COVERED CALIFORNIA POLICY AND ACTION ITEMS

November 18, 2021 Board Meeting

CHANGES TO ELIGIBILITY AND ENROLLMENT REGULATIONS FOR INDIVIDUAL MARKETS

Bahara Hosseini, Office of Legal Affairs

POLICY CONTEXT FOR PROPOSED CHANGES TO ELIGIBILITY AND ENROLLMENT REGULATIONS

- Upcoming implementation of auto-enrollment for individuals transitioning from Medi-Cal to Covered California
  - Provisions for consumers to opt-in and opt-out of coverage
  - Provisions for premium payment dates
- Alignment with recent federal regulation and procedure changes
  - New option for year-round enrollment for individuals with income below 150% of the federal poverty level
  - New income verification procedures
  - Eligibility refinements related to the American Rescue Plan

BACKGROUND ON REGULATIONS

- Covered California was granted emergency rulemaking authority by the Legislature through January 1, 2025.
- These regulations are the result of ongoing collaboration and consultation with the CDSS, DHCS, DMHC, CDI, FTB, consumer advocates, QHP issuers, and other stakeholders.

OVERVIEW OF THE MAIN PROPOSED CHANGES

- Revised the definition of “Premium payment Due Date” in section 6410 to specify the initial premium (binder) payment due date for SB 260 enrollees to comply with Gov. Code, Section 100503.4, subdivision (c), and to specify the binder payment due date for non-SB 260 enrollees and the subsequent premium payments due date for all enrollees.
- Revised the income verification process in sections 6484 and 6486 to specify that the income inconsistency threshold is 50% or $12,000 (whichever is greater), in accordance with the guidance issued by the HHS, for any benefit year for which the applicable percentages for purposes of calculating the APTC amount, as defined in Section 36B(b)(3)(A) of the IRC, are between zero and 8.5, inclusive. Otherwise, the income threshold shall be 25 percent or $6,000 (whichever is greater).

OVERVIEW OF THE MAIN PROPOSED CHANGES CONT.

- Revised the enrollment regulation in section 6500 to add the SB 260 provisions, including an opt-in requirement for consumers to be auto-enrolled into a QHP with $0 monthly net premium and an opt-out option for all SB 260 consumers.
- Revised the SEP regulation in section 6504 to:
  - Add a new monthly triggering event for APTC-eligible consumers with an expected household income of at or below 150% of the FPL whose applicable percentage (and required contribution) for purposes of calculating the APTC amount is set at zero under the federal rules.
  - Add a new subdivision to specify that eligibility for APTC refers to being eligible for APTC in an amount greater than $0 per month, and ineligibility for APTC refers to being ineligible for APTC or being eligible for maximum $0 APTC per month to comply with the federal regulation in 45 CFR § 155.420(f).

NEXT STEPS

- Government Code section 100504(a)(6) requires the Board to discuss proposed regulations at a properly noticed meeting before adopting them.
- Staff will request the Board to formally adopt the regulation package at the next scheduled board meeting so it can be filed with the Office of Administrative Law.
- Any additional proposed changes to the proposed emergency regulations for eligibility and enrollment in the individual market will be communicated to stakeholders for review and commenting prior to Action.

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.

2023 QUALIFIED HEALTH PLAN ISSUER MODEL CONTRACTS

James DeBenedetti, Director, Plan Management Division

2023 – 2025 MODEL CONTRACT: ENSURING HEALTH PLANS DELIVER ON QUALITY, EQUITY, AND DELIVERY SYSTEM REFORM

- Covered California's strategic pillars and cross-cutting initiatives drive year-over-year innovation and improvement in partnership with our issuers.
- The Covered California update of its Model Contract for QHP Issuers for the 2023 -2025 contract term has acknowledged the high bar set by the current contract, which keeps California at the forefront of the nation's ACA implementation:
  - **Patient-Centered Benefit Designs,** including coordination of health and pediatric dental MOOPs, and requirement of off-exchange product
  - **Robust Networks** and ECP requirements
  - **Cobranded and Coordinated Marketing**, including ID cards, digital, and social
  - **Provider Directory Requirements**, including consideration of ethnic and language diversity of providers available to serve enrollees
  - **Quality Initiative**, including reducing health disparities, quality management and data submissions
- The 2023-25 Attachment 1 (formerly Attachment 7) refresh strengthens, enhances, and simplifies the quality and equity requirements, building on the foundation of Attachment 7 developed over the past seven years and the substantial revisions made in the 2022 Amendment.
- The 2023-25 Attachments 2 and 3 (formerly Attachment 14) reformat the attachment, further clarifying the changes made in 2022 by splitting performance standards into expectation only vs. with required financial contribution based on poor performance.

MAJOR NEW POTENTIAL REQUIREMENTS UNDER CONSIDERATION

In addition to significant incremental changes to existing requirements, Covered California is considering two areas that aim to spur dramatic improvements in quality and equity:

- **Additional Incentives/Required Financial Contribution Based on Poor Performance for Quality and Equity:** Increased contractual expectations for quality improvement, including introduction of the Quality Transformation Initiative, which incentivizes the delivery of higher quality and equitable care by assessing a required financial contribution based on poor quality performance on lower quality plans at an amount starting at 1% and increasing to 4% of premium.
- **Formalizing Plan Selection/Exclusion Criteria**: The determination of how many plans should be offered in a given area, and what additional criteria should be used to evaluate the addition of new, and/or removal of existing health plans, based on the value they provide to consumers.

In considering these options, Covered California is in the process of conducting a detailed market analysis, review of the literature, assessing legal and regulatory issues and engaging stakeholders as well experts to inform the approaches under consideration to develop proposals for the Board in January 2022.

2023 – 2025 QHP ISSUER CONTRACT UPDATE SUMMARY

Presented here is a summary of the kinds of changes made in the refresh of the 2023 – 2025 QHP Model Contract(s). Reference the Appendix for more section-specific detail about what contract changes were made.

- General update throughout model contracts brought consistency of term to inclusive listings, updating all “including but not limited to” and “including without limitation” to “including.”
- Notification requirements were added or updated in several contract sections for personnel and delegate changes, and for system and operation changes for clarity or definition, and to enhance operational efficiencies.
- New section language added in several contract sections with notification and update timelines with remedies if unmet.
- New section language was added to enhance Agent and Sales operations with new reconciliation files and reporting.
- The defining notification requirement for a “material” change in networks was clarified to increase notification of network disruptions and establish a baseline for notifications to capture more disruption in rural areas.

QUALITY, EQUITY, AND DELIVERY SYSTEM TRANSFORMATION REQUIREMENTS REFRESH

- Attachment 7 will become **Attachment 1, Quality, Equity, and Delivery System Transformation Requirements and Improvement Strategy**
  - Building on seven years of experience and investment
  - Increased focus on data and outcomes over narrative reporting
  - Intentional alignment with other public purchasers
  - Implementation of Quality Transformation Initiative
- Attachment 1 focuses on requirements for:
  - Article 1: Equity and Disparities Reduction
  - Article 2: Behavioral Health
  - Article 3: Population Health
  - Article 4: Delivery and Payment Strategies to Drive Quality
  - Article 5: Measurement and Data Sharing
  - Article 6: Certification, Accreditation, and Regulation Requirements

PROPOSED ATTACHMENT 1, ARTICLE 1 REQUIREMENTS

Article 1: Equity and Disparities Reduction

- Demographic Data Collection: Issuers must collect member self-identified race, ethnicity, and language data. Covered California intends to proceed with measures stratification by income for disparities identification and monitoring purposes.
- Disparities Measurement: Patient Level Data File: Issuers must submit the following Healthcare Effectiveness Data and Information Set (HEDIS) hybrid measure patient level data files for its enrollees: Prenatal Depression Screen and Follow-up (PND-E) Postnatal Depression Screen and Follow-up (PDS-E), and Quality Transformation Initiative (QTI) measures.
- Disparities Measurement: Healthcare Evidence Initiative: Issuer and Covered California will review performance on specified disparities measures using HEI data.
  - Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Testing (NQF #0057);
  - Ambulatory Emergency Room (ER) Visits© per 1,000;
  - Avoidable Ambulatory Emergency Room (ER) Visits© per 1,000;
  - Adult Preventive Visits© per 1,000;
  - Breast Cancer Screening (BCS) (NQF #2372); and
  - Proportion of Days Covered: Three Rates by Therapeutic Category (NQF #0541)
    - Diabetes All Class (PDC-DR)
    - RAS Antagonists (PDC-RASA)
    - Statins (PDC-STA)
- Disparities Reduction Intervention: Issuers will meet a multi-year disparities reduction target.
- NCQA Health Equity Accreditation: Issuers must achieve or maintain NCQA Health Equity Accreditation by year-end 2023 or submit plan to achieve Health Equity accreditation at the expiration of the MHCD period, if their MHCD has not yet expired.

PROPOSED ATTACHMENT 1, ARTICLE 2 REQUIREMENTS

Article 2: Behavioral Health

- Issuers will submit NCQA Health Plan Accreditation Network Management reports, or a comparable report, for the elements related to the issuer's behavioral health provider network.
- Issuers will promote access to behavioral health services and offer telehealth for behavioral health services.
- Issuers will annually report Depression Screening and Follow Up (NQF #0418) measure results for Covered California enrollees; Covered California will engage with issuers to review their performance.
- Issuers will promote the appropriate use of opioids using a harm reduction framework and individualized approach to treatment planning aligned with Smart Care California guidelines.
- Covered California will monitor the Pharmacotherapy for Opioid Use Disorder measure and Medication Assisted Treatment (MAT) prescriptions through HEI and engage with issuers to review their performance.
- Issuers will promote 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 ATTACHMENT 1, ARTICLE 3 REQUIREMENTS

Article 3: Population Health

Population Health Management

- Issuers will continue to submit a copy of NCQA Population Health Management Plan: Standard 1 (Population Health Management Strategy) and Standard 2 (Population Stratification and Resource Integration) and will newly submit Standard 6 (Population Health Management Impact), or a comparable Population Health Management plan.

Health Promotion and Prevention

- Issuers will report its analysis of trended performance over time for its tobacco cessation program and diabetes prevention program utilization rates and its improvement strategies.
- Issuers will report strategies to improve its rates on the Medical Assistance with Smoking and Tobacco Use Cessation measure (NQF #0027).
- Issuers will continue to offer diabetes prevention programs as both online and in-person formats.

Acute, Chronic, and Other Conditions

- Issuers will continue to support transition of enrollment for at-risk enrollees.

Social Health

- Issuers must screen all enrollees for at least housing instability and food insecurity; report aggregated counts of members screened and positive screens for housing instability and food insecurity.
- 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.

PROPOSED ATTACHMENT 1, ARTICLE 4 REQUIREMENTS

Article 4: Delivery and Payment Strategies to Drive Quality

Effective Primary Care

- Issuers will continue to match enrollees with PCPs and report the number of enrollees who select a PCP vs. those who are assigned a PCP.
- Issuers will implement a quality measure set for advanced primary care in collaboration with the California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA). Issuers will submit data to IHA to implement the measure set.
- Issuers will continue to report on primary care payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories and increase the number of PCPs paid through shared savings and population-based payment models.
- Issuers will newly report total primary care spend compared to overall spend by HCP LAN category and a description of the payment models for their 5 largest physician groups.

Promotion of Integrated Delivery Systems (IDSs) and Accountable Care Organizations (ACOs)

- Issuers will continue to report the number of enrollees in IDS and ACO systems and increase the number of enrollees cared for under IDS and ACO systems.
- Issuers will continue to report the characteristics of the issuer's IDS and ACO systems such as payment model, leadership structure, quality incentive programs, data exchange processes, etc. and newly report the percent of spend under ACO and IDS contracts compared to overall spend.
- 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.

ATTACHMENT 1, ARTICLE 4 REQUIREMENTS, CONT.

