COVERED CALIFORNIA POLICY AND ACTION ITEMS

June 16, 2022 Board Meeting

COVERED CALIFORNIA'S PROPOSED FISCAL YEAR 2022-2023 BUDGET

Jim Watkins, CPA, Chief Financial Officer
Financial Management Division

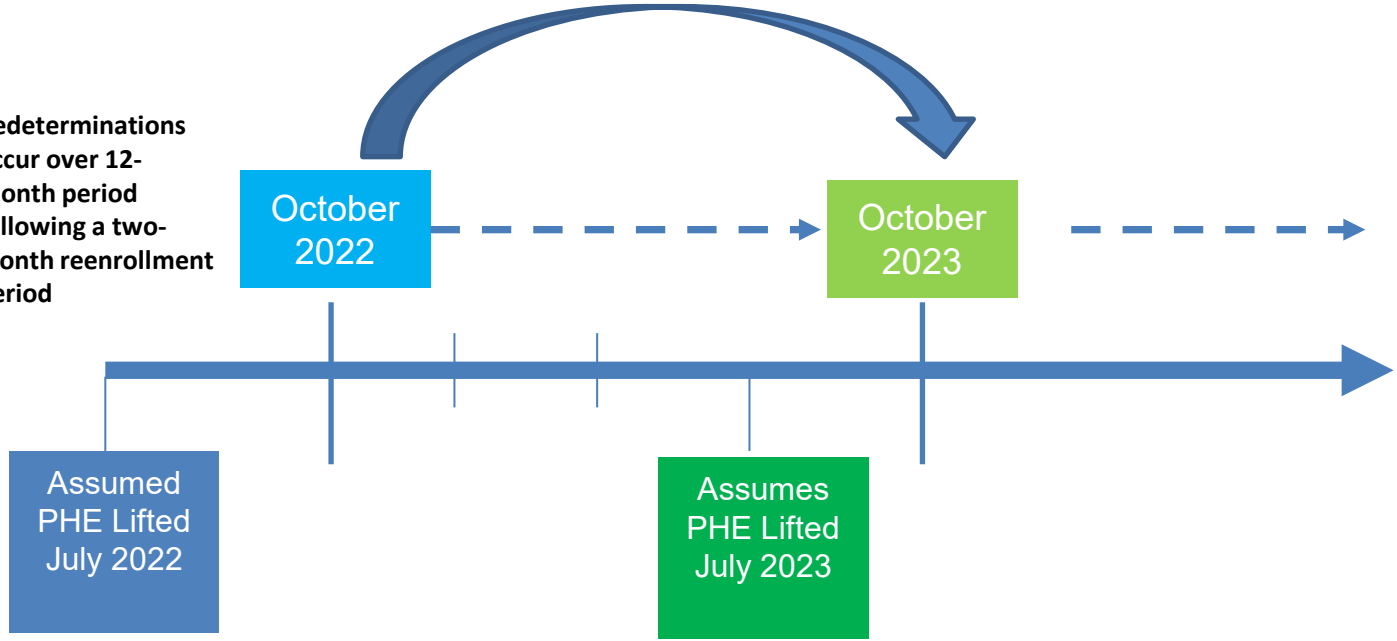
COVERED CALIFORNIA'S PROPOSED FY 2022-23 BUDGET AGENDA

- Adjustment to Enrollment and Revenue Forecast – Timing of Public Health Emergency Unwind and Renewed Medi-Cal inflows pushed back.
- Adjustment to Operating and Capital Investment Expenditure Budget – Added Telework Stipend Funds
- Projected Revenue and Expenditure Budgetary Outlook—Adjustments to Forecasted Revenues
- Recommend Approval of Covered California's FY 2022-23 Budget and 2023 Plan Year Assessment Rates

ADJUSTMENTS TO ENROLLMENT AND REVENUE FORECAST

PUBLIC HEALTH EMERGENCY (PHE) UNWIND ASSUMED TO BE EXTENDED

Redeterminations occur over 12-Month period following a two-month reenrollment period

