PLAN MANAGEMENT ADVISORY GROUP

March 2, 2017

WELCOME AND AGENDA REVIEW

ROB SPECTOR, CHAIR
PLAN MANAGEMENT ADVISORY GROUP

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
Thursday, March 2 , 2017, 10:00 a.m. to 12:00 p.m.

Webinar link: https://attendee.gotowebinar.com/register/8674600665841880066

Welcome and Agenda Review	10:00 - 10:05 (5 min.)
2018 Market Stabilization Regulations	10:05 – 11:05 (60 min.)
2018 Certification Update	11:05 – 11:25 (20 min.)
Dental Benefit Design Update	11:25 – 11:35 (10 min.)
Future Topics Planning Session	11:35 – 11:55 (20 min.)
Open Forum and Next Steps	11:50 – 12:00 (10 min.)

PLAN MANAGEMENT ADVISORY GROUP
NEW 2017 MEMBERSHIP

David Brabender*
Independent Health Insurance Agent
Legislative Chair, Sacramento Association of Health Underwriters

Douglas Brosnan
Emergency Room Physician
Sutter Roseville Medical Center
Director of Provider Relations, CEP America

Mary June Flores
Policy and Legislative Advocate
Health Access California

Emalie Huriaux
Director of Federal and State Affairs
Project Inform

Betsy Imholz
Special Projects Director
Consumers Union

Richard Kronick
Professor, Division of Health Care
Department of Family and PreventSciencesive Medicine
School of Medicine
University of California, San Diego

April Martin
Director, Managed Care
Dignity Health

James Mullen
Director, Public & Government Affairs
Delta Dental of California

Robert Oreilly
Director of Policy
Molina Health Plan

Bill Phelps*
Chief of Program Services
Clinica Sierra Vista

Cary Sanders
Director, Policy Analysis & Having Our Say Coalition
California Pan-Ethnic Health Network

Robert Spector
Area Vice President, Covered California Health Insurance Exchanges
Blue Shield of California

Bill Wehrle
Vice President, Health Insurance Exchanges
Kaiser Permanente

**New as of March 2017*

2018 MARKET STABILIZATION REGULATIONS

KATIE RAVEL, DIRECTOR
POLICY, PROGRAM INTEGRITY AND RESEARCH
ALLIE MANGIARACINO, SENIOR QUALITY ANALYST
PLAN MANAGEMENT DIVISION

PROPOSED FEDERAL REGULATIONS AND POTENTIAL ADJUSTMENTS TO STANDARD PLAN DESIGNS

This draft working document examines potential ways to respond to the new proposed federal regulations released on February 15, 2017 if new de minimis limits are adopted for the 2018 Plan Year. Covered California is considering the four options presented here and seeks comments from stakeholders on the preferred approach. Covered California understands that some changes in the proposed federal regulations may require changes in state law. In those instances, Covered California will work with the regulators and federal partners to determine whether any changes in state law may be necessary.

March 2, 2017

PROPOSED RULE: PPACA MARKET STABILIZATION

Summary of proposed changes to levels of coverage (actuarial value) (§156.140)

- Amends the definition of the de minimis range to a variation of -4/+2 percentage points, rather than +/-2 (silver plan variations remain at +/-1)
- Bronze plans that either cover and pay for at least one major service, other than preventive, before deductible or meet HDHP requirements have a variation of -4/+5

Possible national implications:

- **APTC recipients:** This may result in a "race to the bottom" in other states if all individual market plans move to 66% AV, resulting in increased cost-sharing for low-income enrollees due to the narrowed scope of benefits (i.e. higher deductible and copays) and smaller tax credits.
- **Non-Subsidized enrollees** have higher cost-sharing, but cheaper premiums

Possible California market impacts:

- Covered California's Patient-Centered Benefit Plan Designs are a set of standard benefits that must be offered on and off Exchange, though carriers on the individual market may offer their own unique ACA-compliant benefit designs off-Exchange ("non-mirror" products), in addition to the standard benefit packages.
- An estimated 90% of the individual market on and off Exchange is enrolled in the standard benefit designs; a policy decision on whether to lower the Silver AV has APTC implications mentioned above and affects ability of standard-benefit products to compete with off-Exchange, non-mirror products. The current standard Silver has an AV of 71.5%.
- Non-subsidized enrollees may leave Exchange to seek cheaper products off Exchange

IMPLICATIONS FOR CALIFORNIA

- Covered California's current proposed Silver for 2018 is 71.9%: The proposed changes from 2017 to 2018 include a lower pharmacy deductible ($100) and making generic drugs subject to deductible.
- Carriers could use this rule change to offer stripped-down plans, particularly for Silver:
  - Three contracted carriers already offer Silver off-exchange, non-mirror plans, two of which are "stripped down" (i.e. most services apply to deductible, high deductible)
- **Cheaper Silver plans could greatly reduce unsubsidized enrollment, moving these enrollees to much cheaper off-Exchange, non-mirror plans**

	SUBSIDIZED	UNSUBSIDIZED
	% enrollment	% enrollment
CATASTROPHIC	0.42%	0.71%
BRONZE	17.72%	3.71%
Bronze-HDHP	4.70%	1.38%
SILVER	10.79%	5.12%
Silver 73	9.21%	0.01%
Silver 87	23.57%	0.01%
Silver 94	14.62%	0.01%
GOLD	3.32%	1.56%
PLATINUM	2.02%	1.12%
Grand Total	86.38%	13.62%

Note: As stated on slide 5, some changes in the proposed federal regulations may require changes in state law. In those instances, Covered California will work with the regulators and federal partners to determine whether any changes in state law may be necessary.

2017 RATES: NON-MIRROR vs. STANDARD PLANS

SILVER

	ANTHEM				BLUE SHIELD			KAISER		
	Silver Pathway 1900	Silver Pathway 2000	Silver Pathway (HMO) 2650	Standard Silver	Silver 1850	Silver Seven 3750	Standard Silver	Silver 70 1750/40	Silver HDHP 2700/15%	Standard Silver
Los Angeles, Age 32	$348	$340	**$243**	$389	**$322**	$336	$353	$293	**$268**	$310
Los Angeles, Age 55	$655	$641	**$458**	$734	**$608**	$633	$665	$553	**$506**	$585

BRONZE

	ANTHEM				BLUE SHIELD		KAISER	
	Bronze Pathway 5250	Bronze Pathway 5850	Bronze Pathway 6900	Standard Bronze	Bronze 5550	Standard Bronze	Bronze HDHP 5500/40%	Standard Bronze
Los Angeles, Age 32	$272	**$266**	$277	$274	**$285**	$300	**$223**	$225
Los Angeles, Age 55	$513	**$501**	$523	$517	**$538**	$566	**$421**	$424

Red Bold = cheapest plan in metal tier ***offered in market***

Orange Bold = cheapest plan in metal tier ***offered by the carrier***

OPTIONS FOR CONSIDERATION

If CMS proceeds with a change to the de minimis range, Covered California will need to reconsider its standard design options to retain healthy, unsubsidized enrollment and to be able to compete with off-Exchange, non-mirror products.

Covered California is considering the following options:

1) Maintain current standard Silver proposal (AV=71.9%)

    1a) Maintain current standard Silver proposal while lowering AV for Bronze, Gold, and Platinum. Note that low-AV options already exist in the Platinum and Gold copay plans.

2) Reduce Silver plan AV by 2-4% in expectation of cheaper Silver offerings in the off-Exchange, non-mirror market
3) Offer a “Bronze Plus” plan with an AV of 63-65% and a “Bronze Lite” with an AV of 56-58%
4) Maintain current proposed plan designs and add new requirements for non-mirror plans in the QHP Contract

The following slides outline pros and cons for each option and include sample plan designs to illustrate cost-sharing tradeoffs for options 2 and 3.