Article 4: Delivery and Payment Strategies to Drive Quality

Networks Based on Value

- Issuers will continue to report how cost, quality, patient safety, patient experience, or other factors are considered in network design and provider and facility selection and review.
- Issuers will report on their network payment models by HCP LAN categories and associated subcategories.
- Issuers must participate in the IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results to Covered California annually or allow IHA to submit results to Covered California.
- Issuers will continue to adopt a hospital payment methodology for each general acute care hospital in its QHP networks that ties payment to quality performance.
- Issuers must report its strategies to improve the appropriate use of opioids in its network hospitals.
- Issuers will continue to adopt value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections.

Telehealth

- Issuers will continue to report how they facilitate the integration and coordination of care between third party telehealth vendor services and primary care and other network providers.
- Issuers will report how they screen for enrollee access barriers to telehealth services such as broadband affordability, digital literacy, smartphone ownership, and the geographic availability of high-speed internet services.
- Issuers will continue to report its telehealth reimbursement policies for network providers and for third party telehealth vendor.

Participation in Quality Collaboratives

- Issuers will continue to report participation in any collaborative initiatives that are aligned with Covered California's requirements and expectations for quality improvement, addressing health disparities, and improving data sharing.

PROPOSED ATTACHMENT 1, ARTICLES 5-6 REQUIREMENTS

Article 5: Measurement and Data Sharing

- Issuers will continue to submit data for the Quality Rating System, NCQA Quality Compass and Covered California's Healthcare Evidence Initiative.
- Issuers will implement and maintain a secure, standards-based Patient Access Application Programming Interfaces (API) consistent with the Federally Facilitated Marketplace (FFM) rule.
- Issuers will participate in a Health Information Exchange (HIE) that is a member of the California Trusted Exchange Network (CTEN) and bi-directionally exchange data.
- Issuers will continue to support data aggregation across plans including participation in IHA.

Article 6: Certification, Accreditation, and Regulation Requirements

- All issuers will be required to be NCQA accredited by year end 2024.

PERFORMANCE STANDARDS AND EXPECTATIONS REFRESH

The previous Attachment 14 will be separated into two Attachments for 2023-2025:

Attachment 2 - Performance Standards with Penalties

- Covered California is proposing penalties for key performance areas outside of QTI; these penalties will be separate and distinct from QTI
- Proposing 0.2% of premium at risk for Attachment 2 performance and 0.8% of premium at risk for QTI in 2023
- Proposing to remove some 2022 performance standards, add several new standards, and re-distribute the percent at risk for each standard
- See 2023-2025 Distribution of Performance Penalties slide for details

Attachment 3 - Performance Standards and Expectations

- Issuer performance will be posted publicly on Covered California's website
- Customer Service, Operational (except HEI Data), Covered California Customer Service

2023-2025 DISTRIBUTION OF PERFORMANCE PENALTIES

Performance Area	Performance Standards with Penalties (0.2% of premium at risk)	Distribution of 0.2% at risk 2023	Distribution of 0.2% at risk 2024	Distribution of 0.2% at risk 2025
Health Disparities	1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%	5%	5%
	2. Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language	10% (for reporting)	5%	5%
	3. Reducing Health Disparities: Disparities Reduction Intervention	10%	10%	10%
	4. National Committee for Quality Assurance (NCQA) Health Equity Accreditation	0%	10%	10%
Payment	5. Primary Care Payment	10%	10%	10%
	6. Primary Care Spend	10% (for reporting)	5%	5%
	7. Payment to Support Networks Based on Value	10% (for reporting)	10%	10%
Enrollee Experience	8. Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating	20%	20%	20%
Data	9. Healthcare Evidence Initiative (HEI) Data Submission	20%	20%	20%
Oral Health	10. Dental Quality Alliance (DQA) Pediatric Measure Set	0%	5%	5%

PUBLIC COMMENT AND BOARD APPROVAL TIMELINES

2023 – 2025 Model Contracts

- Responses to Comment Cycle 1 are available online
- Comment Cycle 2 ends December 6, 2021
- Responses to Comment Cycle 2 will be posted online by the end of December

2023 Certification Application

- Plan Year 2023 Certifications (including crosswalk of changes PY22 to PY23) will be available online December 3rd
- Comment Cycle ends December 17, 2021

Attachment 1 (formerly Attachment 7)

- Comment Cycle 2 ends December 6, 2021
- Formal response to Cycle 1 comments and updated versions of Attachment 1 are available online

Attachments 2 & 3 (formerly Attachment 14)

- Comment Cycle 2 ends December 17, 2021
- Formal response to Cycle 1 comments and updated versions of Attachments 2 & 3 will be available online

All 2023 Certification and Contract Documents will be presented in January 2022 for Board discussion, with final approval anticipated in February or March 2022

APPENDIX – 2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS

PROPOSED REQUIREMENTS: SECTION 1.3

Section 1 – General Provisions

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 1.3 Relationship of the Parties Defines CovCA and Contractor's relationship as independent contractors. Contractor to require all subcontractors, assignees, or delegates to comply with applicable requirements of agreement, and to monitor for compliance.	**New notification requirement item c) addition:** New language ensuring Covered California is notified when a Carrier newly assigns or delegates services to a Vendor or changes to existing for: Enrollment and Eligibility, Customer Service Call Center, Managed Behavioral Health Organizations (MBHOs) or Behavioral Health Vendor, Third-Party Administrator for Dental Providers, Third-Party Administrator for Provider Contracts, or Third-Party Administrator for Claims Administration	Several Issuers voiced concerns over the volume of notifications this requirement would create and questioned its value. *"Various vendors are used to provide services under the agreement. It is not practicable for Contractor to provide prior notification in each instance."*	Covered California agrees to modify Section 1.3c) with the following list for notification requirements: 1. Enrollment and Eligibility 2. Customer Service Call Center 3. Managed Behavioral Health Organizations (MBHOs) or Behavioral Health Vendor 4. Third Party Administrator for Dental Providers 5. Third Party Administrator for Provider Contracts 6. Third Party Administrator for Claims Administration

PROPOSED REQUIREMENTS: SECTION 1.5

Section 1 – General Provisions

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 1.5 General Duties of the Contractor Subsection b) states a dedicated liaison is the primary contact for Covered California and is working with Covered California to implement the agreement. The dedicated liaison, along with other personnel, is available as needed to fulfill Contractor's duties under this Agreement.	**New notification requirement item i. addition:** New language ensuring timely notification by Issuers of changes in "Key Personnel" as listed in the Contractor's organizational chart provided during the annual Certification Application process along with contact information: Chief Executive Officer, Chief Finance Officer, Chief Operations Officer, Chief Medical Officer, Contracts, Plan and Benefit Design, Network and Quality, Enrollment and Eligibility, Legal, Marketing and Communications, Information Technology, Information Security, Policy and Dedicated Liaison.	Several Issuers requested a limit of the notice obligation to only certain "Key Personnel"; such as CEO, CFO, COO and Dedicated Liaison. An issuer requested changing the notification requirement from 10 days to 30 days.	Covered California agrees to limit the notice requirement of key personnel to: CEO, COO, CFO, CMO, and Dedicated Liaison only. The notification timeline will remain 10 days.

PROPOSED REQUIREMENTS: SECTION 2.1.2

Section 2 – Eligibility and Enrollment Responsibilities

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 2.1.2 Contractor Responsibilities Subsection c) requires Contractor to participate in the Reconciliation Process comparison of Covered California enrollment against the Contractor's membership enrollment and financial databases, and to implement identified changes within 10 business days.	**New text added to 2.1.2c) for Reconciliation Process:** New language requires Contractor to notify Covered California by the 10th business day if they can't implement changes within the given timeline, provide information explaining why can't be implemented by the due date, and to identify another date in which the changes will be implemented. The Contractor will be required to conduct root cause analysis, develop a corrective action plan to resolve the issues, and provide an implementation for resolution if Covered California identifies ongoing and persistent data issues with the Contractor through the Reconciliation Process.	Issuers request for timeline extension from ten (10) business days business days to fifteen (15) business days for implementation of Reconciliation Process changes.	Covered California agrees to modify Section 2.1.2c) to allow fifteen (15) business days for confirmation the enrollment and financial changes identified through the Reconciliation Process have been implemented.

PROPOSED REQUIREMENTS: SECTION 2.2.6

Section 2 – Eligibility and Enrollment Responsibilities

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements - Comment Based Update
Section 2.2.6 Agents in Covered California for the Individual Market Subsection f) Agent of Record explains an Agent delegation might occur at initial enrollment and Covered California will send notice to the Contractor via the 834 enrollment file. The process requires Contractor's approval, with the exception of unlicensed or unappointed Agents, upon receipt of the 834 file and allows 5 days for system update. Language is included recognizing the different organizational structures delegated Agents may be working within. The requirement for what an Agent of Record Exception Report contains is defined and only required upon request.	**New text added to f) Agent of Record for Reconciliation Process:** Additional language identifying a possible weekly Reconciliation file to be sent to the Issuers, in addition to 834 Enrollment files for use in update of Agent delegations in Issuer systems. Addition of exceptions to the required Contractor approval process for a delegation that would conflict with Contractor's vesting provisions of its Agent agreements. Additional organizational structure language added as to who may be delegated Agents: "the Agency, or primary Agent at the Agency, instead of the specific Agent who enrolled a consumer. As such, an Agent delegation may consist of an Agent, Agency, or primary Agent with an Agency." The requirement for an Agent of Record Exception Report for updates requested but not made changed to the last day of the month.	Issuers request for timeline extension from five (5) business days to ten (10) business days for update of their system. Issuers request the Agent of Record Exception Report remain 'upon request', not a monthly requirement.	Covered California agrees to modify Section 2.2.6f) to allow ten (10) business days for update of Agent of Record to their system. Covered California will keep the contract language requiring the Agent of Record Exception Report on a monthly basis to improve consistency in Issuer system reconciliation of Agent of Record information.

PROPOSED REQUIREMENTS: SECTIONS 2.2.6 AND 2.3

Section 2 – Eligibility and Enrollment Responsibilities

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 2.2.6 Agents in Covered California for the Individual Market	**New subsection i) Agent Communication and Sales Strategy inserted:** Annual requirement added and defined for Contractor to supply an "agent communication and sales strategy" for the individual market. Also allows Covered California to request updates if individual market conditions change due to legislative action or economic fluctuations.	Issuers questioning the intent and a request for removal.	Covered California has declined removal and explained the need to understand each Agent Marketing and Sales Strategy for alignment with changes made by Covered California, for example changes in the market for both on and off exchange markets in response to the State subsidy and American Rescue Plan.
Section 2.3 Enrollment and Marketing Coordination and Cooperation Subsection o) lists marketing plan submittals are due at least thirty (30) days prior to Open Enrollment, and within thirty (30) days after Open Enrollment begins for Retention and Renewal effort marketing plans.	**New text added:** All deadlines were made a consistent "at least" deadline, and a SEP reporting requirement was added: at least thirty (30) days prior to Open Enrollment and Special Enrollment Period, and at least thirty (30) days after Open Enrollment begins for Retention and Renewal efforts.	No comments received.	No contract update made.

PROPOSED REQUIREMENTS: SECTION 2.3, CONT.

Section 2 – Eligibility and Enrollment Responsibilities

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 2.3 Enrollment and Marketing Coordination and Cooperation Subsection p) lists actualized spend amount submittals are due within thirty (30) days after OEP closes, thirty (30) days after calendar year end for SEP, and thirty (30) days after OEP begins for retention and renewal. OEP actualized spend submissions requirements of spend by media channel to include : • distribution by Designated Market Area (DMA) • brand versus direct response spend allocation • categorization of messaging and indication of co-branding efforts.	**New text added:** Request made for “annual” actualized spend amounts and deadlines made consistent “at least” requirements: at least thirty (30) days after OEP closes, at least thirty (30) days after calendar year end for SEP, and at least thirty (30) days after OE begins for retention and renewal. OEP actualized spend submissions requirements of spend by media channel revised : • Designated Market Area (DMA) • brand versus direct response • as well as note if messaging was co-branded with Covered California.	No comments received.	No contract update made.

