Jessica Altman, Executive Director, Covered California

Department of Managed Health Care's Financial Solvency Standards Board Meeting

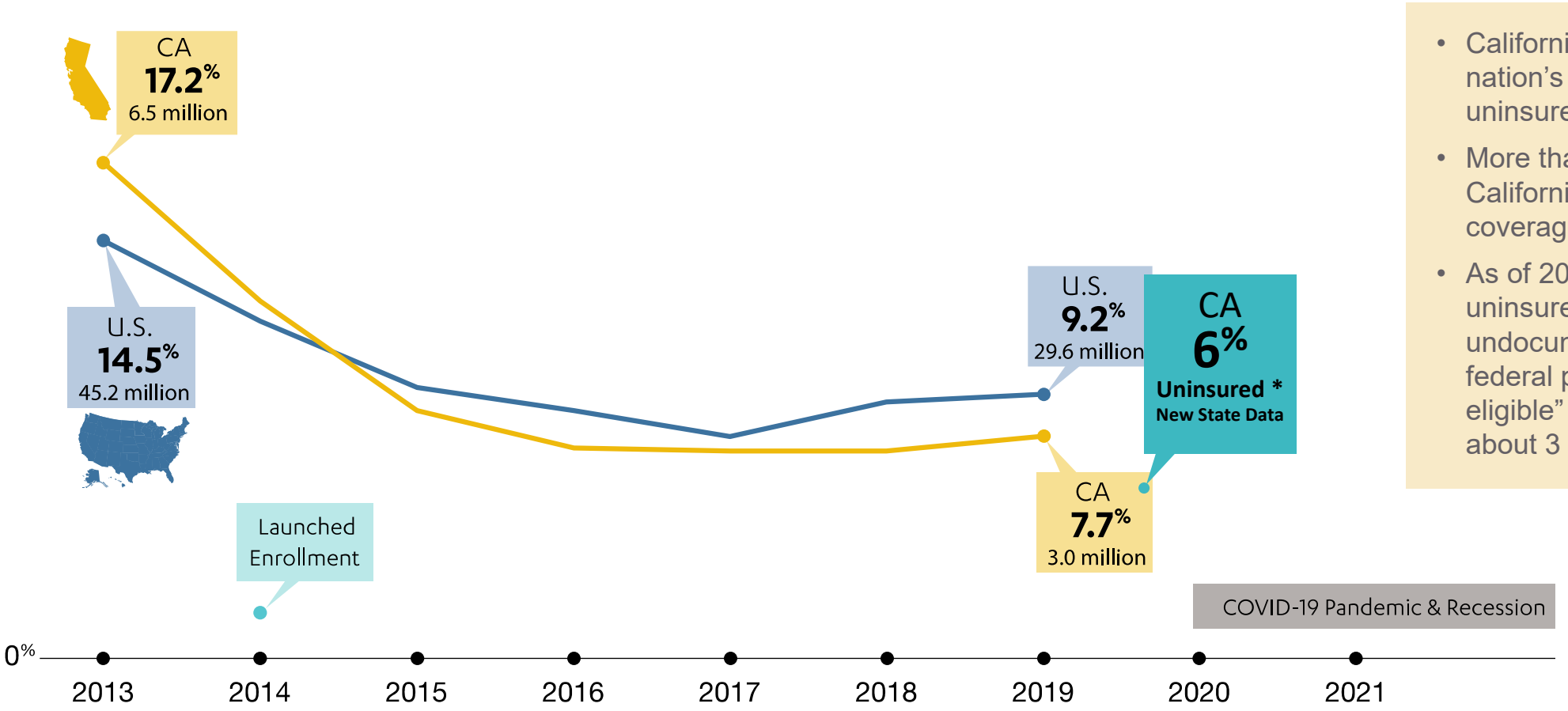
February 22, 2023

COVERED CALIFORNIA'S 10TH OPEN ENROLLMENT PERIOD: 10 YEARS STRONG

- **Current enrollment:** 1.7 million enrollees
    - With more financial help, 90% of enrollees are receiving federal subsidies
- **California's Preliminary Statewide Average Rate Change:** 5.6%
    - Following the passage of the Inflation Reduction Act, carriers resubmitted 2023 rates which reduced the preliminary average statewide rate change from 6% to 5.6%
- **The national average** increase is approximately 10%
- **California's average** rate change over the past 4 years is just 2.3%

RECORD DECREASE IN CALIFORNIA'S UNINSURED RATE

Comparing the Rate of Uninsured in California and the United States



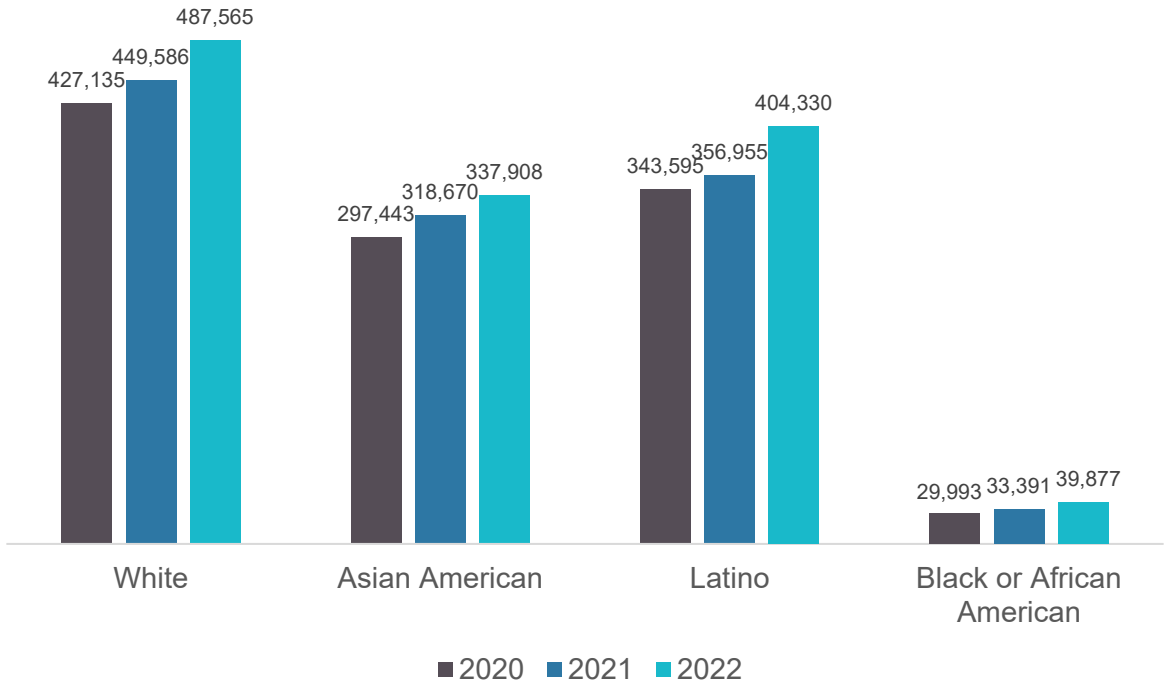
- California experienced the nation's largest drop in the uninsured rate.
- More than 4.7 million Californians have gained coverage since 2013.
- As of 2019, about 3 million uninsured, with about 60% undocumented/ ineligible for federal programs ("currently eligible" uninsured rate is about 3 percent).

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

COMMUNITIES OF COLOR HAD THE LARGEST GAINS IN ENROLLMENT IN 2022

- White enrollment for 2022 is 14 percent higher (nearly 60,000 more enrollees) compared with 2020.
- Asian American enrollment for 2022 is 14 percent higher (nearly 41,000 more enrollees) compared with 2020.
- Latino enrollment for 2022 is 18 percent higher (nearly 61,000 more enrollees) compared with 2020.
- African American enrollment for 2022 is 33 percent higher (nearly 10,000 more enrollees) compared with 2020.

Open Enrollment Plan Selections
(selected races/ethnicities, 2020-2022)

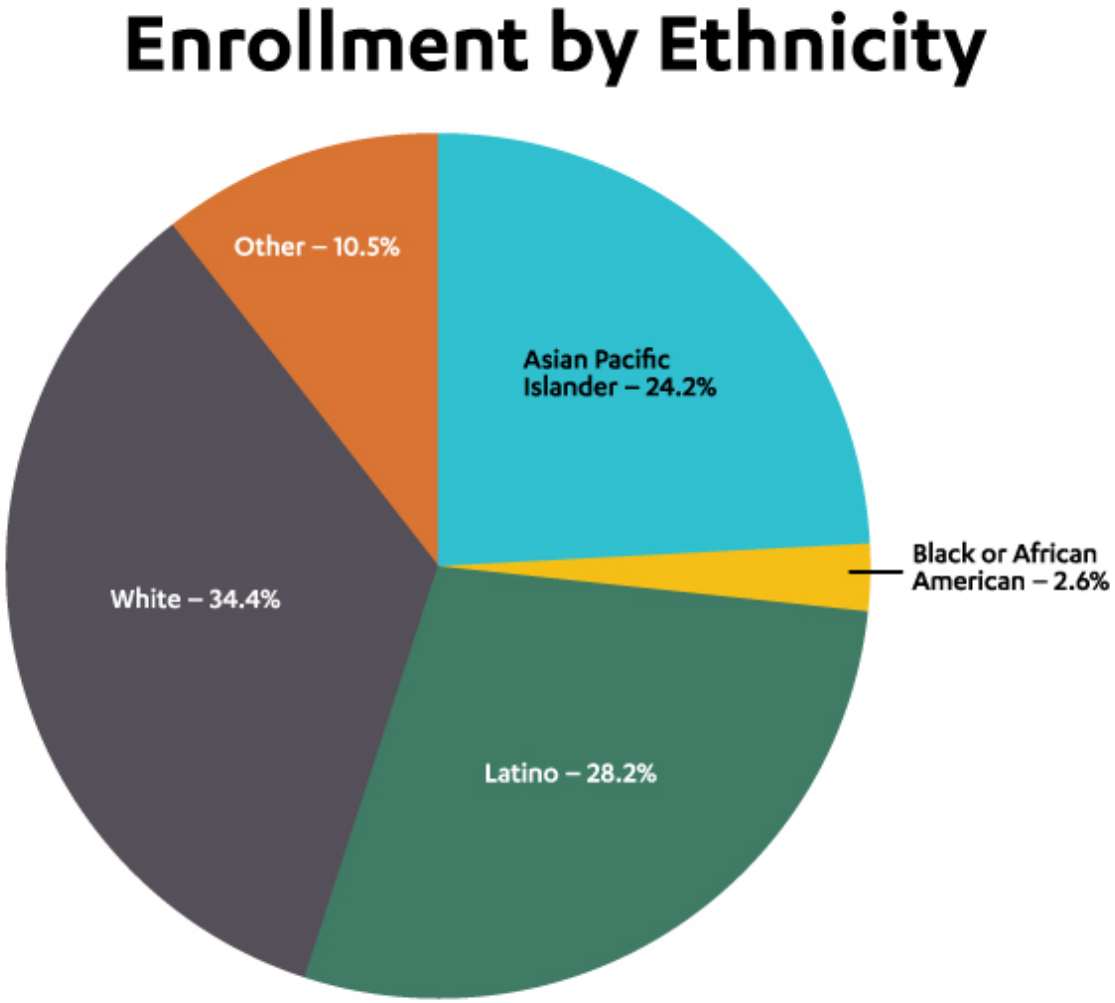


Source: Covered California administrative data as of 2/4/2022.

