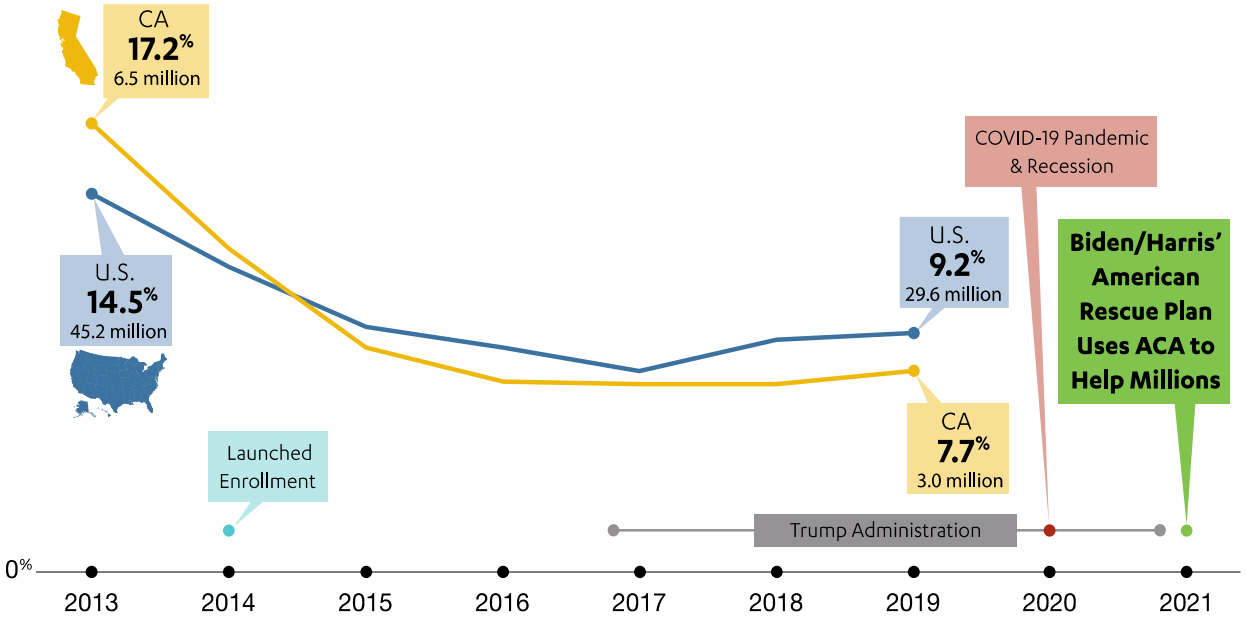
COVERED CALIFORNIA POLICY AND ACTION ITEMS

March 18, 2021 Board Meeting

AMERICAN RESCUE PLAN
WHO BENEFITS & STRATEGIES FOR IMPLEMENTATING EFFECTIVELY

CALIFORNIA BUILDING ON ITS HISTORY OF MAKING THE AFFORDABLE CARE ACT WORK

- Since launch of ACA, California experienced the nation's largest drop in the uninsured rate.
- More than 4.7 million Californians have gained coverage since 2013.
- As of 2019, there are about 3 million uninsured, with about 60% undocumented/ineligible for federal programs.
- In 2020, California implemented state subsidies and a state penalty, which resulted in a 40% increase in new enrollment and contributed to premium increases of less than 1% for 2020 **and** 2021.
- COVID Special Enrollment Period in 2020 led to surge in sign-ups



Source: U.S. Census 2014-2020

WHO CAN BENEFIT FROM THE AMERICAN RESCUE PLAN'S NEW HEALTH SUBSIDIES:THE NATIONAL AND CALIFORNIA PICTURE

Landscape of the 25 Million Americans Eligible for New Assistance*

			US Total		California	
ACTION NEEDED BY CONSUMER	Currently Uninsured	Uninsured Marketplace Eligible, below 400% FPL	11.2M	45%	990,000	32%
		Uninsured Marketplace Eligible, above 400% FPL	2.1M	8%	230,000	8%
		SUBTOTAL: Currently Uninsured - Action Needed to Benefit	***13.3M***	***54%***	***1,220,000***	***40%***
	Currently Insured	Off-Exchange Enrollees, below 400% FPL	.8M	3%	210,000	7%
		Off-Exchange Enrollees, above 400% FPL	.7M	3%	220,000	7%
		SUBTOTAL: Currently Enrolled - Action Needed to Benefit	***1.5M***	***6%***	***430,000***	***14%***
NO ACTION NEEDED BY CONSUMER	Currently Insured	Marketplace Enrollees, below 400% FPL - No Action Needed to Benefit	9.1M	37%	1,270,000	42%
		Marketplace Enrollees, above 400% FPL - Newly Eligible for ARP	.9M	4%	140,000	5%
		SUBTOTAL: Currently Enrolled - No Action Needed to Benefit	***10.0M***	***40%***	***1,410,000***	***46%***
TOTAL		**Total Eligible to Benefit from Subsidies**	**24.9M**	**100%**	**3,060,000**	**100%**
ACTION NEEDED	Currently Uninsured	Uninsured Medicaid Eligible	7.3M		1.0M	
TOTAL		**Total Eligible to Benefit from Affordable Coverage**	**32.2M**		**4.0M**	

Average New Monthly Financial Help For Current Marketplace Enrollees, below 400% FPL	$ 80	$ 74
Average Monthly Financial Help for Newly Enrolling Individuals, below 400% FPL	$ 571	$ 527
Average Monthly Financial Help Per Newly Eligible Enrollee, above 400% FPL	$ 335	$ 309

* Table only shows those estimated to be eligible for subsidies based on maximum required contribution percentage of household income using available administrative data (on income, age, and benchmark premiums) from California's marketplace: the actual eligibility may differ to the extent that there are differences in the age, income, and premium costs for other states and the off-exchange from what is observed in Covered California's data. **Not shown are the estimated 1.4 million consumers who may receive higher subsidies because they are receiving unemployment insurance income.** Additionally, off-exchange estimates do not include consumers who may be enrolled in coverage that is not ACA compliant (e.g. "grandfathered" plans), who may also benefit from new subsidies.

** Federally-Facilitated Exchanges includes State-Based Exchanges utilizing the Federal Marketplace Platform.

*** The "states with largest drops in unsubsidized enrollment" reflects total of the nine States (which were all in FFE) that had 2016 to 2019 drop of unsubsidized enrollment of over 70% (AZ, GA, IA, MS, NB, NH, OK, TN, WV).

POTENTIAL DOES NOT MEAN WILL BENEFIT: THE CONGRESSIONAL BUDGET OFFICE PROJECTS ONLY ABOUT ONE IN TEN OF ELIGIBLE UNINSURED WILL BENEFIT

The Congressional Budget Office projects that over 2021 and 2022 combined about 10 percent of uninsured eligible for the American Rescue Plan increased subsidies will enroll and 20 percent of those currently insured but unsubsidized will enroll. They think millions of Americans will leave big money on the table for good reasons:

- Most uninsured want insurance they just don't think they can afford it. The CBO does not think the Rescue Plan will change that.
- The American Rescue Plan is starting "mid-year" when consumers are less likely to switch.
- Since the program is temporary, many will just sit on the sidelines.

And there are other reasons for conservatism:

- Moving Consumers from "Off-Exchange" IS Difficult (inertia is a powerful force)
- Nationally need to rebuild awareness of Healthcare.gov and support navigators
- Danger of lower than needed marketing spending and risk that health plans don't "lean in"