PROPOSED REQUIREMENTS: SECTION 2.4.2

Section 2 – Eligibility and Enrollment Responsibilities

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 2.4.2 Marketing Materials that Must Be Submitted to Covered California Subsection b) defines marketing materials and related collateral to be submitted to Covered California as reasonably requested by Covered California.	**New deadline text added:** Subsection b) changes the submittal of marketing materials and related collateral to Covered California to at least 30 days prior to OEP, and at least thirty (30) days prior to SEP.	Issuer request for a March 1 deadline by which Covered California will update the document.	Covered California has agreed to the March 1 Contact Guideline update and the contract will be updated.

PROPOSED REQUIREMENTS: SECTIONS 3.1.3 AND 3.1.4

Section 3 – QHP Issuer Program Requirements

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 3.1.3 Plan Naming Conventions Requires Contractor adhere to CovCA's Plan Naming Conventions on all State Regulators plan filings, marketing material, Enrollee material, and SERFF submissions.	**New text added:** Expands the plan naming requirement to off-Exchange mirrored products.	No comments received.	No contract update made.
Section 3.1.4 Operational Requirements and Liquidated Damages **Communication with Plan Manager and Covered California** Requires Contractor notify Covered California of changes with operational impacts to CovCA, Enrollees or CalHEERS. Example given, change to Contractor's vendor interfacing with CalHEERS. Contractors are to attempt to avoid making any operational changes impacting CalHEERS 30 days prior to and during each Renewal and Open Enrollment Period.	**New text added to d) Communication with Plan Manager and Covered California:** Adds a new notification requirement for any "system", as well as operational change, and adds 60-day advance notification timelines for planned system activities or modifications affecting electronic transmissions, any transition or migration to a different platform, or new vendors supporting electronic integration and interfacing with CalHEERS. Adds 30-day advance notification for unplanned activities or system changes and listed operational changes at call centers. Adds 'upon request' provision of technical documentation.	Issuers request for recognition of emergent problems that would make 60 and 30 day notifications untenable. Issuer requests for timeline adjustments.	Covered California agreement to add qualifying language to allow for notification "immediately upon Contractor's knowledge" in 60 day notifications, and in one requested 30 day notification. No timeline adjustments were agreed to.

PROPOSED REQUIREMENTS: SECTIONS 3.3.2-4

Section 3 – QHP Issuer Program Requirements

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 3.3.2 Network Adequacy Subsection c) Notice of material network changes, requires Contractor to notify Covered California of pending material change in its provider network , or its participating provider contracts, at least 60 days prior to any change or immediately upon Contractor's knowledge.	**Changes to Notice of material changes:** "Material" struck, section moved to fall within renumbered section 3.3.3 Network Stability, subsection c) Network Disruptions	Issuers request for reinsertion of "material" in many subsections of now numbered Section 3.3.3.	Covered California has declined all such updates based on Covered California's objective to be aware of upcoming network changes which might require time to prepare our Service Centers. The contract change will stand, to make contract compliance clearer for the carriers as there is no common definition for "material".
Section 3.3.3 Essential Community Providers	**Renumbered 3.3.4 Essential Community Providers, d) Notice of changes to ECP network:** Refers back to 3.3.3c) for same Network Disruption requirements, deletes the work "material."	Issuers concern over deletion of section is misunderstanding of redline effect when text is moved. Issuers request to remove 3.3.3c) and c)i. references to hospital disruptions, don't apply to ECP.	Covered California has agreed to delete the references to 3.3.3c) and c)i.
Section 3.3.4 Special Rules Governing American Indians and Alaskan Natives	**Renumbered 3.3.5**	Issuers concern over apparent deletion of section is misunderstanding of redline effect when text is moved.	No contract update made.

PROPOSED REQUIREMENTS: SECTIONS 3.3.5 AND 3.6.16

Section 3 – QHP Issuer Program Requirements

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 3.3.5 Network Stability Subsection c) Network Disruptions, requires Contractor to provide prior notice to Covered California and State Regulators if there are disruptions making it necessary for Enrollees to change QHPs or Participating Providers.	**Renumbered 3.3.3 Network Stability and new text added:** Update clarifies what constitutes a network disruption and when Issuers are required to report. Establishes a notification baseline of 10% impacted enrollees residing within any county of an affected region, defines notification requirements to Covered California, and adds language to ensure access to care.	Issuer request to modify new threshold of 10% of impacted enrollees to providers. Issuers request to delete a notification requirement to State Regulators in 3.3.3c).	Covered California declines this update request as the intent of an impacted enrollee baseline is to establish a safety net for rural region populations. Covered California agreed to and made the update request to delete a State Regulator notification requirement in 3.3.3c)
Section 3.6.16 Required Reports Requirement to submit standard reports as mutually agreed upon and defined as: customer service reports, use of plan website, enrollment reports, and premiums collected.	**Change to reporting requirement:** Updates submittal requirement to “as specified by” Covered California for the existing list of reports for Enrollee customer service, Use of Plan website, Enrollment, and Premiums collected.	Issuer comment to restore by ‘mutual agreement’ to standard report submittal requirements.	Covered California always seeks to ensure required reports are both accurate representations of the situation and administratively feasible to produce, but cannot commit to always reaching mutual agreement on their design and declines this update request.

PROPOSED REQUIREMENTS: GENERAL CONTRACT UPDATE

General Contract Update

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
General Contract Terms for Inclusive Listing Varied references used throughout contract: including, including but not limited to, including without limitation	General update throughout model contracts brought consistency of term to inclusive listings, updating all “including but not limited to”, and “including without limitation”, to “including.”	Issuer comments to restore “including but not limited to” in several specific instances.	Covered California’s clean-up of inconsistent language throughout the contract to the appropriate language of “including” will remain. "Including" is by definition not an exhaustive list.

APPENDIX
PROPOSED 2023-2025 ATTACHMENT 1 CHANGES AND PUBLIC COMMENT THEMES

PROPOSED CHANGES: SECTIONS 1.01 AND 1.02

Article 1: Equity and Disparities Reduction

Notable Changes to Draft Attachment 1	Rationale
1.01.1 Expanded Demographic Data Collection Covered California will proceed with stratification by income for disparities identification and monitoring.	Explicit statement of Covered California's intention to stratify HEI measures by income and expand disparities identification and improvement work.
1.01.2 Race, Ethnicity, and Language Data Collection Considering revision of the current threshold (80% of enrollees by 2025) for collection of spoken and written language.	Covered California will continue to research existing language data collection processes (including the default to English if a language preference is not provided) to identity the appropriate threshold and timeline for this requirement.
1.02.1 Disparities Measurement: Patient Level Data Removed requirement to include commercial and Medi-Cal lines of business in summary file submission and added the following measures: • Prenatal Depression Screen and Follow-up (PND-E) • Postnatal Depression Screen and Follow-up (PDS-E)	Covered California will work with purchasers to monitor disparities across enrolled populations; narrowed data submission requirement reduces administrative burden on issuers and focuses resources on preparation of actionable data. Disparities in maternal health disproportionately affect Black and Latino populations at higher rates than other racial or ethnic groups; Covered CA is proposing several requirements to assess and monitor disparities in maternal health for Covered California members.

PROPOSED CHANGES: SECTIONS 1.02, 1.03, AND 1.04

Article 1: Equity and Disparities Reduction

Notable Changes to Draft Attachment 1	Rationale
Clarifying Language **1.02 Identifying Disparities in Care** Language modified to ***determined*** *by Covered California and Contractor.* **1.03.1 Disparities Reduction Intervention** Language modified to *Contractor will* ***meet*** a *multi-year disparities reduction target.* **1.04.1 Health Equity Accreditation** Addition of ***at the expiration of the current MHCD period*** for the NCQA Health Equity Accreditation requirement.	Clarifies disparities identification and disparities improvement requirements. Clarifies intent of disparities reduction requirement. Clarifies that an unexpired Multicultural Health Care Distinction (MHCD) meets accreditation requirement throughout its term before Health Equity Accreditation is required.

PROPOSED CHANGES: SECTIONS 2.01, 2.03, AND 2.04

Article 2: Behavioral Health

Notable Changes to Draft Attachment 1	Rationale
2.01.1 Behavioral Health Provider Network – Revised NCQA reporting requirements from annually to every three-years in accordance with the NCQA accreditation cycle (if no significant changes).	Revised based on issuer feedback and in accordance with the three-year NCQA accreditation cycle. If significant changes are made during the three-year cycle, issuers must resubmit the reports.
2.01.2 Offering Telehealth for Behavioral Health and **2.01.3 Promoting Access to Behavioral Health Services** – Re-organized sections and revised to clarify the requirements.	Revisions to clarify the requirements and ensure emphasis on access to in-person behavioral health services.
2.03.1 Guidelines for Appropriate Use of Opioids – Revised language to emphasize using a harm reduction framework and individualized approach to treatment planning.	Revisions based on feedback to emphasize the harm reduction framework, individualized approach to treatment planning, and access to non-pharmacological approaches to pain management.
2.03.2 Monitoring Access to Opioid Use Disorder Treatment – Re-organized sections and revised requirements including replacing *Use of Pharmacotherapy for Opioid Use Disorder* measure with *Pharmacotherapy for Opioid Use Disorder* measure and removing *Concurrent Use of Opioids and Benzodiazepines* and *Use of Opioids at High Dosage in Persons Without Cancer*.	Transitioned from the CMS measure *Use of Pharmacotherapy for Opioid Use Disorder* to the NCQA measure *Pharmacotherapy for Opioid Use Disorder* to align with other public purchasers. Removed measures other measures to emphasize Medication Assisted Treatment (MAT) and concerns about potential harm and lack of improved safety.
2.04 Integration of Behavioral Health Services with Medical Services – Added definition of Collaborative Care Model.	Issuers requested a definition of the Collaborative Care Model. Reference the definition from the AIMS Center at the University of Washington.

PROPOSED CHANGES: SECTIONS 3.01 AND 3.02

Article 3: Population Health

Notable Changes to Draft Attachment 1	Rationale
3.01.1 Population Health Management Plan Submission – Added NCQA Population Health Management Plan: Standard 6 (PHM Impact) to PHM plan submission requirement Revised NCQA reporting requirements from annually to every three-years in accordance with the NCQA accreditation cycle (if no significant changes).	Adding the NCQA Population Health Management Plan: Standard 6 will assist Covered California in developing and strengthening our population health management requirement by assessing the impact of the population health management programs. Revised plan submission frequency to be in accordance with the three-year NCQA accreditation cycle. If significant changes are made during the three-year cycle, issuers must resubmit the reports.
3.02.1 Tobacco Cessation Program – Removed reporting requirements for utilization rates and replaced with new requirement for issuers to report analysis of trended performance over time for tobacco cessation program utilization. Added new requirement for issuers to report analysis of tobacco use prevention strategies and its impact on smoking prevalence rate.	Covered California is committed to reducing tobacco use as part of our health promotion and prevention mission. The collection of analysis of trended utilization performance over time and improvement strategies will help inform future tobacco cessation requirements.

PROPOSED CHANGES: SECTIONS 3.02 AND 3.04

Article 3: Population Health

Notable Changes to Draft Attachment 1	Rationale
3.02.2 Diabetes Prevention Program – Added new requirement for issuers to report strategies to close the gap on diabetes prevention program utilization.	Covered California is committed to diabetes prevention as part of our health promotion and prevention mission. The collection of diabetes prevention strategies to close the gap on diabetes prevention program utilization rates will help inform future diabetes prevention requirements.
3.04.1 Screening for and Addressing Social Health - Considering focused requirement to screen and refer for hunger, with encouraged or required use of standard two question screening. Screening and referral requirements for housing instability and homelessness would be added in future years. Considering approaches to requirements that minimize fragmentation or duplication of screening and referral activities.	Health-related social needs impact all members, not only those involved in plan-based programs. The intention of screening all Enrollees is to identify and address these needs in a timely manner before unmet needs lead to adverse health outcomes. Food insecurity in California has dramatically increased across the state during the COVID-19 pandemic. 25% of Californian households are currently food insecure, a rate 2.5 times higher than pre COVID-19 levels.

