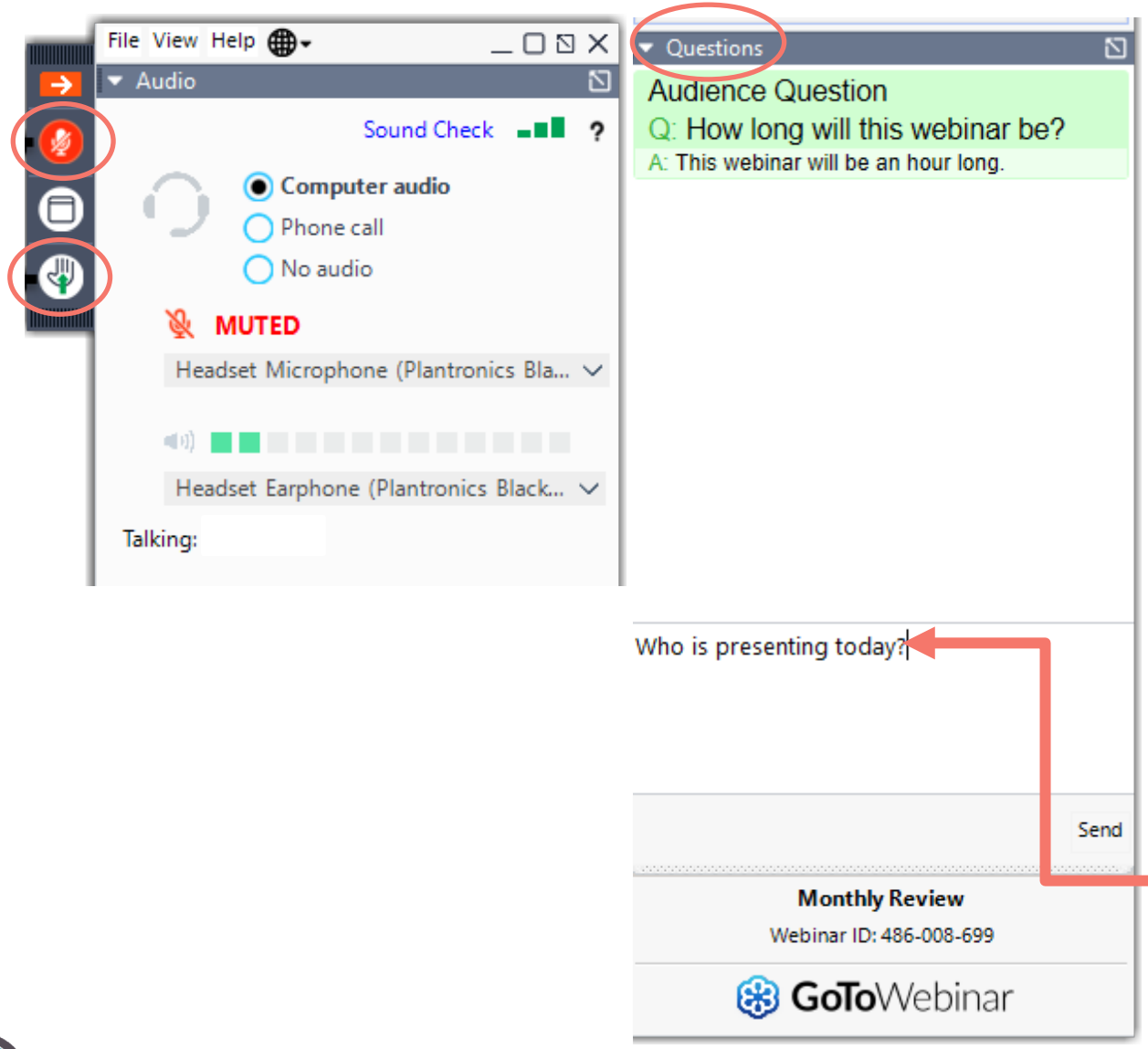
COVERED CALIFORNIA TRIBAL CONSULTATION

October 9, 2024

GOTO WEBINAR FUNCTIONALITY



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BLESSING

Chris Devers
Designated Representative, Southern California Tribal Chairmen's Association and
Chair of the Covered California Tribal Advisory Workgroup

AGENDA

- Blessing
- Introductions
- Executive Director Message and Covered California Update
- Policy Updates
- Equity & Quality Transformation Division - Efforts and Updates
- Tribal Program Updates
- QHP Discussion Forum
- Open Forum

INTRODUCTIONS

WELCOME AND COVERED CALIFORNIA UPDATE

Jessica Altman, Executive Director, Covered California

AMERICAN INDIAN ENROLLMENT BY HEALTH PLAN

As of	4/26/2024	7/24/2024	9/22/2024
Issuer	# of Enrollees*		
Aetna Health CA	66	84	103
Anthem Blue Cross	1,075	1,197	1265
Blue Shield	**2,769**	**2,826**	**2,938**
Chinese Community Health Plan	<10	<10	<10
Health Net	448	470	489
Inland Empire Health Plan	31	40	54
Kaiser	**2,626**	**2,675**	**2,731**
LA Care	153	170	208
Molina Health Care	68	68	70
SHARP Health Plan	106	100	108
Valley Health	36	45	46
Western Health	71	65	69
Grand Total	**7,450**	**7,741**	**8,082**

*Active **or** Pending Status

ENROLLMENT BY REGION

As of	4/26/2024	7/24/2024	9/22/2024
Issuer	**# of Enrollees***		
1 Northern Counties	**1097**	**1254**	**1401**
2 North Bay	444	522	577
3 Sacramento Valley	**776**	**849**	**873**
4 San Francisco County	83	97	104
5 Contra Costa County	154	186	204
6 Alameda County	224	232	229
7 Santa Clara County	116	121	132
8 San Mateo County	58	47	49
9 Monterey County	105	98	112
10 San Joaquin County	484	500	524
11 Central San Joaquin	328	357	401
12 Central Coast	358	364	409
13 Eastern Counties	54	60	75
14 Kern County	170	206	217
15 Los Angeles County, Partial	**354**	**368**	**399**
16 Los Angeles County, Partial	**525**	**570**	**623**
17 Inland Empire	656+	688	745
18 Orange County	407	443	482
19 San Diego County	442	488	526
Grand Total	**6,835**	**7,450**	**8,082**

*Active **or** Pending Status

RATING REGIONS

	AETNA HMO	ANTHEM HMO	ANTHEM EPO	BLUE SHIELD HMO	BLUE SHIELD PPO	CCHP HMO	HEALTH NET HMO	HEALTH NET PPO	INLAND EMPIRE HMO	KAISER HMO	L.A. CARE HMO	MOLINA HMO	SHARP HMO-1 CoPay	SHARP HMO-2 Coinsurance	VHP HMO	WESTERN HEALTH ADV. HMO
1 Northern counties			●	○	●					○						
2 North Bay Area			●	○	●					○						●
3 Greater Sacramento	●		●	○	●			○		○						○
4 San Francisco County			●	●	●	●				●						
5 Contra Costa County	●		●	●	●					●						
6 Alameda County	●		●	●	●					●						
7 Santa Clara County			●	●	●					○					●	
8 San Mateo County			●	●	●	●				●						
9 Santa Cruz, San Benito, Monterey			●	○	●					○					○	
10 Central Valley			●	○	●					○						
11 Fresno, Kings, Madera counties	●	●		○	●					○						
12 Central Coast			●	○	●					○						
13 Eastern counties			●		●		○			○		○				
14 Kern County			●	○	●		○			○						
15 Los Angeles County East		●		○	●		●	●		○	○	○				
16 Los Angeles County West		●		○	●		●	●		●	●	○				
17 Inland Empire		●		○	●		○	○	●	○		○				
18 Orange County		●		●	●		●	●		●		●				
19 San Diego County		●		○	●		●	●		○		●	○	○		

● Full Region
○ Partial Region

MIXED HOUSEHOLDS AND ANNUAL ENROLLMENT

Mixed HH* by Metal Level (total unique HH) 1,388

AI/AN Member	
Catastrophic	<10
Bronze	**1,469**
Silver	476
Gold	111
Platinum	64
Total	**2,127**
Non-AI/AN and or Non-Tribal	
Catastrophic	<10
Bronze	560
Silver	**992**
Gold	179
Platinum	88
Total	**1,827**

***Mixed Households**: Households with federally recognized tribal members and non-federally recognized **and/or** non-tribal members enrolled on one application in Covered CA

Enrollment Year over Year*

Year	Total Enrollment	AI/AN enrollment as percentage of total	AI/AN enrollment
2017	1,337,347	0.34%	4,570
2018	1,368,893	0.36%	4,947
2019	1,341,113	0.39%	5,244
2020	1,566,150	0.37%	5,764
2021	1,683,450	0.37%	6,251
2022	1,681,949	0.40%	6,674
2023	1,780,172	0.38%	6,742
2024	**1,813,533**	**0.39%**	**7,012**

*As of Sept. 22, 2024. **No** pending included

Enrollees that indicate race as AI/AN but NOT enrolled in an AI/AN Plan

RACE	COUNT
American Indian or Alaska Native	**1,388**

COMMUNITY ENGAGEMENT

- In February, Covered California met with the Southern California Tribal Chairmen's Association and local partners.