OPTION 1

Maintain current standard Silver proposal (AV=71.9%)

Rationale: Maintain consistency year-to-year regardless of federal changes

PRO

- Consistent with Covered CA principles on standard benefit design
- Easy messaging to consumers on plan design changes
- Approval already in progress
- Generous APTC (relative to other options presented in these slides)

CON

- Expensive premiums compared to off-Exchange Silver offerings
- Could lose most healthy unsubsidized to off-Exchange market (but mitigated by inertia and better benefits)
- Loss of Covered CA revenue stream

OPTION 2

Reduce Silver plan AV by 2-4%

Rationale: Offer a cheaper Silver in expectation of low-AV Silver offerings in the off-Exchange, non-mirror market (see options on next slide)

PRO

- Ability to tout lower Silver premiums in 2018
- Keep unsubsidized, healthy enrollees in Silver plans

CON

- Dramatic changes required from previous years, including applying deductible to more services
- Inconsistent with Silver approach built up over four years
- Could be a major “gotcha” to consumers settled into the Silver design
- Higher cost-sharing could result in barriers to care
- Lower APTC (Average: $70 per enrollee / $80 million total loss for California)

OPTION 2 (cont.): SILVER PLAN DESIGN OPTIONS (AV 70, 68, 66)

Benefit	Current Proposed Silver		Silver 70		Silver 68		Silver 66	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible								
Medical Deductible		$2,500		$3,000		$4,350		$5,500
Drug Deductible		$100		$100		$100		$250
Coinsurance (Member)		20%		20%		20%		20%
MOOP		$7,000		$7,000		$7,000		$7,000
ED Facility Fee		$350	X	$350	X	20%	X	20%
Inpatient Facility Fee	X	20%	X	20%	X	20%	X	20%
Inpatient Physician Fee	X	20%	X	20%	X	20%	X	20%
Primary Care Visit		$35		$35		$50		$50
Specialist Visit		$70		$70		$75		$75
MH/SU Outpatient Services		$35		$35		$50		$50
Imaging (CT/PET Scans, MRIs)		$300		$300	X	20%	X	20%
Speech Therapy		$35		$35		$50		$50
Occupational and Physical Therapy		$35		$35		$50		$50
Laboratory Services		$35		$35		$35		$35
X-rays and Diagnostic Imaging		$70		$70		$70		$70
Skilled Nursing Facility	X	20%	X	20%	X	20%	X	20%
Outpatient Facility Fee		20%		20%	X	20%	X	20%
Outpatient Physician Fee		20%		20%	X	20%	X	20%
Tier 1 (Generics)	X	$15	X	$15	X	$15	X	$15
Tier 2 (Preferred Brand)	X	$55	X	$55	X	$55	X	$55
Tier 3 (Nonpreferred Brand)	X	$80	X	$80	X	$80	X	$80
Tier 4 (Specialty)	X	20%	X	20%	X	20%	X	20%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250
Maximum Days for charging IP copay								
Begin PCP deductible after # of copays								
Actuarial Value (2018 AVC)		**71.87**		**69.71**		**68.08**		**66.20**

Key: Increase member cost from current proposed Silver

X Subject to deductible

COVERED CALIFORNIA

OPTION 3

Offer a "Bronze Plus" plan with an AV of 63-65% and a "Bronze Lite" with an AV of 56-58%

Rationale: Offer a more generous Bronze plan, in addition to a low-AV standard Bronze, to compete with low-AV Silver plans off Exchange

PRO

- Would not interfere with APTC
- Compete with off-Exchange products
- Keep unsubsidized, healthy enrollees on Exchange with an in-between option (and potentially draw new enrollees)
- Offer a very low-cost option for Bronze enrollees

CON

- Increased differentiation and confusion in plan design options (presents a third Covered CA Bronze option)
- Inconsistent with Bronze approach built up over four years
- Operational challenges implementing a third Bronze plan (e.g. CalHEERS)

OPTION 3 (cont.): BRONZE PLAN DESIGN OPTIONS

This table models several plan design options if Covered California were to create ***two*** standard Bronze plans:

- "Bronze Plus" – a higher AV of 63-65%
- "Bronze Lite" – a lower AV of 56-58%

Note that current interpretation of state law on the MOOP limit, as well as California law on drug caps, limits the lowest-possible AV for "Bronze Lite" to 59-60%.

