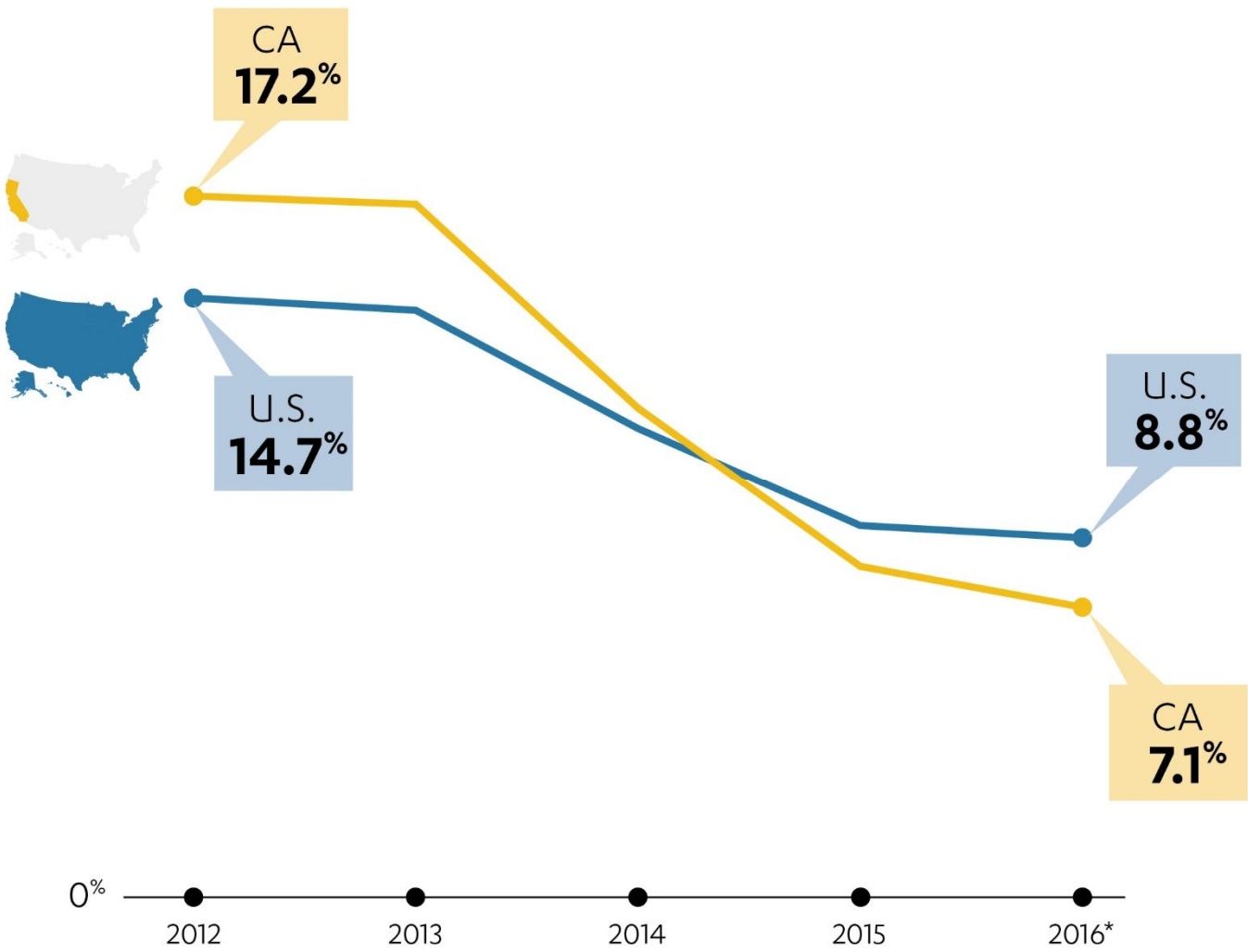
Covered California's Promise

Vision:
To improve the health of all Californians by assuring their access to affordable, high-quality care.

Mission:
To increase the number of insured Californians, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Better Care • Healthier People • Lower Cost

Coverage Expansion Having Dramatic Effects in California



With California's expansion of Medicaid and the creation of a state-based marketplace, the rate of the uninsured has dropped to historic lows. Almost four million new enrollees are in the Medi-Cal program and 1.3 million people are enrolled through Covered California.

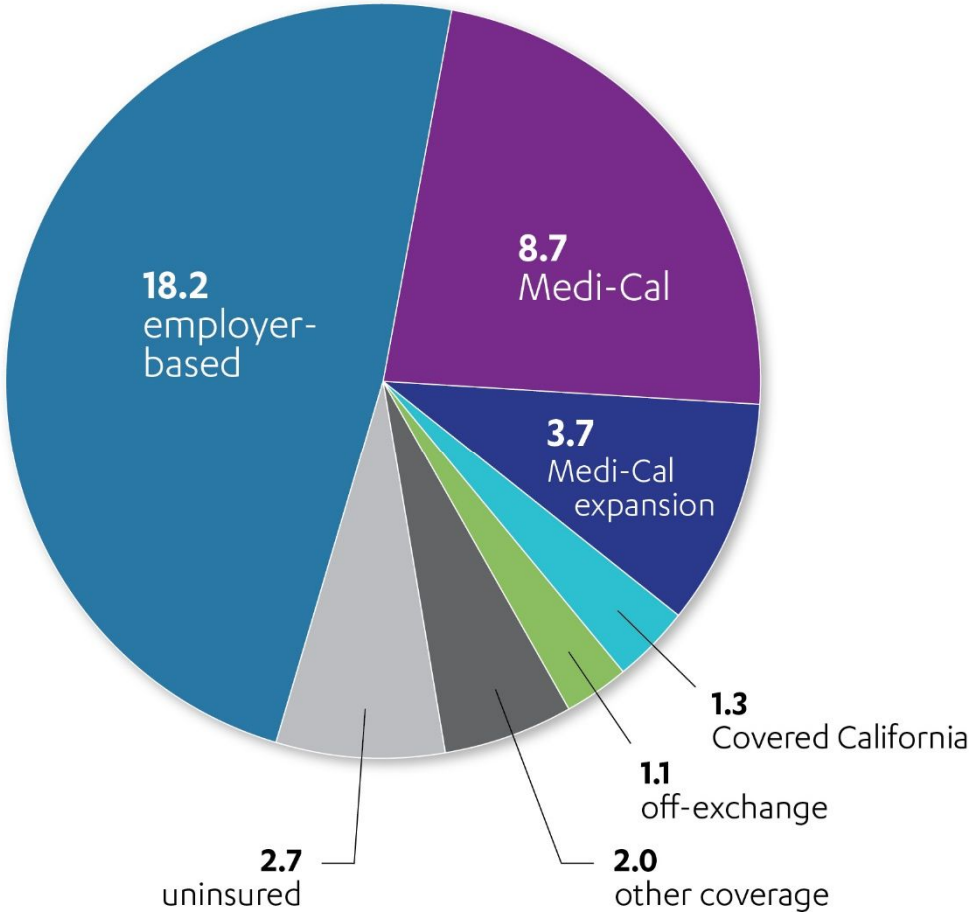
* Estimate of the first nine months of 2016 (all ages)
Source: U.S. Centers for Disease Control and Prevention's National Health Institute Survey

Coverage Expansion Has Been Woven Into the Fabric of Health Care in California

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

California's 2016 Health Care Market

(in millions — ages 0-64)



- As of March 2016, Covered California had approximately 1.3 million members who have active health insurance. California has also enrolled nearly 4 million more into Medi-Cal.
- Consumers in the individual market (off-exchange) can get identical price and benefits as Covered California enrollees.
- From 2013 to 2016, the Centers for Disease Control and Prevention report cutting the rate of uninsured in half (1.5 million are ineligible for Covered California due to immigration status).

