Covered California: Potential Major Health Plan Contracting Changes for 2023 and Beyond to Promote Quality Improvement & Health Equity

Shared for Input and Concept Development

For Public Distribution: November 10, 2021

Introduction

As Covered California considers new and significant revisions in how we seek to promote competition and hold health plans accountable, we are seeking input from CMS, health plans, consumer advocates, other purchasers, thought leaders and others to inform these efforts.

Given the fragmented health care financing and delivery system, we believe we must work in alignment with others to improve the affordability and quality of care for ALL Californians and Americans. In California, we have "walked this talk" by working closely with the state Medicaid program (Medi-Cal), the California Public Employees' Retirement System, and groups such as the Purchaser Business Group on Health and the Integrated Healthcare Association.

We are also now reaching out to learn from and align with efforts of CMS, other state-based marketplaces, purchasers, health plans, advocates, policy and academic leaders and others for input. We seek this input as we considering role of marketplaces within the construct of the "3 M's" – Medicaid, Marketplaces, and Medicare – and the relationship of these three to employer sponsored insurance.

Covered California's Marketplace Competition and Oversight Strategies

Covered California was created to establish a marketplace where Californian's can purchase affordable, quality plans. It was specifically charged by the Legislature to strengthen the health care delivery system in California and to require participating health carriers to compete on the basis of price, quality, and service. To that end, since its inception Covered California has played an active role in working to create and foster a competitive marketplace that works for consumers and holds health plans accountable for the care they provide. Major dimensions of Covered California's strategy in ensuring effective competition and oversight include:

- Administering coverage eligibility standards
- Selecting and excluding participating health plans
- Establishing standard patient-centered benefit designs
- Applying contractual requirements beyond state regulatory or national QHP standards
- Overseeing and monitoring health plans on cost, quality, health equity and networks – including conducting annual negotiating/reviews, reports and data collection/analysis
- Doing marketing/outreach and requiring health plans to invest in complementary promotional efforts
- Supporting and establishing standards to ensure informed consumer choice during enrollment (whether performed by Covered California, health plans, agents, or navigators)

Covered California's Positive Outcomes: 2014 – 2021

- **Many carriers and broad consumer choice:** Substantial consumer choice (12 health plans in 2022, with 70% of enrollees having five or more health plans to choose among) and market stability (10 of the 12 health plans having participated continuously since 2014).

- **High enrollment, healthy risk mix, and lower costs:** By effectively supporting broad enrollment, California has a risk mix that is far healthier than the national average, equating to premiums being about 20 percent lower than they would have been if the risk mix were at the national rate.

- **Low annual premium increases:** Over the past seven years, premium increases in California have been about half as large as those in federally facilitated marketplace states. Low premium increases have resulted in not only strong subsidized enrollment, but also more unsubsidized consumers able to afford keeping coverage than in FFE (on AND off exchange).

- **Biggest decrease in uninsured in nation:** Covered California has been a key contributor to California's experiencing the largest drop in uninsured in the nation – from pre-ACA rate of 18 percent to reported rate as of 2020 of 6 percent.

- See Appendix – Covered California Market Context for additional information.

Ongoing Challenges for Covered California and Health Care Nationally

Covered California's positive results and accomplishments have occurred in the context of challenges that are shared by consumers across the nation, regardless of whether they get care through Medicaid, Marketplaces, Medicare or ESI, including:

- **Inconsistent and limited improvement in quality**: Uneven quality across and within contracted health plans, resulting in many consumers getting low quality care – particularly communities of color and lower income Americans – with little improvement over time.
- **Persistent health disparities:** Challenges in tracking and addressing disparities despite Covered California's longstanding focus on equity.
- **Unaffordability of coverage and care for many:** Prior to the American Rescue Plan subsidy increases, many found coverage or care unaffordable (and many with ESI and Medicare struggle with affordability).
- **Coverage transitions difficult:** Consumers moving between ESI, Medicaid, Marketplace and Medicare coverage often find the process difficult and confusing, leading to gaps in coverage.
- **Consumers making poor decisions:** Too often, consumers are not making adequately informed choices, as evidenced by enrollees not taking full advantage of available subsidies.
- **More choice NOT translating to better value:** In Covered California, most consumers have many health plan choices with unclear evidence that adding more plan choices would add consumer value (e.g., reducing costs, improving quality or providing access to new/different providers).
- **Challenges in rural areas:** In California's northernmost region, there are access challenges and little plan or provider competition (impacting about 6% of enrollees).

Covered California Market Context: Uneven Progress on Clinical Quality

Good News:

- In 2020 85% of enrollees were in QHPs that received 3 stars or better for Getting Right Care, with one plan receiving 5 star in 2020, and two receiving 4 stars as of 2021.

