



COVERED CALIFORNIA POLICY AND ACTION ITEMS

June 26, 2019 Board Meeting

CALIFORNIA INDIVIDUAL MARKET STABILIZATION AND AFFORDABILITY PROPOSALS

Katie Ravel, Director of Policy, Eligibility and Research

Action

CURRENT AFFORDABILITY PROPOSALS

- The Legislature passed budget and trailer bills* that, if signed by the Governor, will:
 - Establish a California individual mandate and penalty starting in 2020.
 - Establish a state subsidy program providing premium subsidies over the next three years for eligible individuals with incomes at or below 138 percent of the Federal Poverty Level (FPL) and above 200 and at or below 600 percent of the FPL.

*AB 74 (Committee on Budget), AB 105 (Committee on Budget), and SB 106 (Committee on Budget and Fiscal Review) provide the appropriations for the state subsidy program, along with income eligibility, and specified funding allocation by eligibility levels.

AB 78 (Committee on Budget) and SB 78 (Committee on Budget and Fiscal Review) are the omnibus health trailer bills which establish the individual mandate and penalty, as well as the requirements for the state subsidy program.

KEY ELEMENTS OF THE STATE SUBSIDY PROGRAM

- The proposed individual mandate and penalty would closely mirror the federal structure that was in place prior to the penalty being “zeroed out” by Congress.
- The proposed budget bill appropriates \$428,629,000 for plan year 2020 for state premium subsidies for consumers at or below 138 percent FPL and above 200 and at or below 600 percent FPL.
- The budget bill directs Covered California to allocate approximately 17 percent of funding to individuals above 200 and at or below 400 percent FPL and the remaining 83 percent to individuals at or below 138 percent FPL and above 400 and at or below 600 percent FPL.
- To receive state subsidies, individuals must purchase coverage through Covered California and otherwise meet eligibility requirements for federal premium subsidies, except for the income requirements for the 400 to 600 percent FPL population.

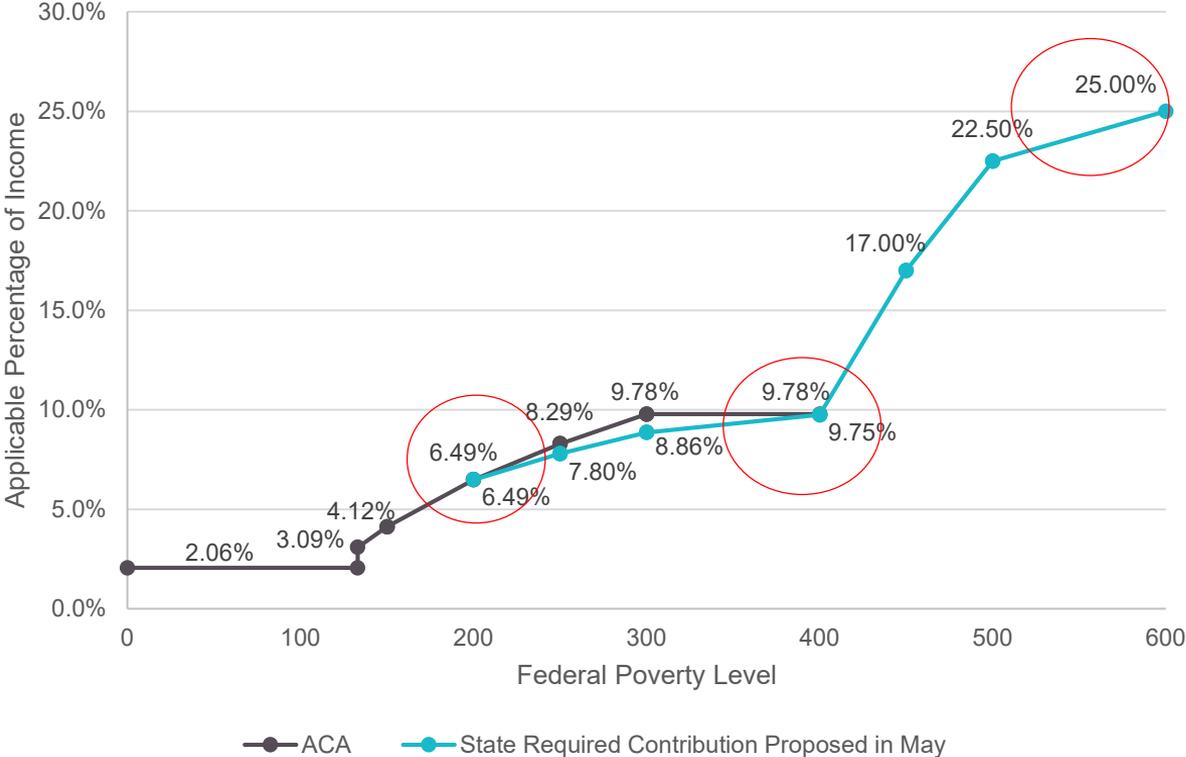
KEY ELEMENTS OF THE STATE SUBSIDY PROGRAM CONT.

- Subsidies would be advanceable and would be reconciled at year-end through the Franchise Tax Board.
- The California penalty would be permanent but the amount of the penalty would be offset if the federal penalty was reinstated.
- The state financial assistance program would sunset December 31, 2022.

