COVERED CALIFORNIA POLICY AND ACTION ITEMS

January 17, 2019 Board Meeting

2019 QUALIFIED DENTAL BENEFIT DESIGN

James DeBenedetti, Director, Plan Management

Action

2019 DENTAL COPAYMENT SCHEDULE

- The 2019 Dental Copayment Schedule was presented in draft at the March Board Meeting. The final 2019 Dental Copayment Schedule is presented today with the new 2019 CDT codes.
- The new 2019 CDT code is:
  - D1354 - Interim caries arresting medicament application - per tooth (Pediatric and Adult - No Charge)
- The new 2019 CDT code is:
  - D4275 - Non-autogenous connective tissue graft procedure (including recipient site and donor material) – first tooth, implant or edentulous tooth position in same graft site (Pediatric – Not Covered, Adult - $190)
  - D6096 - Remove broken implant retaining screw (Pediatric – $60, Adult - Not Covered)

2020 QUALIFIED HEALTH PLAN CERTIFICATION

James DeBenedetti, Director, Plan Management Division

Discussion

2020 STANDARD BENEFIT PLAN DESIGN UPDATE

Background on Essential Health Benefits (EHBs) and the Actuarial Value Calculator (AVC)

- *The Essential Health Benefits, Actuarial Value, and Accreditation final rule (EHB Final Rule).*
  - Requires issuers to use an **Actuarial Value Calculator (AVC)** for the purposes of determining levels of coverage
  - Four tiers of coverage: Bronze (60% AV), Silver (70% AV), Gold (80% AV), Platinum (90% AV)
  - California law mandates an allowable de minimis variation range for AV of +/- 2% (federal rules permit a wider variation range).
- The AVC represents an empirical estimate of the AV to provide a close approximation of the actual average spending by a wide range of consumers in a standard population.
  - The AVC is updated annually and typically released in the fall for public comment. The final AVC and final Notice of Benefit and Payment Parameters (NBPP) are typically released in December or January.

2020 STANDARD BENEFIT PLAN DESIGN UPDATE

- The Plan Management Division convenes the annual Benefit Design Subcommittee of the Plan Management Advisory Group every fall at the time of the federal release of the Notice of Benefit and Payment Parameters (NBPP) and Draft AV Calculator (AVC).

- The federal Office of Management and Budget (OMB) has not released the 2020 NBPP and Draft 2020 AVC.

- The 2020 Benefit Design Subcommittee deferred discussions on cost-sharing changes this fall while awaiting the NBPP/AVC, but held four meetings this fall/winter to discuss various policy items and proposals for the 2020 health and dental benefit designs.

2020 STANDARD BENEFIT PLAN DESIGN UPDATE

Impact to QHP Certification: The continued federal shutdown and delayed release of the Notice of Benefit and Payment Parameters (NBPP) and Draft AV Calculator (AVC) compresses the timeline for Certification Applicants to prepare products, pricing, and regulatory filings for the 2020 plan year.

Contingency planning and next steps:

- Benefit modeling using the 2019 AV Calculator and applying assumptions about expected parameters in the 2020 NBPP/AVC
- Two additional meetings with the Benefits Subcommittee in January
- Setting preliminary benefit designs by January 30th to allow Certification Applicants to proceed with pricing
- Engaging DMHC and CDI on filing deadlines in the event of a continued, major delay

Assuming the 2020 NBPP/AVC is available by February 7th, Covered California plans to present the 2020 Standard Benefit Plan Designs to the Board in February for Discussion.

QUALIFIED HEALTH PLAN AND QUALIFIED DENTAL PLAN CERTIFICATION

Plan Year 2020 Qualified Health Plan (QHP) and Qualified Dental Plan (QDP) Certification Applications open to:

- All licensed health plan carriers.

Currently Contracted Applicants

- For Sections 1-17, QHP and QDP Carriers contracted for Plan Year 2019 will continue to complete a simplified Certification Application for Plan Year 2020.
- For Sections 18-19, we are requiring five Quality and QIS subsections for currently contracted QHP Carriers which were previously required only for new entrant Applicants. The additional requirements acknowledge the one-year contract extension and align the application with Attachment 7 refresh efforts.

Potential New Requirement

- Covered California is considering setting standard related to agent commissions and policy for certified agents offering Sharing Ministry starting in 2020.

PUBLIC COMMENT

- Plan Management received 91 public comments for all four applications.
- Approximately one-third of the comments were technical in nature: question numbering issues, word count, formatting, and updates to section instructions.
- Plan Management received numerous positive comments throughout the Quality and QIS sections regarding the newly added questions.
- The red-line versions of the Applications provided reflect the changes made from the public comment period.

PROPOSED CERTIFICATION MILESTONES

Release draft 2020 QHP & QDP Certification Applications	December 2018
Draft application comment period	December 14 – 28, 2018
Plan Management Advisory: Benefit Design & Certification Policy recommendation	January 2019
January Board Meeting: Discussion of Benefit Design & Certification Policy recommendation	January 17, 2019
Letters of Intent Accepted	February 1 -15, 2019
February Board Meeting: Approval of 2020 Patient-Centered Benefit Plan Designs & Certification Policy	February 21, 2019
Final AV Calculator Released*	February 2019
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 20-28, 2019
QHP & QDP Applications Open	March 1, 2019
March Board Meeting: Approval of 2020 Patient-Centered Benefit Plan Designs & Certification Policy (if February meeting is cancelled)	March 14, 2019
QHP Application Responses (Individual and CCSB) Due	May 1, 2019
Evaluation of QHP Responses & Negotiation Prep	May - June 2019
QHP Negotiations	June 2019
QHP Preliminary Rates Announcement	July 2019
Regulatory Rate Review Begins (QHP Individual Marketplace**)	July 2019/TBD
QDP Application Responses (Individual and CCSB) Due	June 1, 2019
Evaluation of QDP Responses & Negotiation Prep	June – July 2019
QDP Negotiations	July 2019
CCSB QHP Rates Due	July 24, 2019
QDP Rates Announcement (no regulatory rate review)	August 2019
Public posting of proposed rates	July 2019
Public posting of final rates (per CCIIO's proposed rate filing timeline)	September – October 2019

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

COVERED CALIFORNIA'S POLICIES PROMOTING ACCOUNTABILITY AND DELIVERY REFORM

revised January 22, 2019

Discussion

James DeBenedetti, Director, Plan Management

INTRODUCTION

Beginning with the inaugural 2014 plan year, Covered California set forth our standards and strategy for quality improvement and delivery system reform in our QHP Issuer Model Contract, updated in 2017. The "Quality, Network Management, Delivery System Standards and Improvement Strategy" of Covered California's current issuer contract is available online at https://hbex.coveredca.com/insurance-companies/PDFs/Att-7-QHP-Update-for-2018.pdf.

As Covered California assesses the performance of our QHP issuers for the contracting period commencing in 2017, we also plan to refresh our quality improvement and delivery system reform standards and requirements. In doing so, Covered California's efforts should be informed by a clear picture of the potential impacts, as well as performance benchmarks and efforts of major national and California purchasers.

To inform our efforts, we are engaging in four related and complementary efforts that will be used to engage health plans, providers, advocates and other stakeholders as we propose revisions to contractual terms that take effect in plan year 2021. Covered California intends to share summary findings and seek initial feedback from stakeholders in early 2019.

