EXECUTIVE DIRECTOR'S REPORT

Peter V. Lee, Executive Director | March 15, 2018 Board Meeting

WELCOME NEW BOARD MEMBERS

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Jerry Fleming
Senior Vice President at Kaiser Permanente-Retired

Sandra Hernández, MD
President and CEO of the California Health Care Foundation

ANNOUNCEMENT OF CLOSED SESSION

MEETING OVERVIEW

- Executive Director's Report
  - Open Enrollment Update
  - Federal Policy Update
- Covered California Policy and Action Items

  Action
  - Proposed Standard Benefit Design
  - 2019 Qualified Health Plan Certification Policy
  - Covered California for Small Business (CCSB) Eligibility and Enrollment Emergency Regulations Readoption and Permanent Rulemaking Authorization

OPEN ENROLLMENT UPDATE

THE STABILITY WAS SHAKEN IN 2018, BUT OVERALL MARKETS WERE REMARKABLY STEADY

Huge uncertainty going into 2018:

- Reduced marketing to consumers living in states supported by the federal marketplace
- Penalty enforcement unclear
- Fall decision to end direct funding of cost-sharing reduction subsidies

Results — huge state-by-state variation, but:

- Much cajoling and nudges kept coverage in all counties, but we now have 30 percent of Americans in marketplaces with only one plan.
- Most states did “CSR work around” — result was DECREASE in premium for those with subsidies (down 3 percent for FFM states) and unsubsidized shielded from the “CSR Surcharge” (unsubsidized premiums up 15 percent or more).
- Spike in earned media coverage filled some of the gap from drop in marketing.
- While marketplace enrollment dropped slightly, big unknown is changes in off-exchange enrollment — all unsubsidized.

CALIFORNIA'S EFFORTS TO PROMOTE ENROLLMENT – UP TO THE FINISH LINE

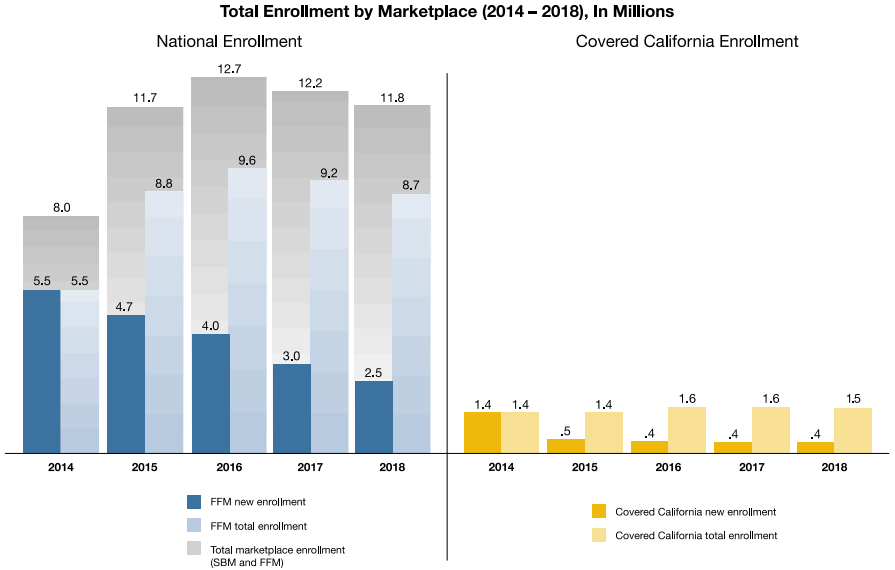
OPEN ENROLLMENT FOR 2018 TOTAL NEW ENROLLEES

423,484

plan selections

A **3 percent** increase over last year.