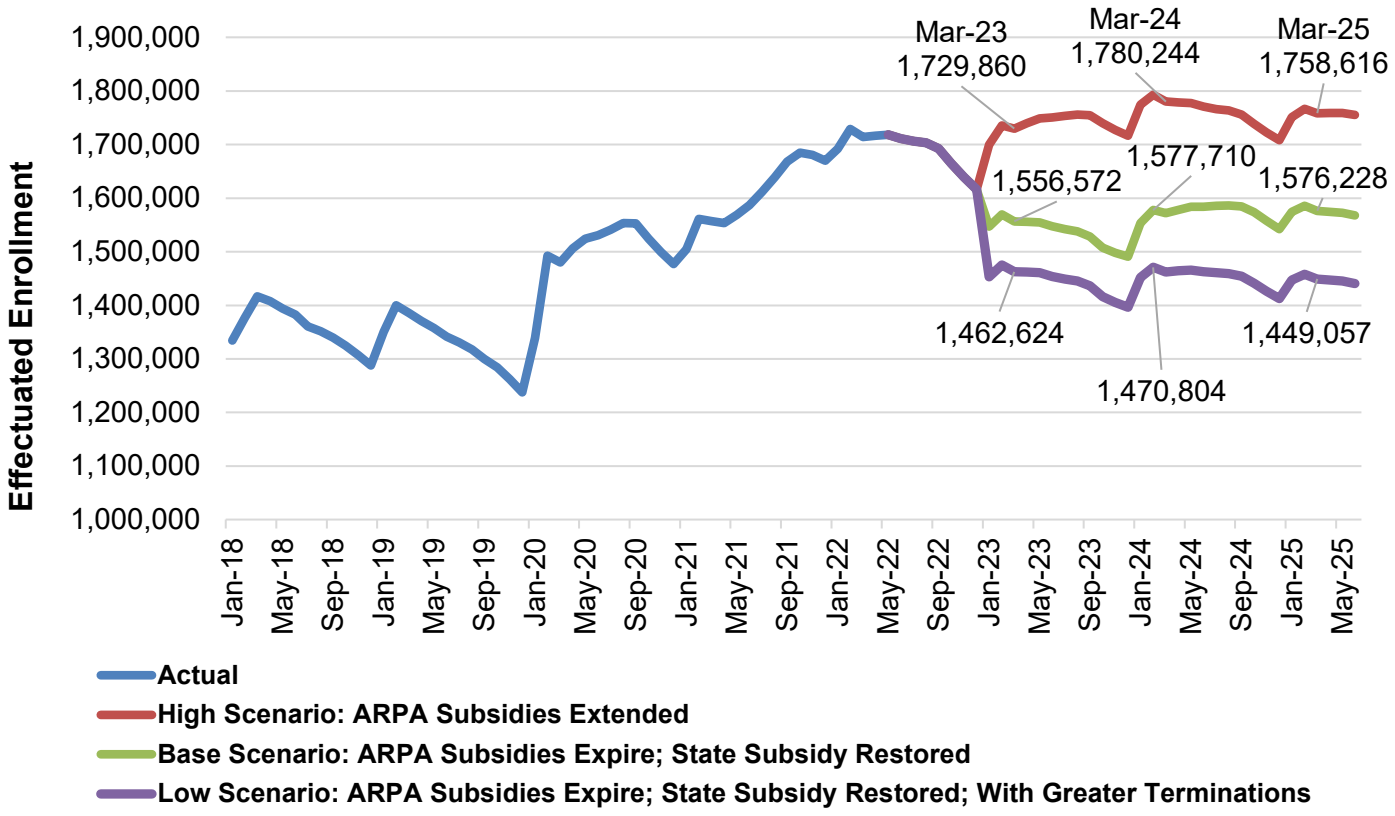


Assumes PHE is extended four additional times. In July and October 2022, and January and April 2023 ending in July 2023.

The Base enrollment forecast for the May 19th proposed budget had assumed that the PHE would end in July 2022 and a portion of individuals losing Medi-Cal coverage would begin transitioning to Covered California in November 2022. During the unwinding period inflows from Medi-Cal would be heavier than normal as the county welfare offices worked through the backlog of redeterminations deferred during the continuous coverage period.

The budget now assumes that the PHE will end in July 2023 and a portion of individuals losing Medi-Cal will begin transitioning to Covered California in November 2023 through October 2024.

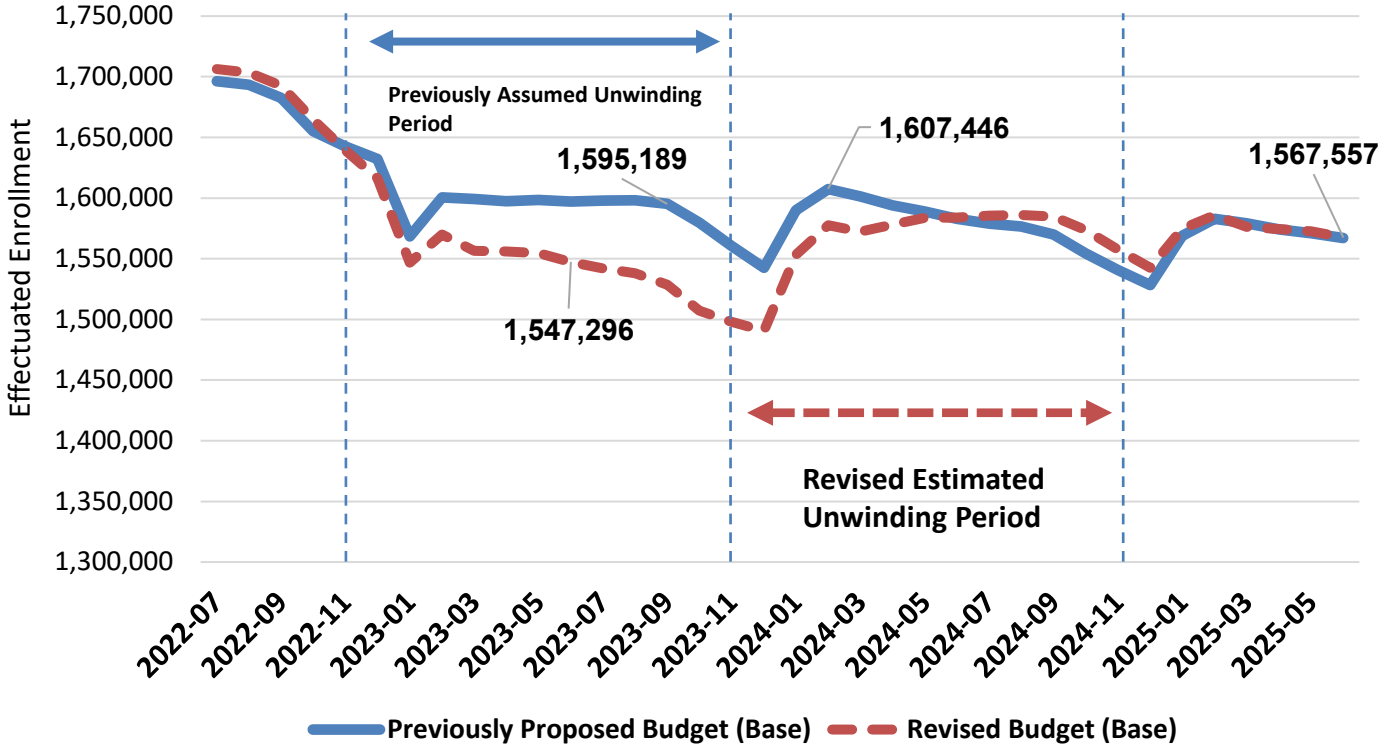
ADJUSTED BASE, HIGH AND LOW FORECASTS



Covered California developed a High, Base, and Low Enrollment forecast.

- The High forecast assumes that ARPA's enhanced subsidies are extended beyond 2022 and the PHE ends in October 2022.
- The Base forecast assumes that ARPA's enhanced subsidies are not extended, and the CA. legislature restores the state subsidy. The PHE is assumed to end in July 2023.
- The Low forecast utilizes the same assumptions as the Base Forecast regarding the ARPA subsidies and PHE, but also incorporates the impact of higher, persistent inflation adversely impacting lower-income consumers.

