COVERED CALIFORNIA POLICY AND ACTION ITEMS

January 18, 2024 Board Meeting

UPDATE TO CONFLICT-OF-INTEREST CODE

Allison Pease, Assistant General Counsel
Office of Legal Affairs

BACKGROUND

- The Political Reform Act requires state agencies to adopt a Conflict of Interest Code identifying designated positions in the agency required to disclose certain financial interests. Agencies are also required to review their codes every two years and update the code when positions change or are created.
- As discussed at the September 21, 2023 Board meeting, Covered California seeks to revise its Code through regulation to update the list of designated positions and clarify which financial interests must be disclosed.
- Staff initiated a 45-day public comment period, which ran from October 20, 2023 to December 4, 2023. No comments were received.
- No substantive changes have been made since the last discussion.

NEXT STEPS

- After Board adoption at this meeting, staff will submit the updated Conflict of Interest Code to both the:
  - Fair Political Practices Commission for final review and approval; and
  - Office of Administrative Law for approval and filing with the Secretary of State.

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.
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- 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.

NAVIGATOR PROGRAM
REQUEST FOR APPLICATION FOR GRANT CYCLE 2024-2027

Terri Convey, Director
Outreach and Sales Division

BACKGROUND

- In May 2023, the Board approved a one-year contract extension to the existing Navigator Program for Fiscal Year 2023-2024. The contract extension represents $7.865 million in annual funding and is the fifth and final year for the 2019 to 2024 grant cycle.

- Covered California in preparation for the upcoming grant cycle conducted an extensive market survey to inform the development of an enhanced program model to better serve communities targeted by the Navigator Program.

‘LISTEN AND LEARN’ APPROACH TO THE NEXT GRANT CYCLE

We spoke to more than a hundred persons, organizations and entities

Covered California met with Navigators, Certified Application Entities, consumer advocates, State-Based Marketplaces, Community-Based Organizations, DHCS Navigator Program representatives, health plans, and internal stakeholders *to explore how we might shape the Navigator Program to better address getting people covered, especially uninsured Californians in hard-to-reach and underserved communities.*

What we heard

- Consumers need person-to-person help
- Many consumers are new to health insurance and have limited proficiency in English
- It takes a long time over multiple sessions to enroll one person into coverage
- Many said that even a small monthly premium can be a barrier to enrollment
- 8 out of 10 people assisted are Medi-Cal eligible
- Many Navigators said the program did not recognize the level of effort to reach and enroll people from vulnerable communities
- Many Navigators work with CHWs and see the value of leveraging this workforce
- Many asked for visibility into Medi-Cal systems
- Don’t fix what is not broken

PRESERVING WHAT WORKS

Navigator entities are awarded block grants paid in five equal installments over the contract period. Grant funds are used to fulfill the requirements in the Statement of Work. The enhanced program model preserves and builds on these features.

Block Grant Funding

- Predictable revenue stream
- Discretionary use of funds
- Administrative ease

Statement of Work

- Hiring and training Certified Enrollment Counselors
- Providing in-person assistance
- Providing culturally and linguistically appropriate services
- Conducting outreach and education to diverse communities
- Providing application assistance and post-enrollment support
- Effectuating enrollment into Covered California

REWARDING OUTREACH AND SUPPORT TO VULNERABLE COMMUNITIES

The Navigator Program serves a strategically important role to reach, educate and enroll people from the state's diverse and vulnerable populations. To better align program incentives with this important mission, Covered California is proposing more weighting be provided to outreach and application assistance when measuring performance. Covered California is also recommending a supplemental outreach grant focused exclusively on outreach and education. Lastly, we are enhancing the enrollment bonus program.

1 Performance Points

- Points assigned for outreach
- Points assigned for application assistance
- Points assigned for enrollment
- 50% weighting for outreach and application assistance
- 50% weighting for enrollment

2 Supplemental Outreach Grant

- Provides additional funding up to $200,000
- Funds outreach efforts to targeted communities
- Funds to be used to contract with CBOs with influence and reach in targeted communities

3 Enhanced Enrollment Bonus

- Pays $30 per member above annual enrollment goal

EXPANDING TODAY'S NAVIGATOR PROGRAM

1 Increase number of Navigator Organizations participating in the program

Expand footprint into targeted communities with the addition of new Navigator grantees

- Launch communications campaign to build awareness about the upcoming Request for Application
- RFA Webinar in February 2024

2 Expand outreach to targeted communities through Supplemental Grants

Navigators can apply for optional grant to expand their reach into targeted communities

- Enables grantees to contract with CBOs that have reach and influence in targeted communities

Ethnicities
African
African American
American
American Indian
Armenian
Cambodian
Caucasian
Chinese
Filipino
Hawaiian
Hispanic
Hmong
Japanese
Korean
Laotian
Mid-Eastern
Russian
Southeast Asian
Ukrainian
Vietnamese
Other

FUNDING RECAP OF MOST RECENT FIVE YEARS, 2019-2024

- Annual program funding has increased from $6.5 million to $7.865 million per year reflecting two 10% increases in funding to cover rising costs
- Enrollment goal has remained constant while actual enrollment has fluctuated downward

Grant Year	Program Funding	# of Entities	Funding Levels	Uninsured Rate	Enrollment Goal	Actual Enrollment
2023-24	$7,865,000	37	$60,500-$605,000	TBD	36,718	37,000 FORECAST
2022-23	$7,150,000	37	$55,000-$550,000	6.5%	36,576	38,182
2021-22	$6,500,000	40	$50,000-$500,000	7.0%	36,293	45,287
2020-21	$7,150,000	41	$55,000-$550,000	6.0%	36,143	49,267
2019-20	$6,500,000	42	$50,000-$500,000	7.7%	36,007	54,409
Total	**$35,165,000**					

NAVIGATOR PROGRAM BUDGET FOR FY 2024-2025

Budget for new program model maintains core funding but increases spending to grow the program

- Enhanced Bonus
- Supplemental Outreach Grant
- More participating Navigators

Funding	# of Grantees	Low Projection	Medium Projection	High Projection
Core Funding	36	$7,774,000	$7,774,000	$7,774,000
Enhanced Bonus	36	$300,000	$500,000	$1,000,000
Supplemental Outreach	TBD	$750,000	$1,000,000	$1,500,000
Core Funding for new Entities	TBD	$500,000	$750,000	$1,000,000
Total		**$9,324,000**	**$10,024,000**	**$11,274,000**

NAVIGATOR PROGRAM FUNDING RECOMMENDATION

- Covered California recognizes that its Navigator Program is its primary channel partner to reach and enroll some of California's hardest-to-serve communities. It is our recommendation to fund the enhanced program model at the high level which will provide resources to add the greatest number of new partners and participating entities.

- Covered California is recommending an annual funding level up to, but not to exceed $11,300,000 per year, and $33,900,000 for the three-year funding cycle covering fiscal years 2024-25, 2025-26 and 2026-27.

- Further, Covered California is recommending continuing the existing entity funding levels, recently augmented with a cumulative 20% increase and shown below.

Grant Year(s)	Program Funding	Funding Levels
2024-2025 (1)	**$11,300,000**	**$60,500-$605,000**
2024-2027 (3)	**$33,900,000**	**$60,500-$605,000**

REQUEST FOR APPLICATION (RFA) TIMELINE FOR GRANT CYCLE 2024-2027

Activity	Approximate Date
Board Action on Navigator Program Model and RFA Issuance	January 18, 2024
Release Navigator Program FY 2024-27 RFA Solicitation Package and Timeline via HBEX website and email list serv	February 1, 2024
RFA Solicitation Webinar	February 7, 2024
RFA Application Submission Deadline	March 15, 2024
Grant Selection & Award Process	March 16, 2024 – April 30, 2024
Intent to Award	May 1, 2024
Grant Execution and Awardee Onboarding	May 6, 2024 – June 28, 2024

RECOMMENDATION FOR ACTION

Covered California requests authority to issue a Request For Application (RFA) and execute contracts with grantees for terms not to exceed three years under the enhanced Navigator Program model for the FY 2024-2027 grant cycle, which will:

- Be funded in a total amount not to exceed $33.9 million for the three-year contract period, with each year funded at no more than $11.3 million;
- Allow Covered California the option to renew the contracts for two additional one-year terms;
- Preserve the previously increased grantee funding levels ranging from $60,500 to $605,000; and offer the enhanced enrollment bonus;
- Provide the Supplemental Outreach Grant as an option in the Navigator Program for Fiscal Year 2024-2025 with funding levels ranging from $50,000 to $200,000.