Estimates based on survey data and adjusted for latest available administrative data, including:
- American Communities Survey, 2015 1-year estimates (Table B27010)
- CDC/National Health Interview Survey (2017) (https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201702.pdf)
- Covered California Active Member Profile (http://hbex.coveredca.com/data-research)
- DMHC and CDI data on enrollment in December 2015 ("AB 1083 reports") as compiled by California Health Care Foundation (http://www.chcf.org/publications/2016/09/california-health-plans-insurers)
- Department of Health Care Services Medi-Cal *Medi-Cal Monthly Enrollment Fast Facts (Sept 2016)* (http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_Sept_16_ADA.pdf)

How Covered California Makes the Promise Real

CREATING **COMPETITIVE MARKETS**	OFFERING **AFFORDABLE PRODUCTS**	EFFECTIVELY **REACHING AND ENROLLING CONSUMERS**	ENCOURAGING **THE RIGHT CARE AT THE RIGHT TIME**
• Plan competition for enrollment (seek at least three plans) • Provider-level competition and distinction between plans • Benefit designs foster informed consumers	• High enrollment of subsidy eligible to assure good risk mix • Long term affordability through delivery system changes	• Robust and ongoing marketing • Cost effective enrollment support	• Benefit design promoting appropriate access • Requirements for plans to promote effective delivery of coordinated care

Covered California is Big and Having Big Impacts

It is now one of the largest purchasers of health insurance in California and the nation.

1.3+ MILLION

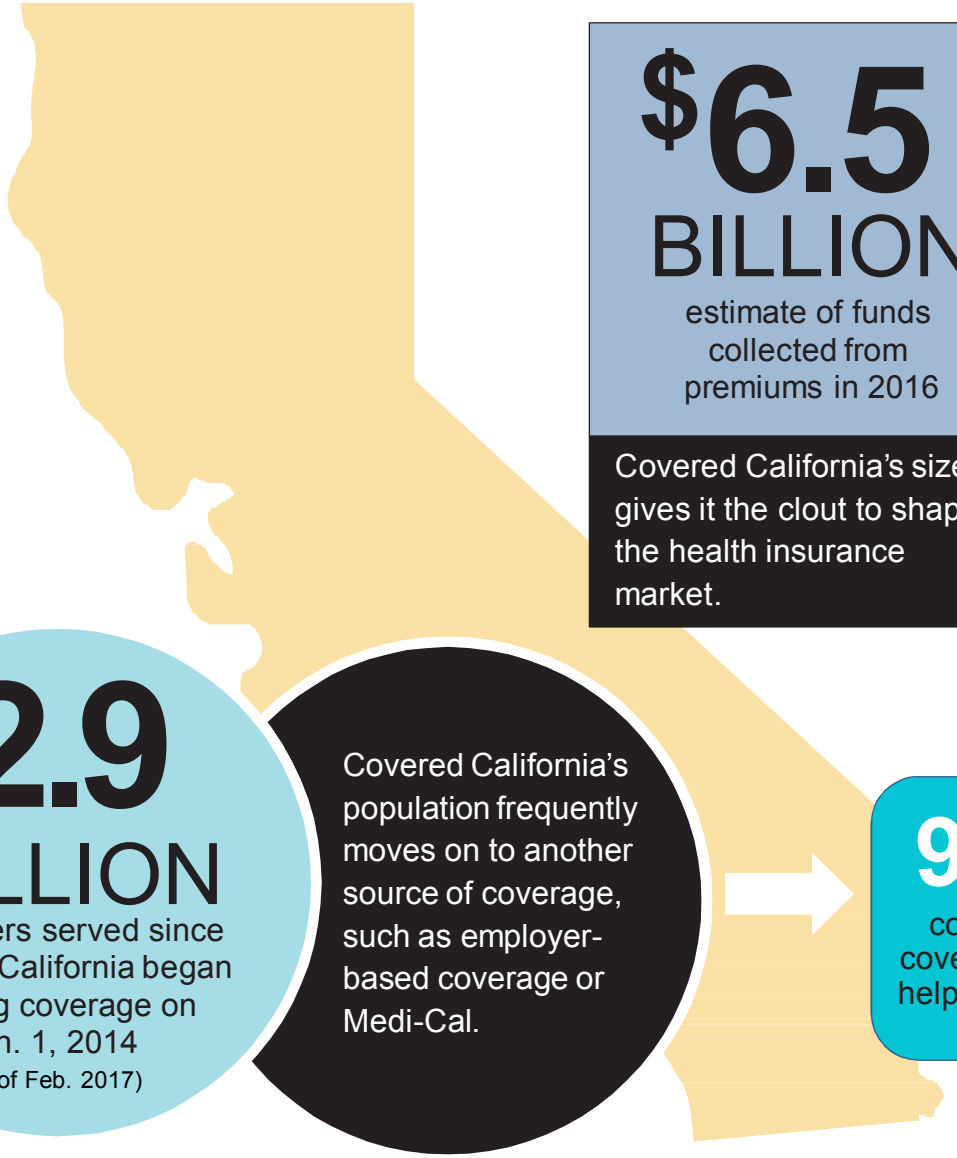
consumers had paid coverage as of June 2016

Covered California is now the second largest purchaser of health insurance in the state for those under age 65.

$6.5 BILLION

estimate of funds collected from premiums in 2016

Covered California's size gives it the clout to shape the health insurance market.



2.9 MILLION

consumers served since Covered California began offering coverage on Jan. 1, 2014

(as of Feb. 2017)

Covered California's population frequently moves on to another source of coverage, such as employer-based coverage or Medi-Cal.