COVERED CALIFORNIA EARLY RESULTS

- The early results collected from QHP issuers are based on available data, most results are for plan year 2017
- Covered California will continue to work with QHP issuers to standardize reporting across issuers to ensure data validity and accuracy

COVERED CALIFORNIA ATTACHMENT 7 REQUIREMENTS

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The requirements within Attachment 7 consist of the following focus areas:

- Article 1: Improving Care, Promoting Better Health and Lowering Costs: Ensuring networks are based on value, addressing high cost providers and high cost drugs
- Article 2: Provision and Use of Data and Information for Quality of Care: Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers & Systems (CAHPS), Quality Rating System (QRS) reporting and IBM Watson data submissions
- Article 3: Reducing Health Disparities and Ensuring Health Equity: Increasing self-identification of race or ethnicity and measuring and narrowing disparities
- Article 4: Promoting Development and Use of Effective Care Models: Primary care provider (PCP) matching, promotion of patient-centered medical homes (PCMH) and integrated healthcare models (IHMs), supporting primary care through value-based payment, increasing mental and behavioral health integration with medical care, and using telehealth

COVERED CALIFORNIA ATTACHMENT 7 REQUIREMENTS

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- Article 5: Hospital Quality and Safety: Payment models to increase value, reducing hospital acquired conditions (HACs) and unnecessary C-Sections
- Article 6: Population Health: Preventive Health, Wellness and At-Risk Enrollee Support: Wellness services, community health, supporting at-risk enrollees, and diabetes prevention
- Article 7: Patient-Centered Information and Support: Price and quality transparency for enrollees, shared decision making, reducing overuse, and using the statewide provider directory
- Article 8: Payment Incentives to Promote Higher Value Care: Increasing value-based reimbursement
- Article 9: Accreditation

COVERED CALIFORNIA EARLY RESULTS: OVERVIEW

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- Strong evidence that, across plans, consumers are likely to receive quality care, with all plans achieving three stars or better for measurement year 2017, ranging from solid to exceptional performance
- Incremental increases in payment linked to value or shared risk; progressive adoption of payment reforms among larger network plans with market power
  - Blended case rates for maternity
  - Value-based contracting with hospitals
  - Accountable Care Organizations (ACO) or Integrated Healthcare Models (IHMs) with accountability for the triple aim
- All QHP issuers have adopted core hospital performance measures in managing low risk C-sections and hospital acquired conditions (HACs) either in contracting or performance management
  - Significant increased participation in California Maternal Quality Care Collaborative (CMQCC) and Partnership for Patients programs
  - Significant improvement in low-risk C-Section and HAC rates

COVERED CALIFORNIA EARLY RESULTS: OVERVIEW

…page 2 of 2

- 99% of enrollees have a PCP
- Significant investment in supporting providers in advanced primary care practice transformation
  - Less progress with primary care payment reform and PCMH recognition
- Significant growth in enrollment in IHM/ACO models for network QHPs, and advances in standardization of measuring ACO performance that will permit comparing ACO models
- Good start on reducing disparities in care
  - Improving capture of self-identified racial and ethnic identity
  - Three years of baseline data for chronic conditions and depression
  - Strategies to reduce disparities in early implementation

EARLY RESULTS FOR 2016-2018 PERFORMANCE PERIOD: QUALITY RATING SYSTEM (QRS) SCORES

- QHP issuers are required to collect and report to Covered California, for each product type, its QRS HEDIS, CAHPS and other performance data
- QHP issuers showed steady improvement over three years for a subset of important measures, including HbA1c levels, diabetes medication adherence, and colorectal cancer screening (next slides)

Global Quality Ratings by Reportable Products for Individual & CCSB Markets						
	# Products with No Global Rating	1 Star ★	2 Star ★★	3 Star ★★★	4 Star ★★★★	5 Star ★★★★★
2018 QRS	**3***	**0**	**0**	**6**	**4**	**2**
2017 QRS	**4***	**0**	**3**	**6**	**1**	**1**
2016 QRS	**5***	**1**	**7**	**2**	**1**	**1**

* No global rating if a newer product and not eligible for reporting or insufficient sample sizes to report results for at least 2 of the 3 summary indicator categories

COVERED CALIFORNIA

EARLY RESULTS FOR 2016-2018 PERFORMANCE PERIOD: DIABETES CONTROL

Why it matters?

- Diabetes is marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin; hemoglobin A1c (HbA1c) tests indicates the average level of blood sugar
- The target HbA1c level for people with diabetes is 8% or lower; lower HbA1c levels indicate better diabetes control
- If not managed, diabetes can lead to heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death

HbA1c < 8% HEDIS Measure			
	2016	**2017**	**2018**
US 90th Percentile for national marketplace plans			0.69
US 50th Percentile for national marketplace plans			0.59
Covered CA Weighted Average	0.59	0.60	0.63
Covered CA Best Performing Plan	0.75	0.70	0.73
Covered CA Lowest Performing Plan	0.38	0.47	0.52

Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

EARLY RESULTS FOR 2016-2018 PERFORMANCE PERIOD: DIABETES MEDICATION ADHERENCE

Why it matters?

- Proper diabetes management is essential to control blood glucose, reduce risks for complications and prolong life
- Diabetes can be managed by taking medications as instructed, eating a healthy diet, being physically active and quitting smoking

Diabetes Medication Adherence HEDIS Measure			
	2016	**2017**	**2018**
US 90th Percentile for national marketplace plans			0.80
US 50th Percentile for national marketplace plans			0.71
Covered CA Weighted Average	0.66	0.69	0.72
Covered CA Best Performing Plan	0.77	0.80	0.87
Covered CA Lowest Performing Plan	0.51	0.50	0.61

Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

EARLY RESULTS FOR 2016-2018 PERFORMANCE PERIOD: CONTROLLING HIGH BLOOD PRESSURE

Why it matters?

- High blood pressure increases the risk of heart disease and stroke, which are the leading causes of death in the United States
- Controlling high blood pressure is an important step in preventing heart attacks, stroke and kidney disease, and in reducing the risk of developing other serious conditions

Controlling High Blood Pressure HEDIS Measure			
	2016	**2017**	**2018**
US 90th Percentile for national marketplace plans			0.77
US 50th Percentile for national marketplace plans			0.61
Covered CA Weighted Average	0.66	0.63	0.66
Covered CA Best Performing Plan	0.85	0.86	0.82
Covered CA Lowest Performing Plan	0.49	0.43	0.43

Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

EARLY RESULTS FOR 2016-2018 PERFORMANCE PERIOD: COLORECTAL CANCER SCREENING

Why it matters?

- Treatment for colorectal cancer in its earliest stage can lead to a 90 percent survival rate after 5 years
- Many adults ages 50–75 do not get recommended screenings; colorectal cancer screening of asymptomatic adults in this age group can catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective

Colorectal Cancer Screening HEDIS Measure			
	2016	**2017**	**2018**
US 90th Percentile for national marketplace plans			0.68
US 50th Percentile for national marketplace plans			0.54
Covered CA Weighted Average	0.54	0.55	0.59
Covered CA Best Performing Plan	0.82	0.80	0.78
Covered CA Lowest Performing Plan	0.28	0.35	0.34

Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

EARLY RESULTS FOR 2016-2018 PERFORMANCE PERIOD: ACCESS TO CARE

Why it matters?

- This QRS survey measure is based on enrollee responses to the QHP Enrollee Survey
- This measure indicates whether enrollees had access to urgent or immediate care as soon as needed, were able to get a routine care appointment when needed, were able to get tests when needed, and were able to access a specialist when needed

Access to Care QHP Enrollee Survey Measure			
	2016	**2017**	**2018**
US 90th Percentile for national marketplace plans			0.84
US 50th Percentile for national marketplace plans			0.80
Covered CA Weighted Average	0.71	0.70	0.72
Covered CA Best Performing Plan	0.78	0.79	0.81
Covered CA Lowest Performing Plan	0.56	0.60	0.67

Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

EARLY RESULTS FOR 2017-2018 PERFORMANCE PERIOD: INCREASES IN PAYMENT LINKED TO VALUE OR RISK

Requirement

- QHP issuers are required to change how hospitals are paid to promote quality:
  - Adopt a payment method that ties 2% of hospital payments to quality performance
  - Adopt a payment method with no financial incentive for hospitals to perform low risk C-Sections

Results: Hospital Payment Method

- Issuers can tie value-based payments to patient satisfaction, clinical measures, safety, readmissions, or any combination. As of 2017, 6 issuers had implemented value-based payments for hospitals, ranging from 23% of network hospitals to 100% of network hospitals.
- These hospital value-based payments provide the foundation for issuers to meet the requirement that 2% of hospital payments for each in-network hospital is tied to value by the end of 2019

Results: Low Risk C-Section Payment Method

- As of 2017, 6 issuers had actively re-contracted payments for low-risk C-Sections while 4 issuers had begun the process.

EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: IMPROVED HOSPITAL MATERNITY CARE

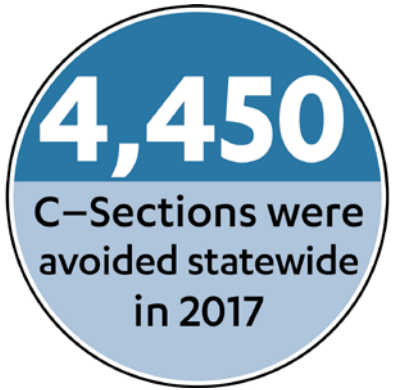
Requirement

Covered California requires QHP issuers to:

- Encourage hospitals to submit data to the California Maternal Quality Care Collaborative (CMQCC) and participate in free coaching programs to improve quality
- Track low-risk C-Section rates with the possibility of excluding a hospital from network if the hospital is a low performer and not working to improve

Results

- Hospital participation in the CMQCC data collection and improvement collaborative is now nearly universal partly due to QHP issuer encouragement and inclusion in contracting discussions with hospitals
- Rates of low-risk C-Sections for low risk first time pregnancies are coming down steadily and the number of hospitals achieving the Healthy People 2020 target of 23.9% or less is growing
- 4,450* C-Sections were avoided statewide in 2017



* A proportionate share of deliveries for Covered California enrollees is approximately 66 fewer C-sections in 2017, not including enrollment through the off-exchange individual market, nor Covered California enrollees who are covered by Medi-Cal for pregnancy

EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: IMPROVED HOSPITAL SAFETY …page 1 of 2

Requirement

Covered California requires QHP issuers to:

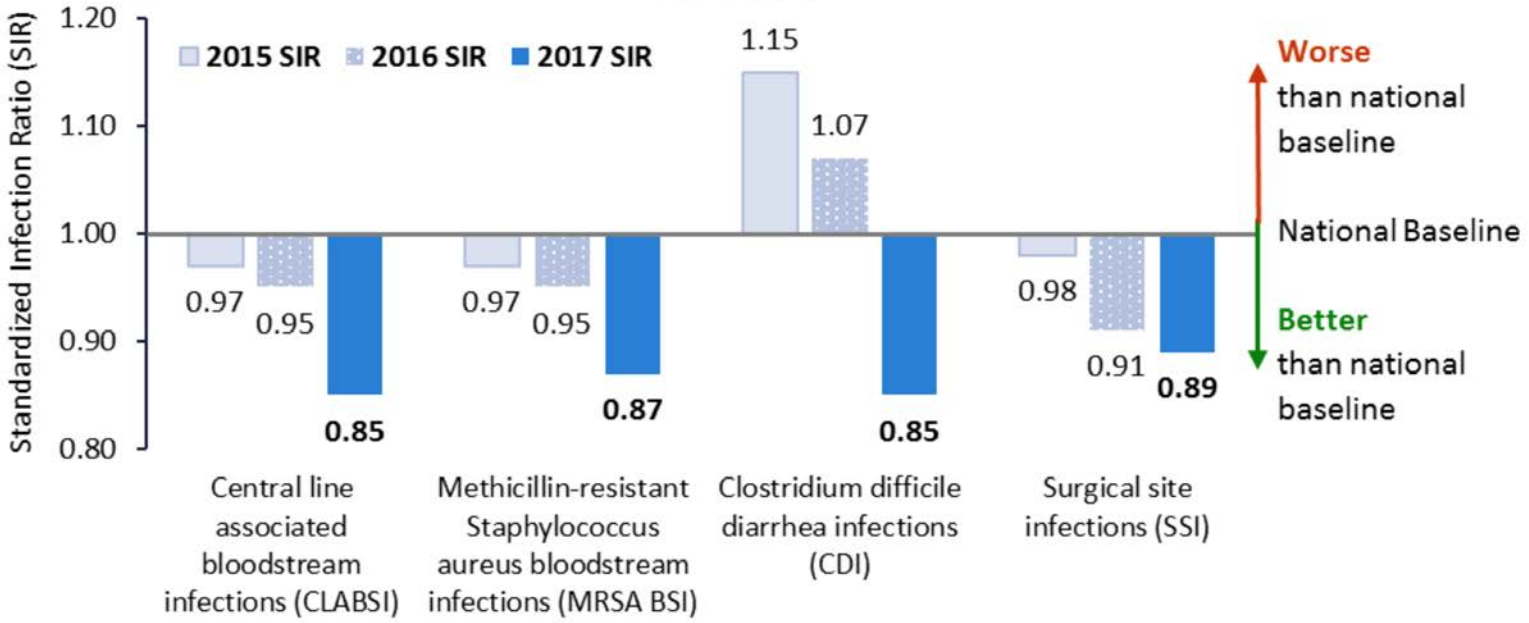
- ❑ Encourage hospitals to participate in free coaching programs to improve HAC rates
- ❑ Track specified HAC rates with the possibility of excluding a hospital from network if the hospital is a low performer and not working to improve
  - ▪ Catheter associated urinary tract infection (CAUTI)
  - ▪ Central line associated blood stream infections (CLABSI)
  - ▪ Methicillin-resistant staph (MRSA)
  - ▪ Clostridium difficile bacterial infection (CDI)
  - ▪ Surgical site infection of the colon (SSI Colon)

Results

- □ Hospital participation in Partnership for Patients improvement collaboratives is now nearly universal
- □ Rates of avoidable HACs are decreasing (next slide)

EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: IMPROVED HOSPITAL SAFETY …page 2 of 2

Figure I. Healthcare-Associated Infection Incidence in California Hospitals, 2015-2017



Source: California Department of Public Health (CDPH), October 2018

EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: PROMOTING ACCESS TO PRIMARY CARE

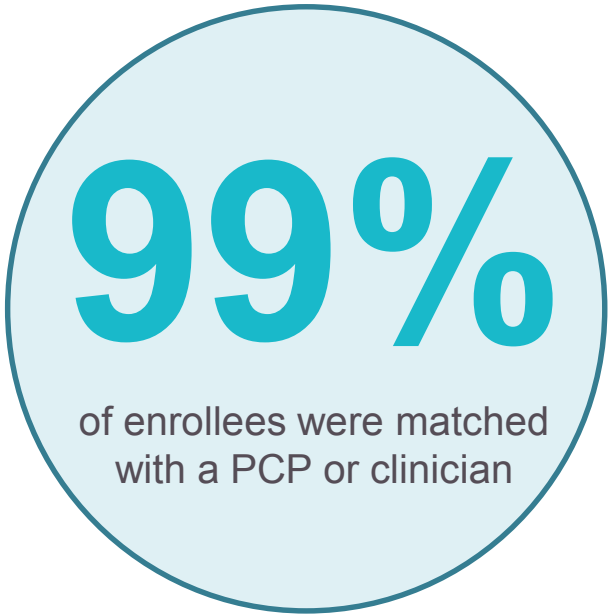
Requirement

Covered California requires that all enrollees are matched to a primary care provider (PCP) or other primary care clinician (such as a nurse practitioner) within 60 days of enrollment

- This requirement effectively applied to PPO and EPO plans as HMO plans already assign enrollees to a PCP as part of their business model

Results

- In 2017, virtually all (99%) of Covered California enrollees (N=1.34 million) were matched with a PCP, a nearly 30-percentage point increase from 2016 (N=1.34 million)



EARLY RESULTS FOR 2016-2017 PERFORMANCE PERIOD: PROMOTING EFFECTIVE PRIMARY CARE …page 1 of 2

Requirement

- Covered California requires QHP issuers to have an increasing number of enrollees who obtain their care in a patient-centered medical home (PCMH) model with advanced primary care

Results

- Enrollment in PCMH-recognized practices has increased slightly between 2016 and 2017

% Cared for in a Patient-Centered Medical Home		
	2016	**2017**
All Enrollment	**25%**	**32%**
Kaiser	*100%*	*100%*
Non-Kaiser	*3%*	*6%*

EARLY RESULTS FOR 2016-2017 PERFORMANCE PERIOD: PROMOTING EFFECTIVE PRIMARY CARE …page 2 of 2

Results

- Covered California is reviewing the current PCMH recognition programs to assess lack of provider interest
- Some have commented that the programs are process-oriented, burdensome, and costly
- Some providers that meet the PCMH recognition requirements may not be pursuing formal recognition
- QHP issuers remain committed to promoting the elements of advanced primary care: accessible, data-driven, and team-based care
- 5 issuers have made significant investments in coaching to support providers in achieving advanced primary care

EARLY RESULTS FOR 2015-2017 PERFORMANCE PERIOD: SIGNIFICANT ENROLLMENT GROWTH IN ACO

Requirement

- Covered California requires QHP issuers to have an increasing number of enrollees who are attributed to or cared for in integrated healthcare models (IHMs) or accountable care organizations (ACOs)

Results

- Significant growth in enrollment in IHMs/ACOs for QHP issuers with EPO and PPO networks

% Cared for in an IHM/ACO		
	2015	**2017**
All Enrollment	**46%**	**55%**
Kaiser	*100%*	*100%*
Non-Kaiser	*29%*	*38%*

- Covered California is supporting advances in standardizing the measurement of ACO performance that will permit comparing ACO models

EARLY RESULTS FOR 2015-2017 PERFORMANCE PERIOD: UNDERSTANDING DISPARITIES

Requirement

- Covered California requires QHP issuers to achieve 80% self-identification of racial and ethnic identity (R/E) by 2019 and encourage use of various data collection methods beyond the enrollment form to identify membership, to understand disparities in care.
- Covered California requires QHP issuers to submit data by R/E group on 14 disease control and management measures for four conditions: diabetes, asthma, hypertension and depression. Issuers submit data for all lines of business excluding Medicare. This work helps “track, trend, and improve” care across R/E groups.