PUBLIC COMMENT

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2025 QUALIFIED HEALTH PLAN ISSUER CONTRACT AND CERTIFICATION PROCESS

2025 QUALIFIED HEALTH AND DENTAL PLAN ISSUER MODEL CONTRACT

James DeBenedetti, Director
Plan Management Division

2025 MODEL CONTRACT UPDATE

- The Qualified Dental Plan Issuer Model Contract for the Individual and Small Business markets was significantly refreshed last year for the 2024-26 period.
- Proposed changes for the 2025 Individual and Small Business health and dental contract amendments are minor (primarily for purposes of clarification) outside of Attachments 1, 2, and 4.
- Responses to comments received on the proposed changes to the 2025 contracts have been posted at: https://hbex.coveredca.com/stakeholders/plan-management/contract-listings/2025/

2025 PLAN YEAR AMENDMENT ATTACHMENTS 1, 2, AND 4

S. Monica Soni, MD
Chief Medical Officer
Health Equity and Quality Transformation

2023-2025 ADVANCING EQUITY, QUALITY AND VALUE PRINCIPLES AND STRATEGIC FOCUS AREAS

Quality is central

Equity is quality

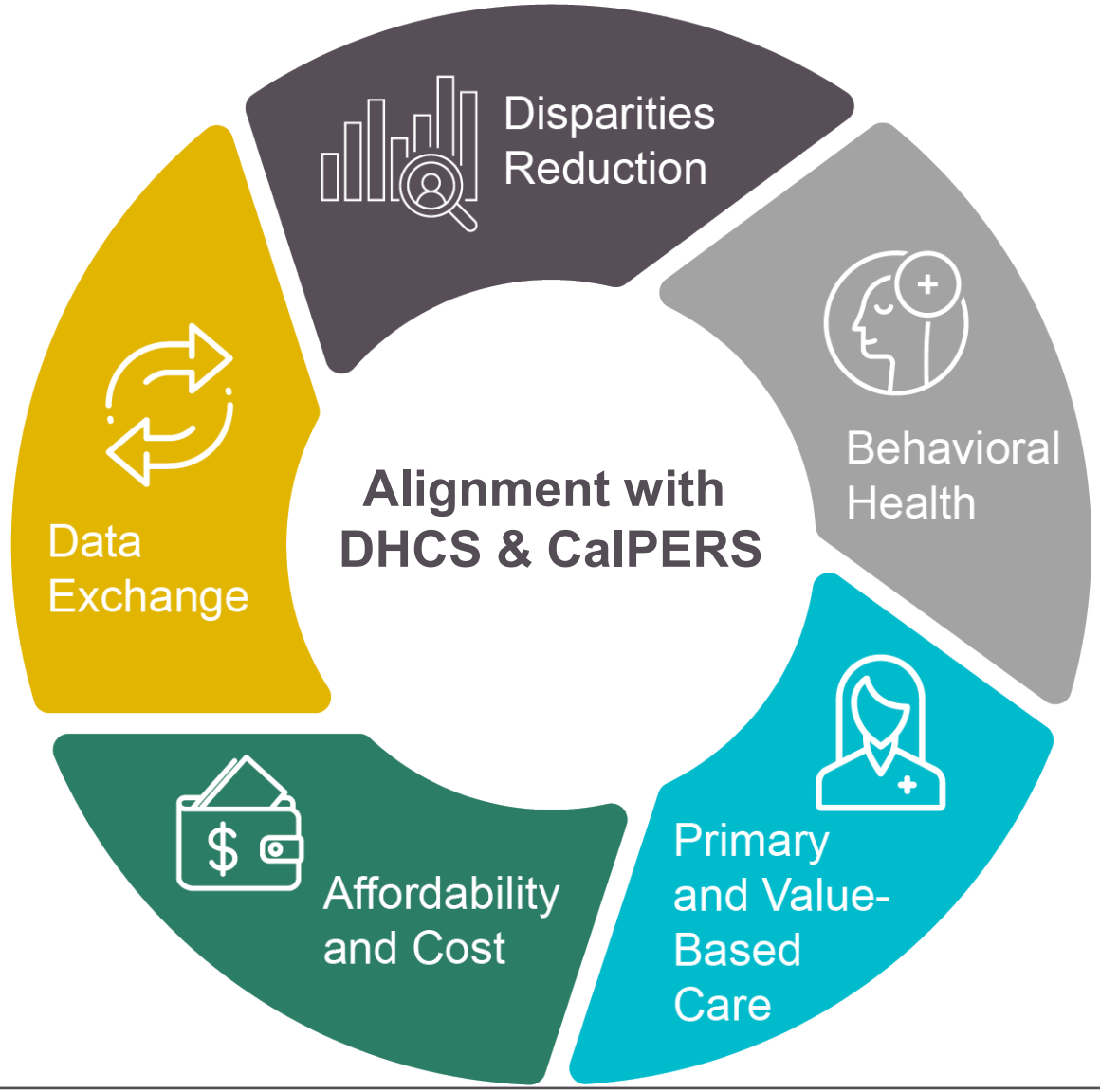
Measures that matter

Make quality count

Amplify through alignment

Promote public good

Care about cost



SUMMARY OF PROPOSED 2025 REVISIONS

Attachment 1 Advancing Equity, Quality, and Value

Article 1 - Equity and Disparities Reduction

- Adding language to address NCQA HEA compliance requirements by year-end 2025 if not already achieved
- Updates to the Patient Level Data (PLD) File measures resulting from QRS measures changes

Article 6 - Certification, Accreditation, and Regulation

- Adding language to include NCQA HPA compliance requirements by year-end 2025 if not already achieved

Attachment 2 Performance Standards with Penalties

Healthcare Evidence Initiative (HEI) Data and Patient Level Data (PLD) Submissions Data Submission specific to HEI

- Clarification of requirements in Performance Standard 9
- Discontinuing performance penalty for PLD File data

SUMMARY OF PROPOSED 2025 REVISIONS

Attachment 4 Quality Transformation Initiative

- Defining QHP eligibility requirements, consistent with CMS Quality Rating System governance
- Updated language to finalize measures payment amount of up to 2.8% gross premium
- Establishing program elements including collection and use of funds and adding key clarifications around authority, accountability and process for the Quality Transformation Fund

2025 PROPOSED REVISIONS
ATTACHMENT 1: ADVANCING EQUITY, QUALITY, AND VALUE

Attachment 1 Article	Summary of Revisions
Article 1: Equity and Disparities Reduction	• Adding language to address NCQA HEA compliance requirements by year-end 2025 if not already achieved • Updates to the Patient Level Data (PLD) File measures resulting from QRS measures changes
Article 2: Behavioral Health	• No proposed changes
Article 3: Population Health	• No proposed changes
Article 4: Delivery System and Payment Strategies to Drive Quality	• No proposed changes
Article 5: Measurement and Data Sharing	• No proposed changes
Article 6: Accreditation	• Adding language to include NCQA HPA compliance requirements by year-end 2025 if not already achieved

2025 PROPOSED REVISIONS
ATTACHMENT 2: PERFORMANCE STANDARDS WITH PENALTIES

Attachment 2 Performance Standards	Summary of Revisions
Attachment 2	Removal of reference to Initial Contractor Performance Standard Evaluation Report Updates language to reflect current practice
Attachment 2 Standard 9	Removal of PLD files from data quality performance standard as files received required little engagement for corrections, performance penalty not necessary
Attachment 2 Standard 9.1	Update contract language to support a standard HEI Submission Schedule. Removal of detailed language on methodology because details on submission requirements are included in separate methodology document.
Attachment 2 Standard 9.2	No changes
Attachment 2 Standard 9.3	Removal of reference to provider type; Taxonomy is more detailed and granular and is more useful for analytic purposes. Removal of reference to drugs claims as it was originally included in error.
Attachment 2 Standard 9.4	Removal of Tax ID Number (TIN) submission requirements, NPI is the preferred identifier for individual primary care providers
Attachment 2 Standard 9.5	Removal of Tax ID Number (TIN) submission requirements, NPI is the preferred identifier for individual primary care providers