9 out of 10

consumers enrolled in coverage receive financial help to pay their premiums

Covered California Health Plan Offerings for 2017: Broad Choice and Multiple Local Options

PRICING REGION	EPO	ANTHEM PPO	ANTHEM HMO	BLUE SHIELD PPO	BLUE SHIELD HMO	CCHP HMO	HEALTH NET EPO	HEALTH NET HMO	KAISER PERMANENTE HMO	L.A. CARE HMO	MOLINA HEALTHCARE HMO	OSCAR EPO	SHARP HEALTH PLAN HMO-1 Copay	SHARP HEALTH PLAN HMO-2 Coinsurance	VALLEY HEALTH PLAN 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, partial	●		◓	●	◓			●	●	●	◓					
16 Los Angeles County , partial	●		◓	●	◓			●	●	●	◓	●				
17 Inland Empire	●		◓	●	◓			◓	◓		◓					
18 Orange County	●		●	●	●			●	●		●	●				
19 San Diego County	●		◓	●	◓			●	◓		●		◓	●		

● Full Region

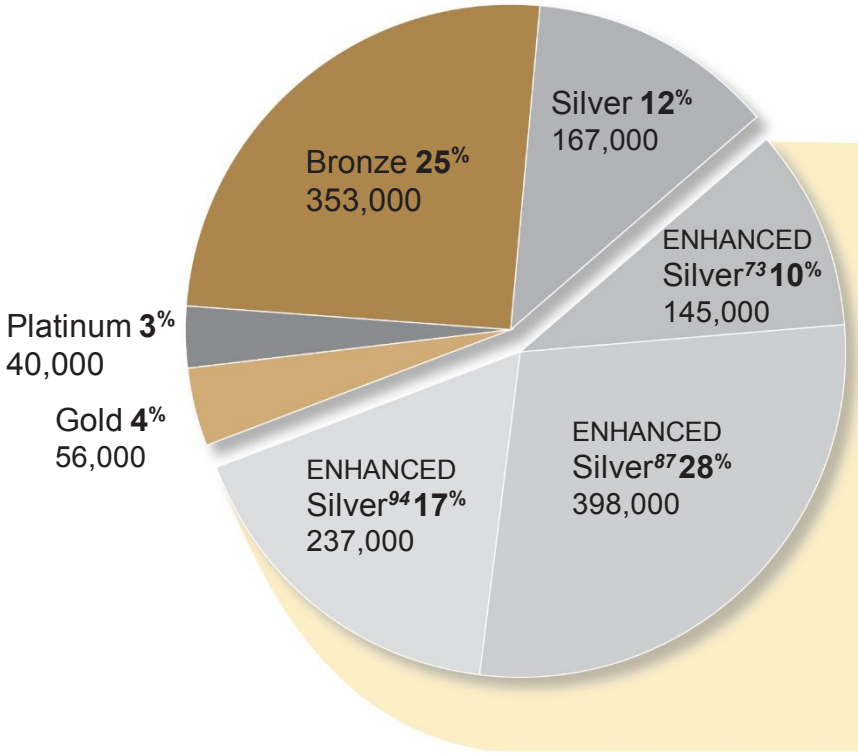
◓ Partial Region

For full details on plans and rates, see Health Insurance Companies and Plan Rates for 2017: http://bit.ly/2c6AS9U

Covered California Enrollees Able to Choose Both Low Premium and Low Out-of-Pocket Designs

More than 68 percent of Covered California subsidy-eligible enrollees selected a Silver plan, which have NO deductibles for any out-patient services and 56 percent of all subsidy-eligible enrollees qualified for an "Enhanced Silver" plan, which means they benefit for Cost-Sharing Reduction subsidies, leading to lower out-of-pocket costs when accessing services.

2016 Subsidized Enrollment
by Metal Tier



Eliminating the direct federal support for Cost-Sharing Reduction subsidies would result in higher federal spending in California of more than $220 million, due to increased APTC.[1]

A few notes on monthly premium costs:

73 percent pay less than $150 per month per individual.

More than 192,000 enrollees pay less than $25 per month per individual.

For consumers enrolled in an Enhanced Silver 94 plan, more than half pay less than $50. *In addition, these individuals pay only $3 for doctor visits.*

Covered California's Patient-Centered Benefit Design:

- Bronze — three office visits and lab work, not subject to deductible.
- Silver, Gold, Platinum — no deductibles on **any** outpatient services.

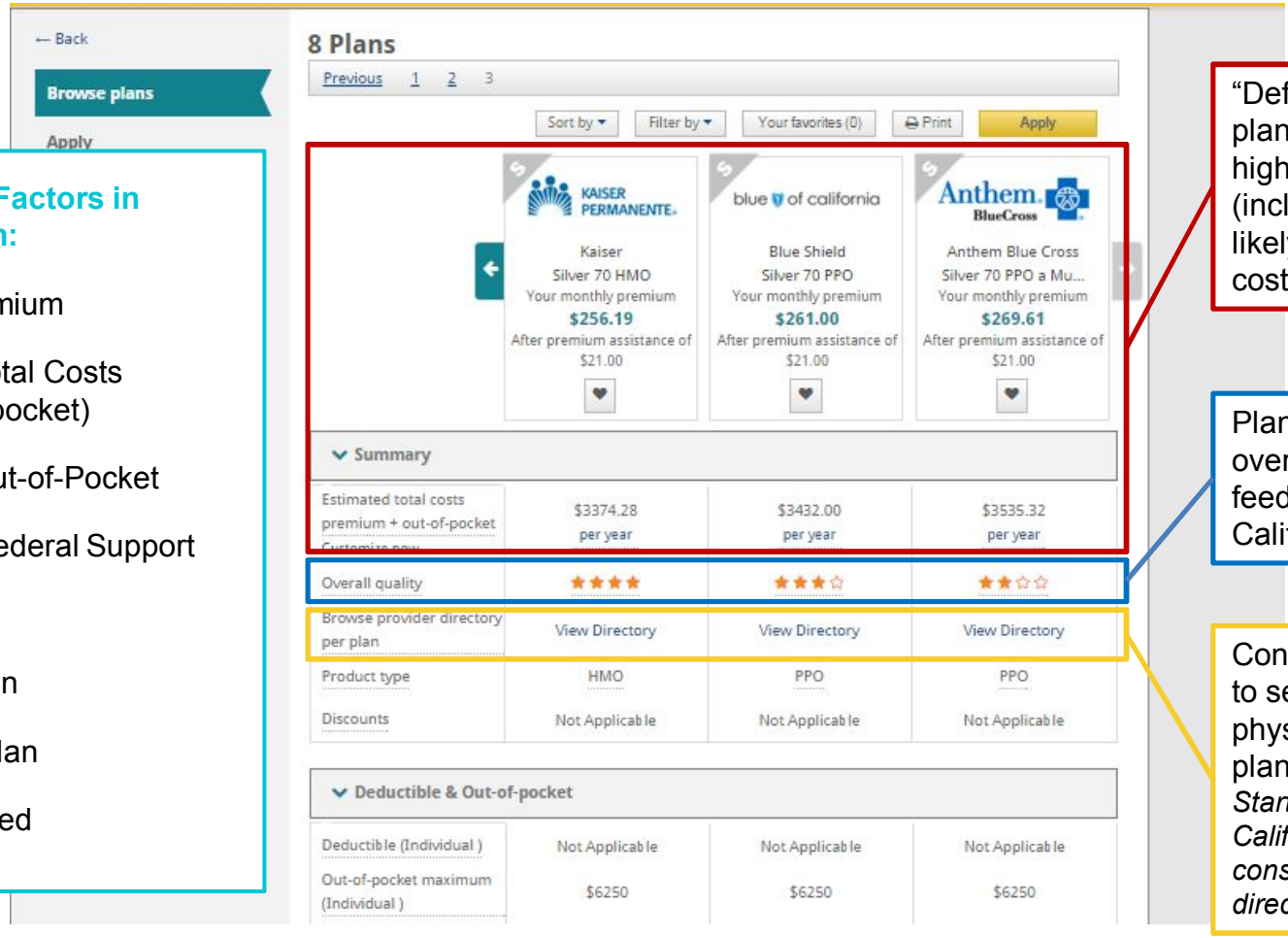
Source: Covered California enrollment data as of June 2016, including only subsidized enrollees who have paid for coverage.