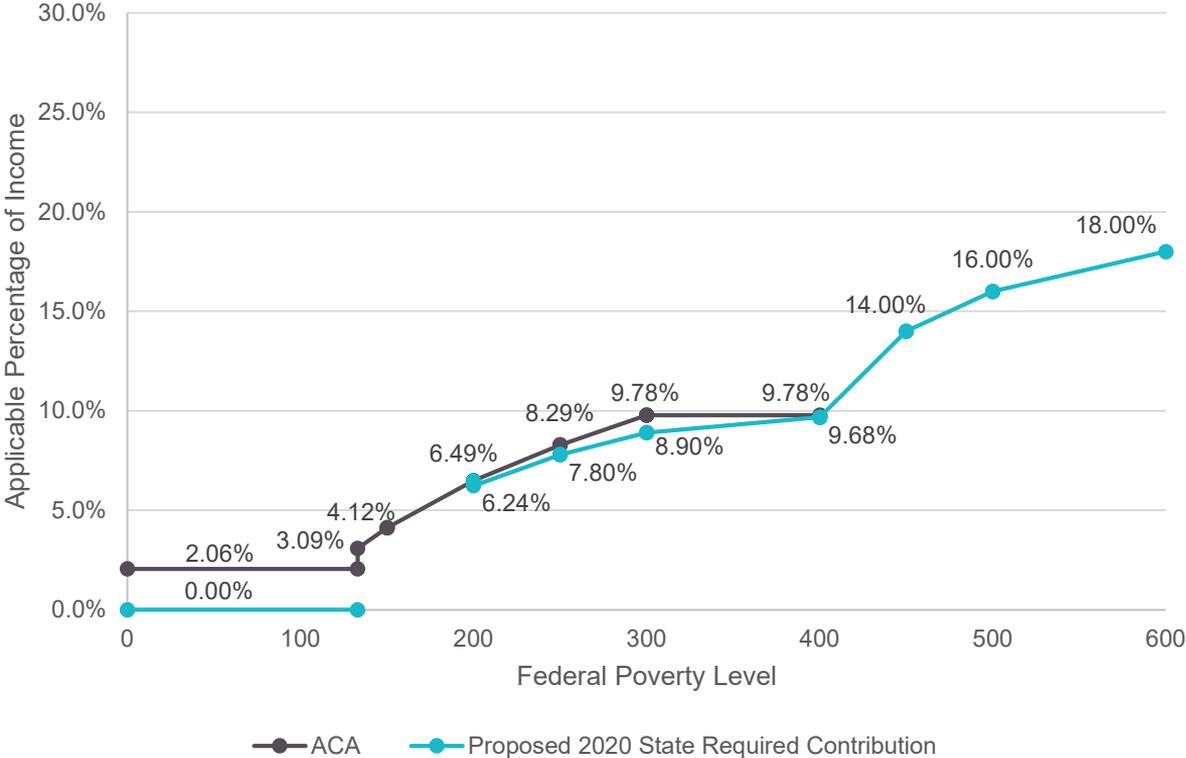
ANNUAL SUBSIDY PROGRAM DESIGN CYCLE

- State Budget process provides Covered California: (1) required use(s) of funding; (2) appropriation; and (3) allocation of funding above and below 400 percent FPL.
- Covered California Board to adopt annual program design in accordance with budget targets.
- Covered California to submit program design to Director of the Department of Finance for approval following notification to the Joint Legislative Budget Committee.

STATE REQUIRED CONTRIBUTION LEVELS FOR 2020 AS PRESENTED IN MAY BASED ON MAY REVISION



2020 STATE REQUIRED CONTRIBUTION LEVELS PROPOSED FOR ADOPTION BASED ON BUDGET BILL



MODELING OF KEY IMPACTS OF BUDGET AGREEMENT

Projected Outcomes, Coverage Year 2020	Total	Below 400% FPL	Above 400% FPL
Number of Individuals Eligible to Receive a State Subsidy	922,000	687,000	235,000
Estimated Number of Newly Insured Individuals through Covered California	187,000	88,000	99,000
Projected State Subsidy Cost (\$ millions)	\$421,000,000	\$86,000,000*	\$335,000,000

*Total includes an estimated \$81 million for enrollees between 200 and 400% FPL, and \$5 million for enrollees at or below 138% FPL.

Note: we estimate that an additional 42,000 Californians would be newly insured off-exchange under this proposal.

Economists Wesley Yin, University of California at Los Angeles, and Nicholas Tilipman, University of Illinois at Chicago, along with Covered California staff, have analyzed the potential impacts of the proposals on both Covered California's enrollment and the cost to the state of providing these subsidies.

YEAR-END CONSUMER RECONCILIATION OF ADVANCED PREMIUM SUBSIDIES

- State premium subsidies will be reconciled at year-end through the Franchise Tax Board.
- Reconciliation adjusts consumers' final premium subsidy based on their year-end income compared to the income they projected when they applied for coverage.
- Repayment of the federal premium tax credit is capped for individuals whose year-end income is at or below 400 percent FPL, while those above 400 percent FPL must repay the entire amount of credit they received in advance.
- Covered California will amend its program design for discussion in August, and adoption in September, to include reconciliation repayment caps. In developing recommendations, staff will consider:
 - Budget considerations
 - Federal caps and the relationship of the caps to the premium subsidies received by consumers
 - Extension of caps beyond 600 percent FPL to mitigate the impact of the cliff

INDIVIDUAL MANDATE PROPOSAL

- Would require California residents to enroll in and maintain minimum essential coverage, receive an exemption, or pay a penalty.
- Generally mirrors the federal individual mandate and penalty with adjustments for California's filing threshold and other adjustments needed for a state-level penalty.
- Franchise Tax Board would collect the penalty through the income tax system.
- Covered California would grant exemptions year-round for hardship and religious conscience; Franchise Tax Board would grant additional exemptions (e.g., low income, unaffordability of coverage, short-term gaps in coverage) through the filing process.

COVERED CALIFORNIA'S ROLE IN THE ADMINISTRATION'S INDIVIDUAL MANDATE PROPOSAL

- Administration's proposal requires Covered California to administer exemptions for hardship and religious conscience.
 - Hardship includes financial hardship and other life circumstances that would prevent an individual from obtaining coverage
 - Hardship exemptions can be granted throughout the year and entitle a consumer to purchase a catastrophic plan if desired
- Using data provided by the Franchise Tax Board, Covered California will perform outreach to individuals who pay the penalty or receive exemptions.