PROPOSED CHANGES: SECTIONS 4.01 AND 4.03

Article 4: Delivery and Payment Strategies to Drive Quality

Notable Changes to Draft Attachment 1	Rationale
4.01.1 Encouraging Use of Primary Care – Revised language to ensure enrollees are informed about the benefits of primary care upon enrollment and are given the opportunity to select a PCP.	Covered California wants to encourage enrollees to select a PCP to strengthen their connection to PCPs. Issuers should inform enrollees about the role and benefits of primary care upon enrollment.
4.01.3 Payment to Support Advanced Primary Care – Expanded requirement to report on primary care payment models by HCP LAN categories and subcategories.	Reporting by HCP LAN categories and subcategories will allow for more detailed analysis.
4.03.3 Provider Value – Added language to promote collaboration among issuers to improve provider group performance along with Covered California support.	Purchasers recommended Covered California promote collaboration among issuers to improve provider group performance.
4.03.4.4 Hospital Value – Added requirement for issuers to report number and percent of network hospitals in compliance with CMS Hospital Price Transparency Rule.	Covered California supports price transparency as an effective resource for enrollees to assist with their health care planning. There was broad support of the federal hospital price transparency rule from advocates and purchasers.

PROPOSED CHANGES: SECTIONS 4.03, 4.04, AND 4.05

Article 4: Delivery and Payment Strategies to Drive Quality

Notable Changes to Draft Attachment 1	Rationale
4.03.7.2 Maternity Care – Added requirement for issuers to submit patient level data files for maternal health HEDIS measures: • Prenatal Depression Screen and Follow-up (PND-E) • Postnatal Depression Screen and Follow-up (PDS-E) Additionally, issuers will report on their engagement activities with contracted providers to improve performance on these measures as well as how they identify and address maternal health disparities.	Issuers expressed concerns over the effectiveness of these maternal health measures. Covered California is committed to reducing maternal health disparities. The collection and stratification of these measures by race and ethnicity will help inform future maternal health requirements.
4.04.1 Telehealth Offerings – Added language to promote the use of network providers to provide telehealth, note that issuers must continue to comply with network adequacy standards to in-person services, and ensure issuers are educating enrollees about interpreter services for telehealth.	Revisions based on feedback from advocates and provider organizations to ensure emphasis on access to in-person medical services and ensure enrollees are aware of interpreter services for telehealth.
4.05 Participation in Quality Collaboratives – Added requirement for issuers to report on financial support provided to quality collaboratives and revised the list of collaboratives.	Added and removed collaboratives based on feedback from purchasers and collaboratives. Added reporting on financial support for collaboratives based on feedback from purchasers.

PROPOSED CHANGES: ARTICLE 5

Article 5: Measurement and Data Sharing

Notable Changes to Draft Attachment 7	Rationale
Article 5 – Revised introduction to support collaboration between issuers and Covered California to provide feedback on measure development and measure sets.	Issuers suggested Covered California and issuers could work together to provide feedback to NCQA and QRS on measure sets.
5.02.3 Data Exchange – Revised to clarify that issuers must participate in an HIE that is a member of the California Trusted Exchange Network (CTEN).	Issuers requested clarification on this requirement.
5.02.3 Data Exchange – Added language to strengthen collaboration between Covered California and issuers on statewide HIE efforts.	Revisions based on feedback from advocates suggesting issuers should participate in the new state health information exchange network. We will continue to track this effort and collaborate with issuers and others as this effort progresses.

PROPOSED CHANGES: ARTICLE 6

Article 6: Certification, Accreditation, and Regulation Requirements

Notable Changes to Draft Attachment 7	Rationale
Article 6 – There are no significant changes to Article 6.	N/A

PUBLIC COMMENT KEY THEMES: ARTICLE 1

Article 1: Equity and Disparities Reduction

- ❑ Request for more substantive language for Article 1.01.1 Expanded Demographic Data Collection.
- ❑ Require plans to share best practices and plan of action for collection of demographic data; establish a disparities workgroup to determine how to best improve collection of demographic data.
- ❑ Request to make race, ethnicity, and language questions required elements in enrollment application with decline to state response option.
- ❑ Update language data requirement target (currently 80% by 2025) after baseline is established.
- ❑ Request bidirectional data updates between Contractor and Covered California for demographic data.
- ❑ PLD File: request only Covered California data be provided; request that stratification be pursued based on NCQA final timeline.
- ❑ HEI measures: consider additional stratified measures; align measures with NCQA Medi-Cal accreditation measures; establish process to reconcile difference in measure performance to produce accurate results.
- ❑ Clarify that current NCQA Multicultural Health Care Distinction (MHCD) meets requirement through its term before Health Equity Accreditation is required.

PUBLIC COMMENT KEY THEMES: ARTICLE 2

Article 2: Behavioral Health

- ❑ Request to clarify if NCQA Network Management reports must be submitted every year or every three years in alignment with the NCQA three-year accreditation cycle.
- ❑ Suggestions to incorporate Comprehensive Medication Management into behavioral health requirements.
- ❑ Suggestion to add requirements for issuers report on payment parity for behavioral health and telehealth.
- ❑ Request to ensure issuers continue to meet network adequacy requirements for in-person behavioral health services in addition to offering behavioral health telehealth services.
- ❑ Suggestions to revise the appropriate use of opioid requirements to emphasize non-pharmacological pain management treatments and address the potential improper tapering of opioid prescriptions that can be harmful to patients.
- ❑ Request to define the Collaborative Care Model.
- ❑ Requests for telehealth services to be incorporated into quality measure requirements in alignment with NCQA HEDIS.

PUBLIC COMMENT KEY THEMES: ARTICLE 3

Article 3: Population Health

- ❑ Request for clarification on the term “financially responsible” in the introduction language.

Population Health Management

- ❑ Requests to receive automatic credit, if NCQA accredited, in substitution of submitting a copy of their NCQA Population Health Management plan.
- ❑ Request to clarify if the NCQA Population Health Management plan must be submitted every year or every three years in alignment with the NCQA three-year accreditation cycle.
- ❑ Concerns about potential algorithm bias within population health management stratification and segmentation methods.

Health Promotion & Prevention

- ❑ Requests to obtain trended performance analysis for tobacco cessation programs from HEI claims submissions.
- ❑ Concerns about tobacco cessation population being too low to provide appropriate or accurate results.
- ❑ Requests for clarification on the term “expected rates” in the diabetes prevention program requirements.

Social Health

- ❑ Concerns and questions regarding requirement to screen all enrollees for hunger and housing instability or homelessness; requests to return to 2022 screening requirement limited to enrollees in participating in plan programs.
- ❑ Suggestion to require standard screening questions or instruments.
- ❑ Request to require issuers to adequately fund screening efforts if required of contracted providers.

PUBLIC COMMENT KEY THEMES: ARTICLE 4

Article 4: Delivery and Payment Strategies to Drive Quality

Effective Primary Care

- Suggestions to incorporate Comprehensive Medication Management into primary care requirements.

Promotion of Integrated Delivery Systems (IDSs) and Accountable Care Organizations (ACOs)

- Suggestion to incorporate the prevalence of advanced primary care practices in reporting on ACO characteristics.

Networks Based on Value

- General support for leveraging CMS Hospital Price Transparency rules in hospital network contracting.
- Concerns about the collection and reporting of the new proposed maternal health measures.

Telehealth

- General support for integration and coordination of care between telehealth vendors and primary care and encouraging telehealth provided through network providers. Request to ensure issuers continue to meet network adequacy requirements for in-person services in addition to offering telehealth services.
- Request to require issuers to report how interpreter services for telehealth are made available to enrollees.

Participation in Quality Collaboratives

- General support for issuers to participate in quality collaboratives. Request to add reporting on the financial support provided by issuers for quality improvement and technical assistance.
- Request to add the California Right Meds Collaborative to the list of collaboratives.

PUBLIC COMMENT KEY THEMES: ARTICLE 5

Article 5: Measurement and Data Sharing

- ❑ Request to expand beyond the federal rules for patient-facing Application Programming Interfaces (APIs) and support electronic prior authorization.
- ❑ Request to enhance requirements beyond Health Information Exchange (HIE) participation to require participation in the new state health information exchange network and eventual community information exchanges.
- ❑ Suggestions to revise the Healthcare Evidence Initiative section.
- ❑ Request for clarification on the Health Information Exchange (HIE) participation requirements.
- ❑ Suggestion to collaborate on feedback or input on measure and measure set development for QRS and NCQA, including NCQA ECDS measures.

PUBLIC COMMENT KEY THEMES: ARTICLE 6

Article 6: Certification, Accreditation, and Regulation Public Comment Themes and Changes

- There are no significant changes to Article 6.

APPENDIX
PROPOSED 2023 - 2025 ATTACHMENT 2 & 3
QHP AND CCSB PERFORMANCE STANDARDS

APPROACH TO PENALTIES

- With the implementation of the Quality Transformation Initiative (QTI) in 2023, Covered California is proposing to focus Attachment 2 - Performance Standards with Penalties on the following areas:
  - Health disparities
  - Payment reform
  - Enrollee experience (QRS)
  - HEI data
  - Oral health
- For 2023, Performance Standards with Penalties (formerly Attachment 14), the total amount at risk is decreasing from ten percent (10%) of the total participation fee paid by the issuer (0.325% of premium) to 0.2% of premium due to the implementation of QTI
- Covered California is proposing to include the 0.2% of premium for Performance Standards with Penalties within in overall percentage at risk for QTI
  - For 2023, 0.8% of premium would be at risk for QTI performance and 0.2% would be at risk for Performance Standards with Penalties

QHP PROPOSED CHANGES FOR 2023 PERFORMANCE STANDARDS AND EXPECTATIONS (NO PENALTY)

Performance Standards and Expectations	Covered California will create an Annual Report of Performance Standards and Expectations, displaying Contractor's final Plan Year 2022 performance in Performance Standards and Expectations, Standards 1.1 - 1.11, to be posted publicly on Covered California's website. Covered California will continue public reporting of its service level performance metrics.	Proposed Change
1.1 Abandonment Rate	Expectation: No more than 3% of incoming calls abandoned in a calendar month. Divide number of abandoned calls by the number of calls offered to a phone representative.	No change
1.2 Service Level	Expectation: 80% of calls answered in 30 seconds or less.	No change
1.3 Grievance Resolution	Expectation: 95% of Covered California enrollee grievances resolved within 30 days of initial receipt.	No change
1.4. Covered California member Email or Written Inquiries Answered and Completed	Expectation: 90% of Covered California member email or written inquiries not relating to Urgent Access to Care issues answered and completed within 15 business days of the inquiry.	No change
1.5 ID Card Processing Time	Expectation: 99% of ID cards issued within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer(s).	No change
1.6 Implementation of Appeals Decisions	Expectation: 90% of Administrative Law Judge decisions will be implemented within ten (10) days of Contractor's receipt of all necessary data elements from Covered California required to implement the appeals decision.	No change
1.7 834 Processing	Expectation: Covered California will receive a TA1 or 999 file, or both as appropriate within three business days of receipt of the 834 transaction 95% of the time.	No change
1.8 834 Generation – Effectuation and Cancellation Transactions	Expectation: Covered California will successfully receive and process effectuation, and cancellation 834 transactions within 60 days from either the coverage effective date or transaction timestamp, whichever is later 95% of the time.	No change

QHP PROPOSED CHANGES FOR 2023 PERFORMANCE STANDARDS AND EXPECTATIONS (NO PENALTY), CONT.