REVISIONS TO THE ENROLLMENT FORECAST - EXPECTED TIMING OF THE PHE UNWIND



The Base enrollment forecast for the proposed budget had assumed that the PHE would end in July 2022 and a portion of individuals losing Medi-Cal coverage would begin transitioning to Covered California in November 2022. During the unwinding period inflows from Medi-Cal would be heavier than normal as the county welfare offices worked through the backlog of redeterminations deferred during the continuous coverage period.

The budget now assumes that the PHE will end in July 2023 and a portion of individuals losing Medi-Cal will begin transitioning to Covered California in November 2023 through October 2024.

REVISIONS TO THE BASE ENROLLMENT AND INDIVIDUAL MEDICAL REVENUE FORECAST DUE TO THE CHANGE IN THE PHE UNWIND ASSUMPTION

Individual Medical Enrollment Average Monthly Enrollment	FY 2022-23	FY 2023-24	FY 2024-25
Previous Estimate - Assumed July 2022 PHE Unwind	1,630,293	1,586,564	1,566,035
Current Estimate - Now Assuming a July 2023 PHE Unwind	1,612,814	1,546,130	1,573,479
Difference	**-17,479**	**-40,434**	**7,444**
Individual Market Fee Revenue	**FY 2022-23**	**FY 2023-24**	**FY 2024-235**
Previous Estimate - Assumed July 2022 PHE Unwind	$377,372,080	$387,859,304	$407,806,266
Current Estimate - Now Assuming a July 2023 PHE Unwind	$373,180,550	$378,147,531	$409,680,292
Difference	**$(4,191,530)**	**$(9,711,503)**	**$1,874,026**

- Extending the PHE and pushing back the expected enrollment inflows from Medi-Cal during the unwinding period reduces the revenue estimate by $4.2 million for FY 2022-23, by $9.7 million in FY 2023-24, and increases our revenue estimate by $1.9 million in FY 2024-25.
- Revenue increases in FY 2023-24, year-over-year despite falling enrollment, is due to an expected average 6 percent increase in gross premiums.
- In FY 2024-25, enrollment is expected to grow as a result of individuals transitioning from Medi-Cal during the PHE unwind period. Revenue is expected to increase again in FY 2024-25, year-over-year, due to volume increases and expected average 7 percent increase in gross premiums.

ADJUSTMENTS TO BUDGETED EXPENDITURES

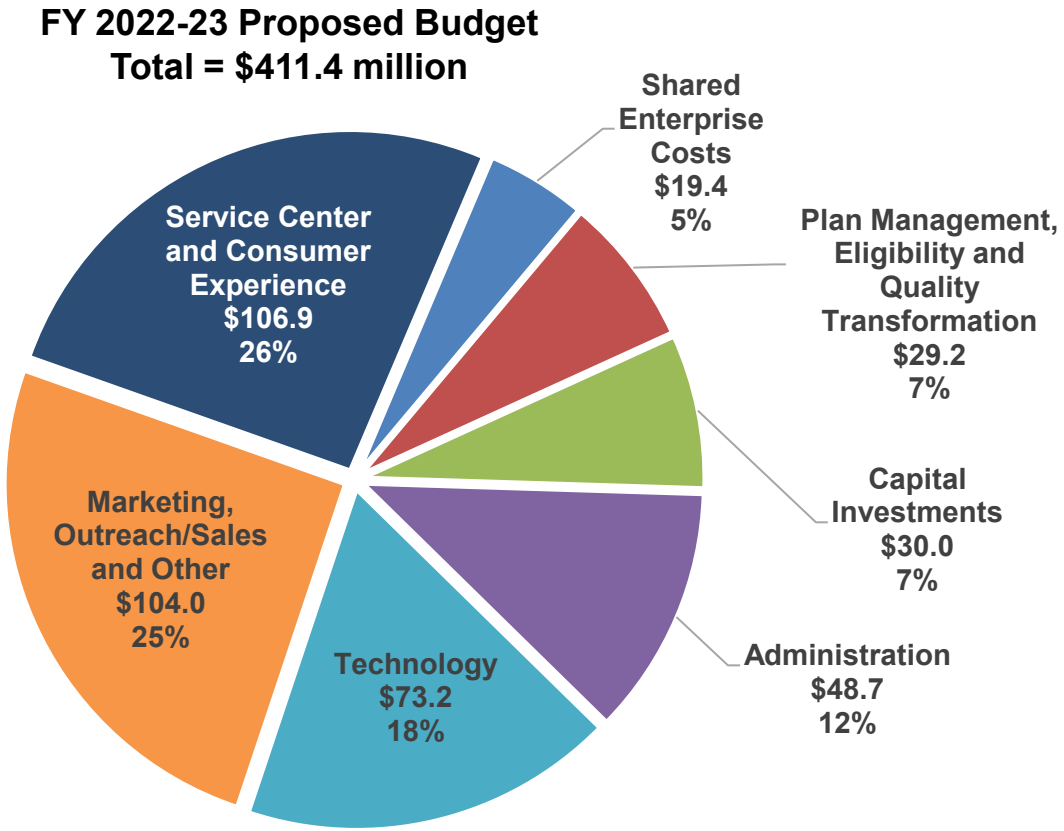
COVERED CALIFORNIA FY 2022-23 PROPOSED OPERATING AND CAPITAL EXPENDITURE BUDGET

	May 19th Board Presentation			Proposed Revisions	
	FY 2022-23 Baseline Budget	Budget Augmentations	FY 2022-23 Proposed Budget Presented May 19, 2022	Adjustments	FY 2022-23 Revised Proposed Budget
Personnel Count	**1,441**	**26**	**1,467**	**-**	**1,467**
Operating Expenditures					
Personnel Expenditures	$ 161,049,943	$ 3,143,771	$ 164,193,714	$ 743,546	$ 164,937,260
Other Operating Expenditures	$ 194,530,382	$ 2,478,917	$ 197,009,299	$ -	$ 197,009,299
Subtotal	**$ 355,580,325**	**$ 5,622,688**	**$ 361,203,013**	**$ 743,546**	**$ 361,946,559**
Allocated Expenditures					
Prorata/Supp. Pension/Other	$ 19,419,224	$ -	$ 19,419,224		$ 19,419,224
Total Operating Expenditures	**$ 374,999,549**	**$ 5,622,688**	**$ 380,622,237**	**$ 743,546**	**$ 381,365,783**
Capital Investments					
CalHEERs	$ 24,773,115	$ -	$ 24,773,115		$ 24,773,115
Other	$ 5,226,296	$ -	$ 5,226,296		$ 5,226,296
Total - Capital Project Expenditures	$ 29,999,411	$ -	$ 29,999,411	$ -	$ 29,999,411
Total Operating & Capital Expenditures	**$ 404,998,960**	**$ 5,622,688**	**$ 410,621,648**	**$ 743,546**	**$ 411,365,194**

