COVERED CALIFORNIA POLICY AND ACTION ITEMS

January 20, 2022 Board Meeting

CHANGES TO ELIGIBILITY AND ENROLLMENT REGULATIONS FOR INDIVIDUAL MARKETS

Bahara Hosseini, Office of Legal Affairs

BACKGROUND

- 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.
- The Board discussed this emergency regulation package during the Board meeting on November 18, 2021.
- The Office of Legal Affairs now requests the Board to formally adopt this regulation package so it can be filed with the Office of Administrative Law.

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

James DeBenedetti
Director, Plan Management Division

REVIEW OF PLAN CONTRACTING MATERIAL

A. Context for Covered California's 2023-25 Contracting
B. Research and Input to Develop Proposals
C. 2023 Qualified Health Plan Issuer Model Contract
D. Quality Transformation Initiative
E. 2023 Certification Application
F. 2023 Benefit Designs
G. Appendix
    1. Comments Received on General Terms of the Model Contract
    2. Comments Received on Attachment 1. of the Model Contract
    3. Comments Received on the Certification Application

CONTEXT FOR COVERED CALIFORNIA'S 2023-2025 CONTRACTING: BUILDING ON NINE YEARS OF MAKING A MARKET WORK FOR CONSUMERS

Peter V. Lee
Executive Director

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.

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

INPUT RECEIVED FROM HEALTH PLANS

Covered California has received feedback from the following carriers regarding the 2023-25 certification effort and Quality Transformation Initiative (QTI).

Comments Received from Current Covered California Carriers
Anthem
Blue Shield of California
Bright Healthcare
Centene/HealthNet
Kaiser Permanente
LA Care
Molina Healthcare
Oscar Health
Sharp Health Plan
Valley Health Plan
Western Health Advantage

Covered California also received feedback from national health plans and California regional health plans that have expressed interest potentially in entering the Covered California market in 2023 or 2024.

POLICYMAKER, ADVOCATES AND ASSOCIATION INPUT

Covered California has discussed or conducted interviews with the following federal and state policy leaders 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

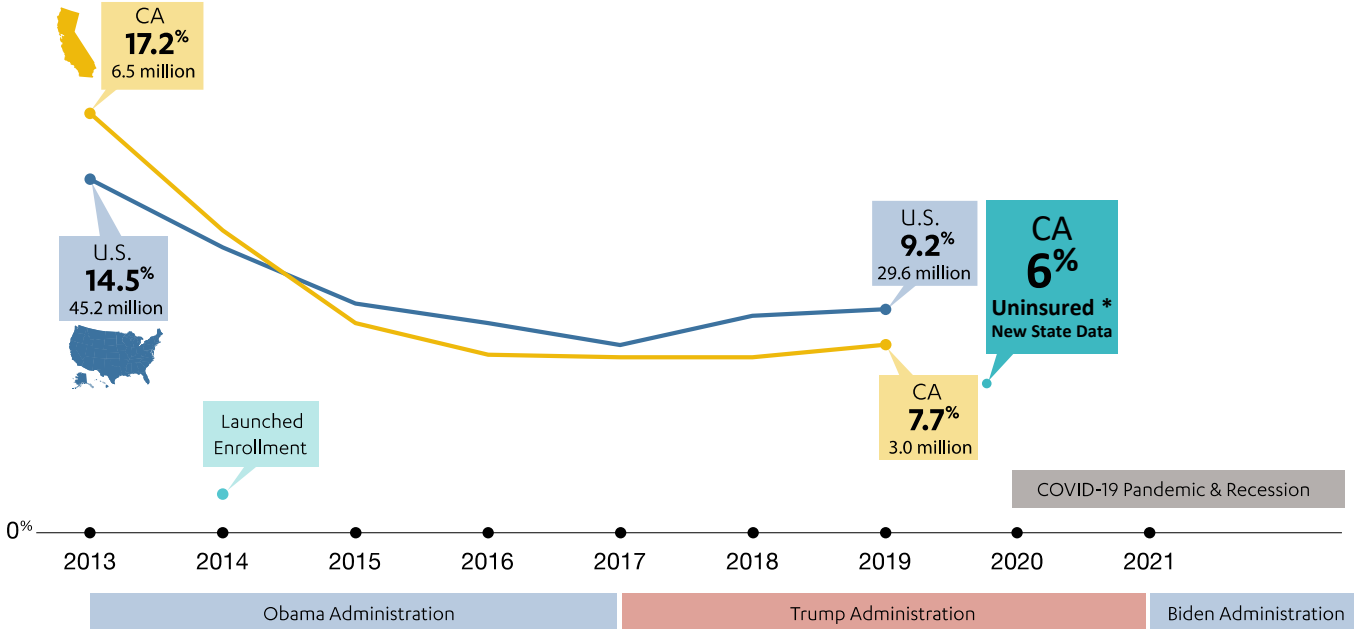
Advocates
CPEHN
Families USA
Health Access
NHeLP
Western Center

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

RECORD DECREASE IN CALIFORNIA'S UNINSURED RATE

Comparing the Rate of Uninsured in California and the United States

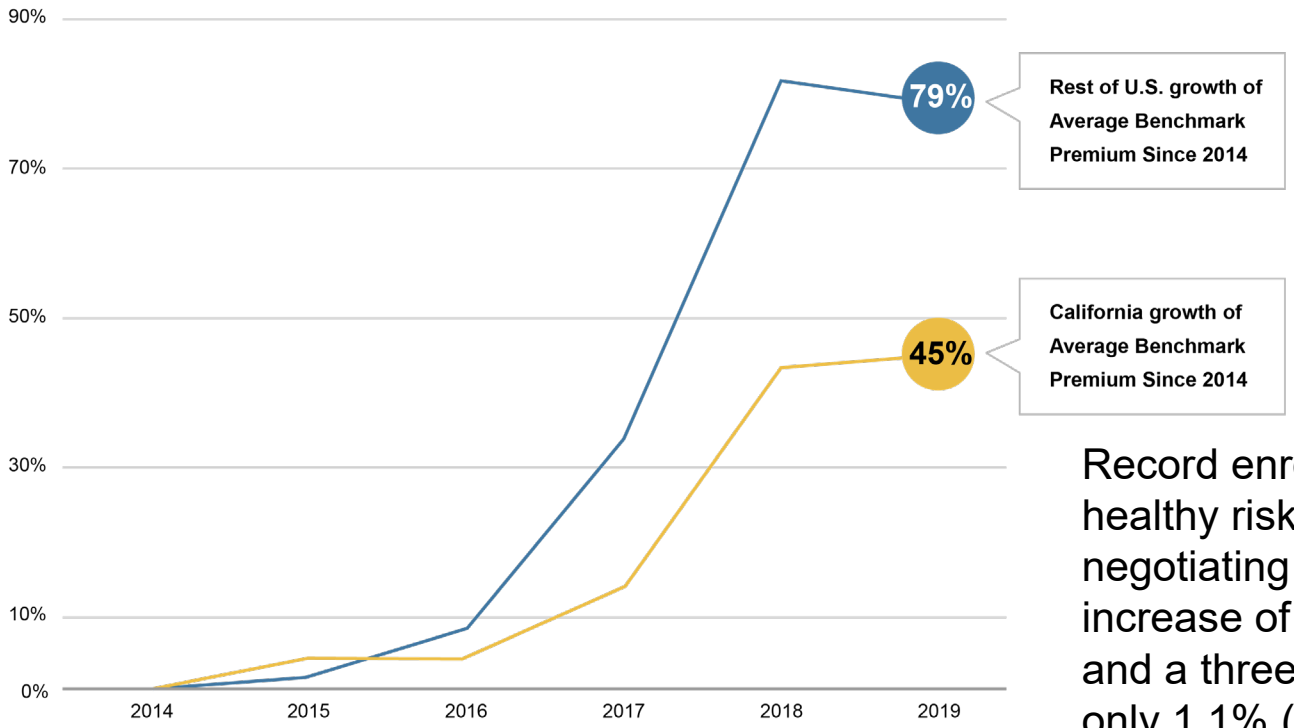
- California experienced the nation's largest drop in the uninsured rate.
- More than 4.7 million Californians have gained coverage since 2013.
- As of 2019, about 3 million uninsured, with about 60% undocumented/ ineligible for federal programs ("currently eligible" uninsured rate is about 3 percent).



