COVERED CALIFORNIA POLICY AND ACTION ITEMS

February 17, 2022 Board Meeting

FISCAL YEAR 2022-23 NAVIGATOR GRANT PROGRAM CONTRACT

Terri Convey, Director, Outreach and Sales

NAVIGATOR PROGRAM REVIEW

Today's Discussion

(1) Current Navigator Program funding level and how it works today

(2) Proposal for the next Fiscal Year (FY) contract amendment

Background for Today's Discussion

- The Navigator Program awards outreach and enrollment grants to community-based organizations qualified to reach California's diverse and hardest-to-serve communities.

- The Board approved a total Navigator Grant Program funding cap of $19.5 million across a three-year grant cycle period (FY 2019-20, 2020-21, and 2021-22). The Request for Application solicitation for the current grant cycle included language reserving the option to extend the resulting grants for an additional year beyond the approved three-year term. The current FY 2021-22 program funding is for the third year at $6.5 million. Covered California awarded $6.4 million to 40 organizations as the Navigator grantees.

- Pandemic challenges, including grantee entity staffing concerns, new Coronavirus strains, and continued social distancing expectations have made a new grant application cycle unlikely to return a broad and qualified applicant pool. Lower than expected application responses would result in a reduction of the program's effectiveness and geographical footprint, reducing the number of available Navigator grantees to assist consumers.

NAVIGATOR PROGRAM YEARLY FUNDING LEVELS

- Annual program funding level has been steady at $6.5 million
- 40 lead partner organizations and 61 active subcontractors for a total of 101 participating entities
- More than 500 locations within a 15-minute drive time for 89% of all Californians
- Program reach includes Latino, Asian, African American and other communities

Grant Year	Program Funding	# of Entities	Funding Range	Actual Enrollment
2021-22	$6,500,000	40	$50,000-$500,000	TBD
2020-21	$6,500,000	41	$50,000-$500,000	49,267*
2019-20	$6,500,000	42	$50,000-$500,000	52,409*
2018-19	$6,475,000	42	$50,000-$500,000	44,684
2017-18	$6,425,000	43	$50,000-$500,000	40,355
2016-17	$7,100,000	46	$50,000-$500,000	35,858
2015-16	$10,550,000	69	$50,000-$500,000	40,096
2014-15	$10,886,569	65	$25,000-$500,000	77,457

* These numbers represent “effectuated enrollments” which is different from the previous grant year’s enrollment count of plan selections.

HOW THE NAVIGATOR PROGRAM WORKS TODAY

- Funding levels from $50,000 to $500,000
- Grants awarded based on Navigator organization's ability to meet performance requirements
- Enrollment and outreach goals assigned at the grant funding level

Program Features

- $30 per member bonus above 110% of the prior contract year-end enrollment results
- $30 per member penalty if below enrollment goal not to exceed 20% of total grant amount
- Outreach points used to calibrate activity
- Grants are funded in five equal payments

Funding Level	Enrollment Goal	Outreach Points
$50,000	286	50
$75,000	429	64
$125,000	714	92
$150,000	857	106
$175,000	1000	120
$200,000	1143	134
$250,000	1429	162
$300,000	1714	190
$325,000	1857	204
$350,000	2000	218
$425,000	2429	260
$500,000	2857	300

NAVIGATOR PROGRAM FISCAL YEAR 2022-23 CONTRACT AMENDMENT RECOMMENDATION

Recommendation:

- Amend the existing Navigator grants for FY 2022-23, adding funding for the new fiscal year and extending grant contract term dates to June 30, 2023.
- Allocate the Navigator Program funding level to $6.5 million for the additional year (FY 2022-23), to be awarded across the current active Navigator grantees.
- Continue the current Minimum Enrollment Requirements and current Outreach Activity goal expectations for FY 2022-23.

Next Step:

- Seek input from Navigator partners and stakeholders and bring those findings to the Board for discussion in March 2022.

BACKGROUND ITEMS

Fiscal Year 2022-2023
Navigator Enrollment Goals

FY 22-23 NAVIGATOR PROGRAM TIMELINE

Date	Action
February 17, 2022	Program presents Fiscal Year 2022-23 grant contract amendment to the Covered California Board for approval and public announcement.
June 15-30, 2022	Program finalizes individual grantee evaluation and payment reconciliation for FY 21-22 grant period funding and sends out FY 22-23 contract amendment to entities for execution.
June 30, 2022	End of FY 21-22 grant contract period.
July 1, 2022	Start of grant cycle FY 2022-23 contract period.

OUTREACH ACTIVITY GOALS

Grant entities are assigned outreach points based on their Grant Amount Award Level; and will earn points throughout the grant award year by participating in, tracking, and reporting various outreach activities such as events and social media, earned and paid media, etc.

Outreach Activity Goals	
Grant Amount	**Outreach Points Goal**
$50,000	50
$75,000	64
$100,000	78
$125,000	92
$150,000	106
$175,000	120
$200,000	134
$225,000	148
$250,000	162
$275,000	176
$300,000	190
$325,000	204
$350,000	218
$375,000	232
$400,000	246
$425,000	260
$450,000	274
$475,000	288
$500,000	300

Activities that Earn Outreach Points		
Category	**Point(s) Earned**	**Qualifying Activity**
Events	3	3 points earned per education or enrollment event logged in the event portal or bi-monthly report (Note: office hours do not constitute events)
Paid Media	1	1 point earned per $100 spent on advertising promoting Covered California enrollment
Earned Media	10	10 points earned per documented instance of earned media
Twitter	1	1 point earned per month wherein 4 tweets are published mentioning Covered California (via in-tweet "@CoveredCA" linked tagging) from an account with at least 1,000 followers (Max 3 point per month per primary Grantee)
Facebook	1	1 point earned per month wherein 2 posts are published mentioning Covered California (via in-post "@Covered California" linked tagging), (Max 3 point per month per primary Grantee)
Instagram	1	1 point earned per month wherein 2 posts are published mentioning Covered California (via in-post "@CoveredCA" linked tagging), (Max 3 point per month per primary Grantee)
LinkedIn	1	1 point earned per month wherein 2 posts are published mentioning Covered California (via in-post "@Covered California" linked tagging), (Max 3 point per month per primary Grantee)
Outbound/Phone	3	3 points earned per outbound/phone event logged in the event portal or bi-monthly report. Events must be pre-approved by Covered California. Examples could be an outbound call campaign to generate new leads, or phone-bank to follow up on existing leads (Note: appointment follow-up calls do not constitute phone events.)
Unpaid/Other	Up to 10	Covered California program staff will determine points awarded on a case-by-case basis, not to exceed 10 points for the category in total each grant year. Covered California retains sole discretion to determine the number of points that can be awarded for each Unpaid/Other activity.

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 CONTRACT AND CERTIFICATION PROCESS

2023 QUALIFIED HEALTH PLAN ISSUER MODEL CONTRACT

James DeBenedetti
Director, Plan Management Division

2023-2025 QUALIFIED HEALTH PLAN MODEL CONTRACT

- Insurance issuers certified by Covered California (Contractor) to offer a Qualified Health or Dental Plan in the Covered California marketplace have a contract agreement with Covered California (Contract) which guides Contractor performance through its terms to further Covered California's mission to increase the number of insured Californians, improve health care quality and access to care, promote health, lower costs, and reduce health disparities. The three marketplaces for these products are: the Individual, Small Business, and Dental. The Contract structure consists of a "model contract" which details the standard terms and requirements of Covered California and each Contractor, and associated attachments specialized in their focus on discrete areas of Contractor and Covered California performance.
- This "Triple Aim" framework of the Covered California Contract seeks to improve the patient care experience including quality and satisfaction, improving the health of the population, and reduce the per capita costs of Covered Services through the defining key expectations for:
  - The delivery of services and benefits to Covered California Enrollees;
  - The respective roles of Covered California and the Contractor related to marketing and promoting enrollment, eligibility, and customer service for existing and potential Covered California Enrollees;
  - Coordination and cooperation between Covered California and Contractor to promote quality, high value care for Covered California Enrollees and other health care consumers;
  - Covered California's expectation of alignment between Contractor and its participating providers to deliver high quality, high value health care services; and
  - Administrative, financial, and reporting relationships and agreements between Covered California and Contractor.

2023-2025 QUALIFIED HEALTH PLAN MODEL CONTRACT

The Qualified Health Plan Contract for the Individual Marketplace is structured into fourteen Articles containing State and Federal requirements, Covered California specific requirements may also be included as noted in the section topics of Articles below:

- **ARTICLE 1 – GENERAL PROVISIONS** includes relationship of the parties, general duties of the Contractor and Covered California, coordination with other programs, evaluation of Contractor performance, required notice from the Contractor of changes in their organization, nondiscrimination, conflict of interest, fraud-waste-and-abuse, and current enrollee notification of Covered California coverage and subsidies.
- **ARTICLE 2 – ELIGIBILITY AND ENROLLMENT** includes responsibilities of Covered California and the Contractor , requirements for Contractor's collection practices, effective dates of coverage including as relates to binder and premium payments, premium payment policies, terminations of coverage including non-payment of premium and notification requirements, termination process.
- **ARTICLE 3 – PROMOTING ENROLLMENT** includes responsibilities of Covered California and the Contractor to promoting enrollment, including transitions of coverage to maximize continuity of coverage for enrollees transitioning between other coverage and Covered California, marketing requirements including Contractor spend requirements to increase enrollment and promote the value of health insurance coverage, defined actions and communications to promote enrollment by Covered California and the Contractor, requirements for marketing materials and plans, and requirements acknowledging the importance of Certified Agents to successful enrollment.