BUT –THE AMERICAN RESCUE PLAN PROVIDES NEW OPPORTUNITIES BY MAKING COVERAGE MORE AFFORDABLE THAN EVER BEFORE

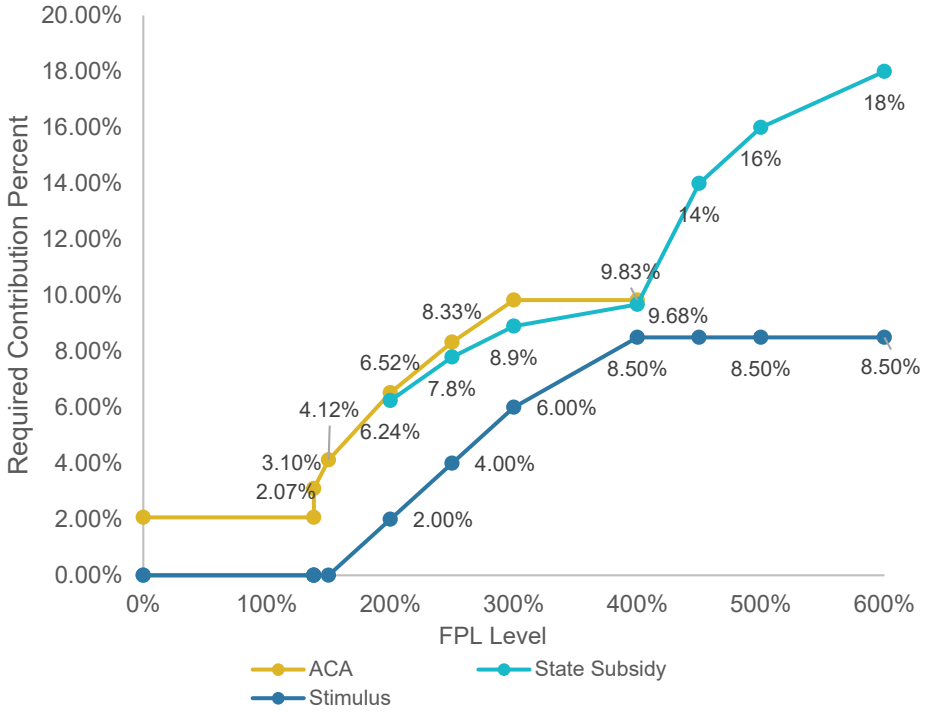
There are clear pathways and huge needs to be met that can help ensure consumers access subsidies:

- **Uninsured:** the new subsidies are large and make coverage MUCH more affordable than ever before for millions of Americans, IF Americans are told how much they can save.
- **Currently Insured "Off-Exchange" Consumers:** Qualified Health Plans and insurance agents can help consumers understand they can save thousands of dollars and convert to coverage that meets their needs.
- **Currently Subsidized Marketplace Consumers:** Consumers who are currently enrolled in either the Federally Facilitated Exchange (FFE) or a State Based Exchange (SBE) can gain the bigger subsidies automatically – either in the form of lower monthly premiums or by receiving a bigger tax refund at the end of the year without any action necessary on their part.
- **Health Insurance Carriers Can and Should Lean In:** New subsidies will help ensure that off-exchange enrollees in their plans will no longer terminate their plans prematurely because they can now better afford coverage.

THE AMERICAN RESCUE PLAN: PROVIDING MORE HELP TO MILLIONS AND MORE THAN COVERING CALIFORNIA'S TEMPORARY STATE SUBSIDIES

The new "required contribution curve" will significantly reduce the share of income that consumers must pay towards their premiums, fully replacing the current ACA policy design for plan years 2021 and 2022.

The Rescue Plan also includes a provision that allows anyone receiving Unemployment Income in 2021 to receive Advanced Premium Tax Credits (APTCs) at the level of eligibility at 138% FPL (meaning they pay 0% of their monthly income towards their benchmark plan and be eligible for Silver 94).



Required contribution curves are for the 2021 plan year.

AMERICAN RESCUE PLAN LOWERS PREMIUMS AS A SHARE OF INCOME

2021 Coverage Year: Percent of Household Income Paid for Benchmark Silver Premium						
Income Range		**Required Contribution as Share of Income**			**Enrollees to be redetermined without taking action**	
Income As Percent of Federal Poverty Level (FPL)	**Income** for Single Household	**Affordable Care Act**	**California State Subsidy Program**	**American Rescue Plan**	**Covered California enrollees**	**Percent of total**
Under 138%*	$0 to $17,609	2.07%	0.0%	0.0%	38,000	3%
138% – 150%**	$17,609 to $19,140	3.10% – 4.14%	N/A	0.0%	226,000	16%
150% – 200%	$19,140 to $25,520	4.14% – 6.52%	N/A	0.0% – 2.0%	442,000	31%
200% – 250%	$25,520 to $31,900	6.52% – 8.33%	6.24% – 7.80%	2.0% – 4.0%	236,000	16%
250% – 300%	$31,900 to $38,280	8.33% – 9.83%	7.80% – 8.90%	4.0% – 6.0%	198,000	14%
300% – 400%	$38,280 to $51,040	9.83%	8.90% – 9.68%	6.0% – 8.5%	192,000	13%
Over 400%	$51,040 and up	Not eligible for subsidies	9.68% – 18.0%***	8.5%	112,000	8%

NOTES:
*Individuals with income at or below 138% of the federal poverty level are generally eligible for Medi-Cal, California's Medicaid program. In certain limited circumstances, however, they are eligible for the federal premium tax credit and the California state subsidy program.
** Under the American Rescue Plan, Covered California enrollees receiving Unemployment Insurance (UI) in 2021 are treated as though their income is no more than 138.1% of the federal poverty level for the purposes of the federal premium tax credit meaning their required contribution for a benchmark plan will be 0%.
*** Eligibility for the California state subsidy program ends at 600% of the federal poverty level.

SAVINGS TO CALIFORNIANS UNDER THE AMERICAN RESCUE PLAN

Uninsured Californians earning between $19,000 and $32,000 per year – comprising 2/3rds of the eligible uninsured – can enroll in a benchmark silver plan (with reduced cost sharing) for an average cost of $61 per month, and virtually all can get a Bronze plan for $1 per month per member.

Off-exchange consumers over 400% FPL, who enroll with Covered California in May, will receive on average of $500 per month in federal financial assistance, for a potential savings of nearly $10,000 if enrolled for 20 months from May 2021 through December 2022.

Current Covered California consumers who will receive subsidies, will pay an estimated $119 less per month per household on average, which translates to $1,428 per year.

			Monthly Premiums		**Savings Due to American Rescue Plan** (for those who receive credits only)		
	Income Ranges for Single Person Household	**Share of Enrollment**	**Gross Premium**	**Consumer's Premium After American Rescue Plan Assistance**	Monthly Savings compared to ACA	Monthly Savings compared to Gross Premium	Savings from 20 months of ARP subsidies (compared to gross)
Under 150% FPL	Under $19,140	18%	$734	$55	$59	$679	$13,588
150% - 250% FPL	$19,140 - $31,900	47%	$766	$61	$93	$704	$14,088
250% - 400% FPL	$31,900 - $51,040	27%	$964	$228	$144	$736	$14,720
Over 400% FPL	More than $51,040	8%	$1,100	$507	$593	$593	$11,860
Total		100%	$820	$118	$119	$702	

COVERED CALIFORNIA

Note: Modeling assumes uninsured population characteristics match Covered California membership, including plan choice. Source: Covered California administrative data of effectuated enrollees' current plan selections, and only reflect those who are estimated to receive subsidies greater than $0. Premiums are at the household level.

SCENARIO: MIDDLE-INCOME OFF-EXCHANGE COUPLE CAN SAVE $14,000 IF SWITCH TO MARKETPLACE THROUGH 2022

A couple in Oakland, both 45 and earning $77,580 (450% FPL) purchased a benchmark silver plan off-exchange.* Now, if they switch to enroll at Covered California, they can keep the exact same place and receive financial help worth $722 per month, or over $14,000 if enrolled from May 2021 to December 2022.

		Enrolled Off-Exchange	American Rescue Plan	*Difference for Enrolling through Covered California*
Couple	Benchmark Silver Premium (monthly)	$1,271	$1,271	
Oakland, CA	Percent of Income Spent on Premium	19.6%	8.5%	*11.1% of income saved*
Both Age 45	Net Premium (monthly)	$1,271	**$550**	*$722 saved*
Income: $77,580	Federal Subsidy (monthly)	$0	$722	*$722 new monthly credits*
450% FPL	Federal Subsidy (20 months in 2021 and 2022)	$0	$14,438	*$14,438 savings if enrolled 20 months*

COVERED CALIFORNIA

* Not shown: this household would have been eligible for $366 per month in state subsidy had they enrolled on-exchange for 2021.

SCENARIO: YOUNGER UNINSURED IN LOS ANGELES CAN NOW GET SILVER PLAN FOR LESS THAN $50 PER MONTH

Uninsured younger consumers in low-cost regions can now get even more affordable coverage: a 21 year old in LA earning $25,520 per year (200% FPL) can purchase a benchmark plan (Enhanced Silver 94) for $43 per month, or a Bronze plan for $1 per month.