2025 PROPOSED REVISIONS
ATTACHMENT 2: PERFORMANCE STANDARDS WITH PENALTIES

Attachment 2 Performance Standards	Summary of Revisions
Attachment 2 Standard 9.6	Changes made to accommodate differences in financial field submissions between fee-for-service claims and encounters, based on product type.
Attachment 2 Standard 9.7	Clarifying edit that reflects vendor's process for matching medical claims and encounters, drug claims, or capitation records to a current or prior enrollment record to accommodate claims received outside of enrollee's enrollment period.
Attachment 2 Standard 9.8	Clarifying edit that reflects vendor's process for matching enrollees to known insurance products; matching enrollees to medical claims and encounters, drug claims, and capitation records is addressed in standard 9.7.
Attachment 2 Standard 9.9	Clarifying edit to add reference to tax amount which is included in rule vendor applies when assessing drug financial reconciliation.
Attachment 2 Standard 9.10	No changes

2025 PLAN YEAR AMENDMENT
ATTACHMENT 4
QUALITY TRANSFORMATION INITIATIVE (QTI)

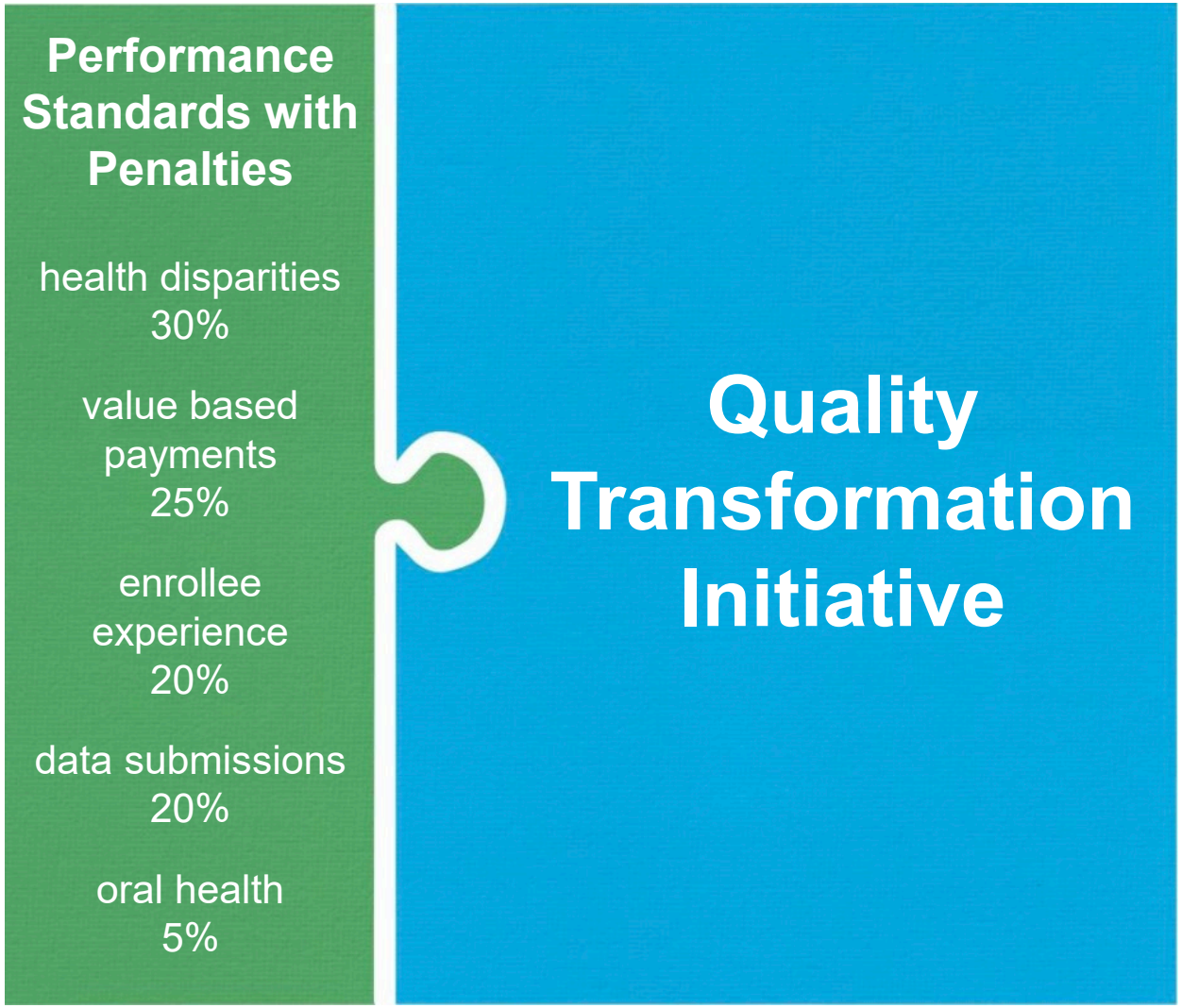
MAKING QUALITY COUNT: CONTRACT PROVISIONS ON QUALITY

For existing carriers: “25/2/2” allows for selective contracting and removal from marketplace for consistent poor performance on quality measures.

Quality Transformation Initiative: assesses quality improvement payments up to 66th percentile national performance.

FINANCIAL INCENTIVES FOR QUALITY AND EQUITY

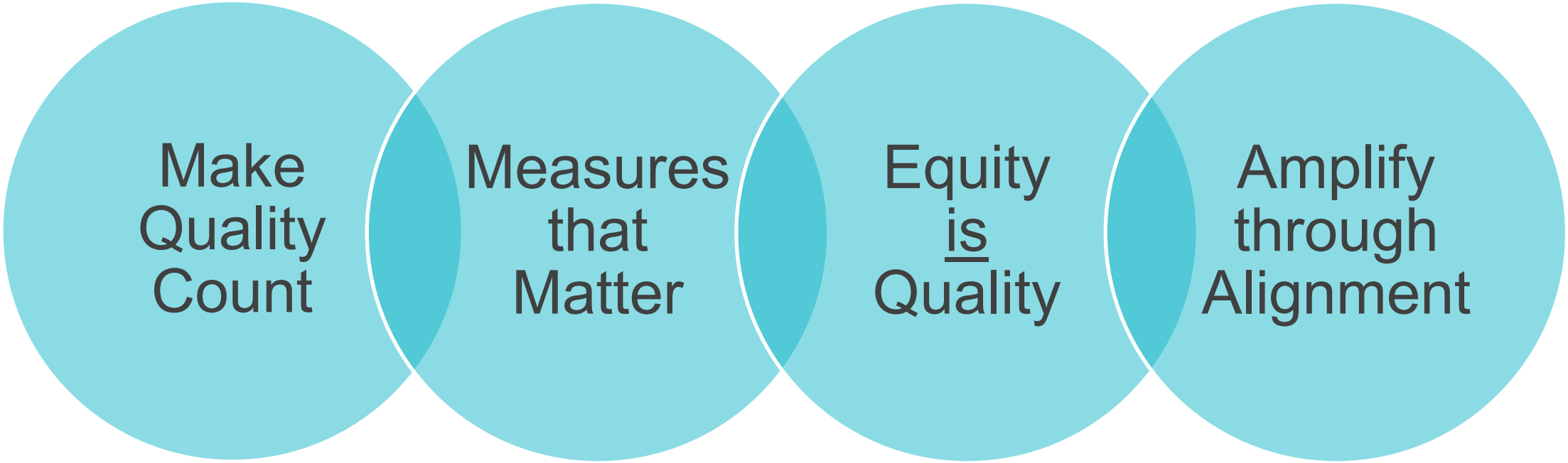
0.2% of premium at risk across 5 domains