- This meeting was a continuation of the October Tribal Consultation, supporting Covered CA's broader goals of community engagement and outreach.

- **Discussion Highlights:**
  - Strengthening collaboration with Tribal Nations
  - Enhancing Healthcare Access and Equity
  - Tribal Sponsorship Initiative
  - Culturally Competent Outreach

2025 COVERED CALIFORNIA RATES

2025 Rate Increase: **7.9%**

Causes:

- Continued rise in health care utilization
- Increased pharmacy costs
- Inflation: cost of care, labor shortages, wage increases

Context:

5% average annual rate change over past 5 years, including record lows in previous years

California's Individual Market Rate Changes

YEAR	2021	2022	2023	2024	2025	5-YR COMPOUNDED AVERAGE	5%
WEIGHTED AVERAGE	0.5%	1.8%	5.6%	9.6%	7.9%		

Full Rates Release: https://www.coveredca.com/newsroom/news-releases/2024/07/24/2025-rates-and-plans/

HEALTH COVERAGE UPDATES

Region 9 (Central Coast)

- Kaiser Permanente partially expands into Monterey County
- Valley Health Plan exits the region

Statewide Coverage:

12 Carriers Statewide

DENTAL UPDATES

- 2025 Preliminary Rate Increase: **1.55%**
- Humana to offer statewide coverage
- Dental Health Services (DHS) exiting

Anthem BlueCross

California Dental Network
A DentaQuest company

DELTA DENTAL

Humana

blue california

California's Dental Plan Rate Changes

YEAR	2022	2023	2024	2025
WEIGHTED AVERAGE	-0.95%	-1.7%	4.31%	**1.55%**

4-YEAR AVERAGE	0.8%

Full Rates Release: https://www.coveredca.com/newsroom/news-releases/2024/09/03/2025-dental-rates/

OPEN ENROLLMENT 2024 RECAP

LET'S TALK HEALTH

KI HE MO'UI LELEI 健康について話しましょう LÅT OSS PRATA HÄL

HABLEMOS DE SALUD आइये स्वास्थ्य पर बात करें PARLIAMO DI SALUTE

NS SANTÉ 让我们谈谈健康 USAP TAYO SA KALUSUGAN 我哋講下

WB THAM TXOG KEV NOJ QAB HAUS HUV ПОГОВОРИМ О ЗДОРОВЬ

地講下健康啦 건강을 이야기

KI HE MO'UI LELEI 健康について話しましょう LÅT OSS PRATA HÄL

让我们谈谈健康 HABLEMOS SALUD आइये स्वास्थ्य पर बात करें

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NS SANTÉ 让我们谈谈健康 USAP TAYO SA KALUSUGAN 我哋講下

OPEN ENROLLMENT 2025 - STATEWIDE MEDIA CAMPAIGN WITH A FOCUS ON HEALTH LITERACY

- Simplify the complexity of health insurance and empower consumers to enroll, regardless of language, ethnicity, region or income
- Leverage new partners, as well as our incredible network of enrollers and navigators to deepen reach
- Multi-layered campaign messaging covering enrollment, record-level of affordability support, and DACA
- Media, stakeholder elected official and community leader engagement

CAMPAIGN HIGHLIGHTS

- Statewide kickoff tour starting the week before November 1 – Sacramento (Oct. 29), Fresno (Oct. 30), Los Angeles (Nov. 1)
- Local/regional events and activations, driven by data, insights and need
- Development of new materials and collateral, in conjunction with health literacy experts
- Partnerships with California State Library and local libraries

QUESTIONS/FEEDBACK

2025 PROGRAM DESIGN UPDATE

Melanie Droboniku, Plan Management Division

2025 ENHANCED CSR PROGRAM

- The California Enhanced Cost-Sharing Reduction (CSR) Program began in 2024 with a $82.5 million budget from the State of California.
- CSR eliminated deductibles for lower-income enrollees up to 250% FPL, simplified benefit designs, and reduced out-of-pocket costs.
- The Governor's FY 24-25 budget includes $165 million for the 2025 affordability program.
- Covered California's Board approved the 2025 CSR program in mid-May, expanding eligibility to enrollees with incomes above 200% FPL for a Silver 73 plan.
- AI/AN members with income above 300% FPL will get the enhanced Silver 73 design if enrolled in a silver plan.

Household Income Eligibility by Percentage of FPL	2025 California Enhanced CSR Program Plan
100% up to 150%	Silver 94
Above 150% up to 200%	Silver 87
Above 200% up to 250%	Silver 73
Above 250%	Silver 73
American Indian/Alaska Native Above 300%	Silver 73

2025 ENHANCED CSR PROGRAM BENEFIT DESIGNS

Benefit	Individual-only Silver 70		CA Enhanced CSR Silver 73	
	Ded	Amount	Ded	Amount
Deductible				
Medical Deductible		$5,400		$0
Drug Deductible		$50		$0
Coinsurance (Member)		30%		30%
MOOP		$8,700		$6,100
ED Facility Fee		$400		$350
Inpatient Facility Fee	X	30%		30%
Inpatient Physician Fee		30%		30%
Primary Care Visit		$50		$35
Specialist Visit		$90		$85
MH/SU Outpatient Services		$50		$35
Imaging (CT/PET Scans, MRIs)		$325		$325
Speech Therapy		$50		$35
Occupational and Physical Therapy		$50		$35
Laboratory Services		$50		$50
X-rays and Diagnostic Imaging		$95		$95
Skilled Nursing Facility	X	30%		30%
Outpatient Facility Fee		30%		30%
Outpatient Physician Fee		30%		30%
Tier 1 (Generics)		$18		$15
Tier 2 (Preferred Brand)	X	$60		$55
Tier 3 (Nonpreferred Brand)	X	$90		$85
Tier 4 (Specialty)	X	20%		20%
Tier 4 Maximum Coinsurance		$250		$250
Maximum Days for charging IP copay				
Begin Specialist deductible after # of copays				
Actuarial Value				
2025 AV		**71.59†**		**79.22**

- Medical and Drug deductibles eliminated
- Lower office visit fees, including Primary Care, Specialty Care, and Mental Health/Substance Use Disorder Outpatient Services
- Lower prescription drug costs

KEY		
	X	Subject to deductible
	†	Additive adjustment included in AV
		Enhanced member cost from Silver 70
		Does not meet AV
		Within .5 of upper de minimis
		Securely within AV

COVERED CALIFORNIA

2025 AMERICAN INDIAN/ALASKA NATIVE BENEFIT EXAMPLE

The following is an example of the differences in cost sharing between a Silver 70 standard plan, a Zero Cost Share AI/AN plan and a Limited Cost Share AI/AN plan for some **covered services**.

Covered services	Silver 70 Standard Plan	Zero Cost Share AI/AN Plan	Silver 70 Limited Cost Share AI/AN Plan - Enhanced CSRs	Silver 70 Limited Cost Share AI/AN Plan if Member Goes to an AI/AN Provider*
Primary Care Visit	$50	$0	$35	$0
Specialist Visit	$90	$0	$85	$0
Mental Health/Substance Use	$50	$0	$35	$0
Urgent Care Visit	$50	$0	$35	$0

*Indian Health Service (IHS), an Indian tribe, Tribal Organization, Urban Indian Organization, or receives a referral to a QHP provider from an IHS clinic.

CHANGE IN SILVER PLAN DEDUCTIBLES OVER TIME

Income-based Plans	2021	2022	2023	2024	AI/AN member cost with Enhanced CSR Program 2025 Adopted
Up to 300% FPL – Zero Cost Share Plan	$0 inpatient $0 pharmacy	$0 inpatient $0 pharmacy	$0 inpatient $0 pharmacy	$0 inpatient $0 pharmacy	**$0 inpatient $0 pharmacy**
AI/AN Silver 70 for enrollees above 300% FPL ***starting at about $43,740 for a single person and $90,000 for a family of 4***	$4,000 inpatient $300 pharmacy	$3,700 inpatient $10 pharmacy	$4,750 inpatient $85 pharmacy	$5,400 inpatient $150 pharmacy	**$0 inpatient $0 pharmacy**

QUESTIONS/FEEDBACK

MEDI-CAL TO COVERED CALIFORNIA UPDATE

Latonia Richardson, Senior Manager, Analytics
Policy, Eligibility, and Research Division

BACKGROUND

California Senate Bill 260 (2019)

- Authorized Covered California to auto-enroll consumers in a health plan upon losing Medi-Cal coverage if eligible for subsidized Covered California coverage.
- Aimed to prevent coverage gaps for consumers losing Medi-Cal, given they effectuated coverage within a month of disenrollment.

