Policy and Action Items

March 19, 2026 Board Meeting

2027 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 2026 - 2028. Currently contracted QHPs will have reduced application response requirements. New entrants will complete the entire application.
- **Qualified Dental Plan (QDP)** Contract period is 2024 - 2027. Currently contracted QDPs will have reduced application response requirements. New entrants will complete the entire application.
- There have been no further substantive updates since the presentation at the January 15, 2026, Board meeting.
- **Plan Year 2027 Certification Health and Dental Applications will be open to all Applicants.**
- The four Certification Applications are posted on the HBEX Certification 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 and Dental Plans (QHP and QDP) which are used in selecting Issuers and making 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 2027 Certification Milestones

Milestone	Date
Release Draft 2027 QHP & QDP Certification Applications	September 15, 2025
Draft Application Comment Periods End	September 30, 2025
Plan Management Advisory: Benefit Design* & Certification Applications Policy Recommendation	January 2026
Board Meeting: Discussion of Benefit Design* & Certification Applications Policy Recommendation	January/February 2026
Letters of Intent Accepted	February 2-13, 2026
Final AV Calculator Released*	February 2026
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 2026
Board Meeting: Anticipated approval of 2027 Patient-Centered Benefit Plan Designs* & Certification Applications	March 2026
QHP & QDP Applications Open	March 2, 2026
QHP & QDP Application Responses (Individual and CCSB) Due	April 30, 2026, noon (12:00 pm PT)
Evaluation of QHP Responses & Negotiation Prep	May – June 2026
QHP Negotiations	June 2026
QHP Preliminary Rates Announcement	July 2026
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2026
Evaluation of QDP Responses & Negotiation Prep	June – July 2026
QDP Negotiations	July 2026
CCSB QHP Rates Due	July 2026
QDP Rates Announcement (no regulatory rate review)	August 2026
Public Posting of Proposed Rates	August 2026
Public Posting of Final Rates	September – October 2026**
Execution of Covered California Contract	September – October 2026**

***CCA Benefit Designs, final AV Calculator and final SERFF Templates availability dependent on CMS release**
****Dates subject to change based on rate filing requirements**

Requested Action: Plan Year 2027 Certification Applications

STAFF REQUESTS THE BOARD TO:

- ❑ Formally adopt the 2027 Certification Criteria and QHP and QDP Applications for the individual and small business health and dental plans.
- ❑ Authorize staff to issue applications for selection of QHPs and QDPs for Plan Year 2027.

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.

Written comments can be submitted to *BoardComments@covered.ca.gov*

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2027 Qualified Health and Dental Plan Issuer Model Contracts

James DeBenedetti, Director, Plan Management Division
Taylor Priestley, Director, Health Equity and Quality Transformation

2027 Plan Year Amendments

The Qualified Health Plan (QHP) Issuer Contracts for the Individual and Covered California for Small Business (CCSB) marketplaces have been amended for Plan Year 2027, aligning with the 2026-2028 contract duration. Similarly, the Qualified Dental Plan (QDP) Issuer Contract for the Individual and CCSB marketplaces has been amended for Plan Year 2027, extending its contract term to 2024-2027.

The Plan Management Division (PMD) will provide a summary of updates for the model contracts:

- 2026-2028 QHP Individual Model Contract
- 2024-2027 QDP Issuer Model Contract

Additionally, the Health Equity and Quality Transformation (EQT) Division will provide a summary of updates for the following contract attachments:

- QHP Individual Attachment 1: Advancing Equity, Quality, and Value
- QHP Individual & QDP Attachment 2: Performance Standards with Penalties

2027 Amendment Updates

Minimal updates have been made to the 2027 QHP and QDP Amendments, with general revisions applied throughout the contract documents for clarity, accuracy, and alignment where applicable. The specific updates to the content are summarized below:

- **Article 10 – Privacy and Security (QHP Individual, QDP):** Updates throughout Article 10 were made to align with the National Institute of Standards and Technology (NIST), current Federal Information Processing Standards, (FIPS), and the information Practices Act (IPA). Contract language within this article was also updated for conciseness, clarity, and to better reflect current Covered California provisioning processes.
- **Section 3.3 Agents in the Covered California for the Individual Market, 3.3 b) Compensation Methodology (QHP Individual):** Considering recent changes to Agent commission rates in the second half of the year, which may compromise Agent operations and their active participation in essential retention and enrollment efforts for the upcoming Renewal and Open Enrollment Periods, Covered California proposed an updated contractual requirement. This requirement calls for Contractors to seek approval for any reductions to Agent commission rates following the annual Qualified Health Plan Certification negotiation meetings (July-December).
- There have been no further updates since the presentation at the January 15, 2026, Board meeting.

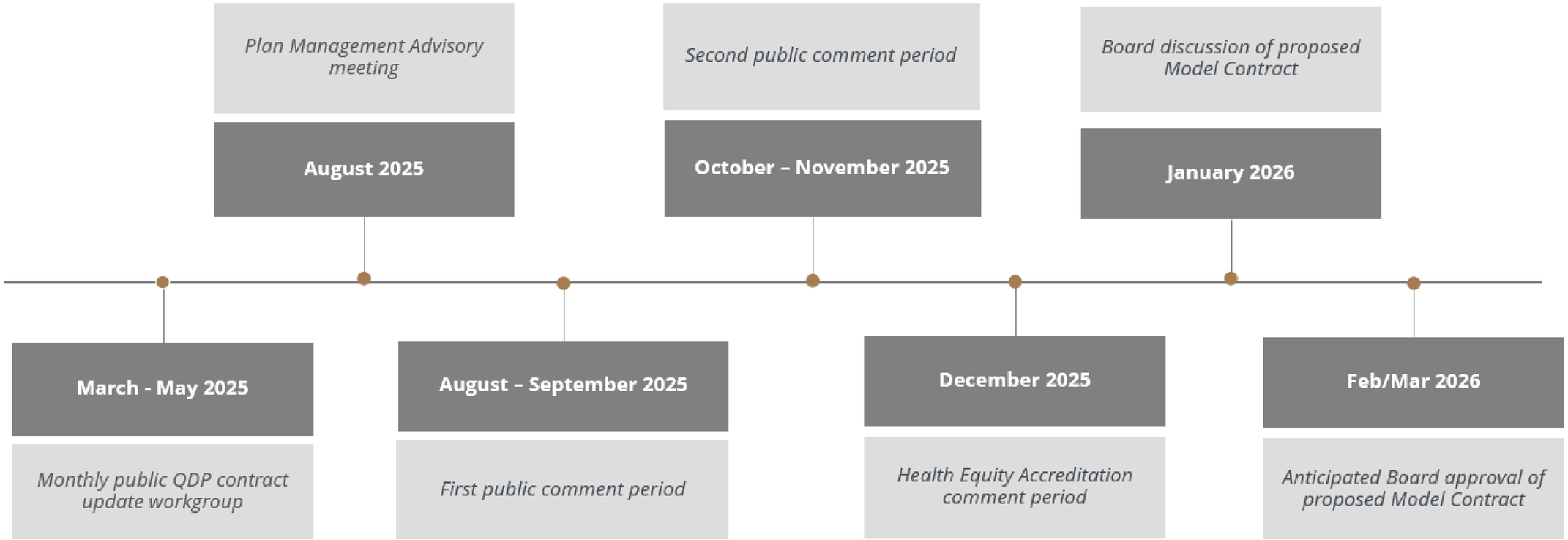
2027 Plan Year Amendment Drafts & Response to Comments

2027 QHP & QDP Issuer Contract Amendment Drafts and Response to Comment documents are posted to the Covered California Health Benefit Exchange website:
https://hbex.coveredca.com/stakeholders/plan-management/contract-listings/2027/

Any questions please email PMDContractsUnit@covered.ca.gov and EQT@covered.ca.gov

2027 Qualified Health and Dental Plan Attachments 1 and 2 Amendments

2027 QHP & QDP Issuer Contract Amendment Development Timeline



2027: QHP & QDP Contract Amendment Updates

QHP Attachment 1

- NCQA Health Equity Accreditation

QHP Attachment 2

- Pediatric Oral Health performance standards

QDP Attachment 2

- Pediatric Oral Health performance standards

2027 Qualified Dental Plan Amendment

Stakeholder Engagement and Public Comment

2027 QDP Amendment

- Contract Workgroup open to all Issuers, Public Purchasers, and Consumer Advocate Groups
- Participants reviewed and offered feedback on the proposed contracts and preliminary contract language
- Two public comment and response periods for draft Contract feedback

QDP Contract Workgroup

- 3 public meetings from March – May 2025

Public Comment Cycle 1

- Comment Cycle 1 was held between 8/15/2025 – 9/15/2025
- 2 unique organizations commented with 6 total comments. Comments and responses are available online

Public Comment Cycle 2

- Comment Cycle 2 was held between 10/9/2025 – 11/10/2025
- 2 unique organizations commented with 9 total comments. Comments and responses are available online

All 2027 Certification and Contract Documents will be presented in Feb/March 2026 for Board approval

QDP Utilization Data Analysis

KEY FINDINGS

- Pediatric utilization of QDPs is overall higher than adult utilization, and services used skew more toward Preventive for Pediatric than Adult members
- We see the largest differences in dental plan utilization by plan type: DPPO utilization is 3 times DHMO utilization and this holds true for Pediatric members and Adults
- While we see utilization differences by age, race/ethnicity and income, these findings were not statistically significant and dwarfed by utilization differences by plan type

Summary of Proposed 2027 QDP Attachment 2 Performance Standards & Percent At Risk

Performance Area	Performance Standards with Penalties	Percent of At-Risk Amount 2024-2026	Percent of At-Risk Amount 2027
Data Submission 50%	1. Healthcare Evidence Initiative (HEI) Data Submission	45%	45%
	2. Provider Directory Submission	5%	5%
Oral Health 50%	3. Pediatric Oral Evaluation, Dental Services	5%	5%
	4. Pediatric Topical Fluoride for Children, Dental Services	5%	5%
	5. Pediatric Sealant Receipt on Permanent First Molars	5%	5%
	6. Adult Preventive Services Utilization	35%	35%

2027 Performance Standards – No Proposed Changes

Notable Changes to Draft Attachment 2	Rationale
Performance Standard 1 - Healthcare Evidence Initiative (HEI) Data Submission	Accurate and complete dental services data remains a priority and serves as the foundation for quality and equity accountability.
Performance Standard 2 – Provider Directory Submission	Accurate and complete provider directory data remains a priority as a critical component of enrollee access to care.