Refer to the appendix for further explanation of federal and state legal constraints on benefit design.

	OPTIONS: Low AV Bronze								OPTIONS: High AV Bronze					
	Bronze HDHP		Bronze Lite		Bronze Lite		Current Proposed Bronze		Bronze Plus		Bronze Plus		Bronze Plus	
	No drug cap		*Higher Rx deductible*		*Higher med deductible*				*Low deductible plan*		*Low deductible, low copays*		*ER not subject to deductible*	
Benefit	**Ded**	**Amount**	**Ded**	**Amount**	**Ded**	**Amount**	**Ded**	**Amount**	**Ded**	**Amount**	**Ded**	**Amount**	**Ded**	**Amount**
Deductible		$6,550												
Medical Deductible				$6,000		$6,500		$6,300		$3,000		$4,250		$5,500
Drug Deductible				$1,000		$500		$500		$500		$500		$1,000
Coinsurance (Member)		0%		100%		100%		100%		30%		30%		40%
MOOP		$6,550		$7,000		$7,000		$7,000		$7,000		$7,000		$7,000
ED Facility Fee	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%		40%
Inpatient Facility Fee	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Inpatient Physician Fee	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Primary Care Visit	X	100%	X	100%	X	100%	X	$75		$65		$50		$75
Specialist Visit	X	100%	X	100%	X	100%	X	$105		$105		$75		$105
MH/SU Outpatient Services	X	100%	X	100%	X	100%	X	$75		$65		$50		$75
Imaging (CT/PET Scans, MRIs)	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Speech Therapy	X	100%	X	100%	X	100%		$75		$65		$50		$75
Occupational and Physical Therapy	X	100%	X	100%	X	100%		$75		$65		$50		$75
Laboratory Services	X	100%	X	100%	X	100%		$40		$40		$40		$40
X-rays and Diagnostic Imaging	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Skilled Nursing Facility	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Outpatient Facility Fee	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Outpatient Physician Fee	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Tier 1 (Generics)	X	100%	X	100%	X	100%	X	100%	X	$16	X	$15	X	$15
Tier 2 (Preferred Brand)	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Tier 3 (Nonpreferred Brand)	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Tier 4 (Specialty)	X	100%	X	100%	X	100%	X	100%	X	30%	X	30%	X	40%
Drug Cap - Maximum Coinsurance				$500		$500		$500		$500		$500		$500
Maximum Days for charging IP copay														
Begin PCP deductible after # of copays								3 visits						
Actuarial Value (2017 AVC)	**60.49**		**59.88**		**60.04**		**60.75**		**64.91**		**64.99**		**64.98**	

Making ED not subject to the deductible results in higher cost sharing for all other services.

Not a typo; need to set copay at $16 to keep lab copay the same, decrease office visits slightly and lower deductible.

Lowest possible AV for an HDHP

Lowest possible AV due to CA law: MOOP limit and drug cap (see Appendix for explanation)

Key:

- Increased member cost from current proposed Bronze
- Decreased member cost from current proposed Bronze
- X — Subject to deductible

Draft working document as of March 2, 2017

OPTION 3 (cont.): BRONZE PLAN DESIGN OPTIONS

This plan design for a "Bronze Lite" differs from the low-AV options presented in the preceding slide:

- This plan design assumes that California law can be interpreted to set the MOOP at the maximum allowed of $7,350 (i.e. MOOP is not set $350 lower to accommodate enrollees purchasing standalone pediatric dental products)
- "3-visit rule" (member pays a copay for the first 3 visits; visits afterward are subject to the deductible) is maintained for primary care, specialist, and MH/SU office visits.