Source: U.S. Census 2014-2020

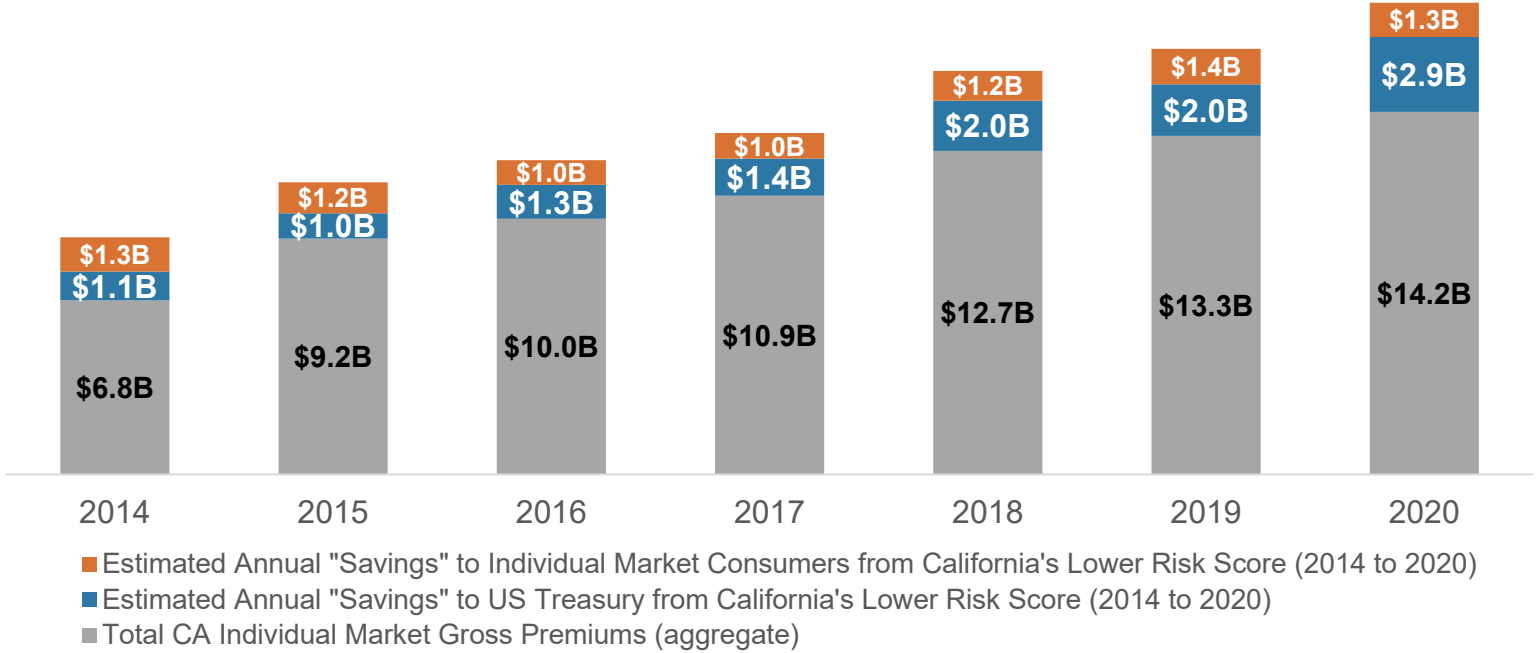
*Source: California Health Insurance Survey, Sept. 22 - https://healthpolicy.ucla.edu/publications/Documents/PDF/2021/access-to-care-policybrief-sep2021.pdf. The survey is based on interviews conducted continuously throughout the year with respondents from more than 20,000 California households in a variety of languages. U.S. Census data on California's uninsured rate in 2020 has been delayed due to the pandemic and is not reflected.

COVERED CALIFORNIA PREMIUM INCREASES HAVE BEEN ABOUT HALF OF THOSE IN FEDERALLY FACILITATED MARKETPLACE STATES



Record enrollment and healthy risk mix key factors in negotiating a preliminary rate increase of just 1.8%in 2022, and a three-year average of only 1.1% (2020-2022).

CALIFORNIA'S HEALTHY RISK MIX MAY HAVE SAVED CONSUMERS AND THE FEDERAL GOVERNMENT NEARLY $16 BILLION

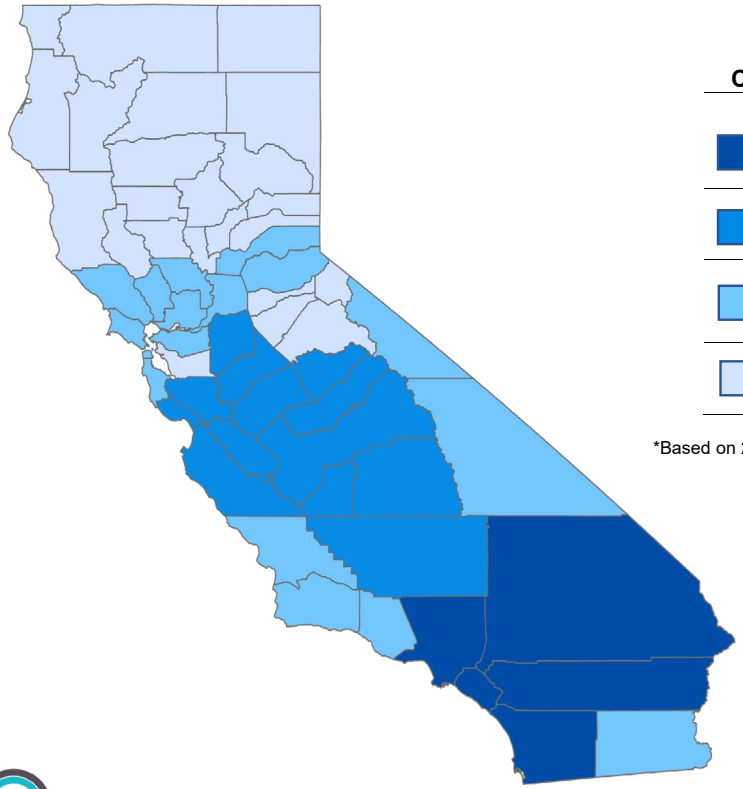


Covered California's actions have likely resulted in $15.9 billion in total savings to enrollees and the U.S. Treasury between 2014 and 2019 - with about $7.1 billion accruing to the federal government and $5.7 billion to California consumers.

MARKETPLACE PREMIUM SUPPORT AND COST-SHARING SUBSIDIES – ADJUSTED FOR INCOME AND AMERICAN RESCUE PLAN FILLING BIG GAPS

	0-150% FPL	150-200% FPL	200-250% FPL	250-300% FPL	300-400% FPL	400-600% FPL	600%+ FPL
Annual Income Range – Single Person Household	$0 - $19,140	$19,140 - $25,520	$25,520 - $31,900	$31,900 - $38,280	$38,280 - $51,040	$51,040 - $76,560	$76,560 and up
Annual Income Range – Four Person Household	$0 - $39,300	$39,300 - $52,400	$52,400 - $65,500	$65,500 - $78,600	$78,600 - $104,800	$104,800 - $157,200	$157,200 and up
ACA required contribution for 2nd lowest Silver plan (rounded % of income)	2 - 4%	4 - 6.5%	6.5 - 8%	8 - 10%	10%	100%	100%
ACA required contribution for 2nd lowest Silver plan (dollars)	$30 - $66	$66 - $139	$139 - $221	$221 - $314	$314 - $418	-	-
ARP required contribution for 2nd lowest Silver plan (% of income)	0%	0 - 2%	2 - 4%	4 - 6%	6 - 8.5%	8.5%	8.5%
ARP required contribution for 2nd lowest Silver plan (dollars)	$0	$0 - $43	$43 - $106	$106 - $191	$191 - $362	$362 - $542	$542+
Value of Silver cost-sharing reduction plan (if available)	Silver 94 Better-than-Platinum coverage at Silver plan premium	Silver 87 Close-to-Platinum coverage at Silver plan premium	Silver 73 Modest cost-sharing support above standard Silver plan	N/A	N/A	N/A	N/A

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%

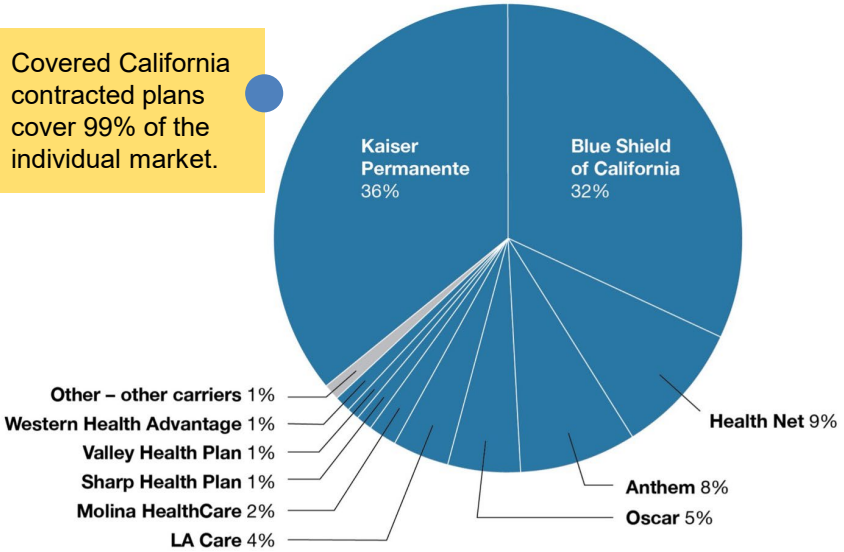
R2 – KP 77%; R3 - KP 71%; R4 – KP 67%; R5 - KP 81%; R6 - KP 84%, R8 – KP 80%; R12 – BSC 82%; R13 – Molina 83%

R1 – Anthem 56%, BSC 42%

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

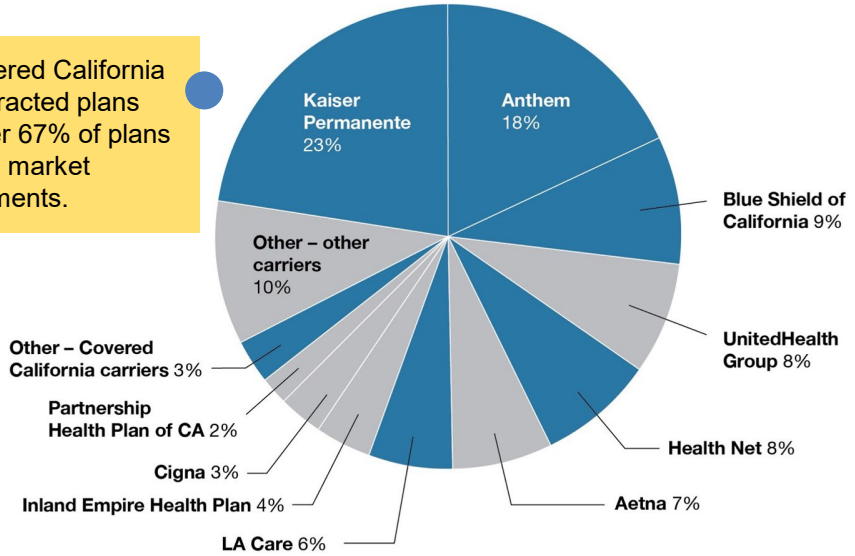
California Healthcare Market by Health Plan:
Individual

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.