Results

- In 2017, 9 of 11 QHP issuers have seen increases in the self-identification rate over 2015
- 6 QHP issuers have met and exceeded the 80% target a year early; 3 have exceeded 95%
- QHP issuers have increased identification rates due to improved data collection and incorporation of best practices in asking enrollees for R/E information
- Covered California is working with QHP issuers to analyze early condition-specific data and to address challenges related to data quality, small denominators, and data interpretation

EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: ACHIEVING VALUE IN DRUG SPEND

Requirement

- QHP issuers are required to report whether and how value is considered in formulary selection, whether and how formularies are constructed assessing for total cost of care, and how off-label pharmaceutical use is monitored

Results

- 7 of 11 QHP issuers (covering **1,159,510** or **86%** of enrollees in 2017) have a process for analyzing drug efficacy in the context of total cost of care and outcomes, and actively uses those results
- All QHP issuers have a systematic, evidence-based approach for monitoring the off-label use of pharmaceuticals

EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: ACCESS TO TELEHEALTH SERVICES

Requirement

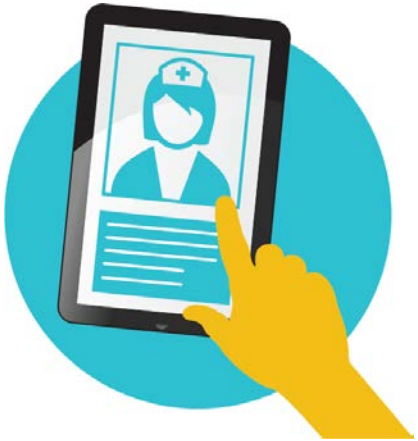
- QHP issuers are required to report the extent to which they support and use technology to assist in providing higher quality, accessible, patient-centered care to enrollees

Results

- 10 of 11 QHP issuers (covering **1,329,150** or **99%** of enrollees in 2017) offer telehealth services

- 5 of 11 QHP issuers (covering **775,250** or **58%** of enrollees in 2017) offer primary care telehealth visits at the same cost of a primary care visit or less

- 4 of 11 QHP issuers (covering **553,900** or **41%** of enrollees in 2017) offer primary care telehealth visits at no cost share



EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: CONSUMER DECISION SUPPORT TOOLS

Requirement

- QHP issuers are required to offer tools that enable enrollees to look up provider-specific cost shares of common elective inpatient, outpatient, and ambulatory surgery services and prescription drugs, and accumulations toward deductibles and maximum out of pockets (MOOPs)
- QHP issuers with fewer than 100,000 members with Covered California can provide this information to enrollees through another method such as a call center

Results

- 9 of 11 QHP issuers (covering **1,327,350 or 99%** of enrollees in 2017) provide an online tool with cost information to consumers, including 4 issuers with fewer than 100,000 enrollees

EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: MEMBER PORTAL TOOLS

Requirement

- Covered California requires QHP issuers to report on enrollee access to personal health information and the tools offered through their member portals

Results

- All QHP issuers offer the following services through their member portal:
  - premium payment
  - provider search
  - selecting or changing a PCP
  - managing prescription drugs

- 7 of 11 QHP issuers (covering **1,152,230** or **86**% of enrollees in 2017) offer access to personal health information through their member portal

PROPOSED GUIDING PRINCIPLES FOR DEVELOPING EXPECTATIONS OF HEALTH PLANS 2021-2023 …page 1 of 2

1. Driven by the desire to meet two complementary and overlapping objectives:
   - **Right Care/Accountability:** Ensure our members receive the right care, at the right time, in the right setting, at the right price.
   - **Delivery System Improvement:** Promoting value-enhancing strategies that have the potential to reform the delivery system in the near and long term.
2. Seek to improve the health of the population, improve the experience of care, reduce the cost of care, reduce administrative burden, and reduce health care disparities.
3. Success will be assessed by outcomes, measured at the most appropriate level, in preference to adoption of specific strategies.
4. We will promote alignment with other purchasers as much as possible.

PROPOSED GUIDING PRINCIPLES FOR DEVELOPING EXPECTATIONS OF HEALTH PLANS 2021-2023 …page 2 of 2

5. Consumers will have access to networks offered through the QHP issuers that are based on high quality and efficient providers.
6. Enrollees have the tools needed to be active consumers, including both provider selection and shared clinical decision making.
7. Payment will increasingly be aligned with value and proven delivery models.
8. Variation in the delivery of quality care will be minimized by ensuring that each provider meets minimum standards.

FRAMEWORK FOR RIGHT CARE/ACCOUNTABILITY AND DELIVERY SYSTEM IMPROVEMENT EXPECTATIONS

Covered California has organized the complementary and mutually reinforcing strategies to support these expectations in two domains:

Right Care/Accountability Strategies	Delivery System Improvement Strategies
Chronic Care, General Care, and Access	Networks Based on Value
Hospital Care	Promotion of Effective Primary Care
Major/Complex Care	Promotion of Integrated Healthcare Models and Accountable Care Organizations
Mental/Behavioral Health and Substance Use Disorder Treatment	Alternate Sites of Care Delivery
Preventive Services	Consumer and Patient Engagement
Health Equity: Disparities in Healthcare	Population-Based and Community Health Promotion Beyond Enrolled Population
Pharmacy Utilization Management	

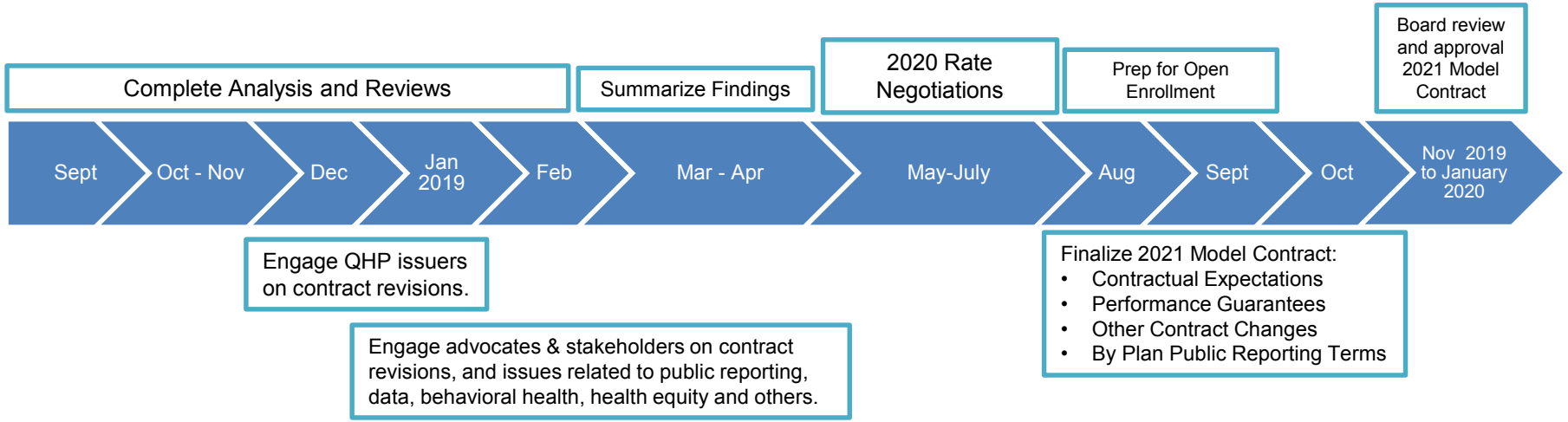
EXPECTATIONS DEVELOPMENT APPROACH: REFRESHING COVERED CALIFORNIA'S STRATEGY

1. Outside Consultants: review and synthesis of the available evidence base for Right Care and Delivery System Improvement Strategies, organized in the following projects:
   - *Benchmarking (PwC):* Identify relevant benchmarks and data sources to provide valid comparison points for current expectations and performance standards for QHP issuers and Covered California's populations overall.
   - *Purchaser Strategy/Measurement Review (PwC):* Review activities and initiatives of other large health purchasers to identify key areas of focus, strategies and performance measures that Covered California should consider for potential adoption or alignment.
   - *Best Evidence Value-Enhancing Strategies (HMA):* Synthesize the evidence for each value-enhancing strategy and evaluate its potential effectiveness in terms of cost, quality of care, improved health, reduction in health disparities, and provider burden.

