COVERED CALIFORNIA POLICY AND ACTION ITEMS

March 9, 2023 Board Meeting

2024 QUALIFIED HEALTH PLAN ISSUER CONTRACT AND CERTIFICATION PROCESS

2024-26 QUALIFIED DENTAL PLAN ISSUER MODEL CONTRACT

James DeBenedetti
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2024-26 QUALIFIED DENTAL PLAN ATTACHMENTS 1 & 2 PUBLIC COMMENT KEY THEMES

Attachment 1

- **Consumer Advocates** expressed disappointment with reduced population health management plan requirements narrowed to children, adolescents, and members with disabilities and disagreed with removing some reporting requirements
- **Consumer Advocate** recommended minor language change to ensure that all patients should be screened and referred for tobacco use; language revised to clarify original intent
- **Issuers** recommended removal of pregnancy tracking and reporting due to limitations in dental practice management systems; requirement language revised

Attachment 2

- **Consumer Advocates** expressed disappointment that all oral health performance standards focus on utilization of dental services and that demographic data collection requirements were removed.
- **Issuers** requested adjusting the proportion of at-risk amounts between pediatric and adult measures to reflect the larger adult population; adjusted at-risk amounts proposed
- **Issuers** requested decreasing the year over year 10% improvement performance level; language revised
- **Issuer** expressed concern with pediatric sealant receipt on permanent first molars as an annual performance standard with a year over year improvement requirement level and suggested reducing the at-risk amount for this measure.

PROPOSED QUALIFIED DENTAL PLAN ATTACHMENT 1 CONTRACTUAL REQUIREMENTS

No substantive changes to proposed requirements:

Article 1 - Equity and Disparities Reduction

- Annual progress report describing efforts to establish or expand the infrastructure to successfully identify, monitor, and reduce disparities.

Article 2 - Population Health

- Submit a population assessment plan

Article 3 - Health Promotion and Prevention

- Actively outreach, engage, and educate enrollees on member benefits and cost-sharing, provider location and matching, and health assessments
- Conduct tailored outreach and education based on identified needs or health status

Article 4 - Delivery System and Payment Strategies to Drive Quality

- DHMO issuers required to report and implement primary dentist assignment
- Report provider payment type by HCP LAN APM category
- Report teledentistry offerings and utilization
- Report participation in dental collaboratives or initiatives

Article 5 - Measurement and Data Sharing

- Healthcare Evidence Initiative (HEI) data submission and participation

PROPOSED QUALIFIED DENTAL PLAN ATTACHMENT 2 OVERVIEW

Performance Area	Performance Standards with Penalties	% of At-Risk 2024	% of At-Risk 2025	% of At-Risk 2026
Data Submission 50%	1.1 HEI; Incomplete, irregular, late or non-useable submission	15%	15%	15%
	1.2 HEI; Allowed amount total varies by more than plus or minus 2%	10%	10%	10%
	1.3 HEI; Rendering provider taxonomy and type missing/invalid	10%	10%	10%
	1.4 HEI; Rendering NPI and TIN missing/invalid	10%	10%	10%
	2. Provider Directory	5%	5%	5%
Oral Health 50%	3. Oral Evaluation, Dental Services for Children	5%~~10%~~	5%~~10%~~	5%~~10%~~
	4. Topical Fluoride for Children	5%~~10%~~	5%~~10%~~	5%~~10%~~
	5. Sealant Receipt on Permanent First Molars for Children	5%~~10%~~	5%~~10%~~	5%~~10%~~
	6. Preventive Services Utilization for Adults	35%~~20%~~	35%~~20%~~	35%~~20%~~
Total		100%	100%	100%

The total amount at risk for Contractor's failure to meet the Performance Standards is equal to 1.0% of the total Gross Premium for the applicable Plan Year (At-Risk Amount).