Federal COVID-19 Public Health Emergency

- Required states to maintain Medicaid continuous coverage for most enrollees; terminations were barred and continuous coverage requirement ended on March 31, 2023.

Medi-Cal Renewals Redetermination

- Process started in April 2023 for June 2023 renewals.
- Covered California initiated the Medi-Cal to Covered California Enrollment Program at the end of May 2023.

AI/AN CONSUMERS TRANSITIONING FROM MEDI-CAL

AI/AN (American Indian/Alaska Native) Consumers

- Covered California selected plans for AI/AN consumers transitioning from Medi-Cal based on an enrollment hierarchy to ensure the most beneficial plan option, based on income.
- Consumers had the option to change their plan or opt-out.

Enrollment Hierarchy

- AI/AN consumers with income **at or below 300% FPL**: enrolled in the lowest cost AI/AN plan available in their region, generally a bronze plan.
- AI/AN consumers with income **above 300% FPL**: enrolled in the lowest cost AI/AN variant of the silver plan.

MEDI-CAL TO COVERED CALIFORNIA ENROLLMENT – TOTAL POPULATION

KEY PERFORMANCE INDICATORS

		2023						2024						
Medi-Cal to Covered California Transition Data By Month Marketplace Eligibility Begins*	**Grand Total**	July	August	September	October	November	December	January	February	March	April	May	June	July
Medi-Cal Transitions eligible in CalHEERS	**2,285,179**	**35,778**	**48,230**	**284,564**	**217,852**	**222,445**	**225,737**	**216,154**	**150,321**	**181,414**	**203,566**	**169,017**	**187,797**	**142,304**
Medi-Cal Transitions with plan selection**	**599,051**	9,996	11,805	36,479	38,890	47,076	47,480	62,589	48,177	59,820	67,652	58,062	63,958	47,067
*Auto Plan Selections****	**563,642**	*9,253*	*10,430*	*32,895*	*35,921*	*43,232*	*43,289*	*57,764*	*44,955*	*56,711*	*65,452*	*56,318*	*61,903*	*45,519*
Effectuated Coverage After Auto Plan Selection	**192,209**	**3,041**	**3,823**	**9,000**	**11,495**	**14,216**	**15,697**	**19,628**	**15,724**	**18,778**	**21,914**	**19,683**	**21,966**	**17,244**
Effectuated after APS - Eligible for $0 plan	***34%***	*32%*	*37%*	*39%*	*33%*	*32%*	*29%*	*37%*	*34%*	*33%*	*34%*	*34%*	*37%*	*38%*
Effectuated after APS - Switched out of default plan	***30%***	*32%*	*30%*	*29%*	*27%*	*29%*	*30%*	*34%*	*36%*	*31%*	*30%*	*28%*	*28%*	*27%*
Effectuation Rate After Auto Plan Selections (APS)	***34%***	**33%**	**37%**	**27%**	**32%**	**33%**	**36%**	**34%**	**35%**	**33%**	**33%**	**35%**	**35%**	**38%**
Effectuation rate among APS - eligible for $0 plan	***36%***	*36%*	*43%*	*32%*	*32%*	*33%*	*34%*	*35%*	*36%*	*33%*	*37%*	*39%*	*40%*	*44%*

** Data excludes any consumers with Medi-Cal redetermination, initially found marketplace eligible, but who returned to Medi-Cal eligibility before losing coverage.*
*** Includes plan selections by individuals who do not qualify for subsidies and members who were automatically added to an existing family enrollment.*
**** A subset of Medi-Cal Transitions with a plan selection. Indicates that consumer received an automatic plan selection when first transitioning from Medi-Cal. Includes consumers who were automatically added to an existing enrollment in the same household, and includes those who later switched into a different plan after auto plan selection.*

*All Medi-Cal to Covered California Transitioners. Data as of September 12, 2024.

MEDI-CAL TO COVERED CALIFORNIA ENROLLMENT – FEDERAL TRIBE ENROLLEES

KEY PERFORMANCE INDICATORS

		2023						2024						
Medi-Cal to Covered California Transition Data By Month Marketplace Eligibility Begins*	**Grand Total**	July	August	September	October	November	December	January	February	March	April	May	June	July
Medi-Cal Transitions eligible in CalHEERS	**11,827**	**258**	**338**	**1,544**	**1,217**	**1,179**	**1,231**	**924**	**775**	**913**	**1,025**	**839**	**908**	**676**
Medi-Cal Transitions with plan selection**	**2,630**	40	72	127	149	197	202	272	249	281	328	270	267	176
*Auto Plan Selections****	**2,463**	*37*	*51*	*111*	*136*	*181*	*183*	*247*	*230*	*271*	*316*	*269*	*258*	*173*
Effectuated Coverage After Auto Plan Selection	**656**	**10**	**20**	**38**	**38**	**38**	**39**	**64**	**56**	**62**	**80**	**80**	**77**	**54**
Effectuated after APS - Eligible for $0 plan	***62%***	*60%*	*60%*	*63%*	*63%*	*53%*	*72%*	*63%*	*55%*	*47%*	*55%*	*78%*	*68%*	*63%*
Effectuated after APS - Switched out of default plan	***48%***	*40%*	*40%*	*53%*	*71%*	*63%*	*56%*	*42%*	*57%*	*48%*	*44%*	*45%*	*38%*	*37%*
Effectuation Rate After Auto Plan Selections (APS)	***27%***	**27%**	**39%**	**34%**	**28%**	**21%**	**21%**	**26%**	**24%**	**23%**	**25%**	**30%**	**30%**	**31%**
Effectuation rate among APS - eligible for $0 plan	***27%***	*26%*	*35%*	*33%*	*32%*	*17%*	*23%*	*26%*	*26%*	*16%*	*24%*	*39%*	*33%*	*31%*

** Data excludes any consumers with Medi-Cal redetermination, initially found marketplace eligible, but who returned to Medi-Cal eligibility before losing coverage.*
*** Includes plan selections by individuals who do not qualify for subsidies and members who were automatically added to an existing family enrollment.*
**** A subset of Medi-Cal Transitions with a plan selection. Indicates that consumer received an automatic plan selection when first transitioning from Medi-Cal. Includes consumers who were automatically added to an existing enrollment in the same household, and includes those who later switched into a different plan after auto plan selection.*

*Enrollees who indicate they are a member of a federal tribe within their application. Data as of September 12, 2024.

QUESTIONS/FEEDBACK

REASONABLE OPPORTUNITY PERIOD AMERICAN INDIAN/ALASKA NATIVE

Linda Ly, Eligibility & Enrollment Compliance Senior Manager
Policy, Eligibility, and Research Division

REASONABLE OPPORTUNITY PERIOD OVERVIEW

- The Reasonable Opportunity Period (**ROP**) discontinuance process identifies consumers who are conditionally eligible for Covered California programs and are past the due date for providing documentation to clear their inconsistency.
  - The ROP process attempts to re-verify the pending information to either clear the conditional eligibility or to discontinue the eligibility if the verification continues to remain outstanding.
- Consumers who attest to being a member of a federally recognized tribe or community group are found Conditionally Eligible for the AI/AN specific benefits and provided the **95-day** ROP to provide proof. At this time, there is no electronic verification source, so all individuals must provide documentation.
- While the consumer is Conditionally Eligible, they can enroll in a plan with the AI/AN benefits based on their FPL %.
- In **April 2023**, we implemented a new process to discontinue the AI/AN benefits and update enrollment to the non-AI/AN version of the current plan for consumers who do not provide proof by the due date.
- During the 2024 ROP process, we were able to identify and move approximately **670** individuals from AI/AN specific enrollment to non-AI/AN enrollments.