2023-2025 QUALIFIED HEALTH PLAN MODEL CONTRACT

- **ARTICLE 4 – QHP ISSUER PROGRAM REQUIREMENTS** includes requirements of Contractor or Covered California related to:
  - Offering patient-centered standard benefit designs, plan naming conventions, non-mirrored Silver-level plan offering outside Covered California, mirrored and non-mirrored offerings outside Covered California, pediatric dental benefits, prescription drug formularies
  - Be licensed in good standing, deadlines for regulatory approval
  - Communication requirements, Contractor and provider disclosure of enrollee costs, Covered California and Symphony provider directories
  - Covered California Individual Market rates, rate methodology
  - Network requirements for service areas, network provider disruption notification requirement when affecting 10% or more of enrollees within any county of a region, access to care during provider network changes, provider contracts, essential community provider standards including reporting requirements for Covered California qualified Alternate Standard Contractors and sufficient geographic distribution
  - Covered California certification, operational requirements, customer service standards, call centers, secure plan website, required reports, and Contractor staff training and liquidated damages

2023-2025 QUALIFIED HEALTH PLAN MODEL CONTRACT

- **ARTICLE 5 – ADVANCING EQUITY, QUALITY, AND VALUE** includes activities seek to further the shared goals of improved health, reduced health disparities, and high-quality healthcare through, in conjunction with:
  - Attachment 1 – Advancing Equity, Quality, and Value: quality management improvement and disparities reduction programs
  - Attachment 2 – Performance Standards with Penalties detailing potential payment obligations for quality performance
  - Attachment 4 – Quality Transformation Initiative
  - Potential removal from the Exchange
  - Required quality improvement plans for poor performance
  - Data submission requirements.
- **ARTICLE 6 – FINANCIAL PROVISIONS** includes requirements for rates and payments in conjunction with the Covered California certification process, Contractor payment for additional marketing activities, financial consequences of non-payment of premium including enrollee terminations and disenrollment, and participation fees including possible Covered California adjustments.
- **ARTICLE 7 – PERFORMANCE STANDARDS** in conjunction with Attachment 2 – Performance Standards with Penalties and Attachment 3 – Performance Standards and Expectations defines: penalties, and no waiver standards.

2023-2025 QUALIFIED HEALTH PLAN MODEL CONTRACT

- **ARTICLE 8 – CONTRACT TERM; RECERTIFICATION AND DECERTIFICATION** includes agreement term, agreement termination by Covered California or Contractor, notice of termination, remedies in case of Contractor default or breach, Contractor insolvency, Contractor annual recertification, Contractor Non-Recertification Election, Covered California decertification, effect of termination, and coverage following termination and decertification.
- **ARTICLE 9 – INSURANCE AND INDEMNIFICATION** includes Contractor's required coverage amounts.
- **ARTICLE 10 – PRIVACY AND SECURITY**
- **ARTICLE 11 – RECORDKEEPING** includes Covered California record retention requirements for clinical and financial records along with accessibility and storage, examination and audit submittal and review, corrective actions, noticing, confidentiality, and electronic commerce.
- **ARTICLE 12 – INTELLECTUAL PROPERTY**
- **ARTICLE 13 – SPECIAL TERMS AND CONDITIONS** including dispute resolution, attorneys' fees, notice delivery, amendments, time is of the essence, publicity, force majeure, further assurances, binding effect, title/section, severability, order of precedence, waivers, incorporation of amendments to applicable laws, choice of law, jurisdiction, and venue, counterparts, ambiguities not held against drafter, clerical error administration of agreement, and performance of requirements.
- **ARTICLE 14 – DEFINITIONS**

ARTICLE 3. PROPOSED (NEW) CONTRACT TERMS CONCERNING ENROLLMENT

- For plan year 2023, the contract will more clearly articulate the agreement between Covered California and its Carriers that we are jointly responsible for and committed to working together to maximize the enrollment of individuals eligible for subsidies in Covered California and in individual coverage generally. That agreement will be reflected in requirements for carriers to:
  - Support smooth member transitions and facilitate continuous coverage for enrollees to and from Covered California and other health coverage programs, including Medi-Cal and other governmental health care programs and for consumers leaving coverage provided by Employers, including enrollees eligible for COBRA or Cal-COBRA but may have better coverage options through Covered California.
  - Continue sharing plans and budgets for marketing and coordinating marketing efforts with Covered California. The contract will also continue the expectation that Carriers commit resources to marketing and outreach efforts, though we will maintain the existing terms that do not establish minimum marketing spend. Covered California will reduce the current expectation for certification that 0.6% of premium be spent on marketing to 0.4%, with the expectation that this amount be spent on direct response advertising, outreach and community-based efforts, and non-open enrollment “brand” marketing that includes co-branding of Covered California. Brand marketing that does not reference Covered California will not be reflected in determining the “creditable marketing.”
  - Support and adequately compensate Certified Agents for enrollments in its QHPs.

- Covered California will consider Carriers’ engagement, partnership and how these requirements are met as a critical component when deciding whether to re-contract with Carriers for future contract periods or whether to make the requirement tied to specific liquidated damages or enforcement criteria in future years.

Article 5. PROPOSED (NEW) QUALITY STANDARDS FOR POTENTIAL EXCLUSION OF PLANS EFFECTIVE 2023

- Health plan products that fall below established quality benchmarks for two consecutive years will be put on notice they will be required to improve within two years or be decertified in the subsequent plan year.
- The quality benchmark is the composite 25th percentile performance using the Quality Rating System (QRS) “Getting the Right Care” standard measures.
- The exclusion policy will not be applied in a region where removal of one or multiple plans would lead to fewer than three issuers remaining in the region.
- Issuers will be required to submit a plan detailing the action(s) they will take to improve quality and equity.
- Covered California will monitor and work with issuers to minimize any negative impacts improvement efforts may have on consumers.
- If the health plan product does not meet the quality benchmark within the improvement two-year period, that health plan product will be decertified and removed from Covered California’s Marketplace and consumers will be assisted in selecting a new health plan.
- Issuers will be eligible to reapply to offer the health plan product that was removed once its quality scores have improved and are above the performance threshold for two consecutive years following removal.
- Covered California will continue to analyze the impact of demographic and socio-economic factors that affect quality scores for potential adjustments to these quality standards. If carriers can demonstrate or provide evidence of the negative impact on quality scores, Covered California will evaluate such evidence and consider adjustments.

ARTICLE 5. PROPOSED (NEW) MONITORING REQUIREMENTS FOR ISSUERS CONDUCTING REQUIRED IMPROVEMENT

- Any issuers with one or more plan product performing at or below the 25th percentile of national performance for any QTI measure OR that have been put on notice for potential exclusion from Covered California based on two years of poor performance will be required to report on their planned interventions to improve their performance in a quality improvement plan.
- Covered California will closely monitor and review the quality improvement plans and monitor how issuers follow-up to assess for and mitigate potential negative impacts, including during Quarterly Business Reviews. The assessment will be used to inform the next cycle of contract renewal decisions, with a pattern of “negative actions” weighted heavily in decisions regarding ongoing participation in Covered California.

POTENTIAL CARRIER RESPONSES TO THE QUALITY TRANSFORMATION INITIATIVE AND THE POTENTIAL OF REMOVAL FOR POOR QUALITY

Covered California will review and monitor quality improvement plans to improve quality as required for those health plan products that either are subject to removal from Covered California or are performing below the 25th percentile in any core measures of the Quality Transformation Initiative. This review will seek to ensure that carrier actions do not have unintended negative impacts on consumers. Proposed intervention plan actions may include, but are not limited to:

1. Engaging and supporting provider groups in improvement activities, for example: development of registries and data analytics, facilitating data exchange, and innovative approaches to patient engagement in order to improve coordination, integration and care delivery.
2. Contract with higher-quality providers (which may decrease affordability if those higher-quality providers are also higher-cost providers).
3. Developing quality incentive programs for contracted providers and groups narrowly focused on the same or similar measures (which may improve measures but may or may not improve underlying systems of care).
4. Use consumer incentive programs to target desired behavior (Covered California has found no strong evidence that this is effective, but it may be an additional lever).
5. Focusing on data issues, including completeness (which is foundational but doesn't represent true improvements in quality and will not impact outcomes).
6. Eliminating poor performing providers or provider groups from their contracted networks (limited by the need to meet access and network adequacy requirements from both regulators and Covered California and which could have the unintended consequence of penalizing providers serving higher risk or more vulnerable patients).

ENSURING THE REMOVAL POLICIES AND THE QUALITY TRANSFORMATION INITIATIVE ARE BASED ON IMPROVEMENTS FOR WHICH HEALTH PLANS CAN AND SHOULD BE HELD ACCOUNTABLE

- Covered California is committed to assuring that differences in performance are not substantially driven by differences in the populations served by its contracted carriers.
- As part of this initiative, Covered California will engage in continued analysis and welcome analysis from its carriers that provide evidence that any carriers population served has characteristics related to the income of enrollees or their race and ethnicity that may warrant adjusting targets of either the Quality Transformation Initiative or the plan removal policy.
- To the extent adjustments are warranted, Covered California would bring such adjustments to the board for consideration and amend the contract as needed.

PROPOSED 2023-2025 CONTRACT
ATTACHMENT 1: ADVANCING EQUITY, QUALITY, AND VALUE

Attachment 1 Article	Summary of Requirements
Article 1: Equity and Disparities Reduction	• Collect race, ethnicity, and language demographic data • Submit quality measure data stratified by race and ethnicity • Implement disparities interventions and meet a multi-year disparities reduction target • Achieve NCQA Health Equity Accreditation by year end 2023
Article 2: Behavioral Health	• Promote access to behavioral health services; offer telehealth for behavioral health • Collect Depression Screening and Follow-Up measure results • Implement policies and programs to promote the appropriate use of opioids • Promote the integration of behavioral health services with primary care services
Article 3: Population Health	• Submit population health management plans • Conduct prevention efforts including tobacco cessation and diabetes prevention • Screen enrollees for food insecurity and support linkages to appropriate social services
Article 4: Delivery System and Payment Strategies to Drive Quality	• Match all enrollees to a PCP; increase value-based payment models for PCPs • Report on enrollment in IDSs or ACOs; measure and report on performance • Track provider organization and hospital quality and costs and report on improvement efforts • Monitor maternal health disparities and report on intervention efforts
Article 5: Measurement and Data Sharing	• Participate in QRS and submit QRS measure results to Covered California • Submit data to Covered California for the Healthcare Evidence Initiative (HEI) • Participate in a Health Information Exchange (HIE) • Submit data to the Integrated Healthcare Association (IHA)
Article 6: Accreditation	• Achieve NCQA health plan accreditation by year end 2024

PROPOSED 2023-2025 CONTRACT
ATTACHMENT 2: PERFORMANCE STANDARDS WITH PENALTIES

- Attachment 2 - Performance Standards with Penalties (formerly Attachment 14) captures performance standards in the areas of health disparities, payment strategies, enrollee experience, data quality and completeness, and oral health, that are critical to Covered California meeting its mission.
- For 2023, Performance Standards with Penalties, the total amount at risk is 0.2% of premium.

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%

PROPOSED 2023-2025 CONTRACT
ATTACHMENT 3: PERFORMANCE STANDARDS AND EXPECTATIONS

- Attachment 3 - Performance Standards and Expectations (formerly Attachment 14).
- Contractor performance will be posted publicly on Covered CA's website.