ENROLLMENT DEMOGRAPHICS – RACE/ETHNICITY

Snapshot of Covered California's enrollment by ethnicity as of March 2022:

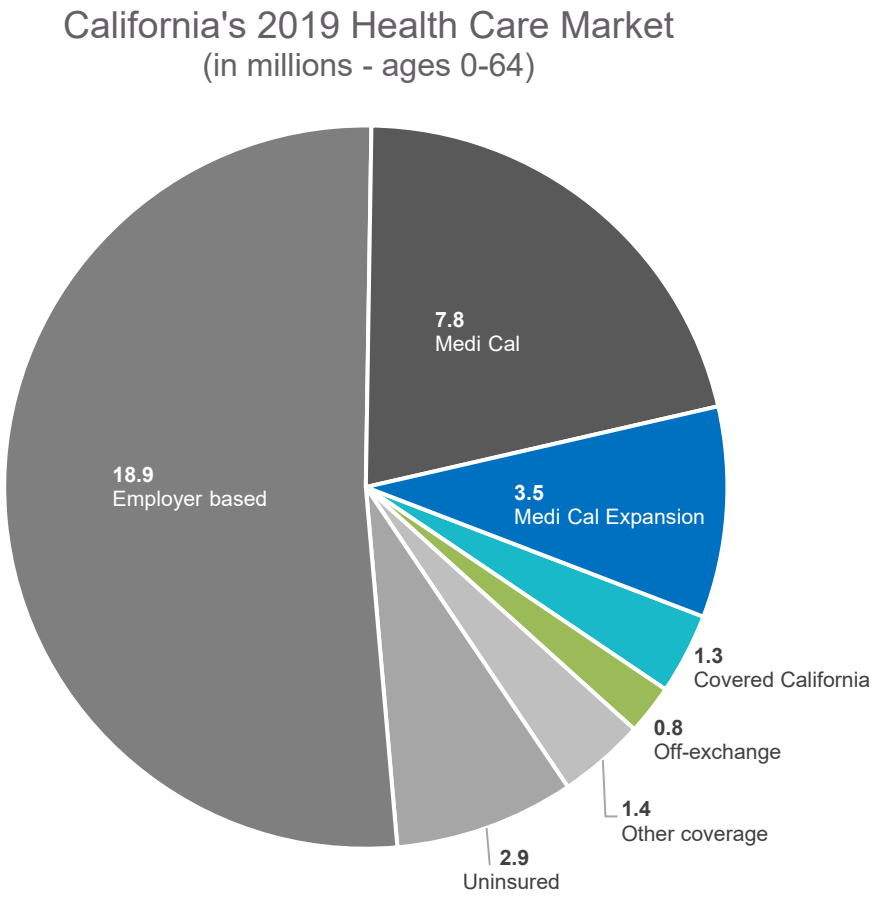
- White—34.4%
- Latino—28.2%
- Asian Pacific Islander– 24.2%
- Other—10.5%
- Black or African American—2.6%



Source: Covered California March 2022 Active Mem Profile. https://hbex.coveredca.com/data-research/

OPPORTUNITIES FOR COVERAGE

The Affordable Care Act has dramatically changed the health insurance landscape in California with the expansion of Medicaid, Covered California and new protections for all Californians.



- As of August 2020, Covered California had approximately 1.53 million members who have active health insurance. California has also enrolled nearly 4 million more into Medi-Cal due ACA expansion.
- Consumers in the individual market (off-exchange) can get identical price and benefits as Covered California enrollees.
- From 2013 to 2019, the U.S. Census Bureau states California cut its uninsured rate by 55 percent. Accounting for those ineligible because of their immigration status, California's eligible uninsured population is just over 1 million.

COVERED CALIFORNIA

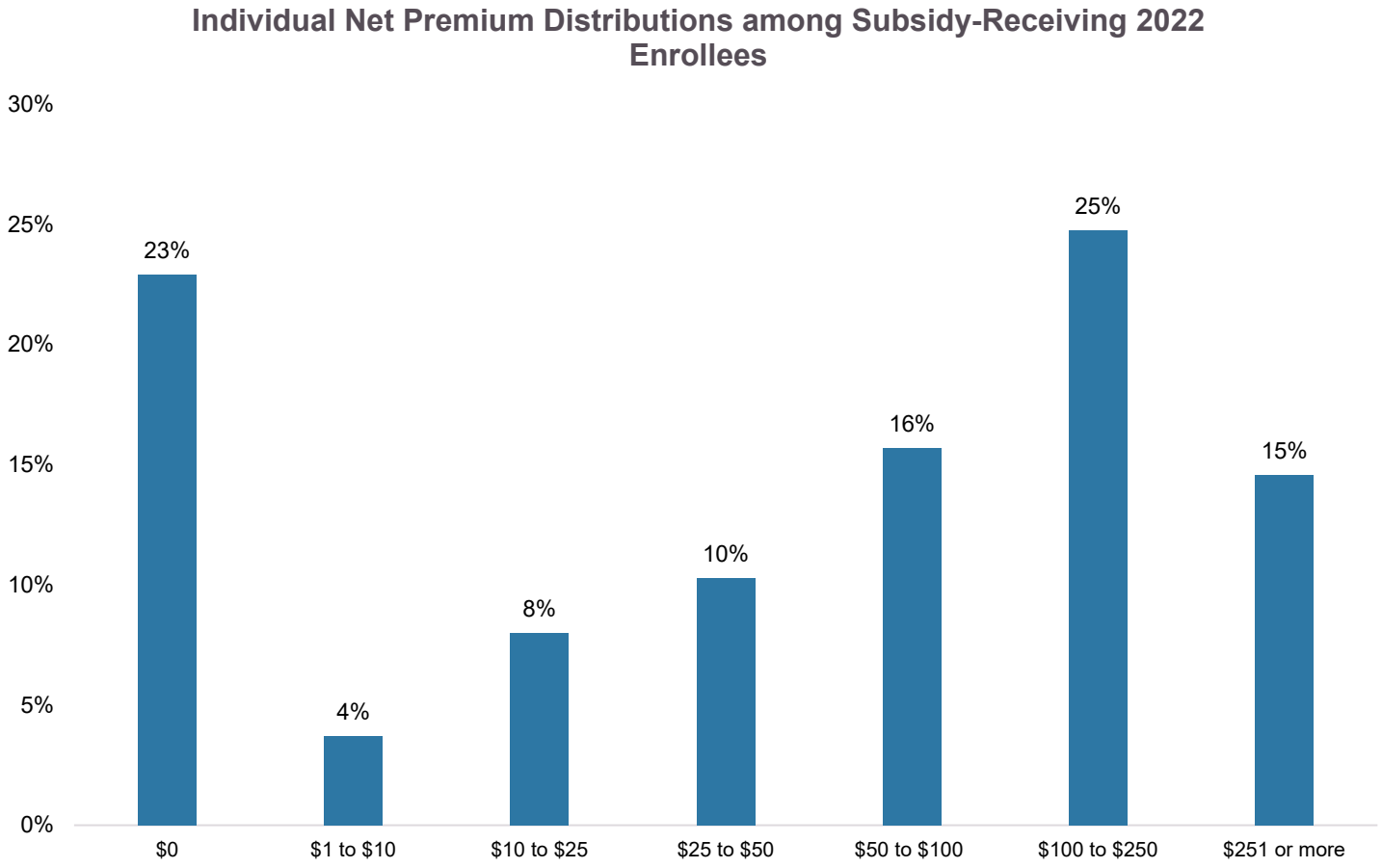
California administrative data sources are used for enrollment totals when possible. All other enrollment estimates are from the 2019 American Community Survey. The total enrollment population sums to more than California's total population as some Californians were covered by more than one type of insurance during the same year.

INFLATION REDUCTION ACT SUBSIDY EXTENSION: WHAT THIS MEANS FOR CONSUMERS AND HEALTH PLANS

NET PREMIUMS WITH THE ARP SUBSIDIES

With enhanced subsidies available through the American Rescue Plan, nearly a quarter of subsidized enrollees have a $0 monthly net premium in 2022.

Nearly half of enrollees pay $50 or less per month.