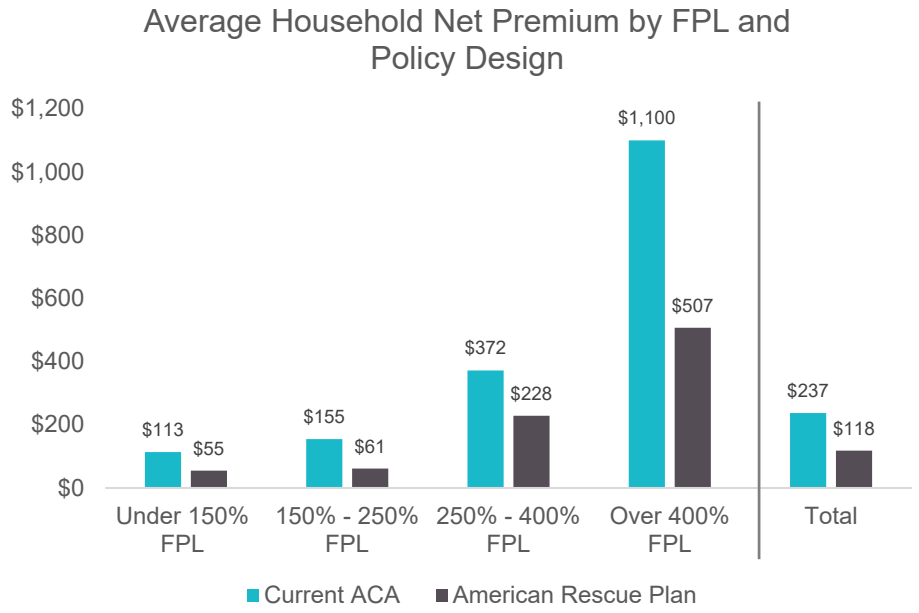
		ACA Baseline	American Rescue Plan
One-Person Household	Benchmark Silver Premium (monthly)	$275	$275
Los Angeles, CA	Cap on Share of Income for Benchmark Plan	6.52%	2%
21 year old	Net Premium (monthly)	$139	**$43**
Income: $25,520	Federal Subsidy (monthly)	$137	$233
200% FPL	Federal Subsidy (if enrolled all of 2021 and 2022)	$2,736	$4,659

FOR THOSE RECEIVING SUBSIDIES NOW THROUGH COVERED CALIFORNIA AVERAGE "NET PREMIUMS" WILL DROP A LOT

For current Covered California members, "net premiums" – the monthly amount consumers pay after the federal subsidy – will decrease by an estimated $119 per household per month ($1,428 annualized) compared to what costs would be under the ACA.*

Many consumers in the lower income range will become newly eligible for $1 Enhanced Silver premiums, while consumers over 400% of FPL will see significant reductions thanks to new federal premium assistance.

We estimate the American Rescue Plan will provide over $1.5 Billion in new financial help *for current enrollees alone.*



Note: Modeling assumes uninsured population characteristics match Covered California membership, including plan choice. Source: Covered California administrative data of effectuated enrollees' current plan selections, and only reflect those who are estimated to receive subsidies greater than $0. Premiums are at the household level, and net premiums do not include state subsidies.

MOST CALIFORNIANS PAYING FOR INSURANCE TODAY "OFF-EXCHANGE" CAN REDUCE THEIR COSTS IMMEDIATELY

Covered California estimates, based on income alone, that nearly three-quarters of all off-exchange households *could* be eligible to receive subsidies under the stimulus based on their income:

- Of households eligible to receive subsidies (of more than $0), 94% could receive more than $100/month, representing substantial benefit to these off-exchange consumers.
- For those households earning between 400% and 600% FPL, an estimated 82 percent would be eligible for financial help which would average $690 per household – **that assistance would have a value of $13,800 for a household that enrolled for May 2021 coverage and kept their insurance with same subsidy until December 2022**.
- Off-exchange households are ineligible due to their incomes meaning they can purchase a benchmark plan that costs less than 8.5% of income, and thus would qualify to receive subsidies.

FPL Group	Average Household Subsidy	Individuals Eligible to Receive Subsidies	Share of Total Households Eligible to Receive Subsidies
Less than 400% FPL	$800	210,000	100%
400%-600% FPL	$690	120,000	82%
More than 600% FPL	$500	100,000	43%

COVERED CALIFORNIA

* Not shown are an additional over 150,000 Californians enrolled in grandfathered plans who may also benefit from new financial help.

COVERED CALIFORNIA'S CORE STRATEGIES TO MAXIMIZE ENROLLMENT AND HELP AS MANY CALIFORNIANS AS POSSIBLE

1. **Establish a NEW American Rescue Plan special-enrollment period starting April 12th through the end of 2021.**

$20-30 MILLION

2. **Maintain consumer-focus, support agents and navigators, new partnerships and significant marketing investments April, May, and June.**

3. **Hold health carriers accountable by encouraging them to invest in marketing and reaching out to every consumer who is eligible for a subsidy.**

COVERED CALIFORNIA STRATEGY 1:
NEW AMERICAN RESCUE PLAN SPECIAL ENROLLMENT PERIOD

Establish a NEW American Rescue Plan Special Enrollment Period – *Covered California will have a special enrollment period starting April 12th and going through the end of 2021*

- The Special Enrollment Period needs to be **NEW** because the benefits to consumers ARE NEW – need to create buzz, discussion and engagement by all interested (and disinterested) individuals so uninsured consumers "check-again."
- A longer Special Enrollment Period allows for roll-out of effective marketing and will allow for broader word of mouth – minimum period should be through June 30, 2021.
- There is virtually no risk of "adverse risk selection" – Covered California's 2020 COVID Special Enrollment saw same risk mix as our overall enrollment
- We do NOT want to turn away an uninsured person who is newly eligible for $800 a month in subsidies (and many able to get virtually free coverage) in July to tell them "come back for coverage starting in January
- AND we can and must still market with the "sell" of urgency and "sign-up now" (which is often triggered by a deadline) with BIG marketing focus April through June.

COVERED CALIFORNIA STRATEGY 2: DOING ALL WE "NORMALLY" DO AND DOING IT WELL

Covered California must do all its "regular" activities and more – and we've got to do them well – to effectively reach and enroll all possible eligible consumers

- Consumer-centered technology to support getting the increased subsidies TO CONSUMERS as quickly as possible.
- Robust marketing – leaning in for April through June as if it were an Open Enrollment Period
  - Major spending, with current plans of spending $20 to $30 million in April through June.
  - Disproportionately targeting communities hardest hit by the recession: communities of color and lower income
  - Benefiting from lower cost of media buying AND we will "own" the health insurance market
- Actively reach out to subsidized members and eligible consumers in our "funnel" and provide great customer service for consumers and for those who help consumers (e.g., navigators and agents)
- Engage in partner activities with major state entities: the Employment Development Department, the Franchise Tax Board and California's Medi-Cal Department

MARKETING TO PROMOTE THE NEW LOWER COST COVERAGE FROM THE AMERICAN RESCUE PLAN

- Covered California plans a statewide marketing campaign mirroring Open Enrollment levels with $20-30 million investment reaching at least 97% of consumers 18 times April 12 – June 30.
- Build strong momentum out the gate with maximum media weight levels in the first three weeks of the campaign.
- Enhanced emphasis on ethnic market media across Hispanic, Asian and African-American/Black audience segments in all mediums possible within the timeline. Highlights include:
  - Dedicated digital buys on contextually relevant sites.
  - Purchase the most circulated Spanish, Black and API print publications in CA.
  - Purchase through every Black-owned radio station in the state as well as partner with influential Black, Hispanic and Asian radio personalities to deliver our message.

IN COMMUNITIES THROUGHOUT CALIFORNIA, THOUSANDS OF CERTIFIED AGENTS AND ENROLLERS ARE READY TO HELP

10,000 Certified Insurance Agents

581 Covered California Storefronts

3,753 Navigators and other Community-Based Organizations

COVERED CALIFORNIA

COVERED CALIFORNIA WILL PARTNER WITH KEY STATE AND OTHER GROUPS TO MAKE A DIFFERENCE

Covered California will work to promote insurance enrollment with our public partners, including key state agency partners:

- **Employment Development Department (EDD) – for Californians receiving Unemployment Insurance:** Covered California will continue to work with the Employment Development Department (EDD), California's unemployment insurance agency, to provide messaging that will be sent by EDD to unemployment compensation recipients. We will also work with EDD to explore any opportunities for data sharing to enable direct outreach by Covered California to unemployment compensation recipients.
- **California Franchise Tax Board (FTB) – for Californians who paid penalty for being uninsured in 2020:** By state law, California's Franchise Tax Board will share data with Covered California to enable direct outreach to penalty payers. Covered California will develop material to make penalty payers aware of the new subsidies and the stimulus special enrollment period.
- **California Department of Health Care Services (DHCS) – for Californians leaving Medi-Cal coverage:** Covered California with partner with the Department of Health Care Services, California's Medicaid Agency, to plan for the expected influx of newly eligible individuals coming from Medicaid when the public health emergency is lifted at the end of 2021 and early 2022.