PROPOSED ATTACHMENT 2 ORAL HEALTH MEASURES PERFORMANCE STANDARDS

Measurement Year 2024	Measurement Year 2025	Measurement Year 2026
Contractor establishes a baseline rate for this measure using HEI data. Contractor does not establish baseline rate: 10% penalty Contractor establishes baseline rate of 0% or more: no penalty	Contractor demonstrates an increase of less than 10% over the baseline rate: 10% penalty Contractor demonstrates (a) an increase of 10% or more over the baseline rate or (b) if the baseline rate is 0%, demonstrates an absolute rate of at least 10%: no penalty	Contractor demonstrates an increase of less than 10% over prior year: 10% penalty Contractor demonstrates an increase of 10% or more over prior year: no penalty

New language added: *The proposed 10% improvement performance level may be revised if appropriate once HEI data are analyzed and baseline rates are established.*

COVERED CALIFORNIA MEASURE SET CRITERIA

- **Epidemiologically relevant:** target conditions that are key drivers of morbidity and mortality for Californians, with significant racial or ethnic disparities in outcomes
- **Outcomes focused:** select measures with clear linkage to clinical outcomes
- **Established:** minimize administrative burden by relying on nationally endorsed metrics that, as much as possible, are shared across multiple measure sets
- **Actionable:** choose measures where improvement is clearly amenable to health care intervention
- **Parsimonious:** focus on a select subset of measures to achieve impact
- **Aligned:** strive to align measure sets and measure specifications to allow maximal synergy across health plans and providers

DENTAL HEALTH MEASURES INVENTORY

- For the 2024-26 contract, Covered CA researched and reviewed more than a dozen DHCS & DQA measures for dental care: preventive, diagnostic, and treatment services; continuity and usual source of care; overall utilization of dental services over time; emergency department visits; and cost of clinical services.
- US Preventive Services Task Force has had a limited focus on clinical preventive dental services. Existing USPSTF recommendations focus on the prevention of dental caries and oral fluoride in pediatric sub-populations and less so on adult populations.
- DHCS and the Dental Quality Alliance are the primary sources of dental measures in use.
  - In comparison, NCQA HEDIS supplies a majority of the validated, evidence-based health plan measures in use, many of which have been endorsed by the National Quality Foundation (NQF) and included by CMS in the Quality Rating System and the Medicaid Adult Core Set.
- HEDIS MY 2023 includes the Oral Evaluation - Dental Services and Topical Fluoride measures for pediatric populations.
- Most recently, the CMS Universal Foundation includes one pediatric measure (Oral Evaluation – Dental Services) in its preliminary set.
- Dental care quality measurement (and its evidence base) is much more limited than health care quality measurement.

COVERED CALIFORNIA DENTAL MEASUREMENT ALIGNMENT

Oral Health Measures Performance Standards	Evidence & Alignment
Pediatric Oral Evaluation, Dental Services (NQF #2517)	HEDIS MY 2023 CMS Child Core Set 2023
Pediatric Topical Fluoride for Children, Dental Services (NQF #2528)	HEDIS MY 2023 CMS Child Core Set 2023 USPSTF Grade B DHCS Dental Pay-for-Performance
Pediatric Sealant Receipt on Permanent First Molars	CMS Child Core Set 2023 DHCS Dental Pay-for-Performance
Adult Use of Preventive Services	DHCS performance measure

In addition to Attachment 2 performance standards, Covered California will monitor a robust set of dental metrics to assess utilization and engagement in care, and evaluate potential additional measures.

REQUESTED ACTION: 2024-2026 QUALIFIED DENTAL PLAN ISSUER CONTRACT UPDATE

- Covered California staff presented draft contract language at the January Board meeting consisting of:
  - The Daft Model Contract
  - Draft Attachments 1, 2, and 3
    - Attachment 1: No substantive changes to proposed requirements since the January Board meeting
    - Attachment 2: Change to percent at risk between Pediatric and Adult oral health measures and to language regarding 10% improvement performance level since the January Board meeting
- Staff requests that the Board formally adopt the 2024 - 2026 Qualified Dental Plan Issuer contract with updates from the January Board meeting consisting of:
  - The Draft Model Contract
  - Draft Attachments 1, 2, and 3

2024 QUALIFIED HEALTH PLAN ISSUER MODEL CONTRACT

James DeBenedetti
Director, Plan Management Division

2024 MODEL CONTRACT UPDATE

- Qualified Health Plan Issuer Model Contracts for the Individual and Small Business markets were significantly refreshed last year for the 2023-25 period.
- Proposed changes presented for discussion at the January 19, 2023, Board meeting, of the 2024 Individual and Small Business contracts were minor (primarily for purposes of clarification) outside of Attachments 1, 2, and 4.
- There have been no further substantive updates since presentation at the January 19, 2023, Board meeting.
- The current draft 2024 Amendment to the 2023-2025 QHP Issuer Model Contract, posted March 6, 2023, can be viewed here: https://hbex.coveredca.com/stakeholders/plan-management/ .

