Plan Management Advisory Group

March 2, 2023

AGENDA

Time	Topic	Presenter
10:00 – 10:05	Welcome	James DeBenedetti
10:05 – 10:25	2024-26 QDP Refresh Update	EQT
10:25 – 10:35	PY2024 Standard Benefit Designs Update	PMD
10:35 – 10:50	SB 260 Continuity Considerations	Policy
10:50 – 11:00	Open Forum	All

2024-26 QDP REFRESH UPDATE

Equity & Quality Transformation Division

2024-26 QDP ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 1: Equity and Disparities Reduction

- **Consumer Advocate** requested to have annual reports for disparity reduction and cultural and linguistic requirements made publicly available.

Article 2: Population Health

- **Consumer Advocate** expressed disappointment that requirements have been narrowed for only a select group of populations (children, adolescents, and members with disabilities) rather than all members.
- **Consumer Advocate** expressed disappointment that population health management plan and strategy requirements have been removed.

2024-26 QDP ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 3: Health Promotion and Prevention

- **Consumer Advocate** expressed disagreement with the removal of 3.01.5c, the proposed requirement to report the number and percent of Covered California Enrollees who complete recommended preventive services and treatment plans.
- **Consumer Advocate** recommended minor language change to ensure that all patients should be screened and referred for tobacco use.
- **Consumer Advocate** expressed disagreement with the removal of 2b and 4c, the proposed requirements to report the number and percent of Covered California Enrollees who use tobacco and pregnant Covered California Enrollees with periodontitis.
- **Issuers** recommended removal of tracking and reporting of pregnancy (3.03.1) as dental practice management systems do not support this requirement.

2024-26 QDP ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 3: Health Promotion and Prevention

Notable Changes to Draft Attachment 1	Rationale
3.01 Dental Plan Benefits and Services Communication Added Covered California monitoring activity to establish and maintain a robust set of utilization metrics.	Utilization metrics can be used to ensure adequate oversight of adult utilization and engagement in care.
3.02 Tobacco Cessation Revised language to reflect all Enrollees should be screened and referred for tobacco use.	Clarification to reflect original intent.
3.03.1 Pregnancy Revised language to define tracking	Covered California recognizes the limitations of current dental practice management systems.

2024-26 QDP ATTACHMENT 2 PUBLIC COMMENT KEY THEMES

- **Consumer Advocate** expressed concern that all performance standards are related to utilization of dental services and additional measures should be included to assess outcomes.
- **Consumer Advocate** expressed disappointment that "preferred spoken or written language" and "race and ethnicity" are optional and not required.
- **Issuer** requested adjusting the weight of the percentages between HEI Data Submission and Provider Directory Submission.
- **Issuers** requested consideration to decrease the 10% improvement performance level.
- **Issuer** requested adjusting the weight of the four oral health standards so that the adult preventive services is greater percentage than the sum of the three pediatric oral health measures.
- **Issuer** suggested not including pediatric sealant receipt on permanent first molars within the plan-specific relative improvement approach and considering lowering the percentage distribution for this measure.

PROPOSED 2024-26 QDP ATTACHMENT 2 CHANGES

Notable Changes to Draft Attachment 2	Rationale
Shifted percent at risk between Pediatric and Adult oral health measures, reducing 30% total to 15% total for the three Pediatric oral health measures and increasing from 20% to 35% for Adult Preventive Services Utilization	Covered California recognizes the majority of QDP members are adults and has adjusted the percent at risk to reflect that distribution
Added language regarding 10% improvement performance level	Covered California will consider adjusting the proposed 10% improvement performance level, if appropriate, once HEI data are analyzed and baseline rates are established

COVERED CALIFORNIA MEASURE SET CRITERIA

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

DENTAL HEALTH MEASURES INVENTORY

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

MEASUREMENT DISCUSSION FEEDBACK THEMES

Need to recognize and consider

- State legislative efforts
- NCQA adoption of dental measures
- Industry process and technological infrastructure limitations
- Dental practices' reliance on financial sustainability model emphasizing dental treatment
- Dental plan premiums lower than health, expense of data collection and improvement efforts
- Limited clinical evidence and measures for adult dental quality

Suggestions to address challenges

- Increase encounter data collection, monitor data quality, focus on health promotion, prevention, and utilization as foundational efforts
- Select measures with strong evidence base, validity, administrative simplicity to collect, and amenable to current dental plan capacity of improvement efforts
- Nearly universal support for a focused, parsimonious set of performance measures
- DQA measures nationally recognized and widely used by dental plans and providers

COVERED CA DENTAL MEASUREMENT ALIGNMENT

Oral Health Measures Performance Standards	Evidence & Alignment
Pediatric Oral Evaluation, Dental Services (NQF #2517)	HEDIS MY 2023 CMS Child Core Set 2023
Pediatric Topical Fluoride for Children, Dental Services (NQF #2528)	HEDIS MY 2023 CMS Child Core Set 2023 USPSTF Grade B DHCS Dental P4P
Pediatric Sealant Receipt on Permanent First Molars	CMS Child Core Set 2023 DHCS Dental P4P
Adult Use of Preventive Services	