Proposed QDP 2027 Attachment 2 Changes

Notable Changes to Draft Attachment 2	Rationale
Performance Standard 3 - Pediatric Oral Evaluations, Dental Services **Performance Standard 4 - Pediatric Topical Fluoride for Children, Dental Services** **Performance Standard 5 - Pediatric Sealant Receipt on Permanent First Molars** **Performance Standard 6 - Adult Preventive Dental Services Utilization** ❑ Introduction of differentiated improvement targets for DHMO and DPPO plans: 5% penalty assessed for DHMO products if the annual performance increase is less than 20% and for DPPO products if the annual performance increase is less than 10%, with no penalty applied for increases equal to or exceeding these thresholds ❑ Introduction of performance threshold of 70%, above which annual improvement not subject to financial penalty. ❑ Addition of Alternate Standard for newly contracted QDP Issuers: Contractor must submit pediatric dental data in the first measurement year, establish a baseline in the second measurement year, and demonstrate compliance with data submissions in the first Assessment Year.	❑ The very low DHMO baseline performance rates result in a much lower improvement expectation compared to DPPOs if the same year over year percentage improvement target is used, widening the disparity already seen. ❑ Covered California recognizes continued improvement is increasingly difficult to achieve at higher performance; performance rates of 70% and higher reflect meaningful care delivery to members. ❑ In alignment with QHP Issuer Model Contract Attachment 2, implements applicable requirements and timeline for QDP Issuer Contractors who execute contracts after the first year of the contract term.

2027 Qualified Health Plan Amendments

NCQA Health Equity Accreditation Proposed Updates for 2026

Type of Change	Standard Change(s) from 2024-2026	NCQA Rationale	Example Redlines
Removal of language specifically referencing health equity, diversity	Organizational Readiness HEA1A: Removal of language "diverse staff" to be replaced by "responsive workforce"	To "**Adapt to the evolving policy environment**" and "focus on respectful, appropriate, responsive care, **rather than abstract concepts such as reducing bias or promoting inclusion**"	HE1: The organization has a workforce capable of supporting its goals to provide opportunities for members or patients to achieve their best possible health. ~~supports health equity goals and takes action to reduce bias and improve diversity, equity and inclusion.~~
Removal of requirements to collect specific patient demographic data factors, and removal of standardized approach to measure stratification	Collection of Data on Gender Identity HE 2D: Retirement of requirement to collect data on gender identity Use of Data to Assess Disparities HE 6B	To "**Adapt to the evolving policy environment**"	HE2~~: The organization gathers individuals' race/ethnicity, language, gender identity and sexual orientation data using standardized methods.~~ The organization gathers member- or patient-level demographic data using standardized methods.
Removal of language around culturally and linguistically appropriate services and serving multicultural populations	Revise language including in program description in HE 5A Change "Use of Data to measure CLAS and inequities" (HE 6D) to "Evaluating Effectiveness of Interventions" (HO 7D)	To "**Adapt to the evolving policy environment**" and to "better **describe the intent of activities formerly referenced by broader terminology such as "diversity** of the community" And enable "organizations to select data quality lenses that are most meaningful for their population and regulatory priorities"	HE5: ~~The organization continually improves its services to meet the needs of multicultural populations.~~ The organization has clearly defined processes, goals and responsibilities for continuously improving the appropriateness and accessibility of its services.
Additional requirements to expand demographic data collection to include disability status, disability accommodations, and geographic data elements	Collection of new data elements on Disability Status & Disability-Related Accommodations HO 2 Collection of new data elements on geographic data HO 2	To "Add content for disability" and "Add content for geographic classification" Both to "expand the selection of data types so that organizations can select data quality lenses that are most meaningful for their population and regulatory priorities."	"The organization has a documented process for direct collection of data on disability function for all patients or members that includes: • The following response options: – Hearing. – Seeing (including when wearing glasses). – Concentrating, remembering or making decisions. – Walking or climbing stairs. – Dressing or bathing..."

NCQA Health Equity Accreditation: QHP Issuer Current Status

QHP Issuer Product	Expiration Year
Aetna HMO	2026
Anthem Blue Cross EPO	2026
Anthem Blue Cross HMO	2026
Blue Shield California HMO	2028
Blue Shield California PPO	2028
Chinese Community Health Plan HMO	2027
Health Net HMO	2027
Health Net PPO	2027
Inland Empire Health Plan HMO	2026
Kaiser Permanente HMO (NorCal)	2026
Kaiser Permanente HMO (SoCal)	2027
L.A. Care HMO	2027
Molina Healthcare HMO	2028
Sharp Healthcare HMO	2026
Valley Health Plan HMO	2027
Western Health Advantage HMO	2028

Stakeholder Engagement and Public Comment

Public Comment Cycle 1

- November Plan Management Advisory meeting focused on Attachment 1: NCQA Health Equity Accreditation changes
- Participants reviewed and offered feedback on the proposed contracts and preliminary contract language
- Three public comment and response periods for Contract feedback

Public Comment Cycle 1

- Comment Cycle 1 was held between 8/15/2025 – 9/15/2025
- 3 unique organizations commented with 4 total comments. Comments and responses are available online

Public Comment Cycle 2

- Comment Cycle 2 was held between 10/9/2025 – 11/10/2025
- 2 unique organizations commented with 16 total comments. Comments and responses are available online

Public Comment Cycle: Health Equity Accreditation removal

- Additional comment cycle was held between 11/13/2025 – 12/2/2025
- No comments received

All 2027 Certification and Contract Documents will be presented in Feb/March 2026 for Board approval

Article 1: Equity & Disparities Reduction

Notable Changes to Draft Attachment 1	Rationale
Health Equity Capacity Building Effective Plan Year 2027, Covered California will remove the requirement for QHP Issuers to achieve or submit evidence of NCQA Health Outcomes Accreditation, formerly known as Health Equity Accreditation, from its contract requirements.	As NCQA's proposed updates to the HEA standards are not fully aligned with Covered California strategic approach or the evidence base for health equity work, this contract change supports continued tailoring of efforts and those of the contracted QHP Issuers to meet the needs of Enrollees and achieve meaningful progress in equity-focused initiatives.
Health Equity Capacity Building QHP Issuers will be required to maintain a diverse workforce representative of the populations they serve to support equitable health outcomes. QHP Issuers can either submit evidence of compliance with NCQA Health Equity Accreditation 2024 Standards or report on efforts to achieve workforce diversity, including assessments of representation, recruitment practices, cultural humility, and staff training. Issuers who demonstrate proof of NCQA HEA 2024 Standards in Plan Year 2026 are exempt from resubmitting during this contract period.	This proposed requirement is intended to ensure QHP Issuers continue to prioritize developing and maintaining a workforce that reflects the diversity of the populations they serve. Covered California supports meaningful progress, and this change emphasizes accountability, transparency, and the critical role of workforce diversity and cultural humility in addressing health disparities.
Culturally and Linguistically Appropriate Care Clarified requirement to demonstrate provision of culturally and linguistically appropriate services to Enrollees, which can be met through either submission of NCQA Health Equity Accreditation Standards reports or reports outlined by Covered California. Health Outcomes Accreditation and its associated reports will not be accepted to meet this requirement.	This language clarification reflects Covered California's commitment to ensuring the consistent implementation and monitoring of culturally and linguistically appropriate services to best serve our diverse Enrollees.

Proposed QHP 2027 Attachment 2 Changes

Notable Changes to Draft Attachment 2	Rationale
Performance Standard 5 - Pediatric Oral Evaluations, Dental Services **Performance Standard 6 – Pediatric Topical Fluoride for Children, Dental Services** ❑ Introduction of performance threshold of 70%, above which annual improvement not subject to financial penalty.	❑ Covered California recognizes continued improvement is increasingly difficult to achieve at higher performance; performance rates of 70% and higher reflect meaningful care delivery to members. ❑ Performance thresholds and annual improvement targets adjusted in alignment with QDP contract updates proposed for 2027

Requested Action: Plan Year 2027 Contract Amendments

STAFF REQUESTS THE BOARD TO:

- ❑ Formally adopt the 2027 Qualified Health and Dental Plan Issuer Model Contract Amendments for the Individual and Covered California for Small Business marketplaces.

PUBLIC COMMENT
Call: (877) 336-4440
Participant Code: 6981308

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2027 Standard Benefit Designs

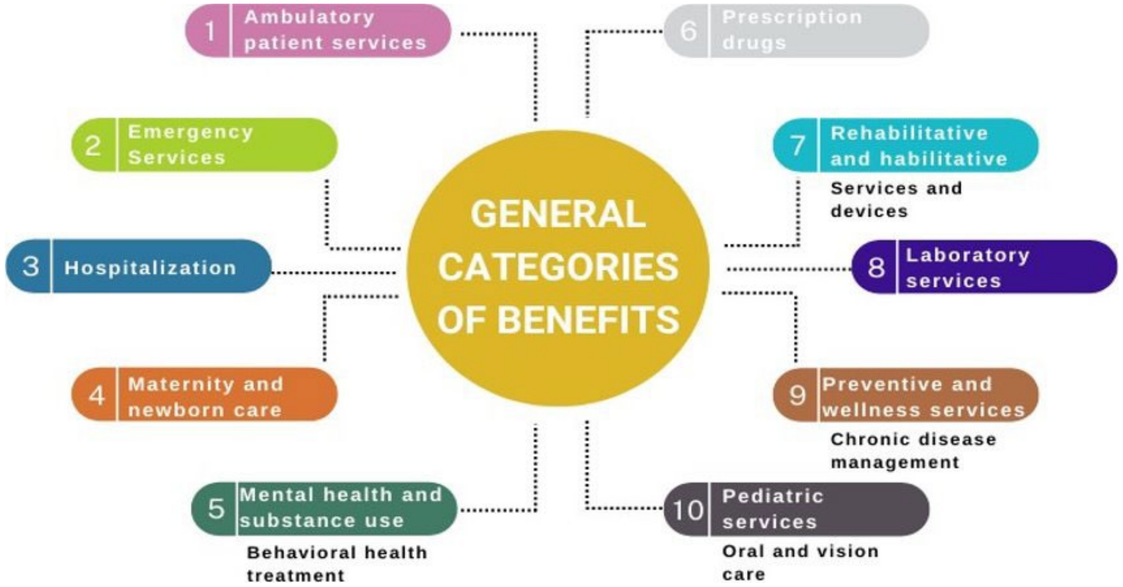
David Bishop, Deputy Director, Plan Management Division

The Importance of Standard Benefit Designs

- **Standard benefit designs** are health insurance cost-sharing configurations that specify enrollee out of pocket amounts, e.g. deductibles, copays and coinsurance for covered services and prescription drugs.
- The Covered California Board of Directors is authorized under state law to standardize products offered through the Exchange and **contracted plans are required to offer products using Covered California's Board-approved standard benefit design plans.**
- Standardizing plan designs allows consumers to make apples to apples comparisons between plans available through Covered California, **allowing consumers to focus their choice on plan premium, network, and quality.**
- The standard **benefit plan designs are adjusted annually** to meet federal actuarial value (AV) requirements, clarify benefit administration, and incorporate benefit design innovations.
- **Covered California convenes a standard benefit workgroup** that is open to the public to help shape the standard benefit design every year and in accordance with federal requirements. The workgroup proposes the standard benefit design every Spring to the Covered CA Board of Directors for approval and implementation for the following plan year.