PLAN YEAR 2024 AMENDMENT APPROACH

- Covered California is proposing several revisions within the Plan Year 2024 Attachment 1, Attachment 2, and Attachment 4 amendment to clarify or add to the 2023 contract requirements

- Covered California's approach to the Plan Year 2024 amendment includes:
  - Proposing revisions consistent with Covered California's key priority areas for the 2023-2025 contract refresh
  - Adjusting requirements to reduce administrative burden on providers and health plans where feasible
  - Prioritizing use of standard measures when available
  - Implementing revisions that were previewed during the 2023-2025 contract refresh development
  - Further alignment with other public purchasers and organizations, especially DHCS, CalPERS, and NCQA

- Covered California solicited public comments on proposed revisions through a round public comments in November 2022

SUMMARY OF PROPOSED 2024 REVISIONS

No changes to proposed revisions:

Attachment 1: Advancing Equity, Quality, and Value

- ❑ Adding requirements to demonstrate provision of culturally and linguistically competent care
- ❑ Adding requirements for behavioral health subcontractor oversight and accountability
- ❑ Adjusting social needs screening measure and reporting
- ❑ Revising Healthcare Evidence Initiative (HEI) measures based on learnings from ongoing HEI work

Attachment 2: Performance Standards with Penalties

- ❑ Implementing performance standards for Patient Level Data file submission completeness and accuracy
- ❑ Defining oral health performance standards using standard measures

Attachment 4: Quality Transformation Initiative

- ❑ Specifying distribution of percent at risk between Attachment 2 and Attachment 4 for Plan Year 2024

REQUESTED ACTION: 2024 QUALIFIED HEALTH PLAN ISSUER CONTRACT UPDATE

- Covered California staff presented draft contract amendment language at the January Board meeting consisting of:
  - The draft model contract.
  - Attachments 1, 2, and 4. Attachment 3 was not presented as there were no updates in 2024.
- Staff request the Board formally adopt the 2024 Qualified Health Plan Issuer contract update as presented at the January Board meeting consisting of:
  - The draft model contract.
  - Attachments 1, 2, and 4. Attachment 3 will be included as approved in the 2023 Plan Year as there were no updates in 2024.

2024 QUALIFIED HEALTH AND DENTAL PLAN CERTIFICATION

James DeBenedetti
Director, Plan Management Division

CERTIFICATION APPLICATION UPDATES

Qualified Health Plan (QHP)
Currently contracted QHPs will have greatly reduced application response requirements. New entrants will complete the entire application. If certified, the new contracts will be from Plan Year 2024 – 2026.

Qualified Dental Plan (QDP) Application Rewrite
All dental Issuers are considered New Entrants and must complete the entire application.

Plan Year 2024 Certification Applications will be open to all Applicants.

The four Certification Applications are posted on the Certification HBEX page.

CERTIFICATION SELECTION CRITERIA

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

These guidelines are:

- ❑ Promote Affordability and Value for the Consumer – Both in Premiums and at Point of Care
- ❑ Encourage Competition Based upon Quality
- ❑ Encourage Competition Based upon the Populations Served
- ❑ Encourage Competition Based upon Meaningful QHP Choice and Product Differentiation: Patient-Centered Benefit Plan Designs
- ❑ Encourage Competition throughout the State
- ❑ Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform
- ❑ Demonstrate Administrative Capability and Financial Solvency
- ❑ Encourage Robust Customer Service

PLAN YEAR 2024 CERTIFICATION MILESTONES

Milestone	Date
Release Draft 2024 QHP & QDP Certification Applications	December 2022
Draft Application Comment Periods End	December 2022
Plan Management Advisory: Benefit Design & Certification Policy Recommendation	January 2023
January Board Meeting: Discussion of Benefit Design & Certification Policy Recommendation	January 2023
Letters of Intent Accepted	February 1-15, 2023
Final AV Calculator Released*	February 2023
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 2023
March Board Meeting: Anticipated approval of 2024 Patient-Centered Benefit Plan Designs & Certification Policy	March 2023
QHP & QDP Applications Open	March 1, 2023
QHP & QDP Application Responses (Individual and CCSB) Due	April 28, 2023
Evaluation of QHP Responses & Negotiation Prep	May – June 2023
QHP Negotiations	June 2023
QHP Preliminary Rates Announcement	July 2023
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2023
Evaluation of QDP Responses & Negotiation Prep	June – July 2023
QDP Negotiations	July 2023
CCSB QHP Rates Due	July 2023
QDP Rates Announcement (no regulatory rate review)	August 2023
Public Posting of Proposed Rates	July 2023
Public Posting of Final Rates	September – October 2023