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

PY2024 STANDARD BENEFIT DESIGNS UPDATE

Plan Management Division

COVERED CALIFORNIA

NEW MODELS FOR SILVER 70 AND 73

Benefit	Individual-only Silver P		Individual-only Silver Q		Silver 73 L		Silver 73 M	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible	-	-	-	-	-	-	-	-
Medical Deductible		$4,750		$5,400		$4,750		$5,400
Drug Deductible		$180		$150		$180		$150
Coinsurance (Member)		30%		30%		30%		30%
MOOP		$9,100		$9,100		$7,550		$7,550
ED Facility Fee		$450		$450		$450		$450
Inpatient Facility Fee	X	30%	X	30%	X	30%	X	30%
Inpatient Physician Fee		30%		30%		30%		30%
Primary Care Visit		$50		$50		$50		$50
Specialist Visit		$90		$90		$90		$90
MH/SU Outpatient Services		$50		$50		$50		$50
Imaging (CT/PET Scans, MRIs)		$325		$325		$325		$325
Speech Therapy		$50		$50		$50		$50
Occupational and Physical Therapy		$50		$50		$50		$50
Laboratory Services		$50		$50		$50		$50
X-rays and Diagnostic Imaging		$95		$95		$95		$95
Skilled Nursing Facility	X	30%	X	30%	X	30%	X	30%
Outpatient Facility Fee		30%		30%		30%		30%
Outpatient Physician Fee		30%		30%		30%		30%
Tier 1 (Generics)		$19		$19		$19		$19
Tier 2 (Preferred Brand)	X	$60	X	$60	X	$55	X	$55
Tier 3 (Nonpreferred Brand)	X	$90	X	$90	X	$85	X	$85
Tier 4 (Specialty)	X	20%	X	20%	X	20%	X	20%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250
Maximum Days for charging IP copay		-		-		-		-
Begin PCP deductible after # of copays								
Actuarial Value								
2024 AV (Draft 2024 AVC)		**71.82†**		**71.84†**		**73.96†**		**73.96†**
2024 Additive Adjustment		**0.16**		**0.16[1]**		**0.15**		**0.15**
2023 AV (Final 2023 AVC)		**71.57†**		**71.57†**		**73.86†**		**73.86†**
Enrollment as of June 2022		285,897		285,897		141,322		141,322
Percent of Total enrollment		17%		17%		8%		8%

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

PROPOSED PY2024 PLAN DESIGNS – IFP

Benefit	Individual-only Platinum Coinsurance C		Individual-only Platinum Copay E		Individual-only Gold Coinsurance B		Individual-only Gold Copay D		Individual-only Silver P		Silver 73 L		Silver 87 C		Silver 94 F		Bronze F		Bronze HDHP A	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible																				$7,050
Medical Deductible										$4,750		$4,750		$800		$75		$6,300		
Drug Deductible										$180		$180		$50		$0		$500		
Coinsurance (Member)		10%		10%		20%		20%		30%		30%		20%		10%		40%		0%
MOOP		$4,500		$4,500		$8,700		$8,700		$9,100		$7,550		$3,150		$1,150		$9,100		$7,050
ED Facility Fee		$150		$150		$350		$350		$450		$450		$150		$50	X	40%	X	0%
Inpatient Facility Fee		10%		$225		30%		$330	X	30%	X	30%	X	20%	X	10%	X	40%	X	0%
Inpatient Physician Fee		10%		---		30%		---		30%		30%		20%		10%	X	40%	X	0%
Primary Care Visit		$15		$15		$35		$35		$50		$50		$15		$5	X	$60	X	0%
Specialist Visit		$30		$30		$65		$65		$90		$90		$25		$8	X	$95	X	0%
MH/SU Outpatient Services		$15		$15		$35		$35		$50		$50		$15		$5		$60	X	0%
Imaging (CT/PET Scans, MRIs)		10%		$75		25%		$75		$325		$325		$100		$50	X	40%	X	0%
Speech Therapy		$15		$15		$35		$35		$50		$50		$15		$5		$60	X	0%
Occupational and Physical Therapy		$15		$15		$35		$35		$50		$50		$15		$5		$60	X	0%
Laboratory Services		$15		$15		$40		$40		$50		$50		$20		$8		$40	X	0%
X-rays and Diagnostic Imaging		$30		$30		$75		$75		$95		$95		$40		$8	X	40%	X	0%
Skilled Nursing Facility		10%		$125		30%		$150	X	30%	X	30%	X	20%	X	10%	X	40%	X	0%
Outpatient Facility Fee		10%		$75		30%		$130		30%		30%		20%		10%	X	40%	X	0%
Outpatient Physician Fee		10%		$20		30%		$40		30%		30%		20%		10%	X	40%	X	0%
Tier 1 (Generics)		$7		$7		$15		$15		$19		$19		$6		$3	X	$17	X	0%
Tier 2 (Preferred Brand)		$16		$16		$60		$60	X	$60	X	$55	X	$25		$10	X	40%	X	0%
Tier 3 (Nonpreferred Brand)		$25		$25		$85		$85	X	$90	X	$85	X	$45		$15	X	40%	X	0%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%	X	15%		10%	X	40%	X	0%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$150		$150		$500*		
Maximum Days for charging IP copay				5				5												
Begin PCP deductible after # of copays																		3 visits		
Actuarial Value																				
2024 AV (Draft 2024 AVC)		**91.88**		**90.74**		**81.92**		**81.54**		**71.82†**		**73.96†**		**87.86†**		**94.93**		**64.39†**		**64.94**
2024 Additive Adjustment										**0.16**		**0.15**		**0.04**				**0.10**		
2023 AV (Final 2023 AVC)		**91.76**		**89.75**		**81.92**		**80.11**		**71.57†**		**73.86†**		**87.86†**		**94.88**		**64.73**		**64.17**
Enrollment as of June 2022		76,108				171,183				285,897		141,322		333,668		223,646		345,044		98,811
Percent of Total enrollment		5%				10%				17%		8%		20%		13%		21%		6%
Enrollment as of June 2022		21,755		54,353		90,229		80,954												
Percent of Total enrollment		29%		71%		53%		47%												