EXPECTATIONS DEVELOPMENT APPROACH: REFRESHING COVERED CALIFORNIA'S STRATEGY page 2 of 2

2. QHP Issuers: Covered California seeks to understand each issuer's intended direction, investment strategy, and perspective on how best to ensure right care is being delivered and it is fostering delivery change.
3. Other Stakeholders: Covered California seeks input from diverse stakeholders, including providers, consumers, purchasers, and regulators.

EXPECTATIONS DEVELOPMENT APPROACH: TIMELINE



EXPECTATIONS DEVELOPMENT NEXT STEPS

Engagement

Covered California will convene meetings of subject matter experts and stakeholders specific to the various topics. For more information, please refer to *Refreshing Contractual Expectations* available at https://board.coveredca.com/meetings/2019/01-17%20Meeting/Refreshing-Contractural-Expectations.pdf.

Public Comment

Covered California will solicit feedback throughout the expectations refresh initiative. Comments in response to *Request for Input* available at https://board.coveredca.com/meetings/2019/01-17%20Meeting/Request-for-Input.pdf are requested by February 15, 2019.

OPTIONS TO IMPROVE AFFODABILITY IN CALIFORNIA'S INDIVIDUAL INSURANCE MARKET

DRAFT REPORT PRESENTATION

Katie Ravel, Director, Policy, Eligibility and Research
Nicholas Tilipman, University of Illinois at Chicago
Wesley Yin, UCLA and The National Bureau of Economic Research
January 17, 2019

Discussion

AB 1810 AFFORDABILITY OPTIONS REPORT

The 2018-19 budget trailer bill (Assembly Bill 1810) requires Covered California to develop an Affordability Options Report to the Legislature, Governor, and the new Council on Health Care Delivery Systems

Covered California must:

- Consult with stakeholders, Department of Health Care Services, and the Legislature and develop options for providing financial assistance to help low and middle-income Californians access health care coverage.
- Include options to assist low-income individuals paying a significant percentage of income on premiums, even with federal financial assistance, and individuals with annual income of up to 600 percent of federal poverty level.

Report due by February 1, 2019

AB 1810 AFFORDABILITY WORKGROUP MEMBERS

Alicia Kauk……	National Health Law Program
Amber Kemp…….	California Hospital Association
Beth Capell……	Health Access California
Bill Wehrle……	Kaiser Permanente
Cary Sanders……	California Pan-Ethnic Health Network
Catrina Reyes……..	California Medical Association
Dave Brabender…..	California Association of Health Underwriters
Jen Flory……	Western Center on Law and Poverty
Marjorie Swartz…….	Office of Senate President Pro Tempore Toni Atkins
Mary June Flores….	Health Access California
Mike Odeh……	Children Now
Robert O'Reilly…….	Molina Healthcare
Robert Spector…….	Blue Shield of California
Teri Boughton……	California State Senate Committee on Health
Wendy Soe……	California Association of Health Plans

Covered California Board Members
Dr. Sandra Hernandez
Jerry Fleming

AFFORDABILITY CHALLENGES

Affordability of premiums

- Remains a challenge for low- and middle-income individuals, even with federal premium tax credits
- For some people above the tax credit “cliff,” premiums are a high fraction of income

Cost-sharing

- Low to middle-income consumers enroll in lower actuarial value plans with high deductibles
- High deductibles discourage medical care seeking—both high and lower value care

Penalty elimination leading to lower enrollment and increased premiums

- Higher premiums particularly impactful for unsubsidized consumers

AFFORDABILITY OPTIONS MODELED

Policies were selected to build on existing affordability and market stability mechanisms of the Affordable Care Act

Policies modeled include:

- **Premium subsidies**: reducing the Affordable Care Act's income-based premium contribution cap for consumers earning less than 400 percent of the federal poverty level (FPL) and expanding eligibility for consumers earning more than 400 percent FPL
- **Cost sharing subsidies**: enhancing the value of cost sharing subsidies for individuals up to 250 percent of the federal poverty level and extending eligibility for cost sharing subsidies above current eligibility limits
- **Implementing a state individual mandate and penalty**: instituting a state-level individual mandate and penalty using the 2018 federal framework
- **Reinsurance**: creating a reinsurance program funded at the level required to reduce individual market premiums by 10 percent per year

TWO APPROACHES MODELED

Approach 1: Market-wide Affordability Enhancements

- Goal of enhancing affordability for all individual market enrollees
- Policy Option 1: reduce required premium contributions for benchmark coverage, eliminate the tax credit cliff, and expand cost-sharing subsidies
- Policy Option 2: add a state individual mandate to Policy Option 1
- Policy Option 3: add a reinsurance program to Policy Options 1 and 2

Approach 2: Targeted Affordability Enhancements

- Several discrete options were modeled for enhancing affordability for specific income groups:
  - Under 400 percent FPL
  - Over 400 percent FPL
  - Between 0 and 600 percent FPL
- Affordability policy options designed with targeted budgets in mind

PROJECTING THE IMPACT OF VARIOUS POLICY OPTIONS

For each policy option, project five key outcomes:

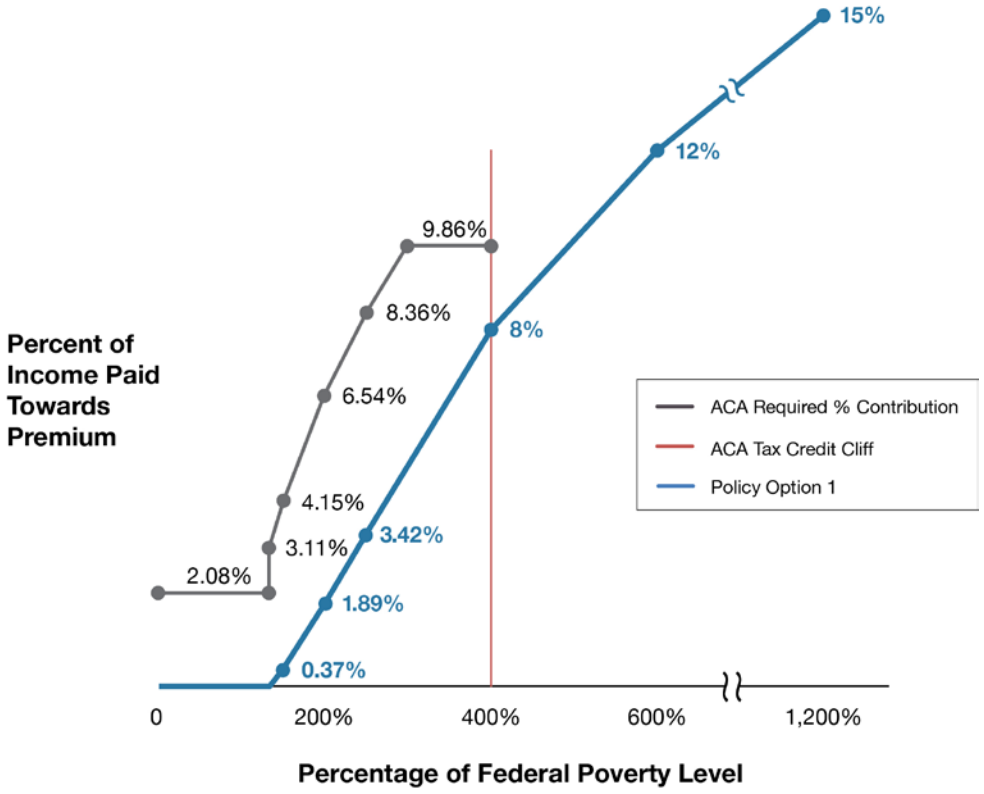
- Total enrollment, coverage rates, metal tier choice, new State funding for proposed subsidies, and impacts on federal premium tax credits
- Total and separately by consumer income groups
- Projection year 2021

Analyses based on a microsimulation model:

- Use administrative data on enrollment, premiums, and plans; plus survey data and economic theory, to estimate how premiums and subsidies affect consumer enrollment and plan choice (“elasticities”).
- Using estimated elasticities and economic theory to forecast premium, enrollment and plan choice in response to Policy Options