Overview of Essential Health Benefits

The Patient Protection and Affordable Care Act (PPACA, or ACA) 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 (EHBs). 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 is 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.
California submitted a proposed revision to our benchmark plan in May 2025 but review by CMS has been suspended.

Standard Benefit Designs – Federal Influence

- In the fall of each year, Centers for Medicaid and Medicare Services (CMS) releases a draft AV Calculator (AVC) and Notice of Benefit and Payment Parameters (NBPP). The AVC and NBPP are used to model how benefit cost shares can be changed to ensure all plans fit within the de minimis range for each metal tier.
    - This year, the draft NBPP were released and AV Calculator were released very late in the cycle, delaying our work to update the benefit designs for PY2027 and severely compressing the design update timeline.
- CMS also updates the Maximum Out of Pocket (MOOP) and cost sharing limitations for cost-sharing reduction silver plans.
- New rules have been proposed that would expand eligibility for Catastrophic (AKA Minimum Coverage) plans.
    - These do cover preventive services but are automatically set at the highest MOOP, and this year there is a proposal to set this at 130% of the normal MOOP.

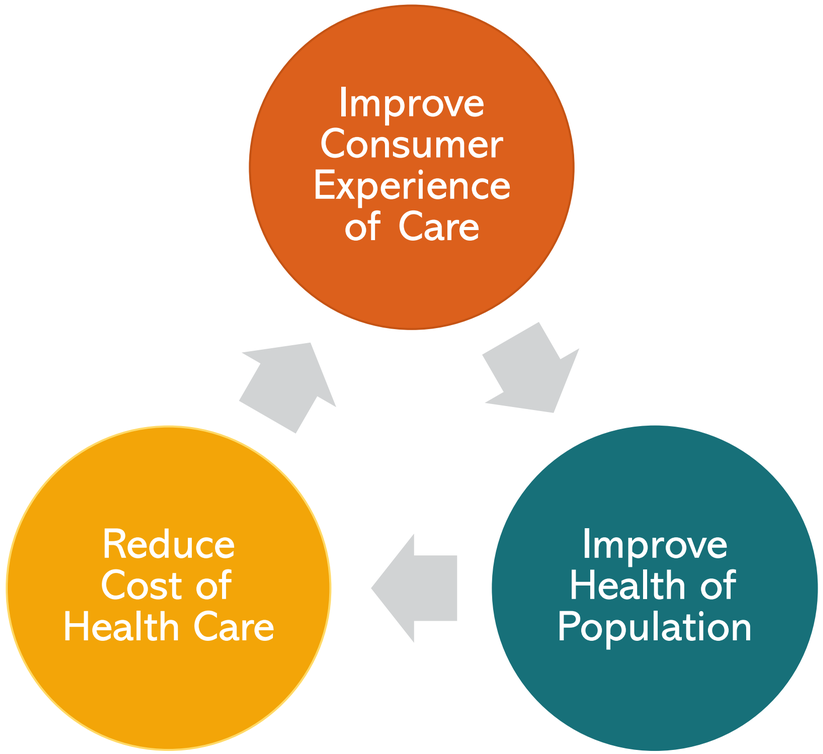
Strategy for Patient-Centered Benefit Plan Designs

ORGANIZATIONAL GOAL

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

PRINCIPLES

- Multi-year progressive strategy with consideration for market dynamics: changes in benefits should be considered annually based on consumer experience related to access and cost.
- Adhere to principles of value-based insurance design by considering value and cost of clinical services.
- Set fixed copays as much as possible and utilize coinsurance for services with wide price variation to encourage members to shop for services.
- Apply a stair-step approach for setting member cost shares for a service across each metal level, e.g., for Plan Year 2026, a Primary Care visit was $50 in the Silver tier, $40 in Gold, and $15 in Platinum.

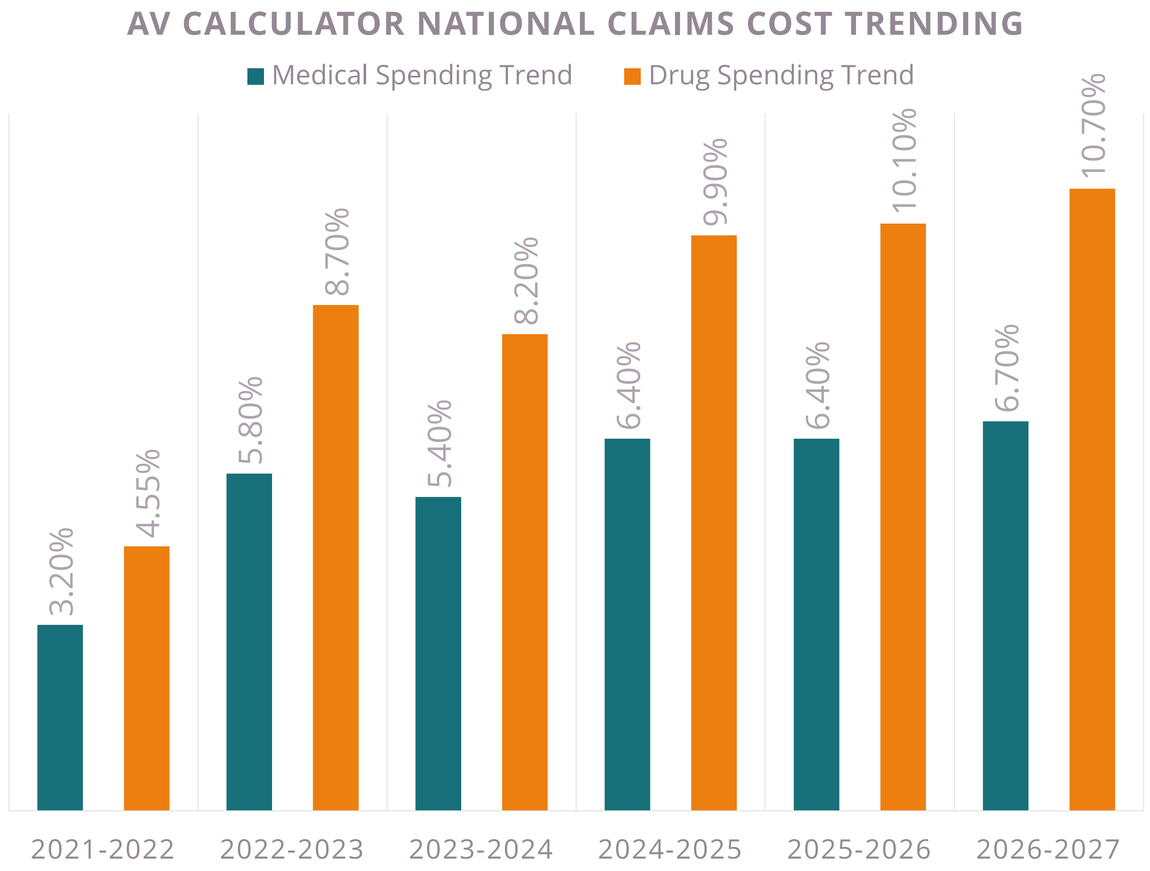


Benefit Design Requirements

- The ACA requires individual and small group plans to meet actuarial value (AV) requirements for four levels of coverage:
  - Platinum: 90% AV
  - Gold: 80% AV
  - Silver: 70% AV
  - Bronze: 60% AV

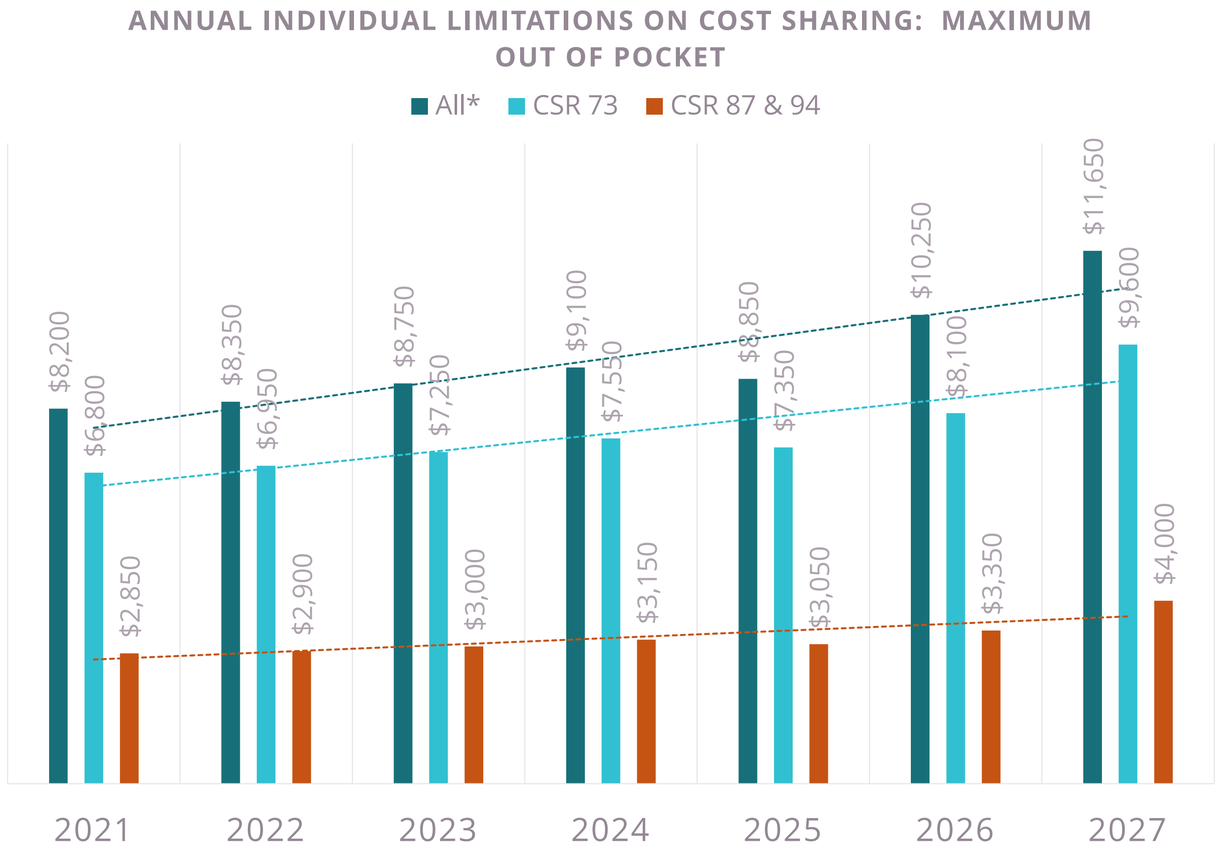
- Additional plan designs with a richer benefit package, known as “Cost Sharing Reduction Plans”, are available to individuals meeting income eligibility requirements
  - Silver 94: 94% AV, 100% - 150% Federal Poverty Level (FPL)
  - Silver 87: 87% AV, 150% - 200% FPL
  - Silver 73: 73% AV, 200% - 250% FPL