[1] Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding (http://www.coveredca.com/news/pdfs/CoveredCA_Consequences_of_Terminating_CSR.pdf)

Covered California Provides Consumers With Tools to Make Informed Choices Among Plans

Key Consumer Factors in Choosing a Plan:

- Monthly Premium
- Estimated Total Costs (with out-of-pocket)
- Maximum-Out-of-Pocket
- Amount of Federal Support
- Plan Quality
- Doctor in Plan
- Hospital in Plan
- Drugs Covered



"Default" display of plans is from lowest to highest by **total cost** (including premium and likely out-of-pocket costs.

Plans are rated on overall quality based on feedback from Covered California members

Consumers can search to see if a desired physician is in the plan's network. *Starting in 2017, Covered California plans to have a consolidated physician directory.*

Covered California 2017 Patient-Centered Benefit Designs

In California, standard benefit designs allow apples-to-apples plan comparisons and seek to encourage utilization of the right care at the right time with many services that are not subject to a deductible. *Benefits below shown in blue are not subject to a deductible.*

2017 PATIENT-CENTERED BENEFIT DESIGNS BY METAL TIER

MEDICAL COST SHARES				
Coverage Category	Bronze	Silver	Gold	Platinum
	Covers 60% average annual cost	Covers 70% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Annual Wellness Exam	$0	$0	$0	$0
Primary Care Visit	$75	$35	$30	$15
Specialty Care Visit	$105	$70	$55	$40
Urgent Care Visit	$75	$35	$30	$15
Emergency Room Facility	Full cost until out-of-pocket maximum is met	$350 once medical deductible is met	$325	$150
Laboratory Tests	$40	$35	$35	$20
X-Ray and Diagnostics	Full cost until out-of-pocket maximum is met	$70	$55	$40
Deductible	Individual: $6,300 medical $500 drug Family: $12,600 medical $1,000 drug	Individual: $2,500 medical $250 drug Family: $5,000 medical $500 drug	N/A	N/A
Annual Out-of-Pocket Maximum	$6,800 individual and $13,600 family	$6,800 individual and $13,600 family	$6,750 individual and $13,500 family	$4,000 individual and $8,000 family

Benefits shown in blue are not subject to any deductible. White corner = not subject to a deductible after first three visits. Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, they will be at full cost until the out-pocket-maximum is met.

DRUG COST SHARES — 30 DAY SUPPLY				
Generic Drugs (Tier 1)	full cost up to $500, after deductible is met	$15 or less	$15 or less	$5 or less
Preferred Drugs (Tier 2)	full cost up to $500, after deductible is met	$55 after drug deductible	$55 or less	$15 or less
Non-preferred Drugs (Tier 3)	full cost up to $500, after deductible is met	$80 after drug deductible	$75 or less	$25 or less
Specialty Drugs (Tier 4)	full cost up to $500, after deductible is met	20% up to $250 after drug deductible	20% up to $250	10% up to $250

2017 PATIENT-CENTERED BENEFIT DESIGNS BY INCOME

MEDICAL COST SHARES			
Coverage Category	Enhanced Silver 94	Enhanced Silver 87	Enhanced Silver 73
Eligibility Based on Income and Premium Assistance	Covers **94%** average annual cost	Covers **87%** average annual cost	Covers **73%** average annual cost
Single Income Ranges	up to $17,655 (≤150% FPL)	$17,656 to $23,450 (>150% to ≤200% FPL)	$23,451 to $29,425 (>200% to ≤250% FPL)
Annual Wellness Exam	$0	$0	$0
Primary Care Visit	$5	$10	$30
Specialty Care Visit	$8	$25	$55
Urgent Care Visit	$5	$10	$30
Laboratory Tests	$8	$15	$35
X-Ray and Diagnostics	$8	$25	$65
Imaging	$50	$100	$300
Deductible	Individual: $75 medical Family: $150 medical	Individual: $650 medical $50 drug Family: $1,300 medical $100 drug	Ind.: $2,200 medical $250 drug Family: $4,400 medical $500 drug
Annual Out-of-Pocket Maximum	$2,350 individual and $4,700 family	$2,350 individual and $4,700 family	$5,700 individual and $11,400 family

Benefits shown in blue are not subject to any deductible.

COVERED CALIFORNIA

Toward Lower Costs and Better Care — Averting a Collision between Consumer- and Provider-Focused Reforms

Elliott S. Fisher, M.D., M.P.H., and Peter V. Lee, J.D.

Over the past 20 years, two major approaches to slowing the growth of health care costs have emerged. One focuses on the delivery system, encouraging physicians, hospitals, and others to improve the way they deliver care. The other targets consumers, hoping to turn patients into more price-sensitive shoppers. Although both have had some success, it's increasingly clear that these approaches are on a collision course: poorly structured benefit designs will sharply limit the effectiveness of efforts to promote higher-value care through payment and delivery-system reform. But a crash is not inevitable.

Interest in reforming care delivery grew out of observations regarding the relative efficiency of integrated medical group practices, growing concern about variation in quality of care, and evidence that the greater use of specialist and hospital-based care in high-cost U.S. regions and health systems did not translate

See full article here

“High Deductibles” Are Often Barriers to Health Care — But They Don’t Have To Be!

Percent of plan offerings that require consumers to **meet their deductible before** they could access their primary care physician:

Employer-Sponsored Plans (PPO)	Individual Market: Federally-Facilitated Market (Silver Products)	Individual Market: Covered California (Silver Products)
28%	34%	0%

Covered California is Promoting Improvements in the Delivery of Care

Covered California contract requirements to promote the triple aim of improving health, delivering better care and lowering costs for all Californians include:

Promoting innovative ways for patients to receive coordinated care, as well as have immediate access to primary care clinicians

- All Covered California enrollees (HMO and PPO) must have a primary care clinician.
- Plans must promote enrollment in patient-centered medical homes and in integrated healthcare models/Accountable Care Organizations.

Reducing health disparities and promoting health equity

- Plans must "track, trend and improve" care across racial/ethnic populations and gender with a specific focus on diabetes, asthma, hypertension and depression.

Changing payment to move from volume to value

- Plans must adopt and expand payment strategies that make a business case for physicians and hospitals.

Assuring high-quality contracted networks

- Covered California requires plans to select networks on cost and quality and in future years, will require exclusion of "high cost" and "low quality" outliers — allowing health insurance companies to keep outlier providers, but detailing plans for improvement.

