019 Qualified Health Plan (QHP) and Qualified Dental Plan (QDP) Certification Applications open to:

- Issuers offering QHPs certified for 2018
- Issuers offering QDPs certified for 2018
- Medi-Cal Managed Care Plans
- Issuers newly licensed since May 2, 2017
- Covered California for Small Business (CCSB) QHP application only: All currently licensed health plan issuers

Currently Contracted Applicants

- QHP and QDP Issuers contracted for Plan Year 2018 will complete a simplified certification application since their three year contract with the Exchange covering 2019-2019 plan years imposes ongoing requirements included in the certification application and this contract performance is considered in the evaluation process.

2019 CERTIFICATION APPLICATION STRATEGY – CONTRACTED ISSUERS

Plan Management recently performed an extensive review of the Individual QHP Certification Application to ensure the questions posed were still appropriate and to ensure consistency in speech, format and approach.

Impact:

- Removal of questions or sections addressed in the QHP Issuer contract.
- Removal of questions or sections not relevant to returning QHP Issuers.

Benefit:

- Reduce resources used to review already established, monitored, and reported elements according to the Issuer contract.
- Increase collaboration on quality initiatives and proposed product, and network strategies.
- Emphasis on areas that "really matter" to the Consumer experience and align with the Triple Aim.

Sample explanation legend

Section	Category Information	Comments
3. Licensed & Good Standing (Full Section)	○ 3.1: DMHC or DOI license. ○ 3.2: Material fines related to good standing. ○ 3.3: Material fines in CA.	Included in Issuer contract section 8.1. Remove full section.
15. Marketing & Outreach (Partial Section)	○ 15.1: Marketing org chart. ○ 15.2: Adhere to Exchange branding. ○ 15.3: Submit materials per deadline. ○ 15.4: Submit Member communication calendar. ○ 15.5: Submit proposed marketing plan.	Items 15.1 – 15.3 established and/or included in Issuer contract. Remove. Items 15.4 – 15.5 required.

PROPOSED CERTIFICATION MILESTONES

Final AV Calculator Released	December 28, 2017
Release draft 2019 QHP & QDP Certification Applications	January 12. 2018
Draft application comment period	January 12-26, 2018
January Board Meeting: discussion of benefit design & certification policy recommendation	January 18, 2018
Letters of Intent Accepted	February 1 – 15, 2018
February Board Meeting: anticipated approval of 2019 Patient Centered Benefit Plan Designs & Certification Policy	February 15, 2018
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 20-28, 2018
QHP & QDP Applications Open	March 1, 2018
March Board Meeting: approval of 2019 Standard Benefit Plan Designs & Certification Policy (if Feb meeting cancelled)	March 15, 2018
QHP Application Responses (Individual and CCSB) Due	May 1, 2018
Evaluation of QHP Responses & Negotiation Prep	May - June 2018
QHP Negotiations	June 25, 2018
QHP Preliminary Rates Announcement	July 2018
Regulatory Rate Review Begins (QHP Individual Marketplace**)	July 25, 2018/TBD
QDP Application Responses (Individual and CCSB) Due	June 1, 2018
Evaluation of QDP Responses & Negotiation Prep	June – July 2018
QDP Negotiations	July 2018
CCSB QHP Rates Due	July 25,2018
QDP Rates Announcement (no regulatory rate review)	August 2018
Public posting of proposed rates**	July 25, 2018
Public posting of final rates** (per CCIIO's proposed rate filing timeline)	November 1, 2018

* Final SERFF template dependent on CMS release
** TBD = dependent on CCIIO rate filing timeline requirements

COVERED CALIFORNIA FOR SMALL BUSINESS (CCSB) ELIGIBILITY AND ENROLLMENT EMERGENCY REGULATIONS READOPTION AND PERMANENT RULEMAKING AUTHORIZATION

Linda Anderson, Senior Manager, Covered California For Small Business (CCSB)

Action

HIGHLIGHTS TO PRIMARY PROPOSED CHANGES

Section and Title	Proposed Changes

Section 6528 (f)
Initial and Annual Enrollment Periods for Qualified Employers
	• Clarify effective dates for plan changes received during the first thirty days of coverage effective date
	  • Plan change received between 1st and 15th of month will be effective retroactively to 1st of the month, unless the employer requests an effective date of the first of the following month
	  • Plan change received between 16th and 30th of the month will be effective 1st of the following month; earlier requested effective determined on case-by-case basis

Section 6522 (4)(A) Eligibility Requirements for Enrollment in the SHOP.	• A lesser minimum participation percentage may be determined by prevailing market practice through a CCSB survey of market practices • CCSB to notify issuers at least 210 days prior to proposed effective date and changes will be published on CCSB website • Remove 100% participation requirement for employers with 1 to 3 employees

HIGHLIGHTS TO PRIMARY PROPOSED CHANGES

Section and Title	

Section 6520 (a)(13) & (f)
Employer and Employee Application Requirements
	• New qualified employer application submissions are due five days prior to the requested effective date
	  • Application received after this date will carry an effective date no earlier than the first of the following month unless the qualified employer submits a signed CCSB New Business Submission Acknowledgement Form
	  • Exceptions for exceptional circumstances will be considered on a case-by-case basis
	• If a qualified employee declines coverage, the employee must sign the declination of coverage and state other sources of coverage, if any

Section 6522 (4)(B) Eligibility Requirements for Enrollment in the SHOP	• Valid waivers to include special federal or state programs – excluding Qualified Health Plan coverages that are sold in the Individual Exchange

HIGHLIGHTS TO PRIMARY PROPOSED CHANGES

Section and Title	

Section 6532 (f) – (h)
Employer Payment of Premiums
	• Reinstatements and Re-Application:
	• Qualified employer requesting to reinstate within 30 days after the effective date of termination must pay past due premiums to be reinstated without lapse in coverage
	• A Qualified employer may not reinstate coverage 31 or more days following the effective date of termination
	  • may only reinstate once during the 12-month period
	• Terminated employers seeking to reapply for coverage after 31 or more days following the effective of termination shall be considered a new group
	  • Past due premiums for the past 12 months, if any, must be paid prior to application approval

Section 6532 (j) Employer Payment of Premiums	• Collections for delinquent accounts payable will be performed as per State Accounting Manual (SAM) section 8776.6
	• Typographical edits made throughout for clarity and consistency