COVERED CALIFORNIA

[For more information, see Link: Covered California Market Analysis of Carrier Enrollment]

SUPPORTING CONSUMERS' ACCESS TO CARE WITH STANDARDIZED PATIENT-CENTERED BENEFIT DESIGNS

COVERED CALIFORNIA™

2022 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 73% average annual cost	Covers 87% average annual cost	Covers 94% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	$25,761 to $32,200 (>200% to ≤250% FPL)	$19,321 to $25,760 (>150% to ≤200% FPL)	up to $19,320 (100% to ≤150% FPL)	N/A	N/A
Annual Wellness Exam	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Vist	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	$65*	$35	$35	$15	$5	$35	$15
Urgent Care		$65*	$35	$35	$15	$5	$35	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$70	$70	$25	$8	$65	$30
Emergency Room Facility		40% after deductible is met	$400	$400	$150	$50	$350	$150
Laboratory Tests		$40	$40	$40	$20	$8	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$85	$85	$40	$8	$75	$30
Imaging			$325	$325	$100	$50	$150 copay or 20% coinsurance***	$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	$18**	$15**	$15**	$5	$3	$15	$5
Tier 2 (Preferred Drugs)		40% up to $500 per script after drug deductible is met	$55**	$55**	$25	$10	$55	$15
Tier 3 (Non-preferred Drugs)			$85**	$85**	$45	$15	$80	$25
Tier 4 (Specialty Drugs)			20% up to $250** per script	20% up to $250** per script	15% up to $150 per script	10% up to $150 per script	20% up to $250 per script	10% up to $250 per script
Medical Deductible	N/A	Individual: $6,300 Family: $12,600	Individual: $3,700 Family: $7,400	Individual: $3,700 Family: $7,400	Individual: $800 Family: $1,600	Individual: $75 Family: $150	N/A	N/A
Pharmacy Deductible	N/A	Individual: $500 Family: $1,000	Individual: $10 Family: $20	Individual: $10 Family: $20	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$8,700 individual $17,400 family	$8,200 individual $16,400 family	$8,200 individual $16,400 family	$6,300 individual $12,600 family	$2,850 individual $5,700 family	$800 individual $1,600 family	$8,200 individual $16,400 family	$4,500 individual $9,000 family

Drug prices are for a 30 day supply.

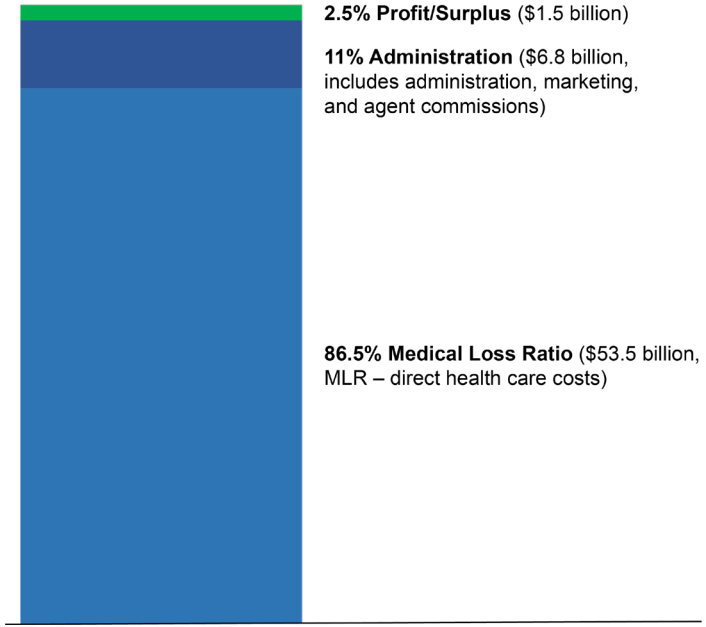
* Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, future visits will be at full cost until the medical deductible is met.

** Price is after pharmacy deductible amount is met.

*** See plan Evidence of Coverage for imaging cost share.

COVERED CALIFORNIA – CONSUMER-CENTERED COMPETITION DRIVING VALUE AND EFFICIENCY

Covered California Issuers: Cumulative Medical Loss Ratio, Administrative Expenses and Profit 2014-2019: Total Health Care Premium of $61.8 billion.



The Value/Efficiency Story Nationally

- **Profit margins in 2019:**
  - 8.9% Individual
  - 4.1% Small Group
  - 2.5% Large Group
  - 3.3% Medicare Advantage
  - 0.6% Medicaid managed care
- **Medical Loss Ratio (MLR) in 2019**
  - 81.6% Individual
  - 83.5% Small Group
  - 89.3% Large Group
  - 85.6% Medicare Advantage
  - 87.3% Medicaid managed care

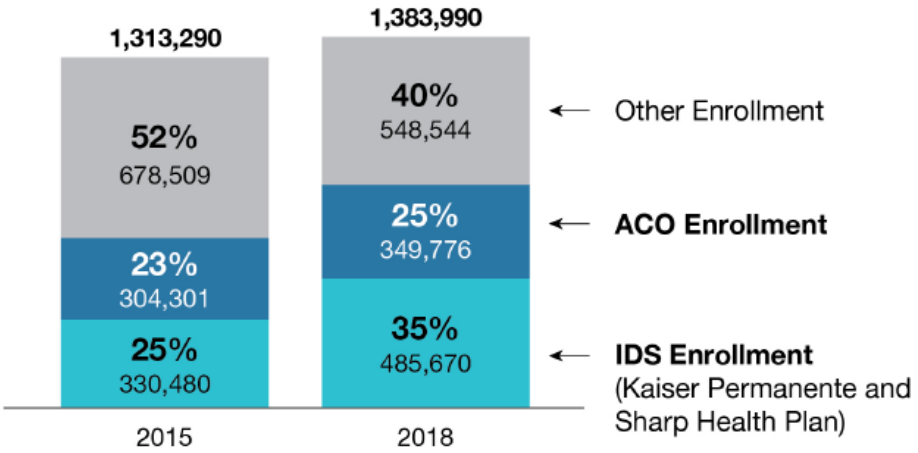
Sources: Medicare Advantage financial results for 2019; Commercial health insurance: Detailed 2019 financial results and emerging 2020 Trends; Medicaid managed care financial results for 2018, Milliman

COVERED CALIFORNIA PUSHING ALIGNED PAYMENT REFORM

The 2023-25 contract builds upon existing contract terms to promote payment reform, including:

- Adopt a hospital payment methodology for each general acute care hospital in its QHP networks that ties payment to quality performance.
- Adopt value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections.
- Report on payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories and increase reach and value of payments through shared savings and population-based payment models.
- Participate in the IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results to Covered California annually

Covered California Enrollment in ACOs, Integrated Delivery Systems and Other Systems – 2015 and 2018



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: MODELING THE IMPACT OF PERFORMANCE IMPROVEMENT IN CALIFORNIA

Covered California engaged the National Quality Forum to project the real-world impact of improving care related to three of the four core measures that are the proposed focus of Covered California's Quality Transformation Initiative (QTI): High Blood Pressure Control, Diabetes Control, and Colorectal Cancer Screening.

- The modeling was developed with the following assumptions:
  - We model the potential impacts of improvement for ALL Californians – not only those enrolled in Covered California. This population-based approach reflects Covered California's goal of aligning quality improvement efforts – including measure selection and major financial incentives for quality – with those of Medi-Cal and CalPERS. The intent of this initiative is to improve the care of all Californians – including current, future and past enrollees in Covered California.
  - The potential impacts are reported as lives saved or harm avoided over the time periods of the relevant research studies, e.g. four years for blood pressure control; eleven years for diabetes control, 22 years for colorectal cancer screening.
  - The modeling was performed based on the assumption that California's population distribution mirrored the distribution of health plan performance, e.g. 25% of Californians are at or below 25th percentile performance for a given measure.
- The modeling of the potential impacts of performance is presented in the following ways:
  - The first is the clinical impact if all Californians who are currently receiving care below the 25th percentile of national health plan performance instead received care at the 66th percentile of national performance. This threshold is based on the 66th percentile being the lower of the two "ceilings" of required improvement payments being proposed in the Quality Transformation Initiative.
  - The second is what would happen if all Californians who are currently receiving care below the 66th percentile of national health plan performance instead received care at the 90th percentile.