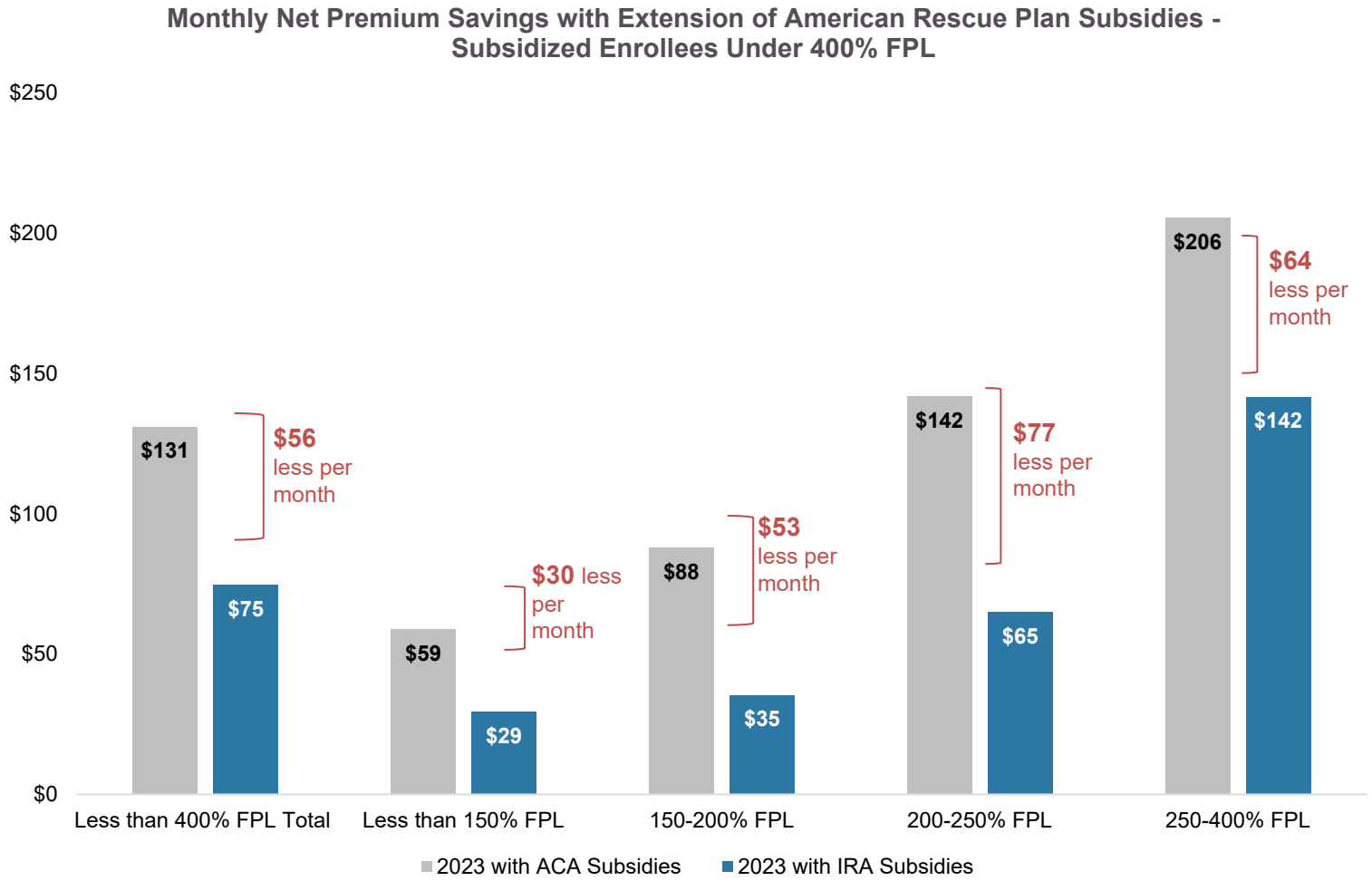


Source: Snapshot of May 2022 Covered California enrollment, among individuals receiving monthly APTC. Premiums reflect net of subsidy cost per member per month.

INCREASED AFFORDABILITY WITH THE PASSAGE OF THE IRA

The Inflation Reduction Act extends the enhanced subsidy levels of the American Rescue Plan through 2025.

Consumers with incomes less than 400% FPL will pay, on average, $56 less per month in 2023 – compared to with ACA subsidies.

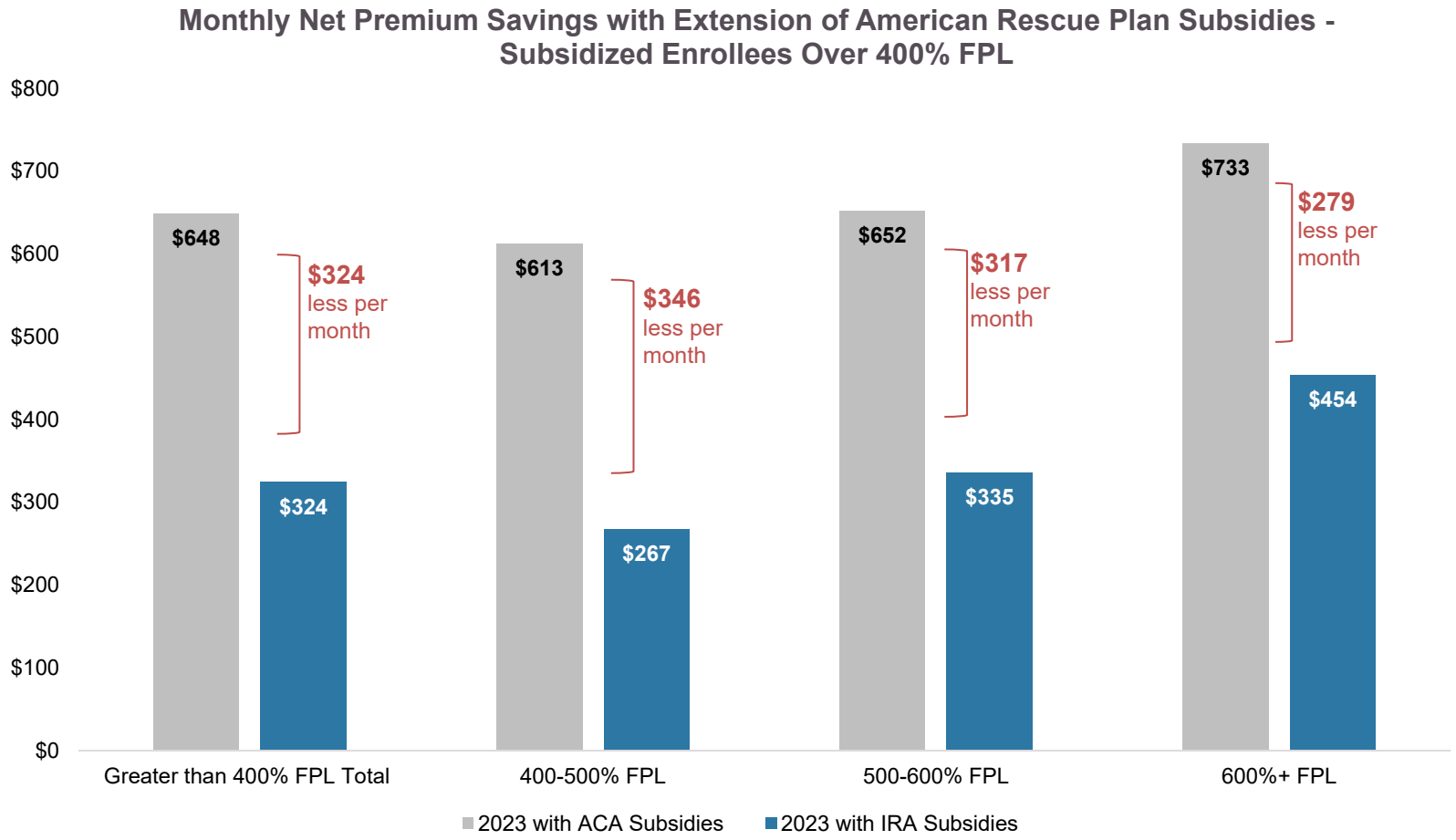


Source: Snapshot of May 2022 Covered California enrollment, among individuals receiving monthly APTC. Premiums reflect net of subsidy cost per member per month, using preliminary 2023 rates.

INCREASED AFFORDABILITY WITH THE PASSAGE OF THE IRA (CONTINUED)

Without the subsidy extension, middle income consumers would have no longer received any federal financial assistance.

Now, middle income consumers who are eligible for financial help will save an average of $324 on their monthly premiums.



Source: Snapshot of May 2022 Covered California enrollment, among individuals receiving monthly APTC. Premiums reflect net of subsidy cost per member per month, using preliminary 2023 rates. Individuals who can purchase a benchmark silver plan at cost below the maximum percentage of income set by program rules are not included in these estimates.

INFLATION REDUCTION ACT SUBSIDY EXTENSION

- Nearly a quarter of subsidized enrollees have a $0 monthly premium in 2022.
- Nearly half of enrollees pay $50 or less per month
- Nearly half of current enrollees with incomes under 400% FPL can enroll in a Silver plan for less than $10 a month in 2023
- About 260,000 uninsured Californians could get covered with a Covered CA plan for under $10 a month. Of these, over 240,000 could get a Bronze plan for free.

STANDARD BENEFIT DESIGNS AND IMPACT ON COMPETITIVE FACTORS IN THE MARKET

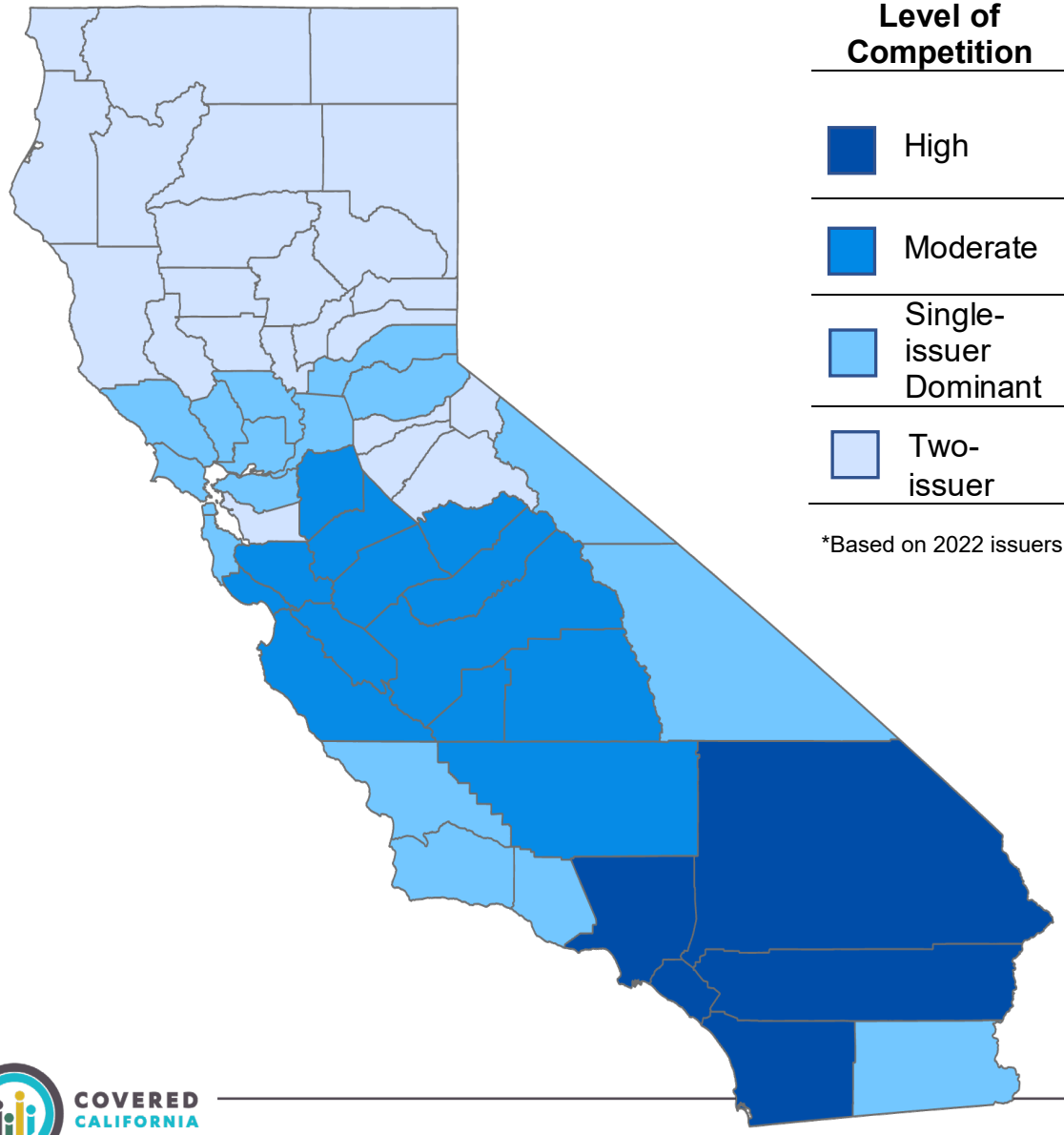
STANDARD BENEFIT PLAN DESIGNS AND ACTUARIAL VALUE