Performance Standards and Expectations	Covered California will create an Annual Report of Performance Standards and Expectations, displaying Contractor's final Plan Year 2022 performance in Performance Standards and Expectations, Standards 1.1 - 1.11, to be posted publicly on Covered California's website. Covered California will continue public reporting of its service level performance metrics.	Proposed Change
1.9 834 Generation – Termination Transactions	Expectation: Covered California will receive termination 834 transactions within ten days of the grace period expiration 95% of the time.	No change
1.10 Reconciliation Process	Expectation: Covered California shall receive a comparison reconciliation extract in accordance with the file validations and resolution timelines, as mutually agreed upon in the Reconciliation Process Guide (Extranet, Data Home, Contractor's folder) 90% of the time for accuracy and timeliness.	No change
1.11 Provider Directory Data Submission	Expectation: Full and regular submission of provider data according to the standards outlined in the Performance Standard contract specific to contract Section 3.4.4. Submissions occur every month pursuant to the submission schedule (Extranet, Plan Home, Resources, Provider Directory Resources, Covered California Provider Data Submission Schedule_Current Year).	No change
1.12 Essential Community Providers – Article 3, Section 3.3.3	Expectation: 1. Contractor to demonstrate provider agreements with at least 15% of 340B non-hospital providers in each applicable rating region. 2. Contractor to demonstrate provider agreements that reflect a mix of essential community providers (hospital and non-hospital) reasonably distributed to serve the low-income, vulnerable, or medically underserved populations. Or meet Alternate Standard Contractor requirements. Refer to Article 3, Section 3.3.3.	No change
~~1.13 Hospital Safety – Attachment 7, Article 10, Section 10.02~~	~~Contractor shall adopt a payment strategy that places hospital payments in Covered California networks either at risk or subject to a bonus payment for quality performance Contractor may structure this strategy according to its own priorities, with the exception that if the Contractor uses readmissions measure, it shall not be the only measure.~~ ~~Contractor shall report on its strategy and progress on adoption of the payment strategy annually.~~ ~~Expectation: At least 2% of payments to hospitals in Covered California network(s) are at risk for quality performance by year end 2021.~~	Removed from Performance Standards and Expectations; remains in Attachment 7, will evaluate for AB 929 public reporting

SUMMARY OF 2023-2025 PERCENT AT RISK

Performance Area	Performance Standards with Penalties	Percent of At-Risk Amount 2023	Percent of At-Risk Amount 2024	Percent of At-Risk Amount 2025
Health Disparities	1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%	5%	5%
	2. Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language	10% (for reporting)	5%	5%
	3. Reducing Health Disparities: Disparities Reduction Intervention	10%	10%	10%
	4. National Committee for Quality Assurance (NCQA) Health Equity Accreditation	0%	10%	10%
Payment	5. Primary Care Payment	10%	10%	10%
	6. Primary Care Spend	10% (for reporting)	5%	5%
	7. Payment to Support Networks Based on Value	10% (for reporting)	10%	10%
Enrollee Experience	8. Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating	20%	20%	20%
Data	9. Healthcare Evidence Initiative (HEI) Data Submission	20%	20%	20%
Oral Health	10. Dental Quality Alliance (DQA) Pediatric Measure Set	0%	5%	5%

QHP PROPOSED CHANGES FOR 2023 PERFORMANCE STANDARDS WITH PENALTIES (1 OF 2)

Performance Standards With Penalties	2022 % at Risk	Proposed 2023 % at Risk	Proposed Change and Rationale
1. Reducing Health Disparities – Demographic Data Collection – Race/Ethnicity	7.5%	10%	Continue 2022 approach of equal emphasis on demographic data collection and disparity reduction
2. Reducing Health Disparities: Demographic Data Collection – Spoken and Written Language	n/a	10% (for reporting)	New for 2024, 2025 to support prioritization of issuer complete and accurate member demographic data
3. Disparities Reduction Intervention	7.5%	10%	Continue 2022 approach of equal emphasis on demographic data collection and disparity reduction
4. National Committee for Quality Assurance (NCQA) Health Equity Accreditation	n/a	10%	Penalty goes into effect in 2024
5. Primary Care Payment	HMO – 10% PPO/EPO – 20%	10%	Continue overall standard and product-specific performance levels; proposing to adjust performance levels for 2023-2025
6. Primary Care Spend	n/a	10% (for reporting)	New reporting standard starting in 2023 to report primary care spend; start at pay for reporting in 2023 and move to thresholds of spend in 2024 and 2025

Where applicable, scores are provided per product, and penalties and credits are weighted based on the enrollment in each product.

QHP PROPOSED CHANGES FOR 2023 PERFORMANCE STANDARDS WITH PENALTIES (2 OF 2)

Performance Standards With Penalties	2022 % at Risk	Proposed 2023 % at Risk	Proposed Change and Rationale
7. Payment to Support Networks Based on Value	0%	10% (for reporting)	New proposed standard for HCP LAN reporting for a QHPs network payment models; start at pay for reporting in 2023 and move to thresholds of payment in 2024 and 2025
8. Quality Rating System – QHP Enrollee Survey Summary Rating	16.5%	20%	Retained due to breadth of measures and affirmation of federal standards; no change to performance level
9. HEI Data Submission	10%	20%	Increase in percent at risk signals importance of HEI data to monitoring quality and equity performance
10. Dental Quality Alliance (DQA) Pediatric Measure Set	0%	0%	2024 and 2025 performance levels to be established using 2023 baseline HEI data
Total	**100%**	**100%**	

Where applicable, scores are provided per product, and penalties and credits are weighted based on the enrollment in each product.

2022 PERFORMANCE STANDARDS WITH PENALTIES PROPOSED FOR REMOVAL IN 2023

Performance Standards With Penalties	2022 % at Risk	Proposed 2023 % at Risk	Proposed Change and Rationale
Quality Rating System – Clinical Effectiveness Rating	33.5%	n/a	Removed from Performance Standards with Penalties due to implementation of QTI
Health Equity Capacity Building (2% Credit)	0%	n/a	Credit for early achievement replaced with penalty for failure to achieve NCQA Health Equity Accreditation by year-end 2023
Accountable Care Organizations	HMO – 10% PPO/EPO – 0%	n/a	Removed from Performance Standards with Penalties; remains in Attachment 7 with enhanced reporting on ACO structure; will evaluate for AB 929 public reporting
Appropriate Use of C-Sections (maternity payment strategy)	5%	n/a	Removed from Performance Standards with Penalties; remains in Attachment 7 with enhanced requirement for issuers to submit intervention plan to improve low performing network hospitals; will evaluate for AB 929 public reporting

CCSB 2023 ATTACHMENT 14 PROPOSED APPROACH

- Attachment 14 will be separated into two Attachments. New attachment numbers are:
  - Attachment 2 - Performance Standards with Penalties
  - Attachment 3 - Performance Standards and Expectations

- For Attachment 2 - Performance Standards with Penalties:
  - the total amount at risk is decreasing from three percent (3%) of the total participation fee (5.2%) paid by the issuer (approximately 0.156% of premium) to 0.05% of premium due to align with the Individual QHP Contract language.
  - Covered California will not be implementing penalties for the CCSB Attachment 2 in 2023.
  - Covered California is proposing penalties for HEI Data Submission and Dental Quality Alliance (DQA) Pediatric Measure Set beginning in 2024 and beyond.

- For Attachment 3 - Performance Standards and Expectations:
  - Issuers will continue to report on Customer Service and Operational performance.

CCSB PROPOSED CHANGES FOR 2023 PERFORMANCE STANDARDS AND EXPECTATIONS (NO PENALTY)

Performance Standards and Expectations		Proposed Change
1.1 Abandonment Rate	Expectation: No more than 3% of incoming calls abandoned in a calendar month. Divide number of abandoned calls by the number of calls offered to a phone representative.	No change
1.2 Service Level	Expectation: 80% of calls answered in 30 seconds or less.	No change
1.3 Grievance Resolution	Expectation: 95% of Covered California enrollee grievances resolved within 30 days of initial receipt.	No change
1.4. Covered California member Email or Written Inquiries Answered and Completed	Expectation: 90% of Covered California member email or written inquiries answered and completed within 15 business days of the inquiry. Does not include appeals or grievances.	No change
1.5 ID Card Processing Time	Expectation: 99% of ID cards issued within 10 business days of receipt of complete and accurate enrollment information for a specific consumer(s).	No change
1.6 Provider Directory Data Submission	Expectation: Full and regular submission of provider data according to the standards outlined in the Performance Standard contract specific to contract Section 3.4.4. Submissions occur every month pursuant to the submission schedule (Extranet, Plan Home, Resources, Provider Directory Resources, Covered California Provider Data Submission Schedule_Current Year).	Waived for 2023.

CCSB PROPOSED CHANGES FOR 2023 PERFORMANCE STANDARDS WITH PENALTIES

Performance Standards With Penalties	2023% at Risk	Proposed 2024 % at Risk	Proposed 2025 % at Risk	Proposed Change and Rationale
1. HEI Data Submission	0%	80%	80%	Pilot Period January 1, 2023-December 31, 2023 Penalties will not be assessed in 2023. Increase in percent at risk signals importance of HEI data to monitoring quality and equity performance.
2. Dental Quality Alliance (DQA) Pediatric Measure Set	0%	20%	20%	Pilot Period January 1, 2023-December 31, 2023 Penalties will not be assessed in 2023. 2024 and 2025 performance levels to be established using 2023 baseline HEI data.
Quality, Equity, And Delivery System Transformation Standards				Covered California will continue monitor and assess CCSB performance. As CCSB membership grows, performance standards may be added and penalties may be assessed in future years.
Total	**0%**	**100%**	**100%**	

2023-25 ATTACHMENT 2 PUBLIC COMMENT KEY THEMES: STANDARDS 1, 2, AND 4

Reducing Health Disparities: Demographic Data Collection (standards 1 and 2)

- Recommendations to include mandatory race, ethnicity, and language questions in the enrollment application and add "Decline to State" response option
  - Covered California agrees the enrollment application is an important opportunity to collect this information but does not intend to pursue mandatory questions in the enrollment application. We will continue to explore best practices and opportunities to improve capture and sharing of member demographic data.
  - Covered California agrees the enrollment application is an important opportunity to collect this information but does not intend to pursue mandatory questions in the enrollment application.
  - The 80% threshold acknowledges that not all members choose to share this information.

National Committee for Quality Assurance (NCQA) Health Equity Accreditation (standard 4)

- Request to extend credit opportunities for early achievement of Health Equity Accreditation or reduce the at-risk amount.
  - For 2023 and beyond, there are no credit opportunities in Attachment 2, and we do not intend to change the at-risk amount.

2023-25 ATTACHMENT 2 PUBLIC COMMENT KEY THEMES: STANDARDS 5-8

Primary Care Payment (standard 5)

- Requests for separate targets for plan type or plans operating with limited network options.
  - Covered California intends to use the same standards for HMOs and EPO/PPOs in 2023-2025. Our goal is for all plans to meet similar standards. We have adjusted the performance levels to account for this change.

Primary Care Spend and Payment to Support Networks Based on Value (standards 6 and 7)

- Questions and concerns about the reporting process and reporting methodology.
  - Covered California will collaborate with issuers to develop the data collection mechanism and methodology. We will aim to follow standardized methodology that minimizes reporting burden on issuers.

Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating (standard 8)

- Requests to remove this standard or adjust the penalty amounts.
  - Covered California intends to maintain the performance standard for QRS QHP Enrollee Experience. We will adjust the performance levels to 20% penalty for a 1-star rating and 10% penalty for a 2-star rating.

2023-25 ATTACHMENT 2 PUBLIC COMMENT KEY THEMES: STANDARD 9 AND GENERAL COMMENTS

Healthcare Evidence Initiative (HEI) Data Submission (standard 9)

- Overall concerns regarding performance standard expectations and the methodology for each component of the standard.
  - Covered California intends to maintain the performance standard expectations as drafted. After 2022 data is analyzed, Covered California will revisit the expectations.