COVERED CALIFORNIA STRATEGY 3:
MAKE SURE CONTRACTED HEALTH PLANS DO THE RIGHT THING

Covered California will provide the tools and implement the policies to ensure its eleven contracted health plans do the right thing for consumers, including:

- Requiring health plans to actively reach out to all their off-exchange consumers to encourage them to see if they are eligible for assistance AND to help them "convert" if they are:
  - Covered California building "microsite" of CoveredCA.com for each carrier to facilitate these conversions and plan-based enrollment activities
- Requiring health plans to establish consumer-first conversion policies:
  - Assure any spending is carried over to credit deductibles with their new plan
  - Making sure they either keep same doctors/networks or understand the implications of changing
  - Making sure continuity of care issues are well addressed
- Do their fair share of marketing and promotion while coordinating with Covered California's efforts.
- Support and partner with their agents (including paying fairly and being sure all transferring clients are still credited to those agents)

California's plan to make the American Rescue Plan work well is based on the same principles that have supported its effective implementation of the Affordable Care Act:

- Do the right thing for millions of Californians who can and will benefit
- Invest in marketing **and** supporting ground-up efforts in every community across the state
- Target efforts in communities of color and lower-income Californians
- Focus not just on coverage, but assuring consumers get the right care at the right time and delivering on health equity and quality.

Thanks to all the Californians who are working to make high quality, affordable health care real for millions of people in every community across the state.

AMERICAN RESCUE PLAN REVIEW OF IMPLEMENTATION ISSUES

Katie Ravel, Director, Policy, Eligibility & Research Division

COVERED CALIFORNIA'S AMERICAN RESCUE PLAN IMPLEMENTATION TIMELINE

Date	Key Milestones
March 11	American Rescue Plan signed
March 15	Member communication begins for new subsidies
April 12	American Rescue Plan special enrollment period begins
April 12	Covered California begins to redetermine subsidy eligibility for existing members
May 1	American Rescue Plan subsidies effective for Californians
TBD	Implementation of enhanced subsidies for unemployment compensation recipients *(System updates planned for late June with enhanced subsidies likely effective for August coverage)*

POLICY AND TECHNOLOGY FLEXIBILITY TO SUPPORT ENROLLMENT OF SUBSIDY-ELIGIBLE INDIVIDUALS

Katie Ravel, Director, Policy, Eligibility & Research Division

POLICY AND TECHNOLOGY FLEXIBILITY TO SUPPORT ENROLLMENT OF SUBSIDY-ELIGIBLE INDIVIDUALS

- Covered California proposes to offer temporarily flexibility to health plans and certified enrollers to accelerate the enrollment of eligible individuals into subsidized coverage.
- This temporary flexibility will allow a carrier-specific shopping experience to assist Californians currently enrolled off-exchange to maximize their new premium subsidy benefit under the American Rescue Plan.
- Covered California is proposing to offer this flexibility through the 2022 plan year.

POLICY FLEXIBILITY TO SUPPORT ENROLLMENT OF SUBSIDY-ELIGIBLE INDIVIDUALS

Covered California proposes to provide the following flexibility through the 2022 plan year:

- **Policy flexibility** to allow carriers to engage plan-based enrollers and/or certified insurance agents to support their enrollment efforts. These enrollers will have the flexibility to limit the carrier options they present to a consumer when the consumer is enrolled in coverage outside of the exchange to only those Qualified Health Plans (QHP) offered by the consumer's current carrier.

TECHNOLOGY FLEXIBILITY TO SUPPORT ENROLLMENT OF SUBSIDY-ELIGIBLE INDIVIDUALS

Covered California proposes to provide the following flexibility through the 2022 plan year:

- **Covered California microsites** that will enable a carrier-specific enrollment experience through Covered California. Microsites are intended to facilitate the transfer of coverage from a non-exchange product into subsidized coverage, however, uninsured individuals will not be barred from using the microsites. Covered California will include language in plan shopping pages to inform prospective enrollees that other QHP Issuers are available. Plan-based enrollers and certified insurance agents may use the microsites or traditional enrollment channels (i.e., Covered California's broker portal).

MICROSITE DESIGN FEATURES

- **User flow:** consumer will access a microsite via a link on the carrier's website that will take the consumer to the carrier's co-branded Covered California microsite.
- **Eligibility and enrollment:** will occur in Covered California's online application.
- **Plan choice:** the microsite will include clear notice to consumers on shopping pages informing them that other carriers are available, offering identical benefit designs that may be less expensive. The notice will provide mechanism for consumers to link to the full Covered California site and have access other carriers if they chose to.
- **Carrier co-branding:** co-branding will appear during the eligibility and enrollment experience for the consumer's initial plan selection. Consumers who return to their accounts to report changes or renew their coverage after initial enrollment will see all available carriers.

RELATED REQUIREMENTS: HEALTH PLANS WILL BE REQUIRED TO ESTABLISH CONSUMER-FIRST COVERAGE TRANSITION POLICIES

Health plans will be expected to identify, reach out to, and help their off-exchange eligible enrollees get subsidies through Covered California and to ensure that those transitioning do so in a consumer-centered way, including:

- Transferring amounts accrued to deductibles – regardless of plan type within the same carrier;
- To the extent possible, maintaining primary care relationships with the consumers; and
- Assuring continuity of care and addressing potential network changes.

REPORTING ON AND EVALUATION OF THE IMPACT OF MICROSITES ON CONSUMER OUTCOMES

- Covered California's goal is to maximize the benefits Californians receive from the health insurance provisions of the American Rescue Plan. Covered California will use administrative and survey data to evaluate the impact of the temporary microsite program on consumer outcomes.
- Covered California will be able to track enrollments through microsites to compare consumer eligibility, financial and enrollment outcomes and member survey responses to other Covered California enrollees.
- Covered California will be able to study consumer behavior at initial plan selection and renewal.

PROPOSED IMPLEMENTATION MILESTONES AND DATES

MILESTONE	DATE
Board discussion	March
Stakeholder feedback	March and April
Potential Board action	April
Microsite launch	*TBD*
Program evaluation and report	Fall 2022
End of temporary program	December 2022

PUBLIC COMMENT

CALL: (877) 336-4440
PARTICIPANT CODE: 6981308

- To request to make a comment, press 10; you will hear a tone indicating you are in the queue for comment. Please wait until the operator has introduced you before you make your comments.
- If watching via the live webcast, please mute your computer to eliminate audio feedback while calling in. Note, there is a delay in the webcast.
- The call-in instructions can also be found on page two of the Agenda.

EACH CALLER WILL BE LIMITED TO TWO MINUTES PER AGENDA ITEM

NOTE: Written comments may be submitted to BoardComments@covered.ca.gov.

2022 QUALIFIED HEALTH PLAN CONTRACT AND CERTIFICATION PROCESS

James DeBenedetti, Director, Plan Management Division

APPROACH TO 2022 CONTRACTING AND CERTIFICATION

2022 Model Contract

- **Attachment 7:** Focus on incremental changes to set the foundation for more transformational changes in 2023 related to improving health care quality, reducing disparities, and reforming the delivery system
- **Attachment 14:** Transition to penalty-only approach to prepare issuers for a Quality Transformation Fund in 2023, which will have far greater financial incentives to improve health care quality
- **Other Changes:** Primarily to account for recent changes in State and Federal policy

2022 Certification Application

- Accepting new and currently contracted health plans for 2022, with a more comprehensive review process for 2023
- Updated to align with changes to the Model Contract

2022 Benefit Design

- Lower cost-sharing for the Silver plans to enhance their attractiveness and reduce the impact of deductibles and out-of-pocket maximums

2022 QUALIFIED HEALTH PLAN ISSUER MODEL CONTRACT

Alice Chen, Chief Medical Officer

GUIDING PRINCIPLES FOR DEVELOPING EXPECTATIONS OF HEALTH PLANS - 2020 REVISION

1. Contract expectations are driven by the desire to improve the health of the population, improve care delivered, reduce the cost of care and reduce health disparities by assuring three complementary and overlapping objectives are met by health plans:
   - **Assuring Quality Care:** Ensuring our enrollees receive the right care, at the right time, in the right setting, at the right price.
   - **Fostering Improvements in Care Delivery:** Promoting value-enhancing strategies that have the potential to reform the delivery system in the near and long term.
   - **Promoting Health Equity:** Acknowledging the role of social determinants and systemic racism, Covered California expects its issuers and partners to address the impact of social needs and health disparities experienced by Covered California enrollees.
2. Success will be assessed by outcomes, measured at the most appropriate level, in preference to adoption of specific strategies.
3. Prioritizing requirements that meet multiple objectives and leveraging existing initiatives and mechanisms will reduce administrative burden.
4. Promoting alignment with other purchasers will maximize impact, elevate shared priority objectives and increase efficiency.
5. Enrollees will have access to networks offered through the issuers that are based on high quality and efficient providers.
6. Enrollees will have the tools needed to be active consumers, including tools for provider selection and shared clinical decision making.
7. Payment will increasingly be aligned with value and proven delivery models.
8. Actively monitoring and reducing variations in quality and cost of care will ensure better outcomes across the network for all Covered California Enrollees.