- The ACA requires that all Qualified health insurance plans (QHPs) offered in the individual and small-group markets must provide a comprehensive package of items and services, known as essential health benefits (EHBs). The 10 EHBs are the framework for benefit plan designs and include preventive, outpatient, emergency and hospitalization services and prescription drugs.
- State law[1] authorizes Covered California to develop **Standard Benefit Plan Designs** (SBPDs) that establish the amount of cost sharing between the consumer and the health insurance plan. QHP issuers are required to offer plans using standard benefit plan designs.
- The SBPDs are adjusted annually to meet Actuarial Value requirements, clarify benefit administration, and incorporate benefit design innovations. SBPDs are offered in four basic levels of coverage known as metal levels or tiers: bronze, silver, gold and platinum.

- **Actuarial Value (AV)** is the percentage of total average costs of benefits that a plan will cover. For example, a consumer with a silver plan (**AV** of 70%) would generally expect to pay 30% of the costs of all covered benefits.

[1]California Government Code 100504(c)(1).

Covered California – Meaningful Choice That Matters to Consumers



Level of Competition	Description*	Region	Lives Covered	Percent of Covered CA Lives
High	Five to eight issuers; no single issuer with more than 40% share. In some cases, two issuers offer HMO and PPO products.	15, 16, 17, 18, 19	862K	55%
Moderate	Three or four issuers; a single issuer has at least 50% share in each region.	7, 9, 10, 11, 14	229K	15%
Single-issuer Dominant	Three to five issuers; a single issuer has more than two-thirds market share in each region.	2, 3, 4, 5, 6, 8, 12, 13	431K	28%
Two-issuer	Two issuers; one having 56% share of region.	1	58K	3%

*Based on 2022 issuers

Current market share by type/region:

- R7 - KP 50%; R9 - BSC 59%; R10 – KP 52%; R11 – BSC 65%; R14 – BSC 64%
- R2 – KP 77%; R3 - KP 71%; R4 – KP 67%; R5 - KP 81%; R6 - KP 84%, R8 – KP 80%; R12 – BSC 82%; R13 – Molina 83%
- R1 – Anthem 56%, BSC 42%

2023 PATIENT-CENTERED BENEFIT DESIGN & MEDICAL COST SHARES

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 73% average annual cost	Covers 87% average annual cost	Covers 94% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	$27,181 to $33,975 (>200% to ≤250% FPL)	$20,386 to $27,180 (>150% to ≤200% FPL)	up to $20,385 (100% to ≤150% FPL)	N/A	N/A
Annual Wellness Exam	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Visit	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	$65*	$45	$45	$15	$5	$35	$15
Urgent Care		$65*	$45	$45	$15	$5	$35	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$85	$85	$25	$8	$65	$30
Emergency Room Facility		40% after deductible is met	$400	$400	$150	$50	$350	$150
Laboratory Tests		$40	$50	$50	$20	$8	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$95	$90	$40	$8	$75	$30
Imaging			$325	$325	$100	$50	$75 copay or 25% coinsurance***	$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	$18**	$16**	$16**	$5**	$3	$15	$5
Tier 2 (Preferred Drugs)		40% up to $500 per script after drug deductible is met	$60**	$55**	$25**	$10	$60	$15
Tier 3 (Non-preferred Drugs)			$90**	$85**	$45**	$15	$85	$25
Tier 4 (Specialty Drugs)			20% up to $250** per script	20% up to $250** per script	15% up to $150** per script	10% up to $150 per script	20% up to $250 per script	10% up to $250 per script
Medical Deductible	N/A	Individual: $6,300 Family: $12,600	Individual: $4,750 Family: $9,500	Individual: $4,750 Family: $9,500	Individual: $800 Family: $1,600	Individual: $75 Family: $150	N/A	N/A
Pharmacy Deductible	N/A	Individual: $500 Family: $1,000	Individual: $85 Family: $170	Individual: $30 Family: $60	Individual: $25 Family: $50	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$9,100 individual $18,200 family	$8,200 individual $16,400 family	$8,750 individual $17,500 family	$7,250 individual $14,500 family	$3,000 individual $6,000 family	$900 individual $1,800 family	$8,550 individual $17,100 family	$4,500 individual $9,000 family

Drug prices are for a 30 day supply.

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

** Price is after pharmacy deductible amount is met.

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

COVERED CALIFORNIA AND RISK ADJUSTMENT

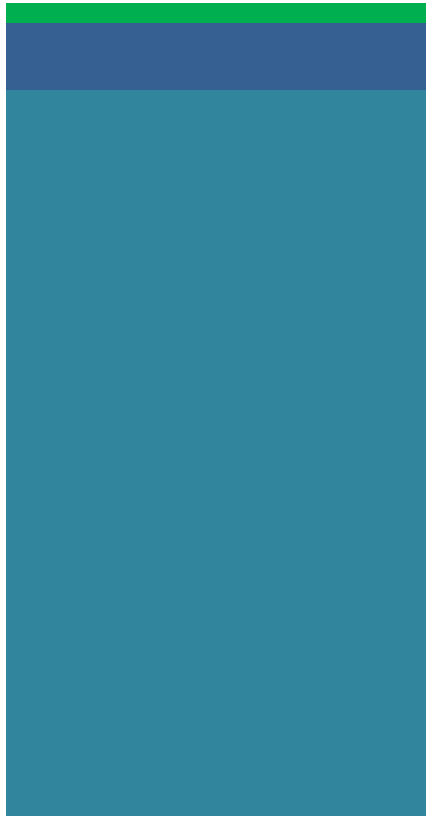
- Covered California's mission is to offer health care coverage choices that offer the optimal combination of choice, value, quality, and service. In order to carry out this task, a data-driven understanding of the risk mix and utilization needs of its population is essential.
- Utilization and risk mix analyses are an essential part of carrier pricing. Covered California enrolls one-third of its membership anew each year, and there is substantial competition and migration between plans during renewal. The high rate of turn-over means that a prior year's population may be very different from the new population. Yet carriers are expected to set rates for the next year only a few months after the current year's open enrollment has closed – not allowing much time for actuarial claims experience to accumulate.

COVERED CALIFORNIA AND RISK ADJUSTMENT (CONT.)

- Covered California utilizes California Department of Health Care Access and Information (HCAI – formerly known as OSHPD) hospital admission data to give QHP Issuers a glimpse into the risk profile of their new enrollment compared to both their prior year's enrollment and the market as a whole. This provides an additional data point for computing their anticipated risk adjustment payable/receivable for the upcoming year.
- HCAI data also lends itself to enabling Covered California to assist Issuers where they might have data submission opportunities within the risk adjustment process to improve their risk adjustment outcomes
- The draft 2024 Notice of Benefits and Payment Parameter (NBPP) is proposing some changes to the risk adjustment methodology, which will not likely cause variations in premiums but is unknown until the QHPs-complete their modeling.

CONSUMER-CENTERED COMPEITITON DRIVING VALUE AND EFFICIENCY

Covered California Issuers: Cumulative Medical Loss Ratio, Administrative Expenses and Profit 2014-2021: Total Health Care Premium of $91.6 billion[1].



2.4% Profit/Surplus ($2.2 billion)

8.9% Administration ($8.1 billion, includes administration, marketing and agent commissions)

88.7% Medical Loss Ratio ($81.4 billion, MLR-direct health care costs)

The Value/Efficiency Story Nationally

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

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

[1] MLR calculations include both on and off-exchange products and where applicable grandfathered products. Profit is assumed to be post-tax and same for grandfathered products