Note: for detailed information about improvements in the delivery of care, Covered California requires health insurance companies to abide by Attachment 7 of the model contract. To view Attachment 7, go to http://hbex.coveredca.com/stakeholders/plan-management/PDFs/2017_QHP_Issuer_Contract_Attachment_7_3-4-2016_CLEAN.pdf

Covered California Board presentation slides on Attachment 7: http://www.coveredca.com/news/pdfs/CoveredCA-Board-QualitySummary-04-07-16.pdf

Shopping Matters: Cost of Care Varies Greatly Even for Those Insured

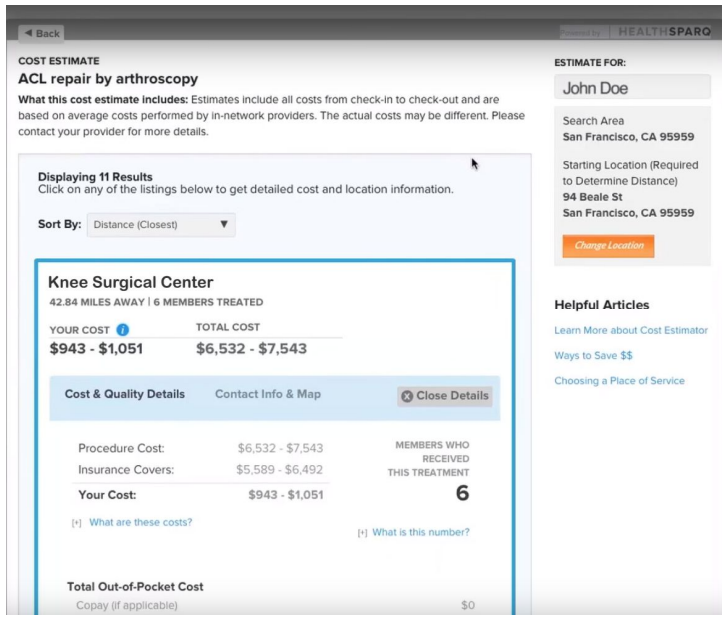
Medical Services Delivered	Range of Payments from Insurance Companies to Providers*	Range of Covered California Enrollee Cost per Service
Appendicitis	$6,381 - $35,645	$1,276 - $6,250
Knee replacement and repair	$15,800 - $84,443	$3,160 - $6,250

- Scenarios represent an individual in a 2016 Covered California Silver 70 plan who met the deductible. Cost of these procedures would be substantially lower for a Covered California member receiving cost-sharing subsidies in a Silver 73, Silver 87 or Silver 94 plan, or in a Gold or Platinum plan.
- The high-end of the range for the Covered California enrollees' cost represents the maximum out-of-pocket for a 2016 Silver 70 plan, assuming these services were received in the plan's network.
- The wide range of insurance company payments may represent a difference in surgery setting (i.e. outpatient vs. hospital), complexity and contract-term differences.

* Source: Insurance Company Payment is taken from California Healthcare Compare http://www.consumerreports.org/cro/health/california-health-cost-and-quality---consumer-reports/index.htm

Covered California is Assuring Consumers Have Tools to Navigate Cost and Quality

blue of california

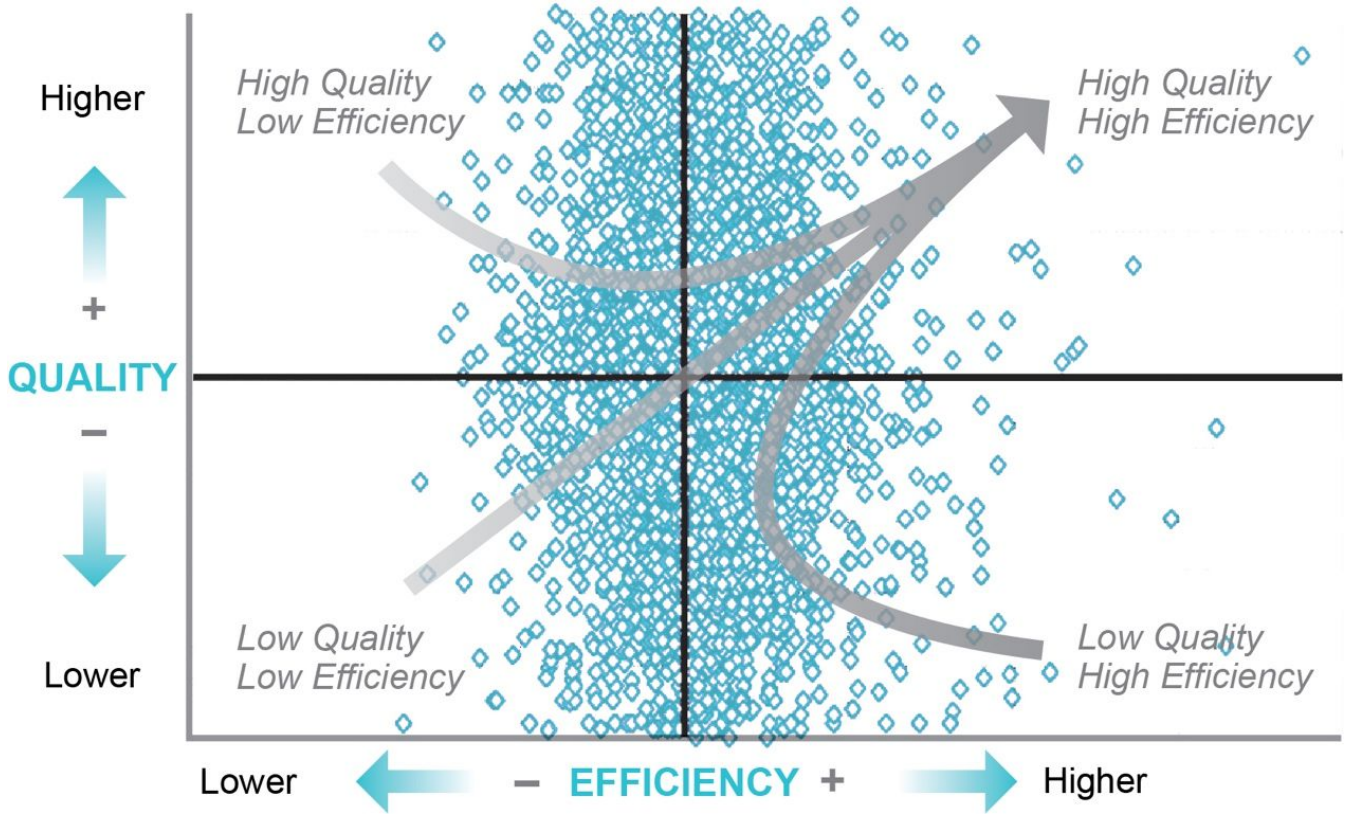


Starting in 2017, Covered California will require health insurance companies to build consumer tools that include the following:

- Consumer out-of-pocket costs for common services.
- Nationally-endorsed quality measures.
- Personalized financial tools to track progress toward deductibles and out-of-pocket expenses.