QUESTIONS/FEEDBACK

BREAK

10-minute break

HEALTH EQUITY AND QUALITY TRANSFORMATION UPDATE

Dr. Monica Soni, Chief Executive Director and
Chief Medical Officer, Health Equity and Quality Transformation

2026-2028 CONTRACT UPDATES

COVERED CALIFORNIA: OUR ROLE IN HEALTHCARE

Covered California as a marketplace is designed to make health insurance more accessible and affordable for all Californians

- Operates by contracting with a diverse range of Qualified Health Plan (QHP) Issuers to offer a variety of choices to consumers
- Health plans are responsible for creating and maintaining provider networks and ensuring members' access to healthcare services for Enrollees

Covered California is committed to ensuring that all health plans offered through the Exchange meet equity and quality standards

- Rigorous oversight through comprehensive evaluation in the annual QHP Certification and Recertification process
- Continued development and improvement of ambitious plan contract requirements
- Year-round monitoring of all contracted plans to assess adherence to quality and equity benchmarks
- Utilizing subject matter experts and stakeholder engagement to remain informed about current healthcare trends, industry-wide best practices, and member and provider experiences

EQT APPROACH TO 2026-2028 CONTRACT UPDATE

Our approach to developing the new contract has been guided by:

- Building on strong foundation of 2023-2025 contract development work
- Prioritizing alignment
- Emphasizing outcomes
- Pursuing administrative simplification

BUILDING ON 2023-2025 WITH BOLD NEW ADDITIONS

Actionable Data

- Selective Contracting for Quality
- Expansion of Demographic Data Collection
- Data Exchange
- Behavioral Health Disparities Reduction
- Quality Transformation Initiative (QTI)

Healthy Workforce

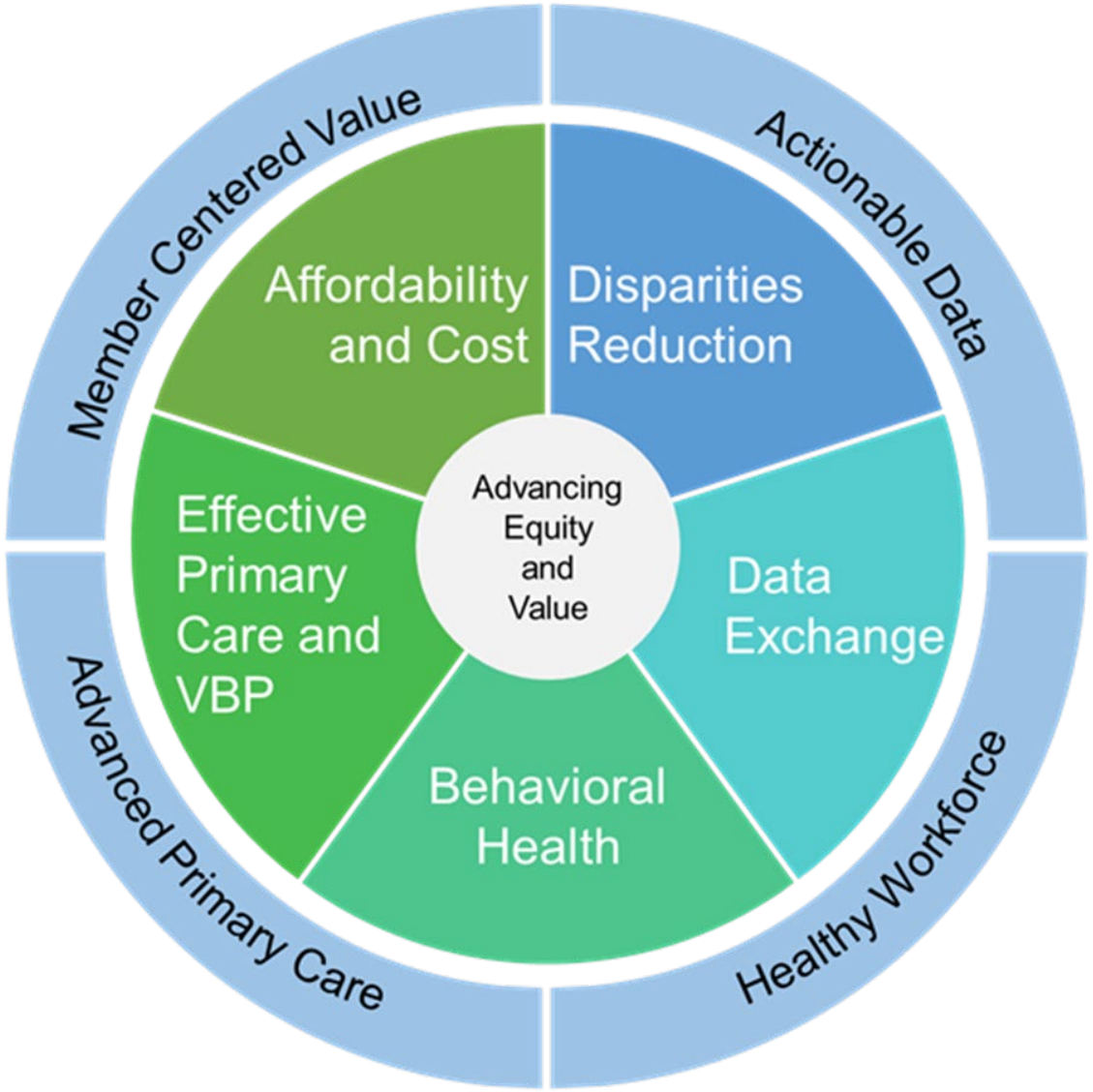
- Essential Community Providers
- Generative Artificial Intelligence
- Primary and Behavioral Health Care Spend Tracking
- Engagement in Collaboratives and with Community

Advanced Primary Care

- Continuity of Care
- Use and Quality of Digital Care
- Behavioral Health Promotion
- SUD
- Behavioral Health Vendor Oversight

Member-Centered Value

- Access to Care
- Comprehensive Maternal Healthcare
- Population Health Investments
- Targeted Engagement and Outreach



PROPOSED 2026-28 ACCESS REQUIREMENTS

Access

- To assess and monitor **Beneficiary Experience and Outcomes**, Covered California will track and publicly report CMS QRS Enrollee Experience performance
- To assess and improve **Provider Availability and Accessibility**, Covered California will leverage Healthcare Evidence Initiative (HEI) for Network measures agreed upon by California public purchasers and/or regulator, with improvement plans required for underperforming Issuers
  - Provider-to-member ratio: The number of providers per beneficiary
  - Active providers : The percentage of providers serving beneficiaries in the past year
  - Provision of telehealth services: The percentage of providers providing telehealth services
- To assess and improve **Service Utilization and Quality**, Covered California may launch a secret shopper survey utilizing questions from DHCS and CalPERS surveys in PY2026 with improvement plans required for underperforming Issuers
  - A repeat survey may be implemented biennially (every other year) if pervasive underperformance

PROPOSED 2026-28 ECP REQUIREMENTS

Essential Community Providers (ECP) Requirements

- Issuers must meet ECP General Standard by maintaining a network with includes a sufficient geographic distribution of care to provide reasonable and **timely access to low-income populations**, individuals living in Health Professional Shortage Areas (HPSAs) and **medically underserved individuals**
- ECP General Standard Sufficiency Requirements:
  - Issuers must demonstrate s**ufficient geographic distribution** of a mix of essential community providers reasonably distributed throughout the geographic service area
  - Issuers must demonstrate providers agreements with at least 15% of **340B non-hospital providers** in each rating region in which it offers QHPs
  - Issues must demonstrate agreements with at least o**ne ECP hospital per county requirement or per rating area** in counties with multiple rating regions
- Issuers in an integrated delivery system may request the ECP alternative standards and must demonstrate compliance by mapping low-income and HPSA member populations and network providers and facilities offering services in all ECP categories

PROPOSED 2026-28 ATTACHMENT 1 REQUIREMENTS

Equity and Disparities Reduction

- Demographic Data Collection: Issuer must collect member self-identified race, ethnicity, and language data. Issuers must expand data collection to include member-level **Sexual Orientation and Gender Identity** (SOGI) data to establish baseline performance.
- Disparities Measurement: Issuer and Covered California will review performance on specified disparities measures using stratified HEI claims data and HEDIS clinical quality measures.
- Disparities Reduction Intervention: Issuer must meet disparities reduction and health equity requirements throughout Attachment 1 and Attachment 4 Quality Transformation Initiative (QTI).

Social Health

- Issuer must **screen enrollees for food, housing and transportation needs** and report stratified results to Covered California.

Comprehensive Maternity Care

- Issuer must report stratified performance on **maternal health and maternal mental health measures.**
- Issuers must monitor and report on **inclusion of midwives and doulas** in QHP networks.