This plan is less generous than the current proposed Bronze in the following ways:

- Medical deductible increased from $6,000 to $6,350
- Drug deductible increased from $500 to $1,000 (maximum allowed under CA drug cap laws)
- Speech/Occupation/Physical Therapy and Labs are subject to the deductible.

Benefit	Bronze Lite	
	Ded	Amount
Deductible		
Medical Deductible		$6,350
Drug Deductible		$1,000
Coinsurance (Member)		100%
MOOP		$7,350
ED Facility Fee	X	100%
Inpatient Facility Fee	X	100%
Inpatient Physician Fee	X	100%
Primary Care Visit	X	$75
Specialist Visit	X	$105
MH/SU Outpatient Services	X	$75
Imaging (CT/PET Scans, MRIs)	X	100%
Speech Therapy	X	100%
Occupational and Physical Therapy	X	100%
Laboratory Services	X	100%
X-rays and Diagnostic Imaging	X	100%
Skilled Nursing Facility	X	100%
Outpatient Facility Fee	X	100%
Outpatient Physician Fee	X	100%
Tier 1 (Generics)	X	100%
Tier 2 (Preferred Brand)	X	100%
Tier 3 (Nonpreferred Brand)	X	100%
Tier 4 (Specialty)	X	100%
Drug Cap - Maximum Coinsurance	$500	
Maximum Days for charging IP copay		
Begin PCP deductible after # of copays	3	
Actuarial Value (2017 AVC)	**59.34**	

The final 2018 Benefit and Payment Parameters set the 2018 annual limitation on cost sharing (MOOP limit) at $7,350.

As CMS considers an expanded de minimis range for Bronze, it is worth noting that a Bronze plan of 56% is technically impossible given the $7,350 annual limitation.

We estimate that a 56% plan can be achieved ***if*** CMS raises the annual limit to $8,500.

Key:
- Increased member cost from current proposed Bronze
- X — Subject to deductible

OPTION 3 (cont.): BRONZE PLAN PREMIUM ESTIMATES

The following table presents the estimated weighted-average bronze premium for “Bronze Plus” and “Bronze Lite” plans, using the weighted-average premium for the 2017 Bronze plan as a reference point.

		Estimated Monthly Premium		
Plan Design Name	**AV**	**Age 25**	**Age 40**	**% difference from current Bronze**
Bronze Lite	**56.00**	**$ 194.08**	**$ 247.05**	**-9.6%**
Current 2017 Standard Bronze	61.93	$ 214.64	$ 273.21	--
Bronze Plus	**64.99**	**$ 225.24**	**$ 286.71**	**4.9%**

OPTION 4

Maintain current proposed plan designs and add new requirements for non-mirror plans in the QHP Contract

Rationale: Prevent flow of enrollment into stripped-down health plans and set consumer-friendly standards in the entire individual market

PRO	CON
• Would not interfere with APTC	• Opposition by contracted carriers
• Set standards in entire individual market, such as adherence to VBID, first-dollar coverage for some services, etc.	• Takes away cheaper options for off-Exchange market

2018 CERTIFICATION UPDATE

TAYLOR PRIESTLEY, CERTIFICATION PROGRAM MANAGER
PLAN MANAGEMENT DIVISION
BOB MANZER, DEPUTY DIRECTOR
SMALL BUSINESS EXCHANGE AND AGENT PROGRAM MANAGEMENT