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

SB 260 CONTINUITY CONSIDERATION

Policy, Eligibility, and Research Division

DISCUSSION OVERVIEW

Continuity of Care: should consumers keep their current health plan, if available, when they transition from Medi-Cal to Covered California?

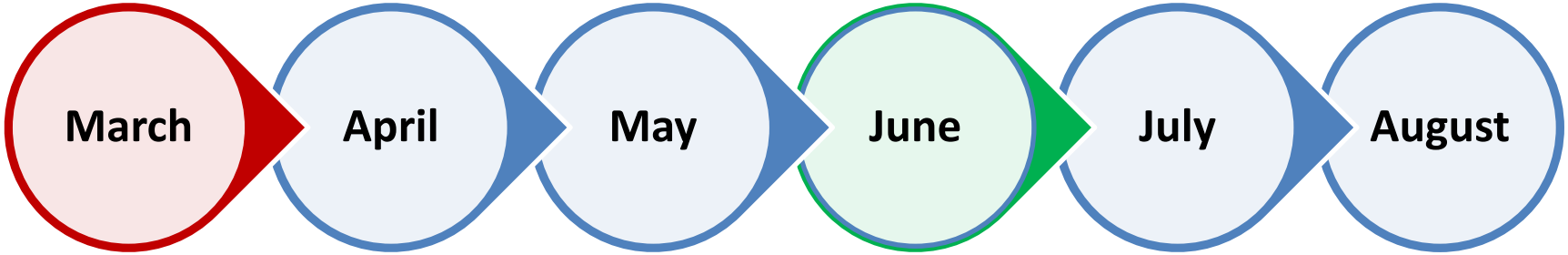
- SB 260 overview
- SB 260 enrollment authority and initial implementation approach
- Background data
- Care continuity considerations and feedback requested
- Open discussion

SB 260 OVERVIEW

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 to prevent a gap in coverage.
- The first premium payment (binder payment) due date to be no sooner than the last day of the first month of enrollment.
- 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.

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

SB 260 ENROLLMENT AUTHORITY AND INITIAL IMPLEMENTATION APPROACH

SB 260 PLAN ENROLLMENT AUTHORITY IN STATE STATUTE

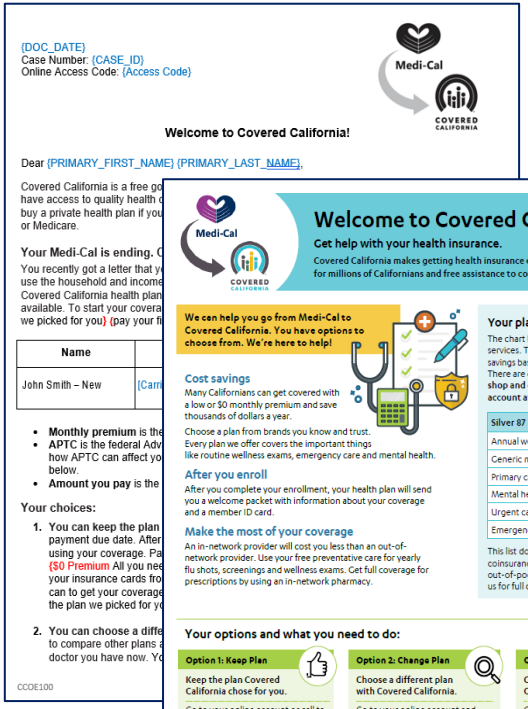
"The Exchange shall use the available information to enroll the individual or individuals in the lowest cost silver plan available, unless the Exchange has information from the county, State Department of Health Care Services, managed care plan, or another plan as determined by the Exchange that enables the Exchange to enroll the individual with the individual's previous managed care plan within the timeframe required by subdivision (b)."