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.
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.
1.2 Service Level	Expectation: 80% of calls answered in 30 seconds or less.
1.3 Grievance Resolution	Expectation: 95% of Covered California enrollee grievances resolved within 30 days of initial receipt.
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.
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).
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.
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.
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.
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.
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.
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).
1.12 Essential Community Providers	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.

PUBLIC COMMENT PROCESS

- Covered California has solicited public comments, along with many other informal opportunities for input, on the Model Contract and Attachments 1, 2, and 3 through two rounds of public comments in September 2021 and November 2021.
- We solicited public comments on new contract language from January 28 to February 11, 2022, for:
  - Quality Standards for Exclusion of Existing Plans
  - Contract Terms Concerning Enrollment
  - Monitoring Requirements for Issuers Conducting Required Improvement
  - Quality Transformation Initiative
- Covered California is currently reviewing the public comments and will release any necessary revisions to contract language and responses to those comments prior to the March Board meeting.

QUALITY TRANSFORMATION INITIATIVE UPDATE

Alice Hm Chen, MD, MPH, Chief Medical Officer

OVERARCHING QUALITY TRANSFORMATION INITIATIVE STRATEGY

- The Quality Transformation Initiative (QTI) is one component of Covered California's multipronged measurement strategy which includes annual tracking, monitoring and reporting of about 40 HEDIS and CAHPS measures that are part of the national Quality Rating System (QRS) as well as ongoing assessment of care through Healthcare Evidence Initiative (HEI) measures as outlined in Attachment 1 and 2 of the proposed 2023-2025 contract.
- There are four core QTI measures tied to quality payments; in addition, there are two "reporting only" behavioral health measures as well as stratification of all measures by race/ethnicity, with the intent to tie quality payments to performance in future years.
- The first year of the contract would have 0.8% of premium as the total potential quality payment, moving up to 3% as of PY 2025, with intention to increase to 4% maximum in PY 2026.
- Funds from quality payments would be used to establish an internal, separately tracked, Quality Transformation Fund.
- For any measure for which they score below the 25th percentile, issuers would be required to submit a quality improvement plan detailing the actions they plan to take to improve quality and equity. Covered California would monitor and work with issuers to ensure proposed actions do not have negative impacts on consumers.
- Covered California will continue to analyze the impact of demographic and socio-economic factors that affect quality scores for potential adjustments to quality payments. If issuers can demonstrate or provide evidence of the negative impact on quality scores, Covered California will evaluate such evidence and consider adjustments.

QTI MEASURES: RECOMMENDED INITIAL CORE SET OF 4 METRICS

QTI measure set:

- Controlling High Blood Pressure (NQF #0018)
- Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575)
- Colorectal Cancer Screening (NQF #0034)
- Childhood Immunization Status (Combo 10) (NQF #0038)

Reporting only measures:

- Depression Screening and Follow-Up for Adolescents and Adults (DSF)
- Pharmacotherapy for Opioid Use Disorder (POD)

All measures will be stratified by race/ethnicity for reporting only in initial years. Quality payments tied to reducing health disparities for the QTI measure set will begin in 2025 or 2026 once a methodology has been established.

QTI MEASURES: CORE SET MY 2019 PERFORMANCE

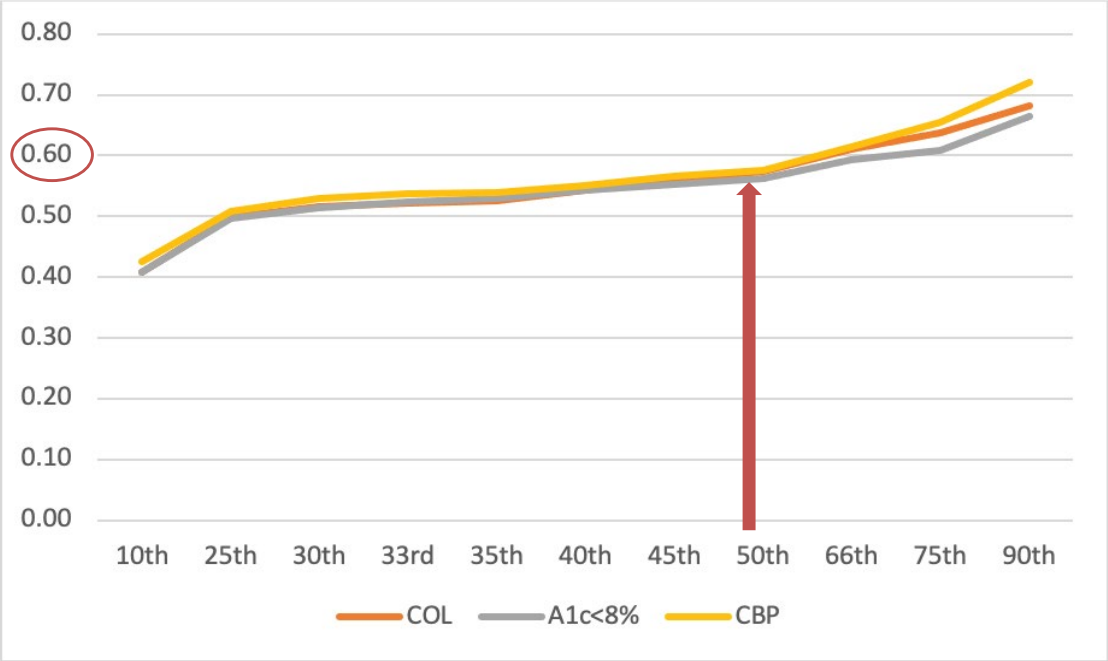
- Kaiser's HMO is the only plan product that has no measure below 50th percentile national performance.
- 2 plan products (Anthem EPO and Oscar EPO) have all four measures below 50th percentile national performance.
- 3 plan products (Blue Shield PPO, HealthNet PPO, Molina HMO) have three measures below 50th percentile national performance.

Benchmark:	≥90th Percentile	50th - 90th Percentile	25th - 50th Percentile	<25th Percentile

Measure Title	Year	Anthem HMO	Anthem PPO	Anthem EPO	BSC HMO	BSC PPO	CCHP HMO	Health Net HMO	Health Net EPO	Health Net PPO	Kaiser HMO	LA Care HMO	Molina HMO	Oscar EPO	Sharp HMO	VHP HMO	WHA HMO
Colorectal Cancer Screening	2019			45	59	51	60	62	53	40	76	54	31	36	66	54	52
	2020																
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	2019			57	64	64	57	61	63	61	70	62	58	50	76	69	53
	2020																
Controlling High Blood Pressure	2019			45	66	56	68	63	59	55	81	68	65	46	79	64	65
	2020																
Childhood Immunization Status (Combination 3)	2019			51	64	63		69		55	84	82	74	34	77		
	2020																

QTI MEASURES: MY2019 NATIONAL DISTRIBUTION

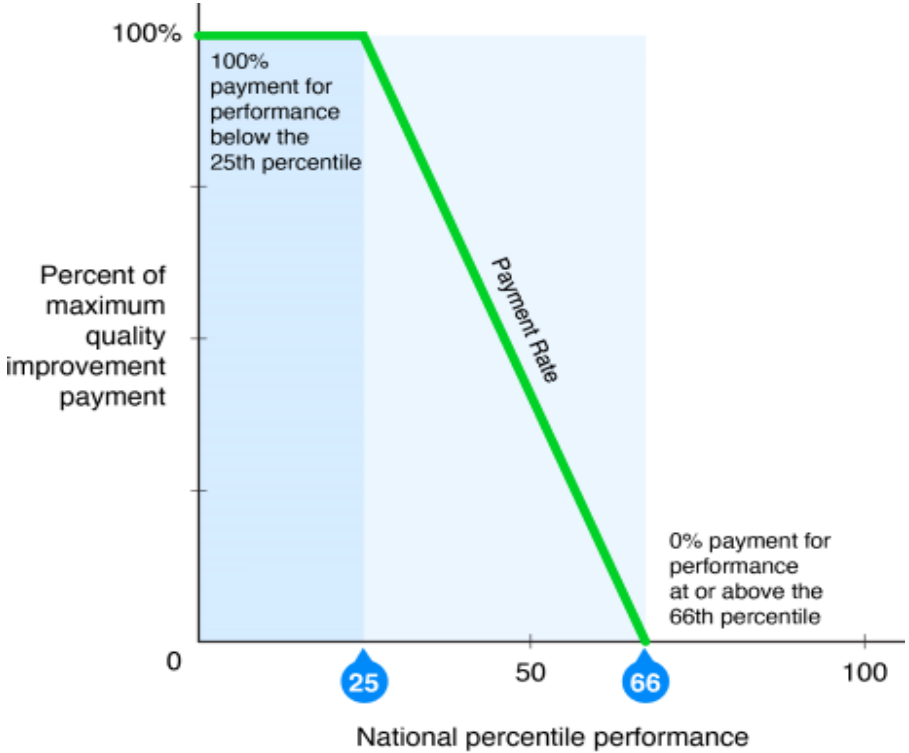
At the 50th percentile of national performance for blood pressure control, diabetes control and colorectal cancer screening measures means that fewer than 60% of enrollees receive recommended care.



PROPOSED QTI PERFORMANCE THRESHOLDS

- Performance thresholds for 2023 – 2025 will be based on national percentiles for Measurement Year 2021 (or Measurement Year 2022 for Childhood Immunization Status Combo 10) performance to allow for improvement over time against static frame of reference.
- Covered California proposes the following payment structure:
  - Issuer contributes quality payments to the Quality Transformation Fund based on the following quality levels for each measure:
    - Full per measure amount if the measure score is below the 25th percentile.
    - Per measure amount at a declining constant linear rate, as determined by Covered California, for each measure score between the 25th and 65.9th percentile.
    - No payment for each measure score at or above the 66th percentile.

PROPOSED QUALITY TRANSFORMATION FUND PAYMENT STRUCTURE



THE QUALITY TRANSFORMATION INITIATIVE – INTENT, ESTABLISHING FUND, AND USE OF FUNDS

- **Intent:** The goal of the Quality Transformation Initiative (QTI) is to provide substantial economic incentives for issuers to invest in quality, while aiming for "global premium net neutrality."
- **QTI Structure:** As part of an issuer's contractual agreement with Covered California for the 2023 – 2025 plan years, issuers have a contractual obligation to make quality payments into the Quality Transformation Fund based on their QHPs' performance on key quality, and in future years, equity indicators.
- **Establishment of Quality Transformation Fund:** Covered California shall establish an internal, separately tracked, Quality Transformation Fund. As part of its annual budgeting and public reporting, Covered California shall report on payments made into the Fund and how all such funds are spent.
- **Quality Transformation Fund Use:** Covered California shall spend the Quality Transformation Fund for quality related operations and activities. These activities would have been previously reviewed and approved as part of the regular annual budget adopted by the board of directors. Covered California will detail the timing and implications of both payment into the Quality Transformation Fund and the impact on Participation Fees related to Quality Transformation Fund expenditures reducing the need for issuer assessments.