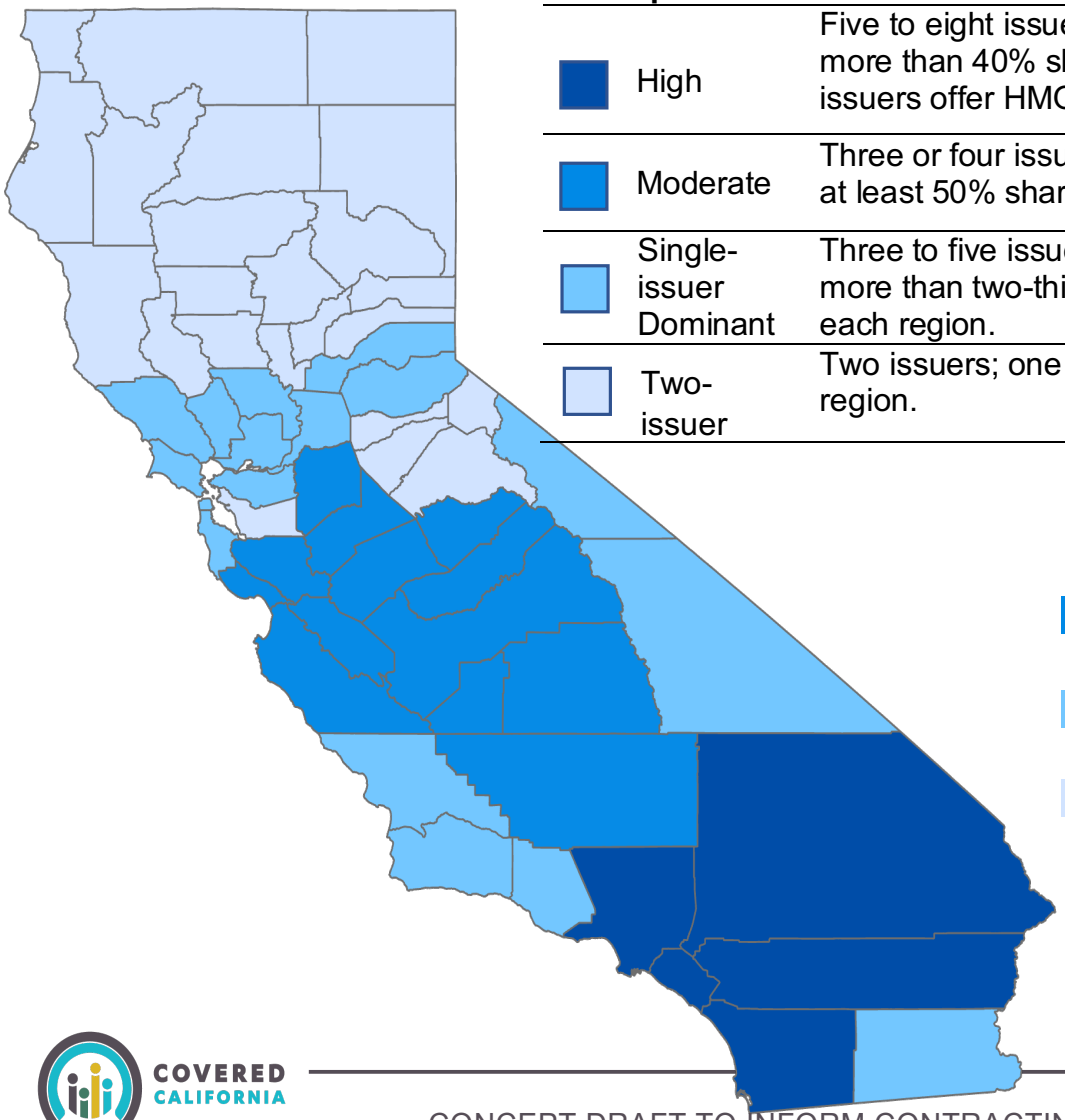
Bad News:

- QHP performance has not consistently or substantively improved over time
- Three QHPs – Anthem, Molina and Oscar (representing 13% enrollees) received 2 stars for three consecutive years (2019, 2020 and 2021) for Getting the Right care

Qualified Health Plan Issuer	2021 Enrollees	2016	2017	2018	2019	2020	2021*
Anthem HMO	1.9%	3	-	-	-	NA	NA
Anthem PPO	-	2	-	-	-	-	-
Anthem EPO	4.5%	2	NA	3	2	2	2
Blue Shield HMO	7.4%	NA	NA	NA	2	3	3
Blue Shield PPO	20.6%	2	2	3	2	3	3
CCHP HMO	0.3%	3	3	3	3	3	3
Health Net HMO	8.3%	3	3	3	3	3	3
Health Net EPO	0.05%	NA	2	3	2	3	NA
Health Net PPO	2.7%	-	NA	NA	NA	3	2
Kaiser Permanente HMO	36.9%	5	4	5	5	5	4
LA Care HMO	6.1%	1	3	4	3	4	3
Molina Healthcare HMO	3.5%	2	3	3	2	2	2
Oscar Health Plan EPO	4.3%	NA	NA	3	2	2	2
Sharp Health Plan HMO	1.5%	4	4	5	4	4	4
Valley Health Plan HMO	1.4%	3	3	5	4	4	3
Western Health Advantage HMO	0.6%	3	3	3	2	2	3

* 2021 represents measurement year 2020 which may not be representative due to COVID-19

Covered California Market Context: Most Consumers Benefit from Robust Competition



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

Current market share by type/region**:

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

* Based on 2022 issuers
** See Appendix: 2022 Health Plan Offerings

Health Plan Contracting 2023-2025: Building on and Improving a Strong Foundation

Stable and desirable marketplace:
- Eleven carriers have participated for over 5 years
- Multiple national and regional plans have expressed interest in joining

Ongoing contract requirements set a high bar:
- Standard patient-centered benefit designs to reduce consumer confusion and ensure quality of coverage
- Requirements related to scope of marketing, including coordination, targeting and co-branding
- Adequate provider networks, including inclusion of Essential Community Providers
- Initiatives to improve healthcare quality, address health disparities, and promote delivery system and payment reform

Significant additions to existing contractual requirements in the areas of:
- Disparities reduction
- Behavioral health
- Value based delivery systems (advanced primary care, integrated delivery systems, payment reform)
- Affordability and cost (provider networks and consumer affordability)
- Data exchange requirements

Across the board, Covered California's contracting is designed to be aligned with and complement efforts of other major purchasers, including CMS, Medi-Cal, CalPERS (the state employee purchasing program), and others.

Health Plan Contracting 2023-2025: Major New Potential Requirements Under Consideration

In addition to significant incremental changes to existing requirements, Covered California is considering two areas that aim to spur dramatic improvements in quality and equity:

- **Additional Requirements for Quality and Equity:** Increased contractual requirements for quality improvement, including introduction of the Quality Transformation Initiative, which incentivizes the delivery of higher quality and equitable care by requiring lower quality health plans to contribute an amount starting at 1% and increasing to 4% of premium towards quality improvement activities.

- **Formalizing Plan Selection/Exclusion Criteria**: The determination of how many plans should be offered in a given area, and what additional criteria should be used to evaluate the addition of new, and/or removal of existing health plans, based on the value they provide to consumers.