THE QUALITY TRANSFORMATION INITIATIVE: POTENTIAL LIVES SAVED AND HARM AVOIDED FROM IMPROVING CARE

Estimate of Potential Lives Saved and Harm Avoided in California						
	Hypertension Control			Diabetes Control		Colorectal Cancer Screening
Californians by percentile	Lives Saved	Strokes Averted	Heart Attacks Averted	Lives Saved	Strokes Averted	Lives Saved
< 25th to 66th percentile	5,014	8,327	4,576	5,275	1,637	5,636
< 66th to 90th percentile	**16,445**	**27,302**	**15,002**	**14,820**	**4,612**	**16,930**

Results presented are based on preliminary modeling from the National Quality Forum and represent point estimates within a potential range of impact that includes broad confidence intervals. This material will be updated and shared in more detail in the future, including national, and California potential lives saved and harm avoided.

Control/Screening Levels at 25th, 66th and 90th Percentile			
National Percentile	Hypertension Control	Diabetes Control	Colorectal Cancer Screening
25th	54%	52%	47%
66th	66%	62%	61%
90th	75%	68%	69%

2023 QUALIFIED HEALTH PLAN CONTRACT AND CERTIFICATION PROCESS

The elements of the contract described in this presentation complement a range of other contracting and certification requirements. Some of these policies have been in place for many years, while others have been subject to extensive engagement or are relatively new and are organized in the restructured contract. These include:

Ongoing contract requirements:

- Standard patient-centered benefit designs to reduce consumer confusion and ensure quality of coverage
- Requirements related to scope of marketing, including coordination, targeting and co-branding, and expectations to provide adequate support to certified agents
- Adequate provider networks, including inclusion of Essential Community Providers
- Initiatives to improve healthcare quality, address health equity and disparities, and promote delivery system and payment reform

Revised Attachment 1 (formerly Attachment 7) and Attachment 2 (formerly Attachment 14) of the contract including significant additions to existing contractual requirements in the areas of:

- Disparities reduction
- Behavioral health
- Value based delivery systems (advanced primary care, integrated delivery systems, payment reform)
- Affordability and cost (provider networks and consumer affordability)
- Data exchange requirements

Focus on providing incentives to improve quality and equity, while building on a competitive market that holds existing and new potential entrants to high standards, including:

- Quality Transformation Initiative with quality improvement payments that could grow to 4 percent of premium to promote care that is better than the 66th percentile nationally
- Remove plans that are delivering poor quality care for consumers and not demonstrating improvement
- Allow new entrants that meet clear standards
- Expanded focus on coordination with all carriers to foster effective transitions in coverage between Covered California and Medi-Cal, Employer coverage and Medicare

Across the board, Covered California's contracting is designed to be aligned with and complement efforts of other major purchasers, including CMS, Medi-Cal, CalPERS (the state employee purchasing program), and others.

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 CONTRACT

James DeBenedetti
Director, Plan Management Division

MODEL CONTRACT OVERVIEW

- This section covers new contract provisions that have been developed since the draft was posted last November concerning:
  - Quality standards for exclusion of existing plans
  - Contract terms concerning enrollment
  - Key revisions to Attachment 1
  - Quality improvement requirements and monitoring
  - Potential carrier responses to quality improvement responses
  - Quality Transformation Initiative update

- Comments received on the prior draft, and changes made (or not) in response to those comments are covered in Appendices I (general terms) and II (Attachment 1).

- Use of the term “Enrollee” has also been refined throughout the contract to better clarify when it applies to Covered California enrollees vs. those in other markets (Medi-Cal, employer sponsored insurance, off-exchange products, etc.).

NEW: QUALITY STANDARDS FOR EXCLUSION OF EXISTING PLANS EFFECTIVE PLAN YEAR 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 equivalent of 25th percentile of 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 health plans remaining in the region.
- ❑ Carriers 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 carriers to reduce or eliminate 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.
- ❑ Carriers 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 to the standards.

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.

KEY REVISIONS TO ATTACHMENT 1

The following are key revisions made to the 2023-2025 Attachment 1 between the November 2021 draft and the January 2022 proposed final:

- ❑ Added language to distinguish between new and returning carriers and clarify the timeline for new carriers to meet the 80% race/ethnicity threshold and implement disparities reduction interventions
- ❑ Added requirement to submit patient level data files, stratified by race/ethnicity, for proposed Quality Transformation Initiative measures
- ❑ Further strengthened and revised requirements to promote access to behavioral health services and ensure the appropriate use of opioids
- ❑ Reduced focus to food insecurity screening for minimum required screening requirements, added requirement to use a standardized questions, and added requirement to stratify reporting measures by race/ethnicity for 2024
- ❑ Strengthened requirements for carriers to notify Covered California and the appropriate state regulator and licensing entity if they decide to remove a provider or hospital from its network due to poor performance
- ❑ Strengthened requirements related to maternity care and maternal health disparities
- ❑ Revised reporting for contract performance assessment purposes; reporting will no longer occur only through the annual application for certification; Covered California has revised the language to specify that reporting will occur annually (unless otherwise specified) at a time and in a manner determined by Covered California

Further details are in Appendix II: Comments Received on Attachment 1 of the Model Contract

NEW MONITORING REQUIREMENTS FOR CARRIERS CONDUCTING REQUIRED IMPROVEMENT

- Any carriers with one or more plan product performing at or below the 25th percentile of national performance for QTI measures 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, including but not limited to the six categories of activities described on “Potential Carrier Responses to the Quality Transformation Initiative AND the Potential of Removal for Poor Quality” slide (next slide).

- Covered California will closely monitor and review the intervention plans and how carriers 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.

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 are now soliciting public comments focused on new concepts till January 31, 2022:
  - Quality Standards for Exclusion of Existing Plans
  - Contract Terms Concerning Enrollment
  - Monitoring Requirements for Carriers Conducting Required Improvement
  - Quality Transformation Initiative
- We will solicit public comments on new contract language for these concepts once the contract language is available, until February 11, 2022. The new contract language will be distributed to carriers and stakeholders via email and posted on https://hbex.coveredca.com/stakeholders/plan-management/
- Please email public comments to PMDContractsUnit@covered.ca.gov

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.

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.
- The first year of the contract would have 0.8% of premium as the total potential quality improvement fund payment, moving up to 3% as of PY 2025, with plan/expectation to increase to 4% maximum in PY 2026 based on either contract amendment or new contract. The first quality improvement fund payment would be calculated based on 2023 performance and due in 2024.
- Disparities reduction measures and quality improvement fund payments are integral to the Quality Transformation Initiative. The methodology for such payments will be developed with input from DHCS and CalPERS.
- "Reporting only" measures related to behavioral health are measures for which there are not currently established national benchmarks and are included to signal intent to incorporate into QTI during the next contract cycle.
- Metrics and targets will be regularly reassessed. Those that are topped out may be dropped, with new measures and targets added only as part of formal contract amendment process or during the next contract cycle.
- Funds from quality improvement fund payments would go into a segregated account. The fund would be structured to allow for the potential of receiving funds from or on behalf of CalPERS or DHCS in the future, and to allow for potential joint governance in deciding what activities to support.
- The carriers would be required to submit quality improvement plan detailing the actions they plan to take to improve quality and equity for any measure for which they score below the 25th percentile. Covered California would monitor and work with carriers to ensure improvement efforts 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 improvement fund payments. If carriers can demonstrate or provide evidence of the negative impact on quality scores, Covered California will evaluate such evidence and consider adjustments to payments.

QTI MEASURES: NUMBER, APPROACH TO SELECTION

Measure Criteria

- ✓ Established/vetted
- ✓ Available/low burden
- ✓ Clinical outcomes focused
- ✓ Epidemiologically important
- ✓ Opportunities to address disparities
- ✓ Impacted by healthcare
- ✓ National benchmarks through QRS measures set (if $)

- Widespread agreement with parsimony (fewer than 10 with many encouraging fewer than 5).

"If you measure everything, you measure nothing."

- Some concerns that focusing on selected conditions would be to the detriment of others.
- Widespread support for alignment with DHCS/CalPERS.

"Alignment of measures is more important than using the best measures."

- Suggestions for additional measures included maternal care, total cost of care, avoidable ED visits, and readmissions.