PROPOSED 2018 QHP CERTIFICATION MILESTONES

Updated 3/2/2017

Release draft 2018 QHP & QDP Certification Applications	December 22, 2016
Draft application comment periods end	January 13, 2017
Plan Management Advisory: Benefit Design & Certification Policy recommendation	January 19, 2017
January Board Meeting: discussion of benefit design & certification policy recommendation	January 26, 2017
Letters of Intent Accepted	February 1 – 15, 2017
Final AV Calculator Released*	February 2017
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 22-24, 2017
March Board Meeting: anticipated approval of 2018 Standard Benefit Plan Designs & Certification Policy	March 14, 2017
QHP & QDP Applications Open	March 3, 2017
QDP Application Responses (Individual and CCSB) Due	May 1, 2017
Evaluation of QDP Responses & Negotiation Prep	May - June 2017
QDP Negotiations	June 2017
QHP Application Responses (Individual and CCSB) Due	May 1, 2017
Evaluation of QHP Responses & Negotiation Prep	May - June 2017
QHP Negotiations	June 2017
QHP Preliminary Rates Announcement	July 2017
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2017
CCSB QHP Rates Due	July 17, 2017
QDP Rates Announcement (no regulatory rate review)	August 2017
Public posting of proposed rates	July 2017
Public posting of final rates	October 2017

*Final AV Calculator and final SERFF Templates availability dependent on CMS release
TBD = dependent on CCIIO rate filing timeline requirements

2018 QHP/QDP CERTIFICATION APPLICATION REVISIONS

Applications opening March 3rd reflect the following changes:

Currently Contracted Applicants

QHP Issuers contracted for Plan Year 2017 will complete a simplified certification application since their three year contract with the Exchange imposes ongoing requirements included in the certification application and this contract performance is considered in the evaluation process.

- Updates to 2017 application responses accepted for Customer Service and Financial Requirements
- Fraud, Waste, and Abuse responses limited to new questions
- QHP delayed submission deadline of July 10, 2017 for Quality and Quality Improvement Strategy (QIS) submissions

Simplified CCSB Applications

Applicants completing the Individual Marketplace applications may refer to those responses, if applicable, for the following sections:

- Fraud, Waste, and Abuse; Healthcare Evidence Initiative; Privacy and Security; Provider Network; Quality; QIS

Document Clean-up

- Corrected response options
- Updated System for Electronic Rate and Form Filing (SERFF) Template links

COVERED CALIFORNIA FOR SMALL BUSINESS (CCSB) ALTERNATE BENEFIT DESIGNS

CCSB encourages the proposal of Alternate Benefit Designs (ABDs) by CCSB Applicants.

ABD Proposal Details:

- Up to two ABDs per metal tier may be proposed for applicant's geographic licensed service area.
- ABD proposals must comply with state statutory and regulation requirements.
- ABD proposals are voluntary and are not required

Plan Year 2018 ABD proposals must include the following components:

- Description of rationale and benefit to members of proposed ABD offer.
- Description of the population that the ABDs are meant to benefit.
- Description of differences in coverage that are incorporated into the proposed ABD vs. standard plan.
- Indication of any additional or enhanced benefits relative to the Essential Health Benefits (EHBs) with confirmation of no actuarial value impact
- Confirm if plans include pediatric dental EHB.

COVERED CALIFORNIA FOR SMALL BUSINESS (CCSB) ALTERNATE BENEFIT DESIGNS

For Plan Year 2018, CCSB will include consideration of proposed premium rates in the evaluation of proposed Alternate Benefit Designs (ABDs). To accommodate this change and minimize administrative burdens on CCSB applicants, staff proposes the following adjusted timeline:

May 1, 2017: QHP Certification Application for Covered California for Small Business Due

Friday June 30, 2017: ABD proposals due in Proposal Tech

- Attachment G benefit design and alternative cost-sharing proposal (*existing*)
- Attachment H Preliminary Premium Rates (*new*)
  - 40 year old rates for all standard and alternate plans proposed, all regions proposed

Friday July 7, 2017: ABD Proposals Decisions communicated to Applicants

Monday July 17, 2017: Only approved ABDs included in SERFF submissions and rate filings

If ABD evaluations are not completed before the July 17 rates submission, CCSB Applicants will need to remove any potential rejected ABDs from SERFF templates at a later date

DENTAL BENEFIT DESIGN UPDATE

TAYLOR PRIESTLEY, CERTIFICATION PROGRAM MANAGER
PLAN MANAGEMENT DIVISION

EMPLOYER-SPONSORED DENTAL BENEFIT DESIGN

Dental Copay Schedule

- Some Diagnostic and Preventive procedure codes changed from “Not Covered” to “No Charge” to allow coverage of these services if dental plans choose

Employer-Sponsored Dental Benefit Design

Benefit Design

- No waiting period for any service category.
- Periodontal Services included in Basic Services.