Full text of SB 260: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB260

INITIAL IMPLEMENTATION APPROACH

- CalHEERS does not contain, and Covered California does not otherwise have access to, Medi-Cal managed care plan data at present
- Medi-Cal Transitioners will be assigned to the lowest cost Silver plan when SB 260 launches
- Call to action throughout consumer journey is “keep, change or cancel” and carrier options will be displayed in notices and web experience

CONSUMER EXPERIENCE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Case Number: {CASE_ID}
Online Access Code: {Access Code}

Medi-Cal
COVERED CALIFORNIA

Welcome to Covered California!

Dear {PRIMARY_FIRST_NAME} {PRIMARY_LAST_NAME},

Covered California is a free go
have access to quality health c
buy a private health plan if you
or Medicare.

Your Medi-Cal is ending. C

You recently got a letter that y
use the household and income
Covered California health plan
available. To start your covera
we picked for you} {pay your fi

Name	
John Smith – New	[Carri

- **Monthly premium** is the
- **APTC** is the federal Adv
how APTC can affect yo
below.
- **Amount you pay** is the

Your choices:

1. **You can keep the plan**
payment due date. After
using your coverage. Pa
{$0 Premium All you nee
your insurance cards fro
can to get your coverage
the plan we picked for yo

2. **You can choose a diffe**
to compare other plans
doctor you have now. Yo

CCOE100

Medi-Cal
COVERED CALIFORNIA

Welcome to Covered California

Get help with your health insurance.

Covered California makes getting health insurance easier, with financial help for millions of Californians and free assistance to compare your options.

We can help you go from Medi-Cal to Covered California. You have options to choose from. We're here to help!

Cost savings

Many Californians can get covered with a low or $0 monthly premium and save thousands of dollars a year.

Choose a plan from brands you know and trust. Every plan we offer covers the important things like routine wellness exams, emergency care and mental health.

After you enroll

After you complete your enrollment, your health plan will send you a welcome packet with information about your coverage and a member ID card.

Make the most of your coverage

An in-network provider will cost you less than an out-of-network provider. Use your free preventative care for yearly flu shots, screenings and wellness exams. Get full coverage for prescriptions by using an in-network pharmacy.

Your plan benefits

The chart below shows c
services. This plan offers
savings based on your ho
There are other plans you
shop and compare plans
account at CoveredCA.

Silver 87
Annual wellness exam
Generic medication cop
Primary care visit copay
Mental health services
Urgent care visit copay
Emergency room copay

This list does not include
coinsurance, deductibles
out-of-pocket maximum
us for full details.

Your options and what you need to do:

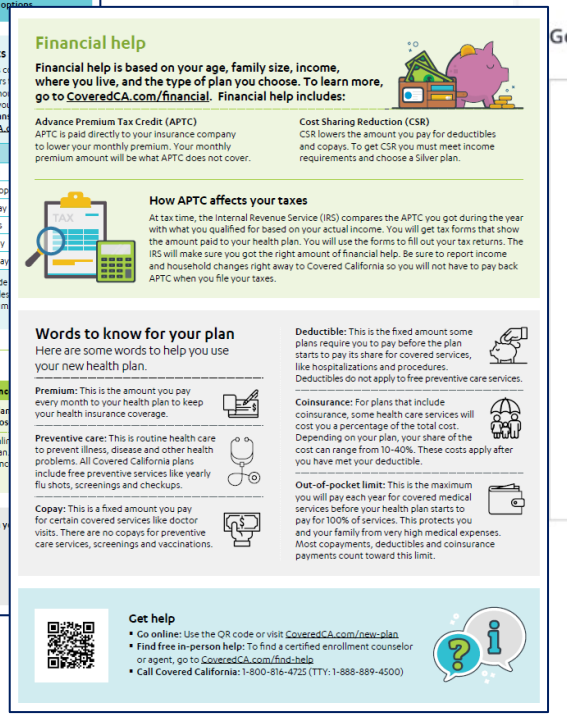
Option 1: Keep Plan
Keep the plan Covered California chose for you.
Go to your online account or call to confirm you want to keep this plan.
If your plan has a monthly premium, pay the bill to start your coverage.

Option 2: Change Plan
Choose a different plan with Covered California.
Go to your online account and choose the plan you want.

Option 3: Canc
Cancel the plan
California chos
Go to your onlin
cancel this plan
and we will canc

With Covered California, you can choose a health plan from insurance companies available in y

Anthem BlueCross · blue shield of california · Balance · healthnet · Kaiser Permanente · Bright HealthCare · MOLINA HEALTHCARE · oscar · SHARP · VHP Valley Health Plan


Financial help

Financial help is based on your age, family size, income, where you live, and the type of plan you choose. To learn more, go to CoveredCA.com/financial. Financial help includes:

Advance Premium Tax Credit (APTC)
APTC is paid directly to your insurance company to lower your monthly premium. Your monthly premium amount will be what APTC does not cover.

Cost Sharing Reduction (CSR)
CSR lowers the amount you pay for deductibles and copays. To get CSR you must meet income requirements and choose a Silver plan.

How APTC affects your taxes

At tax time, the Internal Revenue Service (IRS) compares the APTC you got during the year with what you qualified for based on your actual income. You will get tax forms that show the amount paid to your health plan. You will use the forms to fill out your tax returns. The IRS will make sure you got the right amount of financial help. Be sure to report income and household changes right away to Covered California so you will not have to pay back APTC when you file your taxes.