In considering these options, Covered California is in the process of conducting a detailed market analysis, review of the literature, assessing legal and regulatory issues and engaging stakeholders as well experts to inform the approaches under consideration to develop proposals for the Board in January 2022.

Covered California's Theory of Change: Incentives to Improve Quality and Potential Plan Actions

Covered California Actions

- **Alignment on measures and market signals to health plans & providers:** Covered California is committed to aligning with other purchasers to send strong and consistent quality improvement direction to health plans and providers.
- **Substantial financial consequences:** Through required contributions linked to poorer quality, health plan selection and removal policies and other contractual provisions, Covered California will seek to make improvement in quality and equity a core business imperative for health plans and providers.
- **Public notice:** Covered California would amplify the impact of the Quality Transformation Initiative and decisions to include or remove health plans by publicly sharing actions taken.

Potential Health Plan Responses

Covered California's goal is to foster concerted and ongoing efforts that result in improvement in health care quality and equity for its enrollees and all Californians. The list below represents a range of potential health plan responses to either required financial contributions based on poor quality performance or consideration of inclusion or removal in the marketplace. From Covered California's perspective, the first three represent desirable plan responses, whereas the latter three may require additional assessment and interventions to avoid negative unintended consequences for consumers.

1. Engaging and supporting provider groups in improvement activities, for example development of registries and data analytics, facilitating data exchange, and innovative approaches to patient engagement.
2. Developing quality incentive programs for contracted providers and groups focused on the same or similar measures and generally improve coordination, integration and care delivery.
3. Use consumer incentive programs to target desired behavior.
4. Eliminating poor performing providers or provider groups from their contracted networks (a strategy that would necessarily be limited by the need to meet access and network adequacy requirements from both regulators and Covered California, but could have the unintended consequence of penalizing providers serving higher risk or more vulnerable patients).
5. Using targeted efforts to enroll healthier individuals.
6. Focusing on data issues, including completeness.

Covered California's Potential Quality Transformation Initiative: Significant Incentives to Improve Quality and Equity

Covered California Questions Regarding Financial Contributions for Quality

Quality Transformation Initiative: Instituting Potentially Major Financial Contributions to Spur Quality Improvement

1. Overall: Is the proposed approach directionally sound and well-constructed?

2. Number of and selection of measures: Core to the initiative is selecting a set of measures that are (1) parsimonious in number (fewer than 10); (2) aligned with other purchasers and regulators; (3) clinically important and outcomes-based; and (4) relatively not "gameable." Reactions in general and specifically to the measures under consideration?

3. Performance thresholds: In aiming for substantial improvement in quality, the proposal is to require health plans to contribute funds for performance below low/poor performance (e.g., 25th percentile national performance), but have some health plans contribute funds for quality ratings all the way to the 75th percentile national performance. Reactions?

4. Potential financial contribution: The goal is for the contribution to be financially meaningful, with potential contribution of 1% premium in the first year of implementation, rising by 1% each year over the next three years, for a maximum potential contribution of up to 4% in year four and beyond. Reactions?

5. Use of contributions: Currently we are considering that any financial contributions collected for poor quality could be (a) paid to consumers in some form or (b) used directly to improve quality and equity. Reactions?

6. Anything else we should consider?

See Appendix – Background for Quality Transformation Initiative for additional information.

Covered California's Quality Transformation Initiative (QTI): Financial Incentives to Drive Improvements

- **Financial contribution growing to 4% over time:** amount based on level of quality performance: Year 1 up to 1%; Year 2 up to 2%; Year 3 up to 3%; and Year 4 and ongoing up to 4%.

- **Incentives that matter to consumers and health plans:** After full implementation, health plans could contribute in excess of $20 PMPM, enough to impact consumer enrollment choices, and dedicating millions of dollars towards improving quality.

- **Recognition that low-income consumers could be impacted by additional dollars to improve quality and are definitely impacted by poor care:** Given the funding structure of the Marketplace, any contributions made by health plans are likely to be loaded into health plan premiums and ultimately borne by consumers (unlike Medicaid, where consumers are shielded from cost share, and Medicare, where incentives are only in the form of bonuses). There is a fundamental tension between the size of the financial contribution used to improve quality and the risk of decreased affordability for consumers who choose to stay enrolled in lower quality health plans.

Covered California's Quality Transformation Initiative: Measures Under Consideration

- Goal is to have fewer than 10 measures, with the initial set under consideration developed based on need for national benchmarks (i.e. QRS measures) and in consultation and alignment with Medi-Cal and CalPERS.

- Measures are intended to represent epidemiologically relevant, clinical domains that are amenable to health system improvement:
  - Cervical cancer screening
  - Colorectal cancer screening
  - Blood pressure control
  - Diabetes control
  - Childhood vaccinations
  - Adolescent vaccinations
  - CAHPS Access composite measure (potentially with lower targets)
  - Depression screening and follow-up*
  - Pharmacotherapy for opioid use disorder*

- Measures will be stratified race/ethnicity, but no financial contributions would be required until there are agreed upon national benchmarks on stratified data.

*reporting only for initial periods given lack of national benchmarks

Covered California's Quality Transformation Initiative (QTI): Rewarding Better Care, Promoting Improvement

- The Quality Transformation Initiative would tie financial contributions to health plan quality performance on a parsimonious set of "measures that matter" for both health outcomes and, over time, disparities.

- The goal is to improve and eliminate poor performance. Financial contributions are weighted to worse performance, and structured to foster excellence:
  - Financial contributions begin at performance below 25th percentile national performance;
  - The majority of the contribution would be applied between the 25th and 50th percentile national performance; and
  - To promote high – not "average" – performance, results between the 50th and 75th percentile national performance would still be subject to a small contribution.

- Covered California plans to develop the measures and methodology to pilot the QTI with no financial contribution in 2022, with the first measurement year in 2023, and first contribution in 2024.