COVERED CALIFORNIA'S ROLE IN ESTABLISHING THE PREMIUM SUBSIDIES: PROGRAM DESIGN DOCUMENT

- Administration's proposal requires Covered California's Board to adopt an annual program design document.
- For the 2020 benefit year, the program design document must establish eligibility levels and reconciliation caps designed to meet budget targets and required funding allocation to direct 83 percent of the funding to individuals at or below 138 percent FPL and above 400 percent FPL.
- Staff is requesting Board adoption of the 2020 program design without reconciliation caps; however, in August, staff will return with an amended program design detailing the reconciliation caps for Board discussion.

OVERVIEW OF THE PROGRAM DESIGN DOCUMENT

The program design document has five main components:

1. Establishes the required contribution amounts for the state premium subsidy for 2020. The amounts are based on modeling performed by Covered California and designed to meet the budget parameters.
2. Establishes the calculation of the advanced payment of the state premium subsidy which mirrors the calculation of the federal premium tax credit with the exception that the advanced payment of the state premium subsidy amount is reduced by any federal advance payment of the premium tax credit. The consumer's total monthly credit will be the difference between the gross premium for the second lowest cost silver plan and the consumer's income-based required contribution.
3. Establishes eligibility requirements for state premium assistance that mirror the requirements for the federal premium tax credit with the exception of the federal income limits for those above 400 percent FPL.
4. Defines key terms related to the calculation of the state premium assistance.
5. Reserves reconciliation repayment limits for a future amendment to the document.

IMPLEMENTATION CONSIDERATIONS

2020 Rates:

- Finalize rates in early July and transmit to State Regulators

System Development for Key Operations:

- Eligibility determinations begin in October for the 2020 plan year
- Carrier payments of state premium subsidy begins first quarter of 2020
- Reconciliation of state subsidies begin first quarter of 2021

Expenditure Monitoring:

- Within a benefit year, budget bill provides mechanism to request a funding augmentation should expenditures exceed program funding

KEY MILESTONES AND NEXT STEPS

Key Milestones	Dates
Two Program Design Stakeholder Meetings	June 2019
Qualified Health Plan Preliminary Rates Announcement	July 2019
CalHEERS System Testing	July – September 2019
Reconciliation Cap Development	August – September
Program Regulations Development	August – September
Start of Renewal for 2020 Benefit Year	October 2019

BOARD ACTION REQUESTED

Approve the 2020 Program Design as presented to the Board today, contingent upon the Governor's approval of the underlying bills.

COVERED CALIFORNIA FY 2019-20 REVENUE, BUDGET AND ASSESSMENT PROPOSAL

Peter V. Lee, Executive Director
Karen Johnson, Chief Deputy Executive Director, Operations

REVIEWED AT MAY BOARD MEETING

- FY 2018-19 financial update to projected revenue and expenditures.
- FY 2019-20 proposed enrollment, revenue and multi-year outlook from both a 'steady state' and a state subsidy and individual mandate perspective.
- FY 2019-20 proposed operating budget and capital projects reserve budget.
- Proposed assessment fee rate for plan year 2020.

STATE SUBSIDY AND INDIVIDUAL MANDATE

- Recent legislation passed that will enact a new state subsidy program and individual mandate beginning January 1, 2020 and appropriates \$428.6 million in 2020, \$479.7 million in 2021, and \$547.1 million in 2022 from the General Fund to provide advanceable premium assistance subsidies during the three coverage years.
- This appropriation does not increase Covered California's operating budget, augment the California Health Trust Fund, change the agency's status as an independent public entity, or impede the Board's authority to authorize expenditures from the California Health Trust Fund to pay program expenses to administer operations.

ENROLLMENT/REVENUE FORECAST

The Base enrollment forecast reflects an increase of approximately 300,000 new enrollees in 2020 of which approximately 188,000 are anticipated to be currently uninsured and as many as 118,000 are anticipated to transition from off-exchange to on-exchange policies.

Effectuated Enrollment (Fiscal Year End)				
Scenario	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
High	1,370,413	1,678,880	1,797,510	1,887,563
Base	1,362,052	1,595,887	1,646,057	1,676,695
Low	1,361,251	1,460,054	1,408,488	1,373,395

Plan Assessments-Cash Basis (Dollars in Millions)				
Scenario	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
High	\$371.8	\$402.8	\$457.4	\$482.5
Base	\$371.7	\$394.9	\$435.2	\$441.7
Low	\$371.6	\$384.2	\$392.9	\$376.3