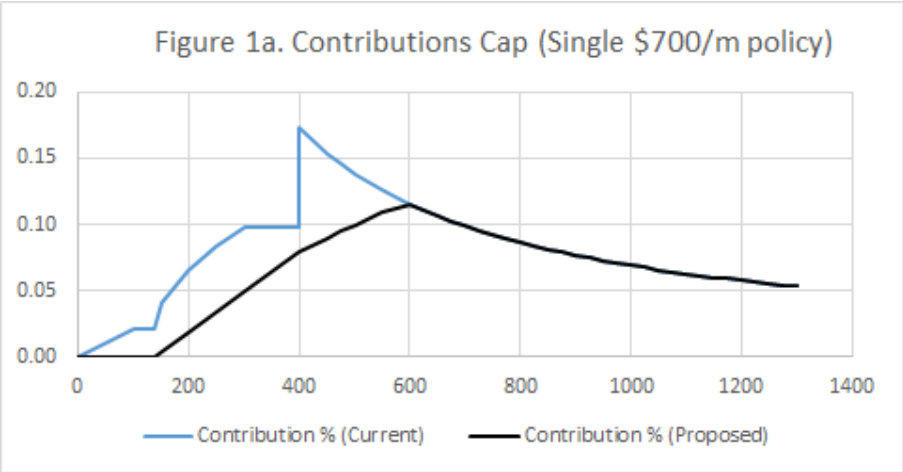
APPROACH 1: REDUCTION IN REQUIRED CONTRIBUTION FOR BENCHMARK PLAN

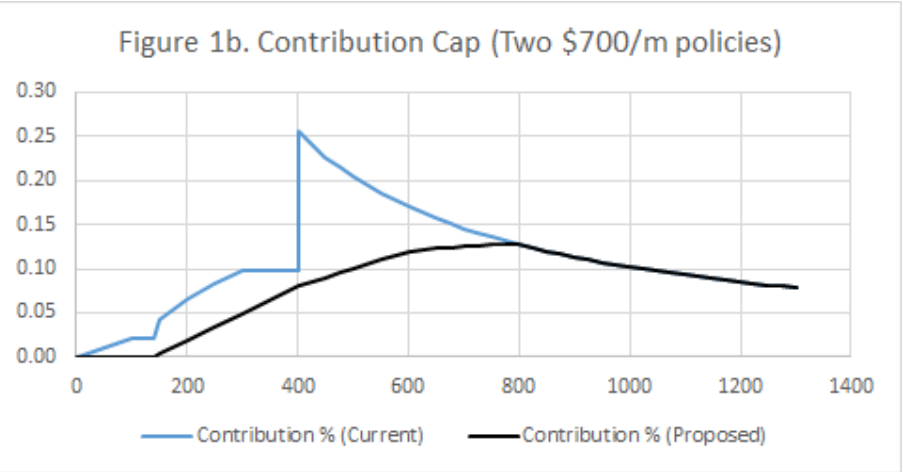
- Approach 1 significantly reduces premium contributions for benchmark coverage for individuals under 400 percent FPL who are eligible for federal tax credits today
- Approach 1 also eliminates the tax credit "cliff" by capping consumer cost for a benchmark premium at no more than 15 percent of income



ILLUSTRATING THE VALUE OF EXTENDING PREMIUM SUBSIDIES ABOVE THE CURRENT TAX CREDIT CLIFF

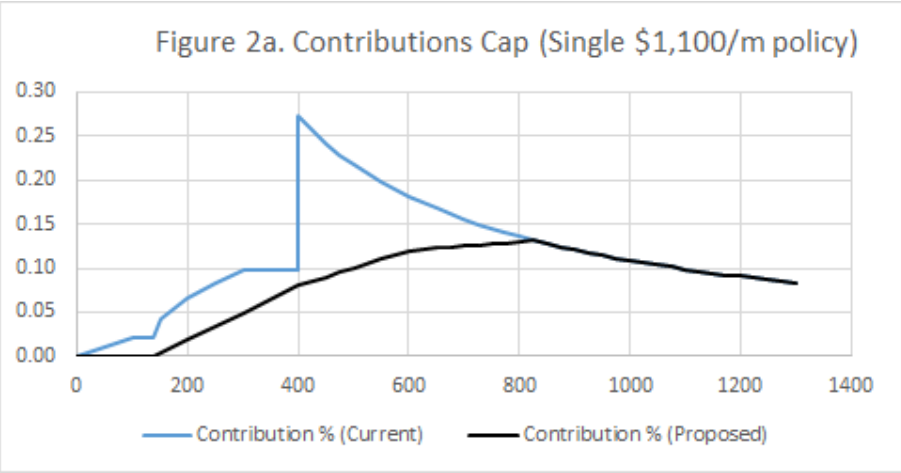
Figures show the difference in consumers' premiums as a percent of their income for $700 benchmark plan when a cap on premiums is added above 400 percent FPL

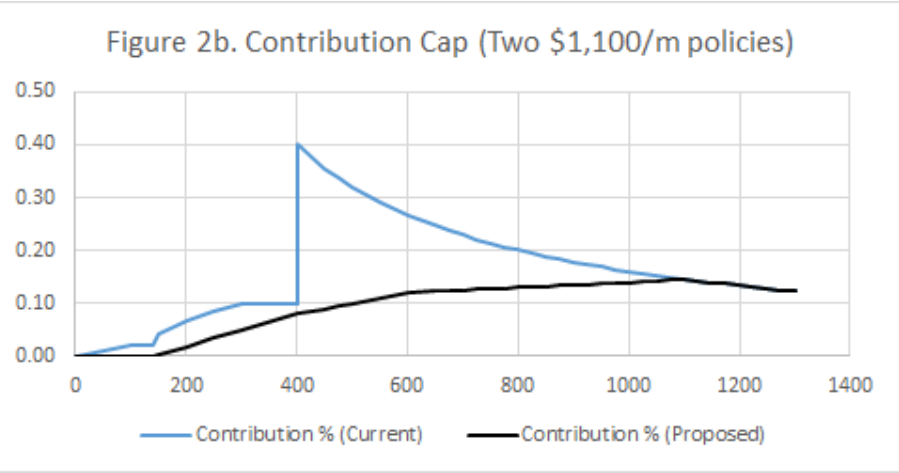




ILLUSTRATING THE VALUE OF EXTENDING PREMIUM SUBSIDIES ABOVE THE CURRENT TAX CREDIT CLIFF

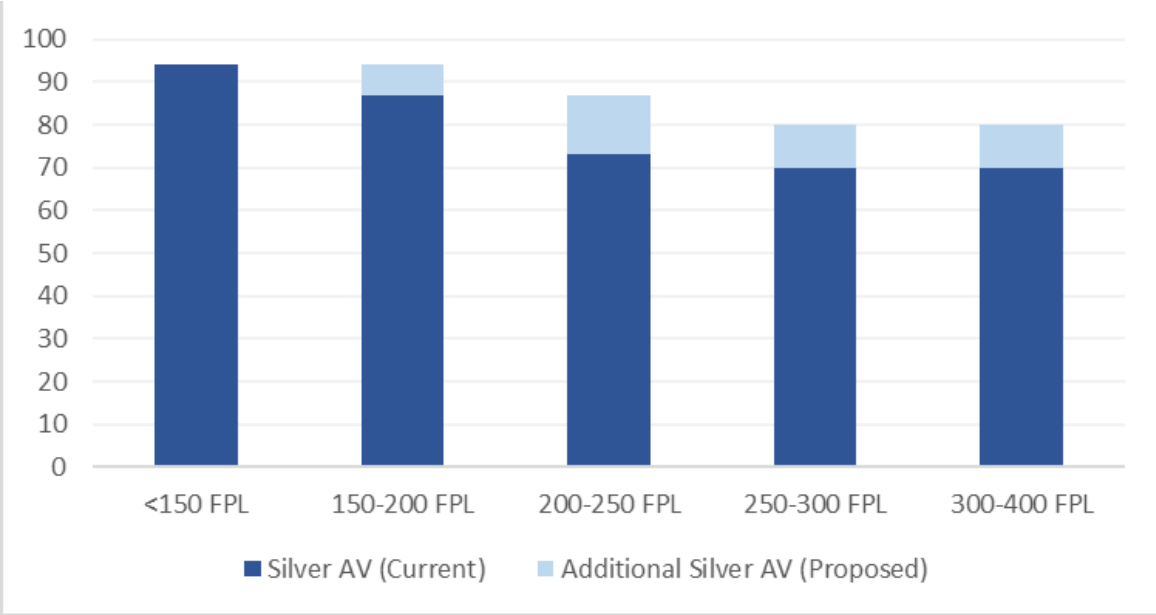
Figures show the difference in consumers' premiums as a percent of their income for $1,100 benchmark plan when a cap on premiums is added above 400 percent FPL