General Comments

- Request for credits to offset penalties.
  - Covered California will not be implementing credits for 2023-2025 Attachment 2.
- Requests for the 0.2% of premium at risk for Attachment 2 be included in an overall 1% at risk for QTI and Attachment 2.
  - Covered California has adjusted the percent at risk for performance standards and QTI. We are proposing to adopt 0.2% of premium at risk for performance standards with penalties in Attachment 2 and 0.8% of premium at risk for QTI for 2023. We are proposing the total percent at risk will continue to increase by 1% each year to 4% and QTI will remain the majority of the percent at risk over time.

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.

UPDATE ON HEALTH CARE AFFORDABILITY RESERVE FUND REPORT

Katie Ravel, Director, Policy, Eligibility & Research Division

POLICY CONTEXT FOR ADDRESSING REMAINING AFFORDABILITY CHALLENGES IN THE INDIVIDUAL MARKET

- Prior to the American Rescue Plan, many consumers struggled to afford monthly premiums even with financial assistance. Affordability challenges remain for some consumers, particularly those facing high out-of-pocket costs relative to their income.
- Covered California's charge under Assembly Bill 133 is specific to cost-sharing, but California's policy choices will vary dramatically if the American Rescue Plan premium subsidies are not extended past 2022.
- In line with the statute, Covered California modeled several options that could be considered to enhance cost sharing support. Options have a wide range of richness and state cost.
- Given the current uncertainty around extension of the American Rescue Plan premium subsidies, Covered California also modeled the cost to "backfill" those subsidies in whole or part.

HEALTH CARE AFFORDABILITY RESERVE FUND REPORT

- The 2021-2022 State Budget (AB 128) and Health Omnibus trailer bill (AB 133):
  - Redirected $333.4 million from the General Fund to the Health Care Affordability Reserve Fund to be used for affordability programs operated by Covered California starting in plan year 2023; and
  - Directed Covered California to produce a report developing options for providing cost sharing reduction subsidies.

AB 133 WORKING GROUP MEMBERS

Working Group Member	Organization
Dawn McFarland	Agent
Rick Krum	Anthem
Robert Spector	Blue Shield
Anete Millers	California Association of Health Plans
Faith Borges	California Association of Health Underwriters (CAHU)
Stesha Hodges	California Department of Insurance
Janice Rocco	California Medical Association
Cary Sanders	California Pan-Ethnic Health Network (CP-EHN)
Mike Odeh	Children Now
Diana Douglas	Health Access
Amy Frith	Health Net of California
John Newman	Kaiser
Alicia Emanuel	National Health Law Program (NHLP)
Marjorie Swartz	Policy Consultant to Senate President Pro Tempore Toni Atkins at California State Senate
Cicely Rucker	Sharp
Jen Flory	Western Center on Law and Poverty
Jerry Fleming	Covered California Board Member
Jarrett Tomás Barrios	Covered California Board Member
Teri Boughton	Senate Committee on Health
Ryan Witz	California Hospital Association
Doreena Wong	Asian Resources
Anika Lee	California Consortium of Urban Indian Health Consortium (CCUHI)

OVERVIEW OF THE MAIN ELEMENTS OF TODAY'S PRESENTATION AND NEXT STEPS

- Review of modeling of cost-sharing reduction options
- Review of operational considerations for implementing a state cost-sharing reduction program
- Review of modeling of extension of American Rescue Plan premium subsidies
- Next steps including sharing draft report with working group and seeking additional input prior to submitting final report
  - Feedback on today's presentation is welcome and can be sent to policy@covered.ca.gov
  - Information about workgroup meetings is available here.

BACKGROUND ON FEDERAL COST-SHARING REDUCTION PROGRAM

FEDERAL COST-SHARING REDUCTION PROGRAM

- The ACA requires health insurance issuers to reduce out-of-pocket maximums and cost-sharing amounts (such as deductibles and copays) for consumers at 250 percent FPL and below.
- Eligible individuals access these benefits by enrolling in what are known as cost-sharing reduction (CSR) plans built on Silver-level coverage.
- For the lowest-income enrollees, cost-sharing reduction plans provide coverage at or near the Platinum level for Silver premium prices.
- Under the ACA, consumers up to 250% FPL are eligible for CSR benefits that increase the value of a Silver plan thereby lowering out-of-pocket costs as follows:
  - Silver 94 for consumers with income below 150% FPL
  - Silver 87 for consumers with income between 150% to 200% FPL
  - Silver 73 for consumers with income between 200% to 250% FPL

AMERICAN INDIAN/ALASKA NATIVE ZERO-COST AND LIMITED-COST SHARING PLANS

- **Zero-cost sharing plans:** If below 300 percent federal poverty level (FPL), consumer is eligible for AI/AN plan that is not subject to deductible, coinsurance and cost sharing. Does not need a referral from an Indian Health Clinic.

- **Limited-cost sharing plans:** If above 300 percent FPL, consumer is not subject to deductible, coinsurance and cost sharing if receiving health care services from an Indian Health Clinic or with a referral to a QHP provider from an Indian Health Clinic.

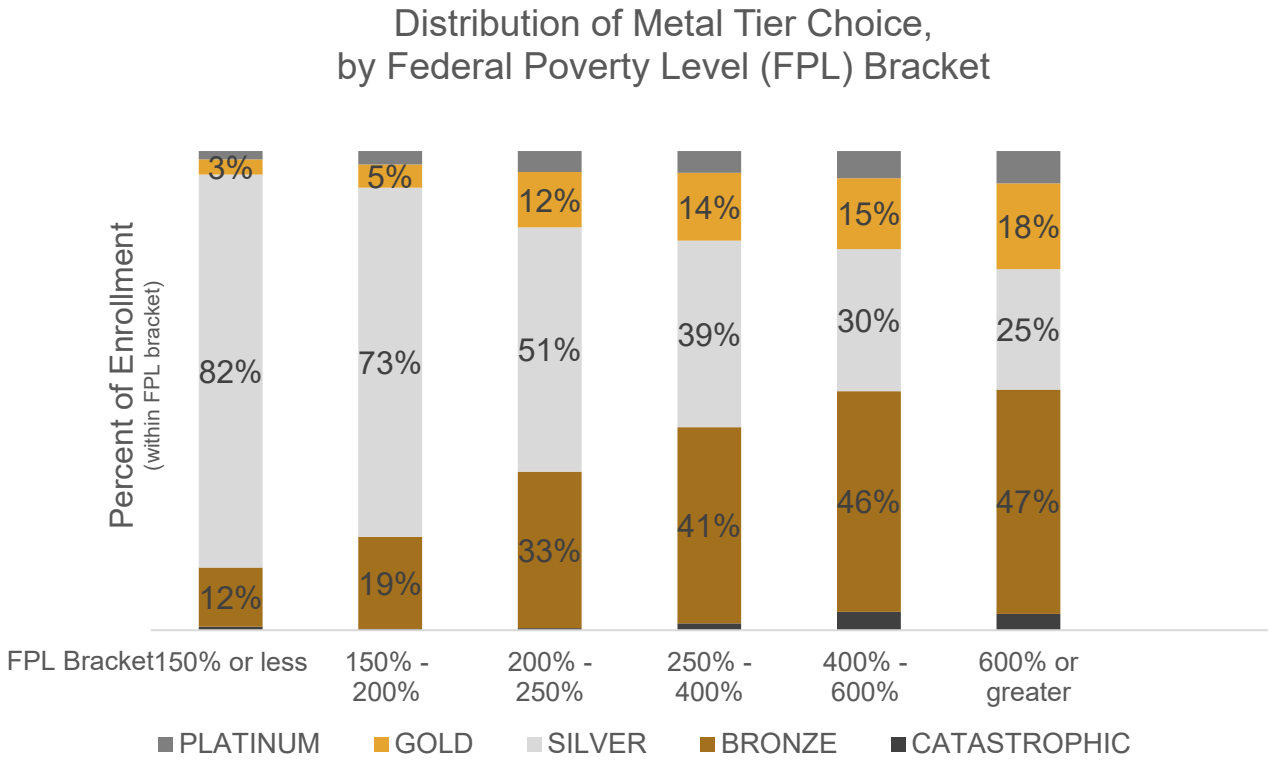
IMPACT OF FEDERAL CSR PROGRAM ON COVERED CALIFORNIA'S 2022 SILVER PLAN DESIGNS

Benefit	Individual-only Silver		Silver 73		Silver 87		Silver 94	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible								
Medical Deductible		***$3,700***		***$3,700***		***$800***		***$75***
Drug Deductible		$10		$10		$0		$0
Coinsurance (Member)		20%		20%		15%		10%
MOOP		***$8,200***		***$6,300***		***$2,850***		***$800***
ED Facility Fee		$400		$400		$150		$50
Inpatient Facility Fee	***X***	20%	***X***	20%	***X***	15%	***X***	10%
Inpatient Physician Fee		20%		20%		15%		10%
Primary Care Visit		***$35***		***$35***		***$15***		***$5***
Specialist Visit		$70		$70		$25		$8
MH/SU Outpatient Services		$35		$35		$15		$5
Imaging (CT/PET Scans, MRIs)		$325		$325		$100		$50
Speech Therapy		$35		$35		$15		$5
Occupational and Physical Therapy		$35		$35		$15		$5
Laboratory Services		$40		$40		$20		$8
X-rays and Diagnostic Imaging		$85		$85		$40		$8
Skilled Nursing Facility	***X***	20%	***X***	20%	***X***	15%	***X***	10%
Outpatient Facility Fee		20%		20%		15%		10%
Outpatient Physician Fee		20%		20%		15%		10%
Tier 1 (Generics)	***X***	***$15***	***X***	***$15***		***$5***		***$3***
Tier 2 (Preferred Brand)	X	$55	X	$55		$25		$10
Tier 3 (Nonpreferred Brand)	X	$85	X	$85		$45		$15
Tier 4 (Specialty)	X	20%	X	20%		15%		10%
Tier 4 Maximum Coinsurance	$250		$250		$150		$150	
Maximum Days for charging IP copay								
Begin PCP deductible after # of copays								

COVERED CALIFORNIA ENROLLMENT BY FPL AND METAL TIER

The selection of Silver plans decreases as income increases.

As FPL brackets increase, the level of premium assistance falls and the AV of Silver plans decreases, with no CSR plans above 250% of FPL.



Denominator is a total of each FPL bracket (consumers who applied on unsubsidized application are excluded). Population reflects June 2021 effectuated enrollment.

ADDITIONAL CONTEXTUAL INFORMATION PRESENTED AT THE WORKING GROUP

- Information about state-based cost sharing reduction programs in Massachusetts, Vermont and Colorado. Information about other states informed our modeling and operational considerations.
- Information related to remaining affordability challenges in the individual market and how impact of various policy options could be evaluated.