Plan Assessments include Individual and Covered California for Small Business

COVERED CALIFORNIA MULTI-YEAR FINANCIAL OUTLOOK

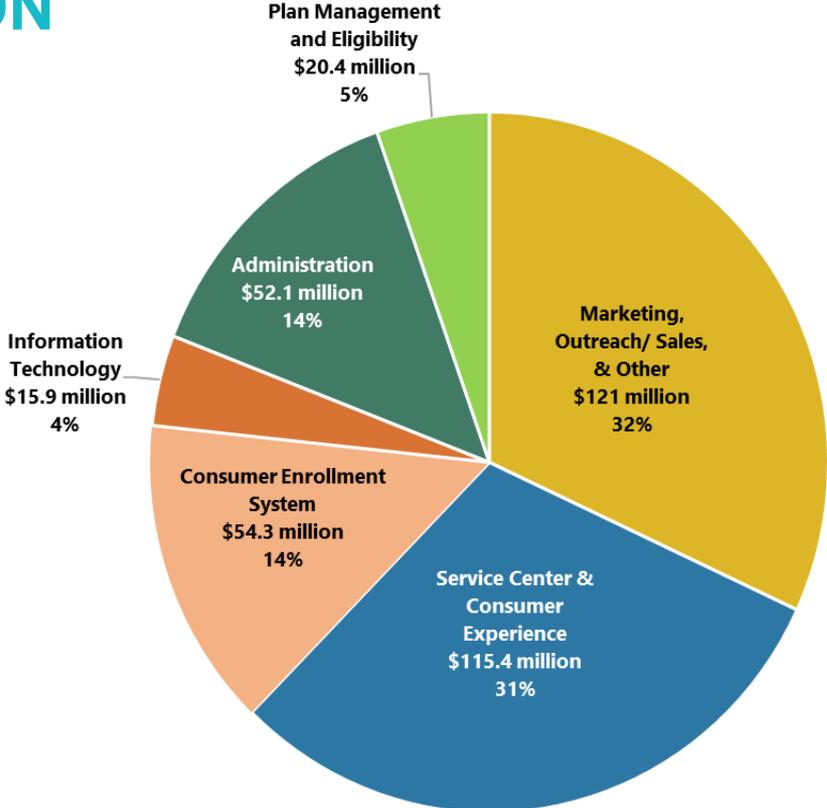
BASE ESTIMATE

<i>Dollars in Millions</i>	<i>FY 2018-19 Approved Budget</i>	<i>FY 2018-19 Projected Actuals</i>	<i>FY 2019-20 Projected</i>	<i>FY 2020-21 Projected</i>	<i>FY 2021-22 Projected</i>
Effectuated Enrollment (fiscal year end)	1,201,447	1,362,052	1,595,887	1,646,057	1,676,695
Opening Reserve Balance	\$313.6	\$325.6	\$347.2	\$343.0	\$360.1
Plan Assessments-Cash Basis	\$351.1	\$371.7	\$394.9	\$435.2	\$441.7
Projected Operating Expenditures	(\$340.2)	(\$320.0)	(\$379.1)	(\$398.1)	(\$418.0)
Margin Contribution - Cash Basis	\$10.9	\$51.7	\$15.8	\$37.1	\$23.8
Capital Projects Reserve	(\$10.0)	(\$30.0)	(\$20.0)	(\$20.0)	(\$20.0)
Year-End Operating Reserve	\$314.5	\$347.2	\$343.0	\$360.1	\$363.9
<i>Number of months of reserve</i>	<i>10.9</i>	<i>11.0</i>	<i>10.3</i>	<i>10.3</i>	<i>10.4</i>

The Base estimate includes:

- ❑ Enrollment gains of 300K in 2020 from state subsidies and mandate.
- ❑ 2020 Average premium growth: 4.6% (Medical Trend +7.0%, State Mandate -4.0%, HIT +1.6%)
- ❑ An assessment rate reduction from 3.75% to 3.5% for plan year 2020, 3.25% in 2021 and 3.0% in 2022.
- ❑ FY 2019-20 expenditures of \$379.1M are based on the proposed expenditures, with the out year expenditures projected to increase at 5% per year.
- ❑ Plan assessments revenue includes CCSB revenue of \$17.3M in FY 2019-20 and \$20.2M in FY 2020-21.

PROPOSED FY 2019-20 OPERATING BUDGET OF \$379.1 MILLION



COVERED CALIFORNIA'S FY 2019-20 SUMMARY UPDATES FROM MAY PROPOSED BUDGET

- The Board is being asked to formally set Covered California's enrollment assessment rates for benefit year 2020, and to formally approve the Budget for FY 2019-20.
- Changes to the FY 2019-20 Proposed Budget presented in May total \$17.7 million and include:
 - An increase over three years for enhancements to the CalHEERS system in support of state subsidy activities of \$9.33 million in FY 2019-20, which includes a shift in funding years and overall increase of \$4.7 million;
 - An increase in Marketing efforts to educate consumers about the individual mandate and promote enhanced state subsidy assistance to consumers of \$10 million; and
 - An adjustment of (\$1.54) million for minor technical and baseline adjustments.
- The FY 2019-20 Proposed Budget of \$399.1 million includes:
 - An operating budget of \$379.1 million, along with 1,386 positions; and
 - Funding for the capital projects reserve of \$20 million for facility related projects.
- A proposed reduction in assessment rates to 3.5 percent of premium on Qualified Health Plans, including dental plans, for benefit year 2020 with an average rate of 2.3 percent when including those enrolled in mirrored products off the exchange.
- The recommended rate for CCSB policies remains at 5.2 percent of premiums.

RECOMMEND APPROVAL OF COVERED CALIFORNIA'S FY 2019-20 BUDGET AND 2020 ASSESSMENT RATES

Covered California recommends that the Board adopt Board Resolution 2019-42 to:

- Approve the Operating Budget for Fiscal Year 2019-20, providing expenditure authority of \$379,145,590.
- Approve the Capital Projects Reserve Budget and appropriate \$20,000,000 from unspent operating funds in Fiscal Year 2018-19 and \$20,000,000 for Fiscal Year 2019-20, for a total reserve of \$60,000,000. Expenditures from the Capital Projects Reserve in excess of \$1,000,000 in value will require Board review and approval. Any unexpended funds will remain in the Capital Projects Reserve and be made available for expenditure in subsequent fiscal years.
- Grant authority to the Executive Director to make adjustments to the Operating Budget, provided that Fiscal Year 2019-20 expenditures remain at or below the level of expenditure authority approved by the Board; and that any material adjustments to program budgets and positions must be reported to the Board.
- For plan year 2020, charge a per-member per-month assessment of 3.5% of premiums on Qualified Health Plans, including dental plans, sold through the individual exchange and 5.2% of premiums for such plans sold through Covered California for Small Business.

STAKEHOLDER CONSULTATION PLAN AMENDMENT

Doug McKeever, Chief Deputy Executive Director of Program

Action

SUMMARY

- In 2012, the Board established the following three advisory groups to provide advice, recommendations, and to serve as sounding boards to the Covered California Board and staff (Resolution 2012-54):
 - **Plan Management Advisory Group:** to advise on qualified health plan selection, monitoring, recertification, decertification, quality rating, and standard benefit designs.
 - **Marketing, Outreach and Enrollment Assistance (MOEA) Advisory Group:** to advise on marketing strategies by target population and media channel, effective community outreach strategies, and strategies for providing in-person assistance with enrollment in insurance affordability programs.
 - **Small Employer Health Options Program (SHOP) Advisory Group:** to advise on strategies to raise interest in the SHOP and ensure that it provides value for small employers.