AV Calculator and Trends



- Claims cost trending continues to rise in the PY2027 AV Calculator at a rate more rapid rate than in previous years, with drugs increasing at a faster pace.
- These trends underlie the function of the AV calculator and are part of what drives the needed increases in cost sharing to bring the plans back into AV compliance.

2027 Annual Limitation on Cost Sharing



Notes: Non-CSR MOOP is Less Covered California $350 Dental MOOP. Family MOOP is double the individual MOOP.

- Annual limitation on cost sharing continues to rise faster than inflation, and 2026 and 2027 represent a change in the methodology such that a higher premium trend factor yields a higher maximum out of pocket (MOOP).
- High MOOPs have been shown to be a primary driver of medical debt but increasing the MOOP on our plans was required to achieve AV targets.

AV Changes From 2026 to 2027 & De Minimis Ranges – Baseline Modeling

	Bronze		Silver				Gold		Platinum	
	HDHP	Standard	Silver	Silver 73	Silver 87	Silver 94	Copay	Coins	Copay	Coins
AV Target	60	60	70	73	87	94	80	80	90	90
Deviation Allowance	+5/-4%	+5/-4%	+2/0%	+1/0%	+1/0%	+1/0%	+2/-2%	+2/-2%	+2/-2%	+2/-2%
2026 Final AV	64.76	63.49	71.66	73.69	87.80	94.81	81.64	81.46	91.58	91.90
2026 CA Enhanced CSR AV			**81.56**	**81.56**	**90.83**	**97.04**				
2027 AV	**66.16**	**65.08**	**73.92**	**75.94**	**89.42**	**96.63**	**83.05**	**81.93**	**93.84**	**93.43**

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%	+/-2%	+2/-2%	+2/-2%
2026 Final AV	70.81	71.17	70.61	81.70	80.25	91.13	91.79
2027 AV	**72.10**	**72.49**	**71.84**	**83.02**	**81.98**	**93.38**	**93.42**

*Draft AV does not include 2027 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

Yellow text: AV is within de minimis range but could be too high to accommodate final AV adjustments and buffer for MHPAEA outcomes

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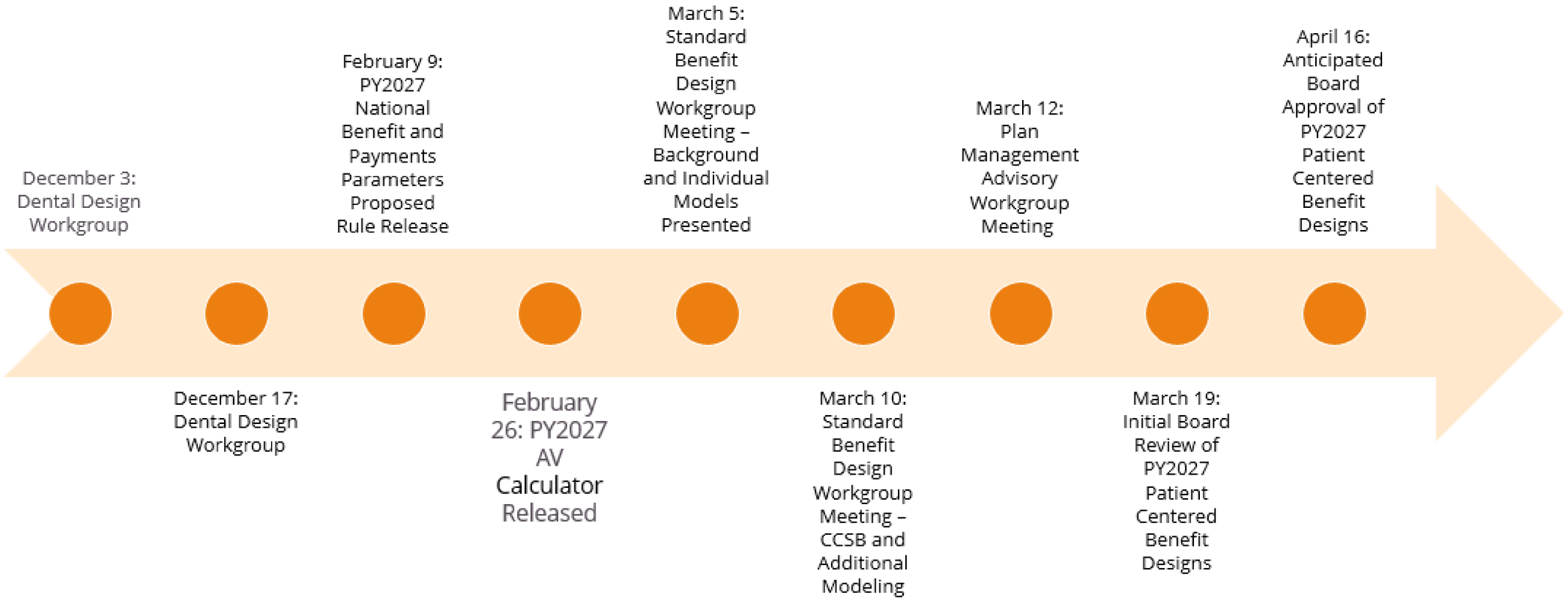
2027 Timeline for Benefit Design Updates



PY2027 Individual Design Models

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2027 Changes – Overall Themes

- All plans required large increases to the Maximum Out of Pocket, though only a small percentage of enrollees reach the maximum in any given year so this was the preferred approach
- CMS changed the weighting and sample population for Platinum calculations, requiring extensive remodeling in that tier as compared to previous years
- Plans that already had high medical deductibles, including Silver 70 and Bronze 60, counterintuitively yielded a lower AV when we reduced the deductible, and reducing these deductibles without an AV tradeoff was supported by the workgroup

PY2027 Proposed Patient Centered Benefit 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		Catastrophic	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible																				$7,800		$15,600
Medical Deductible										$4,700		$4,700		$1,100		$200		$5,800				
Drug Deductible										$50		$50		$50		$0		$450				
Coinsurance (Member)		10%		10%		20%		20%		30%		30%		20%		10%		40%		0%		0%
MOOP		$5,500		$5,500		$9,600		$9,600		$11,650		$9,600		$4,000		$3,000		$11,650		$7,800		$15,600
ED Facility Fee		$225		$225		$350		$350		$400		$400		$200		$50	X	40%	X	0%	X	0%
Inpatient Facility Fee		10%		$325		30%		$375	X	30%	X	30%	X	20%	X	10%	X	40%	X	0%	X	0%
Inpatient Physician Fee		10%		---		30%		---		30%		30%		20%		10%	X	40%	X	0%	X	0%
Primary Care Visit		$20		$20		$40		$40		$50		$50		$15		$5		$60	X	0%	X	0%
Specialist Visit		$45		$45		$80		$80		$100		$100		$30		$8	X	$100	X	0%	X	0%
MH/SU Outpatient Services		$20		$20		$40		$40		$50		$50		$15		$5		$60	X	0%	X	0%
Imaging (CT/PET Scans, MRIs)		15%		$90		25%		$125		$325		$325		$100		$50	X	40%	X	0%	X	0%
Speech Therapy		$20		$20		$40		$40		$50		$50		$15		$5		$60	X	0%	X	0%
Occupational and Physical Therapy		$20		$20		$40		$40		$50		$50		$15		$5		$60	X	0%	X	0%
Laboratory Services		$25		$25		$40		$40		$50		$50		$35		$10		$50	X	0%	X	0%
X-rays and Diagnostic Imaging		$35		$35		$85		$85		$95		$95		$50		$10	X	40%	X	0%	X	0%
Skilled Nursing Facility		10%		$175		30%		$150	X	30%	X	30%	X	20%	X	10%	X	40%	X	0%	X	0%
Outpatient Facility Fee		10%		$100		30%		$150		30%		30%		20%		10%	X	40%	X	0%	X	0%
Outpatient Physician Fee		10%		$50		30%		$75		30%		30%		20%		10%	X	40%	X	0%	X	0%
Tier 1 (Generics)		$10		$10		$19		$19		$20		$20		$10		$3		$20	X	0%	X	0%
Tier 2 (Preferred Brand)		$25		$25		$60		$60	X	$65	X	$55	X	$30		$10	X	40%	X	0%	X	0%
Tier 3 (Nonpreferred Brand)		$45		$45		$90		$90	X	$95	X	$95	X	$50		$15	X	40%	X	0%	X	0%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%	X	15%		10%	X	40%	X	0%	X	0%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$150		$150		$500*				
Maximum Days for charging IP copay		5		5				5														
Begin Specialist deductible after # of copays																		3				
Actuarial Value																						
2027 AV Calculator		**91.76**		**91.55**		**81.22**		**81.92**		**71.71†**		**73.88†**		**87.87†**		**94.90**		**62.99†**		**64.91**		Not supported in AV Calculator
September 2025 Enrollment		62,120				109,310				48,760		606,850		469,800		228,780		350,960		81,340		11,980
Percent of Total enrollment		3.2%				5.5%				2.5%		30.8%		23.8%		11.6%		17.8%		4.1%		0.6%
Percent of Total enrollment		29%		71%		53%		47%														

KEY			
	X	Subject to deductible	Decreased member cost from 2026
	*	Drug cap applies to all drug tiers	Does not meet AV
	†	Additive adjustment (included in AV)	Within .5 of upper de minimis
		Increased member cost from 2026	Securely within AV

PY2027 Covered California for Small Business Design Models

COVERED CALIFORNIA

Covered California for Small Business Approach

- Covered California also offers plans in the Small Group Market.
- These plans are subject to the same maximum out of pocket (MOOP) limits, though have a lower deductible.
- Premiums are paid by employers, who tend to be price sensitive, and are not eligible for the subsidies offered in the individual market.
- We design these plans to be competitive in a marketplace where the competition offers carrier-designed plans but continue to focus on enrollee experience and value-based design.