APPROACH 1: ENHANCEMENT TO COST-SHARING SUBSIDIES

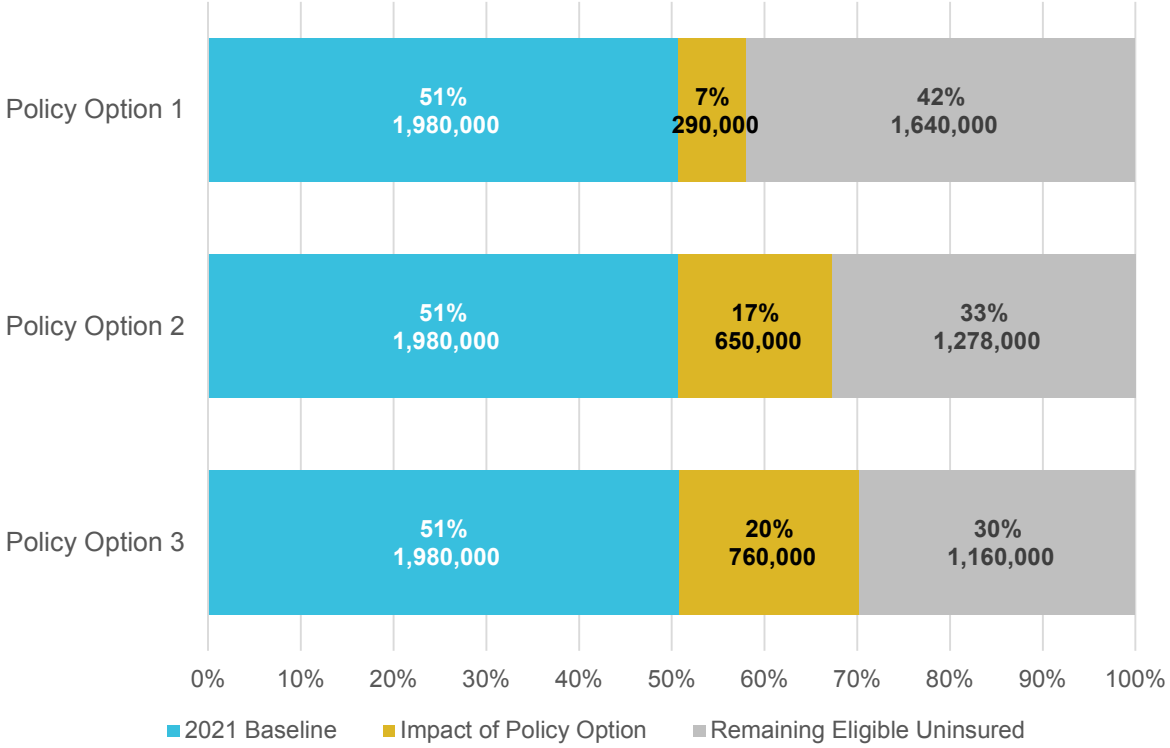
- Approach 1 enhances cost-sharing subsidies so that consumers up to 400 percent FPL receive at least Gold level coverage at a Silver premium price



APPROACH 1: ENROLLMENT, COVERAGE, PLAN CHOICE AND SPENDING IMPACTS

Summary of Approach 1 – Market-wide Affordability Enhancements				
	ACA Baseline 2021	**Policy Option 1**	**Policy Option 2**	**Policy Option 3**
Enrollment Increase		290,000	648,000	764,000
Individual Market Take Up Rate	51%	58%	67%	70%
Percent of Enrollees in Silver Coverage or Higher	69%	79%	77%	79%
New State Spending		**$2,209,000,00**	**$2,562,000,000**	**$4,201,000,000**
Premium Support		*$1,561,000,000*	*$1,886,000,000*	*$1,874,000,000*
Cost Sharing Support		*$649,000,000*	*$676,000,000*	*$604,000,000*
Reinsurance		*None*	*None*	*$1,724,000,000*
Potential State Spending Offsets				
Penalty Revenue		None	**$441,000,000**	**$393,000,000**
Potential 1332 Funding				**$1,132,000,000**
Change in Federal Tax Credit Expenditures		$670,000,000	$975,000,000	-$331,000,000

CHANGE IN INDIVIDUAL MARKET COVERAGE BY POLICY OPTION – 2021 PROJECTIONS



ILLUSTRATING THE VALUE OF ENHANCED AFFORDABILITY THROUGH CONSUMER SCENARIOS

	Alfonso		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	25	Monthly Premium (SLS)	$350	$343	$333	$299
Region	Low Cost Region	Net Premium	$136	$39	$39	$39
Income	$25,000	Net Premium Income Share	6.54%	1.89%	1.89%	1.89%
FPL	206					
		Federal Premium Subsidy	$214	$207	$196	$163
		New Premium Subsidy	$0	$97	$97	$97
		Silver Plan Medical Deductible	$2,200	$650	$650	$650
		Annual Penalty	None	None	$695	$695

	Bianca		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	45	Monthly Premium (SLS)	$720	$706	$684	$616
Region	Medium Cost Region	Net Premium	$329	$194	$194	$194
Income	$40,000	Net Premium Income Share	9.86%	5.83%	5.83%	5.83%
FPL	329					
		Federal Premium Subsidy	$391	$377	$355	$287
		New Premium Subsidy	$0	$134	$134	$134
		Silver Plan Medical Deductible	$2,500	None	None	None
		Annual Penalty	None	None	$700	$700

ILLUSTRATING THE VALUE OF ENHANCED AFFORDABILITY THROUGH CONSUMER SCENARIOS

	Don		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	45	Monthly Premium (SLS)	$720	$706	$684	$616
Region	Medium Cost Region	Net Premium	$720	$706	$684	$616
Income	$80,000	Net Premium Income Share	10.80%	10.58%	10.26%	9.23%
FPL	659					
		Federal Premium Subsidy	$0	$0	$0	$0
		New Premium Subsidy	$0	$0	$0	$0
		Silver Plan Medical Deductible	$2,500	$2,500	$2,500	$2,500
		Annual Penalty	None	None	$1,700	$1,700

	Erin and Francis		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	62	Monthly Premium (SLS)	$2,250	$2,205	$2,138	$1,924
Region	High Cost Region	Net Premium	$2,250	$578	$578	$578
Income	$75,000	Net Premium Income Share	36.00%	9.25%	9.25%	9.25%
FPL	456					
		Federal Premium Subsidy	$0	$0	$0	$0
		New Premium Subsidy	$0	$1,627	$1,559	$1,346
		Silver Plan Medical Deductible (family)	$5,000	$5,000	$5,000	$5,000
		Annual Penalty	None	None	$3,150	$3,150

APPROACH 1: MAIN TAKE-AWAYS

Premium and cost-sharing subsidies alone make significant gains in coverage

- Consumer cost (especially among subsidy ineligibles), behavioral frictions, low demand for insurance limit their impact on enrollment

Penalty Reinstatement

- Has large impact when paired with policies that make plans affordable; while decreasing the impact on State budget and inducing more federal spending

Reinsurance

- Only *direct* way modeled to improve affordability for people ineligible or not qualified for premium subsidies
- Cost of reinsurance depends on how 1332 waiver is applied

APPROACH 2: ENROLLMENT, COVERAGE, PLAN CHOICE AND SPENDING IMPACTS

Summary of Approach 2 – Targeted Affordability Enhancements			
Policy Objective	**Policy Options**	**New Enrollment**	**New State Cost**
Targeted improved affordability for consumers earning less than 400 percent FPL	**T1. Premium support** that lowers premium contributions for consumers earning less than 400 percent FPL	70,000	$425,000,000
	T2. Cost sharing support that reduces out-of-pocket costs for consumers between 200-400% FPL who do not qualify for more generous federal cost sharing subsidies	27,000	$215,000,000
Targeted improved affordability for consumers earning more than 400 percent FPL	**T3. Premium support that lowers premium contributions for consumers earning between 400 and 600 percent FPL**	**47,000**	**$285,000,000**
	T4. Premium support that lowers premium contributions for consumers earning more than 400 percent FPL	**50,000**	**$324,000,000**
	T5. Reinsurance that lowers premiums by 10 percent per year	**118,000**	**$1,456,000,000** *(**$878,000,000** potential offset from 1332 reinsurance waiver)*
Targeted improved affordability for consumers earning less than 600 percent FPL	**T6. Premium support** that lowers premium contributions for consumers earning less than 400 percent FPL	125,000	$765,000,000
	T7. Premium support that lowers premium contributions for consumers earning less than 400 percent FPL **and an individual mandate**	478,000	$891,000,000 *($482,000,000 potential offset from penalty revenue)*

AFFORDABILITY OPTION IMPLEMENTATION CONSIDERATIONS

Key considerations highlighted include:

- Determining the method for distribution of **premium subsidies** including whether advanceable or refundable
- Implementing the **cost-sharing subsidy** program in a way that integrates with the federal program and does not impact current program financing
- Conforming i**ndividual mandate** to federal individual mandate
- Developing a 1332 waiver strategy if **reinsurance** is desired

Modeling assumes implementation in 2021. Implementation timing considerations include:

- Covered California system and benefit design changes, rate negotiations and new consumer outreach programs.
- Franchise Tax Board system changes and consumer outreach for penalty implementation.

