



Comments to the Board

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Re: Covered California: selling insurance that puts profits above people

Dear Mr. Lee and Board of Covered California:

I am writing to you as a follow-up to my letter to the board of April 7, 2014 objecting to “narrow networks” and excessive “out-of-network” deductibles and out-of-pocket maximums associated with Anthem Blue Cross Bronze plans “certified” and marketed by Covered California in the individual market both on and off the healthcare exchange.

Health insurance products “certified” by Covered California, the California health benefit exchange, sold on and off the exchange in the individual market need regulation, oversight, and strong consumer protections. Currently there is no regulation or oversight by Covered California, the Department of Insurance, or the Department of Managed Healthcare of these products. The Department of Insurance reported to me that Anthem Blue Cross was regulated by DOI until 12/31/2013. However, none of the health plans offered for Alameda County through Covered California (including Anthem Blue Cross) fall under the jurisdiction of the Department of Insurance currently.

For informed consumer choice, it’s more than just premiums. Consumers need complete and accurate information on cost sharing and payments with respect to any out-of-network coverage. Deductibles (both in-network and out-of-network), maximum out-of-pocket (in-network and out-of-network) must be clearly disclosed prior to consumers purchasing a policy.

Covered California’s own marketing brochure (Covered California Health Insurance Plans 2014 “Making the Individual Market in California Affordable”) doesn’t define key terms like “deductible” and “network” and “out-of-network”—key to understanding total cost of ownership and true financial exposure. When Covered California spokesman Roy Kennedy was asked who decides the out-of-network dollar limits, he replied, “The out-of-network, out-of-pocket costs for each plan would be at the plan’s discretion. You would need to inquire with the individual plans on what their policy is for out-of-network costs.” Insurance companies, like Anthem Blue Cross, are free to determine the maximum financial exposure of consumers who go to providers outside of network.

Most importantly, a definition of what constitutes a network and a clear, complete, provider list (that remains stable over the annual benefit period) is essential. On April 9, Anthem admitted that almost a thousand doctors were wrongly listed as network

providers for Anthem Blue Cross on the Covered California exchange during the enrollment period.

Here is what I've heard:

“I am an internist in Pasadena who is encountering the same absurd insurance issues you describe. Suddenly I find that Anthem Blue Cross who sold me an 'equivalent PPO' to my prior PPO is egregiously fraudulent because the policy is NOT a PPO despite what they said and what is printed on our cards.”

“My partner is in need of a knee replacement and has documents to show there is not a single provider available to her in our community--even though the Coachella Valley is full of orthopedic surgeons and hospitals.”

Dr. Jeff Rideout M.D., Senior Medical Adviser with Covered California explained at the April 17 board meeting, “We (Covered California) do not contract with providers. Plans make choices, choices to narrow networks significantly.” Dr. Rideout commented that Alameda County served by Anthem Blue Cross and Blue Shield had seen some of the most drastic network narrowing. Narrow networks are not limited to Alameda.

When it comes to health care under ACA, you are buying access to a network—that's it. Currently there is no oversight over provider networks from any regulator. This needs to change.

“Narrow networks” key strategy in the health insurance business model—no disclosure to consumers

Narrow networks, though not new, have become a major strategy in California to control the number and value of claims paid to providers. Many consumers were misled to expect the same network of Anthem Blue Cross PPO providers that they had had access to through 2013.

“In the past, the individual market in the state was dominated—with the substantial and significant exception of Kaiser Permanente—by broad network PPOs. Insurers kept premiums down for consumers primarily through risk selection, as well as through **often nontransparent changes to consumer cost-sharing (bold added)**. However, in a policy framework in which consumer cost-sharing is standardized and risk selection is not possible, the only effective, immediate-term way to generate a lower price point is to purchase health insurance from lower-cost providers. Hence **the networks that were put together by insurers for Covered California**, as well as those for networks across the nation, **whether or not the exchanges chose to be selective purchasers are quite narrow.**” (p. 26) According to “*California: Round 1 State-Level Field Network Study of the Implementation of the Affordable Care Act*” (March 2014) Included in the Covered California board meeting materials for April 17.

Separate deductibles and out-of-pocket maximums for going “out-of-network” guarantee that insurers can minimize health care claims paid

Many who purchased “Bronze” metal tier plans thought they were purchasing a plan with a \$5,000 deductible and the federally mandated \$6,350 annual out-of-pocket maximum.

But let’s take the hypothetical case of 60-year-old Ms. X of Alameda county who purchased a “Bronze” plan from Anthem Blue Cross at a premium cost of about \$7,000 per year (with no government subsidy) because she makes \$50,000 per year (more than 400% of the federal poverty level).