QUALITY TRANSFORMATION INITIATIVE – POTENTIAL IMPACTS ON PREMIUM

- **Potential Impact on Premiums of Quality Transformation Fund Payment by Issuers:** The extent to which payments into the Quality Transformation Fund would impact premiums would depend on the affected issuer's market decisions. Issuers could potentially raise premiums; however, given that raising prices would lead to lower enrollment, issuers may instead choose to reduce profits or other administrative expenses. Covered California would review an issuer's actions as part of the annual negotiations between the issuer and Covered California.

- **Impact of Quality Transformation Fund Spend on Participation Fee and Potentially on Premiums:** Since Quality Transformation Funds would be spent on Covered California's budgeted quality related activities, the spending on such activities would reduce the need to have such expenses covered by the annual Participation Fee and would result in the Fee being reduced across all QHPs by the amount of the Quality Transformation Fund spend. To the extent the Participation Fee would be reduced, it is Covered California's expectation that QHP premiums would also be reduced by the same amount.

POTENTIAL TIMELINES FOR IMPLEMENTATION OF THE QUALITY TRANSFORMATION INITIATIVE

Covered California will work with health plans, advocates and other stakeholders to develop the specific timeline for implementing the payment calculation, payment into the Quality Transformation Fund. By the end of 2023, that process and timeline will be shared with the board. Two options now under consideration include:

Option 1. Adjust Participation Fee only after final review and collection of payments into the Quality Transformation Fund (outlined in table below).

Option 2. Calculate Payment to the Quality Transformation Fund in June and based on that estimate, adjust Participation Fee for upcoming Plan Year (making subsequent adjustments as needed based on final Payments)

Option 1 Timeline: Adjust Participation Fee after Quality Transformation Fund Payment

	QHPs Submit Data to CMS QRS and Covered CA	Payment Calculated by Covered CA	Review by QHP Issuers	Public Announcement of Payment	QHPs Submit Funds to Covered CA	Fiscal Year	Potential Impact on Participation Fee
2023	June 15, 2024	July 2024	August 2024	September 2024	January 2025	2025-26	Plan Year 2026
2024	June 15, 2025	July 2025	August 2025	September 2025	January 2026	2026-27	Plan Year 2027
2025	June 15, 2026	July 2026	August 2026	September 2026	January 2027	2027-28	Plan Year 2028

2023 CERTIFICATION

James DeBenedetti
Director, Plan Management Division

CERTIFICATION APPLICATION UPDATES

Qualified Health Plan (QHP) New Contract

All Issuers are considered New Entrants and must complete the entire application. If certified, the new contracts will be from Plan Year 2023 – 2025.

QHP Application Rewrite

The health applications have been heavily reorganized. Many questions have been grouped by product type: HMO, PPO, EPO, and Other. Each product specific section includes subsections: Benefit Design, Benefit Administration, Provider Network, and Delivery System and Payment Strategies to Drive Quality.

Qualified Dental Plan (QDP) Contract and Application

The QDP Contract period will be extended by one-year so dental plan issuers currently contracted will continue to be contracted through 2023, if certified.

Plan Year 2023 Certification Applications will be open to all Applicants. The Applications will go live on March 1, 2022 and are due on April 29, 2022.

CERTIFICATION SELECTION CRITERIA

Following a comprehensive stakeholder process and consideration of a set of recommendations by staff, Covered California's Board of Directors articulate guidelines for the selection and oversight of Qualified Health Plans (QHP) which are used in selecting QHP issuers and making QHP certification decisions.

These guidelines are:

- Affordability for the consumer – both in premiums and at the point of care;
- "Value" Competition Based upon Quality, Service, and Price;
- Competition Based upon Meaningful QHP Choice and Product Differentiation: Patient-Centered Benefit Plan Designs;
- Competition throughout the State;
- Alignment with Providers and Delivery Systems that Serve the Low-Income Population;
- Delivery System Improvement, Effective Prevention Programs and Payment Reform;
- Administrative Capability and Financial Solvency; and
- Robust Customer Service.

CERTIFICATION APPLICATION SECTIONS

The Qualified Health Plan Certification Application for the Individual Marketplace is comprised of 22 sections:

- **SECTION 1 – APPLICATION OVERVIEW** - Statewide health insurance exchange to make it easier for individuals to compare plans and buy health insurance in the private market. Covered California is guided by the following values: Consumer-Focused, Affordability, Catalyst, Integrity, Transparency, & Results
- **SECTION 2 – ADMINISTRATION AND ATTESTATION –** Certificates of Insurance, organizational structure, and corporate structure
- **SECTION 3 – LICENSED AND GOOD STANDING** – Holds or pursuing all licenses needed to operate in CA with no material fines, penalties, or disputes in the past two years
- **SECTION 4 – FINANCIAL REQUIREMENTS** – Description of systems to invoice and collect payments
- **SECTION 5 – OPERATIONAL CAPACITY** – Issuer operations, account management support, and Open Enrollment readiness
- **SECTION 6 – CUSTOMER SERVICE –** Grievance procedures, service center operations, and consumer experience.
- **SECTION 7 – SALES CHANNELS** – Agent services support team to provide communication and sales strategy to assist in facilitating the ease of business
- **SECTION 8 – MARKETING AND OUTREACH ACTIVITIES** – Enrollment promotion
- **SECTION 9 – PRIVACY AND SECURITY REQUIREMENTS FOR PERSONALLY IDENTIFIABLE DATA** – Privacy-related requirements set forth within Subpart E of the Health Insurance Portability and Accountability Act
- **SECTION 10 – FRAUD, WASTE, AND ABUSE DETECTION** – Policies, procedures, and systems to prevent, detect, and respond to fraud, waste, and abuse
- **SECTION 11 – AUDITS** - Description of internal and external audit functions

CERTIFICATION APPLICATION SECTIONS (CONTINUED)

- **SECTION 12 – ELECTRONIC DATA INTERFACE** – Description of interface system, data model, vendors, and anticipated changes
- **SECTION 13 – SYSTEM FOR ELECTRONIC RATE AND FORM FILING (SERFF)** – Confirmation of complete and accurate SERFF templates submission
- **SECTION 14 – HEALTHCARE EVIDENCE INITIATIVE** – Data submission related to choice, value, quality, and service.
- **SECTION 15 – ESSENTIAL COMMUNITY PROVIDERS (ECP)** - Geographic sufficiency of ECP network
- **SECTION 16 – HEALTH EQUITY AND QUALITY TRANSFORMATION** – Accreditation, Health Equity and Disparities Reduction, Behavioral Health, Health Promotion and Prevention, Population Health Management, Complex Care, Affordability and Cost, Participation in Quality Improvement Collaboratives, and Data Sharing and Exchange
- **SECTION 17 – HEALTH PLAN PROPOSAL** – Proposed rates, networks, and plan designs
- **SECTION 18 – HEALTH MAINTENANCE ORGANIZATION (HMO)*** - Benefit Design, Benefit Administration, Provider Network, & Delivery System and Payment Strategies to Drive Quality
- **SECTION 19 – PREFERRED PROVIDER ORGANIZATION (PPO)*** - Benefit Design, Benefit Administration, Provider Network, & Delivery System and Payment Strategies to Drive Quality
- **SECTION 20 – EXCLUSIVE PROVIDER ORGANIZATION (EPO)*** - Benefit Design, Benefit Administration, Provider Network, & Delivery System and Payment Strategies to Drive Quality
- **SECTION 21 – OTHER NETWORK TYPE (OTHER)*** - Benefit Design, Benefit Administration, Provider Network, & Delivery System and Payment Strategies to Drive Quality
- **SECTION 22 – Glossary**

*Required only if Applicant is proposing these product(s).

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 BENEFIT DESIGN

Jan Falzarano
Deputy Director, Plan Management Division

BENEFIT PLAN DESIGN OVERVIEW

The Affordable Care Act (ACA) requires that each plan offered on the Exchange include 10 Essential Health Benefits (EHBs).

The ACA requires individual and small group plans to meet actuarial value (AV) requirements for four levels of coverage:

- Platinum: 90% AV
- Gold: 80% AV
- Silver: 70% AV
- Bronze: 60% AV

Additional plan designs with a richer benefit package, known as Cost Sharing Reduction Plans (CSRs), are available to individuals meeting income eligibility requirements:

- Silver 94: 94% AV, 100% - 150% Federal Poverty Level (FPL)
- Silver 87: 87% AV, 150% - 200% FPL
- Silver 73: 73% AV, 200% - 250% FPL

California law authorizes the Covered California Board to standardize products offered through the Exchange. Contracted issuers are required to offer products using Covered California's Board-approved standard benefit plan designs.

The standard benefit plan design is adjusted annually to meet AV requirements, clarify benefit administration, and incorporate benefit design innovations.

STRATEGY FOR PATIENT-CENTERED BENEFIT PLAN DESIGNS

Organizational Goal

- Covered California should have benefit designs that are standardized, promote access to care, and are easy for consumers to understand = PATIENT-CENTERED.

Principles

- Multi-year progressive strategy with consideration for market dynamics: changes in benefits should be considered annually based on consumer experience related to access and cost
- Adhere to principles of value-based insurance design by considering value and cost of clinical services
- Set fixed copays as much as possible and utilize coinsurance for services with wide price variation to encourage members to shop for services
- Apply a stair-step approach for setting member cost shares for a service across each metal level, e.g., a primary care visit is $40 in the Silver tier, $35 in Gold, and $15 in Platinum

APPROACH TO COST SHARING IN THE PLAN DESIGNS

Covered California plan designs are distinguished by several key approaches to member cost-sharing to ensure the right care at the right time:

Deductibles and Member Cost Shares

- Platinum and Gold plans do not have a deductible.
- In the Silver Plan, all office visits, labs, emergency room, and x-rays are NOT subject to the medical deductible. Only inpatient admissions and skilled nursing facilities are subject to the medical deductible in Silver.
- In the Bronze plan, the first three office visits are NOT subject to the deductible, and the member pays a flat-dollar copay. At the fourth visit, the member pays the full cost until the deductible is met.