ENROLLMENT TRENDS 2014 — 2018: FEDERALLY FACILITATED MARKETPLACE SHOWING DRAMATIC DECLINE IN NEW ENROLLMENT



- Total marketplace enrollment in 2018 **declined 4 percent** from 2017 to 2018 and **declined by 7 percent** since 2016.
- The FFM has seen a decline of **38 percent** in new enrollments since 2016 — from 4 million to 2.5 million.
- Covered California's overall enrollment has been stable since 2015 and 2018, with each year attracting about the same number of new enrollees during open enrollment, which helps maintains a healthy risk mix and put downward pressure on premium rates.

Centers for Medicaid and Medicare Services (2014-2016). "Marketplace Open Enrollment Period Public Use Files" (last modified May 11, 2017): https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html
Centers for Medicaid and Medicare Services (2017). "Final Weekly Enrollment Snapshot For 2018 Open Enrollment Period" (Dec. 28, 2017): http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-12-28.html
National Academy for State Health Policy (2018). "State Health Insurance Marketplace Enrollment (Plan Selections) 2017 and 2018" (Feb. 7, 2018): https://nashp.org/state-health-insurance-marketplace-enrollment-2017-and-2018/

FEDERAL UPDATE

ABSENT POLICY CHANGES, PREMIUM INCREASES IN 2019 LIKELY TO RANGE FROM 12 – 32 PERCENT; THREE YEAR CUMULATIVE INCREASES FROM 36 TO 94 PERCENT

Estimates reflect potential state average increases; some states and individual carriers could be higher or lower. Premium estimates reflect gross premiums and would be fully born by the 6 million Americans who do not receive subsidies. For those who receive subsidies, premium increases would likely be far less.

Factors Affecting Premiums	2019	2020	2021
Medical Trend for Individual Market	7%	7%	7%
Elimination of Individual Mandate Penalty	+7 to 15%	+2.5 to 10%	+ 2.5 to 10%
Enrollment effect due to decreases in federally facilitated marketplace states due to less marketing/ shortened open-enrollment period	-2% to +9%	0% to +2%	0% to +2%
Association Health Plans and Short-Term Policies	+0.3% to 1.3%	+0.5 to 2%	+0.5 to 2%
Total Increase Effect	**Range of 12% to 32%**	**Range of 10% to 21%**	**Range of 10% to 21%**
Total Cumulative Effect			**Range of 36% to 94%**

See: Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Action, With Wide Variation Among States (http://hbex.coveredca.com/data-research/library/CoveredCA_High_Premium_Increases_3-8-18.pdf)

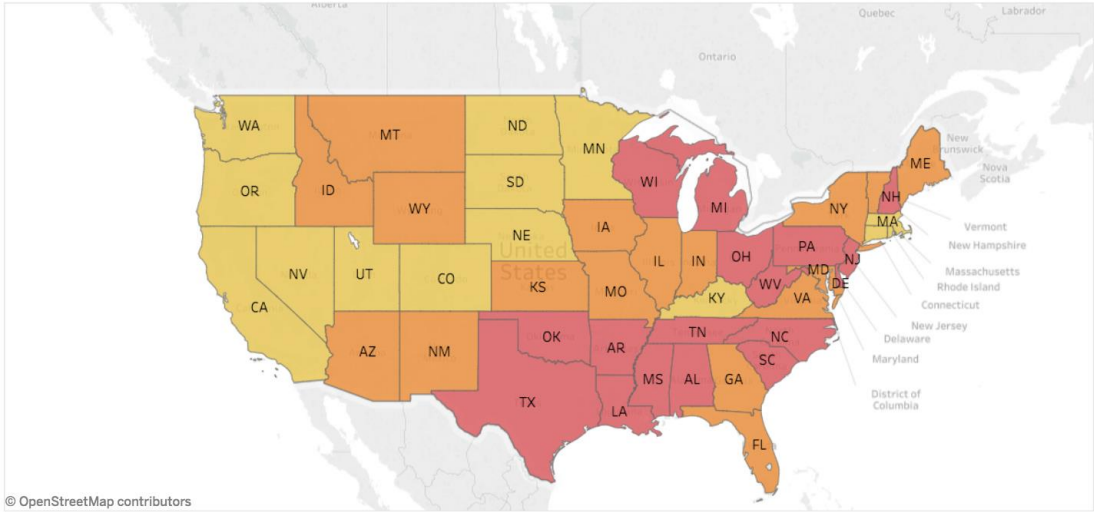
NATIONAL VARIATION IN POTENTIAL PREMIUM INCREASES FOR 2019 TO 2021: FROM BAD TO REALLY BAD