Enrollment

- Employer choice to offer employer-sponsored Group Dental Plan only.
- Employer required to contribute 50% of the premium for the Group Dental Plan **and** meet 70% participation of eligible employees for enrollment in the Group Dental Plan.
- No other dental plans are offered to employees.
- If the participation rate isn’t met then all employees are notified, CCSB invalidates selections, and all employees are offered the regular array of Children’s and Family Dental Plans.

FUTURE TOPICS PLANNING SESSION

ROB SPECTOR, CHAIR
PLAN MANAGEMENT ADVISORY GROUP
LINDSAY PETERSEN, QUALITY SPECIALIST
PLAN MANAGEMENT DIVISION

2017 FUTURE STRATEGIC TOPICS: PROPOSED SCHEDULE

Meeting Month	Strategic Topic	Expected Outcomes
2-Mar	2018 Stabilization Regulations	Gather input for Covered California comments on 2018 stabilization regulations and discuss policy change options.
6-Apr	Account Based Health Plans (HDHP, HSA, HRA)	Awareness of the current operational capabilities for account based health plans; Primer on the different types of account based plans; Ideas on operational, policy and member facing impacts on Account Based Health Plans (ABHP) in alignment with potential ACA changes.
11-May	Consumer Lifecycle Work Group- Input Session	Covered California is embarking on a long term "lessons learned" project to improve the consumer experience. The initial phase will review how various channels (Covered California, agents, navigators, enrollment system etc.) interact with consumers in efforts to understand weaknesses and gaps to strategize on improvements. Goal is to introduce the project and discuss the potential for Advsiory and/or sub work group involvement.
11-May	Integrated Timelines: Federal, State and Covered CA	Review how Federal and State law cycle overlap with Covered California's certification cycle and major decision points for each. Goal is to set groundwork for understanding when changes for 2019 would likely come and when response actions would need to be taken by Covered California.
8-Jun	Covered California Provider Directory	Demonstrate proposed member functionality for provider look up & PCP selection; Feedback on improving experience and developing readiness plans.
13-Jul	Primary Care QIS: PCP for PPO and PCMH update and input gathering session	Gather ideas to improve the assignment and rollout for new members and how to improve awareness and positive acceptance of PCP in the PPO environment.
10-Aug	Off Exchange Products - Market Scan	Gather ideas on any benefit designs found off exchange (non-mirrored) that should be considered for on-exchange. Understand why members purchase off-exchange with a focus on subsidy eligible (as a mechanism to improve targeting for CC enrollment) Consider variety in telehealth offerings and possibility of best practice encouragement.
10-Aug	Open Enrollment 2018 User Experience	Preview for stakeholders, no specific outcomes.
28-Sep	Healthcare Evidence Initiative (Truven) Progress	Share a baseline on key metrics in our quality agenda/dashboard based on the data submitted via Truven (disparities, etc); share top prioritieis in research queue.
No Oct meeting		
9-Nov	Hospital Safety QIS	Goal is to hold an update and input session on network improvements so far and momentum gained (number of hospitals signed up for HIINs and CMQCC, improvement in timing of data flow, annual C-Section Honor Roll etc.) and on payment strategies for quality and for reducing low risk C section.
14-Dec	Health Disparities QIS	Goal is to hold an input session on plan submissions, efforts to improve rates of data capture, and preliminary work and best practices discussion on projects to improve chronic disease management (Plan Care Management Programs).

WRAP UP AND NEXT STEPS

JAMES DEBENEDETTI, DIRECTOR
PLAN MANAGEMENT DIVISION
ROB SPECTOR, CHAIR
PLAN MANAGEMENT ADVISORY GROUP