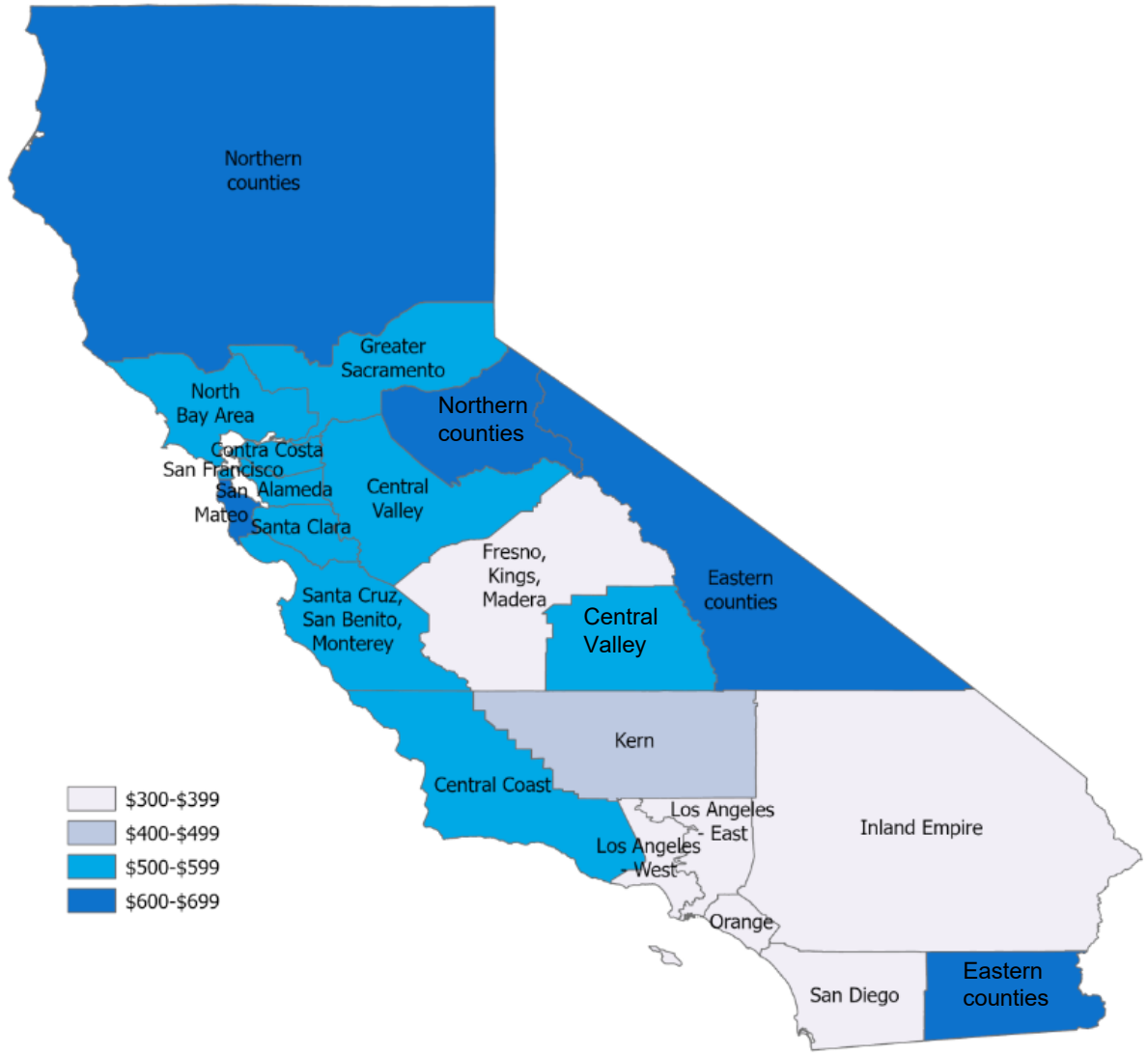
MEDICAL LOSS RATIO (MLR)

- Covered California has collected MLR data for the past seven years (2014 through 2021). For those years, Covered California's MLR averaged 88.7% which is 8.7% above the required minimum medical spending.
- Rebates for the Individual Market are rare. The following table displays the MLR rebates from Covered California QHP issuers since 2014:

Plan Year	Market	Carrier
2014	Individual	Blue Shield
2020	Individual	Molina
2020	Individual	LA Care

- 2022 MLRs will be used for 2024 premiums and have yet to be made public.

COVERED CALIFORNIA REGIONAL PREMIUM VARIATION



Weighted 2023 second lowest silver rates in each rating region

COLLABORATION: COVERED CALIFORNIA AND DMHC

- DMHC and Covered California Actuaries meet when appropriate to discuss trends, issues, and premiums to ensure the best outcome for consumers.

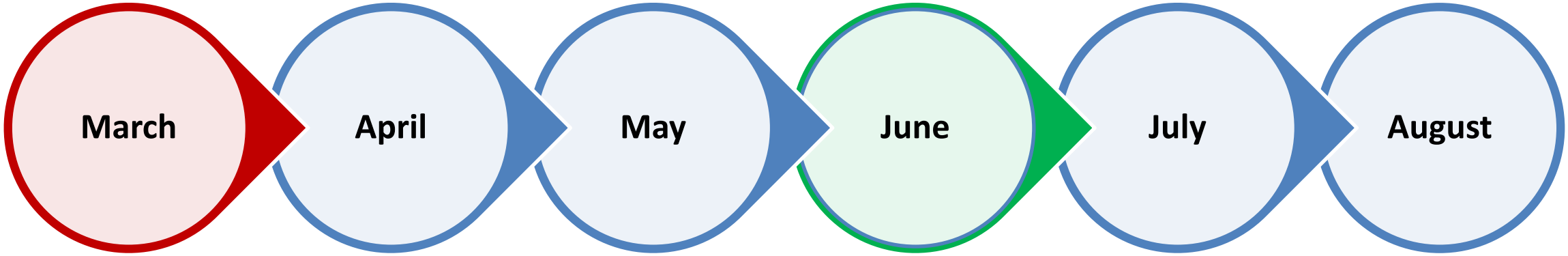
PUBLIC HEALTH EMERGENCY UNWIND

PUBLIC HEALTH EMERGENCY UNWIND

- In preparation for the end of the COVID public health emergency (PHE) when Medi-Cal redeterminations will resume, Covered California is working closely with DHCS to implement Senate Bill 260 (Chapter 865, Statutes of 2019) that will transition subsidy-eligible individuals into Covered CA following a Medi-Cal discontinuance.

- Individuals transitioning will be “auto-enrolled” in the lowest cost silver plan to maximize premium tax credit and cost sharing support. Consumers may opt into selecting another available plan or opt out of coverage.

MEDICAID CONTINUOUS COVERAGE & SB 260 FACILITATED ENROLLMENT



MC MOE Ends

*For illustrative purposes, the Medicaid Continuous Coverage requirement ends in **March 2023**.*

Medi-Cal Renewal Activities

Medi-Cal Renewal Begins

*Medi-Cal Renewal activities begin for individuals with **June** renewal month.*

Medi-Cal Renewal Ends & Covered CA Facilitated Enrollment Begins

*Medi-Cal eligibility is redetermined and if found ineligible, the last day of Medi-Cal eligibility will be **6/30/2023**.*

If found eligible for financial help, Covered California SB 260 facilitated enrollment starts, and letters are sent to individuals to inform them of their options and next steps.

Special Enrollment Period (SEP)

Covered CA Coverage Begins

Covered CA SEP begins as soon as the re-determination is completed for individuals who lose Medi-Cal coverage.

*Covered CA coverage starts **7/1/2023**.*

*The individuals have until **7/31/2023** to make a payment or opt-in to keep the selected plan.*

SEP Ends

The individuals' SEP lasts until 8/29/2023.

Individuals who keep the selected plan can still change it during SEP.

Individuals who opt out or miss the payment/opt-in deadline can still shop for a plan during SEP.

Individuals who maintain income at or below 150% can enroll or change their plan anytime during the year

QUALITY TRANSFORMATION INITIATIVE

COVERED CALIFORNIA HOLDING PLANS ACCOUNTABLE

Domains for Equitable, High-Quality Care

PHYSICAL | BEHAVIORAL | ORAL | SOCIAL

- Population health management
- Health promotion and prevention
- Acute care
- Chronic care
- Complex care

Care Delivery Strategies

- Effective primary care
- Appropriate, accessible specialty care
- Integrated delivery systems and ACOs
- Networks based on value
- Leveraging technology
- Cultural and linguistic competence

Goals

- Improvement in health status
- Elimination of disparities
- Evidence-based care
- Patient-centered care
- Affordability for consumers and society

Key Levers

Covered California recognizes that promoting change in the delivery system requires **aligning** with other purchasers and working with all relevant payers in a way that improves value for consumers and society while minimizing administrative burden on plans and providers.

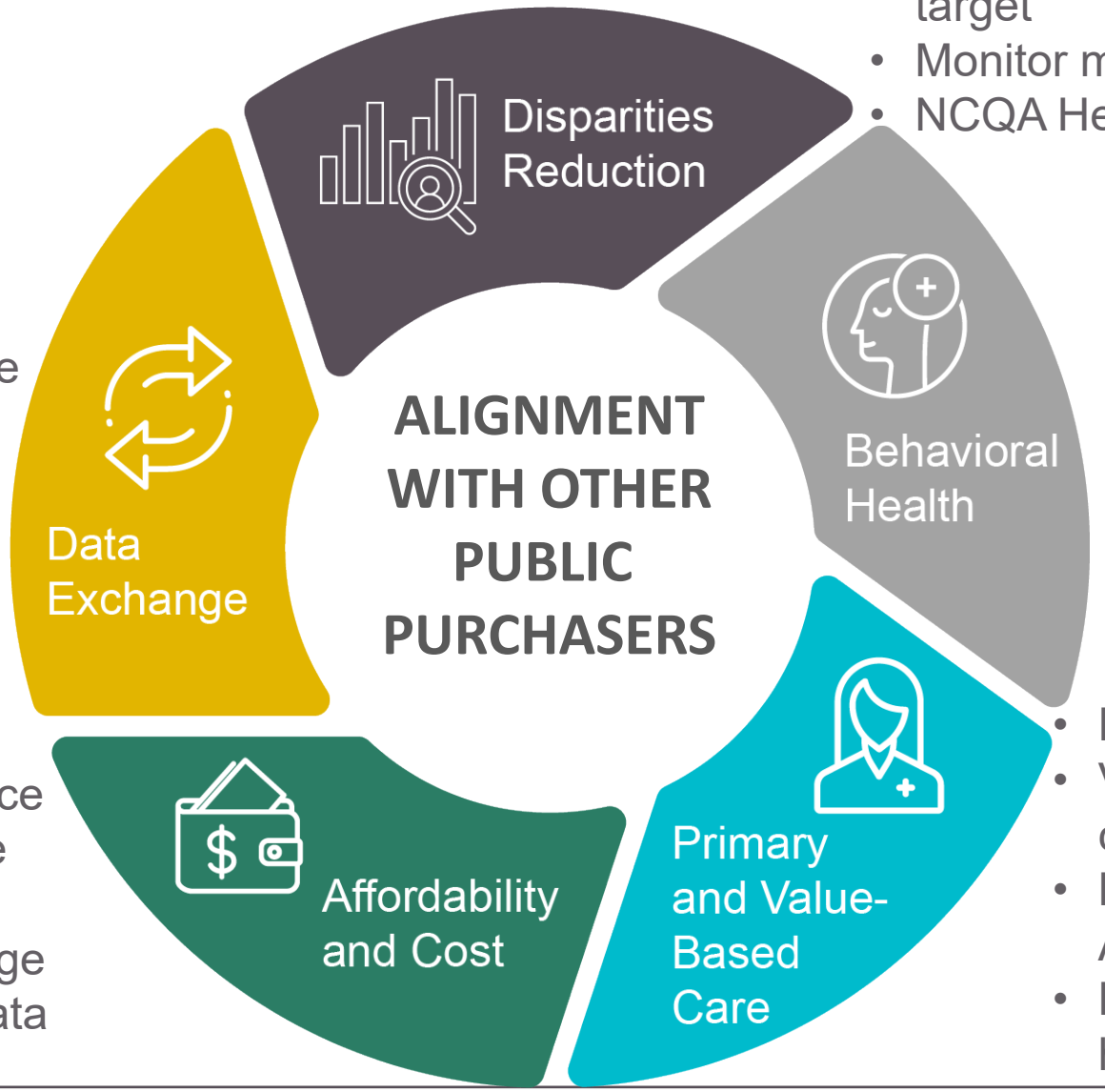
- Benefit design
- Measurement for improvement and accountability
- Data sharing and analytics
- Payment reform
- Consumer empowerment
- Quality improvement collaboratives
- Technical assistance
- Certification and accreditation