Unfortunately, she encountered several unexpected medical issues requiring prescriptions, specialists and hospital surgeries—totaling \$29,500—catastrophic to most people. Even though insured with a Bronze plan, due to the narrow network in Alameda County, the difficulty of identifying doctors in the Anthem Pathway network and separate deductibles and out-of-pocket maximums for “in-network” and “out-of-network” services, Ms. X is told by Anthem Blue Cross that she is responsible for \$21,350 of the total billings of \$29, 500. Anthem Blue Cross pays out \$8,150.

When Ms. X purchased the Bronze PPO plan from Anthem Blue Cross, she thought she was purchasing a plan with a \$5,000 annual deductible. In fact the plan comes with two separate deductibles--an in-network annual deductible of \$5,000 and an out-of-network annual deductible of \$10,000. Ms. X learned that she must pay herself for medical and prescription costs up to the deductible before Anthem Blue Cross will pay any medical costs. The deductibles for in-network of \$5,000 AND out-of-network of \$10,000 must be applied separately and cannot be combined. The same is true for Out-of-Pocket maximums (in-network \$6,350; out-of-network \$15,000)—they are separate and do not apply toward each other.

When Ms. X incurred \$9,500 in in-network medical costs. She paid the first \$5,000 (her in-network deductible) then she paid \$1,350 in co-insurance for a total of \$6,350. Anthem Blue Cross paid \$3,150 of her in-network medical costs. Ms. X also incurred \$20,000 from an out-of-network hospital and related medical costs for surgery. She paid the first \$10,000 (her out-of-network deductible) then she paid \$5,000 in co-insurance for a total of \$15,000 (her out-of-network OOP maximum). Anthem Blue Cross paid \$5,000 of her out-of-network medical costs.

To recap, Ms. X paid \$7,000 in premiums to Anthem Blue Cross and \$21,350 of “her share” of her medical costs--\$28,350 for health care in 2014.

On the other hand, Anthem Blue Cross collected \$7,000 in premium revenue from Ms. X and paid out only \$8,150 in claims for Ms. X—a loss on her policy of \$1,170. The insured certainly bears a disproportionate share of the medical costs involved compared with for-profit insurer Anthem.

According to Emily Bazar with the CHCF Center for Health Reporting, “Darrel Ng, an Anthem spokesman, says out-of-pocket maximums for out-of-network providers range from \$10,000 to \$18,000 for the company’s individual plans and \$20,000 to \$36,000 for family plans on the private market. On Covered California, they range from \$10,000 to \$15,000 for individuals and from \$20,000 to \$30,000 for families.”

The health insurance market for individuals has never worked...

“...And you can’t just trust insurance companies either—they’re not in business for their health, or yours. This problem is made worse by the fact that actually paying for your health care is a loss from an insurer’s point of view... This means both that insurers try to deny as many claims as possible, and that they try to avoid covering people who are actually likely to need care,” Paul Krugman wrote in “Why Markets can’t cure healthcare” NYT, 7/25/09.

All insurance companies (car, homeowners, earthquake...or health) make money by collecting monthly premiums (revenues), and paying out claims (expenses)—the net is profit. Once premiums are set, profitability relies on controlling expenses, namely denying or minimizing the amount paid out in claims.

Under ACA, business has never been better for Anthem Blue Cross and Wellpoint

Wellpoint, parent company of Anthem Blue Cross, a major for-profit insurance company, is projecting record profits for 2014. “Our better than expected first quarter results reflect our value proposition in the market, the benefits we are seeing from our strategic investments and our intense focus on execution. Our membership is growing across our platforms and we are pleased with the progress we have seen in the exchanges.” (“Another Sign ObamaCare Works: Wellpoint Boosts Profit Forecast” Forbes 3/21/2014)

And what’s the surprise? Anthem Blue Cross already had 47% of the individual health insurance market in California pre-ACA. With the mandate that all Americans buy insurance by 2014, Anthem has a guaranteed increase of hundreds of millions of enrollees and billions in revenues and profits.

Individual consumers are the big losers

Who and where are the regulators? Californians (and all Americans) without employer or government subsidized health insurance are required under ACA to purchase health insurance. Where’s the consumer protection?

I received a response from the State Department of Insurance, ‘...it (DOI) does not have jurisdiction over all types of health plans available to consumers... The Commissioner has no authority over Covered California, or the agreements they have entered into with their participating insurers.’ (4/18/14) File No.” CCB-6900597, Anthem Blue Cross/ Changes to Provider Networks). The letter added, “Individual health plans offered by Anthem Blue Cross through Covered California fall under the jurisdiction of the Department of

Managed Healthcare, which you have copied in your letter.” No response from DMHC to date.