Drugs

- All drugs, especially specialty drugs, are capped at a maximum amount per 30-day script ($150 / $250 / $500). This means a consumer will not pay thousands of dollars for a single script in any given month.
- In Silver and Bronze, drugs are subject to a separate deductible that is much lower than the medical deductible.

Primary and Emergency Care

- Primary care copays are lower than specialist visit copays.
- Urgent care copays are set at the same amount as a primary care visit.
- Lab tests are not subject to any deductible in any plan (except Health Savings Account (HSA)-eligible High-Deductible Health Plans (HDHPs)).

FACTORS INFLUENCING 2023 BENEFIT PLAN DESIGNS

- The Draft 2023 Notice of Benefit and Payment Parameters (NBPP) – released December 28, 2021

- Department of Health and Human Services (HHS) issued a guidance letter on December 28, 2021, and set the annual limitation on cost sharing at $9,100 for Plan Year 2023
  - Covered California coordinates the Maximum Out-Of-Pocket (MOOP) limit with pediatric dental services and sets the health MOOP $350 lower than the federal annual limitation on cost-sharing to cover MOOP for stand alone dental plans
  - Covered California' plan designs for Plan Year 2023 has a range of between $900 and $8,750, depending on metal tier

- The Draft 2023 Actuarial Value (AV) Calculator was released on Thursday, December 30, 2021
  - Claims costs in the draft 2023 AV Calculator are projected forward:
    - 2018-2021 – annual rate of 5.4 percent for medical and 8.7 percent for drug spending
    - 2021-2022 – the AV Calculator was revised to 3.2 percent for medical spending and 4.55 percent for drug spending. Note: 2021-2022 AV Calculator previously set at 0.0 percent
    - 2022-2023 – Projection of 5.8 percent for medical and 8.7 percent for drug spending

2023 ANNUAL LIMITATION ON COST SHARING

	2019	2020	2021	2022	2023
Maximum annual limitation on cost-sharing (federal)	$7,900 / $15,800	$8,150 / $16,300	$8,550 / $17,100	$8,700 / $17,400	$9,100 / $18,200
Less CA MOOP ($350) for dental	$7,550 / $15,100	$7,800 / $15,600	$8,200 / $16,400	$8,350 / $16,700	$8,750 / $17,500
CSR 73 Maximum annual limitation	$6,300 / $12,600	$6,500 / $13,000	$6,800 / $13,600	$6,950 / $13,900	$7,250 / $14,500
CSR 87 Maximum annual limitation	$2,600 / $5,200	$2,700 / $5,400	$2,850 / $5,700	$2,900 / $5,800	$3,000 / $6,000
CSR 94 Maximum annual limitation	$2,600 / $5,200	$2,700 / $5,400	$2,850 / $5,700	$2,900 / $5,800	$3,000 / $6,000

2022 PLAN DESIGN SIDE-BY-SIDE VIEW
INDIVIDUAL & FAMILY PLAN WITH 2023 AVC OUTPUTS

Benefit	Individual-only Platinum Coinsurance		Individual-only Platinum Copay		Individual-only Gold Coinsurance		Individual-only Gold Copay		Individual-only Silver		Silver 73		Silver 87		Silver 94		Bronze		Bronze HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible																				$7,000
Medical Deductible										$3,700		$3,700		$800		$75		$6,300		
Drug Deductible										$10		$10		$0		$0		$500		
Coinsurance (Member)		10%		10%		20%		20%		20%		20%		15%		10%		40%		0%
MOOP		$4,500		$4,500		$8,200		$8,200		$8,200		$6,300		$2,850		$800		$8,200		$7,000
ED Facility Fee		$150		$150		$350		$350		$400		$400		$150		$50	X	40%	X	0%
Inpatient Facility Fee		10%		$250		20%		$600	X	20%	X	20%	X	15%	X	10%	X	40%	X	0%
Inpatient Physician Fee		10%		---		20%		---		20%		20%		15%		10%	X	40%	X	0%
Primary Care Visit		$15		$15		$35		$35		$35		$35		$15		$5	X	$65	X	0%
Specialist Visit		$30		$30		$65		$65		$70		$70		$25		$8	X	$95	X	0%
MH/SU Outpatient Services		$15		$15		$35		$35		$35		$35		$15		$5	X	$65	X	0%
Imaging (CT/PET Scans, MRIs)		10%		$75		20%		$150		$325		$325		$100		$50	X	40%	X	0%
Speech Therapy		$15		$15		$35		$35		$35		$35		$15		$5		$65	X	0%
Occupational and Physical Therapy		$15		$15		$35		$35		$35		$35		$15		$5		$65	X	0%
Laboratory Services		$15		$15		$40		$40		$40		$40		$20		$8		$40	X	0%
X-rays and Diagnostic Imaging		$30		$30		$75		$75		$85		$85		$40		$8	X	40%	X	0%
Skilled Nursing Facility		10%		$150		20%		$300	X	20%	X	20%	X	15%	X	10%	X	40%	X	0%
Outpatient Facility Fee		10%		$100		20%		$300		20%		20%		15%		10%	X	40%	X	0%
Outpatient Physician Fee		10%		$25		20%		$40		20%		20%		15%		10%	X	40%	X	0%
Tier 1 (Generics)		$5		$5		$15		$15	X	$15	X	$15		$5		$3	X	$18	X	0%
Tier 2 (Preferred Brand)		$15		$15		$55		$55	X	$55	X	$55		$25		$10	X	40%	X	0%
Tier 3 (Nonpreferred Brand)		$25		$25		$80		$80	X	$85	X	$85		$45		$15	X	40%	X	0%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%		15%		10%	X	40%	X	0%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$150		$150		$500*		
Maximum Days for charging IP copay				5				5												
Begin PCP deductible after # of copays																		3 visits		
Actuarial Value																				
2023 AV (Draft 2023 AVC)		**91.76**		**89.75**		**82.64**		**79.20**		**73.88**		**76.24**		**88.44**		**95.19**		**64.73**		**64.17**
2022 Additive Adjustment										**-0.43**		**-0.43**		**-0.13**				**-0.12**		
2022 AV (Final 2022 AVC)†		**91.59**		**89.25**		**81.90**		**78.01**		**71.07†**		**73.42†**		**87.75†**		**94.66**		**64.78†**		**64.60**
Enrollment as of June 2021		61,090				151,430				227,540		124,900		328,850		205,510		352,860		108,220
Percent of Total enrollment		4%				10%				15%		8%		21%		13%		23%		7%

KEY:		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2022
		Decreased member cost from 2022
		Does not meet AV
		Within .5 of upper de minimis
		Securely within AV

COVERED CALIFORNIA

2023 PROPOSED PLAN DESIGN SIDE-BY-SIDE VIEW
INDIVIDUAL & FAMILY PLAN

Benefit	Individual-only Platinum Coinsurance		Individual-only Platinum Copay		Individual-only Gold Coinsurance		Individual-only Gold Copay		Individual-only Silver		Silver 73		Silver 87		Silver 94		Bronze		Bronze HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible																				$7,000
Medical Deductible										$4,750		$4,750		$800		$75		$6,300		
Drug Deductible										$85		$85		$25		$0		$500		
Coinsurance (Member)		10%		10%		20%		20%		20%		20%		15%		10%		40%		0%
MOOP		$4,500		$4,500		$8,550		$8,550		$8,750		$7,250		$3,000		$900		$8,200		$7,000
ED Facility Fee		$150		$150		$350		$350		$400		$400		$150		$50	X	40%	X	0%
Inpatient Facility Fee		10%		$250		30%		$350	X	30%	X	30%	X	25%	X	10%	X	40%	X	0%
Inpatient Physician Fee		10%		---		30%		---		30%		30%		25%		10%	X	40%	X	0%
Primary Care Visit		$15		$15		$35		$35		$45		$45		$15		$5	X	$65	X	0%
Specialist Visit		$30		$30		$65		$65		$85		$85		$25		$8	X	$95	X	0%
MH/SU Outpatient Services		$15		$15		$35		$35		$45		$45		$15		$5	X	$65	X	0%
Imaging (CT/PET Scans, MRIs)		10%		$75		25%		$75		$325		$325		$100		$50	X	40%	X	0%
Speech Therapy		$15		$15		$35		$35		$45		$45		$15		$5		$65	X	0%
Occupational and Physical Therapy		$15		$15		$35		$35		$45		$45		$15		$5		$65	X	0%
Laboratory Services		$15		$15		$40		$40		$50		$50		$20		$8		$40	X	0%
X-rays and Diagnostic Imaging		$30		$30		$75		$75		$95		$90		$40		$8	X	40%	X	0%
Skilled Nursing Facility		10%		$150		30%		$150	X	30%	X	30%	X	25%	X	10%	X	40%	X	0%
Outpatient Facility Fee		10%		$100		20%		$150		20%		20%		15%		10%	X	40%	X	0%
Outpatient Physician Fee		10%		$25		20%		$40		20%		20%		15%		10%	X	40%	X	0%
Tier 1 (Generics)		$5		$5		$15		$15	X	$16	X	$16	X	$5		$3	X	$18	X	0%
Tier 2 (Preferred Brand)		$15		$15		$60		$60	X	$60	X	$55	X	$25		$10	X	40%	X	0%
Tier 3 (Nonpreferred Brand)		$25		$25		$85		$85	X	$90	X	$85	X	$45		$15	X	40%	X	0%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%	X	15%		10%	X	40%	X	0%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$150		$150		$500*		
Maximum Days for charging IP copay				5				5												
Begin PCP deductible after # of copays																		3 visits		
Actuarial Value																				
2023 AV (Draft 2023 AVC)		**91.76**		**89.75**		**81.92**		**80.11**		**71.57†**		**73.53†**		**87.86†**		**94.88**		**64.54†**		**64.17**
2022 AV (Final 2022 AVC)†		**91.59**		**89.25**		**81.90**		**78.01**		**71.07†**		**73.42†**		**87.75†**		**94.66**		**64.78†**		**64.60**
Enrollment as of June 2021		61,090				151,430				227,540		124,900		328,850		205,510		352,860		108,220
Percent of Total enrollment		4%				10%				15%		8%		21%		13%		23%		7%
Enrollment as of June 2021		17,373		43,717		84,815		66,615												
Percent of Total enrollment		28%		72%		56%		44%												

KEY:		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2022
		Decreased member cost from 2022
		Does not meet AV
		Within .5 of upper de minimis
		Securely within AV

2023 PROPOSED BENEFIT PLAN DESIGN CHANGES

Silver 94: 100% - 150% FPL

- Increased MOOP from $800 to $900

Silver 87: 150% - 200% FPL

- Added drug deductible $25 - All drug tiers are subject to the deductible
- Increased MOOP from $2,850 to $3,000
- Increased coinsurance from 15% to 25%: Inpatient facility, inpatient physician, and Skill Nursing Facility