QTI MEASURES: RECOMMENDED INITIAL CORE SET OF 4 METRICS

Measure Proposed 11/10	Feedback	Potential Revisions 12/20
Controlling High Blood Pressure (NQF #0018)*	Strong consensus	Keep
Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575)*	Strong consensus	Keep
Colorectal Cancer Screening (NQF #0034)*	General support	Keep
Childhood Immunization Status (Combo 10) (NQF #0038)*	General support, strong interest DHCS	Keep
Immunizations for Adolescents (Combo 2) (NQF #1407)	General support	Remove to not "overweight" immunizations measures
Cervical Cancer Screening (NQF #0032)	General support, but not in DHCS VBP set	Remove due to high attainment and to align with DHCS
CAHPS Access to Care Composite (NQF #0006)	Patient experience important but CAHPS inadequate	Keep in contract section A2 with performance guarantees, work towards better measures
Depression Screening and Follow-Up for Adolescents and Adults (DSF)	BH important but challenging	Reporting only given not QRS
Pharmacotherapy for Opioid Use Disorder (POD)	No specific comments	Reporting only given not QRS

* Race/ethnicity stratification for reporting only in initial years, with assessments in 2025 or 2026

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

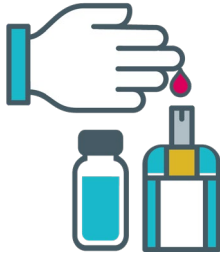
Covered California engaged the National Quality Forum to model the clinical impact of improved quality performance. The work is still in progress, but preliminary point estimates (within a potential range of impact that include broad confidence intervals) suggest that if all Californians who are currently 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 point estimates (within a potential range of impact that include broad confidence intervals) 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 point estimates (within a potential range of impact that include broad confidence intervals) 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.

THE QUALITY TRANSFORMATION INITIATIVE: INCREASING IMMUNIZATION RATES FOR CHILDREN COULD PREVENT SIGNIFICANT DISEASE AND DEBILITY

Childhood Immunizations protect children from several serious and potentially life-threatening disease at a time in their lives when they are most vulnerable. Before childhood vaccinations were available, serious complications from diseases such as poliomyelitis, diphtheria, tetanus, measles, hepatitis, polio, mumps, and rubella were common. This included pneumonia, heart and kidney damage, blindness, deafness, and neurologic diseases such as meningitis, encephalitis, and paralysis. For more information, see Childhood Immunization Status.

In 2019, almost 32% of children in the United States did not receive the recommended vaccines by age 24 months of age. Deferred care due to the COVID-19 pandemic has had a significant impact on receipt of childhood immunizations; for example, in California, 15 % fewer children under age 3 have received the first dose MMR in 2020 compared to 2019. Evidence has shown that populations at greatest risk for under-immunization are those living below the poverty level, minority children from low-income families or children that live in inner-city or rural areas, uninsured children, and African American and Latino children.

Because vaccination impact depends on herd immunity, it is difficult to model the direct clinical benefit of increased rates of childhood vaccination. However, on an annual basis in the United States, childhood vaccines:

- Prevent 10.5 million diseases among all children born each year
- Result in significant savings in direct and indirect costs: for every $1 spent on immunizations, there is as much as $29 in savings.

QTI MEASURES: CORE SET MY 2019 PERFORMANCE

Kaiser's HMO is the only plan product that has no measure below 50th percentile national performance.

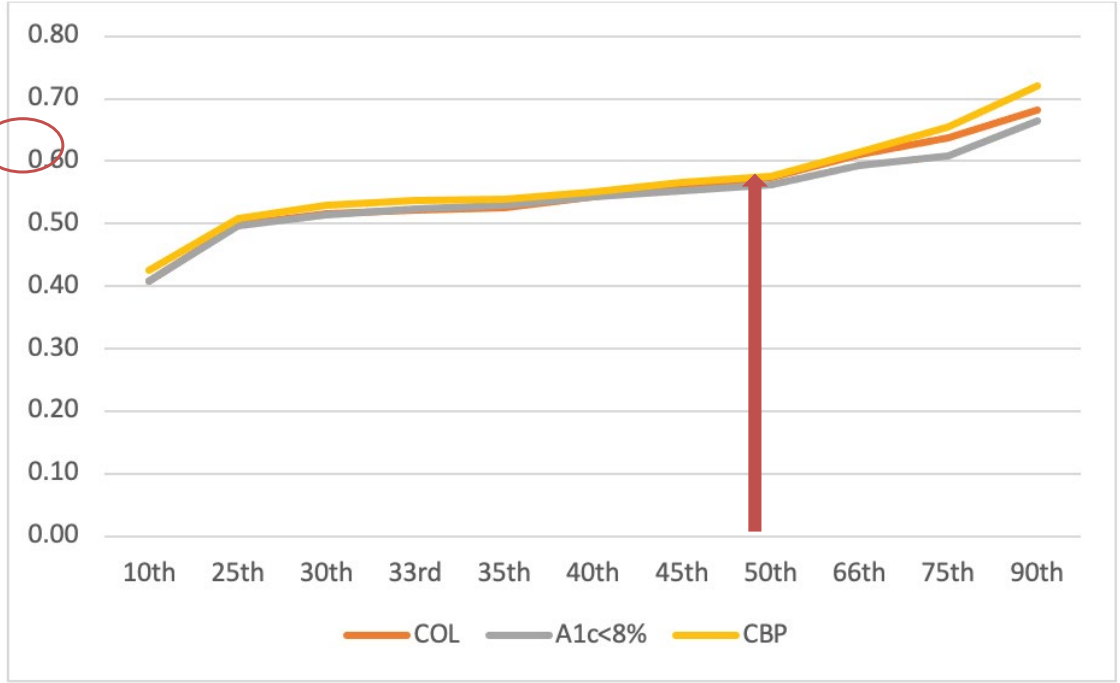
2 plan products (Anthem EPO and Oscar EPO) have all four measures below 50th percentile national performance.

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.



QTI PERFORMANCE THRESHOLDS: OPTIONS UNDER CONSIDERATION

- The exact amount of financial contribution will be determined by both performance and payment rate at each level of performance.

- Percentiles will be based on NATIONAL percentiles and measurement year 2021 performance to allow for improvement over time against static frame of reference.

- Covered California is currently considering two options:

- Option A. Potential payments up to the 66th percentile performance.
  - Full payment below 25th percentile performance.
  - Payment between 25th and 66th percentile at declining rate to no payment at 66th percentile.

- Option B. Potential payments up to the 75th percentile performance.
  - Full payment below 25th percentile performance.
  - Payment between 25th and 75th percentile at declining rate to no payment at 75th percentile.

USE OF CONTRIBUTIONS TO FOSTER QUALITY IMPROVEMENT

- Current proposal is to use funds to foster quality improvement or improvement in population health that would impact the areas of health care performance being addressed by the initiative. Quality improvement efforts would be on a population health level where they could have the greatest potential impact and NOT be limited to, or even specifically targeted for, the enrollees of the carrier paying the financial contribution.
- Funds would go into a segregated account. An external entity would oversee the distribution of funds, as directed by Covered California, to support targeted interventions. The fund would be structured to receive funds from or on behalf of CalPERS or DHCS in the future, with joint governance in deciding what activities to support.
- The goal and intent is for the funds to be considered as part of a carrier's quality improvement activity for medical loss ratio purposes, it is possible that not all expenditures would qualify as such.

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 CERTIFICATION APPLICATION

James DeBenedetti
Director, Plan Management Division

CONTINUING CERTIFICATION EXPECTATIONS

- The evaluation of QHP Certification Applications is not based on a single, strict formula; instead, the evaluation will consider the mix of health plans for each region of California that best meet the needs of consumers in that region and Covered California's goals. Covered California strives to provide an appropriate range of high-quality health plans to participants at the best available price that is balanced with the need for consumer stability and long-term affordability. In consideration of the mission and values of Covered California, the Board articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the Applications. These guidelines are:

  - Affordability for the consumer– both in terms of premium and at point of care
  - 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
  - Commitment and capacity to support transitions in coverage between Covered California and employer-based or Medi-Cal coverage
  - Robust Customer Service and robust promotion of new enrollment

CERTIFICATION APPLICATION OVERVIEW

- This section covers new certification application provisions that have been developed since it was posted in December concerning:
  - Quality standards for new entrants
  - Allowing new entrants to join during any year
  - Marketing spend expectations

- Comments received on the prior draft of the contract, and changes made (or not) in response to those comments are covered in Appendix I of this section. Most of them were technical in nature or for clarification.

NEW: QUALITY STANDARDS FOR NEW ENTRANTS

- New entrants must demonstrate that the likely quality of care provided through its contracted networks and delivery support systems will be above a quality threshold equivalent to the 25th percentile of performance using the QRS “Getting Right Care” standard measures.

- Demonstration of likely performance will be assessed by proxy measures, such as:
  - HEDIS performance from substantively similar provider networks in the carrier’s other lines of business in California.
  - Modeling of quality indicators from providers contracted for the proposed network.

NEW: ADDITIONAL STANDARDS FOR NEW ENTRANTS

- To the extent a new entrant has a network that is “substantially similar” to two or more existing carriers, the new entrant must demonstrate:
  - Health plan level tools, support or structure that have been proven to improve care,
  - Demonstrated quality that is significantly higher (e.g., above 50th percentile), and/or
  - Significantly lower costs that could be assured over at least two or three years.

- Choice and Competition for Consumers: The new entrant may be required to provide coverage in less competitive markets in order to participate in more desirable regions.

- Continuity of Coverage: The extent to which new entrants have existing large enrollment in ESI and/or Medi-Cal is a positive factor, and both new entrants and existing Carriers will be contractually required to work with Covered California to support continuity of coverage between the Carrier’s lines of business through consumer outreach and auto-enrollment efforts.

NEW: ALLOWING NEW ENTRANTS TO JOIN DURING ANY YEAR

- When Covered California was first established, new entrant applications from most carriers were only allowed during the first year of a multi-year contract period. This policy sought to promote a robust and healthy marketplace during the period of uncertainty in launching a new program. Certain carriers (e.g., Medi-Cal local initiatives and newly licensed plans) were exempt from this requirement. As Covered California approaches the completion of its eighth successful Open Enrollment period, Covered California continues to promote stability and certainty for consumers, but intends to update this policy.