Covered California Quality Transformation Initiative: Additional Elements Under Consideration

- The primary rationale for the required contributions from poorer performing health plans is to incent quality improvement. Covered California is currently considering two potential uses of contributions received from health plans:
  - Contributions collected could be paid to consumers in some form; or
  - Contributions could be used directly to improve quality and equity.

  For either potential use of required contributions, Covered California would use its established, transparent process of stakeholder engagement and public Board discussion to develop governance, processes, goals and target outcomes, distributions and monitoring.

  To the extent contributions would be used directly to support quality improvement, Covered California anticipates identifying an external entity with relevant expertise in selecting, managing, evaluating and overseeing programs to support quality and delivery system improvement activities.

- Covered California would need to determine the extent to which QTI measures and policies complement any health plan exclusion/limitation policies based on quality.
  - For example, consideration of barring health plans with persistent low-quality performance will require decision on how quality is assessed (e.g. QRS vs. QTI measure set).

Covered California's Potential Policies for Health Plan Inclusion or Removal to Foster Market Competition for Consumers

Covered California Questions Regarding Health Plan Inclusion and Exclusion Criteria

Potential Policies for Inclusion or Removal of Qualified Health Plans and Qualified Health Plan Issuers from the Covered California Market

1. Covered California proposes to have different standards for Existing Health Plans and potential New Entrants. Reactions?

2. For Existing Health Plans: The potential policy considers removing from the Marketplace Health Plans that have 2 years of "poor quality" performance – for example, QRS scores in the Getting Right Care domain of 2 stars or less – if they do not improve over the following two years. Health Plans will be required to provide a corrective action plan detailing how they will improve over those next two years. Reactions?

3. For the "removal policy" Covered California is considering using either the Quality Transformation Initiative measure set or the full QRS "Getting Right Care" measure set. For either, Covered California is considering using the equivalent of "25th percentile" of national performance as the marker of performance (while examining absolute performance). Reactions?

4. For the "removal policy" Covered California is considering a "threshold level" of essential competition and only removing Health Plans from regions that meet that threshold. Covered California is assessing using the HHI index or establishing a "minimum remaining" number of at least three health plans. Reactions?

5. For New Entrants: Covered California has detailed four elements that it would consider in allowing new health plans: (1) competitive pricing and long-term price stability; (2) provider networks; (3) quality/equity performance; and (4) fostering competition. Reactions?

6. Anything else we should consider?

See Appendix – Background for Health Plan Selection, Exclusion or Limitation Policies for additional information.

Covered California's Historical Approach to Plan Selection

Establishing "minimum standards" of participation – of physicians, hospitals, and health plans – has been a hallmark of Medicare and other public programs. As part of its efforts to actively manage the individual market, Covered California has gone beyond minimum standards provided for under the ACA and state regulation. Covered California has not accepted all health plans that meet national (QHP) or state (DMHC and CDI) regulatory minimums, rather it has evaluated existing and potential new plans for consumer value.

Covered California's focus has included:

- Meaningful consumer benefit considering network composition, cost and quality
- Providing consumers with a choice of carrier options (e.g., at least four competing carriers per region)
- For new carriers wanting to enter competitive regions, seeking distinct/unique offerings (unique providers, technological innovations, integration strategies, ties to underserved populations, etc.)
- Full regional participation to create level playing field among plans
- Encouraging participation of public Medi-Cal managed care plans to strengthen continuity of care

During the first seven years, Covered California has turned away potential carriers but has not removed existing carriers. When consumers shop for health plans, the default display is based on total costs to consumers, with quality and provider participation available as ancillary information.

Covered California 2023 and Beyond: Considering Different Standards for Existing Carriers and New Entrants

As it plans for the 2023 – 2025 contract cycle, Covered California is considering how to apply clearer standards for the inclusion, exclusion or restriction on participation of health plans based on their quality, cost and networks. Covered California is also weighing the role of factors other than cost in consumer presentation of health plans.

Since 2014, California's consumers have benefited from stability of having choice among multiple carriers, resulting in robust competition despite policy shifts and market uncertainty. In recognition of this and due to the desire to assure continuity of plan choice with existing enrollees, Covered California proposes to different standards for:

- **Existing Carriers –** health plans that have been part of the Marketplace for at least 5 years (since 2017) and

- **New Entrants** – health plans seeking to join the Marketplace in 2023 or after that date.

Covered California 2023 and Beyond: Standards Under Consideration for Existing Carriers

Covered California is considering a range of potential policies to assure **existing carriers** provide high value to California's consumers.

- **Policies under development:** the following policies would potentially take effect in plan year 2023
  1. Health plans that fall below established quality benchmarks for two consecutive years would be put on notice that they would be required to improve within two years or be removed from the Marketplace.
     - The quality benchmark would be at the equivalent of 25th percentile performance using either the QRS "Getting Right Care" standard or the Covered California QTI measure set.
     - The exclusion policy would not be applied to health plans in a region with fewer than a minimum threshold of number of health plans or competitiveness (as measured by HHI).
     - The health plans would be required to submit a corrective action plan that meets with Covered California's approval to continue.
  2. If the health plan does not meet the quality benchmark within the two-year period, the plan would be removed from Covered California's Marketplace and consumers would be assisted in selecting a new health plan.
     - Health plans would be eligible to reapply once their quality scores have improved.

- **Additional policies being considered:** the following policies are being explored
  1. During the two-year notice period, additional policies Covered California would consider include:
     - New enrollment be disabled until such time as the health plan's quality meets the quality benchmark; and
     - Covered California would notify all enrollees in the health plan's of the quality deficiencies and remind them of alternative health plan options in their region.
  2. Excluding or limiting offering of PPO products given Covered California's support for care integration and coordination (note: Covered California will continue providing incentives for promotion of advanced primary care and effective care coordination through other contractual means, including exploration of alternate standard benefit designs for PPOs to promote care coordination).
  3. Policies to limit enrollment would be applied only to those health plans that are not in the lowest two price positions in the Bronze or Silver Metal Levels

Covered California 2023 and Beyond: Standards Under Consideration for New Entrants

Covered California is considering a range of potential policies to assure **new health plan entrants** provide high value to California's consumers.