Since the May 19th Board Meeting, Covered California has made one adjustment to the expenditure budget. The revision incorporates $743,546 in funding for a telework stipend. CalHR and the union agreed to provide a monthly stipend to each employee.

BUDGETED EXPENDITURES BY FUNCTION GROUP

Total Staffing = 1,467



FORECASTED BUDGETARY REVENUE AND EXPENDITURE OUTLOOK

STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION-BASE

	FY 2022-23 Proposed Budget	FY 2023-24 Projection	FY 2024-25 Projection
Assessment Fee Indiv./CCSB	3.25% / 5.2%	3.25% / 5.2%	3.25% / 5.2%
Projected Growth in Premiums	5.0%	6.0%	7.0%
Projected Average Monthly Eligibles	1,612,814	1,546,130	1,573,479
Projected Total Member Months – Individual Medical	19,353,768	18,553,560	18,881,754
Total Individual Market PMPM	$19.28	$20.38	$21.70
Individual Market Operating Revenues (Med.& Dental)	$375,295,974	$380,289,333	$412,001,082
CCSB Operating Income	$24,672,930	$26,753,520	$29,381,285
Other Income	$1,500,000	$1,500,000	$1,500,000
Total Revenues	**$401,468,904**	**$408,542,853**	**$442,882,367**
Total Operating and Capital Expenses	**$411,365,194**	**$423,017,771**	**$435,010,042**
Net Operating Income (Loss)	**($9,896,290)**	**($14,474,918)**	**$7,872,325**
End of Year Working Capital	$431,814,928	$417,340,010	$425,212,336
Months of Operations Funded with Working Capital	12.2	11.5	11.7

RECOMMEND APPROVAL OF COVERED CALIFORNIA'S FY 2022-23 BUDGET AND 2023 ASSESSMENT RATES

Covered California recommends that the Board adopt Board Resolution 2022-32 to:

- Approve the Operating and Capital Budget for FY 2022-23, providing expenditure authority of $411,365,194
- Grant the Executive Director authority to make adjustments to the Operating Budget, provided that Fiscal Year 2022-23 expenditures remain at or below the level of expenditure authority approved by the Board.
- Charge a per-member-per-month assessment fee of 3.25 percent for plan year 2023 on Qualified Health Plans, including dental plans, sold through the individual exchange, and 5.2 percent of premiums for such plans sold through Covered California for Small Business.

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 PREMIUM AND COST-SHARING AFFORDABILITY CONTINGENCY PLANNING

Katie Ravel, Director
Policy, Eligibility, and Research Division

STATE FINANCIAL ASSISTANCE PROVISIONS IN 2022-23 STATE BUDGET AS PASSED BY THE LEGISLATURE

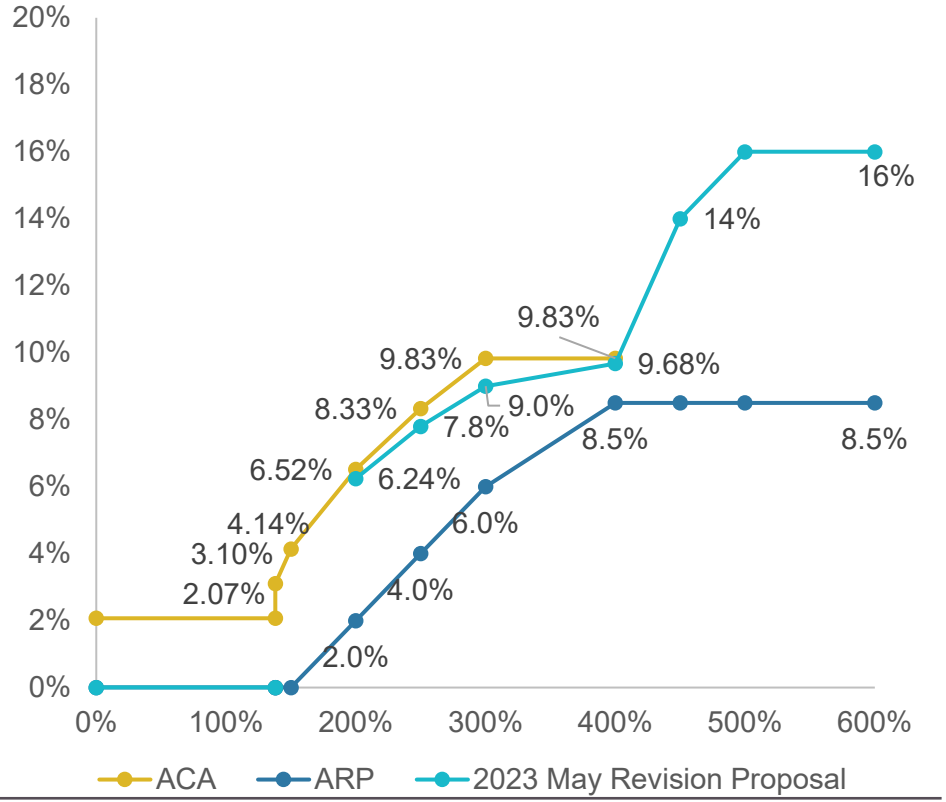
- Budget as passed by the Legislature on June 13th (SB 154) includes $304 million for a financial assistance program to be administered by Covered California for the 2023 plan year.
- SB 154 retains the Governor's May Revision proposal for state premium subsidies if American Rescue Plan premium subsidies are not extended beyond 2022.
- SB 154 adds a provision that would require Covered California to use the appropriation to provide enhanced cost-sharing reduction if American Rescue Plan premium subsidies are extended beyond 2022.
- Final budget negotiations are underway between the Newsom Administration and the Legislature.