PROPOSED 2026-28 ATTACHMENT 1 REQUIREMENTS

Behavioral Health

- Issuer must promote access to behavioral health services and offer telehealth for behavioral health services, and demonstrate **promotion of behavioral health services** across access points and languages
- Issuer must **address disparities in behavioral health utilization** by deploying disparities reduction strategies based on stratified utilization data and informed by engagement with impacted member populations
- Issuer must monitor behavioral health and virtual **behavioral health care quality** through monitoring of behavioral health utilization and submission of **selection criteria for behavioral health care vendors**
- Issuer must provide **staff cultural humility training** and deploy culturally tailored materials and strategies for **historically marginalized groups**
- Issuer must:
  - promote the **appropriate use of opioids** using a harm reduction framework and individualized approach to treatment planning aligned with Smart Care California guidelines
  - develop and maintain programming focused on **tobacco cessation**
  - and monitor Initiation, Engagement, Treatment (IET) and Follow-Up after Hospitalization (FUH) measure rates

HEALTHCARE EVIDENCE INITIATIVE (HEI) MEASURES
ALL POPULATION RESULTS

BACKGROUND AND APPROACH

- Covered California has an all-plan claims database (HEI) with administrative and enrollment data on all members across all health plans
- Critical to our understanding of health outcomes and our ability to identify health disparities
- HEI has administrative data – meaning claims data – but lacks clinical data which we receive from other sources
  - Administrative measure examples: Breast cancer screening, Primary care utilization, Well-Child Visits
  - Limits of administrative data: Disease-control measures such as rates of blood pressure control
- HEI also contains detailed demographic information on race, ethnicity, preferred language, income level, geography

BACKGROUND AND APPROACH

- We used HEI to produce quality measure performance and stratify the results by race and ethnicity
- We evaluated the results for trends and patterns, and applied statistical tests to identify significant outliers in performance
- A selection of measures and results stratified by race and ethnicity are included for review and discussion
  - Breast Cancer Screening
  - Primary Care Utilization & Primary Care via Telehealth
  - Behavioral Health Utilization & Behavioral Health via Telehealth

ALL POPULATION PERFORMANCE

Breast Cancer Screening Summary

- **Definition**: The Breast Cancer Screening measure is the percentage of eligible members, 50-74 years of age, who have received a mammogram in the last twenty-seven months to screen for breast cancer. Breast cancer is the most common cancer among American women; screening and early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options.
- **Key Findings**:
  - Overall rates of breast cancer screening decreased from 2019 to 2020, likely because of the COVID-19 pandemic, but increased in 2022 to the pre-COVID 2019 baseline.
  - While we see differences in rates of screening across race/ethnicity groups, we did not detect any statistically significant outliers when stratifying this measure by race/ethnicity.
  - Higher income members (above 400 FPL) is correlated with a statistically significant higher rate of breast cancer screening as compared to members in other FPL groups.

ALL POPULATION PERFORMANCE

Breast Cancer Screening by Race/Ethnicity

Race/Ethnicity	2019	2020	2021	2022
All Population	**66%**	**63%**	**63%**	**66%**
American Indian / Alaska Native	65%	60%	59%	66%
Asian American	63%	59%	59%	63%
Black or African American	69%	67%	68%	70%
Hispanic or Latino	69%	67%	65%	68%
Multi-racial	66%	63%	63%	67%
Native Hawaiian / Pacific Islander	68%	63%	59%	66%
Non-Respondent	65%	62%	62%	65%
Other	67%	64%	64%	68%
White	67%	64%	64%	67%

Values marked as low rate outliers, based on z-scores or Interquartile Range, are identified with a red box. High rate outliers are identified with a blue circle.
Blank cells are suppressed data due to counts too low to report.

ALL POPULATION PERFORMANCE

Primary Care Visits per 1000 Members

- **Definition**: The Primary Care Visits per 1000 members is the number of members who had a visit with a primary care practitioner during the year per 1,000 enrolled members. Of note, this measure includes all modalities of primary care visits including in-person visits and visits delivered through telehealth modalities.
- **Key Findings**:
  - Overall primary care visit rates decreased in 2020 likely due to the COVID-19 pandemic, increased in 2021 thought to be due to a return to care, and then decreased again in 2022.
  - We observed statistically significant differences in primary care visit rates when stratifying by race/ethnicity:
    - Members identifying as American Indian/Alaska Native have statistically significant higher rates of visits as compared to other race/ethnicity groups from 2019-2022, and members identifying as Asian have statistically significant lower rates of visits in 2019-2020, but this difference did not persist into 2021-2022.

ALL POPULATION PERFORMANCE

Primary Care Visits per 1000 Members by Race/Ethnicity

Race/Ethnicity	2019	2020	2021	2022
All Population	**2011**	**1919**	**2076**	**1985**
American Indian / Alaska Native	2884	2712	2820	2684
Asian American	1782	1554	1734	1715
Black or African American	2190	2294	2417	2101
Hispanic or Latino	2146	2125	2242	2105
Multi-racial	1939	1854	2026	1921
Native Hawaiian / Pacific Islander	2063	1985	2025	1736
Non-Respondent	2025	1952	2127	2057
Other	2078	1953	2130	2030
White	2026	1958	2112	2009

Values marked as low rate outliers, based on z-scores or Interquartile Range, are identified with a red box. High rate outliers are identified with a blue circle.
Blank cells are suppressed data due to counts too low to report.

ALL POPULATION PERFORMANCE

Primary Care via Telehealth

- **Definition**: The Primary Care Delivery via Telehealth measure shows the portion of all primary care visits delivered via telehealth, most commonly through telephone but can also include video visits.
- **Key Findings**:
  - The overall portion of primary care visits delivered via telehealth increased from 2019 to 2020, catalyzed by the onset of the COVID-19 pandemic. Since 2021, the portion of primary care services delivered via telehealth has declined but remains persistently elevated above pre-pandemic levels.
  - We observed intermittently lower than average rates of telehealth use for members identifying as American Indian/Alaska Native, but these differences are not statistically significant as compared to other race or ethnicity groups.

ALL POPULATION PERFORMANCE

Primary Care Through Telehealth by Race/Ethnicity

Race/Ethnicity	2019	2020	2021	2022
All Population	**5%**	**34%**	**29%**	**25%**
American Indian / Alaska Native	6%	32%	28%	24%
Asian American	4%	30%	26%	22%
Black or African American	8%	40%	33%	29%
Hispanic or Latino	4%	35%	29%	24%
Multi-racial	7%	36%	30%	26%
Native Hawaiian / Pacific Islander	8%	41%	33%	30%
Non-Respondent	6%	34%	29%	24%
Other	6%	35%	29%	25%
White	7%	36%	30%	27%

COVERED CALIFORNIA

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Blank cells are suppressed data due to counts too low to report.

ALL POPULATION PERFORMANCE

Behavioral Health Visits / 1,000 Members

- **Definition**: The Behavioral Health Visits measure, for adults aged 18 and older, is the annual number of behavioral health visits per 1,000 enrolled members. Behavioral health (BH) clinicians include counselors, psychologists, psychiatrists, social workers and other therapists. Most visits are for individual patient therapy though other visits may involve group therapy or various behavioral health treatments.
- **Key Findings**:
  - Overall rates of behavioral health visits have increased since the start of the COVID-19 pandemic in 2020, and they remain elevated above pre-pandemic levels through 2022 across all race/ethnicity groups.
  - Observed differences in the rates of behavioral health utilization by race/ethnicity*:
    - Members who identify as Asian or Native Hawaiian/Pacific Islander have lower behavioral health visit rates than members identifying as other race/ethnicities, however the rates are not statistically significantly different from members identifying as other races/ethnicities.
    - Members identifying as American Indian/Alaska Native, Multiple races, or White have higher rates of behavioral health utilization than members identifying as other race/ethnicities, however the rates are not statistically significantly different from members identifying as other races/ethnicities.

*For this measure, BH visits per 1000 members stratified by race/ethnicity have a wide distribution, which means that we may see large overall differences between groups but cannot assert statistical significance. These differences likely need additional exploration to understand if they represent differences that warrant intervention.

ALL POPULATION PERFORMANCE

Behavioral Health Visits per 1,000 Members by Race/Ethnicity

Race/Ethnicity	2019	2020	2021	2022
All Population	**515**	**498**	**600**	**650**
American Indian / Alaska Native	919	865	904	1017
Asian American	146	143	199	218
Black or African American	519	530	711	767
Hispanic or Latino	301	321	429	480
Multi-racial	734	774	955	1039
Native Hawaiian / Pacific Islander	320	246	405	322
Non-Respondent	558	537	616	671
Other	523	494	589	610
White	871	842	977	1048

COVERED CALIFORNIA

Values marked as low rate outliers, based on z-scores or Interquartile Range, are identified with a red box. High rate outliers are identified with a blue circle.
Blank cells are suppressed data due to counts too low to report.