- Effective Plan Year 2023, Covered California will now consider any potential new entrant for certification during all years covered by the contract – not just the first year. New Entrants will be held to all standards applicable to existing carriers.

NEW: MARKETING SPEND EXPECTATION

- 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.
- In alignment with these changes, the current expectation for certification that 0.6% of premium be spent on marketing will be reduced 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.”

PLAN YEAR 2023 CERTIFICATION MILESTONES

Release Draft 2023 QHP & QDP Certification Applications	December 2021
Draft Application Comment Periods End	December 2021
Plan Management Advisory: Benefit Design & Certification Policy Recommendation	January 2022
January Board Meeting: Discussion of Benefit Design & Certification Policy Recommendation	January 2022
Letters of Intent Accepted	February 2022
Final AV Calculator Released*	February 2022
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 2022
March Board Meeting: Anticipated approval of 2023 Patient-Centered Benefit Plan Designs & Certification Policy	March 2022
QHP & QDP Applications Open	March 1, 2022
QHP & QDP Application Responses (Individual and CCSB) Due	April 29, 2022
Evaluation of QHP Responses & Negotiation Prep	May - June 2021
QHP Negotiations	June 2022
QHP Preliminary Rates Announcement	July 2022
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2022
Evaluation of QDP Responses & Negotiation Prep	June – July 2022
QDP Negotiations	July 2022
CCSB QHP Rates Due	July 2022
QDP Rates Announcement (no regulatory rate review)	August 2022
Public Posting of Proposed Rates	July 2022
Public Posting of Final Rates	September – October 2022

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

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 DESIGNS

Jan Falzarano
Deputy Director, Plan Management Division

2023 STANDARD BENEFITS DESIGN UPDATE

- The Draft 2023 Notice of Benefit and Payment Parameters was released on Tuesday, December 28
- The Draft Actuarial Value (AV) Calculator was released on late Thursday, December 30
- Due to the late release of the calculator, there was insufficient time to fully model benefit design proposals for the Individual Family Plan (IFP) and Covered California for Small Business (CCSB) products
  - Full sets of benefit designs will be presented to the Board in February as an information item
  - Final benefit designs will be presented to the Board for action in March
  - As has sometimes occurred in the past, benefits may need (typically minor) revisions after March due to late changes in the the final versions of the AV Calculator and Notice of Benefits and Payment Parameters
- There are other initiatives at the State and Federal level that if implemented, could significantly impact the 2023 benefit designs
- 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 California – or other states – could use federal funds that are anticipated in the proposed Build Back Better Act to expand cost-sharing support and how we can add new State cost-sharing subsidies to enhance benefits to consumers

2023 NOTICE OF BENEFIT AND PAYMENT PARAMETERS

- The Draft 2023 Notice of Benefit and Payment Parameters proposes to narrow the Actuarial Value de minimis ranges related to levels of coverage:
  - Standard Bronze, Gold, and Platinum Tiers will be +2/-2 (from +2/-4)
  - Expanded Bronze/Bronze HDHP will be +5-2 (from+5/-4)
  - Traditional Silver 70 +2/0 (from +2/-4)
  - Enhanced Silver variants have AV range of +1/0 (from +1/-1)
  - Silver 73 would be required to be at least 2 percentage points above the standard Silver plans' AV

- Rules apply to Federal Facilitated Markets and State Based Exchanges on the Federal Platform
  - Narrowing the de minimus range by increasing the bottom levels of all metal tiers will enhance benefits for all consumers
  - California is not affected by the narrower AV values as we have set our standard benefit designs at the upper de minimus range for most of our plans
    - California law sets the AV de minimus range at +2/-2 for all metal products since PY 2017
    - Bronze and Bronze HDHP expanded to +5/-2 for PY 2021

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

2023 ACTUARIAL CALCULATOR TREND

- The Draft 2023 Actuarial Calculator utilizes the Health Intelligence Company, LLC (HIC) database which includes detailed enrollment and claims information from 2018 projected forward to 2023.

- 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 the 2021-2022 AV Calculator was previously set at 0.0 percent
  - 2022-2023 – Projection of 5.8 percent for medical spending and 8.7 percent for drug spending

AV INCREASES FROM 2022 TO 2023

	Bronze		Silver				Gold		Platinum	
	HDHP	Standard	Silver	Silver 73	Silver 87	Silver 94	Copay	Coins	Copay	Coins
AV Target	60	60	70	73	87	94	80	80	90	90
Deviation Allowance	+5/-2%	+5/-2%	+2/0%	+1/0%	+1/0%	+1/0%	+/-2.0%	+/-2.0%	+/-2.0%	+/-2.0%
2022 AV	64.60	64.90	71.5	73.85	87.88	94.66	78.01	81.90	89.25	91.59
2022 Additive Adjustments		-0.12	-0.43	-0.43	-0.13	0.00				
2022 Final AV	64.60	64.78	71.07	73.42	87.75	94.66	78.01	81.90	89.25	91.59
2023 AV*	**64.17**	**64.73**	**73.88**	**76.24**	**88.44**	**95.19**	**79.20**	**82.64**	**89.75**	**91.76**

*Draft AV does not include 2023 copay accumulation additive adjustment

Red text: AV is outside de minimis range

Blue text: AV is within de minimis range

For illustrative purpose only.

PROPOSED PLAN DESIGNS SIDE-BY-SIDE VIEW FOR IFP

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

For illustrative purpose only.

COVERED CALIFORNIA

2023 BENEFIT DESIGN MODELING AND PRELIMINARY OBSERVATIONS

Covered California staff are continuing to model cost-sharing options for the 2023 Patient Centered Benefit Designs. With recent modeling conducted, initial observations indicate:

- ❑ For 2023, some Silver tiered products may require significant increases in MOOP to stay within the AV de minimus range, along with cost sharing increases in some service categories

- ❑ The most difficult plans to find the right balance for cost sharing increases are Silver 70 and Silver 73, which are currently more than 2 percent above the desired de minimus range
  - When cost sharing increases are necessary, we have traditionally targeted less utilized services such as inpatient admissions to minimize the number of people impacted
  - We want to continue promoting high value services such as primary care, with cost-sharing amounts that do not create barriers to care

- ❑ The Gold Coinsurance product presents additional challenges, as changes made to this product impact the Gold Copay plan, limiting adjustment options

- ❑ There is no significant impact to the Platinum and Bronze products for 2023, so we are likely to maintain the 2022 benefit designs for those plans.

NEXT STEPS

- ❑ Continue modeling additional options and engage with stakeholders to develop proposals for the Board to consider in February
- ❑ Submit modeling to Milliman for actuarial review and validation
- ❑ Bring the full Patient Centered Benefit Designs for board review in February, including benefit designs for Covered California Small Business (CCSB) and the dental plans

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.

APPENDICES

APPENDIX I
COMMENTS RECEIVED ON GENERAL TERMS OF THE MODEL CONTRACT

APPENDIX 2023-25 PROPOSED REQUIREMENT UPDATE

Article 2 – Eligibility and Enrollment Responsibilities

2023 Proposed Requirements	Comment	2023-25 Proposed Requirements - Comment Based Update
Section 2.2.6 Agents in Covered California for the Individual Market Subsection g) Change to Agent of Record explains when a Covered California Enrollee notifies Covered California of an Agent delegation change Covered California will send notice to the Contractor via the 834 maintenance or reconciliation 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.	Issuer request the same timeline extension requested in Comment Cycle 1 for f) Agent of Record, from five (5) business days to ten (10) business days for update of their system.	Covered California agrees to modify Section 2.2.6g) Change to Agent of Record to allow ten (10) business days for update to their system.
Section 2.2.6 Agents in Covered California for the Individual Market Subsection h) Carrier Scorecard section describes an annual Covered California survey of Agents of Contractor's services to Agents.	Issuer request that survey results be confidentially shared with each carrier.	Covered California agrees to modify Section 2.2.6h) to confidentially share each Issuer's survey results.

APPENDIX 2023-25 PROPOSED REQUIREMENT UPDATE

Article 3 – QHP Issuer Program Requirements

2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 3.3.3 Network Stability Subsection c) Network Disruptions 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 repeated request to modify new threshold of 10% of impacted enrollees to a "10% network reduction in a region" allowing for use of provider network data for calculating. Issuer asks what the definition of an impacted enrollee will be for making the calculation.	Covered California declines this update request but agrees to include a definition and calculation for determining impacted enrollees in the QHP Network Disruption Reporting Template provided to Issuers. Covered California agreed to add language to this effect in the contract.