CCSB Proposed Benefit Designs

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														$3,200
Medical Deductible						$500		$325		$2,500		$2,500		
Drug Deductible						$0		$0		$350		$350		
Coinsurance (Member)		10%		10%		20%		20%		40%		40%		25%
MOOP		$5,000		$5,000		$8,600		$8,600		$9,000		$9,200		$8,800
ED Facility Fee		$250		$250	X	20%	X	$300	X	40%	X	40%	X	25%
Inpatient Facility Fee		10%		$300	X	20%	X	$600	X	40%	X	40%	X	25%
Inpatient Physician Fee		10%		---	X	20%		--	X	40%		40%	X	25%
Primary Care Visit		$25		$25		$30		$40		$60		$60	X	25%
Specialist Visit		$40		$40		$60		$60		$90		$90	X	25%
MH/SU Outpatient Services		$25		$25		$30		$40		$60		$60	X	25%
Imaging (CT/PET Scans, MRIs)		15%		$150		20%	X	$350	X	40%	X	$300	X	25%
Speech Therapy		$25		$25		$30		$40		$60		$60	X	25%
Occupational and Physical Therapy		$25		$25		$30		$40		$60		$60	X	25%
Laboratory Services		$25		$20		$25		$40		$55		$55	X	25%
X-rays and Diagnostic Imaging		$45		$35		$65		$60		$90		$90	X	25%
Skilled Nursing Facility		10%		$150	X	20%	X	$500	X	40%	X	40%	X	25%
Outpatient Facility Fee		10%		$100		20%	X	$300	X	40%	X	40%	X	25%
Outpatient Physician Fee		10%		$35		20%		$50		40%		40%	X	25%
Tier 1 (Generics)		$10		$10		$20		$15		$25		$20	X	25%
Tier 2 (Preferred Brand)		$30		$25		$50		$50	X	$80	X	$90	X	25%
Tier 3 (Nonpreferred Brand)		$40		$40		$80		$70	X	$110	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														
2027 AV Calculator		**91.76**		**91.89**		**80.32**		**81.17**		**71.14†**		**71.45†**		**71.43**

KEY		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2026
		Decreased member cost from 2026
		Does not meet AV
		Within .5 of de minimis
		Securely within AV

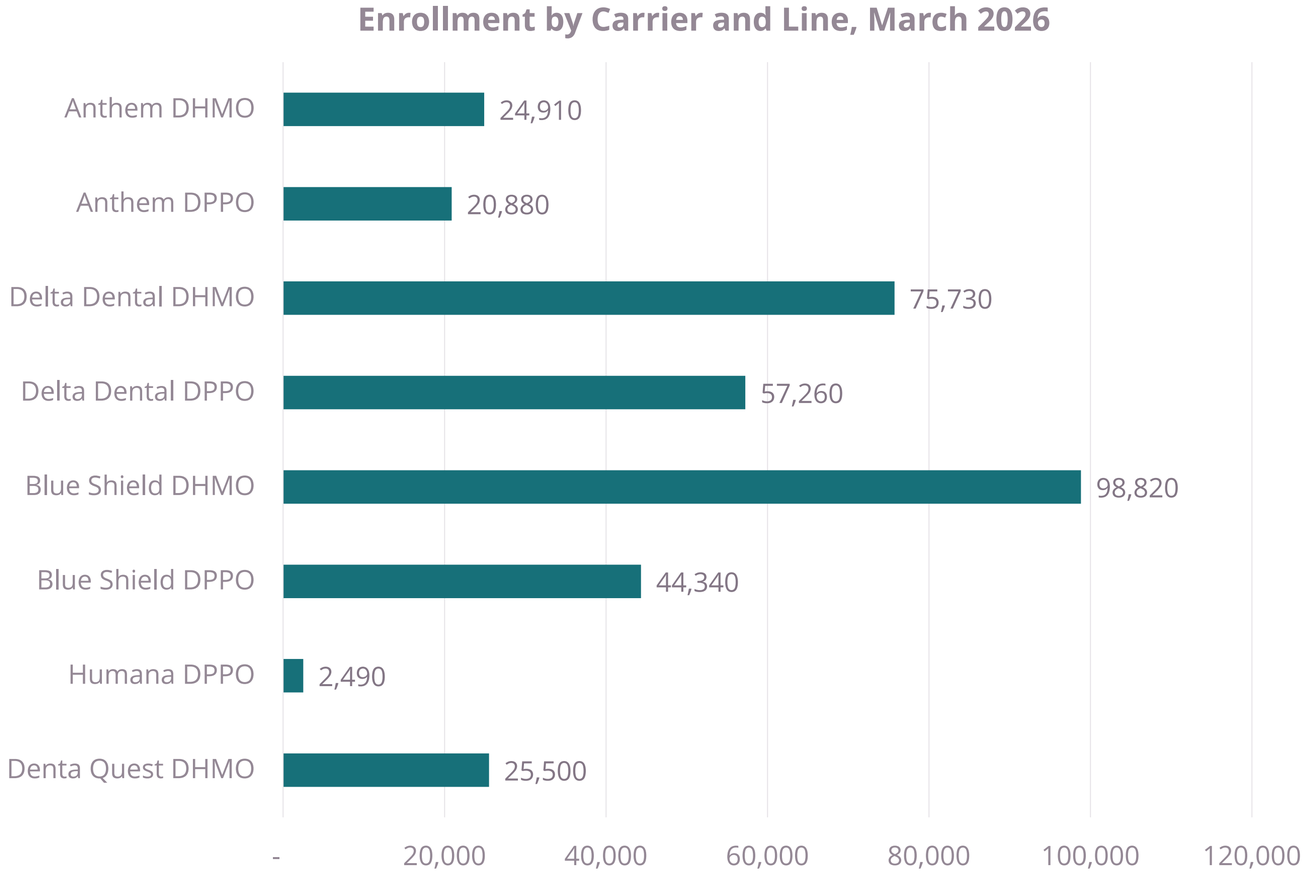
Dental Benefit Background

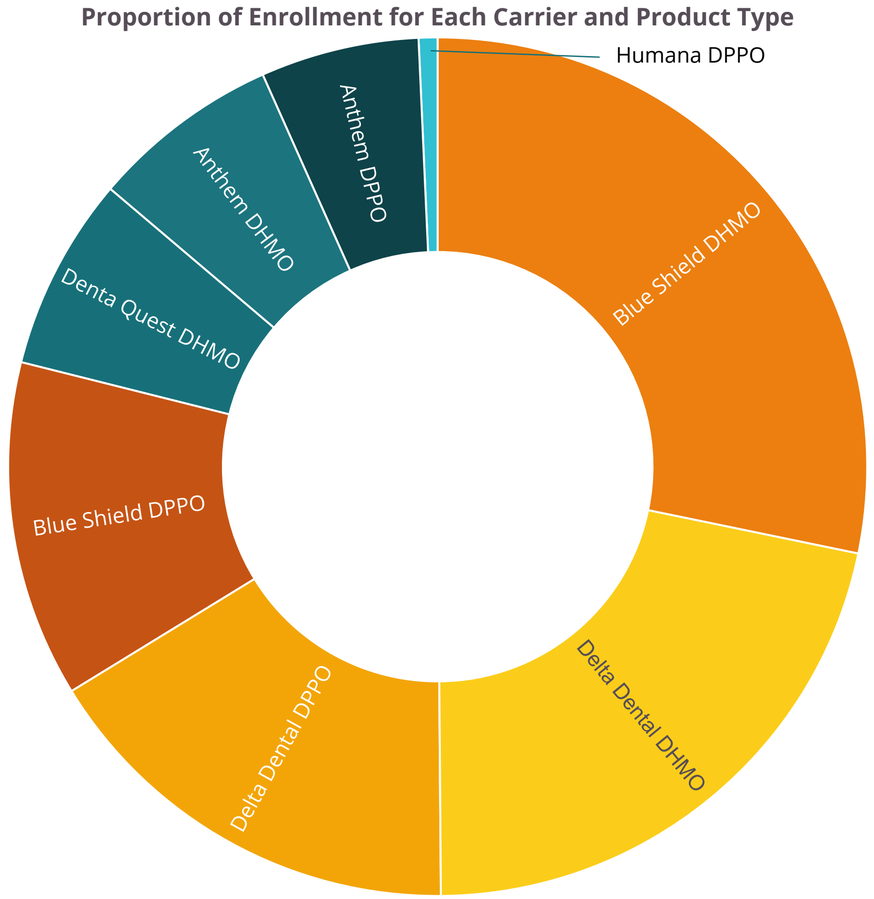
COVERED CALIFORNIA

Qualified Dental Plans

- First offered in plan year 2016
- Covered California requires at least one adult to enroll in a qualified health plan (QHP) before they and their family may purchase a stand-alone qualified dental plan (QDP)
- QDPs offer Family Dental Plans that combine children's and adult dental benefits
  - Adults can enroll without enrolling children into Family Dental Plans
  - If a family enrolls one child, they must enroll all children and at least one adult
- QDPs must include pediatric essential health benefits (EHB) to be certified and available on the Exchange
- Advanced Premium Tax Credits (APTC) cannot be applied to dental premium