0.8% of premium at risk across 4 measures

2023: Total 1% at risk | **2024:** Total 2% at risk | **2025:** Up to 3% at risk

QUALITY TRANSFORMATION INITIATIVE



0.8% to 4% premium at risk for

a small set of clinically important measures

stratified by race/ethnicity

selected in concert with other public purchasers*

*Public purchasers includes CalPERS and DHCS/Medi-Cal

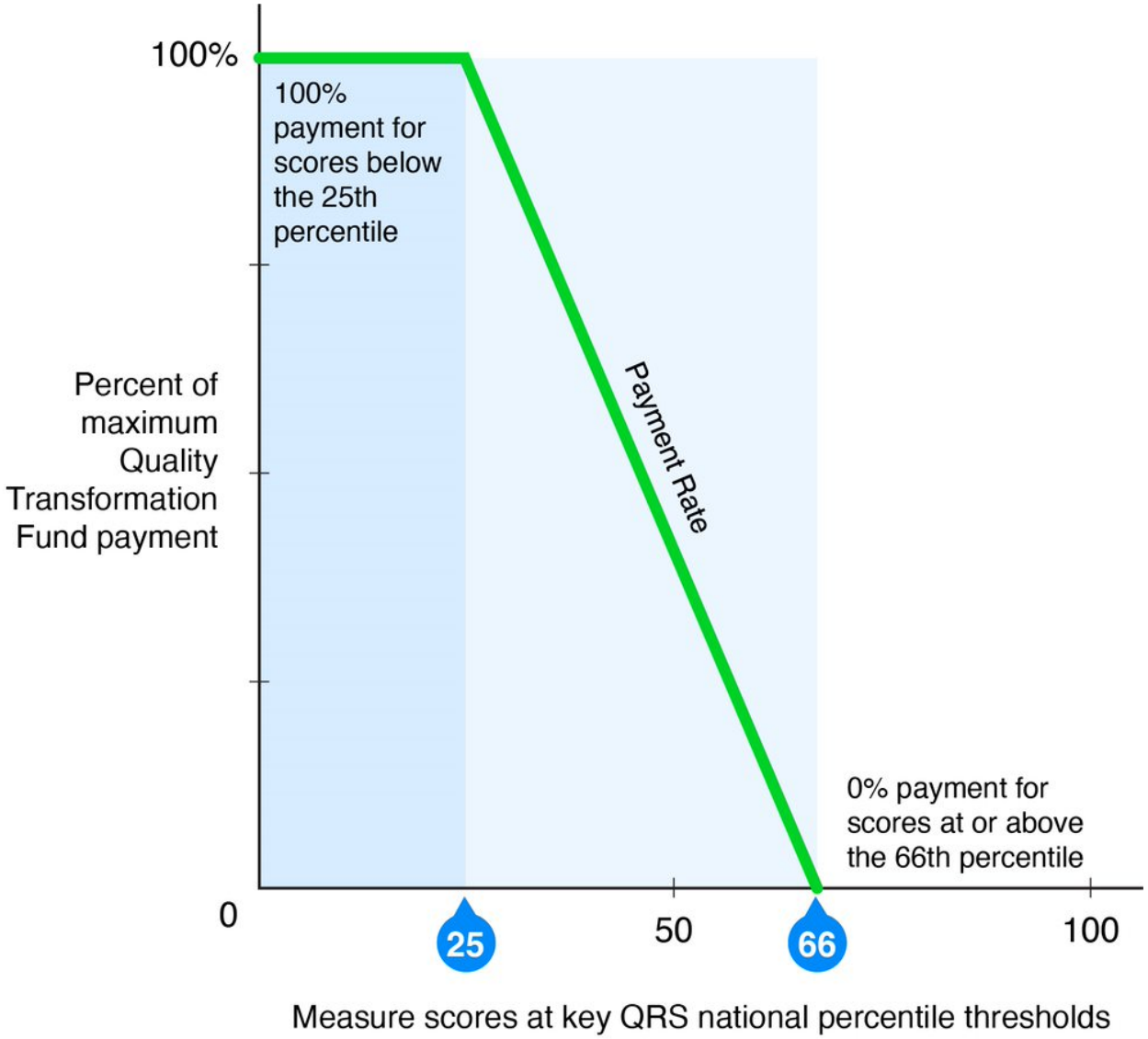
QTI MEASURES

Core Measures*	Clinical Context
Blood Pressure	Key risk factor for cardiovascular disease (heart attacks and strokes), the leading cause of death in the United States
Diabetes (A1c control)	~50% Californians have prediabetes or diabetes, which is a leading cause of blindness and amputation and key risk factor for cardiovascular disease
Colorectal Cancer Screening	Cancer is the second leading cause of death after heart disease, and colorectal cancer is the second leading cause of cancer death after lung cancer. Screening reduces the risk of developing and dying from CRC cancer by 60-70%
Childhood Immunizations	Childhood immunizations prevent 10.5m diseases annually. For every $1 spent on immunizations, there is as much as $29 in savings
Reporting only	Depression Screening and Follow-Up for Adolescents and Adults
Reporting only	Medication Treatment for Opioid Use

*All measures will be stratified by race/ethnicity

QTI PAYMENT STRUCTURE

- Premium at risk for payment 0.8% in PY2023, 1.8% in PY2024, & up to 2.8% in PY2025
- Full per measure payment if the measure score is below the 25th national percentile
- Per measure payment at a declining constant rate for each measure score between the 25th and 66th national percentile
- No payment if the measure score is at or above the 66th national percentile



QTI 2025 AMENDMENT STAKEHOLDER ENGAGEMENT

ADMINISTRATION OF QUALITY TRANSFORMATION FUND

The proposed 2025 amendment adds key clarifications around authority, accountability and process for the Quality Transformation Fund.

- Making payments **does not absolve Contractor of its responsibility** to engage in quality improvement activities to meet or exceed required QTI benchmarks, and engage in other innovative quality improvement strategies
- **Covered California shall manage the collection and administration** of payments
- Covered California shall approve use of payments within the Quality Transformation Fund for one or more **Population Health Investments**.
- Covered California shall engage with stakeholders, including QHP Issuers, in developing **recommendations for Population Health Investments** and program designs.
- Based on engagement with stakeholders, **Covered California, in its sole discretion, shall establish permissible Population Health Investments** for Contractor to implement as specified below.

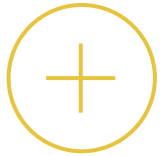
GUIDING PRINCIPLES FOR USE OF FUNDS

Centered on goal to improve health outcomes for Covered California enrollees

Equity First: funds should preferentially focus on geographic regions or communities with the largest identified gaps in health and quality among California subpopulations

Direct: use of funds should lead to measurable improvements in quality and outcomes for enrollees that are related to QTI Core Measure performance

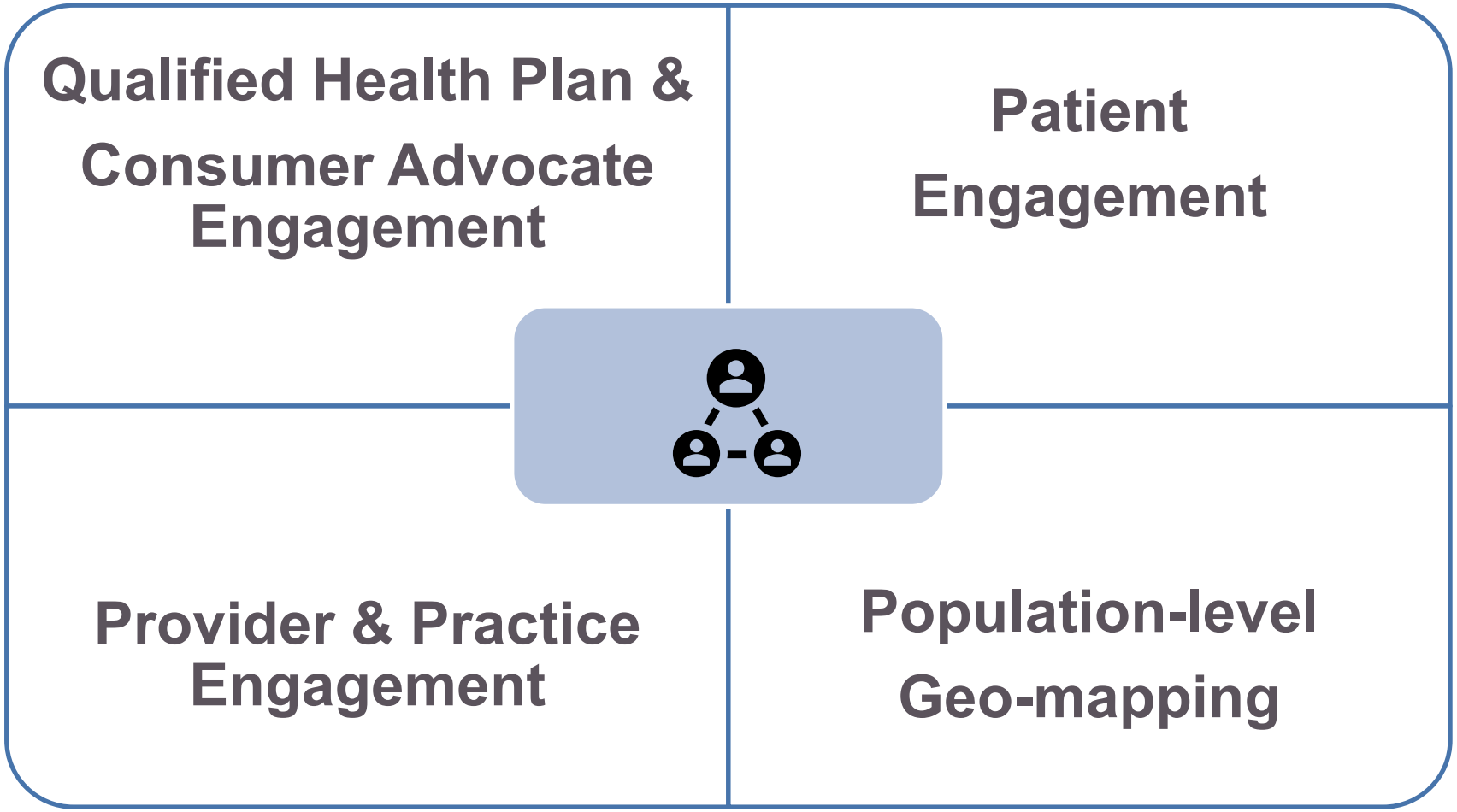
Evidence-based: use of funds should be grounded in approaches that have established evidence of success in driving improvements in quality or outcomes