ALL POPULATION PERFORMANCE

Behavioral Health via Telehealth

- **Definition**: The Behavioral Health Delivery via Telehealth measure shows the portion of all primary care visits delivered via telehealth, most commonly through telephone but can also include video visits.
- **Key Findings**:
  - The overall portion of behavioral health visits delivered via telehealth increased from 2019 to 2020, catalyzed by the COVID-19 pandemic. Telehealth has been the predominant form of delivery of behavioral health care since 2020, and in 2022 we see 76% of all behavioral health visits across the Covered California population continue to be delivered via telehealth modalities.
    - Members identifying as American Indian/Alaska Native had statistically significant lower rates of accessing behavioral health via telehealth than members identifying as other races/ethnicities in 2022. However, as previously noted, members identifying as American Indian/Alaska Native have higher rates of BH visits overall.

*For this measure, BH visits per 1000 members stratified by race/ethnicity have a wide distribution, which means that we may see large overall differences between groups but cannot assert statistical significance. These differences likely need additional exploration to understand if they represent differences that warrant intervention.

ALL POPULATION PERFORMANCE

Behavioral Health Care Through Telehealth by Race/Ethnicity

Race/Ethnicity	2019	2020	2021	2022
All Population	**4%**	**62%**	**78%**	**76%**
American Indian / Alaska Native	4%	55%	73%	63%
Asian American	5%	65%	81%	79%
Black or African American	6%	71%	86%	84%
Hispanic or Latino	4%	65%	81%	79%
Multi-racial	4%	65%	81%	79%
Native Hawaiian / Pacific Islander	5%	70%	82%	80%
Non-Respondent	4%	60%	75%	73%
Other	4%	61%	78%	75%
White	4%	61%	77%	75%

Values marked as low rate outliers, based on z-scores or Interquartile Range, are identified with a red box. High rate outliers are identified with a blue circle.
Blank cells are suppressed data due to counts too low to report.

CONCLUSIONS AND DISCUSSION

- We identify disparities in screening rates and utilization rates when we stratify by race/ethnicity and apply statistical testing
- We are able to bring these observations forward to drive systems changes and hold health plans accountable through:
  - Publishing our annual and publicly available Plan Performance Report
  - Discussing these findings during Semi Annual Business Reviews with health plan leadership
  - Convening learning collaboratives to share best practices for equity
  - Using these findings to inform the development of contract language and performance standards
  - Moving to financial accountability for equity through our Quality Transformation Initiative

QUESTIONS/FEEDBACK

TRIBAL PROGRAM UPDATES

Waynee Lucero, Deputy Director and Tribal Liaison,
External Affairs and Community Engagement

TRIBAL ADVISORY WORKGROUP CHARTER

Membership:

- Tribes nominated regionally diverse Tribal leaders and health program representatives to the Advisory Workgroup via a process facilitated by Covered California.
- Members represent North, South, Central-East, and Central-West California along with non-federally recognized tribes.

Election of Chair:

The Workgroup could elect a Chair to coordinate with Covered California's tribal liaison, help create meeting agendas, and act as a contact point.

Membership Terms:

- Four-year terms starting in 2020, with no term limits.
- New members could be nominated by the group, tribal leaders, or self-nominated.

CURRENT TRIBAL ADVISORY WORKGROUP

REGION	MEMBERSHIP
NORTHERN	OPEN **Karen Shepherd,** Sherwood Valley Band of Pomo Indians VACANT **Andrea Cazares-Diego**, Greenville Rancheria Health Program
SOUTHERN	**Chris Devers**, Southern California Tribal Chairman's Association. Advisory Group Chair **Della Freeman**, Indian Health Council Inc.
CENTRAL EAST	**Bill Thomsen**, Riverside-San Bernardino County Indian Health, Inc. **Selina De La Pena**, Fresno American Indian Health Project
CENTRAL WEST	VACANT **Vickey Macias**, Cloverdale Rancheria (withdrawn) **Scott Black**, American Indian Health & Services
NON-FEDERALLY RECOGNIZED	VACANT **Charlene Storr**, Tolowa Nation (withdrawn)

TRIBAL SPONSORSHIP BACKGROUND

Feedback Received:

- 2023 Tribal Consultation robust conversation specific to tribal community interest to pay for the premiums of their members enrolled in Covered California.

- Discovery Period - Interviews: Covered California conducted interviews with state-based marketplaces including Washington and Nevada.

    - Nevada SBM has a pilot program utilizing data sharing agreements between the Exchange, interested tribe, and the Qualified Health Plan. Will be exploring this option.

Interest Assessment:

- Covered California worked in partnership with the Tribal Advisory Workgroup to develop survey questions and coordinated internal feedback.
- Purpose of the survey is to gauge interest and loop in any Tribes that are interested or need more information and streamline our outreach & engagement.

TRIBAL SPONSORSHIP EXPLORATION

Current Status:

- Tribal Sponsorship Survey: A comprehensive overview of tribal sponsorship highlighting its benefits for prospective participants was developed and in support with our partner agencies and tribal organizations, distributed to an extensive list to ensure broad reach.
- The survey was distributed in August, and we currently have **8** responses from tribes and tribal organizations.
- We are keeping the **survey** open till early next year so we can hear from as many tribes as possible.

Next Steps:

- Report survey feedback and results, internally and externally.
- Develop an outreach and communication plan to engage with survey respondents.
- Create an ad-hoc workgroup with Covered CA, QHP issuers, Tribal leaders and representatives to outline the next steps for the sponsorship program.

TRIBAL SPONSORSHIP SURVEY QUESTIONS

Open text poll

1. Please provide the name of your tribe.

Multiple choice

2. Do you know if any members of your tribe are currently enrolled in Covered California?

Multiple choice

3. What is the estimated range of members in your tribe:

Multiple choice

4. Is your tribe a Covered California Navigator, sub-grantee for a Navigator organization, or a Certified Enrollment Entity?

Open text poll

5. If so, which one?

Multiple choice

6. Would you be interested in sponsoring the premiums of your tribal members who are enrolled in Covered California?

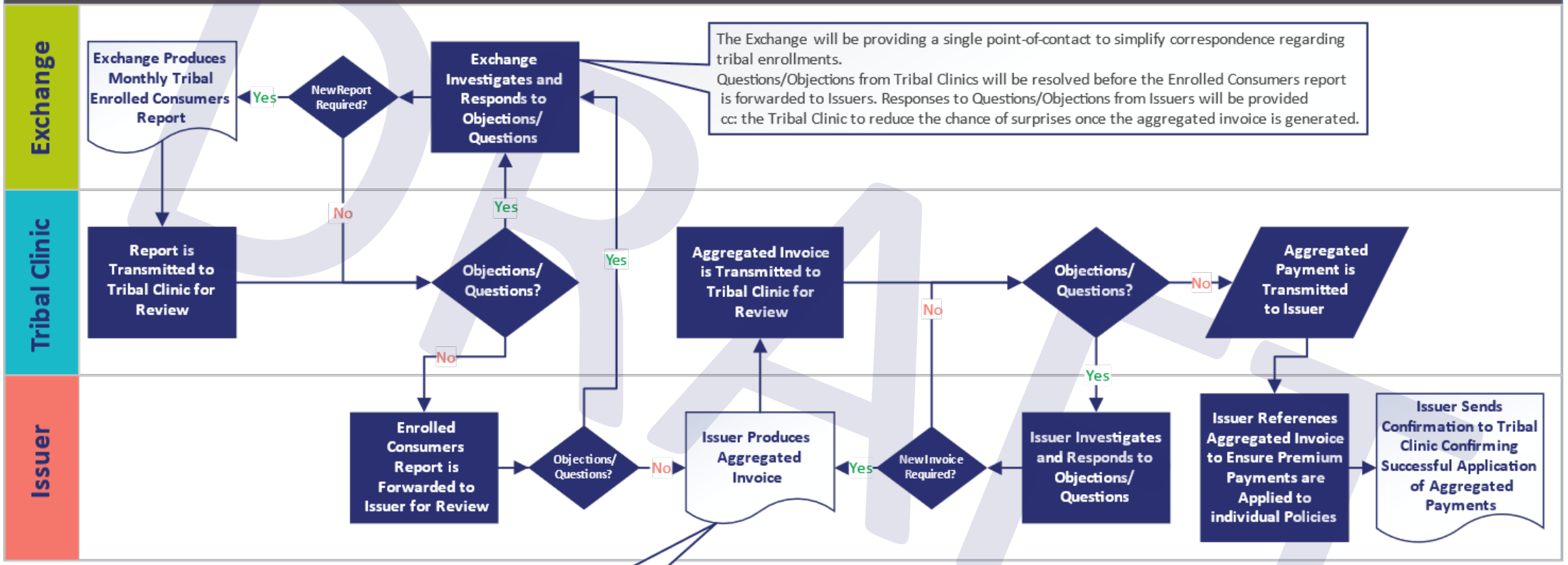
Multiple choice

7. Would you be interested in becoming a certified application entity (member of your staff trained and certified to enroll individuals in Covered California)

Open text poll

8. If you are interested in sponsoring the premiums of tribal members, please provide the best contact.

Sample Tribal Aggregated Billing Workflow



The aggregated invoice must:
-Clearly identify the name of the issuer organization with a logo and/or letterhead
-Include a unique Invoice Number
-Include line-item details, including Policy ID and Subscriber Name, for each policy listed in the Enrolled Consumers report

DRAFT ONLY

OPEN DISCUSSION

QHP DISCUSSION

OPEN FORUM

CLOSING

COVERED CALIFORNIA FOR AMERICAN INDIANS

THANK YOU!