Words to know for your plan

Here are some words to help you use your new health plan.

Premium: This is the amount you pay every month to your health plan to keep your health insurance coverage.

Preventive care: This is routine health care to prevent illness, disease and other health problems. All Covered California plans include free preventive services like yearly flu shots, screenings and checkups.

Copay: This is a fixed amount you pay for certain covered services like doctor visits. There are no copays for preventive care services, screenings and vaccinations.

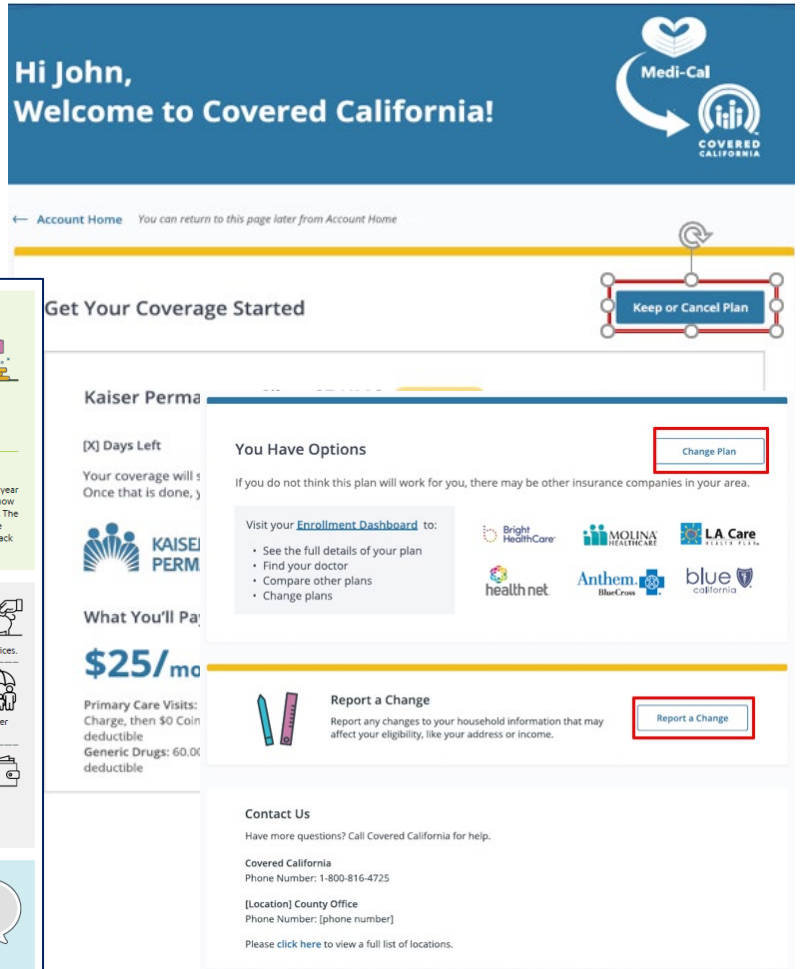
Deductible: This is the fixed amount some plans require you to pay before the plan starts to pay its share for covered services, like hospitalizations and procedures. Deductibles do not apply to free preventive care services.

Coinsurance: For plans that include coinsurance, some health care services will cost you a percentage of the total cost. Depending on your plan, your share of the cost can range from 10-40%. These costs apply after you have met your deductible.

Out-of-pocket limit: This is the maximum you will pay each year for covered medical services before your health plan starts to pay for 100% of services. This protects you and your family from very high medical expenses. Most copayments, deductibles and coinsurance payments count toward this limit.

Get help

- **Go online:** Use the QR code or visit CoveredCA.com/new-plan
- **Find free in-person help:** To find a certified enrollment counselor or agent, go to CoveredCA.com/find-help
- **Call Covered California:** 1-800-816-4725 (TTY: 1-888-889-4500)


Hi John,
Welcome to Covered California!

Medi-Cal
COVERED CALIFORNIA

← Account Home *You can return to this page later from Account Home*

Get Your Coverage Started

Keep or Cancel Plan

Kaiser Perma

[X] Days Left

Your coverage will
Once that is done,

KAISE
PERM

What You'll Pa

$25/mo

Primary Care Visits:
Charge, then $0 Coin
deductible
Generic Drugs: 60.0
deductible

You Have Options

Change Plan

If you do not think this plan will work for you, there may be other insurance companies in your area.

Visit your Enrollment Dashboard to:

- See the full details of your plan
- Find your doctor
- Compare other plans
- Change plans

Bright HealthCare · MOLINA HEALTHCARE · LA Care Health Plan · health net · Anthem BlueCross · blue shield of california

Report a Change

Report any changes to your household information that may affect your eligibility, like your address or income.

Report a Change

Contact Us

Have more questions? Call Covered California for help.