SUMMARY

- The Board established requirements for the scope, structure, and membership composition of each of the advisory groups
- Since 2012, the advisory groups have matured and each have their own unique membership needs and meeting cadence
 - For example, in October, 2018, the Board increased the membership of MOEA to 30 members.
 - On March 7th, 2019, the MOEA Advisory Group membership approved a new charter that determined meeting a minimum of twice per year was sufficient.
 - The topics of discussion for the SHOP Advisory Group are now better suited for the Plan Management Advisory Group.
 - The Plan Management Advisory Group continues to meet on a monthly basis, one week prior to a meeting of the Board of Directors.

RECOMMENDATION TO THE BOARD

- Transfer the SHOP Advisory Group functions to the Plan Management Advisory Group so that the two advisory groups are the:
 - Marketing, Outreach and Enrollment Assistance Advisory Group, and
 - Plan Management Advisory Group
- Direct the Marketing, Outreach and Enrollment Assistance Advisory Group to establish a charter, which shall be approved by the Executive Director, that is consistent with the scope and membership composition established by the Board and that meets at least twice per year.

ELIGIBILITY AND ENROLLMENT REGULATIONS, COVERED CALIFORNIA FOR SMALL BUSINESS (CCSB) AUTHORIZATION TO SUBMIT EMERGENCY RULEMAKING PACKAGE TO THE OFFICE OF ADMINISTRATIVE LAW

Andrea Rosen, Office of Legal Affairs

Action

BACKGROUND

- Covered California was granted emergency rulemaking authority by the Legislature through January 1, 2022 for the eligibility and enrollment regulations for the individual and small business exchanges.

BACKGROUND, CONT.

- CCSB regulations currently limit the charge for processing a check returned to Covered California for nonsufficient funds to \$25.
- This amount represents a fraction of the cost of actually processing a nonsufficient fund payment.
- Government Code 100504 and 100503 authorizes the Board to adopt regulations to operate CCSB including this one.
- CCSB would like to recover the actual costs of processing a payment returned for insufficient funds while staying competitive.

PROPOSED REGULATORY CHANGES

- Program proposes amendments to recover the actual costs of processing a payment returned for insufficient funds.
- Reasonable charges for this service are to be set by Covered California annually.
- Amendments would also require employers to submit a money order or cashiers check after two non-sufficient payments within a 12-month period.
- Notice of annual charge will be included on the premium billings.

PROPOSED REGULATORY CHANGES

6532(e) If a qualified employer makes a premium payment via check that is returned unpaid for any reason, ~~the SHOP shall apply a \$25.00 insufficient funds fee.~~ reasonable charge for the returned check that reflects the actual cost incurred for processing returned checks. A reasonable charge for this service shall be set annually by Covered California ,shall not exceed actual costs incurred and the same charge shall apply to each check returned for non-sufficient funds. This charge will be noticed annually to all qualified employers on the premium billing. When a second payment is returned unpaid for any reason, the qualified employer is required to submit premium payment and the charge for insufficient funds and ongoing monthly payments in the form of a cashier's check or money order for a period of 12 months beginning the first of the month following the last paid through date. If payment is not submitted in one of these two forms, the qualified employer group may be subject to termination of non-payment as described in 6538 (c)(2).

NEXT STEPS

- Government Code section 100504(a)(6) requires the Board to discuss proposed regulations at a properly noticed meeting before adopting them.
- The Board discussed the regulation package during the Board meeting on May 16, 2019.
- The Office of Legal Affairs now requests the Board to formally adopt the regulation package so it can be filed with the Office of Administrative Law.

IDENTITY VERIFICATION REGULATIONS - AUTHORIZATION TO SUBMIT PERMANENT RULEMAKING PACKAGE TO THE OFFICE OF ADMINISTRATIVE LAW

Crystal Hirst, Office of Legal Affairs
Discussion

BACKGROUND

- The Office of Legal Affairs requires Board approval to complete the permanent rulemaking process for the identity verification regulations.
- The identity verification regulations are currently emergency regulations. This rulemaking package seeks to make the emergency regulations permanent. The Board previously approved the emergency regulations on October 27, 2016.
- The Office of Legal Affairs commenced the permanent rulemaking process on May 3, 2019, by providing notice to all interested parties.
- The 45-day public comment period ran from May 3, 2019 to June 21, 2019. Covered California received no comments.

HIGHLIGHTS

- The rulemaking package does not make any major changes to the emergency regulations that the Board previously approved.
- The changes address minor grammatical issues and update citations to federal regulations.
- There are two noteworthy changes:
 - Section 6464(a)(3)(A) has been amended to incorporate by reference the federal regulation defining Service Center Representative.
 - Section 6464(a)(3)(C) has been amended to incorporate by reference the federal regulation defining Certified Application Counselor.

DISCUSSION

- Government Code section 100504(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 to request final Board approval to file the permanent regulation package with the Office of Administrative Law.