SUMMARY OF TODAY'S STATE SUBSIDY PRESENTATION AND REQUESTED BOARD ACTION

- Staff will present program designs for both state premium subsidy and enhanced cost-sharing reduction based on SB 154:
  - Premium subsidy proposal is unchanged from draft presented to the Board May 19, 2022.
  - Enhanced cost-sharing reduction program design was included in AB 133 report and updated for the May 19, 2022 Board meeting.
- Both program designs have been included in the 2023 Program Design Document, which is required by state statute to specify eligibility and benefits for the financial assistance program.
- Staff will ask the Board to approve the 2023 Program Design Document contingent upon the terms of the final 2022-23 state budget.
  - Contingent approval will allow operational preparations for the 2023 plan year to move forward.
  - Any needed changes to the 2023 Program Design Document can be made at an upcoming Board meeting.

PROPOSED 2023 CALIFORNIA PREMIUM SUBSIDY PROGRAM DESIGN – UNCHANGED FROM MAY

- Eliminates the ACA "cliff" for enrollees with income between 400 and 600% FPL. Reduces the required contribution to 16% for enrollees with incomes between 500% to 600% of FPL compared to the 2021 program design.
- Provides state support to individuals with income between 200% and 400% FPL. Increases the required contribution percentage at 300% FPL from 8.9% to 9.0% compared to the 2021 program design.
- Lowers the required contribution to 0% for enrollees under 138% FPL consistent with the 2021 program design.



OVERVIEW OF THE DRAFT PROGRAM DESIGN PROVISIONS FOR PREMIUM SUBSIDIES

- The 2023 Program Design Document has five main premium subsidy components, which are unchanged from the draft presented at the May 19, 2022, Board meeting:

1. Establishes the required contribution amounts for the state premium subsidy for 2023 based on the 2021 design and consistent with the parameters included in the May Revision proposal, namely a $304 M budget target and a required contribution cap of 16% of income.

2. Establishes the calculation of the advanced payment of the state premium subsidy which mirrors the calculation of the federal premium tax credit with the exception that the advanced payment of the state premium subsidy amount is reduced by any federal advance payment of the premium tax credit. Establishes eligibility requirements for state premium assistance that mirror the requirements for the federal premium tax credit with the exception of the federal income limits.

3. Defines key terms related to the calculation of the state premium assistance.

4. Establishes reconciliation caps for 2023 consistent with the latest federal reconciliation caps.

PROPOSED 2023 STATE ENHANCED COST-SHARING REDUCTION PROGRAM

- The proposed state enhanced cost-sharing reduction (CSR) program design provides: (1) new CSR eligibility for individuals with income between 250% and 600% FPL; (2) a new CSR level with an actuarial value of 80 for individuals between 200% and 600% FPL; and (3) elimination of deductibles in CSR products.
  - The proposed design based on Option 5 from AB 133 report with an extension of CSR eligibility up to 600% FPL to align with state statute authorizing the state financial assistance program for individuals up to 600% FPL. (See Appendix for detail.)
- Proposed design also includes an expansion of eligibility for the zero cost sharing plan for American Indian and Alaska Native enrollees with income between 300% and 600% FPL in order to combine both federal and state benefits for this population.

PROPOSED BENEFIT DESIGNS FOR STATE ENHANCED COST-SHARING REDUCTION PROGRAM

- Program design uses three new CSR benefit designs presented to the Board on May 19, 2022: Silver 94 No Deductible (ND), Silver 87 ND and Silver 80 ND.
- Designs are built on the three existing income-based CSR plans specified by the ACA.
- Staff will request approval of these CSR benefit designs as part of the 2023 Patient Centered Benefit Designs.

Enhanced Benefit Design	Enhanced Silver 94 No Deductible		Enhanced Silver 87 No Deductible		Enhanced Silver 80	
2023 ACA plan used to create enhanced design	ACA Silver 94		ACA Silver 87		ACA Silver 73	
	Ded	Amount	Ded	Amount	Ded	Amount
Deductible						
Medical Deductible		$0		$0		$0
Drug Deductible		$0		$0		$0
Coinsurance (Member)		10%		15%		20%
MOOP		$900		$3,000		$4,900
ED Facility Fee		$50		$150		$400
Inpatient Facility Fee		10%		25%		30%
Inpatient Physician Fee		10%		25%		30%
Primary Care Visit		$5		$15		$30
Specialist Visit		$8		$25		$70
MH/SU Outpatient Services		$5		$15		$30
Imaging (CT/PET Scans, MRIs)		$50		$100		$325
Speech Therapy		$5		$15		$30
Occupational and Physical Therapy		$5		$15		$30
Laboratory Services		$8		$20		$40
X-rays and Diagnostic Imaging		$8		$40		$80
Skilled Nursing Facility		10%		25%		30%
Outpatient Facility Fee		10%		15%		20%
Outpatient Physician Fee		10%		15%		20%
Tier 1 (Generics)		$3		$5		$10
Tier 2 (Preferred Brand)		$10		$25		$40
Tier 3 (Nonpreferred Brand)		$15		$45		$70
Tier 4 (Specialty)		10%		15%		20%
Tier 4 Maximum Coinsurance		$150		$150		$250
Maximum Days for charging IP copay						
Begin PCP deductible after # of copays						
Actuarial Value						
2023 AV (Draft 2023 AVC)		**95.14**		**88.62**		**80.98**
2023 SBD AV (2023 AVC)		**94.88**		**87.86†**		**73.86†**

OVERVIEW OF THE PROGRAM DESIGN PROVISIONS FOR STATE ENHANCED COST-SHARING REDUCTION PROGRAM

- The 2023 Program Design Document adds new elements for the potential state enhanced cost-sharing reduction (CSR) program:

  1. Establishes income eligibility for the state enhanced CSR program.
  2. Specifies the qualified health plan features of the state enhanced CSR variants.
  3. Establishes per member per month payment rates for each plan design that will be offered through the state enhanced CSR program.
  4. Defines key terms related to the state enhanced CSR program.