Silver 73: 200-250% FPL

- Increased medical deductible from $3,700 to $4,750
- Increased drug deductible from $10 to $85
- Increased MOOP from $6,300 to $7,250
- Increased coinsurance for inpatient services and skilled nursing facility from 20% to 30%
- Increased copays by $10 for following services: primary care, Mental Health/Substance Use Disorder (MH/SUD) , speech/occupational/physical therapy visits (from $35 to $45), and laboratory services (from $40 to $50)
- Increased copays for x-rays from $85 to $90
- Increased copays for specialist visits from $70 to $85
- Increased Tier 1 drugs cost shares from $15 to $16

Silver 70 - The cost share changes from Silver 73 were made to the Silver 70 plan, with the following exception:

- MOOP is set at $8,750 (2022 benefit designs $8,200)
- Copays for x-rays is $95 ($10 increase from 2022 design)
- Tier 2 and Tier 3 Drugs have cost shares at $60 and $90 ($5 increase from 2022 design)

2023 PROPOSED BENEFIT PLAN DESIGN CHANGES

Gold Coinsurance

- Increased MOOP from $8,200 to $8,550
- Increased coinsurance from 20% to 30%: Inpatient facility, inpatient physician, and skill nursing facility
- Increased coinsurance for imaging services from 20% to 25%
- Increased Tier 2 and Tier 3 drugs cost shares by $5 ($60 and $85)

Gold Copay

- Several copay cost shares in the Gold Copay product is aligned to the Gold Coinsurance product:
  - MOOP at $8,550
  - Tier 2 and Tier 3 drugs at $60 and $85

The following cost shares

- Reduce Inpatient facility copays from $600 to $350
- Reduced Imaging from $150 to $75
- Reduced Skill Nursing Facility and Outpatient Facility fees from $300 to $150

No changes required for Platinum, Bronze and Bronze HDHP products

COVERED CALIFORNIA FOR SMALL BUSINESS

2022 BENEFIT PLAN DESIGNS SIDE-BY-SIDE VIEW FOR COVERED CALIFORNIA FOR SMALL BUSINESS WITH 2023 AV OUTPUTS

Benefit	CCSB-only Platinum Coinsurance		CCSB-only Platinum Copay		CCSB-only Gold Coinsurance		CCSB-only Gold Copay		CCSB-only Silver Coinsurance		CCSB-only Silver Copay		CCSB-only Silver HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible														$2,500
Medical Deductible						$350		$250		$2,250		$2,250		
Drug Deductible						$0		$0		$300		$300		
Coinsurance (Member)		10%		10%		20%		20%		30%		30%		20%
MOOP		$4,500		$4,500		$7,800		$7,800		$8,200		$8,200		$6,850
ED Facility Fee		$200		$150	X	20%	X	$250	X	30%	X	30%	X	20%
Inpatient Facility Fee		10%		$250	X	20%	X	$600	X	30%	X	30%	X	20%
Inpatient Physician Fee		10%		---	X	20%		--	X	30%		30%	X	20%
Primary Care Visit		$15		$20		$25		$35		$50		$55	X	20%
Specialist Visit		$30		$30		$50		$55		$85		$90	X	20%
MH/SU Outpatient Services		$15		$20		$25		$35		$50		$55	X	20%
Imaging (CT/PET Scans, MRIs)		10%		$100		20%	X	$250	X	30%	X	$300	X	20%
Speech Therapy		$15		$20		$25		$35		$50		$55	X	20%
Occupational and Physical Therapy		$15		$20		$25		$35		$50		$55	X	20%
Laboratory Services		$15		$20		$25		$35		$50		$55	X	20%
X-rays and Diagnostic Imaging		$30		$30		$65		$55		$85		$90	X	20%
Skilled Nursing Facility		10%		$150	X	20%	X	$300	X	30%	X	30%	X	20%
Outpatient Facility Fee		10%		$100		20%	X	$300	X	30%	X	30%	X	20%
Outpatient Physician Fee		10%		$25		20%		$35		30%		30%	X	20%
Tier 1 (Generics)		$10		$5		$15		$15		$17		$17	X	20%
Tier 2 (Preferred Brand)		$25		$20		$50		$40	X	$70	X	$80	X	20%
Tier 3 (Nonpreferred Brand)		$40		$30		$80		$70	X	$100	X	$110	X	20%
Tier 4 (Specialty)		10%		10%		20%		20%	X	30%	X	30%	X	20%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$250*
Maximum Days for charging IP copay				5				5						
Begin PCP deductible after # of copays														
Actuarial Value														
2023 AV (Draft 2023 AVC)		**90.71**		**88.80**		**78.91**		**80.49**		**73.17**		**72.53**		**73.37**
2022 Additive Adjustment						**-0.08**		**0.00**		**0.17**		**0.24**		
2022 AV (Final 2022 AVC)†		**90.47**		**88.29**		**78.02†**		**79.43**		**71.43†**		**70.84†**		**71.75**

KEY:		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2021
		Decreased member cost from 2021
		Does not meet AV
		Within .5 of upper de minimis
		Securely within AV

COVERED CALIFORNIA

2023 BENEFIT PLAN DESIGNS SIDE-BY-SIDE VIEW FOR COVERED CALIFORNIA FOR SMALL BUSINESS

Benefit	CCSB-only Platinum Coinsurance		CCSB-only Platinum Copay		CCSB-only Gold Coinsurance		CCSB-only Gold Copay		CCSB-only Silver Coinsurance		CCSB-only Silver Copay		CCSB-only Silver HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible														$2,700
Medical Deductible						$350		$250		$2,500		$2,500		
Drug Deductible						$0		$0		$300		$300		
Coinsurance (Member)		10%		10%		20%		20%		35%		30%		25%
MOOP		$4,500		$4,500		$7,800		$7,800		$8,600		$8,750		$7,200
ED Facility Fee		$200		$150	X	20%	X	$250	X	35%	X	30%	X	25%
Inpatient Facility Fee		10%		$250	X	20%	X	$600	X	35%	X	40%	X	25%
Inpatient Physician Fee		10%		---	X	20%		--	X	35%		40%	X	25%
Primary Care Visit		$15		$20		$25		$35		$55		$55	X	25%
Specialist Visit		$30		$30		$50		$55		$90		$90	X	25%
MH/SU Outpatient Services		$15		$20		$25		$35		$55		$55	X	25%
Imaging (CT/PET Scans, MRIs)		10%		$100		20%	X	$250	X	35%	X	$300	X	25%
Speech Therapy		$15		$20		$25		$35		$55		$55	X	25%
Occupational and Physical Therapy		$15		$20		$25		$35		$55		$55	X	25%
Laboratory Services		$15		$20		$25		$35		$55		$55	X	25%
X-rays and Diagnostic Imaging		$30		$30		$65		$55		$90		$90	X	25%
Skilled Nursing Facility		10%		$150	X	20%	X	$300	X	35%	X	40%	X	25%
Outpatient Facility Fee		10%		$100		20%	X	$300	X	35%	X	35%	X	25%
Outpatient Physician Fee		10%		$25		20%		$35		35%		30%	X	25%
Tier 1 (Generics)		$10		$5		$15		$15		$20		$19	X	25%
Tier 2 (Preferred Brand)		$25		$20		$50		$40	X	$75	X	$85	X	25%
Tier 3 (Nonpreferred Brand)		$40		$30		$80		$70	X	$105	X	$110	X	25%
Tier 4 (Specialty)		10%		10%		20%		20%	X	30%	X	30%	X	25%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$250*
Maximum Days for charging IP copay				5				5						
Begin PCP deductible after # of copays														
Actuarial Value														
2023 AV (Draft 2023 AVC)		**90.71**		**88.80**		**78.91**		**80.49**		**71.89†**		**71.54†**		**71.71**
2022 AV (Final 2022 AVC)		**90.47**		**88.29**		**78.02†**		**79.43**		**71.43†**		**70.84†**		**71.75**
Enrollment as of January 2021		15,864				29,679				20,825				1,724
Percent of Total enrollment		23%				44%				31%				3%

KEY:		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2022
		Decreased member cost from 2022
		Does not meet AV
		Within .5 of upper de minimis
		Securely within AV

COVERED CALIFORNIA

CCSB 2023 PROPOSED BENEFIT PLAN DESIGN CHANGES

No changes required for Platinum and Gold products

CCSB Silver Coinsurance

- Medical deductible increased from $2,250 to $2,500
- MOOP increased from $8,200 to $8,600
- Coinsurance across all benefit categories increased from 30% to 35% (ED, Inpatient Facility/Physician fees, Imaging, Skilled Nursing, Outpatient Facility/Physician fees)
- Cost shares increased $5 for Primary Care, MH/SUD, Speech, Occupational and Physical Therapy, laboratory services (from $50 to $55)
- Copays for x-rays increased $5 (from 85 to $90)
- Tier 1 generic drugs increased from $17 to $20, Tier 2 drugs increased from 70 to $75, Tier 3 drugs increased from $100 to $105

CCSB Silver Copay

- Medical deductible increased from $2,250 to $2,500
- MOOP increased from $8,200 to $8,750
- Coinsurance increased from 30% to 40% for Inpatient Facility, Inpatient Physician fees, Skilled Nursing Facility
- Coinsurance increased for Outpatient facility fee from 30% to 35%
- Tier 1 generic drugs increased from $17 to $19
- Tier 2 increased from $80 to $85

CCSB Silver HDHP

- Integrated deductible increased from $2,500 to $2,700
- MOOP increased from $6,850 to $7,200
- All categories of benefits increased coinsurance cost shares from 20% to 25%

DENTAL UPDATE

DENTAL BENEFIT DESIGNS

Pediatric enrollees can utilize the pediatric dental benefit in either:

- The embedded pediatric dental benefit in their health plan
- A separate, standalone dental plan (either children's dental plan or family dental plan)

Some families opt to enroll children in the separate standalone dental plan to keep the family all under one dental plan, to access a wider network of dental providers, and/or the added financial protection of the $350 MOOP for children's dental benefits.

Covered California standardizes dental plans offered in IFP and CCSB:

- Children's Dental Plan Coinsurance Plan, Children's Dental Plan Copay Plan
- Family Dental Plan Coinsurance Plan, Family Dental Plan Copay Plan
- For copay plans, a separate "copay schedule" is included in the plan designs to identify the standard cost share for every covered service.