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

TBD = dependent on CCIIO rate filing timeline requirements

REQUESTED ACTION: PLAN YEAR 2024 CERTIFICATION APPLICATIONS

- Covered California staff presented four draft contract Certification Applications at the January Board meeting consisting of:
  - QHP Individual and CCSB Applications updates.
  - QDP Individual and CCSB Applications full rewrite.

- Staff requests the Board to formally adopt the 2024 Certification Criteria as presented at the January Board meeting.

2024 STANDARD BENEFIT DESIGNS

Jan Falzarano
Deputy Director, Plan Management Division

BENEFIT PLAN DESIGN OVERVIEW

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

- The Affordable Care Act (ACA) requires individual and small group plans to meet actuarial value (AV) requirements for four levels of coverage:
    - Platinum: 90% AV (+/-2 de minimis)
    - Gold: 80% AV (+/-2 de minimis)
    - Silver: 70% AV (+/-2 de minimis)
    - Bronze: 60% AV (+5/-2 de minimis)

- Additional plan designs with a richer benefit package, known as “Cost Sharing Reduction Plans”, are available to individuals meeting income eligibility requirements.
    - Silver 94: 94% AV, 100% - 150% Federal Poverty Level (FPL)
    - Silver 87: 87% AV, 150% - 200% FPL
    - Silver 73: 73% AV, 200% - 250% FPL
        - The CSR products have (0/+1 de minimis)

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

- Covered California works closely with external stakeholders (advocates, heath plans, dental plans) to solicit input in the development of the patient-centered benefit designs

FACTORS INFLUENCING 2024 BENEFIT PLAN DESIGNS

- The standard benefit plan designs are adjusted annually to meet Actuarial Value (AV) requirements.
- Department of Health and Human Services (HHS) set the annual limitation on cost sharing at $9,450 for PY 2024
  - Covered California' plan designs for PY 2024 have a range between $1,150 and $9,100 (depending on metal tier)
  - Covered California' health plan designs have a maximum out of pocket (MOOP) limit of $9,100 to coordinate the $350 MOOP for pediatric dental services
- Claims cost trending in the draft 2024 AV Calculator

CLAIMS COST TRENDING		
	MEDICAL	DRUG
2018-2021	5.40%	8.70%
2021-2022	3.20%	4.55%
2022-2023	5.80%	8.70%
2023-2024	5.40%	8.20%

2024 ANNUAL LIMITATION ON COST SHARING

	2019	2020	2021	2022	2023	Updated 2024
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	$9,450 / $18,900
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	$9,100 / $18,200
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	$7,550 / $15,100
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	$3,150 / $6,300
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	$3,150 / $6,300

MENTAL HEALTH PARITY TEST IMPACTS ON PY2023

- For PY2023, Covered California approved Carrier-specific deviations to the Standard Benefit Designs due to Mental Health Parity and Equity Act (MHPAEA) calculation failure, including a higher MOOP in the Bronze Plan
- Moving forward, our goal is to create benefit designs that allow flexibility for plans to accommodate MHPAEA testing outcomes without significant deviations to our Standard Benefit Designs
- 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 MHSUD benefits they provide are no more restrictive than those on medical/surgical benefits
- California's regulators (DMHC and CDI) conduct review for MHPAEA compliance

MENTAL HEALTH PARITY TEST IMPACTS ON PY2023

We have explored some approaches to minimizing the variability encountered by Carriers due to MHPAEA calculation outcomes

Approach	Outcome
Setting MHSUD at $0 in benefit designs	Determined not to be feasible due to large AV impact to plan designs
Conversion of coinsurance to copays	Determined to be undesirable due to difficulty balancing AV impact with consumer out of pocket costs; would not solve MHPAEA compliance for all carriers
Leaving an AV buffer to allow Carriers to set MHSUD to $0 if this is required by MHPAEA calculations, without requiring additional modifications to SBD	Determined to be undesirable based on PY2023 designs due to the magnitude of the AV buffer required, especially in the Bronze plan
Lowered cost-sharing for MHSUD in Bronze plan to minimize AV impact of MHPAEA test failure	Determined to be best approach; we removed the deductible requirement from MHSUD in Bronze and left a small buffer to accommodate MHPAEA outcomes without additional deviations