STATE SUBSIDY PROGRAM DESIGN: ACTION REQUESTED AND NEXT STEPS

Action Requested

- Staff request Board action to adopt the 2023 Program Design Document contingent upon the enactment of the 2022-23 state budget.

Next Steps

- Staff will bring for Board approval any amendments to the 2023 Program Design Document necessary to implement the enacted 2022-23 state budget.
- Staff will submit the Board-approved 2023 Program Design Document for review by the Joint Legislative Budget Committee and approval by the Director of the Department of Finance following the enactment of the 2022-23 state budget.

APPENDIX

DETAILED PRESENTATION OF PROPOSED 2023 STATE ENHANCED COST-SHARING REDUCTION PROGRAM

✓ = *benefit or eligibility enhancement*
■ = *richer CSR support*

Enhanced Cost-Sharing Reduction Program Design Description	Up to 150% FPL		150-200% FPL		200-250% FPL		250-300% FPL		300-400% FPL		400-600% FPL		Annual Cost by Tier Switching Scenarios 1, 2, and 3 (millions)		
	CSR Upgrade	No Deductible	CSR Upgrade	No Deductible	CSR Upgrade	No Deductible	New CSR Eligibility	No Deductible	New CSR Eligibility	No Deductible	New CSR Eligibility	No Deductible	Current Rate of Silver Enrollment	Some Tier Switching to Silver	More Tier Switching to Silver
Affordable Care Act Cost-Sharing Reduction Eligibility	*ACA Cost-Sharing Reduction Eligible*						*ACA Cost-Sharing Reduction Ineligible*								
Actuarial value of Affordable Care Act Silver Products	*94*		*87*		*73*		*70*		*70*		*70*				
2022 Covered California Enrollment by FPL (all metal tiers)	*260,000*		*437,000*		*262,000*		*227,000*		*245,000*		*120,000*				
New eligibility for CSR between 250% and 600% FPL. New CSR product (AV 80). No deductibles in CSR products.	94 ND		87 ND		80 ND		80 ND		80 ND		80 ND		$203	$240	$291
		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓			

Notes: ACA = Affordable Care Act, AV = actuarial value (the average amount of a member's health care cost that is paid by the health plan), CSR = cost-sharing reduction, FPL = federal poverty level, ND = no deductible. Green shading indicates richer CSR plan provided in the option compared to the Affordable Care Act. For simplicity, ACA CSR plans with deductibles removed are displayed with their original actuarial values (i.e., 94 and 87), even though their computed actuarial value would be higher due to the removal of the deductible. Estimated 2023 costs are based on projections of 2023 enrollment if American Rescue Plan premium subsidies are extended beyond 2023. Expansion of eligibility for zero cost share plan for American Indian and Alaska Native enrollees not displayed.

AB 133 PROGRAM DESIGN OPTIONS WITH UPDATED COSTS - MAY 2022

✓ = benefit or eligibility enhancement

■ = richer CSR support

	Option	Summary	Description	Up to 150% FPL		150-200% FPL		200-250% FPL		250-300% FPL		300-400% FPL		400-600% FPL		Estimated 2023 Cost
				CSR Upgrade	No Deductible	CSR Upgrade	No Deductible	CSR Upgrade	No Deductible	New CSR Eligibility	No Deductible	New CSR Eligibility	No Deductible	New CSR Eligibility	No Deductible	
		Current CSR Eligibility		*CSR Eligible*						*CSR Ineligible*						
		AV of ACA Silver Products		*94*		*87*		*73*		*70*		*70*		*70*		
Options for Federally-funded Program	1	AV 95/90/85/80 with no deductibles	New eligibility for CSR up to 600% FPL. New products (min AV 80) under 600% FPL. No deductibles at any income below 600% FPL	95		95		90		90		85		80		$748 million
					✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	2	AV 95/90/85 with no deductibles	New eligibility for CSR up to 400% FPL. New products (min AV 85) under 400% FPL. No deductibles at any income below 400% FPL	95		95		90		90		85		70		$721 million
					✓	✓	✓	✓	✓	✓	✓	✓	✓			
	3	ACA CSR plan upgrade with no deductibles and Gold AV for 300-400% FPL	New eligibility for CSR up to 400% FPL. New CSR products (min AV 80) up to 400% FPL.	94		94		87		87		80		70		$552 million
					✓	✓	✓	✓	✓	✓	✓	✓	✓			
Options for State-funded Program	4	ACA CSR plan upgrade with no deductibles and Gold AV for 250-400% FPL	New eligibility for CSR up to 400% FPL. New CSR products (min AV 80) up to 400% FPL.	94		94		87		80		80		70		$490 million
					✓	✓	✓	✓	✓	✓	✓	✓	✓			
	5	ACA CSR plan upgrade for 150-250% FPL	Richer CSR below 250% FPL, moving Silver 87 to Silver 94 and Silver 73 to Silver 87. **Note:** this option uses existing ACA CSR plans that **include deductibles**.	94		94		87		70		70		70		$372 million
						✓		✓								
	6	ACA CSR plans with no Deductibles and Gold AV for 200-400% FPL	New CSR product (AV 80) for 200% FPL. No deductibles at any income below 400% FPL.	94		87		80		80		80		70		$183 million
					✓		✓	✓	✓	✓	✓	✓	✓			
	7	ACA CSR plans with no Deductibles	Existing CSR products across the income spectrum. No deductibles at any income below 600% FPL.	94		87		73		73		73		70		$72 million
					✓		✓		✓		✓		✓			

Source: Updated from Table 6 in Bringing Care Within Reach.

Notes: ACA = Affordable Care Act, AV = actuarial value, CSR = cost-sharing reduction, FPL = federal poverty level. Green shading indicates richer CSR plan provided in the option compared to the Affordable Care Act. For simplicity, ACA CSR plans with deductibles removed are displayed with their original actuarial values (i.e., 94, 87 and 73), even though their computed actuarial value would be higher due to the removal of the deductible. Estimated 2023 costs are based on initial projections of 2023 Silver tier enrollment if American Rescue Plan premium subsidies are extended beyond 2022.