Purchase Requirements: Family dental plans are only available to those who have purchased a health plan through Covered California. There must be at least one adult enrolled in a family dental plan, for a child in the family to enroll. If a family chooses to enroll children in a family dental plan, all children younger than 19 who live in the household must enroll.

2023 DENTAL BENEFIT PLAN DESIGNS

The 2023 Standard Benefit Dental Plan Designs remain unchanged

Cost sharing is detailed on the 2023 Copay Schedule which has been completed and reviewed by Milliman

Changes to CDT Codes

- Minor modifications to existing codes for nomenclature but no significant change to overall benefit design (see attachment for CDT code changes)

Procedure Category	CDT Code	Updated CDT-2319 Nomenclature
Restorative	D2971	Additional procedures to customize a ~~construct new~~ crown to fit under an existing partial denture framework
Periodontics	D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site
Implant Services	D6100	Surgical ~~Implant~~ removal of implant body~~, by report~~

NEXT STEPS

- Final 2023 proposed benefit designs will be presented for action in March
  - Benefits may need (typically minor) revisions after March due to late changes in the final version of the AV Calculator and Notice of Benefits and Payment Parameters

- Other initiatives at the State and Federal level that if implemented, could significantly impact the 2023 benefit designs
  - Example: Federal funding such as what is envisioned in Build Back Better would extend American Rescue Plan (ARP) premium subsidies and provide additional support for cost sharing reductions

- Highlighted in the report entitled "Bringing Coverage within Reach: Promoting California Marketplace Affordability and Improving Access to Care in 2023 and Beyond" are specific options for how Covered California can add new State cost-sharing subsidies to enhance benefits to consumers

NEXT STEPS: POTENTIAL COST-SHARING REDUCTION OPTIONS MODELED

- The following chart shows several options modeled from the Marketplace Affordability report and are potential enhanced cost-sharing options pending continuance of the American Rescue Plan (ARP)
- Covered California will continue engagement with stakeholders in the development of benefit designs for enhanced cost-sharing subsidies

✓ = benefit or eligibility enhancement
■ = richer CSR support

Option	Summary	Description	Up to 150% FPL		150-200% FPL		200-250% FPL		250-300% FPL		300-400% FPL		400-600% FPL		Annual Cost by Tier Switching Scenarios 1, 2, and 3 (millions)		
			CSR Upgrade	No Deductible	CSR Upgrade	No Deductible	CSR Upgrade	No Deductible	CSR Upgrade	No Deductible	CSR Upgrade	No Deductible	CSR Upgrade	No Deductible	Current	Some Tier Switching	More Tier Switching
	Current CSR Eligibility		*CSR Eligible*						*CSR Ineligible*								
	AV of ACA Silver Products		*94*		*87*		*73*		*70*		*70*		*70*				
1	AV 95/90/85/80 with no deductibles	New eligibility for CSR up to 600% FPL. New products (min AV 80) under 600% FPL. No deductibles at any income below 600% FPL.	**95**	✓	**95**	✓ ✓	**90**	✓ ✓	**90**	✓ ✓	**85**	✓ ✓	**80**	✓ ✓	$475	$542	$626
2	AV 95/90/85 with no deductibles	New eligibility for CSR up to 400% FPL. New products (min AV 85) under 400% FPL. No deductibles at any income below 400% FPL.	**95**	✓	**95**	✓ ✓	**90**	✓ ✓	**90**	✓ ✓	**85**	✓ ✓	**70**		$463	$526	$604
3	ACA CSR plan upgrade with no deductibles and Gold AV for 300-400% FPL	New eligibility for CSR up to 400% FPL. New CSR products (min AV 80) up to 400% FPL.	**94**	✓	**94**	✓ ✓	**87**	✓ ✓	**87**	✓ ✓	**80**	✓ ✓	**70**		$386	$433	$489

Adapted from Table 5 in the Milliman AB 133 Health Care Affordability companion report.
https://hbex.coveredca.com/stakeholders/AB_133_Health_Care_Affordability_Working_Group/Bringing-Care-Within-Reach-Milliman-Companion-Report-1-06-22.pdf

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.

APPENDIX

CONTEXT FOR COVERED CALIFORNIA'S 2023 – 2025 CONTRACTING

PROCESS FOR REFINING OPTIONS FOR BOARD CONSIDERATION

Solicited Input: Comments were solicited from major constituent groups, including:

- Covered California's Plan Management Advisory Committee
- Experts
- Health Plans
- Federal and State Policy Leaders
- Regulators
- Legal Counsel
- Others – Advocates, Providers and Associations

The expert and health plan comments and interviews were conducted in confidence to allow for full and frank engagement as well as the potential sharing of proprietary or other non-public information.

Market Analysis: Analysis developed by Milliman incorporated in this report.

Literature and Evidence Review: Conducted by Milliman and was used to inform recommendation development. A summary results will be shared in coming months.

Quality Improvement Modeling: Covered California engaged the National Quality Forum to model the relative impacts to mortality and illness of different levels of improvement in quality performance. Preliminary results are incorporated in this report, further distribution forthcoming.

POLICYMAKER, ADVOCATES AND ASSOCIATION INPUT

Covered California has discussed or conducted interviews with health plans, federal and state policy leaders and experts regarding the 2023-25 certification effort and Quality Transformation Initiative.

Federal Policy Leaders
Centers for Medicare and Medicaid Services (CMS), including the Office of the Administrator, the Center for Consumer Information and Insurance Oversight (CCIIO), the Center for Medicare, and the Center for Medicare and Medicaid Innovation (CMMI)
Department of Health and Human Services (HHS), including Office of the Secretary and of the Assistant Secretary for Planning and Evaluation (ASPE)
Congressional Staff, including in the Offices of the Speaker and of key Committee's with jurisdiction of health policy issues

State of California Policy Leaders
Office of Governor Gavin Newsom
Key California Legislative Staff
Department of Health Care Services
Department of Managed Health Care
California Department of Insurance
CalPERS

Health Plans
Carriers currently participating in Covered California
National and Regional Carriers interested in joining the individual market

Advocates/Experts
CPEHN
Families USA
Health Access
NHeLP
Western Center
Over 24 experts (see next page)

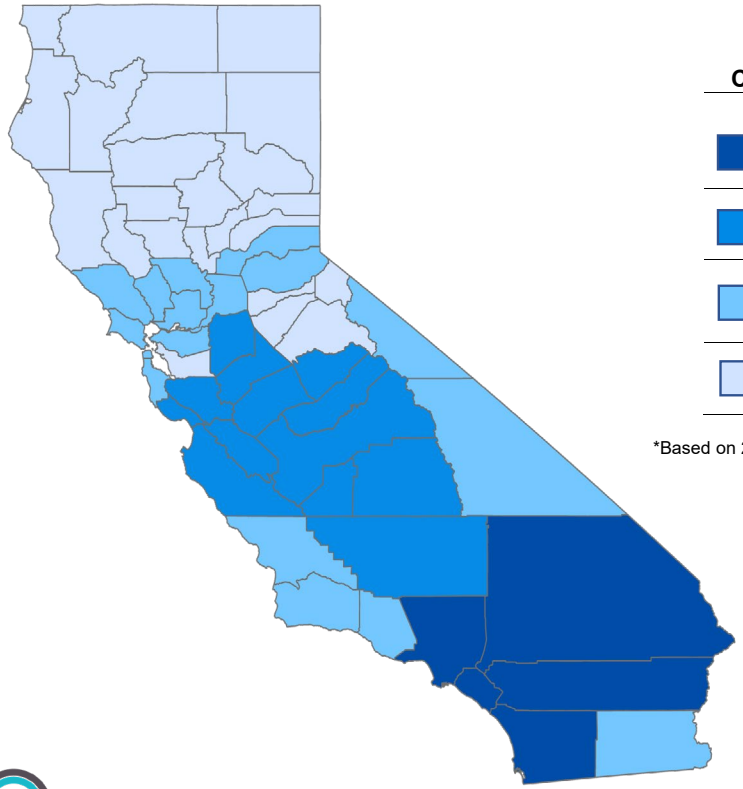
Associations
America's Health Insurance Plans
America's Physician Groups
California Association of Health Plans
California Medical Association

EXPERT INTERVIEWS CONDUCTED TO INFORM PROPOSAL DEVELOPMENT

Covered California met with the following subject matter experts to discuss the 2023-2025 certification effort and Quality Transformation Initiative (QTI). These interviews were confidential to allow experts to be as frank as possible.

Affiliation	Interviewee(s) (with past position)
As individuals	Don Berwick, MD (former CMS Administrator, Obama Admin.), Rick Gilfillan, MD (former Director, CMS/CMMI, Obama Admin.)
As individual	Patrick Conway, MD (currently with Optum/United, formerly CMO of CMS and director of CMMI)
American Enterprise Institute	Joe Antos, Jim Capretta
Aledade	Farzad Mostashari, MD (former national coordinator for health IT, US HHS, Obama Admin.)
Blackstone	Bob Galvin, MD (former CMO and Director Health Services, GE; member National Acad. Medicine; founder Leapfrog Group)
Catalyst for Payment Reform	Suzanne Delbanco (former Executive Director, Leapfrog Group)
Duke University	Mark McClellan, MD (former FDA Commissioner and CMS Administrator, Bush Admin.)
Georgetown University	Sabrina Corlette, JD
Harvard University	Mike Chernew, Joe Newhouse, Leemore Dafny
IE-Care	Mai Pham, MD (former senior staff for CMS, CMMI)
Integ. Healthcare Assoc.	Jeff Rideout, MD
Jennings Policy	Chris Jennings (former Senior Health Advisor to Presidents Obama and Clinton)
MA Health Exchange	Louis Gutierrez, Audrey Gasteier
Manatt	Cindy Mann (former CMS, Director Center on Medicaid), Joel Ario (former Director of CMS Office of Health Insurance Exchanges)
NASHP	Hemi Tewarson
NCQA	Peggy O'Kane and team
National Quality Forum	Dana Gelb-Safran
PBGH	Elizabeth Mitchell
Rand	Cheryl Damberg
Stanford/Hoover Inst.	Lanhee Chen (former senior health policy advisor top Republican office holders and presidential candidates)
UC Berkeley	Jamie Robinson and Ben Handel (separate interviews)
Urban Institute	John Holahan, Linda Blumberg, Judith Feder
Venrock	Bob Kocher, MD (former Special Assistant to President Obama on healthcare and economic policy)
WA Health Exchange	Pam MacEwan, Joan Altman