- **Policies Under Development:** the following policies would take effect in plan year 2023
  1. **Competitive Pricing**: The new entrant must demonstrate that is has competitive pricing of not more than XX% (TBD) over prior year second lowest silver for the region. In addition, Covered California may require multi-year pricing commitments to assure plans do not enter and "buy market share" at an unsustainable price point.
  2. **Provider Networks:** The new entrant must demonstrate that their network of providers adds value to consumers by being appreciably different from those of existing carriers. To the extent a new entrant has a network that is "substantially similar" to two or more existing carriers, the new entrant must demonstrate:
     - Health plan level tools, support or structure that have been proven to improve care,
     - Demonstrated quality significantly higher than the benchmark (e.g., above 50th percentile), and/or
     - Significantly lower costs that could be assured over at least two or three years.
  3. **Quality & Equity:** The new entrant must demonstrate that the likely quality of care provided through its contracted networks and delivery support systems will be above a quality threshold.
     - The quality threshold would be at the equivalent of 25th percentile performance using either the QRS "Getting Right Care" standard or the Covered California QTI measure set.
     - Demonstration of likely quality of care will be assessed by 1) proxy measures including QRS scores in other marketplaces, or HEDIS performance from other lines of business in California, and if those metrics are above the threshold, 2) modeling of QTI quality indicators from contracted providers.
  4. **Fostering Competition for Consumers:** The new entrant may be required to provide coverage in less competitive markets in order to participate in more desirable regions

- **Additional policies being considered:** the following policies are being explored
  1. Categorically barring new entrants in markets that are "highly competitive" to avoid consumer choice overload.
  2. Excluding or limiting offering of new PPO products given Covered California's support for care integration and coordination; Covered California will continue providing incentives for promotion of effective advanced primary care and care coordination in through other contractual means.

Covered California 2023 and Beyond: Preferential Display of Higher Quality Health Plans

Research shows consumers primarily care about overall cost and network/provider participation in the selection of their health plan.

Covered California displays health plan options, ranked from lowest to highest cost, based on consumers' projected total costs (i.e., premium and likely out-of-pocket costs, based on their self-identified health status).

Health plan quality information is displayed using each plan's star rating, and consumers can sort or filter by quality star ratings. It is unclear how much consumers consider this information, as they can filter health plan options by quality, but rarely do.

Covered California is considering the following options to incorporate quality into consumer choice architecture:

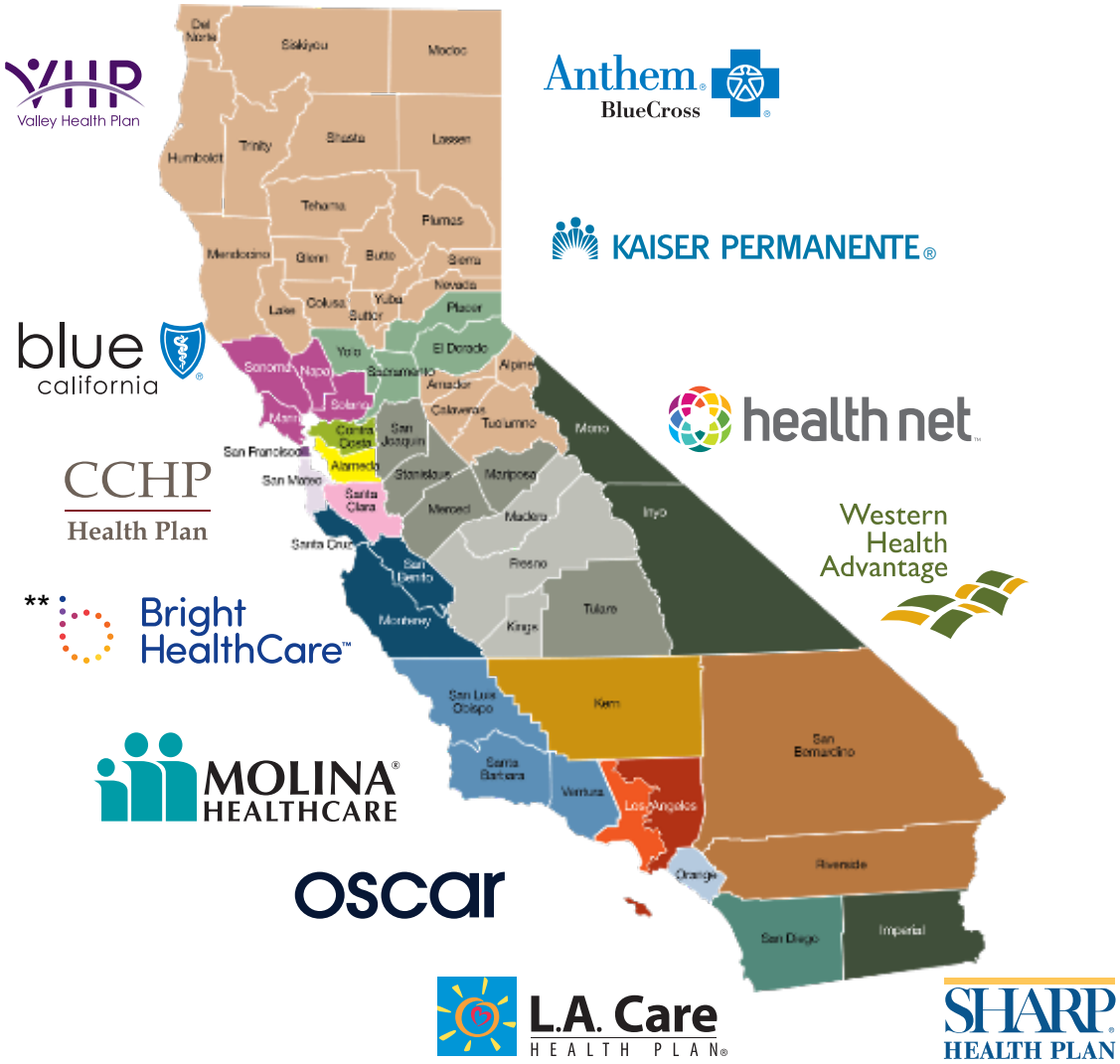
- Integrating quality scores with the cost algorithm used to sort plan options;
- Displaying 4- and 5-star plans ranked by cost, followed by lower quality plans ranked by cost; or
- Displaying "warning" notes for either "lower quality" plans and/or PPO products that do not promote integration and care coordination.