PUBLIC COMMENT

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

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

EACH CALLER WILL BE LIMITED TO TWO MINUTES PER AGENDA ITEM

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

REVISED 2023 PATIENT-CENTERED BENEFIT PLAN DESIGNS

Jan Falzarano, Deputy Director
Plan Management Division

REVISIONS TO 2023 BENEFIT PLAN DESIGNS

- Covered California staff is seeking board approval to make modifications to the 2023 Patient Centered Benefit Plan Designs to account for the following:
  - IRS release of 2023 Annual limitation on Cost sharing for Bronze High Deductible Health Plan (HDHP)
  - Mental Health Parity Testing and impact to 2023 Patient Centered Benefit Plan Designs
  - Cost Sharing Reduction (CSR) benefit plan designs for the state enhanced CSR program contingent upon the enactment of the 2022-23 state budget

2023 BENEFIT DESIGN UPDATE - HDHP MOOP LIMITS

- The IRS released its' Revenue Procedure 2022-24 on April 29th, 2022
- The IRS set the 2023 annual limitation on cost sharing at $7500 for a single individual, which is higher than the $7000 Maximum Out of Pocket (MOOP) limit in our Patient Centered Benefit Plan Designs
- Covered California determined that it could offer a better benefit to consumers by maintaining the $7000 limit in our benefit designs, rather than adopting the IRS MOOP limits. Our recommendation to keep the $7000 MOOP limit for the HDHP will require us to make some minor modifications to the benefit design.
- We are proposing the following edit to the language in endnote #31 in the Patient Centered Benefit Plan Designs:
  - #31) The out-of-pocket maximum in the Bronze HDHP shall ~~be equal to~~ not exceed the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2023 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.[1]
- The Standard Benefit designs will list the specified dollar amount of $7000

2023 BENEFIT DESIGN UPDATE FOR MENTAL HEALTH PARITY REQUIREMENTS

- Due to the Mental Health Parity and Addiction Equity Act's (MHPAEA) impact to 2023 Benefit Designs, we are also proposing the following conforming edit to the language in endnote #21 in the Patient Centered Benefit Plan Designs:
  - #21) Covered California may approve deviations from the benefit plan designs ~~cost-sharing~~ for certain services on a case-by-case basis, if necessary to comply with ~~subject to~~ the California Mental Health Parity or federal Mental Health Parity and Addiction Equity Act (MHPAEA). ~~may be different but not more than those listed in these patient-centered benefit plan designs if necessary for compliance with MHPAEA.~~ 2

MENTAL HEALTH PARITY LAWS

- The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) requires commercial plans that offer mental health and substance use disorder benefits in a comparable manner to medical and surgical benefits
- California's Mental Health Parity Act requires health plans/insurers to provide full coverage for the treatment of all mental health conditions and substance use disorders (MH/SUD)
- Essence of Parity: MHPAEA requires that group health plans and insurance issuers offering group or individual health insurance coverage ensure that the financial requirements (FR) and treatment limitations (TL) on MH/SUD benefits they provide are no more restrictive than those on medical/surgical benefits

MHPAEA'S PARITY TESTING

- Annually, each health plan is required to do their own parity testing using their claims data. Plans may have different outcomes based on their claims experience
- Issuers must meet parity standards in these areas:
  - **Financial requirements (FR) - applies to coinsurance, copays, deductibles and other financial requirements**
  - **Quantitative Treatment Limits (QTL) - day or visit limits or number of items, devices**
  - **Nonquantitative treatment limits (NQTL) - prior authorization policies, formulary design, geographic restrictions**
- These standards are applied according to the classification of benefits:
  - Benefits Classification (eight coverage classification)
    - Inpatient (in-network, out-of-network)
    - Outpatient office visits (in-network, out-of-network)
    - Outpatient services other than office visits (in-network, out-of-network)
    - Emergency care
    - Prescription drugs

MENTAL HEALTH PARITY AND AV COMPLIANCE

- Kaiser annually follows the methodology for calculating MHPAEA compliant financial requirements and cost sharing in the development of its product portfolios

- In the course of 2023 individual and small group portfolio development, Kaiser determined that the cost share for MH/SUD benefits in one or both outpatient classifications would need to be set at $0 in some plans to ensure MHPAEA compliance. When cost share for MH/SUD benefits in the outpatient-office visit subclassification is adjusted to $0, two standard plan designs in Kaiser's 2023 individual and small group on-exchange products fall outside the required AV range:
  - **CCSB Silver 70 HMO copay and CCSB/Individual Bronze 60**

The main factor driving this change is an increases in utilization of zero-dollar benefit services on the medical/surgical side, including telehealth encounters (for which Kaiser does not currently charge cost shares)

- To bring the two standard plans back into AV range, Kaiser will modify their plan designs with the following adjustments:
  - **CCSB Silver 70 HMO**
    - Increase drug deductibles to $370 (2023 SBD is set at $300)
      Rationale: Kaiser believes this adjustment will have limited impact on their members since their physicians prescribe generic medications where medically appropriate that are more affordable.(Tier 1 drugs are not subject to the deductible in this plan).
  - **CCSB and Individual Bronze 60**
    - Increase Maximum Out of Pocket to $8600 (2023 SBD is set at $8200)
      Rationale: for this adjustment: Increasing the Maximum out of Pocket by $400 allows Kaiser to make a single adjustment to the plan to meet AV range and minimizes impact to consumers.