Estimate of 2019 Marketplace Risk

Select a State or Marketplace Type to view a subset of all marketplaces.

State (All) Marketplace Type (All)

Summary of Marketplace Risk
- Catastrophic (possible 90% premium increase by 2021)
- High (possible 50% premium increase by 2021)
- Significant (possible 35% premium increase by 2021)



http://hbex.coveredca.com/data-research/data-viz/individual-market-risks-by-state-2019/

FEDERAL AND STATE ACTIONS THAT COULD PROMOTE STABILITY POLICY ACTIONS THAT COULD PROMOTE STABILITY FOR 2019 AND BEYOND

- **Reinsurance:** State-based and/or national reinsurance programs, could have a dramatic impact on premiums and carrier participation in 2019.
- **Directly Fund Cost-Sharing Reduction (CSR) Subsidies:** Funding CSRs would not directly reduce premiums but would provide needed stability for health plans and reduce federal spending.
- **Increased Subsidies:** Increasing the financial assistance that is available to consumers would help more Americans afford coverage and increase the overall health of the consumer pools.
- **Increased Marketing and Outreach:** Increasing spending on targeting marketing promotes enrollment among healthier individuals and benefits federal taxpayers — who benefit from reduced per-person Advanced Premium Tax Credits — and those who do not receive subsidies and face lower premium increases.
- **State-Based Penalties for Non-Coverage:** States could adopt state-based penalties to promote enrollment.
- **State Regulations on Association Health Plans or Short-Term, Limited-Duration Plans:** States could adopt regulations that limit carriers from offering plans that do not provide comprehensive coverage or protect consumers with pre-existing conditions, which could harm the risk pool in the individual market.
- **Auto-Enrollment:** State or federal policies could promote automatic enrollment of eligible individuals, such as for those who lose employer-based coverage, earn too much for Medicaid or “age out” of coverage eligibility from parents plans

FEDERAL POLICY ACTIONS THAT COULD MITIGATE 2019 PREMIUM INCREASES

Estimates reflect the range of how each stabilizing policy would affect states based on their circumstances. The effect on premiums in some states for individual carriers could be greater.

Proposed Policy Action	Estimated Reduction
Create a multiyear reinsurance program with $15 billion in annual federal funding starting in 2019 (premiums would increase by about the value of reinsurance when the program halted)	10 to 20 percent
Fund CSR payments for 2017, 2019 and 2020	Unlikely to lower premiums for most consumers, see discussion on page 3
Moratorium on health insurance tax for 2019 (premiums would increase when “holiday” ends)	1 to 3 percent
Fund comprehensive marketing and outreach for 2019 to 2021 (premium reductions tied to success at enrolling healthier population)	6 to 8 percent

See: Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Action, With Wide Variation Among States (http://hbex.coveredca.com/data-research/library/CoveredCA_High_Premium_Increases_3-8-18.pdf)

SHORT-TERM, LIMITED-DURATION INSURANCE (STLDI)

Short-term, limited-duration insurance (STLDI) is insurance that covers someone for less than 12 months.