COVERED CALIFORNIA MODEL CONTRACT REFRESH: EXPECTATIONS DEVELOPMENT

Discussion

James DeBenedetti, Director, Plan Management

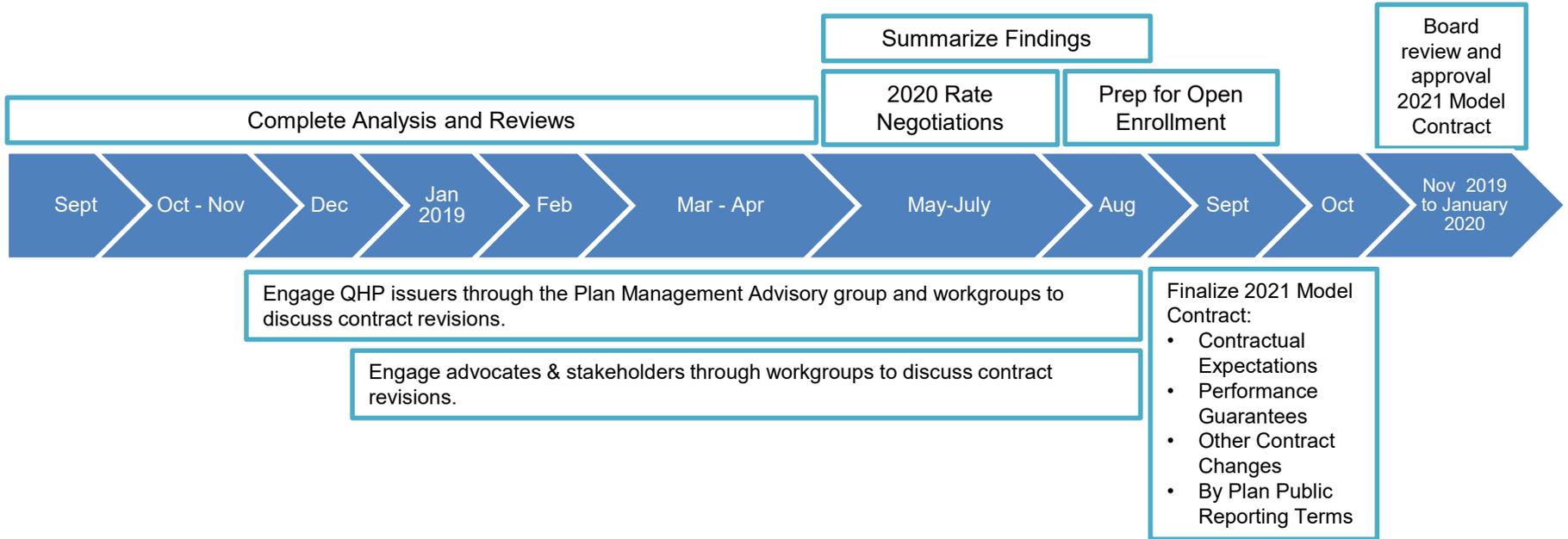
INTRODUCTION: 2021 – 2023 MODEL CONTRACT REFRESH

- Covered California is preparing to refresh the QHP and QDP Issuer Model Contract for the 2021 – 2023 contract period.
- We expect to update the contractual expectations of issuers, refresh the performance guarantees, and define terms for public reporting on individual issuer performance.
- This refresh will include updating our standards and requirements for quality improvement and delivery system reform. The “Quality, Network Management, Delivery System Standards and Improvement Strategy” (also known as Attachment 7) of Covered California’s current issuer contract is available online at https://hbex.coveredca.com/insurance-companies/PDFs/Attachment_7_2019_MOD_Final.pdf.

GUIDING PRINCIPLES FOR DEVELOPING EXPECTATIONS OF HEALTH PLANS 2021-2023

1. Driven by the desire to meet two complementary and overlapping objectives:
 - **Assuring Quality Care:** Ensure our members receive the right care, at the right time, in the right setting, at the right price.
 - **Effective Care Delivery:** 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.
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.

EXPECTATIONS DEVELOPMENT APPROACH: TIMELINE



EXPECTATIONS DEVELOPMENT APPROACH: REFRESHING COVERED CALIFORNIA'S STRATEGY (page 1 of 2)

To inform this refresh, Covered California has initiated four efforts that will be used to engage issuers, providers, advocates and other stakeholders as we propose revisions to the contract.

- 1. Expert Reviews:** review and synthesis of the available evidence base for Assuring Quality Care and Effective Care Delivery Strategies, organized in the following projects:
 - *Measurement Review and Benchmarking (PwC):* Identify relevant measures, benchmarks and data sources to provide valid comparison points for current expectations and performance standards for QHP issuers and Covered California's population overall.
 - *Purchaser Strategy 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 or administrative burden.

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

- 2. Covered California Experience Report:** Summary of QHP issuer progress through the 2018 plan year in meeting the quality improvement and delivery system reform requirements in the 2017 – 2020 contract.
- 3. QHP Issuers:** Covered California sought to understand each issuer's intended direction, investment strategy, and perspective on how best to ensure right care is being delivered and how delivery system change is being fostered through the *Request for Input* questionnaire from the January Board meeting. Covered California will be using issuer responses to inform the expectations refresh and will continue to engage with issuers through the Plan Management Advisory group.
- 4. Other Stakeholders:** Covered California sought input from diverse stakeholders, including providers, consumers, purchasers, and regulators through the *Request for Input* questionnaire from the January Board meeting. Covered California will be using these responses to inform the expectations refresh and will continue to engage with stakeholders through the Plan Management Advisory group.

RESPONDENTS TO REQUEST FOR INPUT TO INFORM REFRESHING EXPECTATIONS

Covered California received input from the following stakeholders through the *Request for Input* questionnaire from the January Board meeting:

- 10 of the 11 QHP issuers
- America's Physician Groups (APG)
- California Medical Association (CMA)
- California Hospital Association (CHA)
- California Primary Care Association (CPCA)
- Private Essential Access Community Hospitals (PEACH)
- Medical groups and provider organizations
- California Pan-Ethnic Health Network
- Health Access
- Western Center on Law and Poverty (WCLP)
- National Health Law Program
- Regional Asthma Management and Prevention (RAMP)
- Francois de Brantes, Remedy Partners
- Peggy O'Kane, NCQA
- James Robinson, UC Berkeley

EXPERT REVIEW: SUMMARY OF PWC PURCHASER STRATEGY REVIEW

- PwC interviewed 5 large employers, 9 health plans, 2 government entities, and 6 “other” purchasers (national coalitions, pharmacy benefit managers, etc.)
- **Assuring Quality Care:** Purchasers generally acknowledge all areas are important, but Chronic Care, Complex Care and Mental Health & Substance Use Disorder Treatment were most frequently cited as highest priority areas. Hospital care, preventive services and pharmacy management were next cited as areas of focus, with employers giving more weight to pharmacy management than some of the other purchasers interviewed.
- **Effective Care Delivery:** Purchasers cited networks based on value and integrated delivery systems or ACOs as highest priority areas as well as alternate sites of care delivery. Primary care promotion is also viewed as important, but those efforts are considered to be captured in the integrated care approaches. Payment and channeling of members each play a significant role in this area and many purchasers cited the need to develop common measure sets for provider level reporting.