Covered California
Phone Number: 1-800-816-4725

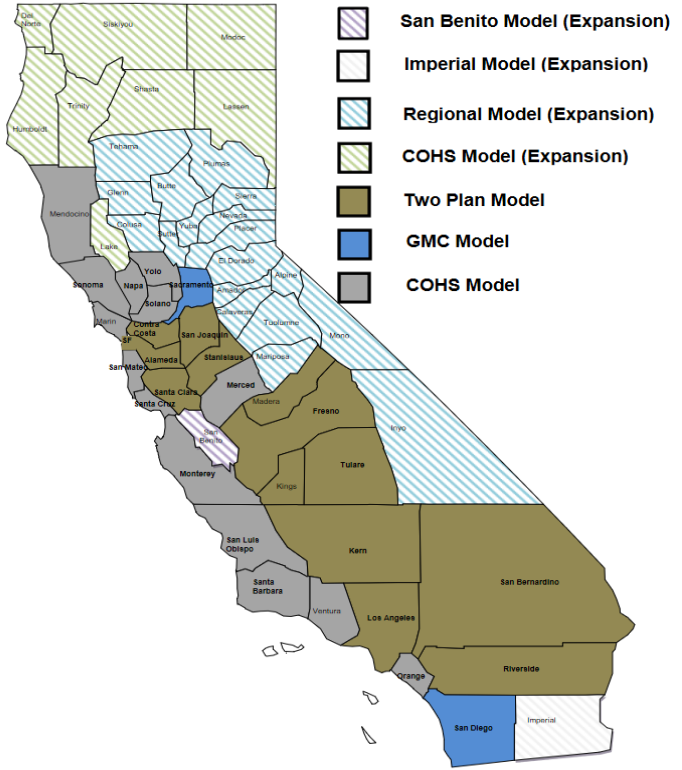
[Location] County Office
Phone Number: [phone number]

Please click here to view a full list of locations.

BACKGROUND DATA

ISSUER OVERLAP BETWEEN MEDI-CAL MANAGED CARE AND COVERED CALIFORNIA IS INCOMPLETE AND CHANGING

- Currently, 32 counties have issuer overlap between Medi-Cal managed care plans and Covered California plans (either full or partial county offerings)
- These issuers include Anthem, Health Net, Kaiser, LA Care, and Molina
- In LA County, most Medi-Cal beneficiaries are enrolled in a managed care plan that overlaps with a Covered California issuer



Medi-Cal Managed Care types from: https://www.dhcs.ca.gov/services/Documents/MMCD-Cnty-Map.pdf

HISTORICAL PLAN SELECTION DATA FOR INDIVIDUALS TRANSITIONING FROM MEDI-CAL TO COVERED CALIFORNIA

- Prior to the pandemic, about 20% of individuals who were found eligible for subsidies after being discontinued from Medi-Cal picked a Covered California plan.
- Enrollment by carrier among Medi-Cal Transitioners tracked closely to total enrollment.
- Of those subsidized Transitioners who selected a plan, about 60% selected a plan in the Silver tier at the statewide level. The next highest share was 20% selecting a plan in the Bronze tier.
- Of those selecting a plan in the Silver tier, about 60% selected the lowest cost Silver plan.
- Variation existed at the region and metal tier level.

2019 Medi-Cal Transitioners by Plan Selection and Region, subsidy-eligible only

QHP Distribution of Medi-Cal Transitioners Selecting a Plan

Rating Region	Anthem	Blue Shield	CCHP	Health Net	Kaiser	LA Care	Molina	Oscar	SHARP	Valley	Western Health	Share Plan Selecting	Percent of Plan Selections choosing LCSP
1	56%	40%			5%							20%	41%
2		7%		0%	80%						13%	26%	43%
3		31%		2%	65%						2%	23%	26%
4		14%	39%	0%	44%			3%				26%	22%
5		12%		0%	88%							27%	43%
6		17%			83%							22%	45%
7	6%	5%			31%					58%		27%	43%
8		12%	3%	0%	85%							25%	41%
9		69%		4%	27%							16%	50%
10	43%	6%		0%	51%							21%	55%
11		83%			17%							16%	63%
12		86%			14%							23%	48%
13		14%			0%		85%					17%	44%
14		67%		7%	26%							12%	53%
15		19%		37%	14%	28%	0%	2%				21%	28%
16		12%		10%	24%	46%	2%	7%				19%	32%
17		36%		23%	22%		19%					15%	30%
18		23%		49%	17%		3%	9%				23%	39%
19		11%		19%	22%		38%		10%			18%	25%
Issuer Share of MCTs	**6%**	**27%**	**1%**	**13%**	**34%**	**7%**	**6%**	**2%**	**1%**	**3%**	**1%**		

COVERED CALIFORNIA

Population: 2019 subsidy-eligible MCTs with plan selection.
Plan that is LCSP in the majority of zip codes in the region is shown.

Carrier not available.

Lowest cost silver plan.