KAISER'S MODIFIED BENEFIT DESIGNS

CCSB Silver 70 HMO

Benefit	CCSB-only Silver Copay		CCSB-only Silver Copay Kaiser Adjustments	
	Ded	Amount	Ded	Amount
Deductible				
Medical Deductible		$2,500		$2,500
Drug Deductible		$300		$370
Coinsurance (Member)		30%		30%
MOOP		$8,750		$8,750
ED Facility Fee	X	30%	X	30%
Inpatient Facility Fee	X	40%	X	40%
Inpatient Physician Fee		40%		40%
Primary Care Visit		$55		$55
Specialist Visit		$90		$90
MH/SUD Outpatient Services		$55		$0
Imaging (CT/PET Scans, MRIs)	X	$300	X	$300
Speech Therapy		$55		$55
Occupational and Physical Therapy		$55		$55
Laboratory Services		$55		$55
X-rays and Diagnostic Imaging		$90		$90
Skilled Nursing Facility	X	40%	X	40%
Outpatient Facility Fee	X	35%	X	35%
Outpatient Physician Fee		30%		30%
Tier 1 (Generics)		$19		$19
Tier 2 (Preferred Brand)	X	$85	X	$85
Tier 3 (Nonpreferred Brand)	X	$110	X	$85
Tier 4 (Specialty)	X	30%	X	30%
Tier 4 Maximum Coinsurance		$250		$250
Maximum Days for charging IP copay				
Begin PCP deductible after # of copays				

CCSB and Individual Bronze 60

Benefit	IND/CCSB Bronze		IND/CCSB Bronze Kaiser Adjustments	
	Ded	Amount	Ded	Amount
Deductible				
Medical Deductible		$6,300		$6,300
Drug Deductible		$500		$500
Coinsurance (Member)		40%		40%
MOOP		$8,200		$8,600
ED Facility Fee	X	40%	X	40%
Inpatient Facility Fee	X	40%	X	40%
Inpatient Physician Fee	X	40%	X	40%
Primary Care Visit	X	$65	X	$65
Specialist Visit	X	$95	X	$95
MH/SUD Outpatient Services	X	$65	X	$0
Imaging (CT/PET Scans, MRIs)	X	40%	X	40%
Speech Therapy		$65		$65
Occupational and Physical Therapy		$65		$65
Laboratory Services		$40		$40
X-rays and Diagnostic Imaging	X	40%	X	40%
Skilled Nursing Facility	X	40%	X	40%
Outpatient Facility Fee	X	40%	X	40%
Outpatient Physician Fee	X	40%	X	40%
Tier 1 (Generics)	X	$18	X	$18
Tier 2 (Preferred Brand)	X	40%	X	40%
Tier 3 (Nonpreferred Brand)	X	40%	X	40%
Tier 4 (Specialty)	X	40%	X	40%
Tier 4 Maximum Coinsurance		$500*		$500*
Maximum Days for charging IP copay				
Begin PCP deductible after # of copays		3 visits		3 visits

ACTION ITEM: REVISED 2023 BENEFIT PLAN DESIGNS

Covered California staff is seeking board approval on the following revisions to the 2023 Patient-Centered Benefit Plan Designs:

- List the HDHP MOOP limit of $7000 rather than a general reference to "see endnote”
- Minor revisions to the Patient Centered Benefit Plan Designs endnotes:
  - Endnote #31 –HDHP MOOP limit **shall not** exceed the MOOP limit specified in the IRS revenue code
  - Endnote #21 – Additional clarity on approval of benefit design changes if necessary to comply with California Mental Health Parity Act or federal Mental Health Parity and Addiction Equity Act (MHPAEA)
- Cost Sharing Reduction (CSR) benefit plan designs for the state enhanced CSR program contingent upon the enactment of the 2022-23 state budget

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.

ELIGIBILITY AND ENROLLMENT REGULATIONS EMERGENCY READOPTION

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 California Department of Social Services (CDSS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), California Department of Insurance (CDI), Franchise Tax Board (FTB), consumer advocates, Quality Health Plan (QHP) issuers, and other stakeholders.

OVERVIEW OF THE MAIN PROPOSED CHANGES

- Revised the following definitions under section 6410:
  - Definition of “Dependent” for purposes of enrollment to include, for a plan year beginning on or after January 1, 2023, a parent and stepparent, as required under state law (AB 570).
  - Revised the cross-referenced citations to the IRS regulations for the definitions of “Minimum Value” and “Qualifying Coverage in an Eligible Employer-Sponsored Plan” to comport with the federal family glitch fix regulations when finalized later this year.
  - Revised the definition of “QHP Issuer” to add “For purposes of Section 6498(l), licensed health care service plans or insurers that are subsidiaries of the same parent company are considered to be the same QHP issuer.”

OVERVIEW OF THE MAIN PROPOSED CHANGES CONT.

- Revised the application regulation under section 6470(c)(14) to include the cost of family coverage as a required information to be provided by the consumer to comport with the federal family glitch fix regulations when finalized, as follows:
  - "Whether the applicant currently has MEC through an employer-sponsored plan, as defined in Section 5000A(f)(2) of IRC (26 USC § 5000A(f)(2)), and if so, the amount of monthly premium the applicant pays for self-only coverage, and family coverage if applicable, through his or her employer and whether it meets the minimum value standards, as defined in Section 6410 of Article 2 of this chapter."

OVERVIEW OF THE MAIN PROPOSED CHANGES CONT.

- Revised the eligibility requirements for Advance Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSR) under section 6474(c)(7) to add the proration formula for calculating partial-month APTC amount to comply with the 2023 Notice of Benefit and Payment Parameters (NBPP) final rule.
- Revised the verification of enrollment in an eligible employer-sponsored plan under section 6490(e) and deleted the random sampling process as it is no longer required based on the 2023 NBPP final rule.
- Revised the eligibility redetermination during a benefit year under section 6496 to add that data matching regarding death and eligibility for or enrollment in Medicare must be conducted at least twice during a calendar year. Also added data matching requirement for “Multiple overlapping QHPs through the Exchange.”

OVERVIEW OF THE MAIN PROPOSED CHANGES CONT.

- Revised the open enrollment periods in section 6502(d)(4) and (f)(3) to add the new Open Enrollment Perion (OEP) dates and coverage effective dates required under state law (SB 1473) as of January 1, 2023.
  - Annual OEP begins on November 1 of the calendar year preceding the benefit year and extends through January 31 of the benefit year.
  - Coverage effective dates for a QHP selection received by the Exchange from a qualified individual:
    - From November 1 through December 31 of the calendar year preceding the benefit year, shall be no later than January 1 of the benefit year; and
    - From January 1 through January 31 of the benefit year, shall be no later than February 1 of the benefit year."

NEXT STEPS

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

PUBLIC COMMENT

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

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

EACH CALLER WILL BE LIMITED TO TWO MINUTES PER AGENDA ITEM

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