Covered California Will Require Transparency, Payment and Network Selection to Promote Higher-Value Care

Repeated research shows no correlation between more expensive health care and better quality.



Covered California will use all tools at its disposal to encourage consumers to use lower-cost/higher-quality providers, such as:

- Plan network policy disclosure.
- Health insurance tools with cost and quality information for consumers.
- Promoting the exclusion or justifying the inclusion of high-cost/low-quality outlier providers.

Distribution of physicians with “Higher Efficiency” equals lower relative cost for each instance of care delivered.

Source: Adapted from Regence Blue Shield and Pacific Business Group on Health

The Goal — As Expressed by Two Great Thinkers

Prescription for healthy eating from **Michael Pollan**

"Eat food
Not too much
Mostly plants"

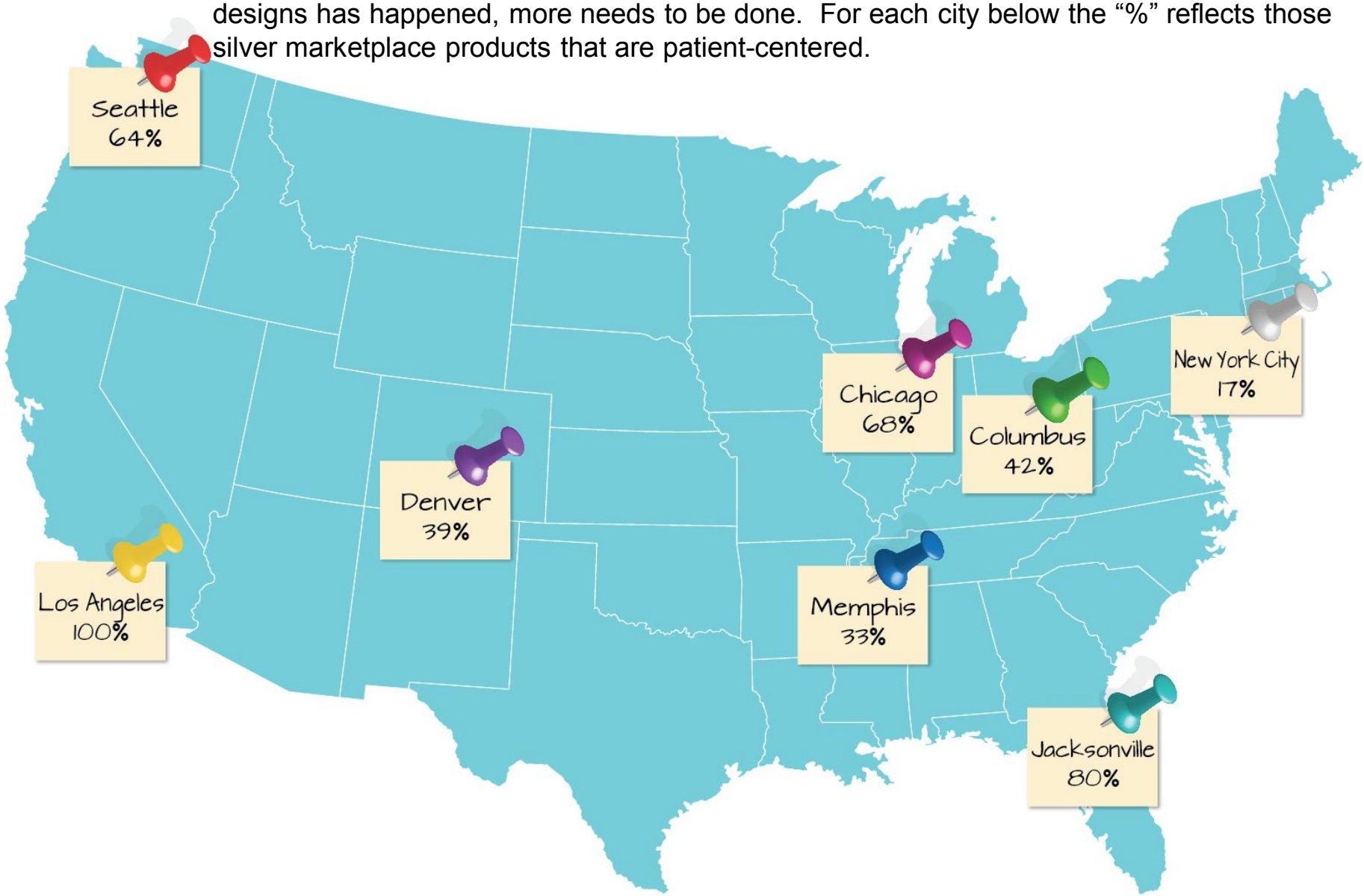
Prescription for high value health care from **Kevin Grumbach**

"Get medical care
Not too much
Mostly primary care"

APPENDIX / BACKGROUND

Patient-Centered Benefit Design: There is a Story in Every City

By offering fewer, but more patient-centered products, Covered California offers **better** options, creating more value for consumers. While progress toward more patient-centered designs has happened, more needs to be done. For each city below the "%" reflects those silver marketplace products that are patient-centered.



Patient-Centered Benefit Design: More is Not Better and Consumers are Playing Benefit Roulette in Many Markets

By offering fewer, but more patient-centered products, Covered California offers **better** options, creating more value for consumers.

City	Number of Carriers	Number of Silver Products Offered in 2016	Number of Patient-Centered Silver Products
Los Angeles	7	8	8
Seattle	9	50	32
Denver	7	31	12
Memphis	4	30	10
Chicago	7	22	15
Columbus	8	33	14
New York City	10	46	8
Jacksonville	5	20	16

* The number of Silver products requiring full deductible to be met before outpatient care is covered.

The Luck of the Draw: Lowest Priced Silver Products — Often Not the Best Deal for Consumers

Lowest Priced Silver Product for 2016* (excluding HSA products)			
 LOS ANGELES, CA Molina Silver 70	 DENVER, CO Humana 4125	 JACKSONVILLE, FL Ambetter Balanced Care 2	 CHICAGO, IL Ambetter Balanced Care 2
Premium: $191 per month after tax credit of $18	**Premium: $208** per month after tax credit of $35	**Premium: $208** per month after tax credit of $25	**Premium: $173** per month After tax credit of $0
Benefits NOT subject to deductible - All Outpatient Care Visits - Laboratory Services - Diagnostics Imaging - X-Rays	**Benefits NOT subject to deductible** - None	**Benefits NOT subject to deductible** - All Outpatient Care Visits - Generic and Preferred Medication	**Benefits NOT subject to deductible** - All Outpatient Care Visits - Generic, Preferred Drugs
Benefits subject to deductible - Inpatient Hospital Stay	**Benefits subject to deductible** - All Outpatient Care Visits - Laboratory Services - Diagnostics Imaging - X-Rays	**Benefits subject to deductible** - All inpatient hospital services - Laboratory Services - Diagnostics Imaging - X-Rays	**Benefits subject to deductible** - All inpatient hospital services - Laboratory Services - Diagnostics Imaging - X-Rays
Deductible: $2,250 medical $250 pharmacy	**Deductible:** $3,000	**Deductible:** $6,500	**Deductible:** $6,500
Maximum Out-of-Pocket: $6,250	**Maximum Out-of-Pocket:** $3,000	**Maximum Out-of-Pocket:** $6,500	**Maximum Out-of-Pocket:** $6,500

*Covered California compared plans in different states for a 30 year old making $30,000 per year seeking a Silver plan.