Community Drivers: Social Influences on Health, Economic and Racial Justice

STRATEGIC FOCUS AREAS

- Collect race, ethnicity, and language data
- Implement disparities interventions and meet a multi-year disparities reduction target
- Monitor maternal health disparities
- NCQA Health Equity Accreditation

- Quality Rating System
- Healthcare Evidence Initiative (HEI) claims database
- Health Information Exchange (HIE) participation
- Data submission to Integrated Healthcare Association (IHA)



- Telehealth to improve access
- Depression screening
- Opiate use disorder treatment
- Primary care behavioral health integration

- Track hospital compliance with CMS Hospital Price Transparency rule
- Review of unit price range and trends via claims data

- PCP assignment for all enrollees
- Value based payment for primary care
- Measure and report enrollment in Accountable Care Organizations
- Monitor provider organization and hospital quality and costs

QUALITY TRANSFORMATION INITIATIVE OVERVIEW

- Intended to set direct and substantial financial incentives for QHP issuers to improve the quality of healthcare and to reduce health disparities.
- 0.8% of premium at risk for payment in PY2023, moving up to 3% in PY2025, with intention to increase to 4% maximum in PY2026.
- Measure scores are compared to national percentile benchmarks of 25th percentile and 66th percentile to determine the per measure payment amount.
- Funds from payments would be used to establish an internal, separately tracked, Quality Transformation Fund.
- Issuers are required to submit a quality improvement plan detailing the actions they plan to take to improve quality and equity for any measure for which they score below the 25th percentile.

QUALITY TRANSFORMATION INITIATIVE OVERVIEW (CONT.)

QTI measure set:

- Controlling High Blood Pressure (NQF #0018)
- Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575)
- Colorectal Cancer Screening (NQF #0034)
- Childhood Immunization Status (Combo 10) (NQF #0038)

Reporting only measures:

- Depression Screening and Follow-Up for Adolescents and Adults (DSF)
- Pharmacotherapy for Opioid Use Disorder (POD)

All measures will be stratified by race/ethnicity for reporting only in initial years. Quality payments tied to reducing health disparities for the QTI measure set will begin in 2025 or 2026 once a methodology has been established.

25-2-2 OVERVIEW

- Issuers must meet quality performance requirements or face removal from the Exchange if requirements are not met.
- **Monitoring Period:** If an issuer has one or more products that falls below the MY2018 25th percentile composite benchmark for its product-reportable subset of the QRS Clinical Quality Management Summary Indicator measures for two consecutive years.
- **Remediation Period:** The product is required to meet or exceed the 25th percentile composite benchmark within the following two years, or it will not be certified for the Plan Year following the performance assessment of the last year of the remediation period.

25-2-2 OVERVIEW (CONT.)

- If an issuer offers more than one product, each product is independently assessed.
- Product performance on the QRS Clinical Quality Management Summary Indicator measures will be assessed annually.
- Issuers will be required to submit a quality improvement plan for each product that enters the remediation period that details the action(s) they will take to meet or exceed the 25th percentile composite benchmark within the remediation period.
- Removal policy will not be applied in a Covered California rating region where removal of one or multiple products would lead to fewer than three issuers remaining in the region.

HEALTH EQUITY AGENDA

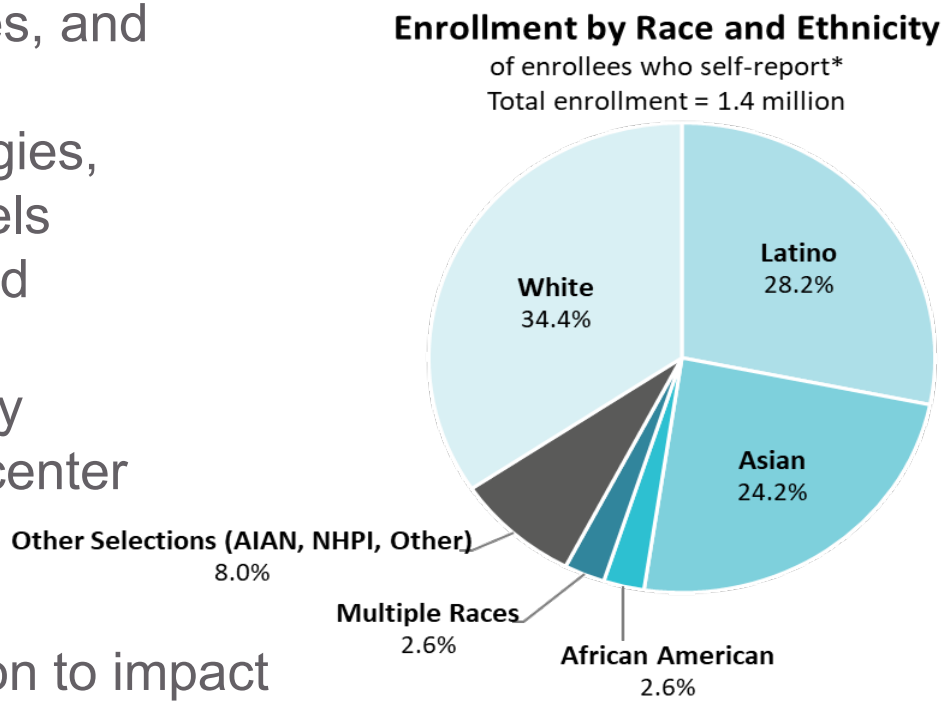
COVERED CALIFORNIA HEALTH EQUITY AGENDA

Enrollment and Outreach Efforts

- Marketing and promotional efforts focus on health insurance literacy, racial and cultural diversity, LGBTQ communities, and rural locales.
- Culturally and linguistically tailored materials and strategies, in-language marketing in nine languages, media channels specific to Latino, African American, Asian American, and LGBTQ+ communities.
- In-language consumer support through racially/ethnically diverse agents, navigators, Covered California service center representatives.

Patient-Centered Benefit Design

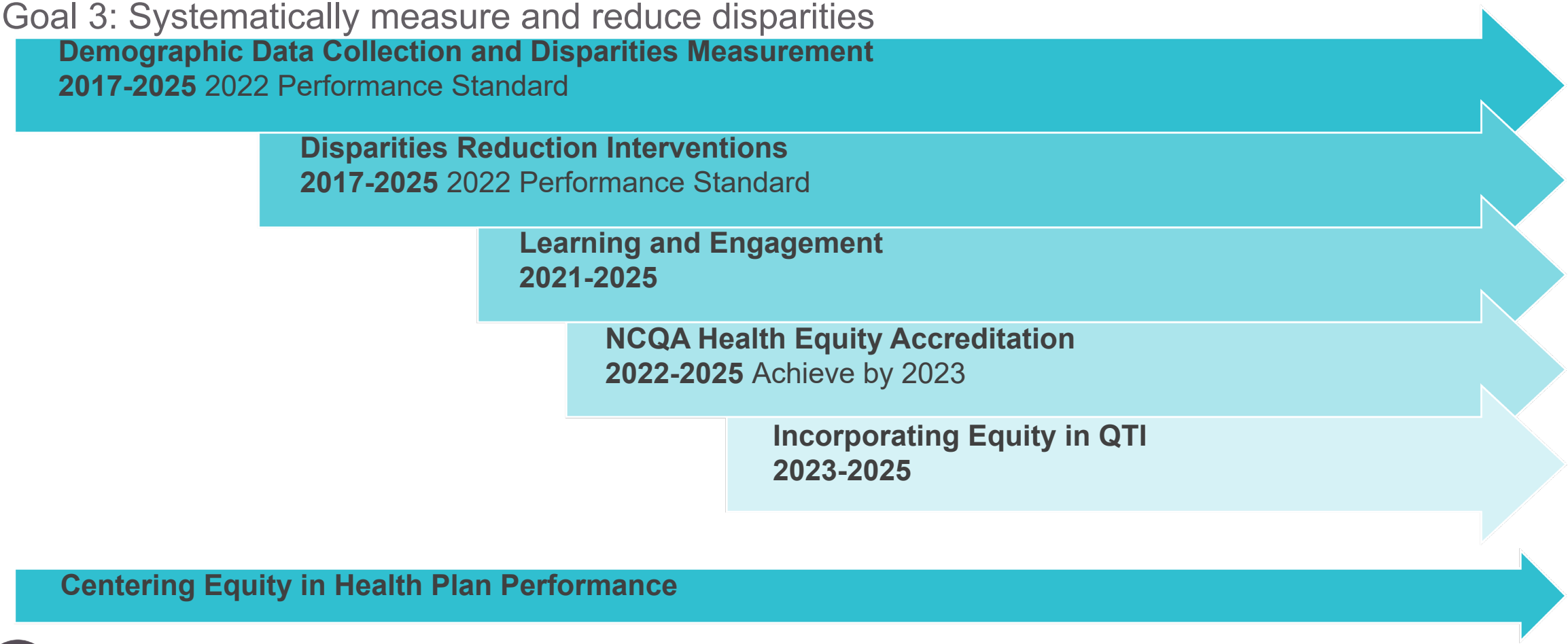
- Focus on “health insurance literacy” and income, attention to impact of cost sharing at each income level,
- Designed to prevent “gotcha” insurance experiences, e.g., standard benefit designs, emphasis on copays over co-insurance.
- Where possible, primary, urgent, and other outpatient care not subject to deductible.