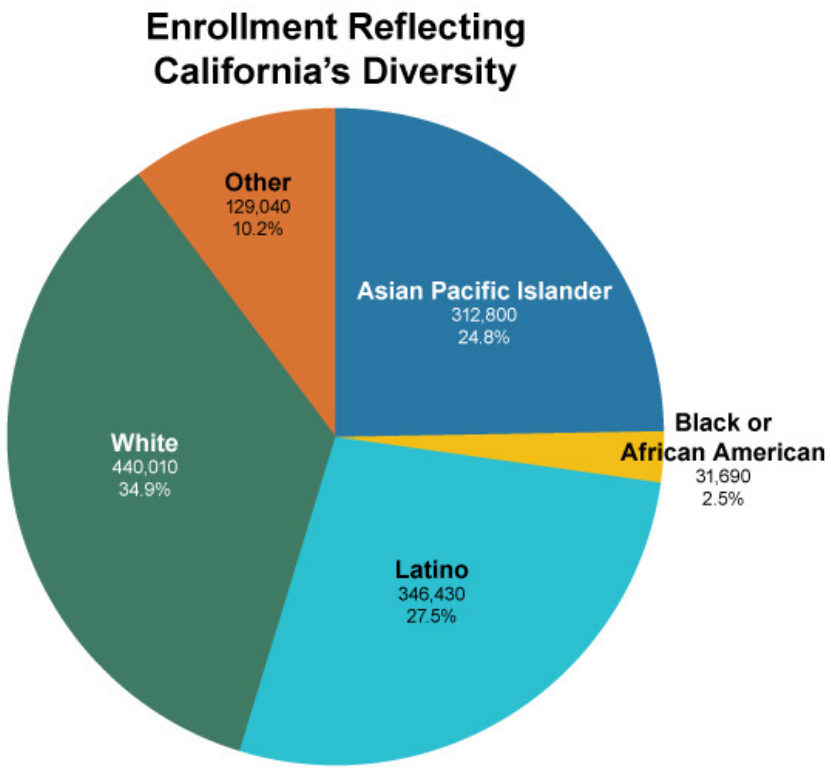
However, changing the default sort to incorporate quality may mean that consumers do NOT shop or enroll if they see higher cost options first.

Proposed Policy: Covered California will develop a testing and research project to assess the implications and best methods for making quality information more prominent and actionable by consumers. The 2023 Contract will include specific language that affirms Covered California's ability to establish and implement plan selection experiences that may include quality in how health plans are displayed and ranked.

APPENDIX – COVERED CALIFORNIA MARKET CONTEXT

Covered California Overview





1.6M Enrolled

Source of enrollment data: Covered California June 2021 Active Member Profile
*Race/Ethnicity is a roll-up dimension that combines application questions on race and ethnicity, where a consumer who reports a Latino, Hispanic, or Spanish origin is counted as "Latino," races of Asian, Native Hawaiian or Pacific Islander are counted as "Asian Pacific Islander," and "Other" comprises all non-Latino selections other than "Black or African American", "White", or "Asian Pacific Islander" from the Race/Ethnicity dimension (including Multiple Races).
**Bright HealthCare is a new entrant in 2022 and not reflected in 2021 enrollment data

2022 Health Plan Offerings

Rating Region	ANTHEM HMO	ANTHEM EPO	BLUE SHIELD HMO	BLUE SHIELD PPO	BRIGHT HMO	CCHP HMO	HEALTH NET OF CA HMO	HEALTH NET OF CA HSP	HEALTH NET LIFE EPO	HEALTH NET LIFE PPO	KAISER HMO	L.A. CARE HMO	MOLINA HMO	OSCAR EPO	SHARP HMO-1 (CalPERS)	SHARP HMO-2 (Catastrophic)	VHP HMO	WESTERN HEALTH ADV. HMO	Issuers in Region (incl. partial)	Products in Region
1 Northern counties		●	○	●							○								3	4
2 North Bay Area		●	○	●					●		○							●	5	6
3 Greater Sacramento		●	○	●						○	○							○	5	6
4 San Francisco County		●	●	●		●			●		●			●					6	7
5 Contra Costa County		●	●	●	●				●		●								5	6
6 Alameda County		●	●	●							●								3	4
7 Santa Clara County		●	●	●							○						●		4	5
8 San Mateo County		●	●	●		●			●		●			●					6	7
9 Santa Cruz, San Benito, Monterey		●	○	●					○		○						○		5	6
10 Central Valley		●	○	●					○		○								4	5
11 Fresno, Kings, Madera counties	●		○	●							○								3	4
12 Central Coast		●	○	●							○								3	4
13 Eastern counties		●		●							○		○						4	4
14 Kern County		●	○	●			○	○			○								4	6
15 Los Angeles County East	●		○	●			●	●		●	○	○	○	○					7	10
16 Los Angeles County West	●		○	●			●	●		●	●	●	○	●					7	10
17 Inland Empire	●		○	●			○	○		○	○		○						5	8
18 Orange County	●		●	●			●	●		●	●		●	●					6	9
19 San Diego County			○	●			●	●		●	○		●		○	○			5	9
Percent of 2021 Total Enrollment	6%		28%		N/A	0%	11%				37%	6%	4%	4%	1%		1%	1%		