Additive: funds should be used to advance quality in a currently underfunded arena

POPULATION NEEDS ASSESSMENT

Covered California is currently leading a multipronged assessment to understand existing supports and barriers to enrollees achieving good health and wellness to inform selection of Population Health Investments.



PLAN ENGAGEMENT

Goal

To gain input from QHP issuers on readiness for QTI, current successes and challenges and feedback on use of funds for Population Health Investments

Methods

1:1 listening sessions with QHP issuers held from July to September

Covered California posed open-ended questions to issuers covering infrastructure improvement opportunities, administrative challenges, and possible quality improvement activities that CCA can support

Themes and Learning

- Support for increased investment in member education and population health outreach
- Desire for reducing out-of-pocket burden for members
- Concerns about redirection of funds from lower performing plans who need support
- Caution about impact of program on premiums

Next Steps

Engagement will continue in 2024 including collaboration on broader population needs assessment findings and selection of Population Health Investments

PATIENT ENGAGEMENT

Goal

To gain insights into the challenges and barriers members face in managing their health conditions that will inform selection of Population Health Investments

Methods

Outbound calls made to members with a diagnosis of diabetes and/or hypertension to gather qualitative feedback on successes and challenges with chronic disease management

Themes and Learning

- Attempts to adopt healthier habits, although **barriers like affordability or time** hinder efforts
- Rising out of pocket and premium costs pose **significant financial challenges** for some
- Difficulties finding culturally sensitive care or desired providers
- **Challenges with access** including rushed consultations and long wait times for visits

Next Steps

Engagement sessions will continue in 2024 to inform Population Health Investment selection

CONSUMER ADVOCATE ENGAGEMENT

Goal

To gain input from advocates on history and options for use of funds for Population Health Investments

Methods

Discussion sessions with consumer advocates held from July to October

Covered California shared guiding principles and framework for administration of funds mechanism

Themes and Learning

- Support for re-evaluation of use of funds and guiding principles
- Caution about **unique profile of Covered California members** as distinct from Medi-Cal and other Commercial lines of business while aligning with other public purchasers
- Desire for continued input and participation in next phase

Next Steps

Engagement will continue in 2024 including collaboration on broader population needs assessment findings and selection of Population Health Investments

PROVIDER ENGAGEMENT

Goal

To gain insights into the challenges and barriers practices face in delivering quality care for Covered California members for consideration in Population Health Investment selection

Methods

1:1 listening sessions with practices with large volumes of attributed Covered California members

Themes and Learning

- **Payor-agnostic practice patterns** and workflow
- Challenges with access for patients in primary care, pediatrics, and ancillary services/preventive screenings
- **Struggles with workforce** turnover: both provider and nursing staff
- **Sub-optimal data exchange**, lack of interoperability & inconsistent EMR use in small, independent practices
- Desire to engage with CBOs, but varying levels of capacity and maturity

Next Steps

Engagement sessions will continue in 2024 to inform Population Health Investment selection

GEO-MAPPING FOR POPULATION-WIDE INSIGHTS

Goal

To gain understanding of population-wide environmental experiences to help inform Population Health Investment selection with equity-first lens

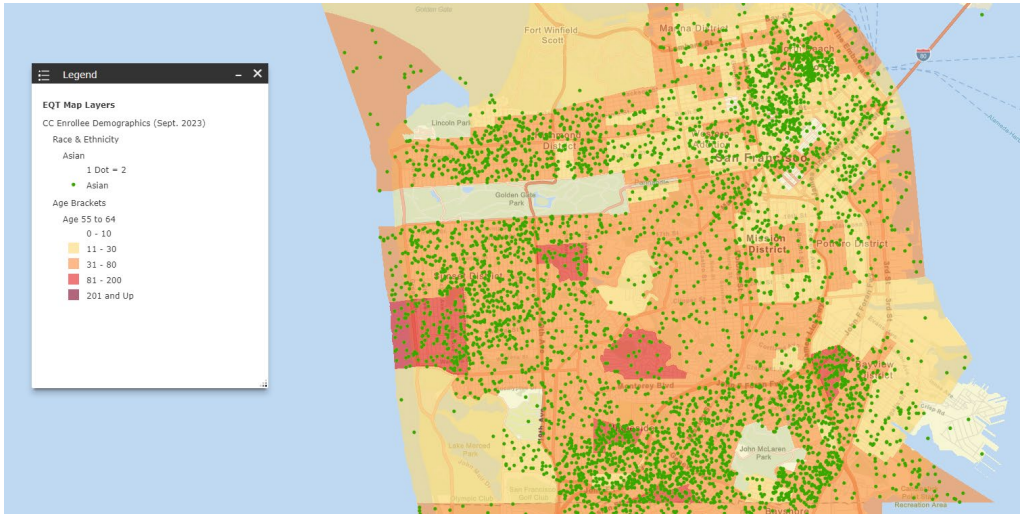
Methods

Create a GIS map with base layer of current enrollee data, including age, race/ethnicity, QHP designee, FPL bracket, and then layer on Healthy Places Index and Environmental Justice Index

Next Steps

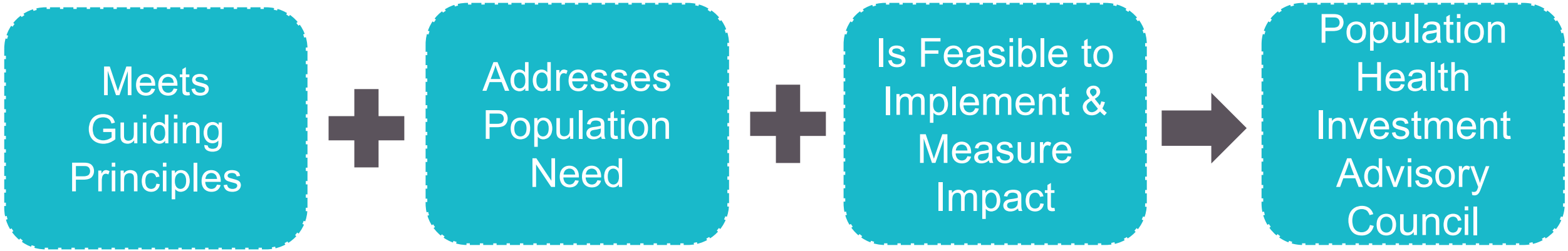
Establish longitudinal understanding of the data, a replicable dataset for subsequent yearly comparative analyses

Continue learning sessions with Consumer Advocates, subject matter experts as map is built



Covered California Enrollee Asian-American Population overlaid on top of Age Bracket 55 to 64

POPULATION HEALTH INVESTMENTS: SELECTION CRITERIA



A prioritized list of Population Health Investments will be presented at Plan Management Advisory Workgroup and Covered California Board in 2024

EVALUATION OF POPULATION HEALTH INVESTMENTS

Impact of Population Health Investments on quality and equity will be assessed continuously.