COVERED CALIFORNIA'S FRAMEWORK FOR HOLDING PLANS ACCOUNTABLE FOR QUALITY CARE AND DELIVERY REFORM

Assuring Quality Care

INDIVIDUALIZED, EQUITABLE CARE

- Population Health Management: Assessment and Segmentation
- Health Promotion and Prevention
- Mental Health and Substance Use Disorder Treatment
- Acute, Chronic and Other Conditions
- Complex Care

Effective Care Delivery Strategies

ORGANIZING STRATEGIES

- Effective Primary Care
- Promotion of Integrated Delivery Systems and ACOs
- Networks Based on Value

Sites and Expanded Approaches to Care Delivery

Appropriate Interventions

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 burdens on providers.

- Benefit Design
- Measurement for Improvement Choice and Accountability
- Payment
- Patient-Centered Social Needs
- Patient and Consumer Engagement
- Data Sharing and Analytics
- Administrative Simplification
- Quality Improvement and Technical Assistance
- Certification, Accreditation and Regulation

Community Drivers: Community-Wide Social Determinants, Population and Public Health, and Workforce

January 2020

OVERALL APPROACH TO 2022, 2023+ CONTRACTS

- **2022 is a transitional year that focuses on a narrowed set of issuer requirements to lay the foundation for more transformational requirements in 2023+.**
- Covered California staff engaged issuers, providers, consumer advocates, and other stakeholders throughout 2020 to develop the 2022 contract.
- Stakeholders are largely in agreement with our guiding principles, areas of focus, and approaches to improve the quality of care delivered to consumers.
- As we transition into developing the 2023+ contract we will ensure ongoing engagement with these stakeholders.
- Areas of significant change expected for 2023+ include:
  - Development of a Quality Transformation Fund (QTF) that has significant financial incentives tied to a parsimonious set of quality measures
  - Expanded health equity agenda incorporated throughout QTF and supported by investments in data collection, infrastructure, and data quality
  - Increased focus on behavioral health – expanding integration with primary care and moving towards patient-reported outcome measures
  - Expanded population health management, including screening for social needs
  - Amplification of our quality and equity efforts through alignment and coordination with other public purchasers

FOCUS OF 2022 ATTACHMENT 7 REVISIONS

Health Equity	• Strengthened current requirements; added requirements to build health plan capacity and culture of equity, including achievement of NCQA Multicultural Health Care Distinction by year-end 2022
Population Health Management	• Added requirements for issuers to develop a Population Health Management plan
Behavioral Health	• Strengthened current requirements; added requirement to track new measures for depression screening and opioid use disorder
Effective Primary Care	• Strengthened current requirements; added requirement to participate in piloting a measure set to track the performance of primary care practices
Telehealth	• Added requirement for issuers to offer telehealth for behavioral health
Patient-Centered Social Needs	• Added requirement for issuers to screen all enrollees receiving plan-based services for at least housing instability and food insecurity
Accreditation	• Revised accreditation requirement to require NCQA Accreditation by year end 2024 to set a base standard of core health plan functions across all issuers

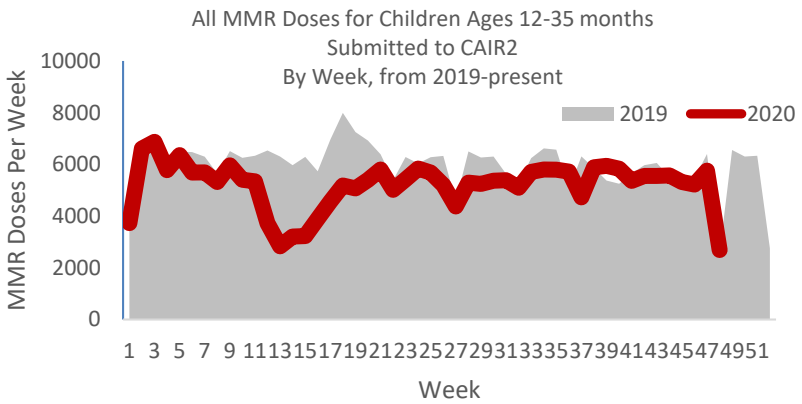
PROPOSAL TO ADDRESS COVID-19 GAPS IN CARE

- Covered California has added an expectation for QHP issuers to address gaps in care and ensure racial and ethnic disparities are not exacerbated for 3 key preventive care measures.

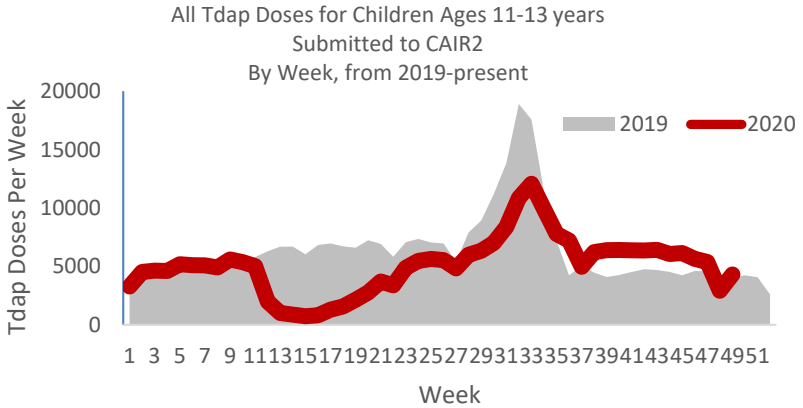
- QHP issuer performance goals:
    1. By Jan 1st 2022, greater than or equal to 2019 pre-pandemic levels; and
    2. By Dec 31st 2022, greater than or equal to the national 50th percentile for the following measures:
        - Childhood Immunization Status (Combination 3) (NQF #0038) *(Anticipated change to Combination 10 for MY 2022 in alignment with NCQA and QRS)*;
        - Immunizations for Adolescents (Combination 2) (NQF #1407); and
        - Colorectal Cancer Screening (NQF #0034)

- Covered California will also work with QHP issuers to assess COVID-19 vaccination rates and ensure appropriate outreach to eligible enrollees.

COVID-19 GAPS IN CARE



15% fewer children under age 3 have received the first dose of Measles, Mumps, and Rubella vaccine.[1]



28% fewer adolescents ages 11-13 have received the Tetanus, Diphtheria, and Pertussis booster vaccine.[1]

National colorectal cancer screening rates remain 36% lower than previous years.[2]

1. "Fill the Gaps. Keep Immunizing Your Patients!" Drop in Immunizations During COVID-19 – California Vaccines for Children (VFC), http://eziz.org/home/immunization-drop/
2. "Delayed Cancer Screenings – A Second Look." Epic Health Research Network (July 17, 2020). Retrieved from: https://ehrn.org/articles/delayed-cancer-screenings-a-second-look/

2022 ATTACHMENT 14 PERFORMANCE STANDARDS

New Attachment 14 Structure

- Removed all credits with the exception of 3.3c) early NCQA MHCD attainment (2%)

- Performance Standards and Expectations *(renumbered 1.1, 1.2, etc.)*
  - Customer Service Performance Standards
  - Operational Performance Standards (with the exception of HEI Data Submission)
  - Essential Community Providers and Hospital Safety Performance Standards
  - Removal of Covered CA Customer Service Performance Standards from contract language

- Performance Standards With Penalties
  - Updated HEI Data Submission Performance Standard *(renumbered 2.1)*
  - Updated Quality Performance Standards *(renumbered 3.1, 3.2, etc.)*
  - Percent at risk for performance standards and performance levels vary by HMO and PPO/EPO products for QHP issuers
  - Dental Quality Alliance Pediatric Measure Set – still in Pilot for 2022 *(renumbered 4.1, 4.2, etc.)*

REVISED ATTACHMENT 14 PERFORMANCE STANDARDS WITH PENALTIES FOR QHP ISSUERS

Performance Standards with Penalties	Current % at Risk	Proposed % at Risk	
		HMO	PPO/EPO
2.1 HEI Data	5%	10%	10%
3.1 Quality Rating System – Clinical Quality Management Summary Rating	3.5%	33.5%	33.5%
3.2 Quality Rating System – QHP Enrollee Experience Summary Rating	3.5%	16.5%	16.5%
3.3 Reducing Health Disparities a) Race/Ethnicity Self-Identification Capture 80% in HEI Data b) Disparity Reduction c) NEW: Proposed 2% Credit for early achievement of NCQA MHCD	 2% 3%	 7.5% 7.5%	 7.5% 7.5%
3.4 Primary Care Payment Strategy	3%	10%	20%
3.5 Accountable Care Organizations	5%	10%	0%
3.6 Appropriate Use of C-Sections	4.5%	5%	5%
Total at Risk - Quality (90%) and HEI data (10%) Standards		100%	100%