2024 DRAFT PATIENT-CENTERED BENEFIT DESIGNS

Taylor Priestley MPH, MSW
Deputy Director, Health Equity and Quality Transformation Division

AV INCREASES FROM 2023 TO 2024

	Bronze		Silver				Gold		Platinum	
	HDHP	Standard	Silver 70	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%	+/-2%	+/-2%	+/-2%
2023 AV	64.17	64.73	71.68	74.18	87.88	94.88	80.11	81.92	89.75	91.76
2023 Additive Adjustments		0.00	-0.11	-0.32	-0.02	0.00				
2023 Final AV	64.17	64.73	71.57	73.86	87.86	94.88	80.11	81.92	89.75	91.76
2024 AV*	**65.05**	**65.34**	**73.04**	**75.08**	**88.86**	**95.49**	**81.16**	**82.75**	**90.31**	**92.14**

CCSB ONLY	Silver			Gold		Platinum	
	Copay	Coins	HDHP	Copay	Coins	Copay	Coins
AV Target	70	70	70	80	80	90	90
Deviation Allowance	+/-2%	+/-2%	+/-2%	+/-2%	+/-2%	+/-2%	+/-2%
2023 AV	71.46	71.77	71.71	80.49	78.96	88.80	90.71
2023 Additive Adjustments	0.19	0.16		0.00	-0.03		
2023 Final AV	71.65	71.93	71.71	80.49	78.93	88.80	90.71
2024 AV*	**69.44**	**69.77**	**72.41**	**80.67**	**78.84**	**89.42**	**91.17**

For illustrative purposes only.

*Draft AV does not include 2024 copay accumulation additive adjustment

Red text: AV is outside de minimis range

Green text: AV is within de minimis range

PROPOSED PY2024 PLAN DESIGNS – 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									-	-	-	-	-	-						$7,050
Medical Deductible										$5,400		$5,400		$800		$75		$6,300		
Drug Deductible										$150		$150		$50		$0		$500		
Coinsurance (Member)		10%		10%		20%		20%		30%		30%		20%		10%		40%		0%
MOOP		$4,500		$4,500		$8,700		$8,700		$9,100		$7,550		$3,150		$1,150		$9,100		$7,050
ED Facility Fee		$150		$150		$350		$350		$450		$450		$150		$50	X	40%	X	0%
Inpatient Facility Fee		10%		$225		30%		$330	X	30%	X	30%	X	20%	X	10%	X	40%	X	0%
Inpatient Physician Fee		10%		---		30%		---		30%		30%		20%		10%	X	40%	X	0%
Primary Care Visit		$15		$15		$35		$35		$50		$50		$15		$5	X	$60	X	0%
Specialist Visit		$30		$30		$65		$65		$90		$90		$25		$8	X	$95	X	0%
MH/SU Outpatient Services		$15		$15		$35		$35		$50		$50		$15		$5		$60	X	0%
Imaging (CT/PET Scans, MRIs)		10%		$75		25%		$75		$325		$325		$100		$50	X	40%	X	0%
Speech Therapy		$15		$15		$35		$35		$50		$50		$15		$5		$60	X	0%
Occupational and Physical Therapy		$15		$15		$35		$35		$50		$50		$15		$5		$60	X	0%
Laboratory Services		$15		$15		$40		$40		$50		$50		$20		$8		$40	X	0%
X-rays and Diagnostic Imaging		$30		$30		$75		$75		$95		$95		$40		$8	X	40%	X	0%
Skilled Nursing Facility		10%		$125		30%		$150	X	30%	X	30%	X	20%	X	10%	X	40%	X	0%
Outpatient Facility Fee		10%		$75		30%		$130		30%		30%		20%		10%	X	40%	X	0%
Outpatient Physician Fee		10%		$20		30%		$40		30%		30%		20%		10%	X	40%	X	0%
Tier 1 (Generics)		$7		$7		$15		$15		$19		$19		$6		$3	X	$17	X	0%
Tier 2 (Preferred Brand)		$16		$16		$60		$60	X	$60	X	$55	X	$25		$10	X	40%	X	0%
Tier 3 (Nonpreferred Brand)		$25		$25		$85		$85	X	$90	X	$85	X	$45		$15	X	40%	X	0%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%	X	15%		10%	X	40%	X	0%
Tier 4 Maximum Coinsurance	$250		$250		$250		$250		$250		$250		$150		$150		$500*			
Maximum Days for charging IP copay			5				5		-		-									
Begin PCP deductible after # of copays																	3 visits			
Actuarial Value																				
2024 AV (Draft 2024 AVC)	**91.88**		**90.74**		**81.92**		**81.54**		**71.83†**		**73.95†**		**87.86†**		**94.93**		**64.39†**		**64.94**	
2023 AV (Final 2023 AVC)	**91.76**		**89.75**		**81.92**		**80.11**		**71.57†**		**73.86†**		**87.86†**		**94.88**		**64.73**		**64.17**	
Enrollment as of June 2022	76,108				171,183				285,897		141,322		333,668		223,646		345,044		98,811	
Percent of Total enrollment	5%				10%				17%		8%		20%		13%		21%		6%	
Enrollment as of June 2022	21,755		54,353		90,229		80,954													
Percent of Total enrollment	29%		71%		53%		47%													