APPENDIX II
COMMENTS RECEIVED ON ATTACHMENT 1 OF THE MODEL CONTRACT

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 1: Equity and Disparities Reduction

- ❑ Issuers would like to partner with Covered California to improve capture of member self-identified race, ethnicity, and language data and request that Covered California make the race, ethnicity, and language questions mandatory in the enrollment application.
- ❑ Issuers would like to see the standardized categories for collection of expanded demographic data, including disability status, sexual orientation, and gender identity.
- ❑ Issuers would like to partner with Covered California to identify opportunities for bidirectional data sharing.
- ❑ Issuers would like to see the performance scoring methodology for the member preferred language data collection requirement and whether there will be bidirectional sharing of language data.
- ❑ Consumer advocates expressed concern on the automatic assignment to English language for members who leave the field for “written and spoken language” blank.
- ❑ Consumer advocates would like to see a performance guarantee applied to reducing health disparities by language.
- ❑ Issuer request to remove the “decline to state” members from the numerator and denominator when calculating the 80% race/ethnicity response rate.
- ❑ Issuer request to remove Avoidable Ambulatory Emergency Room (ER) Visits per 1,000 and Comprehensive Diabetes Care: HbA1c Testing from the HEI measures list.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 1: Equity and Disparities Reduction

Notable Changes to Draft Attachment 1	Rationale
1.01.1 Expanded Demographic Data Collection – No changes made to this section.	
1.01.2 Race, Ethnicity, and Language Data Collection Added language to distinguish between new and returning Contractors, clarify requirement timeline for new Contractors and move accountability for 80% race/ethnicity threshold to PY2024 for new entrant Contractors.	New Contractors will meet 80% self-identified race/ethnicity by PY 2024 rather than PY2025 given the high voluntary response rate in providing this information on the enrollment application and NCQA's adoption of the 80% threshold for measure stratification.
1.02.1 Disparities Measurement: Patient Level Data – added candidate QTI measures	Updated as anticipated following QTI development.
1.02.1 Disparities Measurement: Healthcare Evidence Initiative (HEI) – Removed the following measure from the HEI measure set: Avoidable Ambulatory Emergency Room (ER) Visits© per 1,000.	Covered California will pursue identification of a similar valid and reliable measure for avoidable ambulatory emergency room visits and will keep the HbA1c Testing measure as it continues to be appropriate for diabetes care health disparities assessment.
1.03.1 Disparities Reduction Intervention – Added language to distinguish between new and returning Contractors and to clarify requirement timeline for new Contractors.	New Contractors will meet specified phased requirements based on QHP data availability, including engaging with Covered CA in PY 2023 to demonstrate readiness to meet PY 2024 and 2025 contractual obligations. Returning Contractors will meet a multi-year disparities reduction target beginning PY 2023.

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 2: Behavioral Health

- ❑ Suggestion to add requirements for issuers to educate providers on how to refer to behavioral health services and help ensure enrollees have access to behavioral health services.
- ❑ Request to standardize cost shares for behavioral health telehealth services such that cost shares are equal for in-person and telehealth services.
- ❑ Request to revise requirements for implementing depression screening to specify working with primary care providers.
- ❑ Suggestion 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.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 2: Behavioral Health

Notable Changes to Draft Attachment 1	Rationale
2.01.2 Offering Telehealth for Behavioral Health – No changes made to this section in response to request to standardize cost shares for behavioral health telehealth services such that cost shares are equal for in-person and telehealth services.	Covered California is continuing to explore options for standardizing cost shares for telehealth services. We coordinated with DMHC on the proposed telehealth requirements and the cost shares for telehealth services to ensure these requirements follow DMHC guidance.
2.01.3 Promoting Access to Behavioral Health Services – Added a requirement for QHP issuers to inform primary care providers about the enrollee referral process for behavioral health services.	Revised based on suggestion to add requirements for issuers to educate providers on how to refer to behavioral health services and help ensure enrollees have access to behavioral health services.
2.02.1 Screening for Depression – Revised language to include working with primary care providers to implement the depression screening measure.	Issuers requested the requirements for implementing depression screening to specify working with primary care providers.
2.03.1 Guidelines for Appropriate Use of Opioids – Further 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.

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 3: Population Health

- ❑ Request for clarification in the introduction language to better reflect the responsibility of a QHP to address the health of all Enrollees, not just Enrollees who utilize services.

Population Health Management

- ❑ Concerns about potential algorithm bias within population health management stratification and segmentation methods.

Health Promotion & Prevention

- ❑ Requests for clarification on consumer incentive programs.
- ❑ Requests to stratify Diabetes Prevention Program (DPP) data by patient demographic variables (race, ethnicity, and language).
- ❑ Concerns about developing a corrective action plan for DPP utilization.

Social Health

- ❑ Suggestion to include caregiving in future standard screening requirements.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES (1 OF 2)

Article 3: Population Health

Notable Changes to Draft Attachment 1	Rationale
3.01 Population Health – Clarified the introduction language to better reflect the responsibility of a QHP.	Issuers requested clarification in the introduction language regarding the responsibility of QHPs to address the health of all Enrollees, not just Enrollees who utilize services.
3.02.2 Diabetes Prevention Program – Included additional language to address concerns about potential service area challenges such as rural location or limited program availability.	Covered California included additional language to align with QHP Certification Application and to address concerns about potential service area challenges. We are committed to ensuring all Enrollees have access to preventive diabetes care and education; providing both in-person and online DPP services ensures Enrollees have equitable access to these services in the event of service area challenges and allows Enrollees to choose their preferred modality.
3.02.2 Diabetes Prevention Program – Clarified language regarding the corrective action plan to better reflect our intent.	Covered California is committed to diabetes prevention as part of our health promotion and prevention mission. Our intent is to hold issuers accountable and gain a better understanding of the processes in place to address a potential gap in DPP utilization.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES (2 OF 2)

Article 3: Population Health

Notable Changes to Draft Attachment 1	Rationale
3.04.1 Screening for and Addressing Social Health – removed housing instability from minimum required screening requirements, added requirement to use Accountable Health Community Health-Related Social Needs Screening Tool food insecurity questions, and added PY 2024 requirement to stratify reporting measures by enrollee race and ethnicity	Covered California is committed to use of evidence-based screening questions and measurement for health-related social needs. These proposed revisions reflect increased requirements related to food insecurity screening, referral, and reporting based on strength of evidence and in alignment with December 2021 CMS Measures Under Consideration.

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 4: Delivery and Payment Strategies to Drive Quality

Effective Primary Care

- Request to align the PCP matching requirement with Medi-Cal initial health assessment requirements

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

- No public comments were received for this section

Networks Based on Value

- Comments received expressing concern about possible violations of state regulatory network adequacy standards if health plans are allowed to remove poor performing providers and hospitals from their networks
- Comments received requesting Covered California amend its contract language to be more explicit about providers complying with the California Dignity in Pregnancy and Childbirth Act, which mandates implicit bias training for perinatal providers, staff, and facilities
- General comments supporting Covered California's initiatives to reduce maternal health disparities

Telehealth

- General comments supporting the integration of third-party telehealth providers and primary care

Participation in Quality Collaboratives

- No public comments were received for this section

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 4: Delivery and Payment Strategies to Drive Quality

Notable Changes to Draft Attachment 1	Rationale
4.01.1 Encouraging Use of Primary Care – No changes were made to this section in response to the request to align the PCP matching requirement with Medi-Cal initial health assessment requirements.	Covered California reviewed the Medi-Cal requirements for an initial health assessment. Covered California is requiring enrollees to be provisionally assigned to a primary care clinician within 60 days of effectuation. We are not requiring primary care clinicians to conduct initial health assessments currently.
4.03.3 Provider Value – Contract language updated to ensure that health plans notify Covered California and the appropriate state regulator and licensing entity if they decide to remove a provider or hospital from its network. Additionally, any exclusion of a provider group or hospital may be subject to prior regulatory review and could result in required reductions in the Contractor's licensed service area.	The language was updated in conjunction with DMHC to ensure that health plans comply with network adequacy standards.
4.03.4.4 Hospital Value – Contract language updated to ensure that health plans notify Covered California and the appropriate state regulator and licensing entity if they decide to remove a provider or hospital from its network. Additionally, any exclusion of a provider group or hospital may be subject to prior regulatory review and could result in required reductions in the Contractor's licensed service area.	The language was updated in conjunction with DMHC to ensure that health plans comply with network adequacy standards.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 4: Delivery and Payment Strategies to Drive Quality

Notable Changes to Draft Attachment 1	Rationale
4.03.7.2 Maternity Care – Contract language updated to be explicit about implicit bias training for perinatal providers, staff, and facilities in accordance with the California Dignity in Pregnancy and Childbirth Act	Covered California is committed to reducing maternal health disparities and will align its requirements with current laws where appropriate.
4.04.1 Telehealth Offerings – There are no new significant changes to this section.	
4.05 Participation in Quality Collaboratives – There are no new significant changes to this section.	

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES AND PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 5: Measurement and Data Sharing Public Comment Themes

- ❑ Issuers requested technical clarification and offered suggestions on the Healthcare Evidence Initiative section.

Article 5: Measurement and Data Sharing Proposed Attachment 1 Changes

- ❑ There are no significant changes to Article 5.

PROPOSED 2023-25 ATTACHMENT 1 REQUIREMENTS, PUBLIC COMMENT KEY THEMES AND CHANGES

Article 6: Certification, Accreditation, and Regulation Requirements

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

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

- ❑ No public comments were received and there are no significant changes to Article 6.