OTHER CHANGES

	Proposed Changes	IND	CCSB	QDP
2.2.1	Open Enrollment, Auto Enrollment, and Special Enrollment Periods. Updated to reflect SB 260, addressing a consumer's auto-enrollment into Covered California when they no longer qualify for Medi-Cal or the State's Children's Health Insurance Program.	✓		
2.2.2	Covered California for the Individual Market Coverage Effective Dates. Updated to reflect SB 260 changes to ensure no breaks in coverage by elimination of the 1-month delay in startup if binder payment is made after the 15th day of the month (15 Day Rule).	✓		✓
3.1.3	Accreditation. Moved to Attachment 7.	✓	✓	
3.5.2	Covered California for the Individual Market Rates. Updated language allocating windfall issuer profits (or losses) due to unanticipated ACA-related judgements or changes in federal policy into future premiums.	✓		
5.1.3	Covered California for the Individual Market Participation Fees. New language allows Covered California to offset participation fees in situations where payment or reimbursement to issuers is required.	✓		✓

APPENDIX
DETAILED PROPOSED 2022 ATTACHMENT 7 CHANGES AND SUMMARY OF PUBLIC COMMENTS

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 1: Individualized Equitable Care

- Issuers will continue to meet 80% capture of member race/ethnicity self-identification, assessed in Healthcare Evidence Initiative (HEI) data submission
- Issuers will submit patient level data files for required disparities measures instead of reporting disparities measures rates aggregated across lines of business
- Issuers will participate in collaborative effort to identify opportunities for aligned statewide disparity work
- Issuers must achieve and maintain NCQA Multicultural Health Care Distinction (MHCD) by year-end 2023. For an early distinction credit per Attachment 14, issuers must show evidence of MHCD by December 30, 2022.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 1: Individualized Equitable Care

Notable Changes to Draft Attachment 7	Rationale
1.02 Identifying Disparities in Care Added language describing Covered California intention to use HEI data to produce disparities measures previously reported by QHP Issuers.	New language clarifies intent to continue monitoring a broad set of diabetes, hypertension, asthma, and depression measures for racial and ethnic disparities purposes.
1.03 Disparities Reduction Intervention Revised requirement: issuer must demonstrate meaningful improvement for the intervention population for the identified disparity measure with analysis of results including potential to replicate or scale, rather than demonstrating reduction in disparity in 2022.	Due to COVID-19 impacts in 2020, disparity intervention efforts were delayed and, in most cases, significantly modified, reducing the time period to reasonably expect interventions to result in measurable disparity reduction.
1.04 Statewide Focus on Health Equity Collaborative Efforts Language added to clarify participation requirements and goals of statewide disparity focus.	Clarifying language added to address public comments indicating the requirement objective and participation requirements lacked clarity.
1.05 Culture of Health Equity Capacity Building Deadline to achieve NCQA Multicultural Health Care Distinction extended to year-end 2023. Deadline to achieve a NCQA MHCD early achievement credit (per Attachment 14) extended to December 30, 2022.	This extension acknowledges the impacts of current and new disparities reduction requirements and other new requirements across Attachment 7.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 2: Population Health Management

- Issuers will continue to submit copy of NCQA Population Health Management Plan: Standard 1 (Population Health Management Strategy) and Standard 2 (Population Stratification and Resource Integration) to demonstrate population assessment and segmentation approach or submit a comparable plan

Notable Changes to Draft Attachment 7	Rationale
Added language for requirement to submit NCQA Population Health Management Plan: Standard 1 and Standard 2 or a comparable alternative plan. "When submitting its plan to Covered California, Contractor shall clearly designate any information it deems confidential, trade secret, or proprietary information as such."	Issuers expressed concerns about submitting NCQA accreditation reports to Covered California, which contain information on products that are not subject to Covered California oversight. Covered California has amended draft Attachment 7 to allow Issuers to designate any information provided as confidential, trade secret, or proprietary information.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 3: Health Promotion and Prevention

- Issuers will continue to report on tobacco cessation program and weight management program utilization
- Issuers will report strategies to improve rates of Medical Assistance with Smoking and Tobacco Use Cessation and Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents measures
- Issuers will continue to offer Diabetes Prevention Programs (DPP) as both online and in-person formats
- Issuers will be expected to address gaps in care due to the COVID-19 pandemic with the goal of meeting performance targets of (1) great than or equal to Measurement Year 2019 pre-COVID-10 performance by Jan 1st, 2022 and (2) perform greater than or equal to the national 50th percentile year-end 2022 on the following measures:
  - Childhood Immunization Status (Combination 3) (NQF #0038) *(Anticipated change to Combination 10 for MY 2022 in alignment with NCQA and QRS)*;
  - Immunizations for Adolescents (Combination 2) (NQF #1407); and
  - Colorectal Cancer Screening (NQF #0034)
- Covered California will also work with QHP issuers to assess COVID-19 vaccination rates and ensure appropriate outreach to eligible enrollees

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 3: Health Promotion and Prevention

Notable Changes to Draft Attachment 7	Rationale
Amended language for requirement for issuers to offer Diabetes Prevention Programs (DPP) as BOTH online and in-person formats "The DPP must be available both in-person and online by year end 2022 to allow Enrollees a choice of modality (in-person, online, distance learning, or a combination of modes)."	Issuers requested that the requirement for *both* online and in-person DPP be changed to online *or* in-person, citing a limited number of in-person programs and low attendance. Covered California has amended draft Attachment 7 to clarify the requirement intent and designated an implementation deadline. We are committed to ensuring that all Enrollees have access to preventative diabetes care and education. Providing both in-person and online DPP services ensures Enrollees have equitable access to these services and allows Enrollees to choose their preferred choice of modality.
New expectation for issuers to address gaps in care due to the COVID-19 pandemic with the goal of meeting the following performance targets: (1) greater than or equal to Measurement Year 2019 pre-COVID-19 pandemic performance level by January 1, 2022 (Measurement Year 2021); and (2) greater than or equal to the national 50th percentile threshold by year-end 2022 (Measurement Year 2022) on the following measures reported by the Contractor to CMS for the Quality Rating System (QRS): ▪ Childhood Immunization Status (Combination 3) (NQF #0038) *(Anticipated change to Combination 10 for MY 2022 in alignment with NCQA and QRS)* ▪ Immunizations for Adolescents (Combination 2) (NQF #1407) ▪ Colorectal Cancer Screening (NQF #0034) Covered California will work with QHPs to assess COVID-19 vaccination rates and ensure appropriate outreach to eligible enrollees.	The COVID-19 pandemic has created gaps in quality due to deferred care and highlighted disparities in our health care delivery system. Childhood vaccines protect children from a number of serious and potentially life-threatening diseases at a time in their lives when they are the most vulnerable. 15% fewer children under age 3 have received the first dose MMR. 28% fewer adolescents ages 11-13 have received the Tdap booster. Treatment for colorectal cancer in its earliest stage can lead to a 90 percent survival rate after five years. National colorectal cancer screening rates dropped 86% initially and has remained 36% lower than previous years. MY 2019 performance multiple QHPs below the national 50th percentile threshold on all three measures.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 4: Behavioral Health

- Submit NCQA Health Plan Accreditation Network Management reports (or a comparable report) for the elements related to the issuer's behavioral health provider network
- Offer telehealth for behavioral health services and provide Enrollee education about how to access telehealth services; Covered CA will monitor utilization of telehealth services through HEI
- Annually report *Depression Screening and Follow Up (NQF #0418)* measure results for Covered CA enrollees; Covered CA will engage with issuers to review their performance
- Covered CA will monitor the following measures through HEI and engage with issuers to review their performance:
  - *Antidepressant Medication Management (NQF #0105)*
  - *Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up) (NQF #0576)*
  - *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (NQF #0004)*
  - *Use of Pharmacotherapy for Opioid Use Disorder (NQF #3400)*
  - *Concurrent Use of Opioids and Benzodiazepines (NQF #3389)*
  - *Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940)*
  - *Concurrent Use of Opioids and Naloxone*
  - Medication Assisted Treatment (MAT) prescriptions by clinician and by region
- Report how issuers are promoting the integration of behavioral health services with medical services, report the percent of Enrollees cared for under integrated models, and whether the issuer reimburses for the Collaborative Care Model claims codes