*March 2022 Active Member Profile
**Other Selections is comprised of American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and Other.

COVERED CALIFORNIA HEALTH DISPARITIES INITIATIVES

Covered California's disparities reduction initiatives seek to achieve the following goals:
Goal 1: Improve disparity data capture to support measurement
Goal 2: Improve structure and rigor for disparities intervention development
Goal 3: Systematically measure and reduce disparities



DISPARITIES REDUCTION MOVING FORWARD

Covered California is working to:

- Develop with DHCS and CalPERS a shared disparities reduction methodology to use for disparities measurement and reduction requirements across markets.
- Incorporate disparities reduction accountability in the Quality Transformation Initiative.
- Improve demographic data collected by Covered California and shared with QHP issuers.

ADVANCING PRIMARY CARE INITIATIVES

ALIGNMENT WITH PUBLIC PURCHASERS

Behavioral Health
Aligned contract requirements

Health Equity
Joint development of disparities methodology

Telehealth
Cross-purchaser analysis of telehealth utilization

Clinical Measures
Shared set of parsimonious performance measures

Advanced Primary Care
Shared measure set and reporting requirements

CMS State Transformation Collaborative

COVERED CALIFORNIA ADVANCED PRIMARY CARE ACTIVITIES AND ENGAGEMENTS

Covered California is actively engaged in the following initiatives:

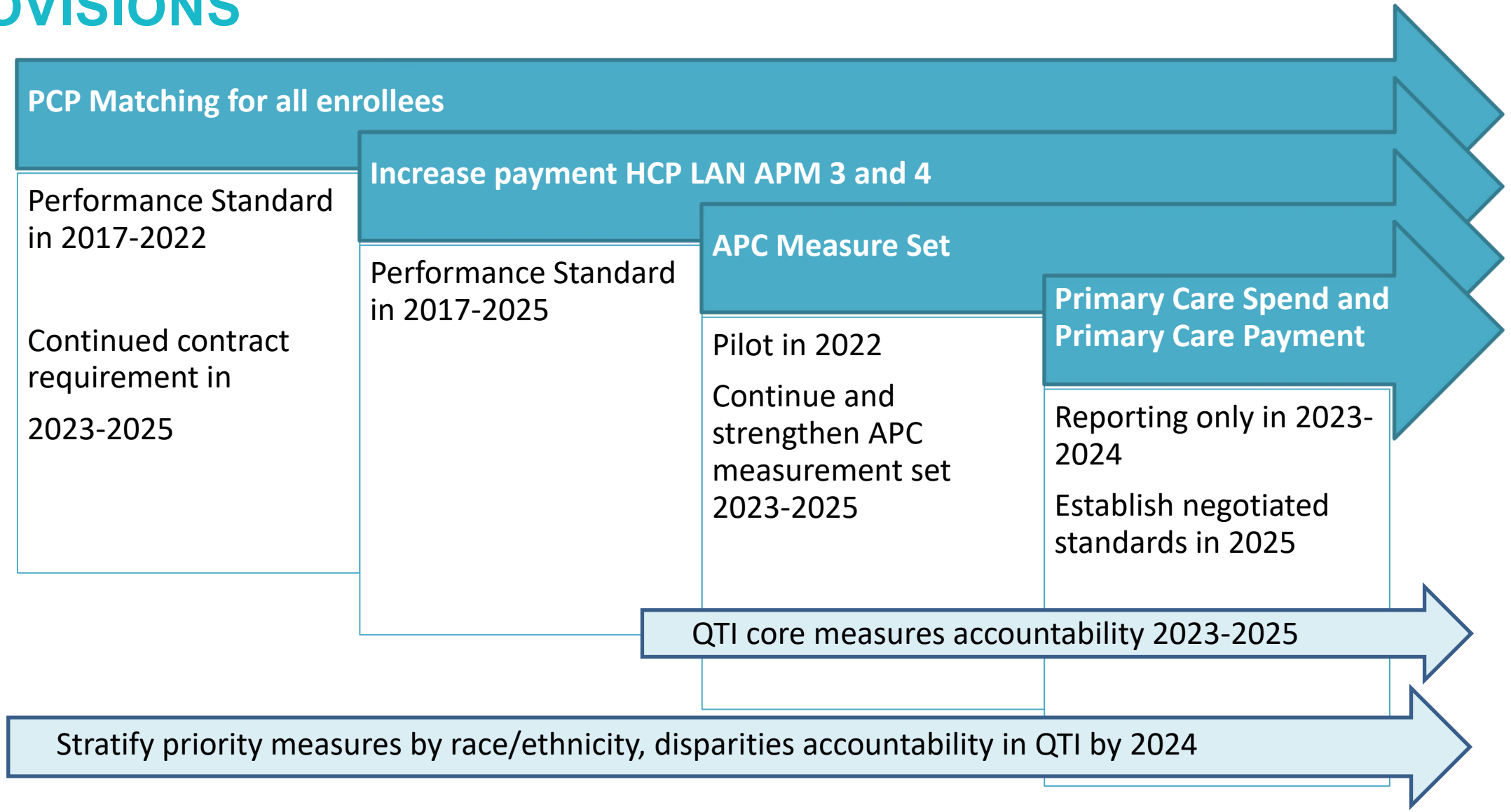
- ✓ **CQC development of Advanced Primary Care measure set**
  - CQC Advanced Primary Care workgroup
- ✓ **Covered CA – IHA primary care spend analysis**
- ✓ **IHA Align. Measure. Perform (AMP) Provider Organization Quality and Cost analysis**
  - IHA/RAND Primary Care Spend Project
- ✓ PBGH Primary Care Payment Reform Work Group
- ✓ CHCF Primary Care Investment Coordinating Group (PICG)

Covered California is actively tracking the following initiatives:

- ✓ CHHS Office of Health Care Affordability
- ✓ CMS Primary Care First program
- ✓ HCP LAN focus on health equity in primary care payment models

Bold indicates related QHP Issuer contractual requirement

2017–2025 ADVANCED PRIMARY CARE CONTRACT PROVISIONS



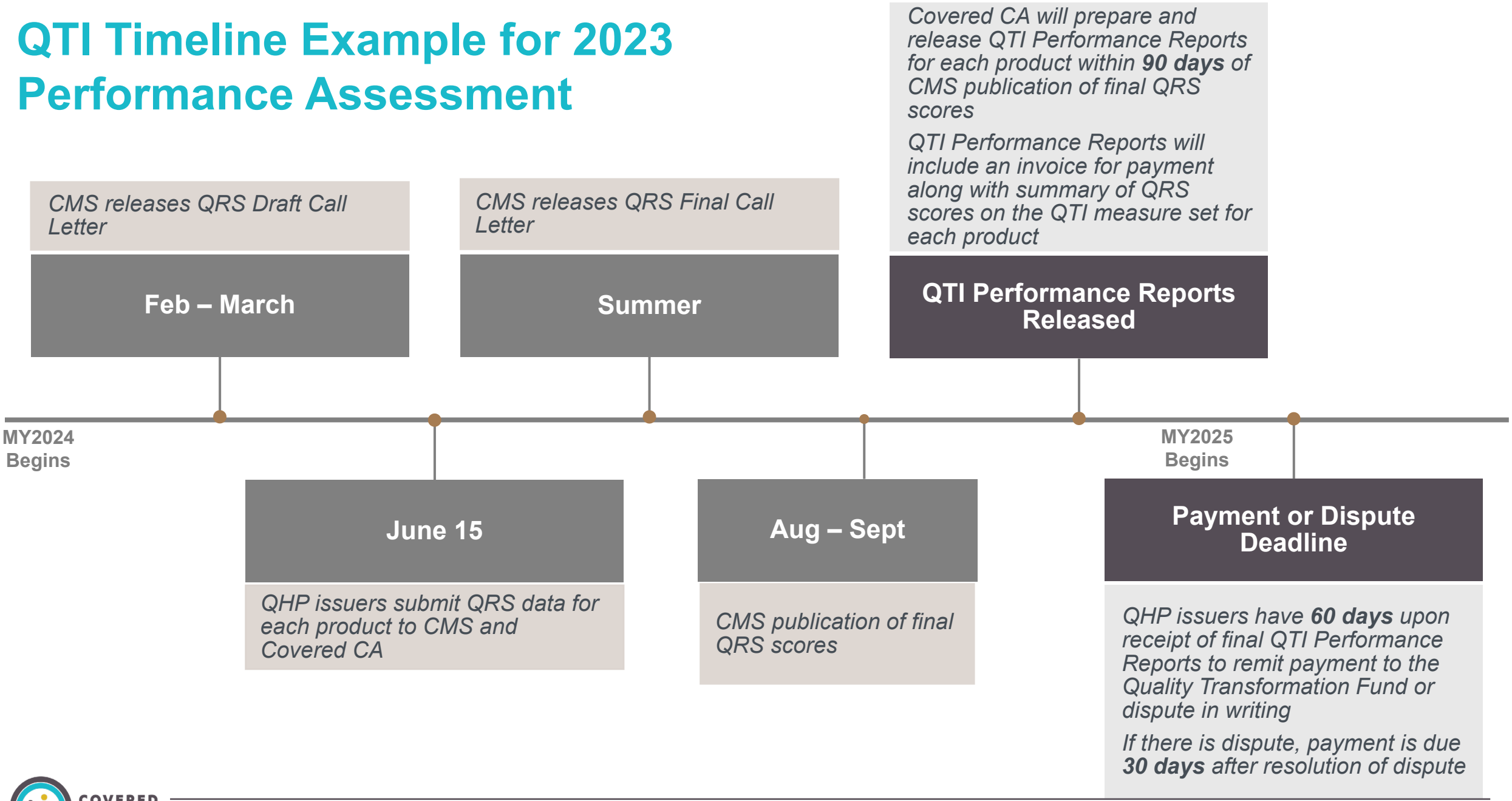
OPPORTUNITIES

- Continuing to explore options for evaluating the impact of PCP matching such as tracking how many enrollees have a visit with their selected or assigned PCP
- Developing improvement requirements for issuers contracted with low quality or low value primary care practices, based on results of the advanced primary care measure set
- Encouraging enrollee selection or assignment of high quality or high value primary care practices, based on results of the Advanced Primary Care measure set
- Data aggregation across purchasers and payers to improve performance, contracting and public reporting (i.e. data submission to IHA to use in Advanced Primary Care measure set)
- Developing a primary care spend and payment target or floor requirement, based on the Covered CA primary care spend analysis with IHA
- Comparing performance on the QTI measure set for IDS/ACO and non-IDS/ACO enrollees
- Integration and coordination of behavioral healthcare in primary care
  - Build on QTI Core Measure set to include Depression Screening and Follow-Up for Adolescents and Adults (DSF) and Pharmacotherapy for Opioid Use Disorder (POD) after benchmarks have been established