Enrollment by Issuer In Covered California

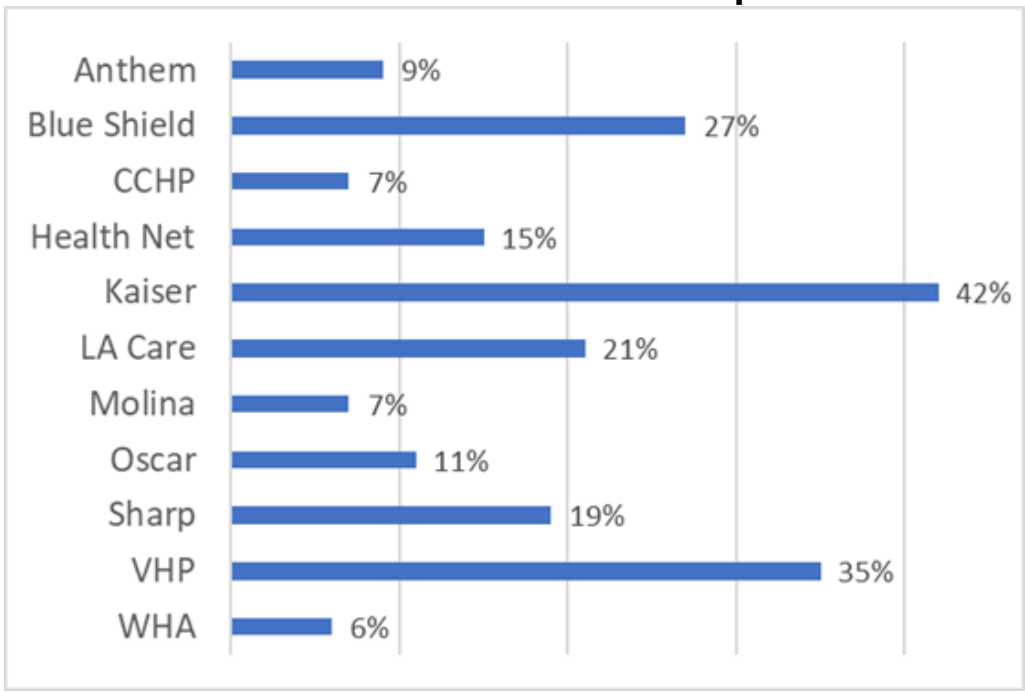
Issuer Market Share by Enrollment

QHP Issuer	Total Regions Served in 2021*	2021 Market Share within Regions Served	Enrollees	% Total Enrollment
Anthem	12	9%	100,960	6%
Blue Shield	19	27%	442,650	28%
CCHP	2	7%	4,800	0%
Health Net	13	15%	173,630	11%
Kaiser	19	42%	583,840	37%
LA Care	2	21%	95,860	6%
Molina	6	7%	55,770	4%
Oscar	5	11%	67,370	4%
Sharp	1	19%	23,700	1%
VHP	1	35%	22,040	1%
WHA	2	6%	9,510	1%
Total			1,580,130	100%

Source of enrollment: Active Member Profile, June 2021

*Includes partial regional coverage

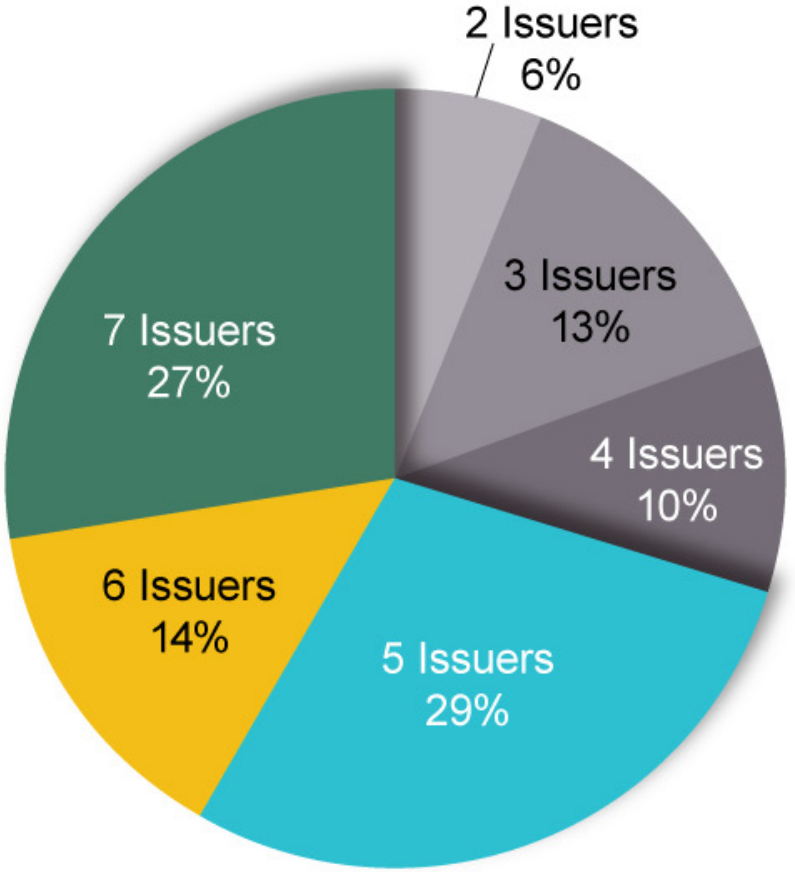
Market Share for each Carrier for Regions in Which the Health Plans Competes



Consumer Choice by Number of QHP Issuers

Choice of at least…	Enrollees	% of Enrollment
2 issuers	99,314	6%
3 issuers	208,866	13%
4 issuers	162,825	10%
5 issuers	450,881	29%
6 issuers	225,080	14%
7 issuers	433,165	27%
Grand Total	1,580,130	100%

Source: Active Member Profile, June 2021



70% of Covered California Enrollees have 5 or more Carriers to choose from.