On February 20th, the Departments of HHS, Labor, and Treasury released a new rule amending the definition of STLDI:

- Expands the maximum duration of short-term coverage from three months to 364 days
- Allows renewals at the end of the policy

STLDI is not subject to ACA requirements:

- Consumer protections such as Essential Health Benefit (EHB) requirements, out of pocket limits, premium rating ratio, medical loss ratio (MLR), prohibitions on underwriting and declining coverage for preexisting conditions, etc.
- In 2016, the average MLR for short-term coverage was 67%. Among the top five companies offering coverage, the MLR ranged from 47% to 79%.1

In 2016, more than 160,000 individuals were enrolled in STLDI policies nationwide.2

[1] [2] National Association of Insurance Commissioners, “2016 Accident and Health Policy Experience Report,” page 79, July 2017

ASSOCIATION HEALTH PLANS (AHP)

Association health plans (AHPs) are a type of multiple employer welfare arrangement (MEWA). They provide health insurance to its members, which typically include self-employed individuals, small businesses, and large businesses.

On January 4th, the Department of Labor released a new rule broadening the definition of AHPs:

- Relaxes requirement that associations exist for a reason other than offering health insurance. Can show commonality of interest by either:
  - 1) being in the same trade, industry, or profession
  - 2) being in the same principal place of business within the same state or common metro area
- Expands availability of AHP group coverage to self-employed individuals referred to as “working owners”

AHPs are exempt from some ACA consumer protections and can rate on factors like age, group size, and type of industry in which an employer works

Potential market impacts:

- Insolvency and unpaid claims among AHPs (based on history of AHPs)
- Less healthy risk mix in individual and small group markets

POTENTIAL MARKET IMPACTS NEW FEDERAL RULES ON STLDI AND AHP

- Consumers enrolling in STLDI or AHP:
  - Lower monthly premiums but fewer consumer protections
  - Financial losses from health services usage that is not covered by STLDI or AHP
- Consumers in ACA-compliant plans:
  - Premium increases (Projected +0.3% to 1.3% in 20191)
  - Potential for future higher out-of-pocket costs, due to the impact of a less healthy population in the ACA plans represented in the AV Calculator
  - Potential for fewer health plan choices
- Health insurers that offer ACA-compliant plans:
  - Adverse selection and less stable risk mix
  - Financial instability

[1]Projected premium impact of new rules on STLDI and Association Health Plans. Covered California, “Individual Markets Nationally Face High Premium Increases in Coming Year Absent Federal or State Action, with Wide Variation Among States”

APPENDICES

APPENDICES: TABLE OF CONTENTS

- Covered California for Small Business Update
- Service Channel Update
- Website Update
- Service Center Update

COVERED CALIFORNIA FOR SMALL BUSINESS

Group & Membership Update (1/31/18)

- Groups: 5,320
- Members: 43,660
- Member Retention: 84%
- Average Group Size: 8.2 members
- Year over Year Net Membership Growth: 34%

Operations Update (1/31/18)

- 100% of New Groups set up in 3 days or less
- 100% of New Groups sent initial invoice in 3 days or less
- 99.7% of Account Maintenance Transactions completed in 3 days or less

ENROLLMENT ASSISTANCE PROGRAMS

- Uncompensated partners supporting enrollment assistance efforts.

ENROLLMENT ASSISTANCE PROGRAM	ENTITIES	COUNSELORS
Certified Application Counselor	293	1,459 Certified
Plan-Based Enroller	11 Plans	725 Certified
Medi-Cal Managed Care Plan	2 Plans	24 Certified