The Luck of the Draw: Lowest Priced Silver Products — Often Not the Best Deal for Consumers

Lowest Priced Silver Product for 2016* (excluding HSA products)			
NEW YORK CITY, NY CareConnect EPO Silver NS	COLUMBUS, OH CareSource Just4Me Silver	MEMPHIS, TN BlueCross BlueShield Silver S04E	SEATTLE, WA Ambetter Balanced Care 2
Premium: $205 per month after tax credit of $160	**Premium: $210** per month after tax credits of $30	**Premium: $201** per month after tax credit of $40	**Premium: $198** per month after tax credits of $0
Benefits NOT subject to deductible - Generic Drugs	**Benefits NOT subject to deductible** - Outpatient Care Visits - Generic, Preferred Drugs	**Benefits NOT subject to deductible** - None	**Benefits NOT subject to deductible** - Outpatient Care Visits - Generic, Preferred Drugs
Benefits subject to deductible - All Outpatient Care Services - Diagnostics Imaging - X-Rays - Laboratory Services - Preferred Drugs	**Benefits subject to deductible** - X-Rays - Diagnostics Imaging - Laboratory Services - All In-patient Hospital Services - Specialty Drugs	**Benefits subject to deductible** - All Outpatient Care Visits - All In-Patient Hospital Services - Diagnostics Imaging - X-Rays - Generic, Preferred, and Specialty Medication	**Benefits subject to deductible** - X-Rays - Diagnostics Imaging - Laboratory Services - All In-patient Hospital Services - Specialty Drugs
Deductible: $3,000	**Deductible:** $3,500	**Deductible:** $2,000	**Deductible:** $6,500
Maximum Out-of-Pocket: $6,850	**Maximum Out-of-Pocket:** $6,500	**Maximum Out-of-Pocket:** $4,000	**Maximum Out-of-Pocket:** $6,500

*Covered California compared plans in different states for a 30 year old making $30,000 per year seeking a Silver plan.

What ANY Health Plan Should be Able to Tell You About Their Benefit Design Decisions

The Affordable Care Act has reshaped health insurance in America — it is no longer about "avoiding sick people" — now it is about getting all those eligible covered and then making sure they are getting the right care at the right time. What follow are questions for insurers to see how they are adapting to this new reality:

1. Has the plan evaluated which enrollees are leaving coverage to become uninsured and the reasons for their terminating? (In particular, are healthy individuals leaving coverage because they face barriers to out-patient care in the face of high deductibles?)
2. Does the health plan have data to support the proposition that consumers "prefer" products that put deductibles between them and seeing a doctor (e.g., results of surveys or focus groups)?
3. Does the plan have any analysis that supports which benefit design better serves consumers and the risk mix? Is it designs where deductibles are a barrier to out-patient and primary care versus patient-centered benefit designs?
4. Does the plan have any data or information that would reconcile claimed support and investments in patient-centered medical home, primary care or Accountable Care Organizations with benefit designs that impede access of consumers to those models?
5. Does the plan have any data that would support a "more is better" hypothesis in deciding to offer many different benefit designs to consumers – which appears at odds with behavioral economic literature that shows consumers are advantaged by there being fewer options that have meaningful differences (e.g., price and network)?

Agenda for Delivery System Reform

- Covered California asks plans and their contracted providers to *"work with us"* to fulfill the quality vision.
    - To collaborate on programs with other payers based on priorities informed by advocates and experts, and
    - To define mutually agreed upon programs and target outcomes.
- Principles in adopting specific strategies.
    - Alignment with other purchasers
        - CMS, CalPERS, DHCS & PBGH
        - Fragmentation starts with Purchasers
    - Encouraging multi-payer collaboration.
    - Holding health plans accountable for managing contracted networks to reduce variation in performance.