APPENDIX – BACKGROUND FOR QUALITY TRANSFORMATION INITIATIVE

Existing Quality Measurement Programs

Marketplace plans are required to participate in CMS' Quality Rating System (QRS), which is similar to the Medicare Advantage program's Star Rating system used for the Quality Bonus Program (QBP) and for consumer plan choice. MedPAC has recommended that QBP be replaced by a "Value Incentive Program" (VIP) whose design principles closely align with Covered California's proposed Quality Transformation Initiative (QTI). The major design principles behind both MedPAC' s recommended VIP and CCA's QTI are intended to address flaws in current programs including:

- Too many measures that dilute impact and focus of health plans and providers;
- Focus on administrative or process indicators that do not have proximate impact on health care quality;
- Scoring systems that are very complex, mask performance differentials and have significant "cliff" effects; and
- No specific focus on closing health disparities gaps.

Current Quality and Equity Requirements

Covered California has extensive contractual requirements designed to drive quality, equity, and delivery system transformation

- CMS' Quality Rating System (QRS) star ratings for Getting the Right Care and Members' Care Experience have been core components of quality strategy tied to performance guarantees.
- These data are supplemented by additional internally generated measures focused on disparities, behavioral health, and network performance.
- Disparities requirements have been a longstanding focus area with recent adoption of performance guarantees tied to:
  - Collection of enrollee self-reported race/ethnicity and language proficiency
  - HEDIS measure stratification by race/ethnicity using submission of patient level data
  - Submission of disparity intervention plan with target disparity reduction
  - Requirement for NCQA Multicultural Health Care Accreditation

Covered California's Quality Transformation Initiative: Measure Set Criteria

- **Epidemiologically relevant**: target conditions that are key drivers of morbidity and mortality for Californians, with significant racial/ethnic disparities in outcomes
- **Outcomes focused**: preferentially 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
- **Available**: data are readily available through established business practices in order to minimize reporting burden for providers
- **Actionable**: choose measures where improvement is clearly amenable to health care intervention
- **Aligned**: strive to align measure specifications to allow maximal synergy across health plans and providers

Covered California's Quality Transformation Initiative: Methodology

- Financial Contributions would be front loaded, with the maximum contribution for performance below 25th percentile national performance, the majority of the contribution being made between 25th and 50th percentile, and a smaller proportion applied between 50th and 75th percentile national performance.
  - 100% contribution at <25th percentile performance
  - 100% - 34% (two thirds) between 25th to 49th percentile national performance (graded continuously)
  - 33% - 1% (one third) between 50th to 74th percentile national performance (graded continuously)
  - No contribution for 75th percentile performance and higher.

- Each individual measure is scored separately; no aggregate scoring.

- Each measure has equal weight.

Covered California's Quality Transformation Initiative: Case Examples of Financial Contribution

Example for 6 available measures

- Individual measure weight for 6 measures = 16.7% [100%/6 = 16.7%] of full contribution
- Each individual measure separately scored; examples below are for one measure
- QHP Issuer's individual measure scores are rounded to whole number
- National QRS Percentiles
  - 25th PCT = 54%
  - 50th PCT = 62%
  - 75th PCT = 70%

Example QHP Issuer A: Measure Score = 50%

- QHP Issuer measure score is below the 25th percentile which equates to full financial contribution for that measure or 16.7% of total possible contribution

Example QHP Issuer B: Measure Score = 59%

- QHP Issuer measure score is in the 25th – 49th percentile range so triggers partial financial contribution in the 25th – 49th percentile range, plus full contribution in the 50th – 74th range
- Component 1 position in 25th – 49th PCT range: [.62-.59]/[.62-.54] *.67 = .25
- Component 2 position in 50th – 74th PCT range: full contribution for range = .33
- Combine the 2 components [.25 + .33 = .58]
- Apply individual measure weight [.58 *16.7%] = 9.7% (of possible 16.7%) of full contribution for that measure

APPENDIX – BACKGROUND FOR HEALTH PLAN SELECTION, EXCLUSION OR LIMITATION POLICIES

Plan Participation Standards: Background on Issues with Applying Quality Standards to Health Plan Inclusion, Exclusion or Limitation

Measures of health care quality and equity at the health plan level are problematic. Challenges to the current measures include:

- Consumers are accustomed to making health plan choices based on costs and benefits, not quality
- Quality "happens" at the provider level, and is not reliably correlated with health plan product quality as currently measured
- Rolled up quality measures, such as through QRS star-rating system, often do not provide clear signals to either health plans or consumers about quality concerns or good care
- Using a smaller number of selected measures, such as those being considered for Covered California's Quality Transformation Initiative, benefit from their being clinically sound and important, however, as a set they are not nationally recognized for comparison purposes
- For many measures, scores are collected at a statewide level, while data on other key factors – such as network design and composition – are regional
- The most expedient approach for a health plan to improve quality is through network contracting (e.g., excluding lower quality/performing medical groups); those changes can take a year or two to implement, and the results will not be immediately apparent
- Addressing health equity and disparities is a critical concern, however the ability to collect accurate and complete demographic data (e.g. race/ethnicity, language spoken/written) is limited, as is the ability to stratify in the context of small subpopulation sizes; also there is no national standard for performance on disparities

Plan Participation Standards: Background on Issues with Considering Lower Cost Coverage Options when Applying Quality or other Standards to Health Plan Inclusion, Exclusion or Limitation

In the individual market, many consumers are lower income and very price sensitive. To the extent a policy led to the exclusion of low(er) cost health plans there could be multiple negative impacts, such as some consumers may decide to forego coverage if they face a higher price and the federal government might bear a higher cost due to increases in the Advanced Premium Tax Credit.

Given this context, there are challenges with **not** considering cost as an important factor in deciding to make exceptions to other factors (e.g., quality or network overlap) upon which to include, exclude or limit (e.g., freeze enrollment) health plans participation and in the individual marketplace. At the same time, allowing "lower quality" health plans to participate because of lower cost mean low-income consumers would be at higher risk of receiving poor health care which would reinforce existing disparities in care.