Standalone Dental Enrollment





Source: CalHEERS enrollment as of 3/1/2026

Total Enrollment: 349,930

Pediatric Embedded Dental Essential Health Benefit

QHP Issuer	Embedded Dental Carrier
Aetna	Liberty Dental Plan DHMO
Anthem Blue Cross HMO	Anthem Blue Cross DHMO
Anthem Blue Cross EPO	Anthem Blue Cross DPPO
Blue Shield HMO	Dental Benefit Providers DHMO
Blue Shield PPO	Dental Benefit Providers DPPO
Chinese Community	Delta Dental of California DHMO
Health Net HMO	Dental Benefit Providers DHMO
Health Net PPO	Dental Benefit Providers DPPO
IEHP	Liberty Dental Plan DHMO
Kaiser	Delta Dental of California DHMO
LA Care	Liberty Dental Plan DHMO
Molina Health Care	California Dental Network DHMO
SHARP	Delta Dental DHMO
Valley Health	Liberty Dental Plan DHMO
Western Health	Delta Dental of California DHMO

- Enrollees younger than 19 enrolled in a QHP are also enrolled in an embedded Pediatric Dental Plan
- Scope of benefits is determined by Denti-Cal's 2014 children's dental plan
- Beginning in plan year 2015, CMS set the standalone dental plan Maximum out-of-pocket (MOOP) at $350 per child and $700 for two or more enrolled children
- In 2018, CMS removed the Actuarial Value requirement for children's dental plans, however Covered CA still calculates AV to guide benefit design

Dental CDT Code Updates

COVERED CALIFORNIA

Update to CDT Codeset – Revisions, Editorial Changes and Deletions

Revision Codes	New Nomenclature
D0180	comprehensive periodontal evaluation – new or established patient
D2391	resin-based composite – one surface, posterior
D5876	add metal substructure to acrylic complete denture – per arch
D5934	mandibular guidance prosthesis with guide flange
D5935	mandibular guidance prosthesis without guide flange
D7285	incisional biopsy of oral tissue – hard (bone, tooth)
D7286	incisional biopsy of oral tissue – soft
D9222	administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof
D9223	administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof
D9230	administration of nitrous oxide
D9239	administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof
D9243	administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof

Editorial Codes	New Nomenclature
D4263	bone replacement graft – retained natural tooth – first site in quadrant
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant
D5863	overdenture – complete maxillary – natural tooth borne
D5864	overdenture – partial maxillary – natural tooth borne
D5865	overdenture – complete mandibular – natural tooth borne
D5866	overdenture – partial mandibular – natural tooth borne
D5982	surgical stent for soft tissue healing
D6080	implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments

Deleted Codes	Nomenclature
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth
D9248	non-intravenous conscious sedation

Update to CDT Codeset - Additions

New Code	Nomenclature	Proposed Pediatric Copay	Proposed Adult Copay
D5909	maxillary guidance prosthesis with guide flange	$350	Not Covered
D5930	maxillary guidance prosthesis without guide flange	$350	Not Covered
D5938	resection prosthesis, maxillary complete removable	$350	$350
D5939	resection prosthesis, mandibular complete removable	$350	$350
D5940	resection prosthesis, maxillary partial removable	$350	$350
D5941	resection prosthesis, mandibular partial removable	$350	$350
D5942	resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch	$350	Not Covered
D5943	resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch	$350	Not Covered
D5944	resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch	$350	Not Covered
D5945	resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch	$350	Not Covered
D5946	resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch	$350	Not Covered
D5947	resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch	$350	Not Covered
D5948	resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch	$350	Not Covered
D5949	resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch	$350	Not Covered
D6049	scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	$35	Not Covered
D6280	implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments – per arch	$20	Not Covered
D9224	administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof	$65	$65
D9225	administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	$65	$65
D9244	in-office administration of minimal sedation – single drug – enteral	$30	Not Covered
D9245	administration of moderate sedation – enteral	$65	$65
D9246	administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof	$65	$65
D9247	administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof	$65	$65

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.

Written comments can be submitted to *BoardComments@covered.ca.gov*

COVERED CALIFORNIA

Proposed Permanent Enrollment Assistance and Certified Application Counselor Program Regulations

Robert Kingston, Director, Outreach and Sales Division

Background

- The ACA added section 402 of the Indian Health Care Improvement Act (IHCIA), which allows Tribes, Tribal organizations, and urban Indian organizations to establish a program to pay the unsubsidized portion of health insurance premiums for eligible members, referred to as Tribal Sponsorship.
- Separately, Tribes and Indian health programs can become Covered California certified enrollment partners, in which staff are trained and certified to assist individuals in enrolling in coverage.
- However, Covered California's current regulations for certified enrollment partners do not permit key activities necessary for implementing a Tribal Sponsorship program, such as paying premiums on behalf of members and related activities.
- Through ongoing collaboration with Covered California's Tribal Advisory Workgroup and Tribal and Tribal and urban Indian certified enrollers, Covered California has recently identified specific regulatory changes needed to fully support Tribal Sponsorship.
- Accordingly, Covered California is initiating permanent rulemaking to amend the Enrollment Assistance and Certified Application Counselor regulations to facilitate Tribal Sponsorship and ensure alignment with federal law.

Overview of Changes

- The proposed changes to the Enrollment Assistance and Certified Application Counselor Program regulations (sections 6664 and 6864) aim to allow Navigators and Certified Application Entities and Counselors affiliated with Tribes, Tribal organizations, and urban Indian organizations to:
  - Pay premiums on behalf of members or provide consideration for them,
  - Accept premium payments from their members, and
  - Input premium payment information into the system.
- Covered California is also proposing updates to make the regulations gender neutral.

Next Steps

- Government Code section 100504(a)(6) requires the Board to discuss proposed regulations at a properly noticed meeting before adopting them.
- The 45-day public comment period will run from April 3 to May 18, 2026.
- Staff will request the Board to formally adopt the regulation package at the June 18, 2026 board meeting.
- Any additional proposed changes to the proposed regulations will be communicated to stakeholders for review and commenting prior to Action.

PUBLIC COMMENT
Call: (877) 336-4440
Participant Code: 6981308

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COVERED CALIFORNIA

Media Investment Analysis and Marketing Mix Findings

Monica Padilla, Paid Media and Brand Strategy Manager, Marketing Division
Zafreen Zerrelli, Senior Vice President of Analytics & Customer Insights at Stella Rising

MARKETING EVOLUTION

From Directional to Data-Driven

- Marketing has long been treated as a core investment in Covered California's enrollment growth.
- Historically, we have led our marketing efforts with subject-matter expertise and industry best practices; now we are pressure-testing those judgments through **rigorous data and analytics.**
- We use data and insights to **inform our strategies**, **optimize in real time**, and **evaluate performance**, and that discipline is now the foundation for how we invest our paid media advertising funds.

TODAY'S DISCUSSION

Marketing Planning and Optimization

Our goal today is to give you a clear, transparent view of how the Marketing Division invests the funds entrusted to us. Our goal is to give you a transparent view on how the Marketing Division makes spending decisions that are rooted in rigorous data-driven analysis.

We will walk through how Covered California deploys these dollars responsibly and strategically to maximize outreach in communities across the state and to uphold our mission of increasing access and improving health.

MISSION-DRIVEN MARKETING

Building Trust, Expanding Access, and Promoting Health Equity

Visible & Clear	Support the Full Ecosystem	Build & Earn Trust	Meet People Where They Are	Measure progress with an Equity Lens	Retain & Engage Members
• Show that affordable coverage exists and who may qualify. • Use plain, in-language, culturally relevant messaging across channels.	• Help people understand and use Medi-Cal, employer/ commercial plans, and Covered California. • Offer side-by-side comparisons and free, in-language assistance online, by phone, and in person.	• Normalize getting help with enrollment and costs; be transparent about savings and fees. • Share real Californians' stories; reinforce that Covered California is a state marketplace and advocate, not an insurer.	• Invest in trusted media, messengers, and community partners for uninsured and underinsured audiences. • Deliver content in-language (e.g., Spanish, Tagalog, Hindi) and weight to underperforming regions.	• Track awareness, familiarity, favorability, and consideration by region, language, age, and race/ethnicity. • Define success as closing gaps vs. statewide averages; coordinate with OE on enrollment impacts.	• Send clear, timely reminders about benefits, renewals, and where to get free help. • Use 1:1 channels (SMS/email/chat) and promote preventive care and cost-savings tips.

Media Investment Analysis Assignment

Assess Covered California's historical media performance and provide recommendations around two key questions:

Question 1

Are we **investing the right amount** to reach uninsured Californians and build the awareness and trust needed to get people covered?

Question 2

Are we **investing efficiently,** and is our advertising driving incremental enrollments?

Before we dive in:

- Marketing Mix Modeling (MMM) is the gold standard for understanding cross-channel media performance.
- The model indicates that our current media budget level is appropriate to reach uninsured Californians; results state that we have not reached the point of diminishing return.
- Using MMM insights, we optimized campaigns and **realized over 10% improvement** in key outcomes (Return on Advertising Spend, Cost per Plan Selection, and Cost per Engagement).