MODELING ENHANCED COST SHARING OPTIONS

COST-SHARING REDUCTION MODELING

- Covered California commissioned Milliman to model a variety of cost sharing reduction options based on prior affordability work, other state programs, federal proposals and suggestions from working group members.
- Modeling assumes that state cost-sharing reductions will only be available in Silver plans similar to the federal program.
- Per member per month costs of various options are presented for each option by FPL level.
- Covered California also requested that Milliman combine options in various ways and estimate total costs for those combinations.
- Full content developed by Milliman for the AB 133 working group is available here: https://hbex.coveredca.com/stakeholders/AB_133_Health_Care_Affordability_Working_Group/Presentation%20by%20Milliman.pdf

Outline

1. Benefit Plans Modeled
2. Marginal PMPM Cost for Enhanced Benefits by Income Band
3. Silver Plan Enrollment Projections by Income Band
4. Estimated Total Cost for Various Combinations Chosen by Covered California
5. Methodology and Limitations

Benefit Plans Modeled

Existing 2022 Covered California Plan Designs and Illustrative Plan Designs

1	2*	3	4*	5*	6*
Individual Silver (Existing)	**Individual Silver with Deductibles Removed (Illustrative)**	**73 Silver (Existing)**	**73 Silver with Deductibles Removed (Illustrative)**	**80 Silver (Illustrative)**	**85 Silver (Illustrative)**
Inpatient deductible: $3,700	Deductibles: $0	Inpatient deductible: $3,700	Deductibles: $0	Deductibles: $0	Deductibles: $0
Outpatient deductible: $0	MOOP: $8,200	Outpatient deductible: $0	MOOP: $6,300	MOOP: $8,200	MOOP: $5,200
Drug deductible: $10	PCP Copay: $35	Drug deductible: $10	PCP Copay: $35	PCP Copay: $35	PCP Copay: $15
MOOP: $8,200	X-Ray Copay: $85	MOOP: $6,300	X-Ray Copay: $85	X-Ray Copay: $75	X-Ray Copay: $40
PCP Copay: $35	Rx Copays: $15/55/85/20%	PCP Copay: $35	Rx Copays: $15/55/85/20%	Rx Copays: $15/55/80/20%	Rx Copays: $5/25/45/15%
X-Ray Copay: $85	Federal AV: 74.29%	X-Ray Copay: $85	Federal AV: 76.28%	Federal AV: 79.80%	Federal AV: 84.98%
Rx Copays: $15/55/85/20%		Rx Copays: $15/55/85/20%			
Federal AV: 71.50%		Federal AV: 73.85%			

Note: Illustrative plans titled with "Deductibles Removed" are modified versions of existing plans (i.e., the deductibles are removed). For ease of reference, we used the parallel naming convention for these illustrative plans, however the AVs are different due to the changes made. For example, 73 Silver with Deductibles Removed (Illustrative) has an AV that is higher than 73%.

Benefit Plans Modeled

Existing Plan Designs and Illustrative Plan Designs

7	8*	9*	10	11*	12*
87 Silver (Existing)	**87 Silver with Deductibles Removed (Illustrative)**	**90 Silver (Illustrative)**	**94 Silver (Existing)**	**94 Silver with Deductibles Removed (Illustrative)**	**99 Silver (Illustrative)**
Inpatient deductible: $800	Deductibles: $0	Deductibles: $0	Inpatient deductible: $75	Deductibles: $0	Deductibles: $0
Outpatient deductible: $0	MOOP: $2,850	MOOP: $4,500	Outpatient deductible: $0	MOOP: $800	MOOP: $250
Pharmacy deductible: $0	PCP Copay: $15	PCP Copay: $15	Pharmacy deductible: $0	PCP Copay: $5	PCP Copay: $0
MOOP: $2,850	X-Ray Copay: $40	X-Ray Copay: $30	MOOP: $800	X-Ray Copay: $8	X-Ray Copay: $0
PCP Copay: $15	Rx Copays: $5/25/45/15%	Rx Copays: $5/15/25/10%	PCP Copay: $5	Rx Copays: $3/10/15/10%	Rx Copays: $0/10/10/10
X-Ray Copay: $40	Federal AV: 88.30%	Federal AV: 89.25%	X-Ray Copay: $8	Federal AV: 94.92%	Federal AV: 99.70%
Rx Copays: $5/25/45/15%			Rx Copays: $3/10/15/10%	Note: Also called 95 Silver	
Federal AV: 87.88%			Federal AV: 94.66%		

Note: Illustrative plans titled with "Deductible Removed" are modified versions of existing plans (i.e., the deductible is removed). For ease of reference, we used the parallel naming convention for these illustrative plans, however the AVs are different due to the changes made. For example, 73 Silver with Deductible Removed (Illustrative) has an AV that is higher than 73%.

Marginal PMPM Cost for Enhanced Benefits by Income Band

Using Estimated 2023 Costs for All California (Rating Regions 1 to 19)

Plan Design	Up to 150% FPL	150-200% FPL	200-250% FPL	250-300% FPL	300-400% FPL
Individual Silver				Baseline Plan	Baseline Plan
Individual Silver without Deductible				$7.30	$7.30
73 Silver			Baseline Plan	$10.70	$10.70
73 Silver without Deductible			$3.10	$13.90	$13.90
80 Silver			$28.60	$39.60	$39.60
85 Silver			$54.00	$64.90	$64.90
87 Silver		Baseline Plan	$62.50	$73.50	$73.50
87 Silver without Deductible		$1.00	$63.60	$74.60	$74.60
90 Silver		$20.40	$83.30	$94.40	$94.40
94 Silver	Baseline Plan	$47.50	$110.60	$121.80	$121.80
94 Silver without Deductible (aka 95)	$0.20	$47.70	$110.80	$122.00	$122.00
99 Silver	$47.60	$96.20	$159.80	$171.20	$171.20
Current Enrollment (Sept. 2021)	**205,050**	**324,850**	**123,800**	**56,850**	**113,650**

Note: For each column, the baseline plan is shown in the row that corresponds to the 'Baseline Plan' label. For example, in the 'Up to 150% FPL' column, the baseline plan is 94 Silver.

Silver Plan Enrollment Projections for 2023 by Income Band

All California (Rating Regions 1-19)

Scenario	Up to 150% FPL	150-200% FPL	200-250% FPL	250-300% FPL	300-400% FPL
2023 Enrollment Scenario 1: Current	205,050	324,850	123,800	56,850	113,650
2023 Enrollment Scenario 2: Some Take-Up Change	209,400	328,000	133,550	65,150	130,350
2023 Enrollment Scenario 3: More Take-Up Change	211,650	329,600	146,300	76,300	152,650
2019 Enrollment in CSR Variant Associated with Income Band	187,658	284,412	106,138	42,625	85,251
2021 Enrollment in CSR Variant Associated with Income Band	205,033	324,816	123,816	56,823	113,646
2021 Enrollment in all Plans by Income Band (all metal levels)	264,868	449,500	245,886	146,096	292,192

Modeling assumptions used for enrollment are described in further detail on slide 21. Note that these projections do not assume growth in total Covered California membership between 2021 and 2023.

- **Scenario 1** assumes no change in Silver plan enrollment from 2021.
- **Scenario 2** assumes some take-up in Silver plan enrollment from Gold and Platinum membership.
- **Scenario 3** assumes more take-up in Silver plan enrollment from Gold and Platinum membership for all incomes and some take-up from Bronze membership for the middle incomes.

Summary of Estimated Total Cost for Various Combinations

	Plan Designs Modeled for Each FPL Range					Cost by Scenarios 1, 2, and 3 (millions)		
	Up to 150% FPL	150-200% FPL	200-250% FPL	250-300% FPL	300-400% FPL	Current	Some Take-Up	More Take-Up
Current CSR variants	94 Silver	87 Silver	73 Silver	70 Silver	70 Silver			
Option 1: 95/90/85, no deductibles	95 Silver	95 Silver	90 Silver	90 Silver	85 Silver	$463.1	$497.1	$540.7
Option 2: No deductibles, and 80% AV for 200-400% FPL	94 Silver, no deduct.	87 Silver, no deduct.	80 Silver	80 Silver	80 Silver	$127.9	$143.2	$163.5
Option 3: Current CSR variants, no deductibles	94 Silver, no deduct.	87 Silver, no deduct.	73 Silver, no deduct.	73 Silver, no deduct.	73 Silver, no deduct.	$37.4	$42.0	$48.1
Option 4: Massachusetts	95 Silver	95 Silver	94 Silver	94 Silver	70 Silver	$433.8	$460.7	$494.9
Option 5: Colorado	94 Silver	94 Silver	73 Silver	70 Silver	70 Silver	$185.2	$187.0	$187.9
Option 6: Vermont	94 Silver	87 Silver	80 Silver	73 Silver	70 Silver	$49.8	$54.2	$60.0
Option 7: Current CSR variants w/ “Level Up” for 150-250%	94 Silver	94 Silver	87 Silver	70 Silver	70 Silver	$278.0	$287.1	$297.6
Option 8: CSR “Level Up”, w/o deductibles	94 Silver, no deduct.	94 Silver, no deduct.	87 Silver, no deduct.	80 Silver	80 Silver	$361.9	$383.1	$409.6

Estimated Total Cost for Various Combinations

Option 1: 95/90/85, no deductibles (All California)

	Up to 150% FPL	150-200% FPL	200-250% FPL	250-300% FPL	300-400% FPL	Total Cost
Current CSR Variant	94 Silver	87 Silver	73 Silver	70 Silver	70 Silver	
Option 1: 95/90/85, no deductibles	**95 Silver**	**95 Silver**	**90 Silver**	**90 Silver**	**85 Silver**	
PMPM Cost	$0.20	$47.70	$83.30	$94.40	$64.90	
Current 2021 Enrollment	205,050	324,850	123,800	56,850	113,650	
Annual Cost (millions) Scenario 1: Current	$0.5	$185.9	$123.8	$64.4	$88.5	$463.1
Annual Cost (millions) Scenario 2: Some Take-Up	$0.5	$187.7	$133.5	$73.8	$101.5	$497.1
Annual Cost (millions) Scenario 3: More Take-Up	$0.5	$188.7	$146.2	$86.4	$118.9	$540.7

Note: Uncertainty in cost is greater when the increase in benefits is greater. Additionally, the middle-income categories have more potential for increased Silver take-up.

PRELIMINARY OBSERVATIONS ON MODELING

- Options modeled can be categorized by cost with the following high-level member impacts:
  - **Highest cost options (e.g., Option 1 – $463M – $540M)**: these options would: (1) increase the value of CSR for those eligible today; and (2) significantly expand cost sharing support to enrollees above 200% FPL to roughly the Platinum level of coverage. Note that these options exceed the existing funding in the Health Care Affordability Reserve Fund for one plan year.
  - **Medium cost options (e.g., Option 2 – $128M – $163M):** these options would generally: (1) increase the value of CSR for those eligible today; and (2) significantly expand cost sharing support to enrollees above 200% FPL to roughly the Gold level of coverage. As modeled, these options would require expenditure of most or all of the existing funding the Health Care Affordability Reserve Fund for one plan year.
  - **Lowest cost options (e.g., Option 3 $37M – $48M):** these options either: (1) provide funding to eliminate deductibles in Silver plans for all individuals under 400% FPL; or (2) provide modest expansion of eligibility for cost-sharing support above the current federal cost sharing "cliff" at 250% FPL. These options could be funded over multiple plans years with the existing funding in the Health Care Affordability Reserve Fund.

ADDITIONAL CONSIDERATIONS

- Cost of eliminating deductibles in Silver plans is low because deductibles are only applied to inpatient hospital and skilled nursing services, for which members very often hit their maximum out-of-pocket limit. However, working group member discussed broader impact deductibles may have on enrollment and consumers' choice of metal tier if they are unclear about how deductibles apply in Silver plans.
- The cost of various options will be impacted by enrollment in two ways:
  - Impact of new enrollment for 2022 plan year
  - Impact of "switching" into Silver plans by existing members currently enrolled in Bronze, Gold or Platinum plans
  - Costs presented here are preliminary and only address switching among current members
  - Costs will need to be updated in early 2022
- Language establishing the Health Care Affordability Reserve Fund does not specify an ongoing funding source. Member and operational impacts would vary if a state cost-sharing program was in effect for one year or multiple years. Note: the state premium subsidy program was established as a three-year program.
- As currently drafted, the federal Build Back Better Act would provide significant funding in plan years 2023 through 2025 for Marketplaces to lower consumer costs including by reducing member cost sharing. Additional modeling would be needed if this legislation is passed.