QUESTIONS

APPENDICES

QTI Timeline Example for 2023 Performance Assessment



25-2-2 TIMELINE EXAMPLE

Example Removal Timeline for a Monitoring Period Beginning in 2021 with No Improvement over the Monitoring and Remediation Period

MONITORING PERIOD		REMEDIATION PERIOD		REMOVAL*
Plans that did not meet the benchmark in MY2021 are in a monitoring period for MY2021–MY2022.		Plans that did not meet the benchmark in MY2021–MY2022 are in remediation for MY2023–MY2024.		Plans that did not meet the benchmark in MY2021–MY2024 will not be certified.
PLAN YEAR 2022	**PLAN YEAR 2023**	**PLAN YEAR 2024**	**PLAN YEAR 2025**	**PLAN YEAR 2026**
MY2021 Assessment Product below MY2018 25th percentile composite benchmark	**MY2022 Assessment** Notice to Issuers of Monitoring Period	**MY2023 Assessment** Notice to Issuers of Remediation Period	**MY2024 Assessment** Notice to Issuers of Removal from Exchange	Product no longer offered on the Exchange **Removal occurs only if there are three (3) issuers remaining after removal*

COVERED CALIFORNIA'S EQUITY-FOCUSED POLICY INITIATIVES

- Covered California's patient-centered plan designs prioritize affordability of key service categories and simplify plan comparison for consumers.
- Robust collection of enrollee demographic data
  - Through the application and with the assistance of enrollment partners
  - QHP performance standard of 80% race/ethnicity self-identification
- NCQA Health Equity Accreditation
  - QHP requirement to be achieved by 2023
- Disparities Reduction Interventions
  - QHP requirement since 2017
  - Examples include efforts to reduce gaps in rates of well-managed diabetes and/or high blood pressure among certain racial/ethnic groups.

COVERED CALIFORNIA BELIEVES EQUITY IS QUALITY

- QHP Contract for PY 2023 requires significant investments in quality improvement.
  - Establishes floor for quality that QHPs must meet and could result in removal from Covered California's competitive regions in future years.
  - Establishes aspirational goals for quality attainment, which QHPs have financial incentive of up to 4% of premium to meet.
- Focus on measures that matter and represent opportunities to address disparities (blood pressure, diabetes, colorectal cancer screening, childhood immunizations).
- Data is stratified by race/ethnicity and we plan to incorporate disparities reduction accountability in future years.
- Aligned with other public purchasers (Medi-Cal and CalPERS).

END OF MEDICAID CONTINUOUS COVERAGE AND SB 260 FACILITATED ENROLLMENT: BACKGROUND

- Medicaid redeterminations have been paused since March 2020 due to the COVID-19 pandemic.
- Enrollment in Medi-Cal enrollment has grown by over 2 million enrollees since the pandemic started.
- Medi-Cal redeterminations will begin in April and span a 14-month period.
- Over the last year, Covered California and the Department of Health Care Services have partnered closely to develop an auto-enrollment program for individuals losing Medi-Cal and gaining eligibility for subsidized coverage through Covered California (under the authority of Senate Bill 260 [Chapter 845, Statutes of 2019]).

OVERVIEW OF REQUIREMENT TO AUTOMATICALLY ENROLL INDIVIDUALS WHO LOSE MEDI-CAL COVERAGE

- California Senate Bill 260 (Chapter 845, Statutes of 2019) directs Covered California to automatically enroll individuals who lose Medi-Cal coverage and gain eligibility for subsidized coverage.
- Individuals will be enrolled in the lowest cost silver plan available, unless Covered California has information that enables enrollment with the individual's previous managed care plan.
- Enrollment is to occur before the Medi-Cal termination date.
- The first premium payment (binder payment) due date to be no sooner than the last day of the first month of enrollment.

OVERVIEW OF REQUIREMENT TO AUTOMATICALLY ENROLL INDIVIDUALS WHO LOSE MEDI-CAL COVERAGE (CONT.)

- Covered California to provide a notice that includes the following information:
  - The plan in which the individual is enrolled.
  - The right to select another available plan and any relevant deadlines for that selection.
  - How to receive assistance to select a plan.
  - The right not to enroll in the plan.
  - Information for an individual appealing their previous coverage through Medi-Cal.
  - A statement that services received during the first month of enrollment will only be covered by the plan if the premium is paid by the due date.

BACKGROUND DATA ON MEDI-CAL TRANSITIONERS

- To prepare for the implementation of SB 260, Covered California used historical data on Medi-Cal transitioners to identify trends in prior marketplace eligibility and enrollment among this population.
- We refer to Medi-Cal transitioners in various stages of eligibility and enrollment as follows:
  - Medi-Cal transitioner (MCT): an individual who lost Medi-Cal eligibility and gained eligibility for Covered California with or without subsidies.
  - Subsidy-eligible MCT: an individual who lost Medi-Cal eligibility AND gained eligibility for an advanced premium tax credit (APTC).
- Administrative data is supplemented with survey data to estimate the universe of Medi-Cal transitioners who may need coverage through the marketplace – whereas administrative data can only identify who may be eligible (without consideration of availability of other coverage).

MEDI-CAL TRANSITIONER OVERVIEW

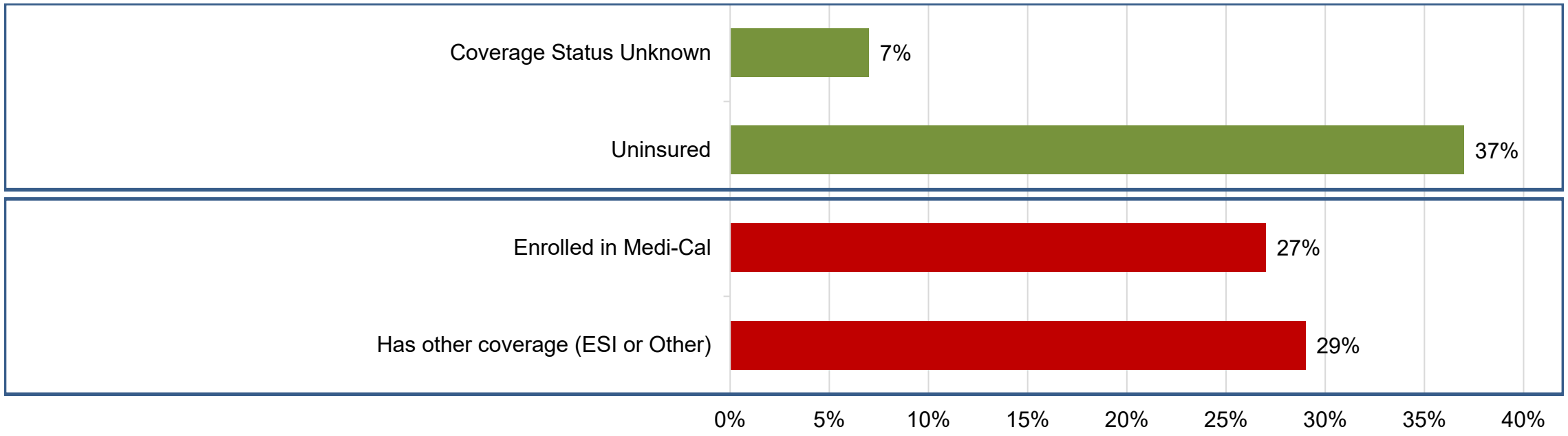
	2018	2019	2020	2021
MCTs- all	553,640	344,910	145,390	76,080
MCTs- subsidy eligible	330,880	213,690	77,480	31,790
Monthly average	27,570	30,530	8,610	5,300
MCTs with plan selection	71,540	43,310	23,720	10,070
Monthly average	5,960	6,190	2,640	1,680
Plan selection rate	22%	20%	31%	32%
Effectuations	62,540	37,030	20,030	8,000
Monthly average	5,210	5,290	2,230	1,330
Effectuation rate	87%	86%	84%	79%

Note: only 2018 represents a full year of data. 2019-2021 are based on partial year's data, which are accounted for in the monthly averages. Plan selection and effectuation rates only based on subsidy-eligible universe.

FINDINGS FROM THE 2018 NORC MEMBER SURVEY

- Among the Medi-Cal Transitioners who qualified for some form of premium assistance and did not enroll in Covered California (n=1057), about 29% stated to have coverage from other sources and 27% stated to have Medi-Cal enrollment.

- These survey statistics are used to estimate the number of consumers who appear to be eligible for financial help from the administrative data, but in reality are not eligible, because they have another source of Minimum Essential Coverage (MEC).



Source: MCT Insights from 2018 Member Survey – 4.18.19, Page 64, OE Consumer in Admin Data – "Percentage without those Enrolled in Covered CA".

AVAILABILITY OF $0 PLANS WITH ENHANCED SUBSIDIES

Applying the subsidy structure from the American Rescue Plan and Inflation Reduction Act to historical subsidy-eligible Medi-Cal transitioners, nearly half would have been eligible for a $0 Silver plan.

Share of Medi-Cal transitioners eligible for a $0 Silver plan, by FPL group

	2018	2019	2020	2021
<150% FPL	100%	100%	100%	100%
150-200% FPL	59%	56%	56%	54%
200-250% FPL	18%	18%	19%	12%
250-300% FPL	5%	6%	6%	4%
300-400% FPL	1%	2%	3%	1%
Total	49%	46%	49%	43%

SB 260 DATA AND REPORTING

Following the launch of SB 260, Covered California plans to publicly report on key outcomes for assessing effectiveness of the program. Reporting products currently planned for 2023 include:

- Monthly administrative data:
  - Volume of automatic plan selections
  - Take-up rates among plan-selected Medi-Cal transitioners
  - Plan choices (e.g. issuer, network, tier), and enrollee demographics
  - Channels for confirming enrollment (i.e., online portal, service center)
  - Volume of Medi-Cal transitioners who actively opt out of coverage
- Updates will also be provided to the Board throughout the unwinding of the Medicaid continuous coverage requirement.