STELLA RISING

Executive Summary: Halo + Spark

COVERED CALIFORNIA

Approach

Covered California has tasked Stella Rising to **assess its historical media performance** and provide **recommendations around these key pillars**

halō

*Based on CC's mission, goal is to expose our ads (reach) to a critical mass of our target audience multiple times a week (frequency)**

North Star: *Awareness*
KPI*: Reach & Frequency*
SR Solution: *R/F Analysis & Optimization*

Determine channel mix to maximize conversions with a budget that will also maintain strong awareness and reach

SPARK

Maximize investment against conversions (plan selections) via modeling analysis ingesting 3+ years of data

North Star: *Conversions*
KPI: *Plan selections*
SR Solution: *Marketing Mix Modeling*

Analysis conducted at an in-language segment** and enrollment period level

STELLA RISING × COVERED CALIFORNIA

*Defined differently at segment and enrollment period levels (see appendix). Overall, looking to hit 99% Reach, 4x a week during OE period and 50% Reach, 1x a week during Special Enrollment
**In Language segment: Hispanic (HSL), General Market (English), and Asian (Asian in language)

MMM Determines what are the "Ingredients" and their Proportions in Driving Plan Selections

Illustrative

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \beta_5 X_5 + \beta_6 X_6 + \beta_7 X7 + \varepsilon$$

$$\text{Plan Selections} = \beta_0 + \beta_1 TV + \beta_2 Search + \beta_3 Unemployment\ Rate + \beta_4 Social + \beta_5 CTV + \beta_6 \text{Email} + \varepsilon$$

We have this, it is known– Covered California to provide

Dynamic intercept represents baseline factors driving enrollments that are not teased out separately within the mode

Media & Non-Media variables' historical values are known – media ad-stocks applied to raw data prior to modeling. These are different tests for decay and diminishing return impacts. Those with the strongest statistical returns are the ones selected in final model build

	Coefficient (Beta)
TV	B1
Search	B2
Unemployment Rate	B3
Social	
CTV	
Email	

Coefficients found in the model translate to the media contribution level to enrollments. For example, for a linear model, if B1 is 0.05, then 5% of KPI is driven by TV efforts

What model is solving for

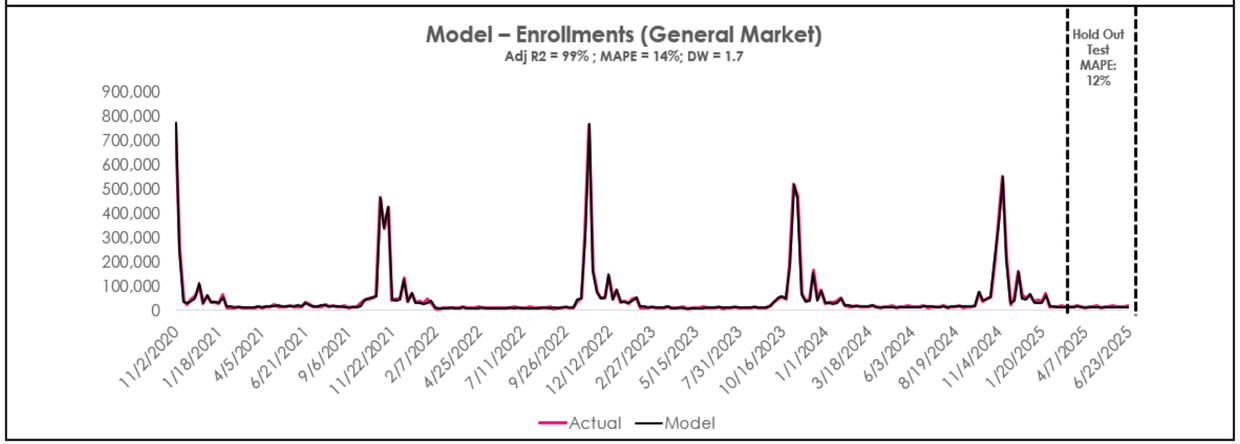
2 cups of flour
1 stick of butter
3 tsp baking powder
3 cups of milk
1 tsp salt
2 tbs oil
3 large eggs

General Market MMM (English Plan Selections)

MODEL FIT VISUAL & PREDICTABILITY

As the model is a continuous equation, we tested its strength in predictability by generating a model with data until April 2025 to see how well it forecasted May – Jun 2025. The 12% forecast MAPE shows the robustness of model for predictability as weeks were only off from actuals on an average of 12%

THE OVERALL MODEL MAPE (USING THE ENTIRE PERIOD FOR BUILD) IS AT 14%.



All Covered California Models have a 99% fit to actual (vs 75% BM) with an average weekly error of less than 14% (vs 15% BM).

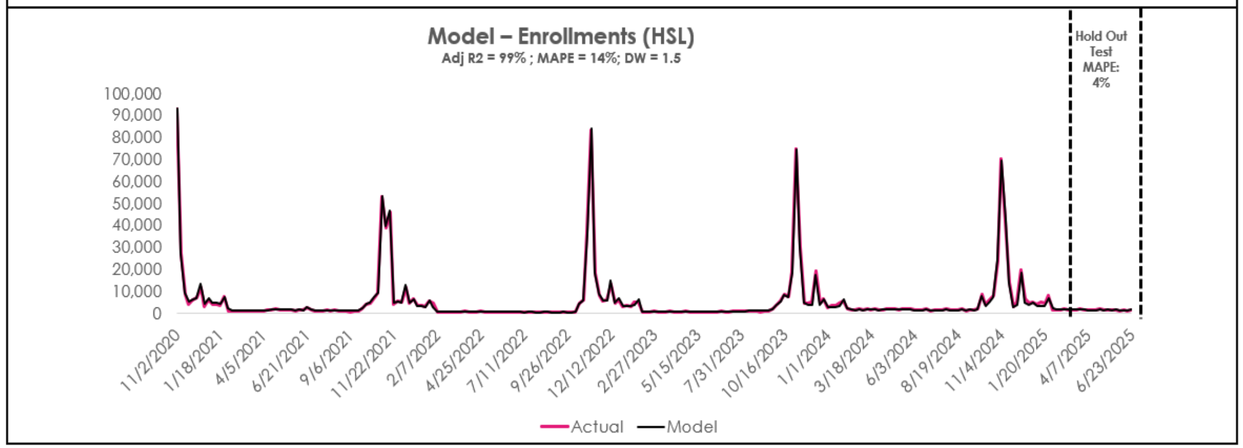
Model predictability (MAPE, holdout test) improved around 20% vs last round of modeling

HSL Market MMM (Spanish Plan Selections)

MODEL FIT VISUAL & PREDICTABILITY

As the model is a continuous equation, we tested its strength in predictability by generating a model with data until April 2025 to see how well it forecasted May – Jun 2025. The 4% forecast MAPE shows the robustness of model for predictability as weeks were only off from actuals on an average of 4%

THE OVERALL MODEL MAPE (USING THE ENTIRE PERIOD FOR BUILD) IS AT 14%.

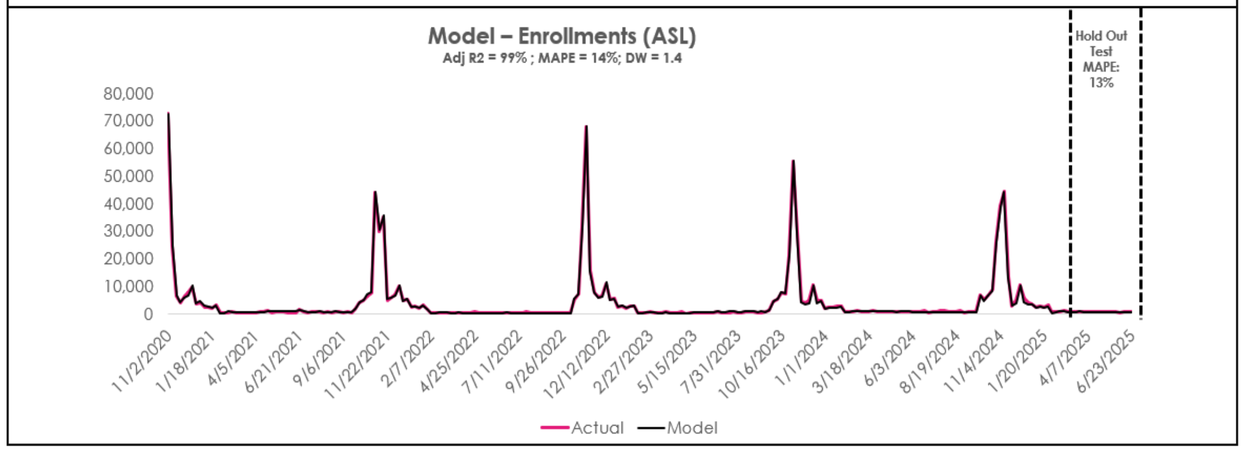


ASL Market MMM (Asian Plan Selections)

MODEL FIT VISUAL & PREDICTABILITY

As the model is a continuous equation, we tested its strength in predictability by generating a model with data until April 2025 to see how well it forecasted May – Jun 2025. The 13% forecast MAPE shows the robustness of model for predictability as weeks were only off from actuals on an average of 13%

THE OVERALL MODEL MAPE (USING THE ENTIRE PERIOD FOR BUILD) IS AT 14%.



Benchmarks are from Financial Services industry – considered strong and reliable regression models. 15% for MAPE, 75% for R squared, and between 1.4 and 2.4 for MAPE.

List of **Inputs Factored in the MMM**

KPI: Total Plan Selections with the ability to drill down to segment & OE/SE performance

VARIABLES ENTERING MODEL SIGNIFICANTLY - ABILITY TO TEASE OUT UNIQUE IMPACT

SEASONALITY*/PASSIVE RENEWAL	**PAID MEDIA BY CHANNEL**	**DIRECT OUTREACH (EMAIL, SMS, DIRECT MAIL)**
ACTIVE AGENT COUNT	**COMPETITOR MEDIA SPEND****	**UNEMPLOYMENT RATE**
ENGLISH MEDIA IMPACT FOR HSL AND ASIAN LANGUAGE PLAN SELECTIONS	**AMERICAN RESCUE PLAN**	**MEDICAL TRANSITION PROGRAM**