- Covered California shall **continuously assess the success** of the Quality Transformation Fund at achieving measurable quality improvements.
- Based on outcomes from Population Health Investments, feedback from stakeholders, and availability of funds, Covered California **may consider revising or establishing additional programs, opportunities, and uses for payments** made to the Quality Transformation Fund.
- If Covered California in its sole discretion determines that Contractor's Population Health Investment has not achieved improvements in quality and outcomes, or otherwise **does not best serve Contractor's enrollees, Covered California may request changes in Contractor's Population Health Investment program design** or may terminate Contractor's Population Health Investment.

2025 PROPOSED REVISIONS: ATTACHMENT 4 CHANGES (1 OF 2)

INTRODUCTION, SECTIONS 1.01, 1.02, AND 1.04

Notable Changes	Rationale
QTI Eligibility Requirements: Consistent with CMS for QRS reporting, QHP Issuers with a minimum of two years of QRS reportable scores will be subject to QTI performance requirements	Provide additional information on QTI eligibility requirements for new entrants
1.01.2 Health Disparities Reduction Requirements: Updated language to specify that QTI health equity methodology will be integrated in 2026 contract	Update to timeline to account for health equity methodology which is being refined alongside other public purchasers
1.02 Benchmarks and Payments to the Quality Transformation Fund: Updated language for MY2025 measure payment amount (up to 2.8%) and outlined accountability expectations	Reinforce the continued need for QHPs to continue to improve performance on measures despite any payments that may be made Confirm the maximum payment amount for MY2025
1.04 Administration of the Quality Transformation Fund: Covered California shall manage the collection, administration and approved uses of payments	Clarification of administration of the payments

2025 PROPOSED REVISIONS: ATTACHMENT 4 CHANGES (2 OF 2)

SECTIONS 1.05, 1.06, 1.07

Notable Changes	Rationale
1.05 Population Health Investments: Incorporates guiding principles for use of funds, implementation of population health investment, tracking of expenses, and evaluation requirement	Outline of intent to create targeted population health investments following guiding principles
1.06 Unspent Funds: Good faith attempt to use payments made in the same calendar year	Clarification of cycle of funds flow
1.07 Ongoing Assessment of the Quality Transformation Fund: Covered California shall continuously assess the success of the Quality Transformation Fund at achieving measurable quality improvements	Outline expectation for continuous re-assessment of program impact at achieving quality outcomes, especially as amount of premium at risk increases in subsequent years

2025 QUALIFIED HEALTH AND DENTAL PLAN CERTIFICATION APPLICATION

James DeBenedetti, Director
Plan Management Division

CERTIFICATION APPLICATION UPDATES

Qualified Health Plan (QHP) The QHP Contract period is 2023 - 2025.

Currently contracted QHPs will have reduced application response requirements. New entrants will complete the entire application.

Qualified Dental Plan (QDP) The QDP Contract period is 2024 - 2026.

Currently contracted QHPs will have reduced application response requirements. New entrants will complete the entire application.

Plan Year 2025 Certification Health and Dental Applications will be open to all Applicants.

PUBLIC COMMENT

- The four draft applications and crosswalks were posted on Monday, 10/16/23 with public comment due back on Monday, 10/30/23.
- The Plan Management and Health Equity and Quality Transformation Divisions received a total of 18 public comments across the four Applications.
- The comments were seeking clarity for instructions, accreditation requirements, and updated contract compliance.
- The Public Comment Summary is available at: https://hbex.coveredca.com/stakeholders/plan-management/qhp-qdp-certification/

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 and QDP 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 2025 CERTIFICATION MILESTONES

Milestone	Date
Release Draft 2025 QHP & QDP Certification Applications	October 16, 2023
Draft Application Comment Periods End	October 30, 2023
Plan Management Advisory: Benefit Design & Certification Applications Policy Recommendation	January 2024
January Board Meeting: Discussion of Benefit Design & Certification Applications Policy Recommendation	January 18, 2024
Letters of Intent Accepted	February 1-15, 2024
Final AV Calculator Released*	February 2024
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 2024
March Board Meeting: Anticipated approval of 2025 Patient-Centered Benefit Plan Designs & Certification Applications	March 2024
QHP & QDP Applications Open	March 1, 2024
QHP & QDP Application Responses (Individual and CCSB) Due	May 1, 2024
Evaluation of QHP Responses & Negotiation Prep	May – June 2024
QHP Negotiations	June 2024
QHP Preliminary Rates Announcement	July 2024
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2024
Evaluation of QDP Responses & Negotiation Prep	June – July 2024
QDP Negotiations	July 2024
CCSB QHP Rates Due	July 2024
QDP Rates Announcement (no regulatory rate review)	August 2024
Public Posting of Proposed Rates	July 2024
Public Posting of Final Rates	September – October 2024

*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

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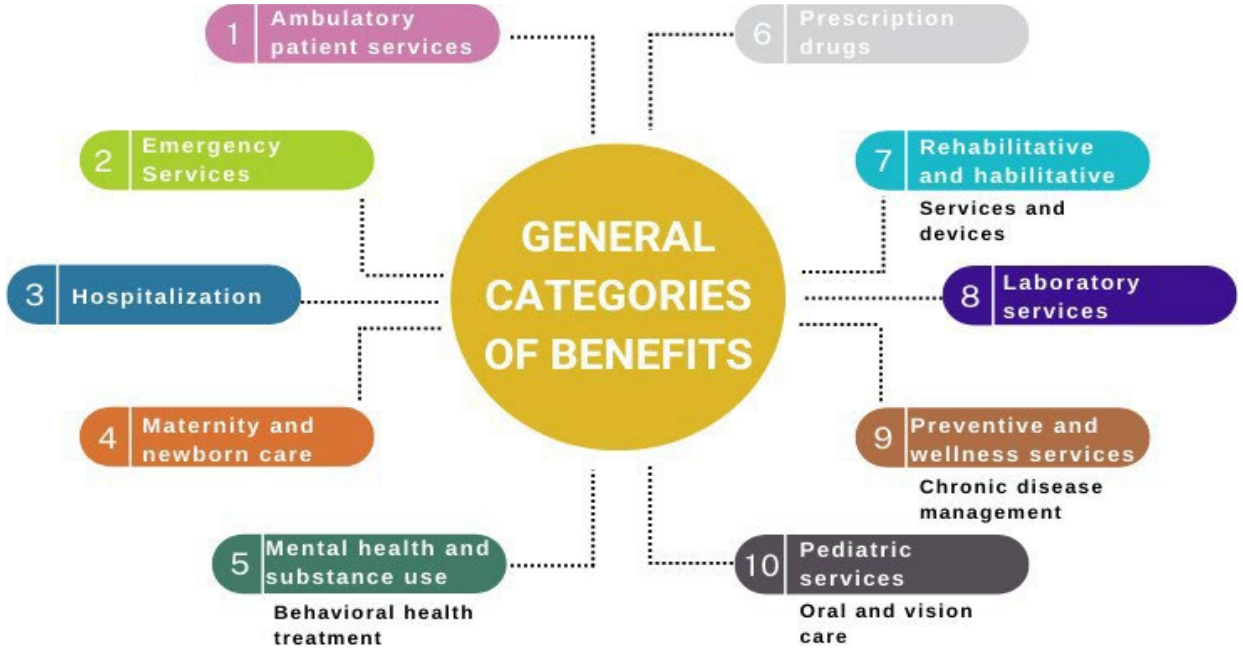
2025 STANDARD BENEFIT DESIGNS

Melanie Droboniku, Interim Deputy Director
Plan Management Division

OVERVIEW OF ESSENTIAL HEALTH BENEFITS

The Patient Protection and Affordable Care Act requires that all health insurance plans offered in the individual and small-group markets must provide a comprehensive package of items and services, known as essential health benefits. These benefits fit into the following 10 categories:



Covered California's covered benefits are based on those identified in our benchmark plan, which was adopted by legislation in 2012. Plans offered on the Exchange must include all the benefits in this plan, and cannot include benefits not included in this plan unless required by Federal legislation, or are otherwise defrayed (i.e. cannot be paid for by premiums). Details of the plan can be found here: https://www.cms.gov/cciio/resources/data-resources/downloads/updated-california-benchmark-summary.pdf

BENEFIT DESIGN REQUIREMENTS

- The Affordable Care Act (ACA) requires individual and small group plans to meet actuarial value (AV) requirements for four levels of coverage, with de minimis ranges that allow some flexibility in the final AV:

	AV Target	de minimis range
Platinum	90%	+/-2%
Gold	80%	+/-2%
Silver	70%	+2%
Bronze	60%	+5/-2%

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

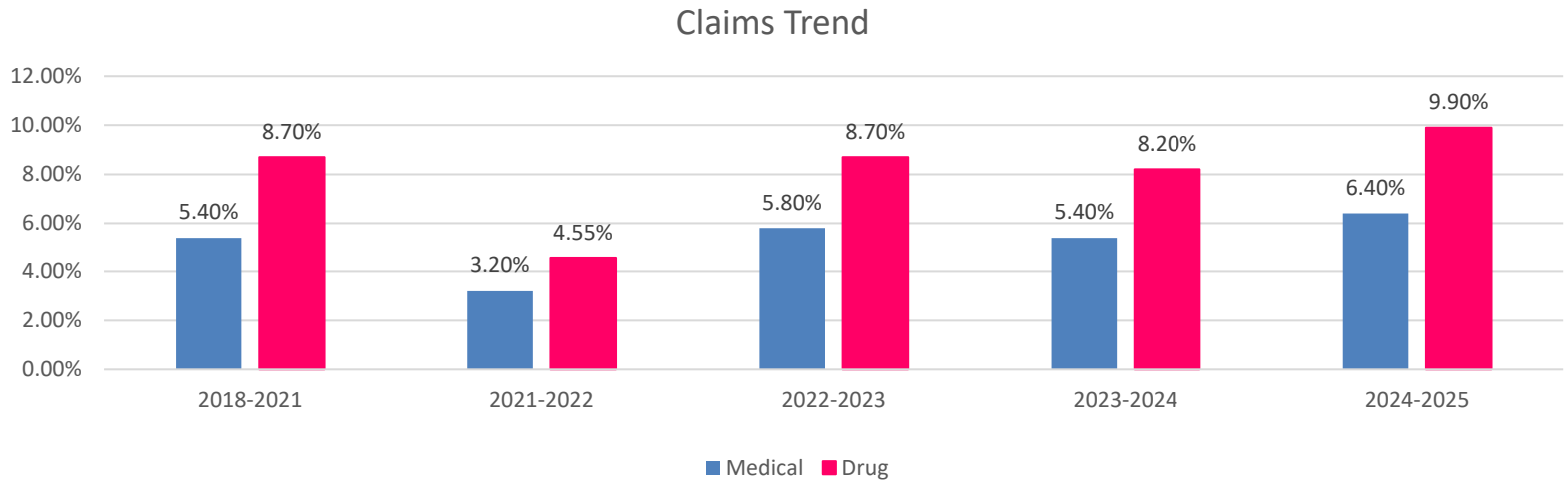
	FPL	AV Target	de minimis range
Silver 94	100-150%	94%	+1%
Silver 87	150-200%	87%	+1%
Silver 73	200-250%	73%	+1%

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

- The standard benefit plan designs are adjusted annually to meet AV requirements, clarify benefit administration, and incorporate benefit design innovations

UPDATES FROM CMS

- AV Calculator
  - The Maximum out of Pocket (MOOP) was adjusted downward this year
  - The underlying claims data source was changed, so benefit relativities are behaving differently than previous years
    - For example, the buffer we built in for MHPAEA test failure in Bronze comprised less than half a percent in the PY2024 calculator, but needs more than a full percentage point in the PY2025 calculator
  - More outlier claims data is excluded, allowing lower cost sharing because it doesn't have to account for very high-cost claims
  - The claims trend was calculated to be higher this year than any of the previous four years:



AV CHANGES FROM 2024 TO 2025 & DE MINIMIS RANGES

	Bronze		Silver				Gold		Platinum	
AV Target	HDHP 60	Standard 60	Silver 70	Silver 73 73	Silver 87 87	Silver 94 94	Copay 80	Coins 80	Copay 90	Coins 90
Deviation Allowance	+5/-2%	+5/-2%	+2/0%	+1/0%	+1/0%	+1/0%	+/-2%	+/-2%	+/-2%	+/-2%
2024 AV	64.94	64.29	71.68	73.81	87.82	94.93	81.54	81.92	90.74	91.88
2024 Additive Adjustments		0.10	0.15	0.14	0.04					
2024 Final AV	64.94	64.39	71.83	73.95	87.86	94.93	81.54	81.92	90.74	91.88
2025 AV	**63.97**	**62.95***	**70.79***	**72.77***	**88.27***	**95.33***	**82.17**	**81.44**	**91.58**	**91.90**

CCSB ONLY	Silver			Gold		Platinum	
AV Target	Copay 70	Coins 70	HDHP 70	Copay 80	Coins 80	Copay 90	Coins 90
Deviation Allowance	+/-2%	+/-2%	+/-2%	+/-2%	+/-2%	+/-2%	+/-2%
2024 AV	69.44	69.77	71.73	80.67	78.84	89.42	91.17
2024 Additive Adjustments	0.27	0.25					
2024 Final AV	69.71	70.02	71.73	80.67	78.93	89.42	91.17
2025 AV	**68.84***	**69.24***	**71.21***	**80.52**	**79.09***	**90.47**	**91.27**

*Draft AV does not include 2024 copay accumulation additive adjustment or custom inputs- these are pending and subject to change

Red text: AV is outside de minimis range

Green text: AV is within de minimis range

Blue text: MOOP for PY2024 designs exceeds PY2025 limit

For illustrative purpose only.

2025 ANNUAL LIMITATION ON COST SHARING

	2020	2021	2022	2023	2024	2025
Maximum annual limitation on cost-sharing (Federal)	$8,150 / $16,300	$8,550 / $17,100	$8,700 / $17,400	$9,100 / $18,200	$9,450 / $18,900	$9,200 / $18,400
Less CA MOOP ($350) for dental	$7,800 / $15,600	$8,200 / $16,400	$8,350 / $16,700	$8,750 / $17,500	$9,100 / $18,200	$8,850 / $17,700
CSR 73 Maximum annual limitation	$6,500 / $13,000	$6,800 / $13,600	$6,950 / $13,900	$7,250 / $14,500	$7,550 / $15,100	$7,350 / $14,700
CSR 87 Maximum annual limitation	$2,700 / $5,400	$2,850 / $5,700	$2,900 / $5,800	$3,000 / $6,000	$3,150 / $6,300	$3,050 / $6,100
CSR 94 Maximum annual limitation	$2,700 / $5,400	$2,850 / $5,700	$2,900 / $5,800	$3,000 / $6,000	$3,150 / $6,300	$3,050 / $6,100

CONSIDERATIONS FOR PY2025

- Continuing to model designs that are compatible with all Mental Health Parity and Equity Act (MHPAEA) requirements
  - In PY2023, MHPAEA calculation outcomes by individual Carriers required setting cost sharing for Mental Health and Substance Use Disorder Services to $0 for Kaiser, resulting in an AV that exceeded the de minimis range for its Bronze plan and requiring acceptance of an alternate benefit design
  - For PY2024, we modified the benefit design and left a small buffer to accommodate this issue
    - PY2025 designs should also include this design change and buffer
- Coordination of Standard Benefit Designs with the California Enhanced Affordability Project
  - For PY2024, we implemented enhanced benefits in the Silver CSR Plans
  - For PY2025, we anticipate continuing this program with additional funding compared to PY 2024 ($165M in PY 2025). The enhanced designs are not included today as modeling is still underway, but will come to the board in February

PROPOSED COST SHARE CHANGES

Platinum Plans: No proposed changes

Individual-only Gold Coinsurance and Gold Copay Plans:

- Decrease Emergency Department Facility Fee from $350 to $330
- Increase Inpatient Facility Fee from $330 to $350, Outpatient Physician Fee from $40 to $60 in the Copay Plan

Individual-only Silver 70 Plan:

- Decrease Drug Deductible from $150 to $50
- Decrease MOOP by $400 from $9,100 to $8,700
- Decrease Emergency Department Facility fee from $450 to $400
- Decrease Tier 1 (Generic) drug copay from $19 to $18

Bronze 60 Plan:

- Reduce Medical Deductible by $900, from $6,300 to $5,400
- Reduce MOOP by $250 from $9,100 to $8,850
- Eliminate deductible from Primary Care Visits and Tier 1 (Generic) drugs
- Increase Tier 1 (Generic) copay from $17 to $19

PROPOSED PY2025 INDIVIDUAL MARKET DESIGNS

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																				$6,650
Medical Deductible										$5,400		$5400**		$1400**		$0		$5,400		
Drug Deductible										$50		$350**		$350**		$0		$500		
Coinsurance (Member)		10%		10%		20%		20%		30%		30%		20%		10%		40%		0%
MOOP		$4,500		$4,500		$8,700		$8,700		$8,700		$7350**		$3,050		$1300**		$8,850		$6,650
ED Facility Fee		$150		$150		$330		$330		$400		$350		$150		$50	X	40%	X	0%
Inpatient Facility Fee		10%		$225		30%		$350	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		$35		$15		$5		$60	X	0%
Specialist Visit		$30		$30		$65		$65		$90		$85		$25		$8	X	$95	X	0%
MH/SU Outpatient Services		$15		$15		$35		$35		$50		$35		$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		$35		$15		$5		$60	X	0%
Occupational and Physical Therapy		$15		$15		$35		$35		$50		$35		$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%		$60		30%		30%		20%		10%	X	40%	X	0%
Tier 1 (Generics)		$7		$7		$15		$15		$18		$20**		**$8		$3		$19	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																				
Actuarial Value																				
2025 AV (Draft 2025 AVC)		**91.90**		**91.58**		**81.46**		**81.64**		**71.59†**		**73.93†**		**87.97†**		**94.74**		**63.7†**		**64.88**
Enrollment as of July 2023		77,615				183,457				293,276		128,845		318,258		221,763		346,158		93,586
Percent of Total enrollment		5%				10%				17%		8%		20%		13%		21%		6%
Enrollment as of July 2023		21,755		54,353		90,229		80,954												

KEY		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
	**	Targeted for CSR Enhancements
		Increased member cost from 2024
		Decreased member cost from 2024
		Does not meet AV
		Within .5 of upper de minimis
		Securely within AV

NEXT STEPS

- Silver CSR Plans (73, 87, 94) will be finalized mid-February in support of the California Enhanced Affordability Project
- Covered California for Small Business designs in development
- Dental Copay Schedule will be updated and finalized
- Final AV Calculator and National Benefits and Payment Parameters will be released later this Spring- all designs will be finalized and certified at that time
- Bronze HDHP is subject to change based on IRS – usually released in May

PUBLIC COMMENT

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APPENDIX 1

NAVIGATOR PROGRAM
REQUEST FOR APPLICATION FOR GRANT CYCLE 2024-2027

HOW THE POINTS SYSTEM WORKS

Total Points Goal is assigned at the funding level to reflect the level of effort expected for the funding dollars

- Total Points Goal is the sum of three subgoals for outreach activity, application assistance, and effectuated enrollment into Covered California
- Over-performance in any one category can contribute towards satisfaction of Total Points Goal

Funding	Total Points Goal	Enrollment Goal	Outreach Goal	CalHEERS Eligibility Goal
$60,500	580	290	174	116
$90,750	860	430	258	172
$121,000	1,140	570	342	228
$151,250	1,420	710	426	284
$181,500	1,700	850	510	340
$211,750	**1,980**	**990**	**594**	**396**
$242,000	2,260	1,130	678	452
$272,250	2,540	1,270	762	508
$302,500	2,820	1,410	846	564
$332,750	3,100	1,550	930	620
$363,000	3,380	1,690	1,014	676
$393,250	3,660	1,830	1,098	732
$423,500	3,940	1,970	1,182	788
$453,750	4,220	2,110	1,266	844
$484,000	4,500	2,250	1,350	900
$514,250	4,780	2,390	1,434	956
$544,500	5,060	2,530	1,518	1,012
$574,750	5,340	2,670	1,602	1,068
$605,000	5,620	2,810	1,686	1,124

HOW THE POINTS SYSTEM WORKS, CONTINUED

Points Goal Per Fiscal Year:

Enrollment
All points count towards Total Points Goal

Outreach
Up to 125% of excess points count towards Total Points Goal

Eligibility
(Application Assistance)
Up to 125% of excess points count towards Total Points Goal

New Points Model for $211,750 Grant Level

Performance Category	Points Goal	Actual Points	Eligible Points	% To Goal
Enrollment	990 (50%)	1,000	1,000	101%
Outreach	594 (30%)	1,600	743*	125%
Eligibility	396 (20%)	400	400	101%
Total	**1,980 (100%)**	**3,000**	**2,143**	**108%**

* Points capped at 125% of fiscal year goal (594 X 1.25 = 743) to be counted towards Total Points Goal.

HOW THE BONUS WORKS

Improved Enrollment Bonus

- Pays $30 for first member above goal
- No charge-back for missed goal enrollment
- Capped at 200% of annual enrollment goal

Funding	Enrollment Goal	Pays $30 per member above enrollment Goal	110% above enrollment Goal	125% above enrollment Goal	150% above enrollment Goal	Maximum 200% above enrollment Goal
$60,500	290	$30	$870	$2,175	$4,350	$8,700
$90,750	430	$30	$1,290	$3,225	$6,450	$12,900
$121,000	570	$30	$1,710	$4,275	$8,550	$17,100
$151,250	710	$30	$2,130	$5,325	$10,650	$21,300
$181,500	850	$30	$2,550	$6,375	$12,750	$25,500
$211,750	**990**	**$30**	**$2,970**	**$7,425**	**$14,850**	**$29,700**
$242,000	1,130	$30	$3,390	$8,475	$16,950	$33,900
$272,250	1,270	$30	$3,810	$9,525	$19,050	$38,100
$302,500	1,410	$30	$4,230	$10,575	$21,150	$42,300
$332,750	1,550	$30	$4,650	$11,625	$23,250	$46,500
$363,000	1,690	$30	$5,070	$12,675	$25,350	$50,700
$393,250	1,830	$30	$5,490	$13,725	$27,450	$54,900
$423,500	1,970	$30	$5,910	$14,775	$29,550	$59,100
$453,750	2,110	$30	$6,330	$15,825	$31,650	$63,300
$484,000	2,250	$30	$6,750	$16,875	$33,750	$67,500
$514,250	2,390	$30	$7,170	$17,925	$35,850	$71,700
$544,500	2,530	$30	$7,590	$18,975	$37,950	$75,900
$574,750	2,670	$30	$8,010	$20,025	$40,050	$80,100
$605,000	2,810	$30	$8,430	$21,075	$42,150	$84,300

HOW THE SUPPLEMENTAL OUTREACH GRANT WORKS

- Applicants applying to be Navigators may also apply for a Supplemental Outreach Grant
- Applicants may choose any grant amount that is equal to or lower than their core grant funding level
- Award decisions will be based on criteria that includes a demonstrated ability to reach and influence targeted communities

Grant Level	Grant Amount	Minimum CBO Collaborative Contract	Minimum Community Health Workers Count	Minimum CHW Outreach & Education Events Requirement Goal	Minimum CHW Consumer Referrals Requirement Goal
1	$50,000	1	2	12	500
2	$100,000	1	4	24	1,000
3	$150,000	2	6	36	1,500
4	$200,000	2	8	48	2,000

- Each funding level has minimum requirements associated to it for the number of Community Based Organizations (CBOs) and number of Community Health Workers (CHWs) or similar workers
- Grantees are expected to meet or exceed Outreach activity and referrals goals

APPENDIX 2

2025 PLAN YEAR AMENDMENTS ATTACHMENTS 1 AND 2