Waynee Lucero
Tribal Liaison and Deputy Director
External Affairs and Community Engagement
Waynee.Lucero@covered.ca.gov

Sana Zulfiqar
External Affairs Specialist, Tribal Liaison Lead
Sana.Zulfiqar@covered.ca.gov

APPENDICES

AI/AN MEMBER CASE RESOLUTION

If you have an AI/AN enrollee that is having issues with their plan, you can contact the following to expedite the case and attempt to resolve as quickly as possible.

externalaffairs@covered.ca.gov
tribalconsultation@covered.ca.gov

For the timeliest assistance, please also include all the following where applicable:

- Constituent's Name
- Case # or Application ID #
- Constituent's Date of Birth
- Constituent's Telephone Number
- Constituent's email
- Signed Information Release Form (if applicable) – see below for more details

2025 HEALTH BENEFIT DESIGN BY METAL TIER

Coverage Category	Minimum Coverage	Bronze	Silver	Silver 73 CA Enhanced CSR	Silver 87 CA Enhanced CSR	Silver 94 CA Enhanced CSR	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	>$30,120 (Above 200% FPL)	$22,591 to $30,120 (>150% to ≤200% FPL)	up to $22,590 (100% to ≤150% FPL)	N/A	N/A
Free Preventive Care Visit	$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	$60	$50	$35	$15	$5	$35	$15
Urgent Care		$60	$50	$35	$15	$5	$35	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$90	$85	$25	$8	$65	$30
Emergency Room Facility		40% after deductible is met	$400	$350	$150	$50	$330	$150
Laboratory Tests		$40	$50	$50	$20	$8	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$95	$95	$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	$19	$18	$15	$5	$3	$15	$7
Tier 2 (Preferred Drugs)		40% up to $500 per script after drug deductible is met	$60**	$55	$25	$10	$60	$16
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 - The amount you pay before the plan pays	N/A	Individual: $5,800 Family: $11,600	Individual: $5,400 Family: $10,800	N/A	N/A	N/A	N/A	N/A
Pharmacy Deductible - The amount you pay before the plan pays	N/A	Individual: $450 Family: $900	Individual: $50 Family: $100	N/A	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$9,200 individual $18,400 family	$8,850 individual $17,700 family	$8,700 individual $17,400 family	$6,100 individual $12,200 family	$3,000 individual $6,000 family	$1,150 individual $2,300 family	$8,700 individual $17,400 family	$4,500 individual $9,000 family

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

COVERED CALIFORNIA

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.

AMERICAN INDIAN/ALASKAN NATIVE PROGRAM ELIGIBILITY

Program Eligibility by Federal Poverty Level for 2025

Your financial help and whether you qualify for various Covered California or Medi-Cal programs depends on your income, based on the Federal Poverty Level (**FPL**)

COVERED CALIFORNIA

SEE NOTE BELOW FOR INCOMES IN THIS RANGE

Federal Premium Tax Credit*

American Indian / Alaska Native (AIAN) Zero Cost Sharing (100%-300%)

AIAN Limited Cost Sharing ** (over 300%)

Silver 94 (100%-150%) | Silver 87 (>150%-200%) | Silver 73 (>200%)

Household Size	% FPL	0%	100%	138%	150%	200%	213%	250%	266%	300%	322%	400%*
	1	$0	$15,060	$20,783	$22,590	$30,120	$32,078	$37,650	$40,060	$45,180	$48,494	$60,240
	2	$0	$20,440	$28,208	$30,660	$40,880	$43,538	$51,100	$54,371	$61,320	$65,817	$81,760
	3	$0	$25,820	$35,632	$38,730	$51,640	$54,997	$64,550	$68,682	$77,460	$83,141	$103,280
	4	$0	$31,200	$43,056	$46,800	$62,400	$66,456	$78,000	$82,992	$93,600	$100,464	$124,800
	5	$0	$36,580	$50,481	$54,870	$73,160	$77,916	$91,450	$97,303	$109,740	$117,788	$146,320
	6	$0	$41,960	$57,905	$62,940	$83,920	$89,375	$104,900	$111,614	$125,880	$135,112	$167,840
	7	$0	$47,340	$65,330	$71,010	$94,680	$100,835	$118,350	$125,925	$142,020	$152,435	$189,360
	8	$0	$52,720	$72,754	$79,080	$105,440	$112,294	$131,800	$140,236	$158,160	$169,759	$210,880
	add'l, add	$0	$5,380	$7,425	$8,070	$10,760	$11,460	$13,450	$14,311	$16,140	$17,324	$21,520

Medi-Cal

Medi-Cal for Adults | Medi-Cal for Pregnant Individuals | Medi-Cal Access Program (for Pregnant Individuals)

Medi-Cal for Kids (0-18 Yrs.) | CCHIP (San Francisco, San Mateo, and Santa Clara county residents)

Note: Most consumers up to 138% FPL will be eligible for Medi-Cal. If ineligible for Medi-Cal, consumers may qualify for a Covered California health plan with financial help including: federal premium tax credit, Enhanced Silver (94, 87, 73) plans and Zero Cost Sharing and Limited Cost Sharing AIAN plans. **Enhanced Silver 94, 87 and 73 plans** have no deductibles, and lower co-pays and out-of-pocket maximum costs.

* Consumers at 400% FPL or higher may receive a federal premium tax credit to lower their premium to a maximum of 8.5 percent of their income based on the second-lowest-cost Silver plan in their area. See the chart on page 2 for more information.

** AI/AN members with household incomes above 300% FPL will be eligible for the Limited Cost Sharing and the Silver 73.

2025 FAMILY DENTAL AND VISION COMPANIES

Anthem BlueCross

blue california

California Dental Network
A DentaQuest company

DELTA DENTAL

Humana

All health plans include dental care for **children** at no extra cost.

Adults can purchase a family dental plan when they enroll in a Covered California health insurance plan.

- There must be at least one adult (age 19 or older) enrolled in a family dental plan for a child in the family to enroll. (Not all adults in the household are required to enroll.) If a family chooses to enroll children in a family dental plan, all children younger than 19 who live in the household must enroll.

https://www.coveredca.com/individuals-and-families/getting-covered/dental-coverage/family/

EyeMed

vsp individual vision plans

SuperiorVision
A MetLife Company

Children under age 19 get free vision care included with their parent's Covered California health plan.

Adults can enroll directly with one of our three contracted vision companies. All offer excellent benefits.

https://www.coveredca.com/vision/adult/
https://www.coveredca.com/vision/childrens-vision/

AMERICAN INDIAN/ALASKA NATIVE ZERO-COST AND LIMITED-COST SHARING PLANS

- **Zero cost sharing plans:** For income **between 100%–300%** of the FPL, consumers are eligible for an AI/AN plan that is not subject to:
  - Deductible, coinsurance and cost sharing.
  - Does not need a referral from an Indian Health Clinic or when receiving Essential Health Benefits (EHB) from a Qualified Health Plan (QHP).

- **Limited cost sharing plans:** For income **below 100% or above 300%** of the FPL, consumers are eligible for an AI/AN plan that is not subject to:
  - Deductible, coinsurance and cost sharing
  - If receiving health care services from an Indian Health Clinic **or with a referral** from an Indian Health Clinic when receiving Essential Health Benefits (EHB) from a Qualified Health Plan (QHP).