Covered California’s “mission is to increase the number of Californians with health insurance.” Covered California selected the health insurance companies and “certified” the plans, “We certify program with a full portfolio of products” Leesa Tori, interim Director of Health Plan Management at Covered California (former Director of Strategy and Product Innovation, Specialty Products at Blue Shield of California).

However, the flaws in the plan benefit designs “certified” by Covered California are structural and systemic, not isolated instances. Network and out-of-network rate setting are major issues that cannot be resolved by 3rd party “secret shopper” surveys or enrollee access satisfaction surveys. A review of preventive services will not reveal the denial of claims due to miscoding or inaccurate network status. Covered California can’t make sure “it has the right products” or judge “access to affordable, quality care” without evaluating “total cost of ownership” of such insurance products.

Further, consumers cannot turn to the courts because all Anthem Blue Cross insurance policies include binding arbitration clauses, such as:
“Both parties to this contract are giving up their constitutional right to have any such dispute decided in court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED BOTH FOR DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE AGREEMENT OR ANY OTHER ISSUES RELATED TO THE AGREEMENT AND MEDICAL MALPRACTICE CLAIMS.” [Note: Anthem’s capitalization]

We need help...

Consumers in the individual health insurance market need regulation and oversight of health insurance products that Californians are required to purchase. Otherwise, Covered California and an unregulated health insurance industry will continue to put insurance profits above people.

Sincerely,
Priscilla Myrick
Berkeley, CA
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May 22, 2014

Secretary Diana Dooley, Chair
Covered California Board

Peter Lee, Executive Director
Covered California
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Re: Data Collection and Reporting

Dear Ms. Dooley and Mr. Lee:

We write to commend Covered California for your commitment to publicly reporting, discussing and acting on demographic enrollment data with regards to race, ethnicity and primary language as was evidenced during the various course changes you undertook during the first enrollment period. We appreciate Covered California's commitment to transparency as demonstrated by your frequent releases of data on Exchange enrollment. It is in that spirit that we express our concerns and share our recommendations with you below on best practices for data collection and reporting in Covered California moving forward.

Data Collection:

Encouraging Higher Response Rates to Questions on Race and Ethnicity:

We, like you, were disappointed to see high non-response rates (22%) to the race and ethnicity optional demographic data questions on the paper and online applications for health coverage. These rates seem particularly high compared to response rates for other health coverage programs, most notably the Healthy Families Program at 4.5%.¹ We offer the following recommendations which we think will help to elicit higher response rates to the optional demographic data questions applicants are being asked. However we note that ***further information from Covered California on response rates by enrollment channel*** which we have not seen, ***would also be extremely helpful in diagnosing problems and strategizing about next steps:***

- **Emphasize the Importance of Data Collection in Trainings of Staff, CECs, Agents and PBEs:** We urge Covered California to ensure proper training of all service channel workers including Call Center staff, Agents, Certified Enrollment Counselors on the importance of collecting this data as well as best practices for eliciting responses to these questions in order to

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maximize the response rates. The 2010 Census enumerator guide includes a section about asking the ethnicity and race questions on the Census which could be used by your staff and included in training materials to CECs, agents and PBEs and other enrollment entities: <http://www.census.gov/foia/pdf/D547.pdf>. The Health Research and Education Trust (HRET) also has a disparities toolkit for collecting race, ethnicity and primary language information that could be useful to Covered California as well: <http://www.hretdisparities.org/Howt-4176.php>

- **Move up Questions on Race, Ethnicity and Primary Language to the Demographic Data Section:** Currently questions on race, ethnicity and primary language are asked in CalHEERs towards the end of the application in a section entitled: Optional Data. We urge you to move these optional questions to the Demographic data section where other questions such as gender and age are asked. This is especially important for language (s) written and spoken as the answer to this question may indicate a problem with accessibility and the need for assistance such as oral interpretation in order for the applicant to complete the enrollment process.
- **Eliminate “English” as the Default Language in CalHEERs and Make the Question Mandatory:** Respondents filling out the online application are automatically assigned “English” as their primary language unless they proactively choose another language from the drop-down menu. CalHEERs should be programmed so the language question is mandatory with a “decline to state” option and consumers should be allowed to choose their spoken and written language. Additionally, *Covered California may wish to include a third question in order to get a more accurate measure on language such as language proficiency or language spoken at home.*
- **Align the Online and Paper Applications on Race/Ethnicity Questions:** We appreciate Covered California’s plan to update and align the online application with the paper application by adding to CalHEERs additional granular race and ethnicity categories that are included in the paper application including Guatemalan and Salvadoran under Ethnicity and Hmong and Laotian under Race. We also urge Covered California to ensure that CalHEERs provides a drop-down menu of additional granular race/ethnicity categories so people can "write in" their race/ethnicity as they are able to on the paper application if they do not see their category listed.
- **Reposition the Ethnicity Question so it comes Before Race and is Asked Only Once:** To elicit better response rates, we urge you to ensure the question on Ethnicity is asked before the question on Race on the paper application as is done on the Census. Additionally, we recommend that you re-draft the question so it is one question rather than two separate questions to elicit better response rates as is done on the federal application (see example below):