2019 Medi-Cal Transitioners by Plan Selection and Region, Silver Plan Selections Only

Actual 2019 MCT plan selections – among those who selected a Silver-tier plan

QHP Distribution of Medi-Cal Transitioners Selecting a Silver Plan

Rating Region	Anthem	Blue Shield	CCHP	Health Net	Kaiser	LA Care	Molina	Oscar	SHARP	Valley	Western Health	Share Plan Selecting Silver Plan	Percent of Silver Plan Selections choosing LCSP
1	58%	38%			4%							14%	59%
2		6%		0%	83%						11%	14%	79%
3		45%		2%	52%						1%	14%	42%
4		12%	42%	0%	45%			1%				14%	39%
5		17%		0%	83%							14%	81%
6		20%			80%							13%	76%
7	4%	4%			26%					66%		19%	62%
8		14%	3%	0%	83%							14%	74%
9		77%		1%	22%							11%	73%
10	51%	6%		0%	43%							14%	80%
11		88%			12%							12%	81%
12		94%			6%							17%	64%
13		21%			0%		79%					8%	92%
14		77%		8%	16%							9%	70%
15		22%		45%	10%	22%	0%	0%				15%	39%
16		12%		13%	18%	53%	2%	2%				12%	49%
17		47%		22%	15%		16%					10%	44%
18		24%		62%	10%		2%	2%				16%	55%
19		14%		25%	14%		41%		6%			11%	39%
Issuer Share of MCTs	**4%**	**21%**	**1%**	**11%**	**18%**	**5%**	**4%**	**0%**	**0%**	**3%**	**0%**		

COVERED CALIFORNIA

Population: 2019 subsidy-eligible MCTs with a Silver-tier plan selection. Percent choosing LCSP may not appear to total due to region-level nuances, including multiple lowest cost plans at the zip code level and the roll up on the table of multiple products offered by carriers.

Carrier not available.

Lowest cost silver plan.

CONSIDERATIONS FOR INCORPORATING PRIOR MEDI-CAL MANAGED CARE ENROLLMENT INTO SB 260 PROCESS

KEY PRELIMINARY CONSIDERATIONS

1. Overlap between issuers and provider networks across Medi-Cal and Covered California
2. Consumer premium considerations
3. SB 260 operational requirements

ISSUER AND PROVIDER NETWORK CONSIDERATIONS

- Carriers differ between Medi-Cal and Covered California, so not all Medi-Cal Transitioners will be able to retain their Medi-Cal managed care plan.
- For carriers with provider networks that differ between Medi-Cal and Covered California, a policy change to map to the same carrier will not guarantee continuity of provider.
- What factors should be considered for mapping Medi-Cal Transitioners to their prior Medi-Cal managed care plan?
  - Degree of overlap in provider networks?
  - Member-level support provided by the issuer to transition care and provider if available?

PREMIUM CONSIDERATIONS

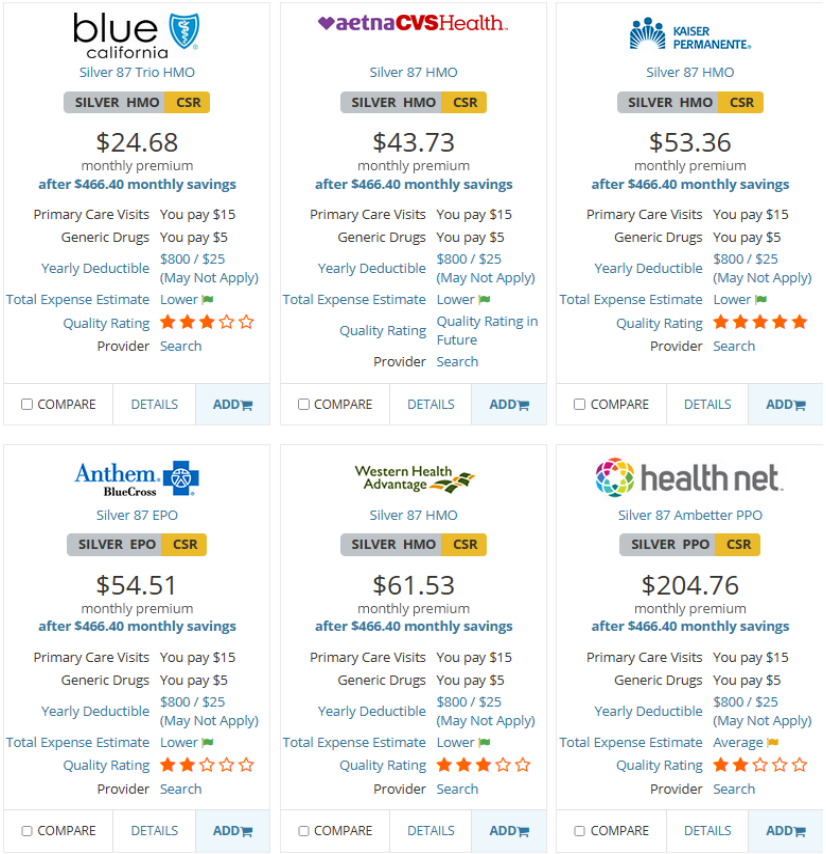
- The “continuity plan” may cost significantly more than the lowest cost Silver plan. Key factors include year, region, carrier and consumer income.
- Applying the subsidy structure from the American Rescue Plan and Inflation Reduction Act to historical subsidy-eligible Medi-Cal transitioners, nearly 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%