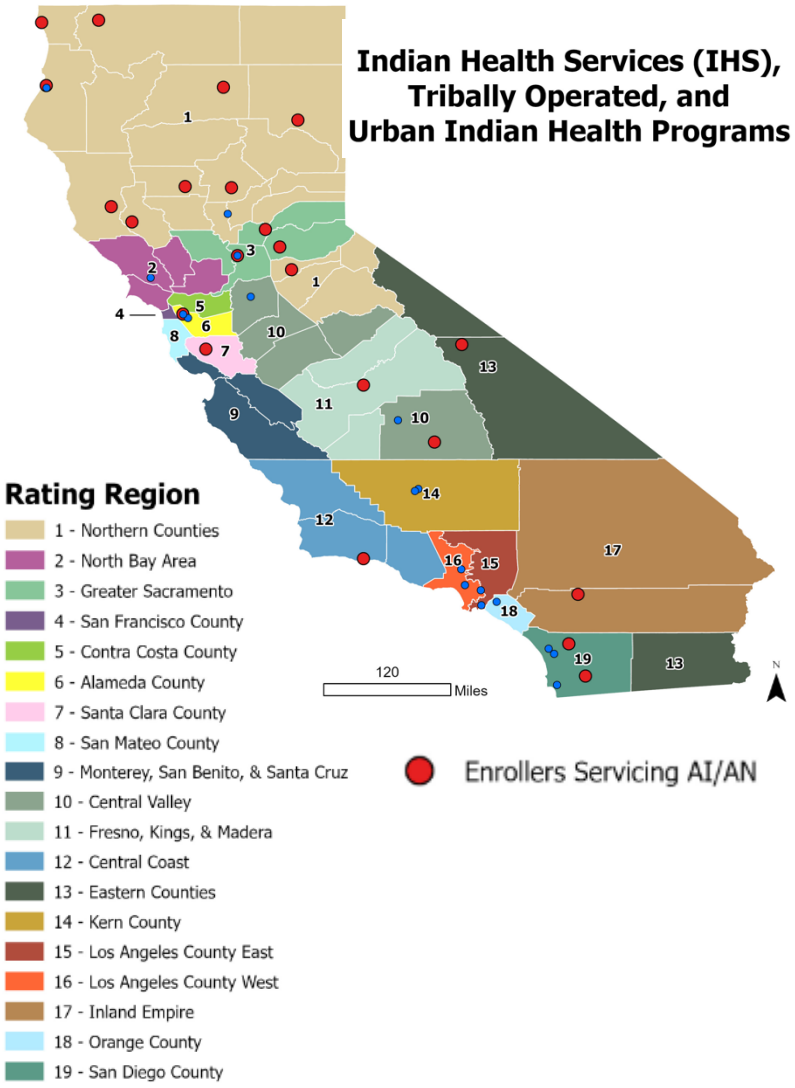
DOCUMENTS TO PROVE AI/AN STATUS

Submit a copy of **one** of the following documents:

1. Tribal Enrollment/Membership Card.
2. Authentic document from a tribe declaring membership for an individual.
3. I-872 American Indian Card.
4. U.S. American Indian/Alaska Native tribal enrollment or shareholder documentation.
    1. Enrollment or membership document from a federally-recognized tribe or the Bureau of Indian Affairs. It must be on tribal letterhead or an enrollment/membership card that contains the tribal seal and/or an official signature.
    2. Document issued by an Alaska Native village/tribe, or an Alaska Native Corporation Settlement Act (ANCSA) regional or village corporation acknowledging shareholder status.
5. Certificate of Degree of Indian Blood (CDIB) issued by the Bureau of Indian Affairs or a tribe, if the CDIB includes tribal enrollment information.
6. Letter from the U.S. Department of Health and Human Services (HHS) granting a tribal exemption based on tribal membership or Alaska Native shareholder status.

CERTIFIED ENROLLMENT ENTITIES

Account Name	Program	Organization Type
American Indian Health and Services, Inc	Certified Application Entity	American Indian Tribes or Tribal Organizations
Chapa-De Indian Health	Certified Application Entity	Licensed health care clinics
Consolidated Tribal Health Project, Inc	Certified Application Entity	American Indian Tribes or Tribal Organizations
Elk Valley Rancheria	Certified Application Entity	American Indian Tribes or Tribal Organizations
Feather River Tribal Health, Inc	Certified Application Entity	Indian Health Services Facilities
Fresno American Indian Health Project	Certified Application Entity	American Indian Tribes or Tribal Organizations
Indian Health Center of Santa Clara Valley	Certified Application Entity	Licensed health care clinics
Indian Health Council, Inc.	Certified Application Entity	Indian Health Services Facilities
Karuk Tribe	Certified Application Entity	American Indian Tribes or Tribal Organizations
Lake County Tribal Health Consortium, Inc.	Certified Application Entity	American Indian Tribes or Tribal Organizations
Lassen Indian Health Center	Certified Application Entity	American Indian Tribes or Tribal Organizations
MACT Health Board, INC.	Certified Application Entity	American Indian Tribes or Tribal Organizations
Native American Health Center	Navigator Entity (sub)	Non-Profit
Northern Valley Indian Health, Inc.	Certified Application Entity	Indian Health Services Facilities
Pit River Health Service, Inc	Certified Application Entity	American Indian Tribes or Tribal Organizations
Riverside San Bernardino Co Indian Health	Certified Application Entity	Indian Health Services Facilities
Sacramento Native American Health Center, Inc	Certified Application Entity	Licensed health care clinics
Shingle Springs Tribal Health Program	Certified Application Entity	American Indian Tribes or Tribal Organizations
Southern Indian Health Council, Inc.	Certified Application Entity	American Indian Tribes or Tribal Organizations
Toiyabe Indian Health Project	Certified Application Entity	American Indian Tribes or Tribal Organizations
Tule River Indian Health Center, Inc.	Certified Application Entity	Indian Health Services Facilities
United Indian Health Services	Certified Application Entity	Licensed health care provider



COVERED CALIFORNIA QHP AI/AN NETWORK

- There are currently 85 Indian Health Service (IHS), tribally operated, and urban Indian health programs in Covered California's QHP networks
  - Majority are in Region 1 (Northern CA) and Region 17 (Inland Empire)
- Covered California continues to encourage QHP Issuers to include and expand the number of Indian Health Service (IHS), tribally operated, and urban Indian health programs in their networks
- A list of Indian Health Service (IHS), tribally operated, and urban Indian health programs that are currently in Covered California's QHP networks are available on the AI/AN toolkit:

https://hbex.coveredca.com/california-tribes/

MARKETPLACE BENEFITS AND COVERAGE LEVELS

The Affordable Care Act (ACA) requires that products sold in the individual market cover **10 essential health benefit categories***.

COVERED CALIFORNIA

*Copays and deductibles may apply to these services

Glossary

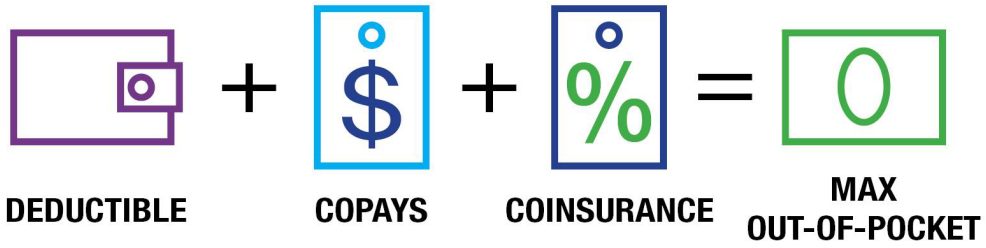
Copays:
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Coinsurance:
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20 percent) of the allowed amount for the service. You pay coinsurance plus any deductible you owe.

Deductibles:
The amount you owe for health care services your health insurance plan covers before your plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you have met your deductible for covered health care services. The deductible may not apply to all services.

Maximum Out-of-pocket (MOOP):
The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments and coinsurances for in-network care and services, your health plan pays 100% of the costs of covered benefits.

Premium:
A health insurance premium is the recurring payments you make to manage your health insurance plan.



Copays do not go towards your deductible.
Only to your max out-of-pocket.

GLOSSARY

Advanced Premium Tax Credit (APTC)

Financial assistance eligible consumers may receive when enrolling in a Covered California health insurance plan, to assist them in paying their monthly premium costs. The amount of premium assistance an individual may receive is determined based on his or her income as a percentage of the federal poverty level. This tax credit may also be described as “premium assistance.” Tax credits are also available to small businesses with fewer than 25 full-time-equivalent employees to help offset the cost of providing coverage

Exclusive Provider Organization (EPO)

An exclusive provider organization (EPO) is a type of health care doctor and hospital network that offers a full array of covered benefits from a single network. Covered benefits are not paid for services rendered by a doctor or hospital that is not part of the network, except in the case of emergency or plan-approved care outside the network.

Federal Poverty Level (FPL)

A measure of income level issued annually by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits. In California, for example, Medi-Cal is available to those making up to 138 percent of the federal poverty level.

Federally Recognized Tribe

Any American Indian or Alaska Native tribe, band, nation, pueblo, village or community that the U.S. Department of the Interior acknowledges to exist as an American Indian tribe.

Health Maintenance Organization (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the health maintenance organization (HMO). It generally won’t cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Preferred Provider Organization (PPO)

A type of health insurance plan that contracts with participating doctors and hospitals to create a network. You pay less if you use doctors and hospitals that belong to the plan’s network. You can use doctors, hospitals and others outside the network for an additional cost.