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 4: Behavioral Health

Notable Changes to Draft Attachment 7	Rationale
Replaced the requirement to track active X waiver licensed prescribers with a requirement to Issuers to engage with Covered California to review its Medication Assisted Treatment (MAT) prescriptions by clinician and by region using HEI data	Issuers commented that it would be challenging to track active X waiver license prescribers since this data is not currently tracked. The US Department of Health and Human Services recently shared a press release announcing plans to publish guidance eliminating certain X-waiver requirements while SAMHSA released a statement that this announcement was made prematurely. Based on the conflicting statements and unclear future of the X waiver license requirements, Covered California has replaced the requirement to track X waiver licensed prescribers with a requirement to track MAT using HEI data.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 5: Acute, Chronic and Other Conditions

- Issuers will continue to engage with Covered California to review QRS measure performance related to acute and chronic conditions
- Issuers will continue to support transition of enrollment for at-risk enrollees

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 6: Complex Care

- Issuers will continue to describe methods to ensure, support, and monitor contracted hospitals' compliance with Medicare Condition of Participation rules to have electronic information exchange to notify primary care providers of Admission, Discharge, Transfer (ADT) events
- Issuers will continue requirements for at-risk enrollee engagement and Centers of Excellence

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 7: Effective Primary Care

- Continue to match enrollees with PCPs and report the number of enrollees who select a PCP vs. those who are assigned a PCP
- Report the quality improvement and technical assistance being provided to physician groups to implement or support advanced primary care models
- Continue to require primary care payment reporting and increase the number of PCPs paid through shared savings and population-based payment models
- Pilot a quality measure set for advanced primary care to assess the prevalence of high-quality, advanced primary care practices within the issuer's network in collaboration with the California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA)

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 8: Promotion of Integrated Delivery Systems (IDS) and Accountable Care Organizations (ACOs)

- Participate in the Integrated Healthcare Association (IHA), submit data for the IHA Commercial HMO and ACO measure sets (as applicable), and report performance on the measure sets to Covered California annually
- Report the characteristics of the issuer's IDS and ACO systems such as payment model, leadership structure, quality incentive programs, data exchange processes, etc.
- Continue to require reporting the number of enrollees in IDS and ACO systems and increase the number of enrollees cared for under IDS and ACO systems

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 9: Networks Based on Value

- Continue to require issuers to include quality and cost in all provider and facility selection criteria
- Continue to require issuers to notify poor performing hospitals and engage these hospitals in improvement efforts to reduce variation in performance across contracted hospitals and report the rationale for continuing to contract with poor performing hospitals
  - Covered California has defined poor performance as hospitals performing in the lowest decile on state or national benchmarks for quality and safety
- Participate in the IHA Align Measure Perform (AMP) program and report contracted physician group performance results to Covered California
- Work collaboratively with Covered California and other issuers to define poor performing physicians and physician groups, notify poor performers, and engage physician groups in improvement efforts to reduce variation in performance across contracted physician groups
  - Covered California will use the IHA AMP program to profile and analyze variation in physician groups performance on quality measures and total cost of care

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 10: Sites and Expanded Approaches to Care Delivery

- Issuers will continue to track and report strategies to reduce hospital associated infections (HAI) and NTSV C-sections to improve hospital quality and patient safety
- Issuers will continue to track and report on telehealth utilization and payment

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 11: Appropriate Interventions

- Issuers will continue to report how it considers value in its medications formulary
- Issuers will continue to ensure Enrollees have access to accurate cost and quality information
- Issuers will report how they are encouraging providers to implement *Choosing Wisely* guidelines or other evidence based shared decision making tools

Notable Changes to Draft Attachment 7	Rationale
Removed requirements for issuers to report detailed utilization information on shared decision making between provider and Enrollee.	Shared decision making occurs at the point of care between a provider and Enrollee. Issuers report that data collection is challenging as they do not have reliable insight into this process. Requirements were removed to reduce reporting burden and data inconsistency. Covered California will continue to investigate the best practices for collecting information on shared decision making to inform future contract requirements.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 12: Key Drivers of Quality Care and Effective Delivery

- Article 12 defines and summarizes the Key Drivers
- Key Drivers with their own article:
  - Article 13: Measurement for Improvement, Choice, and Accountability
  - Article 14: Patient-Centered Social Needs
  - Article 15: Data Sharing and Analytics
  - Article 16: Quality Improvement and Technical Assistance
  - Article 17: Certification, Accreditation, and Regulation
- Key Drivers as an appendix:
  - Appendix A: Measurement for Improvement, Choice, and Accountability
  - Appendix B: Payment
  - Appendix C: Patient and Consumer Engagement
  - Appendix D: Quality Improvement and Technical Assistance

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 13: Measurement for Improvement, Choice, and Accountability

- Continue requirements related to data submission for the Quality Rating System and NCQA Quality Compass
- Consolidated and re-arranged the current measurement requirements in the draft 2022 Attachment 7

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 14: Patient-Centered Social Needs

- Issuers must screen all enrollees receiving plan-based services (such as complex care management or case management) for at least housing instability and food insecurity; report aggregated counts of members screened and positive screens for housing instability and food insecurity
- Issuers must maintain community resources inventory by region served to support linkage to appropriate social services; submit documented process for referrals for housing instability and food insecurity

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 15: Data Sharing and Analytics

- Issuers will continue to implement and maintain a secure, standards-based Patient Access Application Programming Interfaces (API) consistent with the Federally Facilitated Marketplace (FFM) rule
- Issuers will continue requirements to support data exchange with providers and data aggregation across plans

Notable Changes to Draft Attachment 7	Rationale
No changes will be made to the requirement for data exchange with providers to include additional Health Information Exchange (HIE) options	Issuers requested to include additional HIEs to the HIE list included in the contract. Covered California understands this list is not an exhaustive list. Issuers are to clarify their participation in other qualified HIEs with the "Other Health Information Exchange" option. No changes will be made to draft Attachment 7.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 16: Quality Improvement and Technical Assistance

- Issuers will continue to report on participation in any quality improvement collaborative and data sharing initiatives in the annual application for certification
- Issuers will continue to adopt and implement Smart Care California guidelines supporting the appropriate use of C-sections and Opioids

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 17: Certification, Accreditation and Regulation

- Issuers will be required to be accredited by NCQA by year end 2024
  - Previously Covered California allowed issuers to be accredited by one out of three accrediting bodies (NCQA, AAAHC, or URAC)
- Covered California will align with the CMS accreditation timeline and 30-day written notification of changes or actions affecting an issuer's accreditation status

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED CHANGES FOR 2022 PERFORMANCE STANDARDS – GROUPS 1, 2, 3, AND 4

- Retain monthly reporting to maintain accountability, and remove penalties and credits associated with:
  - Group 1 – Customer Service
  - Group 2 – Operational (except HEI Data)
  - Portions of Group 3 – Quality, Network Management and Delivery System Standards
  - Group 4 – Covered California Customer Service

- Retain monthly reporting and penalties. Redistribute % at risk among the remaining performance standards:
  - Group 2 – HEI Data
  - Group 3 – Quality, Network Management and Delivery System Standards

PROPOSED CHANGES FOR 2022 PERFORMANCE STANDARDS – SUMMARY

New Attachment 14 Structure

- Removed all credits with the exception of 3.3c) early NCQA MHCD attainment (2%)

- Performance Standards and Expectations *(renumbered 1.1, 1.2, etc.)*
  - Customer Service Performance Standards
  - Operational Performance Standards (with the exception of HEI Data Submission)
  - Essential Community Providers and Hospital Safety Performance Standards
  - Removal of Covered CA Customer Service Performance Standards from contract language

- Performance Standards With Penalties
  - Updated HEI Data Submission Performance Standard *(renumbered 2.1)*
  - Updated Quality Performance Standards *(renumbered 3.1, 3.2, etc.)*
  - Dental Quality Alliance Pediatric Measure Set – still in Pilot for 2022 *(renumbered 4.1, 4.2, etc.)*

PROPOSED ATTACHMENT 14 PERFORMANCE STANDARDS WITH PENALTIES

Performance Standards with Penalties	Current % at Risk	Proposed % at Risk	
		HMO	PPO/EPO
2.1 HEI Data	5%	10%	10%
3.1 Quality Rating System – Clinical Quality Management Summary Rating	3.5%	33.5%	33.5%
3.2 Quality Rating System – QHP Enrollee Experience Summary Rating	3.5%	16.5%	16.5%
3.3 Reducing Health Disparities a) Race/Ethnicity Self-Identification Capture 80% in HEI Data b) Disparity Reduction c) NEW: Proposed 2% Credit for early achievement of NCQA MHCD	 2% 3%	 7.5% 7.5%	 7.5% 7.5%
3.4 Primary Care Payment Strategy	3%	10%	20%
3.5 Accountable Care Organizations	5%	10%	0%
3.6 Appropriate Use of C-Sections	4.5%	5%	5%
Total at Risk - Quality (90%) and HEI data (10%) Standards		100%	100%

PROPOSED 2022 ATTACHMENT 14 CHANGES BASED ON PUBLIC COMMENT

Notable Changes to Draft Attachment 14	Rationale
3.3b) Health Disparities Interventions – Adjusting the performance level from disparity reduction to intervention population improvement and analysis of results including potential to replicate or scale intervention.	Due to COVID-19 impacts in 2020, disparity intervention efforts were delayed and, in most cases, significantly modified, reducing the time period to reasonably expect interventions to result in measurable disparity reduction.
3.4 Primary Care Payment – Different percent at risk and performance levels by HMO and PPO/EPO products HMO – 10% PPO/EPO – 20% **3.5 ACO Enrollment** – Different percent at risk and performance levels by HMO and PPO/EPO products HMO – 10% PPO/EPO – 0%	Covered California recognizes that many PPO/EPO plans cannot meet the current definition of an ACO with combined risk sharing across physicians and hospitals. Many PPO/EPO plans are focusing on implementing primary care and physician group payment reforms therefore Covered California is proposing to redistribute risk from 3.5 ACO Enrollment to 3.4 Primary Care Payment for PPO/EPO plans. This structure maintains 50% at risk for quality, 15% at risk for disparities reduction, and 25% at risk for payment reform for all products.