OUTREACH & SALES ENROLLMENT SUPPORT: KEY METRICS

Data as of March 12, 2018

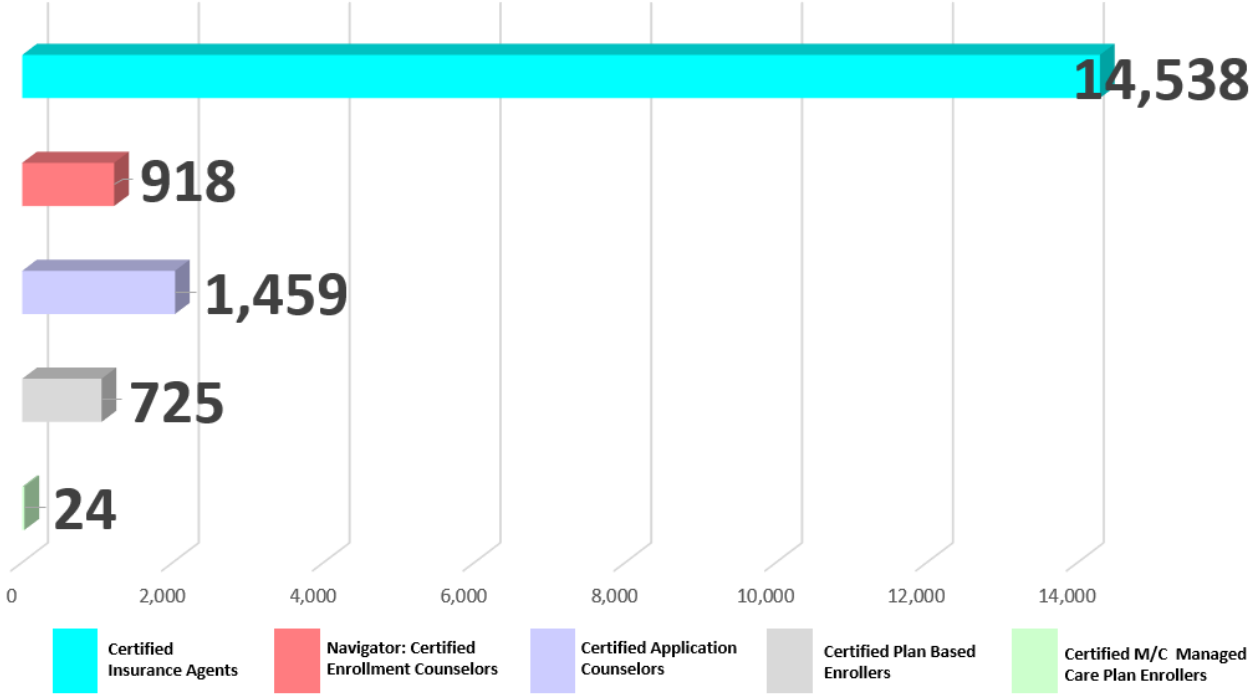
14,538 Certified Insurance Agents
- *17% Spanish*
- *7% Cantonese*
- *7% Mandarin*
- *4% Korean*
- *4% Vietnamese*

918 Navigator: Certified Enrollment Counselors
- *63% Spanish*
- *4% Cantonese*
- *3% Mandarin*
- *3% Vietnamese*
- *2% Korean*

1,459 Certified Application Counselors
- *59% Spanish*
- *5% Cantonese*
- *4% Mandarin*
- *1% Vietnamese*
- *1% Korean*

725 Certified Plan Based Enrollers
- *45% Spanish*
- *10% Cantonese*
- *2% Mandarin*
- *7.5% Vietnamese*
- *7.3% Korean*

24 Certified Medi-Cal Managed Care Plan Enrollers
- *44% Spanish*
- *36% Cantonese*
- *31% Mandarin*
- *1% Russian*



COVERED CALIFORNIA

CALHEERS UPDATES

- CalHEERS deployed Release 18.2 on February 12, 2018, which included the following features:
  - Implementation of features to allow Insurance Agencies to assist consumers and manage business for multiple Agents within their group
  - Improvements for consumers transitioning from Medi-Cal
  - Generating a performance metrics report to track issuers‘ timeliness and accuracy
  - Updated password and account security questions to improve the user experience
- The next release of CalHEERS, Release 18.3, is scheduled on March 12, 2018 and includes:
  - Updates to the User Interface of the secure mailbox pages to improve consumer experience
  - Modifications to the Single Streamlined Application for regulatory and statutory requirements
- CalHEERS also has a release planned for April 9, 2018 (Release 18.4). This release will include:
  - Ability of Counties and Service Centers to create and manage users for their own organization

ENHANCEMENTS PLANNED FOR COVEREDCA.COM WEBSITE

- CoveredCA.com Testing & Complete Redesign- Will begin consumer testing on public facing website. These results will be used to update the User Interface design and flow of the website before Open Enrollment 6.
- Continue to work on updating analytics and tagging strategy for the website to give greater insight into the consumer journey online. This data will be used to fine-tune CoveredCA.com to allow designated staff to make their own timely content updates to their sections of the website.