OPERATIONAL CONSIDERATIONS FOR IMPLEMENTING A STATE COST SHARING REDUCTION PROGRAM

PRELIMINARY LIST OF COVERED CALIFORNIA OPERATIONAL WORKSTREAMS TO IMPLEMENT A STATE COST-SHARING REDUCTION PROGRAM

WORKSTREAM	KEY ACTIVITIES
Benefit design	Incorporate state cost-sharing reduction program design into patient-centered benefit designs. Benefit design workgroup convenes annually to consider changes.
Carrier payment methodology	Develop a methodology to determine cost-sharing reduction payment amounts including any anticipated induced demand.
Enrollment forecasting and budgeting	Assess and incorporate potential enrollment impacts of state cost-sharing reduction program into Covered California enrollment forecast. Develop budget estimates for state cost-sharing reduction program.
Eligibility determination process	Make required changes to CalHEERS (Covered California's eligibility and enrollment system) to define the income ranges and associated Cost Sharing (CS) level for the state program design.
Enrollment process	Display appropriate benefit plans to consumers based on state cost-sharing reduction program design beginning October 1. Automatically renewal consumers into appropriate benefit plan.
Education and outreach	Develop plans for education and outreach to applicants, members and enrollment partners.
Carrier payment process	Develop a process to make state cost-sharing reduction payments to carriers.
Risk adjustment	Assess impact of state cost-sharing reduction program on the federal risk adjustment program.
Plan renaming	Assess the feasibility of renaming cost-sharing reduction plans (e.g., Silver 94) as early as 2023 to reduce consumer confusion and better communicate their value.

COVERED CALIFORNIA OPERATIONAL PLANNING ASSUMPTIONS

For Covered California to implement a state cost-sharing reduction program in 2023, the following must be true:

1. The program would need to leverage existing functionality and processes to a significant degree.
2. Individuals would have to meet eligibility requirements for federal premium tax credits in order to be eligible for the state cost-sharing reduction program.
3. State cost-sharing reduction plans would be offered only at the Silver metal tier consistent with the federal cost-sharing reduction program.
4. Cost of state cost-sharing reduction program would not be “loaded” on premium rates as federal CSR program currently is. Payments for a state cost-sharing reduction program would be made directly by the state to the carrier under a methodology to be determined.
5. State cost-sharing reduction plans would be offered to all renewing and newly applying members for a full benefit year, meaning that products would need to be available for shopping beginning October 1, 2022.

COVERED CALIFORNIA KEY MILESTONES FOR 2023 PLAN YEAR

MILESTONE	ESTIMATED TIMEFRAME
Plan Management Advisory: Benefit Design & Certification Policy Recommendation	January 20, 2022
January Board Meeting: Discussion of Benefit Design & Certification Policy Recommendation	January 2022
Final AV Calculator Released*	February 2022
QHP & QDP Applications Open	March 1, 2022
March Board Meeting: Anticipated approval of 2022 Patient-Centered Benefit Plan Designs & Certification Policy	March 2022
May Board Meeting: Discussion of 2022-23 Covered California Budget	May 2022
June Board Meeting: Anticipated approval of 2022-23 Covered California Budget	June 2022
QHP Negotiations	June 2022
Public Posting of Proposed Rates	July 2022
Carrier Integration Testing for 2023 Plan Year	July – August 2022
CalHEERS Release for 2023 Plan Year	September 2022
Public Posting of Final Rates	September – October 2022

*Final AV Calculator availability dependent on CMS release

ESTIMATING THE ENHANCED VALUE OF AMERICAN RESCUE PLAN PREMIUM SUBSIDIES COMPARED TO THE AFFORDABLE CARE ACT

THE AMERICAN RESCUE PLAN PROVIDES A SIGNIFICANT BUT TEMPORARY INCREASE IN PREMIUM SUBSIDIES FOR ELIGIBLE INDIVIDUALS

The American Rescue Plan (ARP) premium subsidies significantly reduce the share of income that consumers must pay towards their premiums, fully replacing the current ACA policy design and the California premium subsidies for plan years 2021 and 2022.

The Build Back Better Act would extend American Rescue Plan Premium subsidies through 2025.

Required contribution curves are for the 2021 plan year.

COST TO REPLACE ARP SUBSIDIES FOR COVERED CALIFORNIA ENROLLEES

- In 2022, the estimated annual cost difference between ACA and ARP subsidies for Covered California's enrollment is $1.6 billion.

FPL Bracket	Annual ACA-ARP Difference (2022)	Count of Enrollees
0-150% FPL	$160 M	270,000
0-200% FPL	$565 M	706,000
0-250% FPL	$861 M	955,000
0-300% FPL	$1,098 M	1,171,000
0-400% FPL	$1,286 M	1,395,000
0-600% FPL	$1,575 M	1,484,000
All Enrollees	$ 1,617 M	1,519,000

COVERED CALIFORNIA

Estimates based on Covered California June 2021 effectuated subsidy-eligible enrollment using 2022 benchmark rates to calculate maximum APTC for which enrollees are eligible. Annual estimates assume 12 months enrollment.

COST TO REPLACE ARP SUBSIDIES FOR COVERED CALIFORNIA ENROLLEES BY FPL GROUP

FPL Bracket	Annual ACA-ARP Difference (2022)	Count of Enrollees
Under 150% FPL	$160 M	270,000
150-200% FPL	$405 M	436,000
200-250% FPL	$296 M	250,000
250-300% FPL	$237 M	216,000
300-400% FPL	$188 M	223,000
400-600% FPL	$288 M	89,000
All Enrollees	$ 1,617 M	1,519,000

COVERED CALIFORNIA

Estimates based on Covered California June 2021 effectuated subsidy-eligible enrollment using 2022 benchmark rates to calculate maximum APTC for which enrollees are eligible. Annual estimates assume 12 months enrollment.

COST TO REPLACE ARP SUBSIDIES FOR COVERED CALIFORNIA ENROLLEES, UNDER POTENTIAL 2023 RATE INCREASE SCENARIOS

FPL Bracket	Annual ACA-ARP Difference (2022)	Annual Difference with 3% Rate Increase	Annual Difference with 5% Rate Increase
0-150% FPL	$160 M	$160 M	$160 M
0-200% FPL	$565 M	$565 M	$565 M
0-250% FPL	$861 M	$861 M	$861 M
0-300% FPL	$1,098 M	$1,098 M	$1,099 M
0-400% FPL	$1,286 M	$1,288 M	$1,289 M
0-600% FPL	$1,575 M	$1,593 M	$1,605 M
All Enrollees	$ 1,617 M	$1,639 M	$1,654 M

COVERED CALIFORNIA

Estimates based on Covered California June 2021 effectuated subsidy-eligible enrollment using 2022 benchmark rates to calculate maximum APTC for which enrollees are eligible. Annual estimates assume 12 months enrollment.

COST TO REPLACE ARP SUBSIDIES FOR COVERED CALIFORNIA ENROLLEES BY FPL GROUP, UNDER POTENTIAL 2023 RATE INCREASE SCENARIOS

FPL Bracket	Annual ACA-ARP Difference (2022)	Annual Difference with 3% Rate Increase	Annual Difference with 5% Rate Increase
Under 150% FPL	$160 M	$160 M	$160 M
150-200% FPL	$405 M	$405M	$405 M
200-250% FPL	$296 M	$296 M	$296 M
250-300% FPL	$237 M	$238 M	$238 M
300-400% FPL	$188 M	$189 M	$190 M
400-600% FPL	$288 M	$305 M	$316 M
All Enrollees	$ 1,617 M	$1,639 M	$1,654 M

COVERED CALIFORNIA

Estimates based on Covered California June 2021 effectuated subsidy-eligible enrollment using 2022 benchmark rates to calculate maximum APTC for which enrollees are eligible. Annual estimates assume 12 months enrollment.

NEXT STEPS

- Covered California staff will share draft report with stakeholder working group for feedback in December.
- Staff will submit the report by January 1, 2022.
- Covered California will provide technical assistance to the state Administration and the Legislature as requested.

Date	Milestone
December 2, 2022	AB 133 working group #5
December 16, 2022	AB 133 working group #6 (if needed)
January 1, 2022	AB 133 Report Due to Legislature, Governor and the Healthy California for All Commission

Meeting information is available at: https://www.hbex.ca.gov/stakeholders/AB_133_Health_Care_Affordability_Working_Group/
Send questions and feedback to: policy@covered.ca.gov

TECHNICAL APPENDIX

Benefit Modeling Assumptions

We used the Milliman *Health Cost Guidelines*™ and Covered California's standard 2022 plan designs as a starting point for this modeling. We created two separate cost models, one for Northern California and one for Southern California, using Milliman's research about the utilization and unit cost levels for each region. We trended both cost models to calendar year 2023. We used actuarial judgement to populate the input assumptions required to produce the output cost models.

We assumed that plans in Covered California have higher than average discounts, as many plans are HMO style plans with narrower networks and reflected this assumption in our modeling.

The output of the cost models are estimated plan paid per member per month (PMPM) costs for each plan design. We used these to calculate the difference between each proposed plan design and the corresponding baseline plan design for each income band.

We did not adjust the projected PMPM costs for differences in risk score by income band as the risk scores provided by Covered California appeared to be affected by material levels of "noise". We recommend that Covered California gets input from health plans to determine if they would want the PMPM payments by income level to be risk-adjusted.

We understand that Covered California is still determining how it will administer the program, but for the purpose of modeling, we have assumed that:

- The marginal cost to the carrier to administer a richer plan design will be paid to the carrier in the form of a prospective PMPM that is based on each member's income category.
- The program cost will be based on statewide or Northern vs. Southern average costs, rather than carrier and region-specific costs.
- State cost sharing will be delivered via plan design in the Silver tier similar to the federal cost sharing program.

Silver Plan Enrollment Modeling Assumptions

For the purpose of this exercise, we have created three enrollment scenarios. See previous slides 12-14 for enrollment numbers used in modeling.

- Scenario 1: Current The first scenario assumes no change from current 2021 enrollment.
- Scenario 2: Some Take-Up Change The second scenario assumes that a portion of Gold and Platinum membership will move to Silver CSR as the CSR plans get richer.
- Scenario 3: More Take-Up Change The third scenario assumes that a higher portion of Gold and Platinum membership will move to CSR as the CSR plans get richer. It also assumes that a small portion of Bronze will move to Silver CSR for the enrollees who currently only have access to the baseline Silver or Silver 73, while still recognizing that Bronze members are premium price sensitive.

The following table shows the assumptions for the percentage of enrollment that switches to Silver CSR for each scenario.

Scenario	Up to 200% FPL	200-400% FPL
Scenario 1	No change	No Change
Scenario 2	33% of Gold and Platinum	50% of Gold and Platinum
Scenario 3	50% of Gold and Platinum	75% of Gold and Platinum and 25% of Bronze

Limitations

Milliman's work is prepared solely for the internal business use of Covered California. Milliman's work may not be provided to third parties without Milliman's prior written consent. Milliman does not intend to benefit any third-party recipient of its work product, even if Milliman consents to the release of its work product to such third party.

In performing this analysis, we relied on data and other information provided by Covered California. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

The services provided for this project were performed under the signed Agreement Number 20-C-022.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Barb Dewey, Matt Schoonmaker, John Rogers, and Tanya Hayward are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this presentation.

APPROACH TO MODELING VALUE OF AMERICAN RESCUE PLAN PREMIUM SUBSIDIES

- Using a static population snapshot of Covered California effectuated enrollment from June 2021, APTC costs are calculated using enrollees' 2022 benchmark rates, under both ACA and ARP required contribution curves.
- To calculate each program's costs, we used the maximum APTC that each enrollee is eligible for based on their benchmark premium; totals are not specific to the APTC amount enrollees would receive based on their 2021 plan enrollment.
- Annual costs assume 12 months of enrollment. Table values reflect the difference in total annual costs for Covered California's 1.5 million eligible enrollees under each program.
- To estimate effects of rate changes for plan years beyond 2022, we increase the 2022 benchmark rates by 3% and 5% and recalculate APTCs under both ACA and ARP program designs.

PUBLIC COMMENT

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- 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.