2022 QUALIFIED HEALTH PLAN CERTIFICATION POLICY

Jan Falzarano, Deputy Director , Plan Management Division

CERTIFICATION UPDATE

- Letters of Intent were due on February 12, 2021.
- The Applications have not had any material changes since the January Board meeting.
- Individual and Small Business Certification Applications went live on March 1, 2021 and are due on April 30, 2021.
- Rate-related documents will be submitted on May 13, 2021.

PROPOSED CERTIFICATION MILESTONES

Release Draft 2022 QHP & QDP Certification Applications	December 2020
Draft Application Comment Periods End	December 2020
Plan Management Advisory: Benefit Design & Certification Policy Recommendation	January 2021
January Board Meeting: Discussion of Benefit Design & Certification Policy Recommendation	January 2021
Letters of Intent Accepted	February 2021
Final AV Calculator Released*	February 2021
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 2021
March Board Meeting: Anticipated approval of 2022 Patient-Centered Benefit Plan Designs & Certification Policy	March 2021
QHP & QDP Applications Open	March 1, 2021
QHP & QDP Application Responses (Individual and CCSB) Due	April 30, 2021
Evaluation of QHP Responses & Negotiation Prep	May - June 2021
QHP Negotiations	June 2021
QHP Preliminary Rates Announcement	July 2021
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2021
Evaluation of QDP Responses & Negotiation Prep	June – July 2021
QDP Negotiations	July 2021
CCSB QHP Rates Due	July 2021
QDP Rates Announcement (no regulatory rate review)	August 2021
Public Posting of Proposed Rates	July 2021
Public Posting of Final Rates	September – October 2021

*Final AV Calculator and final SERFF Templates availability dependent on CMS release

2022 HEALTH AND DENTAL BENEFIT PLAN DESIGNS

Jan Falzarano, Deputy Director, Plan Management Division

AV CALCULATOR AND NOTICE OF BENEFIT AND PAYMENT PARAMETERS

- The Notice of Benefit and Payment Parameters (NBPP) final rule was released on January 14, and is subject to a 60-day regulatory freeze and 30-day comment period. A final rule is still pending.

- The final Actuarial Value Calculator has not yet been released

- The plan designs will be finalized after the Board meeting due to the timeline in final NBPP and AV calculator

BENEFIT DESIGN SINCE JANUARY BOARD MEETING

- Proposed 2022 Standard Benefit Plan Designs (SBPDs) were presented for discussion at the January Board meeting
- Additional benefit modeling was performed on Silver 70 and 73 (Individual and Family Plans only)
- Dental plan benefit designs have not changed
- CCSB benefit plan designs have not changed

2022 PROPOSED BENEFIT PLAN DESIGN CHANGES

Proposed benefit cost share changes to Silver tier plans with cost share reductions (CSR). Changes since January in red:

- Silver 94: 100% - 150% Federal Poverty Level (FPL)
  - reduced MOOP from $1,000 to $800
- Silver 87: 150% - 200% FPL
  - reduced the medical deductible from $1,400 to $800
  - eliminated the Rx deductible
- Silver 73: 200% - 250% FPL
  - reduced the Rx deductible from $275 to ~~$50~~ $10
  - reduced Tier 1 Rx copay from $16 to $15
  - reduced specialist visits from $75 to $70
  - reduced MOOP from $6,500 to $6,300

2022 PROPOSED BENEFIT PLAN DESIGN CHANGES, cont.

Proposed benefit cost share changes to Silver 70 (MOOP remains at $8,200). Changes since January in red:

- reduced Rx deductible from $300 to ~~$50~~ $10
- copays for: primary care, behavioral health, and speech/occupational/physical therapy visits reduced from $40 to $35
- reduced Tier 1 Rx copay from $16 to $15
- reduced medical deductible from $4,000 to $3,700
- reduced specialist visits from $80 to $70
- reduced tier 2 Rx from $60 to $55
- reduced Tier 3 Rx from $90 to $85

FINAL PLAN DESIGNS

- The plan designs presented to the Board for action in March will still be draft versions until the final NBPP is released
- AV Certification will be completed once the final NBPP is available

APPENDIX

2022 ANNUAL LIMITATION ON COST SHARING - MOOP

	2019	2020	2021	2022
Maximum annual limitation on cost-sharing (federal)	$7,900 / $15,800	$8,150 / $16,300	$8,550 / $17,100	$9,100 / $18,200
Less CA MOOP ($350) for dental	$7,550 / $15,100	$7,800 / $15,600	$8,200 / $16,400	$8,750 / $17,500
CSR 73 Maximum annual limitation	$6,300 / $12,600	$6,500 / $13,000	$6,800 / $13,600	$7,250 / $14,500
CSR 87 Maximum annual limitation	$2,600 / $5,200	$2,700 / $5,400	$2,850 / $5,700	$3,000 / $6,000
CSR 94 Maximum annual limitation	$2,600 / $5,200	$2,700 / $5,400	$2,850 / $5,700	$3,000 / $6,000

PUBLIC COMMENT

CALL: (877) 336-4440
PARTICIPANT CODE: 6981308

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EACH CALLER WILL BE LIMITED TO TWO MINUTES PER AGENDA ITEM

NOTE: Written comments may be submitted to BoardComments@covered.ca.gov.

PROPOSITION 22: ESTABLISHING THE AVERAGE STATEWIDE BRONZE PREMIUM AND EMERGENCY REGULATIONS

Katie Ravel, Director, Policy, Eligibility & Research Division

OVERVIEW

- Proposition 22 requires app-based network companies (Uber, Lyft, etc.) to provide a healthcare stipend to qualifying app-based drivers, on a quarterly basis, based on certain criteria.
- The stipend amount is tied to the average statewide monthly premium for an individual Covered California bronze health insurance plan.
- Covered California must post the average statewide monthly premium for a bronze plan annually.
- Covered California introduced a new Special Enrollment Period effective February 1, 2021 to allow qualifying drivers enrollment in health plans through Covered California and we will begin offering a Proof of Enrollment document around April of this year.

AVERAGE STATEWIDE MONTHLY BRONZE PREMIUM AND CALCULATION METHODOLOGY

- On or before **December 31, 2020** and **September 1 annually**, Covered California must publish the average statewide monthly premium for an individual for the following calendar year for a Covered California bronze health insurance plan.
- The stipend is tied to the "average ACA contribution" of the posted premium, defined as 82% of the premium.
- The average statewide monthly bronze premium is based on the average bronze premium for a 21-year old published by Covered California for the individual mandate penalty, adjusted by the average age of Covered California enrollees.
- Covered California engaged Milliman to review calculations for completeness and accuracy.

PROCESS FOR PUBLISHING THE AVERAGE STATEWIDE MONTHLY BRONZE PREMIUM

- The average statewide monthly bronze premium for 2021 was published on December 31 and is available at: https://www.hbex.ca.gov/stakeholders/.
- Covered California is promulgating regulations related to Proposition 22 healthcare stipend.

REQUESTED ACTION: AVERAGE STATEWIDE MONTHLY PREMIUM

- Covered California staff presented drafted regulation language at the January Board meeting to specify the methodology for calculating the average statewide monthly bronze premium:
  - One-twelfth of the state average premium for an individual, as calculated annually pursuant to section 61015, subdivision (a)(2) of the Revenue and Taxation Code, adjusted to account for the average age of a Covered California enrollee in the current calendar year.
- Staff request that the Board formally adopt the regulation related to the average statewide monthly premium.

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