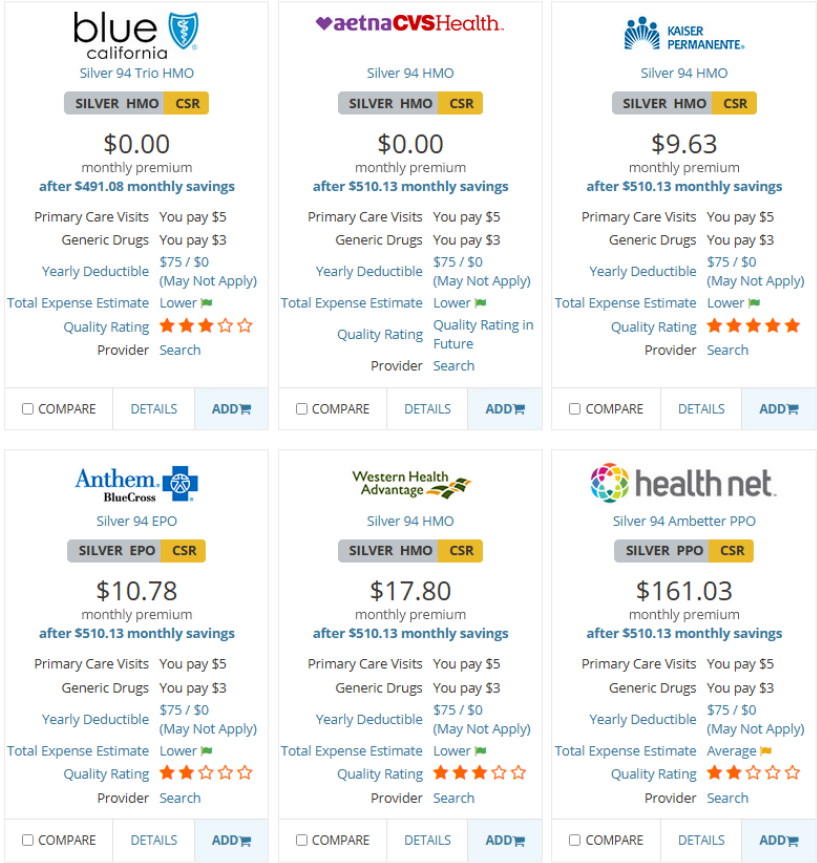
EXAMPLE OF PLAN CHOICE AND PRICE IN SACRAMENTO

- A 40-year-old in Sacramento making just under 200% FPL (about $27,000 a year) could pay $25 for the lowest cost silver plan.
- However, they could instead be mapped to a plan with a premium cost ranging $19 to $180 more per month.



EXAMPLE OF PLAN CHOICE AND PRICE IN SACRAMENTO

- The current implementation approach will enroll many Medi-Cal Transitioners in $0 plans.
- Data from prior to the Public Health Emergency indicate that almost half of Medi-Cal Transitioners could be eligible for a $0 plan with the current implementation approach.



DO WE KNOW IF CONTINUITY OR PRICE IS MORE IMPORTANT TO CONSUMERS?

- When faced with a choice to enroll in coverage, do consumers care more about price or more about network continuity with a prior provider?
- The evidence is mixed – some studies find consumers are highly premium-sensitive and some studies find that consumers are willing to pay more for their preferred provider.
  - Among low-income individuals in Massachusetts, higher premiums were associated with decreased in enrollment (Finkelstein et al. 2017).
  - From 2014-2016, Covered California enrollees tended to select lower-cost bronze and silver plans (Gabel et al. 2017).
  - Anthem's 2017 exit from Covered California: Over half (53%) of enrollees placed in the lowest-cost issuer in their metal tier switched to a higher-cost issuer.
  - Medicaid beneficiaries in New York who were randomly assigned to narrower networks used fewer services and were more likely to switch to a plan that included their prior provider (Wallace 2020).

OPERATIONAL CONSIDERATIONS

- Under SB 260, Covered California must perform plan enrollment before the termination date of Medi-Cal coverage.
- A data source for Medi-Cal managed care enrollment would need to be identified.
- Continuity with the Medi-Cal Transitioner's prior managed care plan would have to be integrated into Covered California's auto-enrollment process. As currently built:
  - Covered California's eligibility system will perform plan enrollment in real time as eligibility transitions occur.
  - Consumer messaging in notices currently describes the lowest cost Silver plan as the "plan with the most financial help available."

FEEDBACK ON CARE CONTINUITY CONSIDERATIONS

- We are requesting feedback on the considerations for care continuity for Medi-Cal Transitioners presented in this deck and any others not addressed here. In particular:
  - How can carriers facilitate care continuity if we auto-assign to a Medi-Cal transitioner's prior Medi-Cal managed care plan?
  - What factors are important to your organization in considering the tradeoff between continuity and premium price?
  - Should we think about additional factors beyond provider network and price?
- Responses are requested by March 30th
- Please send responses to Policy@covered.ca.gov

OPEN FORUM