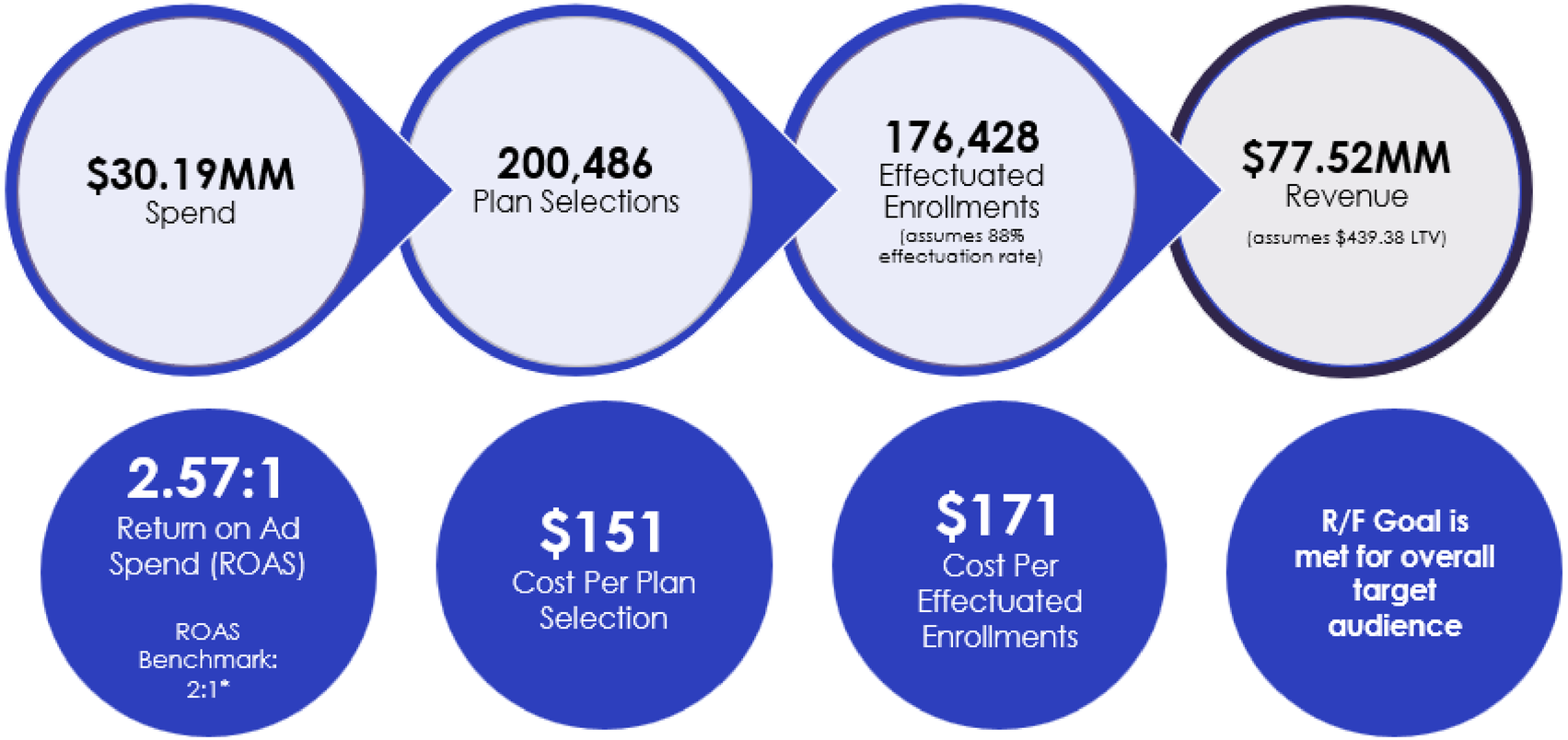
DATE RANGE: Nov 2020 – June 2025

STELLA RISING × COVERED CALIFORNIA

*End of open enrollment periods show spikes YoY

**Competitor List: Aetna CVS, Anthem, Blue Shield, Bright HealthCare, CCHP, IEHP came on, Kaiser, LA Care, Oscar. Sharp, Valley Health Plan, Western Health Adv.

Class-leading FY24/25 Return on Advertising Sales (ROAS).



STELLA RISING × COVERED CALIFORNIA

Assumed that 88% of plan selections become effectuated enrollments. MMM was built on plan selections
Assumed that enrollments have a $439.38 LTV to calculate revenue
ROAS benchmark is Financial Services BM from various sources: Neilsen included
***https://ipa.co.uk/media/9255/profit-ability-the-business-case-for-advertising-2018-full-report.pdf (Financial services at a 1.92 ROAS benchmark)**

Paid Media Investment Has Not Hit Diminished Returns

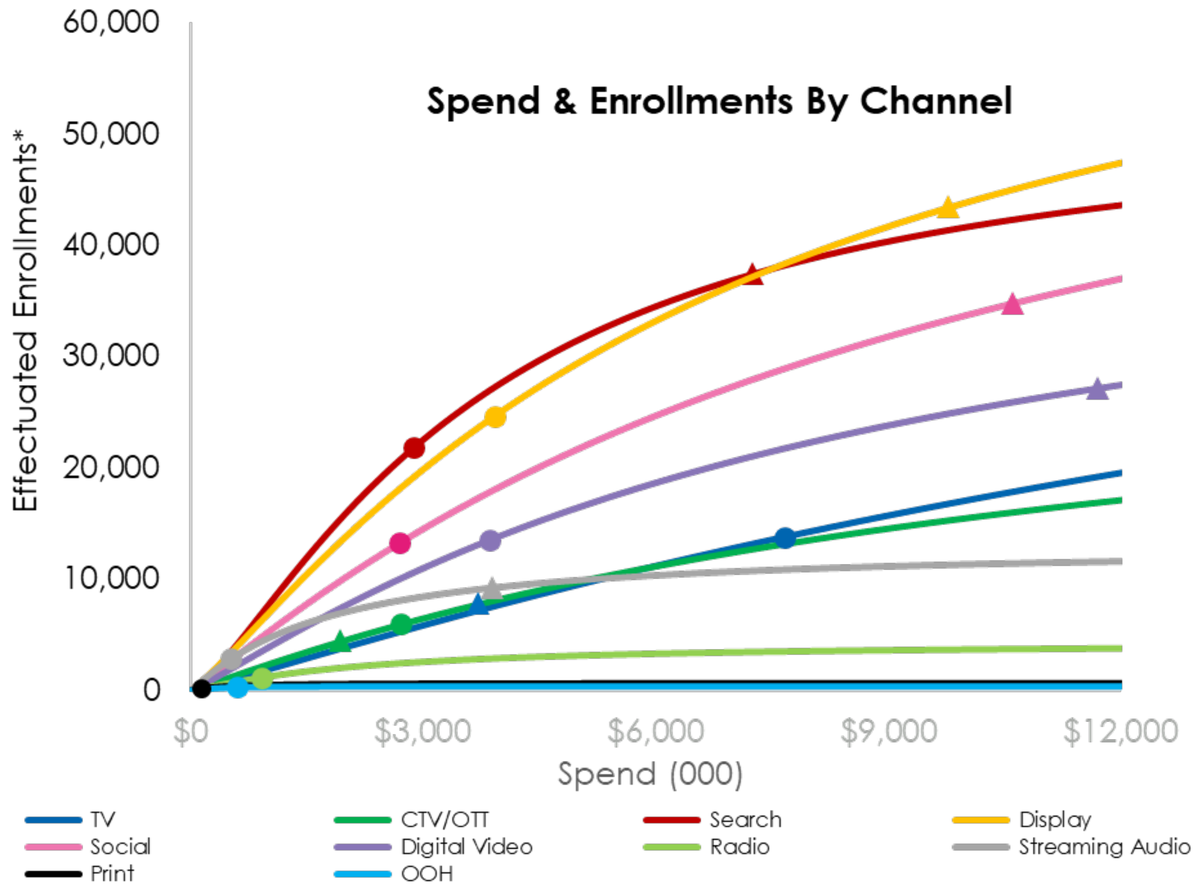
Budget needs to shift into these channels:

Social, Search, Display, Digital Video

KEY FINDINGS:

Paid Search, Display, Social and Digital Video are efficient and have not hit diminished returns for effectuated enrollments

TV and Radio are not as efficient for effectuated enrollments but play a strong role for awareness and driving unduplicated reach, so they need to remain in the mix but at reduced levels



● Spend in FY 24/25

▲ Spend level before diminished returns (incremental CPE > $439.38)

*Assumed 88% of plan selections become effectuated enrollments. MMM is built on planned selections

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Recommended Channel Allocation Mix

ANALYSIS

High awareness channels sometimes differ from efficient conversion channels. Therefore, **channel budget allocation mix for acquisition strategy will ensure**:

- **Awareness/Reach goals are met** for each segment and enrollment period
- The overall **media mix is optimized against driving conversions**
- Please note that optimized allocations differ at a segment and enrollment period level

Channel	FY24/25 Budget Allocation	Optimized Budget Allocation Recommendation
Search	11%	**13%**
Social	10%	**12%**
Digital Video	15%	**17%**
Display	15%	**20%**
TV	30%	**21%**
Radio	4%	**3%**
CTV/OTT	11%	**10%**
Display	15%	**20%**
OOH	2%	**2%**
Streaming Audio	2%	**2%**
Gaming	<1%	**<1%**
Print	<1%	**<1%**
Total	**100%**	**100%**

* MC Segment findings only

*Allocation recommendations will differ at an enrollment period, segment, and altered budget levels

Post MMM Round 1 Implementation Results

ROAS (Return on Ad Spend): Revenue for every $1 spent in advertising. Measures efficiency of our ad dollars
CPPS (Cost Per Plan Selection): The ad dollars required to generate one plan selection. Measures efficiency of converting spend to initial sign up
CPE (Cost Per Effectuated Enrollments): The ad dollars required to generate an effectuated enrollment. Measures the efficiency of converting spend to confirmed, active members

Advertising Efficient at Retaining Plan Selections (OE 23/24)

- When it comes to driving renewals during OE, even when factoring passive renewals, **advertising was highly efficient**
- Callout: **Certified agents** played a very strong role for retention

SUMMARY

- **Paid media delivers strong returns**: at $77.5MM revenue, and 2.57:1 ROAS (vs. 2:1 benchmark) $171 CPE.
- **Retention media is highly efficient**: **5.13:1 ROAS**, and **$86 CPE**, with certified agents reinforcing retention.
- **Headroom before diminishing returns**: incremental effectuated enrollments keep rising with spend, especially in **Search, Social, Display, and Digital Video**.
- **Clear acquisition budget range**: MMM recommends **$37MM–$69MM** annually

DELIVERING ON MISSION

Using Data Driven Insights to Advance Our Mission

Leveraging data to expand access, promote utilization, and improve healthcare outcomes.

Powerful & Authentic Connection

- "For the Love of California" Built a new brand & creative platform for Covered California that connects powerfully with the people we serve.
- Evolved beyond translation and leaned into culture-first storytelling to strengthen trust with California's diverse communities.

Always-On Marketing

- Optimized Open Enrollment vs. Special Enrollment spend and expanded marketing channel mix (e.g. print, broadcast, out-of-home) to reach more Californians without increasing budget.

Optimized Investment

- Leveraged data from a variety of tools including Marketing Mix Modeling, brand health tracking, brand lift studies, creative testing, and media performance analytics.
- Used these insights throughout the year to refine tactics, improve efficiency, and strengthen results.
- Committed to continuous learning from results and sharing performance regularly.

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.

Written comments can be submitted to *BoardComments@covered.ca.gov*

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