GLOBAL REVISIONS TO ATTACHMENT 1

- The 2023-2025 Attachment 1 will no longer specify that reporting for contract performance assessment purposes will occur through the annual application for certification
  - Separating contractually-required reporting from the QHP certification process permits more flexibility to set manageable reporting processes and timelines, and reflects the ongoing engagement model between Covered California and contracted QHP issuers
  - Covered California will continue to consider contract compliance and performance in QHP recertification and issuer participation decisions

- Covered California has revised the language to specify that reporting will occur annually at a time determined by Covered California
  - Some reporting may continue to occur through the application for certification, other reporting will occur through separate mechanisms as Covered California seeks to minimize administrative burden

- Covered California will determine the reporting mechanism for contract performance assessment purposes in collaboration with QHP Issuers and stakeholders as we move closer to the 2023 plan year

APPENDIX III
COMMENTS RECEIVED ON THE CERTIFICATION APPLICATION

CERTIFICATION APPLICATION COMMENTS 1-6

Issue #	Application (QHP IND /QHP CCSB / QDP IND /QDP CCSB)	Section Name / Attachment Name	Page Number	Question #	Comment	Covered California Response	Application Change (Yes / No)
1	QDP IND	Application Overview - Footnote	5		The footnote states, "The certification year Patient-Centered Benefit Plan Designs will be finalized when the certification year federal actuarial value calculator is finalized." However, there is not a federal AV calculator for dental. The comment is a question about whether the footnote should be removed?	The footnote has been removed.	Yes
2	QDP IND	Sales	43	14.7	Regarding the "Off-exchange customers," the contract asks about off exchange eligibility for APTC. The comment is a question about whether or not this is relevant to off-exchange enrollees in a stand-alone dental plan?	The question has been removed.	Yes
3	QDP CCSB	Application Overview - Footnote	6		The footnote states, "The certification year Patient-Centered Benefit Plan Designs will be finalized when the certification year federal actuarial value calculator is finalized." However, there is not a federal AV calculator for dental. The comment is a question about whether the footnote should be removed?	The footnote has been removed.	Yes
4	QHP CCSB	Health Maintenance Organization	76	17.1.4	The pull down lists above reference individual market QHP's, when this is the Covered California for Small Group (CCSB) RFI application. It is also this way in all the other sections like this (EPO etc.)	The correction from individual to small business market has been made in all product types.	Yes
5	QHP CCSB	Administration and Attestation	11		This is question is not very straight forward/clear as it provides 2 different instructions that conflict. The top section above is technically in the question area of the RFI and the second section above are the actual notes in the section of your response. Does the top section instructions actually pertain to QHP's who are apply to participate in CCSB for the first time and they are the only ones who should select "No" or are the instructions for all CCSB participants no matter new or continuing to select "No"? The pull down section tells you to select Yes, application will be completed and "No" application will not be completed?	This question pertains to applicants entering the market in Quarters 2-4 and the online software requires all applicants to answer questions within a table. A third option of "Not applicable" has been added.	Yes
6	QHP CCSB	Multiple	Multiple	(Sections 6, 8, 9, 10, 13, 14, 15, 17.3, 17.4)	If applicant is also currently participating in the individual market and completing the 2023 Certification for the individual market, do these sections/questions need to be completed within the CoveredCA for Small Business Certification Application?	Sections 8, 9, 10, 13, and 14 are not required if an applicant has completed the Qualified Health Plan Individual Marketplace Plan Year 2023. Sections 6, 15, and 17.4 are required for CCSB products. Question 17.3 is triggered by how an applicant answers question 16.6. If the Applicant's network is the same for the IND and CCSB markets, Covered California recognizes the responses will be the same or similar for both markets.	No

CERTIFICATION APPLICATION COMMENTS 7-14

Issue #	Application (QHP IND /QHP CCSB / QDP IND /QDP CCSB)	Section Name / Attachment Name	Page Number	Question #	Comment	Covered California Response	Application Change (Yes / No)
7	QHP CCSB	Marketing	20	7.4	Did not see Attachment I1 I2 in the PY2023 QHP CCSB Attachments and Appendices.	The attachment has been added to the posting.	No
8	QDP IND	Financial Requirements	23	8.5	Questions 8.4 and 8.6 are required for currently contracted Applicants, however, section 8.6 is crossed off and seems to be merged with 8.5. Assumption is we need to respond to 8.5 (instead of 8.6)	The numbering has been corrected.	Yes
9	QDP IND	SERFF	29	10.5	Last question 10.3 (Applicant may not make any changes to its SERFF templates once submitted to Covered California) should be numbered as 10.5	The numbering has been corrected.	Yes
10	QDP IND	Networks	53		16.4 Other Network Type -16.4.1 Network Strategy - Instructions state: Questions 16.4.1.1 – 16.4.14. are required for currently contracted Applicants; however, this section only includes Questions 16.4.1.1 - 16.4.1.8; 16.4.14 may have been a typo	The instructions have been corrected.	Yes
11	QHP IND	Administration and Attestation	11-12	2.4	Are policy copies that we need to provide for 2022 or for 2023?	Please submit documentation of policies in effect at the time of application submission. Applicant must maintain the specified coverage in full force and effect during the plan year. If Applicant amends its policies for 2023, Applicant would submit updated information to Covered California through ordinary channels for amending information.	No
12	QHP IND	Licensed and Good Standing	12-13	3.1	Unsure if someone can select 1. and 2. Consider allowing multiple responses as a carrier may be licensed with both DMHC and CDI.	A QHP issuer licensed by DMHC is considered separate from a QHP issuer licensed by CDI. A carrier that has these two separate licenses should apply as two separate QHP issuers.	No
13	QHP IND	General			Some questions have pretty short word response limits. Are you really getting what you are wanting to read and understand with the words limits? Example: 5.1.5 – 10 words.	If applicants need a higher word count, Covered California will take that into consideration.	No
14	QHP IND	Customer Service	19-20	6.7	Only yes/no responses but questions requests number of staff too.	A column for the number of certified bilingual representatives has been added.	Yes

CERTIFICATION APPLICATION COMMENTS 15-20

Issue #	Application (QHP IND /QHP CCSB / QDP IND /QDP CCSB)	Section Name / Attachment Name	Page Number	Question #	Comment	Covered California Response	Application Change (Yes / No)
15	QHP IND	Health Evidence Initiative	35	14	Please modify to reflect file layout unless mutually agreed to by Covered California and Contractor.	The cited Appendix H - HEI File Specifications represent the standard set in use by almost all QHP Issuers. A few QHP Issuers and Covered California's HEI Vendor, however, maintain specific format variations. Added the following statement to reflect this reality and provide additional flexibility: "Covered California will consider modifications to the layout when appropriate."	Yes
16	QHP IND	Health Evidence Initiative	37	14.3	We cannot send SSNs if they are not provided to us. Please confirm Covered California takes that into consideration.	Added the phrase "when possible" to the requirement. Applicants should use the "If No or Yes with deviation, explain." column to describe limitations on availability of these identifiers, including Member and Subscriber SSN.	Yes
17	QHP IND	Health Equity and Quality Transformation	45	16.2.2.3	"Declined to state":We are concerned that "declined to state" which is an affirmative selection by consumers can negatively impact rates. Please consider removing "declined to state" from both numerator and denominator. Possibly carve out number of "decline to state" consumer count and inquire about strategy to convert those consumers to obtain their self reported race/ethnicity.	There have been no changes to this calculation, it has remained consistent. Members who decline to state either actively or passively remain in the denominator.	No
18	QHP IND	Health Equity and Quality Transformation	56-58	16.4.3	Consider providing requirements of how applicant can identify these consumers in their claims data / HRA, etc. That way all applicants are counting the same way and it's a more consistent report.	Covered California will not amend the recommendation at this time. We will continue to explore your recommendations as we develop and strengthen this reporting requirement.	No
19	QHP IND	General			If Covered California intends to use the Certification Application for AB 929 public reporting, please consider ensuring that the questions that have numbers for reporting be split out since Individual grandfathered and Large Group appears to be out of scope for AB 929. Consider splitting out: Individual On-Exchange, Individual Off-Exchange ACA, Small Group On-Exchange, Small Group Off-Exchange	Covered California does not intend to modify or reformat the Certification Application based on which data elements may appear in AB 929 public reporting. We continue to work separately with QHP Issuers and other stakeholders to identify the content and format of AB 929 public reporting.	No
20	QHP IND	Provider Network	84-85	18.3.1	Consider updating the Guide to V1.12 instead of 1.9. Note: Comment applies to other product sections 19-21	The link has been updated to version 12.	Yes

CERTIFICATION APPLICATION COMMENTS 21-22

Issue #	Application (QHP IND /QHP CCSB / QDP IND /QDP CCSB)	Section Name / Attachment Name	Page Number	Question #	Comment	Covered California Response	Application Change (Yes / No)
20	QHP IND	Provider Network	84-85	18.3.1	Consider updating the Guide to V1.12 instead of 1.9. Note: Comment applies to other product sections 19-21	The link has been updated to version 12.	Yes
21	QHP IND	Health Equity and Quality Transformation	59	16.4.5	We request the following change due to the limited number of in-person DPP programs: ...The DPP must be accessible both in-person and or online. Covered California's preference is that DPP is available both in-person and online...	Covered California will not amend the recommendation at this time but have updated the language to align with Attachment 1 and addressed concerns regarding service issues in rural areas. We are committed to ensuring that all Enrollees have access to preventative diabetes care and education. Providing both in-person and online DPP services ensures Enrollees have equitable access to these services and allows Enrollees to choose their preferred choice of modality.	No

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.