EXPERT REVIEW: SUMMARY OF PWC MEASUREMENT REVIEW AND BENCHMARKING (page 1 of 2)

- Alignment of measures with those used by other purchasers and regulatory agencies minimizes reporting burden, provides an opportunity to compare performance, to establish relevant benchmarks or performance targets for measures with credible and consistent data, and to drive desired health plan and health care system performance change.
- Available data and benchmarks are limited or may not be directly relevant (e.g., based on Medicaid or Medicare populations) to assess QHP performance for many Attachment 7 measures.
- Systemic issues limit the data available for many of the strategies, some of which can be addressed through the key drivers and collaboration opportunities identified in the Purchaser Strategy review.
- Covered California has access to a robust data claims and encounter data set submitted by QHP Issuers and should dedicate sufficient resources to analyze that data to develop its own baselines and trends for additional measures and to improve its understanding of the Covered California enrolled population.
- Covered California should continue to leverage data collection by other California purchasers and regulatory agencies (e.g., Integrated Healthcare Association, Office of the Patient Advocate, Department of Managed Health Care, Department of Health Care Services) to minimize health plan reporting burden.

EXPERT REVIEW: SUMMARY OF PWC MEASUREMENT REVIEW AND BENCHMARKING (page 1 of 2)

PwC's 7 Recommendations

1. Establish and apply clear principles to guide the selection and updating of measures and benchmarks required by Covered California.
2. Covered California should continue to leverage existing data collection measures and processes.
3. In the absence of nationally standardized and already collected measures, for key domains Covered California should use its claims and encounter data to develop additional measures.
4. Given the broad lack of alignment across purchasers and measurement system sponsors, Covered California should make best efforts to align in ways that address priority concerns and that will foster better alignment in the future.
5. Covered California should work to improve analysis and response rates to existing surveys and build on those surveys to better capture patients' perspectives of their experience getting coverage and care.
6. Covered California should update its measurement requirements of health plans.
7. Given the inconsistency of consensus and national standards in many critical domains, Covered California will need to either develop new measures or adopt some in limited use while promoting adoption of national standards.

EXPERT REVIEW: SUMMARY OF HMA BEST EVIDENCE VALUE-ENHANCING STRATEGIES (page 1 of 2)

HMA's 7 Overarching Recommendations

1. Ensure issuers' network strategies deliver both cost effective and high-quality care.
2. Issuers and providers should be required to identify and effectively manage care for high-risk or high-cost individuals.
3. Require or encourage issuers to contract with Accountable Care Organizations or comparable vehicles for care integration that meet criteria for delivering higher value.
4. Require issuers to invest in and promote enrollment in primary care practices that reflect best evidence in delivering and promoting high-value care.
5. Insurers should promote the use of non-clinical providers where they have been demonstrated to improve access to care, address social determinants of health, health disparities, and support more effective engagement of patients and families.
6. Covered California should actively monitor and assess its issuers' activities in channeling patients to alternate sites and expanded approaches to care delivery.
7. Covered California should actively consider and assess its issuers' strategies to engage consumers in making choices regarding their provider, treatment, and source of care.

EXPERT REVIEW: SUMMARY OF HMA BEST EVIDENCE VALUE-ENHANCING STRATEGIES (page 2 of 2)

HMA's 5 Key Driver Observations

1. Standardize and promote data-sharing and data exchange.
2. Promote aligned, effective and parsimonious measurement across all stakeholders.
3. Payment should be used to deliver value.
4. Continued monitoring of and contribution to ongoing research is needed to address current limitations in evidence.
5. Issuers and providers need access to robust analytic services.

IMPACT OF EXPERT FINDINGS ON COVERED CALIFORNIA'S EXPECTATIONS REFRESH

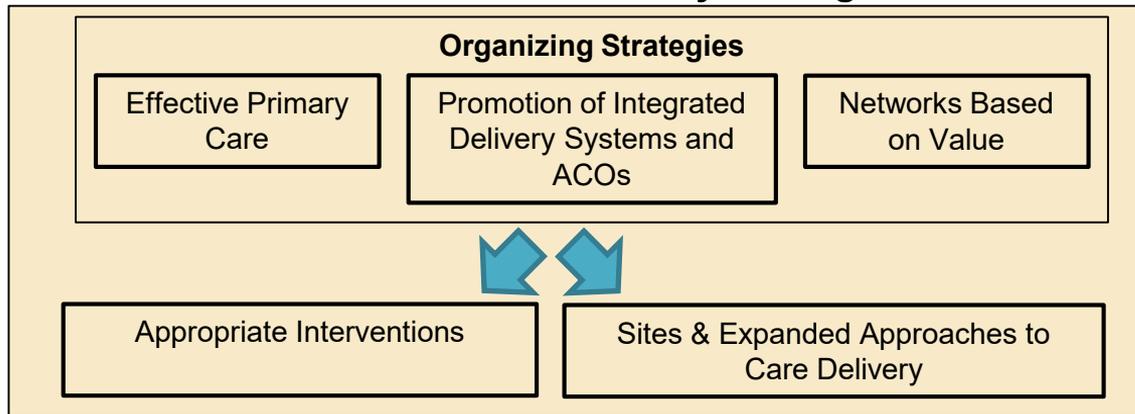
- HMA's evidence report largely reinforces the focus areas and priorities within Attachment 7.
- Covered California anticipates some areas will require more changes than others based on the evidence reviewed by HMA, Covered California experience, stakeholder input and the measurement and benchmarking recommendations from PwC.
 - HMA and PwC both recommend that Covered California could track additional measures and promote greater integration of behavioral health with physical health care to ensure QHP issuers are providing sufficient mental health and substance use disorder treatment.
 - In order to address disparities more comprehensively, Covered California concludes we should promote “individualized equitable care” as consistent with the six domains of health care quality – safe, timely, effective, efficient, equitable, and patient-centered (STEEEP) identified by the Institute of Medicine.