KEY:

Symbol / Color	Meaning
X	Subject to deductible
*	Drug cap applies to all drug tiers
†	Additive adjustment (included in AV)
(peach)	Increased member cost from 2023
(light green)	Decreased member cost from 2023
(red)	Does not meet AV
(yellow)	Within .5 of upper de minimis
(green)	Securely within AV

2024 PROPOSED BENEFIT PLAN DESIGN CHANGES

Proposed benefit changes for PY2024:

Platinum Coinsurance

- Increased generic drugs by $2 (from $5 to $7)
- Increased Tier 2 drugs by $1 (from $15 to $16)

Platinum Copay

- Increased generic drugs by $2 (from $5 to $7)
- Increased Tier 2 drugs by$1 (from $15 to $16)
- Decreased Inpatient Facility Fees by $25 (from $250 to $225)
- Decreased Skilled Nursing Facility by $25 (from 150 to $125)
- Decreased Outpatient Facility Fee by $25 (From $100 to $75)
- Decreased Outpatient Physician fee by $5 (from $25 to $20)

Gold Coinsurance

- Increased MOOP by $150 (from $8,550 to $8,700)
- Aligned coinsurance levels for outpatient facility/physician fees to match the Skilled Nursing and inpatient facility/ physician fees at 30%

Gold Copay

- Increased MOOP by $150 (from $8,550 to $8,700)
- Reduced Inpatient Facility copay by $20 (from $350 to $330)
- Reduced Outpatient Facility copay by $20 (from $150 to $130)

2024 PROPOSED BENEFIT PLAN DESIGN CHANGES

Proposed benefit changes for PY2024:

Silver 94

- ❑ Increased MOOP by $250 (from to $900 to $1,150)

Silver 87

- ❑ Increased drug deductible by $25 (from $25 to $50)
- ❑ Increased MOOP by $150 (from $3000 to $3,150)
- ❑ Aligned coinsurance levels for outpatient facility/physician fees to match the Skilled Nursing and inpatient facility/ physician fees (20%)
- ❑ Increased Tier 1 drugs by $1 (from $5 to $6); removed deductible for Tier 1 Generics

Silver 73

- ❑ Increased medical deductible by $650 (from $4750 to $5400)
- ❑ Increased drug deductibles by $120 (from $30 to $150)
- ❑ Increased MOOP by $300 (from $7,250 to $7,550)
- ❑ Increased Emergency Room copays by $50 (from 400 to $450)
- ❑ Increased copays by $5 for the following services: primary care, MH/SUD, speech therapy, occupational and physical therapy (OT/PT) (from $45 to $50); Specialist visits (from $85 to $90); x-rays (from $90 to $95)
- ❑ Aligned coinsurance levels for outpatient facility/physician fees to match the skilled nursing and inpatient facility/ physician fees at 30%
- ❑ Increased Tier 1 Generic drugs by $3 (from $16 to $19) cost share per script; removed deductible for Tier 1 Generics

Silver 70

- ❑ We made the same cost share changes as the Silver 73 plan with a few differences:
- ❑ Increased MOOP by $350 (from $8,750 to $9,100)
- ❑ Increased drug deductibles by $65 (from $85 to $150)
- ❑ X-rays costs share are the same as PY 2023 ($95)