SERVICE CENTER UPDATE

- Improving Customer Service
  - Reduced 1095 disputes Year To Date (YTD) by 51%
  - Completed proposal reviews for Virtual Assistant/ChatBot and intent to award scheduled for March 15, 2018
  - Improved consumer journey by single skilling bilingual staff - lessening average speed to answer
  - Implemented new Interactive Voice Response (IVR) messaging to inform consumers how to access their 1095 form(s)
  - Developed Request For Proposal for Service Center Benchmarking Assessment
  - Increased Appeals Informal Resolution Rate
- Enhancing Technology Solutions
  - IVR changes for Bilingual consumers for a quicker response time
  - Participated in Customer Relationship Management (CRM) demo's with IT
- Staffing Updates
  - Vacancy rate down to less than 10 percent (2017) from 19 percent (2016) this is a reduction of almost 9 percent
  - Surge vendor ramped down to 400 staff on March 1, 2018
  - Permanent Intermittent (PI's) received notification from HR regarding Permanent full-time eligibility
  - Branch Chief Fresno SSM III starts on March 12, 2018

SERVICE CENTER PERFORMANCE UPDATE*

- Comparing February 2018 vs. 2017 Call Statistics

Year	Calls to IVR	Calls Offered to SCR	Abandoned %	Calls Handled	ASA	AHT	Service Level %
2018	427,815	240,714	4.55%	228,506	0:01:32	0:16:29	66.13%
2017	540,996	313,699	10.07%	281,451	0:05:32	0:16:19	38.94%
Percent Change	21% decrease	23% decrease	55% decrease	19% decrease	72% decrease	1% increase	70% increase

- The total Calls Offered decreased from 2017 by 23%. The Abandoned % decreased by 55% and Service Level Increased by 70%.

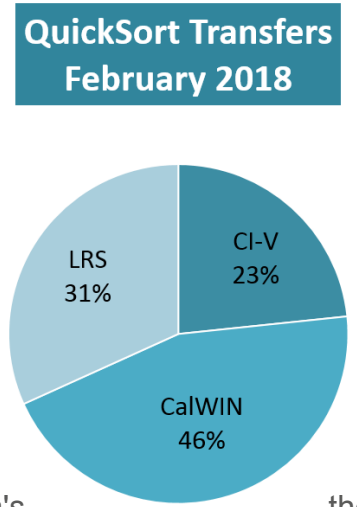
QUICK SORT VOLUMES

Quick Sort refers to the calculator tool used to determine if a consumer is eligible for CoveredCA or should be referred to Medi-Cal. The tool also determines which consortia the consumer should be referred. This volume represents the total of those transfers.

February Weekly Quick Sort Transfers

Week 1*	Week 2	Week 3	Week 4*	Week 5*	Total
121	227	251	202	190	991

*Partial Week - 2/19 - Closed in observance of President's Day.



February Consortia Statistics

SAWS Consortia	Calls Offered	Service Level	Calls Abandoned %	ASA
C-IV	208	97.12%	0.98%	0:00:10
CalWIN	400	95.50%	0.25%	0:00:16
LRS	283	99.80%	1.10%	0:00:08

SAWS = Statewide Automated Welfare System (consortia). California has three SAWS consortia's the counties.
C-IV = SAWS Consortium C-IV (pronounced C 4)
CalWIN = California Welfare Information Network
LRS = formally LEADER = Los Angeles Eligibility Automated Determination, Evaluation and Reporting Systems