NEXT STEPS

- Final comments on draft report requested by Thursday, January 24, 2019
- Send comments to policy@covered.ca.gov
- Final report will be delivered to the Legislature and Governor, and posted on Covered California's website by February 1, 2019

PROPOSED NEW NAVIGATOR FUNDING MODEL FOR 2019 TO 2022

Terri Convey, Director, Outreach and Sales Division

Discussion

COVERED CALIFORNIA'S NAVIGATOR PROGRAM TODAY …page 1 of 2

- $6.475 MM annual program funding
- For 2018, about 40,000 consumers (2.5% of all enrolled on exchange) were enrolled through Navigators
- For 2018, about 60,000 consumers (3.5% of all enrolled on exchange) were enrolled through uncompensated Certified Application Entities (CAEs)
- Funding has successfully targeted hard-to-reach populations including Latinos and African Americans

Grant Year	Total Grant Funding	# of Entities	Grant Funding Range	Number of Effectuations	Average Grant
2018-19	**$6,475,000**	**42**	**$50,000-$500,000**	**Ongoing**	**$154,167**
2017-18	$6,425,000	43	$50,000 - $500,000	40,355	$149,419
2016-17	$7,100,000	46	$50,000 - $500,000	35,858	$154,348
2015-16	$10,550,000	69	$50,000 - $500,000	40,096	$152,899
2014-15	$10,886,569	65	$25,000 - $500,000	77,457	$167,486

COVERED CALIFORNIA'S NAVIGATOR PROGRAM TODAY …page 2 of 2

- Over 100 awardees (42 lead Navigator grantees and 60 subcontractors)
- Navigator program reach extends to 72% of population within 15 minute drive of a location
- Navigators enroll, educate and provide assistance to consumers and they conduct outreach activities including targeted population strategies, public enrollment, media, and publicity events
- Navigator grants are based on performance goals that count consumer plan selections and some but not all renewals

Grant Year	Total Grant Funding	# of Entities	Grant Funding Range	Number of Effectuations	Average Grant
2018-19	**$6,475,000**	**42**	**$50,000-$500,000**	**Ongoing**	**$154,167**
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2014-15	$10,886,569	65	$25,000 - $500,000	77,457	$167,486

COVERED CALIFORNIA'S NAVIGATOR PROGRAM REFRESH…page 1 of 2

Potential Request for Application (RFA) for 2019 – 2022 to be released March 2019

- Funding to be determined – (analysis is underway)
- Navigators chosen on RFA selection criteria
  - Geographic reach
  - Ability to reach targeted populations (Latinos, African Americans, etc.)
  - Outreach activities to include event attendance and successful publicity and social media campaigns
- Navigator grants will be awarded in increments of $25,000 with a minimum award at $50,000

COVERED CALIFORNIA'S NAVIGATOR PROGRAM REFRESH…page 2 of 2

- Navigator grant funds distributed in five equal payments with final payment to increase or decrease based on count of effectuated enrollment. Can go up/down by $30 per effectuated enrollment if above/below goal (likely 3-6% of award "at risk")
- Navigator grants are based on performance goals that are based on effectuated new enrollments and renewals and are specifically intended to support outreach activities including earned and social media

COVERED CALIFORNIA NAVIGATOR PROPOSED SCOPE OF WORK 2019-2022…page 1 of 2

The following is a broad scope of the major expectations of Navigator organizations.

- Agree to a performance goal, assist consumers enroll with Covered California, and maintain expertise in eligibility and enrollment
- Submit strategic work plan and campaign strategy, submit bi-monthly reports, collaborate with Covered California staff on outreach efforts, and serve underserved or vulnerable populations
- Perform enrollment services, outreach and education at publicly accessible events
- Provide post-enrollment support to ensure successful enrollment and retention
- Comply with regulations protecting consumer personally identifiable information, privacy and security
- Provide consumers with information regarding the process of filing eligibility appeals
- Provide referrals to licensed Tax advisors

COVERED CALIFORNIA NAVIGATOR PROPOSED SCOPE OF WORK 2019-2022…page 2 of 2

- Participate in events, press-conferences, meetings and webinars
- Ensure consumer assistance is culturally and linguistically appropriate for population served, accessibility to consumers with disabilities, and that no consumer
- Ensure that counselors comply with program requirements such as annual training and certification, following policy, and maintaining active contact information
- NEW FOR 2019 – Promote Covered California eligibility and enrollment through earned media and social media platforms and report key metrics on a bi-monthly basis
  - A comprehensive scope of work will be included in the Request for Application solicitation

KEY ELEMENTS OF PROPOSED NAVIGATOR PROGRAM REFRESH

Performance-based funding model

1. Grant amount determined by prior year productivity
2. Grant amount adjusted every year based on prior year performance (e.g., an entity that exceeds goal by 100 effectuations may be eligible for a $25,000 funding increase in the following grant year)
3. Productivity over/under goal will adjust final distribution (20% of total grant) by ±$30 per effectuated enrollment above/below performance goal. Example: if an entity with a $100,000 grant misses goal by 100 effectuations final payment will be $17,000 ($20,000 - $3,000 [100 X $30])
4. Over-goal performance payment adjustment could be withheld if Navigator does not meet expectations in social/earned media, attendance at press events, and contract compliance
5. Under-goal performance adjustment could be “earned back” via strong social/earned media performance

PROPOSED CHANGES TO FUNDING MODEL FOR COVERED CALIFORNIA NAVIGATORS

	Plan Selections counted toward enrollment goal	New Effectuated Enrollments counted toward enrollment goal	Active Renewals counted toward enrollment goal	Passive Renewals counted toward enrollment goal	Social & Earned Media included in Scope of Work
OLD MODEL	✓	NO	✓	NO	NO
NEW MODEL	NO	✓	✓	✓	✓

GAP IDENTIFICATION FOR TARGETED AREAS

- Navigators currently reach 72% of population within 15-minute drive time
- Navigators + uncompensated Certified Application Entities reach 91% of population within 15-minute drive time
- Densely-populated urban areas have an adequate certified counselor presence
- Identified 37 zip codes that are not within 15-minute drive time of certified counselor locations where total resident population in zip code exceeds 1,000 people
- Grouped zip codes by meta-region to establish “sales territories” for pilot project

TARGETED GEOGRAPHIC REACH PILOT

- Navigators may apply to receive $25,000 funding above core funding to target one of four rural regions
- Funding will be paid one lump sum at the beginning of the grant year

Meta-Regions	# of target zip codes	Total Population 2017
Greater Yosemite	10	46,091
San Bernardino County	8	34,885
North of Redding	8	26,270
Sierra Foothills	11	47,630
Grand Total	37	154,876

CERTIFIED APPLICATION COUNSELOR PROGRAM PERMANENT REGULATIONS FOR ADOPTION

Brian Kearns, Attorney, Office of Legal Affairs

Discussion

CERTIFIED APPLICATION COUNSELOR PROGRAM

- The Office of Legal Affairs requires Board approval to complete the permanent rulemaking process for the Certified Application Counselor (CAC) regulations.
- The CAC regulations are currently emergency regulations. This rulemaking package seeks to make all emergency regulations permanent. The Board previously approved the emergency regulations on April 6, 2015.
- The Office of Legal Affairs commenced the permanent rulemaking process on December 28, 2018, by providing notice to all interested parties.
- The 45-day public comment period will run from December 28, 2018 to February 11, 2019.

CERTIFIED APPLICATION COUNSELOR PROGRAM

- The rulemaking package does not make any major changes to the emergency regulations that the Board previously approved.
- Most changes address minor grammatical issues, update citations to federal regulations, and clarify training deadline requirements.
- There are two noteworthy changes:
  - Section 6854(a) has been amended to clarify that any person with legal authority can execute the Certified Application Entity agreement on behalf of the entity.
  - Section 6860(d) has been updated to include a deadline to complete annual recertification training.

CERTIFIED APPLICATION COUNSELOR PROGRAM

- Government Code section 100500(a)(6) requires the Board to discuss proposed regulations at a properly noticed meeting before adopting them.

- The Office of Legal Affairs intends to return to the Board at the completion of the public comment period to request final Board approval to file the permanent regulation package with the Office of Administrative Law.