2024 PROPOSED BENEFIT PLAN DESIGN CHANGES

Proposed benefit changes for PY2024:

Bronze

- ❑ Increased MOOP by $900 (From $8,200 to $9,100)
- ❑ Decreased Primary Care office visit, MHSUD office visit, OT/PT/Speech, by $5 (From $65 to $60)
- ❑ Removed deductible for MHSUD office visit
- ❑ Decreased Tier 1 Generic Drug by $1 (from $18 to $17)

Bronze HDHP

- ❑ Increased the Deductible and MOOP by $50 (From $7,000 to $7,050)

REVISION TO 2024 ENDNOTES

Minor revision to the 2024 endnotes:

- **Endnote #18** - The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, Podiatrists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services

COVERED CALIFORNIA FOR SMALL BUSINESS

PROPOSED PY2024 PLAN DESIGNS – COVERED CALIFORNIA FOR SMALL BUSINESS

Benefit	CCSB-only Platinum Coinsurance		CCSB-only Platinum Copay		CCSB-only Gold Coinsurance		CCSB-only Gold Copay		CCSB-only Silver Coinsurance		CCSB-only Silver Copay		CCSB-only Silver HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible														$2,850
Medical Deductible						$350		$250		$2,500		$2,500		
Drug Deductible						$0		$0		$300		$300		
Coinsurance (Member)		10%		10%		20%		20%		35%		35%		25%
MOOP		$4,500		$4,500		$7,800		$7,800		$8,600		$8,750		$7,500
ED Facility Fee		$200		$150	X	20%	X	$250	X	35%	X	35%	X	25%
Inpatient Facility Fee		10%		$250	X	20%	X	$600	X	35%	X	35%	X	25%
Inpatient Physician Fee		10%		---	X	20%		--	X	35%		35%	X	25%
Primary Care Visit		$15		$20		$25		$35		$55		$55	X	25%
Specialist Visit		$30		$30		$50		$55		$90		$90	X	25%
MH/SU Outpatient Services		$15		$20		$25		$35		$55		$55	X	25%
Imaging (CT/PET Scans, MRIs)		10%		$100		20%	X	$250	X	35%	X	$300	X	25%
Speech Therapy		$15		$20		$25		$35		$55		$55	X	25%
Occupational and Physical Therapy		$15		$20		$25		$35		$55		$55	X	25%
Laboratory Services		$15		$20		$25		$35		$55		$55	X	25%
X-rays and Diagnostic Imaging		$30		$30		$65		$55		$90		$90	X	25%
Skilled Nursing Facility		10%		$150	X	20%	X	$300	X	35%	X	35%	X	25%
Outpatient Facility Fee		10%		$100		20%	X	$300	X	35%	X	35%	X	25%
Outpatient Physician Fee		10%		$25		20%		$35		35%		35%	X	25%
Tier 1 (Generics)		$10		$5		$15		$15		$20		$19	X	25%
Tier 2 (Preferred Brand)		$25		$20		$50		$40	X	$75	X	$85	X	25%
Tier 3 (Nonpreferred Brand)		$40		$30		$80		$70	X	$105	X	$110	X	25%
Tier 4 (Specialty)		10%		10%		20%		20%	X	30%	X	30%	X	25%
Tier 4 Maximum Coinsurance	$250		$250		$250		$250		$250		$250		$250*	
Maximum Days for charging IP copay			5				5							
Begin PCP deductible after # of copays														
Actuarial Value														
2024 AV (Draft 2024 AVC)	**91.17**		**89.42**		**78.84**		**80.67**		**70.02†**		**69.71†**		**71.73**	
2023 AV (Final 2023 AVC)	**90.71**		**88.80**		**78.93†**		**80.49**		**71.93†**		**71.65†**		**71.71**	
Enrollment as of December 2022	19,243				30,607				20,805				1,691	
Percent of Total enrollment	27%				42%				29%				2%	

KEY	
X	Subject to deductible
*	Drug cap applies to all drug tiers
†	Additive adjustment (included in AV)
(orange)	Increased member cost from 2023
(light green)	Decreased member cost from 2023
(red)	Does not meet AV
(yellow)	Within .5 of upper de minimis
(green)	Securely within AV

2024 PROPOSED BENEFIT PLAN DESIGN CHANGES COVERED CALIFORNIA FOR SMALL BUSINESS

Proposed benefit changes for PY 2024:

- ❑ CCSB Silver Copay
  - Aligned all services subject to coinsurance at 35%(outpatient facility/physician fees, skilled nurse, inpatient, ER)

- ❑ CCSB Silver HDHP
  - Increased medical deductible by $150 (From $2,700 to $2,850)
  - Increased MOOP by $300 (from 7,200 to $7,500)

DENTAL UPDATES

DENTAL UPDATE

We have performed a thorough review of the CDT Code List in consultation with an Actuarial Firm

- List reviewed for completeness, accuracy, and alignment with the DentiCal Pediatric Benchmark Plan and with QDP Issuer input
  - 23 Minor modifications to existing codes for nomenclature but no significant change to overall benefit design
  - 10 New CDT Codes – these codes are new codes added to the 2023 CDT Book
  - 2 Deleted CDT Codes – these codes were retired and replaced
  - 9 Added CDT Codes – these codes were added based on QDP Issuer feedback and in consultation with an Actuarial Firm
  - 1 Updated Cost Share – D3348 (ped/adult), changed from $365 to $350

DENTAL UPDATE

Changes to CDT Codes

- ❑ Teledentistry CDT Codes – D9995 and D9996, changed from “Not Covered” to “No Charge” for Pediatric
- ❑ A new Endnote will be added to 2024 Dental SBD for both Pediatric and Adult Dental Benefit Notes: “To the extent the dental plans can offer Teledentistry, it would be offered at no charge.”

			Pediatric Dental EHB	*Adult Dental
			Up to Age 19	19 and Older
Procedure Category	**CDT Code**	**Updated CDT-24~~23~~ Nomenclature**	**In-Network Member Cost Share**	**In-Network Member Cost Share**
Adjunctive General Services	D9995	Teledentistry - synchronous; real-time encounter	No Charge ~~Not Covered~~	No Charge
	D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Charge ~~Not Covered~~	No Charge

NEXT STEPS

- Final 2024 proposed benefit designs will be presented for action in April 2023
  - Benefits may need (typically minor) revisions after March due to late changes in the final version of the AV Calculator and Notice of Benefits and Payment Parameters

COVERED CALIFORNIA

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.

2024 QUALIFIED HEALTH PLAN ISSUER MODEL CONTRACT APPENDIX

2024 PROPOSED REVISIONS FOR ATTACHMENT 2: PERFORMANCE STANDARDS WITH PENALTIES (1 OF 2)

Performance Standards With Penalties	2023 % at Risk	Proposed 2024 % at Risk	Proposed 2024 Change and Rationale
1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%	5%	*No proposed changes*
2. Reducing Health Disparities: Demographic Data Collection – Spoken and Written Language	10% (for reporting)	5%	Revised to 5% total penalty for spoken ~~and~~ **or** written language
3. Reducing Health Disparities: Disparities Reduction Intervention	10%	10%	*No proposed changes*
4. National Committee for Quality Assurance (NCQA) Health Equity Accreditation	0%	10%	*No proposed changes*
5. Primary Care Payment	10%	10%	*No proposed changes*
6. Primary Care Spend	10% (for reporting)	5%	*No proposed changes*
7. Payment to Support Networks Based on Value	10% (for reporting)	10%	*No proposed changes*
8. Quality Rating System – QHP Enrollee Survey Summary Rating	20%	20%	*No proposed changes*

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

COVERED CALIFORNIA

2024 PROPOSED REVISIONS FOR ATTACHMENT 2: PERFORMANCE STANDARDS WITH PENALTIES (2 OF 2)

Performance Standards With Penalties	2023 % at Risk	Proposed 2024 % at Risk	Proposed 2024 Change and Rationale
9. HEI Data Submission	20%	20%	Added patient level data (PLD) submission standards to ensure complete and accurate submissions; updated refence list of California healthcare facilities
~~10. Dental Quality Alliance (DQA) Pediatric Measure Set~~	~~0%~~	~~5%~~	Removed to add measure-specific oral health performance standards aligned with DHCS priority measures and recently added non-QRS HEDIS measures
10. Oral Evaluation, Dental Services (OEV-CH-A) (NQF #2517) (Pediatric)	0%	2.5%	
11. Topical Fluoride for Children, Dental Services (TFL-CH-A) (NQF #2528) (Pediatric)	0%	2.5%	
Total	**100%**	**100%**	

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