COVERED CALIFORNIA'S QUALITY CARE AND DELIVERY REFORM FRAMEWORK

Assuring Quality Care Domains

- Individualized Equitable Care
- Health Promotion and Prevention
- Mental Health and Substance Use Disorder Treatment
- Acute, Chronic and other Conditions
- Complex Care

Effective Care Delivery Strategies



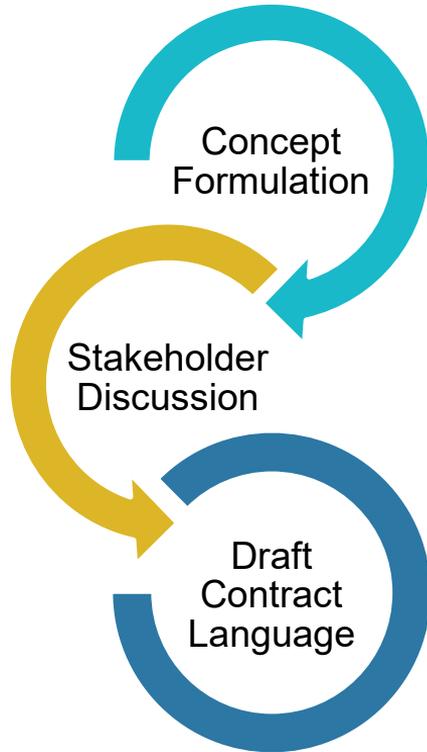
Key Drivers of Quality Care and Effective Delivery

Covered California recognizes that promoting change in the delivery system requires aligning with other purchasers and working with all relevant payers to reform health care delivery in a way that reduces the burden on providers.

- Benefit Design & Network Design
- Measurement & Public reporting
- Payment
- Patient-Centered Social Determinants
- Patient and Consumer Engagement
- Data Sharing and Analytics
- Administrative Simplification
- Quality Improvement
- Certification, Accreditation & Regulation
- Learning & Technical Assistance

Community Drivers: Workforce, Community-wide Social Determinants, Population & Public Health

PROCESS FOR UPDATING COVERED CALIFORNIA'S EXPECTATIONS



- Covered California staff develops a concept proposal per strategy (e.g. Promotion of Integrated Delivery Systems and ACOs) and receives internal input.
- Covered California staff presents the concept to QHP issuers and stakeholders for feedback. Staff updates the concept proposal based on feedback, receives internal input, and finalizes the concept.
- Covered California staff drafts contract language based on the approved concept, receives internal input, and finalizes the draft contract language.
- Contract language for all strategies and key drivers will be developed through this process.
- The complete draft model contract will be available for public comment Fall 2019.

EXAMPLE OF UPDATING COVERED CALIFORNIA'S EXPECTATIONS

Concept proposal for Promotion of Integrated Delivery Systems (IDS) and Accountable Care Organizations (ACOs):

- Continuing requirements:
 - QHP issuers will be required to report on the number and percent of enrollees who are managed under an IDS or ACO across all lines of business.
 - QHP issuers will be required to report on and have an increasing number and percent of enrollees who are managed under an IDS or ACO in the individual market.
 - QHP issuers will be required to track the outcomes of their IDS or ACO model using the IHA Align Measure Perform (AMP) Commercial ACO measure set.
- Potential new requirement(s): Covered California, in collaboration with issuers and organizations like IHA and PBGH, will develop a registry of organizational factors that issuers will use to define their IDS or ACO model including:
 - Payment model (upside only or two-sided risk)
 - Lead organization (physician, hospital, health plan)
 - Structure of payment to physicians within IDS or ACOs (FFS, capitation, salary)
 - Proportion of budget devoted to primary care

EXPECTATIONS DEVELOPMENT NEXT STEPS (page 1 of 2)

- **Review:** Covered California encourages all issuers, stakeholders, and others to review the PwC and HMA reports. The reports will be posted in July with the Board materials:
<https://board.coveredca.com/meetings/index.shtml>
 - Health Purchaser Strategies for Improving the Quality of Care and Delivery System Reform by PwC
 - Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform: Expert Reviews by HMA and PwC
 - Summary of Responses to Covered California's *Request for Input to Inform Refreshing Expectations Designed to Promote Accountability and Delivery System Improvements*
- **Engagement:** Covered California will convene workgroups of subject matter experts and stakeholders to discuss contract revisions. These groups will be facilitated through the Plan Management Advisory group. If you would like to participate in these workgroups, please contact QHP@covered.ca.gov.

EXPECTATIONS DEVELOPMENT NEXT STEPS (page 2 of 2)

- **Public Comment:** Covered California will solicit feedback throughout the expectations refresh initiative. Comments can be sent to QHP@covered.ca.gov.
- **August Board Meeting:**
 - HMA and PwC will present their reports and findings.
 - Release of Covered California Experience Report: Summary of QHP issuer progress through the 2018 plan year in meeting the quality improvement and delivery system reform requirements in the 2017 – 2020 contract.
 - Release of Key Drivers Report: Summary of HMA and PwC evidence and measures for select Key Drivers.