COVERED CALIFORNIA – MEANINGFUL CHOICE THAT MATTERS TO CONSUMERS



Level of Competition	Description*	Region	Lives Covered	Percent of Covered CA Lives
High	Five to eight issuers; no single issuer with more than 40% share. In some cases, two issuers offer HMO and PPO products.	15, 16, 17, 18, 19	862K	55%
Moderate	Three or four issuers; a single issuer has at least 50% share in each region.	7, 9, 10, 11, 14	229K	15%
Single-issuer Dominant	Three to five issuers; a single issuer has more than two-thirds market share in each region.	2, 3, 4, 5, 6, 8, 12, 13	431K	28%
Two-issuer	Two issuers; one having 56% share of region.	1	58K	3%

*Based on 2022 issuers

Current market share by type/region:

R7 - KP 50%; R9 - BSC 59%; R10 – KP 52%; R11 – BSC 65%; R14 – BSC 64%

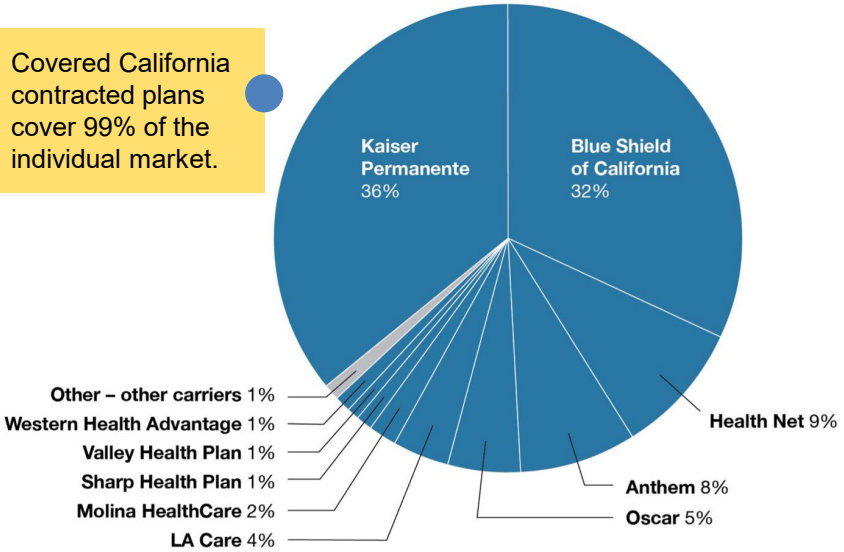
R2 – KP 77%; R3 - KP 71%; R4 – KP 67%; R5 - KP 81%; R6 - KP 84%, R8 – KP 80%; R12 – BSC 82%; R13 – Molina 83%

R1 – Anthem 56%, BSC 42%

COVERED CALIFORNIA CARRIERS AND COVERAGE ACROSS INSURERS LINES OF BUSINESS: BIG OPPORTUNITIES TO PROMOTE CONTINUITY OF COVERAGE

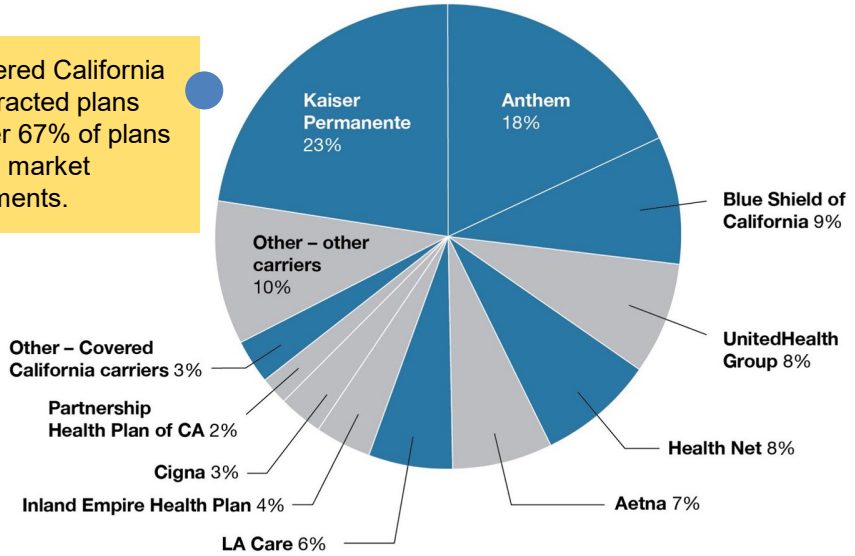
California Healthcare Market by Health Plan:
Individual

Covered California contracted plans cover 99% of the individual market.



California Healthcare Market by Health Plan:
All Market Segments

Covered California contracted plans cover 67% of plans in all market segments.



QUALITY TRANSFORMATION INITIATIVE

COVERED CALIFORNIA'S QUALITY STORY IS THE STORY OF A NATION'S FAILURE TO IMPROVE QUALITY

Good News:

- In 2020 85% of enrollees were in QHPs that received 3 stars or better for Getting Right Care, with one plan receiving 5 stars in 2020, and two receiving 4 stars as of 2021.

Bad News:

- QHP performance has not consistently or substantively improved over time.
- Three QHPs – Anthem, Molina and Oscar (representing 13% enrollees) received 2 stars for three consecutive years (2019, 2020 and 2021) for Getting the Right care.

Qualified Health Plan Issuer	2021 Enrollees	2016	2017	2018	2019	2020	2021
Anthem HMO	1.9%	3	-	-	-	NA	NA
Anthem PPO	-	2	-	-	-	-	-
Anthem EPO	4.5%	2	NA	3	2	2	2
Blue Shield HMO	7.4%	NA	NA	NA	2	3	3
Blue Shield PPO	20.6%	2	2	3	2	3	3
CCHP HMO	0.3%	3	3	3	3	3	3
Health Net HMO	8.3%	3	3	3	3	3	3
Health Net EPO	0.05%	NA	2	3	2	3	NA
Health Net PPO	2.7%	-	NA	NA	NA	3	2
Kaiser Permanente HMO	36.9%	5	4	5	5	5	4
LA Care HMO	6.1%	1	3	4	3	4	3
Molina Healthcare HMO	3.5%	2	3	3	2	2	2
Oscar Health Plan EPO	4.3%	NA	NA	3	2	2	2
Sharp Health Plan HMO	1.5%	4	4	5	4	4	4
Valley Health Plan HMO	1.4%	3	3	5	4	4	3
Western Health Advantage HMO	0.6%	3	3	3	2	2	3

* 2021 represents measurement year 2020 which may not be representative due to COVID-19

THE QUALITY TRANSFORMATION INITIATIVE: IMPROVING CARE FOR PEOPLE WITH HYPERTENSION MATTERS AND IMPROVEMENT COULD SAVE LIVES

Hypertension affects nearly half (47%) of Americans and more than a quarter (26%) of Californians. It significantly increases the risk of heart disease (the leading cause of death), as well as stroke (the fifth leading cause of death), with significant human and economic costs related to care, disability, and premature death. Hypertension control rates are significantly lower in African-American, Latinos, and Asian-American adults The estimated annual direct and indirect cost of heart disease is $220 billion and for stroke is $104 billion. For additional information, see Controlling High Blood Pressure.

Improving Blood Pressure Control Would Have Real Potential Impacts

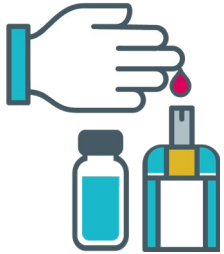
Covered California engaged the National Quality Forum to model the clinical impact of improved quality performance. The work is still in progress, but preliminary results suggest that if all Californians who are currently receiving care below the 66th percentile of national health plan performance instead received care at the 90th percentile national performance for blood pressure control, over the course of four years:

16,000	27,000	15,000
Fewer Deaths	Fewer Strokes	Fewer Heart Attacks

While most of the lives saved and negative health events averted would be a result of improved care of individuals receiving below average (50th national percentile) care, improvement of care to the 90th national percentile performance for those between 50th and 66th percentile would result in more than 2,300 lives saved and a reduction of other health related events by over 6,000 in the same period in California.

THE QUALITY TRANSFORMATION INITIATIVE: IMPROVING CARE FOR PEOPLE WITH DIABETES MATTERS AND IMPROVEMENT COULD SAVE LIVES

Diabetes is one of our nation's most serious public health challenges. In California, nearly half of adults are either diabetic or prediabetic, with higher prevalence rates in American Indians/Alaska Natives, Latinos, and African-Americans. Diabetes is the seventh leading cause of death, and a leading cause of both kidney failure and blindness. It has an estimated direct and indirect cost of $327 billion annually. For additional information, see Comprehensive Diabetes Care – Improving HbA1c Control.



Improving Blood Sugar Control for People with Diabetes Would Have Real Potential Impacts

Covered California engaged the National Quality Forum to model the clinical impact of improved quality performance. The work is still in progress, but preliminary results suggest that if all Californians who are currently receiving care below the 66th percentile of national health plan performance instead received care at the 90th percentile national performance for blood sugar control, over eleven years:

14,500
Fewer Deaths

4,500
Fewer Strokes

While most of the lives saved and negative health events averted would be a result of improved care of individuals receiving below average (50th national percentile) care, improvement of care to the 90th national percentile performance for those between 50th and 66th percentile would result in more than 1,800 lives saved and a reduction of strokes by over 500 in the same period in California.

THE QUALITY TRANSFORMATION INITIATIVE: INCREASED SCREENING AND PREVENTING COLORECTAL CANCER COULD SAVE LIVES

Colorectal Cancer is the second most common cause of cancer death after lung cancer. Importantly, routine screening is extremely effective at reducing the risk of colorectal cancer. The benefits of screening include finding precancerous polyps so they can be removed ***before*** they turn into cancer, as well as detecting colorectal cancer early when treatment is most effective. Treatment for colorectal cancer in its earliest stage can lead to a 5-year survival rate of 90%. Compared to whites, African Americans have a 20% higher incidence of colorectal cancer and a 40% higher mortality. For additional information see Colorectal Cancer Screening.

Improving Colorectal Cancer Screening Rates Would Have Real Potential Impacts

Covered California engaged the National Quality Forum to model the clinical impact of improved quality performance. The work is still in progress, but preliminary results suggest that if all Californians who are currently receiving care below the 66th percentile of national health plan performance instead received care at the 90th percentile national performance for colorectal cancer screening, over a 22 year period:

15,500

Fewer Deaths

While most of the lives saved and negative health events averted would be a result of improved care of individuals receiving below average (50th national percentile) care, improvement of care to the 90th national percentile performance for those between 50th and 66th percentile would result in more than 2,000 lives saved in California.