Promoting and Rewarding Quality Care at the Best Value in Hospital Care

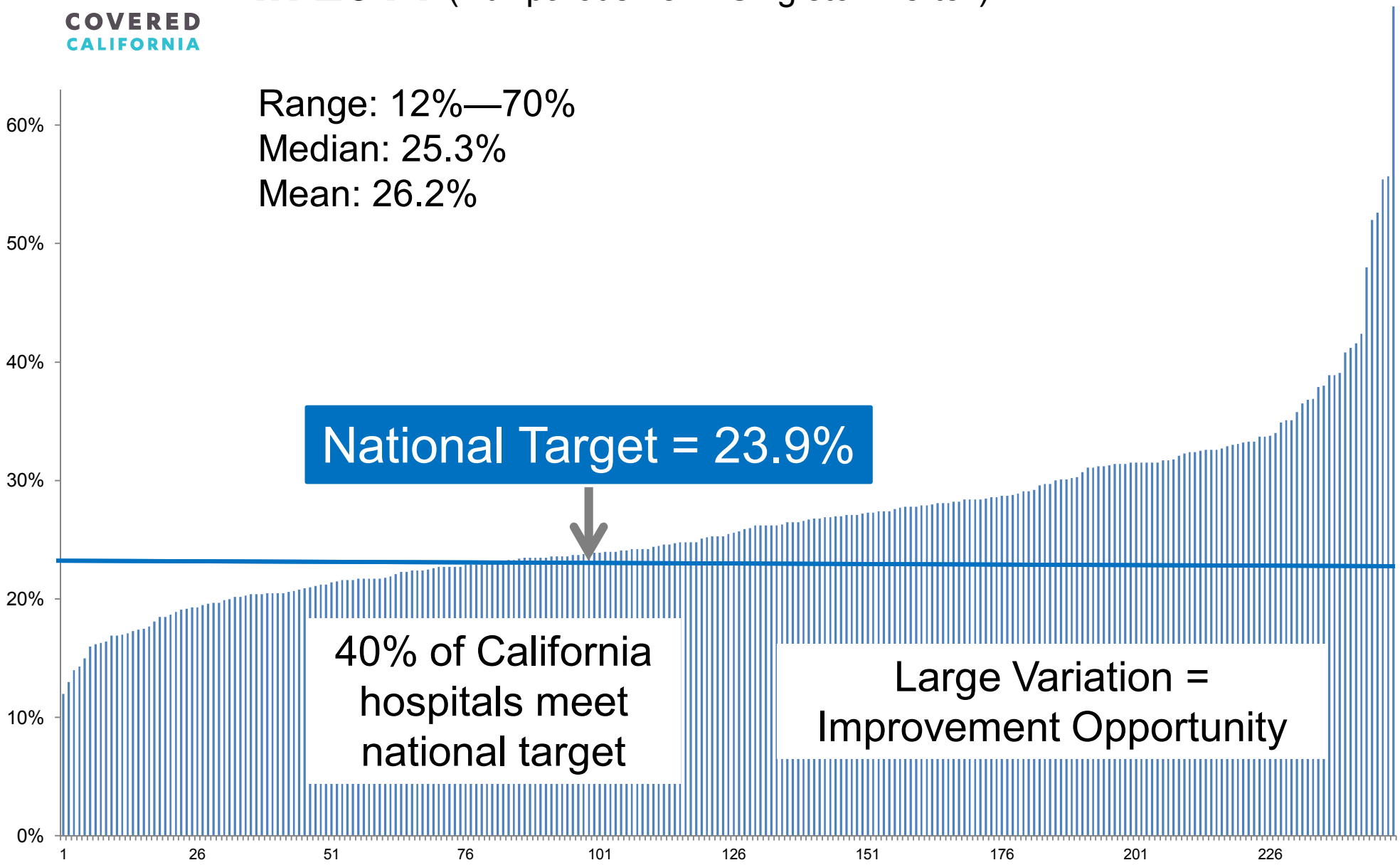
DIAGNOSIS

1. Payments for volume pays more when things go wrong than right
2. Many patients suffer avoidable complications — with an estimated 400,000 Americans dying annually as a result.
    a) Low Risk C-section rate range 12 to 68%
    b) Blood stream infection rate with central line range from 0 to 5.7 times expected

COVERED CALIFORNIA'S SOLUTION

1. Work with health plans to connect doctors and hospitals to quality improvement — track, trend and improve care against measured goals.
2. Require that doctors and hospitals be selected based on quality performance.
3. As of 2019, plans will either exclude low performing outliers or provide a justification for inclusion in the network.
4. Require plans to reward outcomes and results in hospitals through progressively raising proportion of compensation based on quality to at least 6% over 6 years.

NTSV CS Rate Among California Hospitals in 2014 (Nulliparous Term Singleton Vertex)



Source: Linked OSHPD-Birth Certificate Data

Ensuring the Right Care at the Right Time Through Integration and Coordination

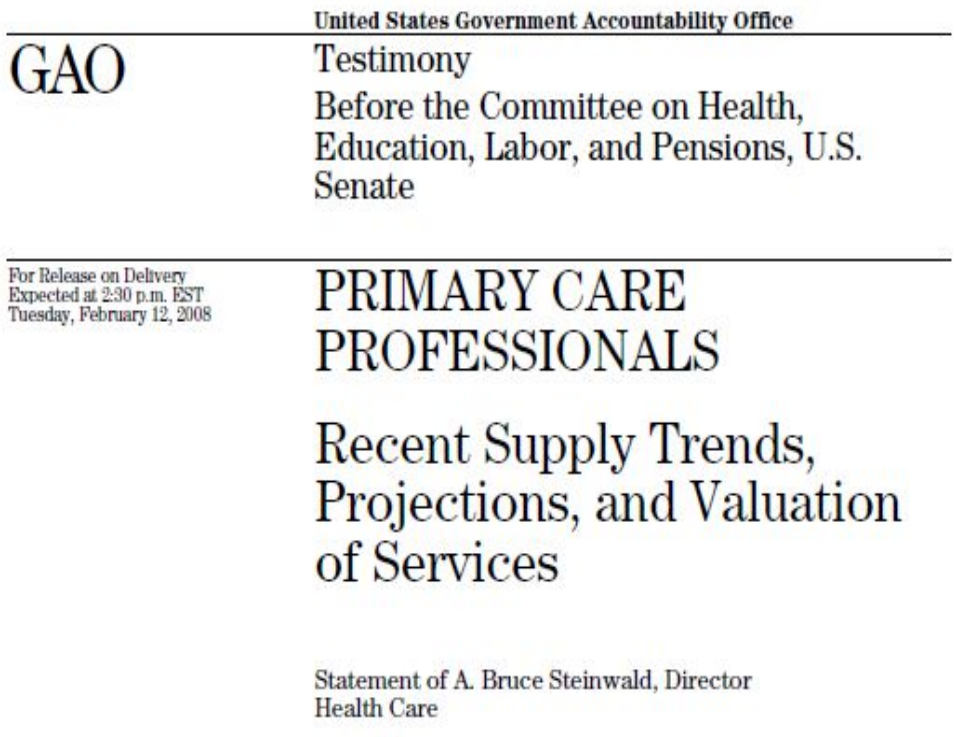
DIAGNOSIS

1. Many consumers — especially the newly insured — do not have a primary care clinician to be their entry point and guide to the delivery system.
2. Patient care is often fragmented and uncoordinated, resulting in care that delivers inconsistent outcomes and high cost.
3. Payment has been based on “more is better” (the fee-for-service model) and not payments that reward outcomes and effective coordination.

COVERED CALIFORNIA’S SOLUTION

1. Require all plans, regardless of model, to connect Covered California enrollees to a primary care clinician within 60 days of their health plan coverage date.
2. Plans must change payments to support populations rather than widgets
   a) Revenue for alternatives to face to face care and for team-based care
   b) Accountability across specialties and institutional boundaries through Advanced Primary Care (PCMH) and Integrated HealthCare Models (ACOs)

Primary Care is Key



United States Government Accountability Office

GAO

Testimony

Before the Committee on Health, Education, Labor, and Pensions, U.S. Senate

For Release on Delivery
Expected at 2:30 p.m. EST
Tuesday, February 12, 2008

PRIMARY CARE PROFESSIONALS

Recent Supply Trends, Projections, and Valuation of Services

Statement of A. Bruce Steinwald, Director
Health Care

"Ample research in recent years concludes that the nation's over reliance on specialty care services at the expense of primary care leads to a health system that is less efficient…research shows that preventive care, care coordination for the chronically ill, and continuity of care — all hallmarks of primary care medicine — can achieve better health outcomes and cost savings."

Covered California Primary Care Agenda

1. Empanelment
2. Payment Reform
3. Move enrollment to PCMH recognized practices
4. Data Exchange

- To be implemented under 2017-19 Qualitied Health Plan Contracts through a multi-stakeholder process
- The Covered California plan is credible partly because of the CMMI Practice Transformation Initiative

Empanelment

All enrollees will be “matched” to a PCP within 60 days of effectuation

A challenging task:

- Communication to PPO enrollees is complicated
- Definition of primary care specialties is inconsistent
    - — Covered CA recognizes FM, IM & Peds
- FQHC’s often have itinerant clinicians

Covered California Contract: Primary Payment Reform

- **Contractor shall describe:**

  A payment strategy for adoption and progressive expansion among Providers caring for Enrollees, that creates a business case for Primary Care Providers to adopt accessible, data-driven, team-based care (alternatives to face-to-face visits and care provided by non-MDs) with accountability for meeting the goals of the triple aim, including total cost of care.

- **Achieving tipping point in support of Advanced Primary Care requires QHPs to adopt common framework**

Information for consumers

CoveredCA.com

Information on exchange-related activities

hbex.CoveredCA.com