Are you of Hispanic, Latino, or Spanish origin? (optional)
 No, not of Hispanic, Latino, or Spanish origin
 Yes, Mexican, Mexican American, Chicano

- Yes, Salvadoran
 - Yes, Guatemalan
 - Yes, Cuban
 - Yes, Puerto Rican
 - Yes, another Hispanic, Latino, or Spanish origin:
-

Other Recommendations:

Expand the Demographic Data Questions to Include Sexual Orientation and Gender Identity:

The lack of enrollment data on gender identity and sexual orientation means that Covered California cannot adequately measure the effectiveness of its outreach and education to these communities. We support advocates for the LGBTQ community in urging that Covered California collect and publicly report this data.

Data Reporting:

We appreciate Covered California's various releases of demographic data on enrollment trends in Covered California. We understand the delicate balance between releasing data frequently and ensuring accuracy in the data released. With that in mind, we make the following recommendations:

- **Report Numbers not Percentages:** We appreciate that Covered California data is point-in-time data and subject to change monthly. As such we recommend that you release the data by numbers of enrolled rather than as a percentage of enrolled since the numbers are volatile and constantly shifting. Additionally, in order to encourage proper data analysis, *each demographic report should incorporate the number of non-respondents and/or "decline to state"* so there is a standard denominator from which others may calculate percentages and/or make comparisons.
- **Provide the Highest Level of Granular Data Available:** While we appreciate the delicate balance between speed and accuracy of the data released, CPEHN and other advocates urge you to release the highest level of granular data available with regards to enrollment. This would have been especially helpful during the open enrollment period for groups providing enrollment assistance to various Asian subpopulations encapsulated under the broad categories: "Asian" and "Native Hawaiian and Other Pacific Islander." The same can be said for reporting on written and spoken languages which were encapsulated under the broad categories: "Asian and Pacific Islander" and "Indo-European" languages. We would urge you in the future to report the number of enrolled for each race, ethnicity and primary language category, even for the smallest "N" greater than 1. There should be no need to suppress even the smallest numbers for fear of personally identifiable information because knowing that even just one person speaks a particular language (without identifying where in the state) would not violate any confidentiality or privacy concerns.
- **Provide Data on Written and Spoken Language:** We encourage Covered California to distinguish between responses to preferred spoken and preferred written language through the inclusion of separate tables for each question. As with all the other demographic categories the number of non-respondents should be included in the table for each question.

- **Provide Additional Granularity on Multiple Races:** The category “mixed race” should be renamed to “multiple races” to reflect the conventional name for this category. In instances where the “multiple races” category is large, we would urge you to provide further disaggregated reporting of the data in this category. For example, if a large number of individuals in the “multiple races” category are selecting Latino and White, those analyzing the data may appropriately count such individuals as Latinos for some purposes. Additionally although there are several different approaches to classifying data on Multiple Races, CPEHN recommends that Covered California use the Office of Management and Budget Appendix B method entitled "for use in civil rights monitoring and enforcement," as it's the simplest and most straightforward method, especially if you are trying to address health disparities: http://www.whitehouse.gov/sites/default/files/omb/assets/information_and_regulatory_affairs/re_a_pp-b-update.pdf
- **Stratify other enrollment data by race, ethnicity, and language:** For enrollment data to be most useful, Covered California should stratify data by race, ethnicity, and primary language on:
 - Types of applicants (ie. subsidy eligible, non-subsidy eligible)
 - Appeals
 - Geographic region
 - Gender/Age
 - Enrollment by venue

Thank you for your consideration of these recommendations to ensure proper reporting of data on enrollment and other trends by race, ethnicity and primary language.

Sincerely,



Caroline B. Sanders, MPP
Director Policy Analysis/CPEHN

ⁱ Covered California’s Historic First Open Enrollment Finishes with Projections Exceeded; April 17, 2014
<http://news.coveredca.com/2014/04/covered-californias-historic-first-open.html>

Healthy Families Program, May 2011 Summary:

http://www.mrmib.ca.gov/mrmib/Agenda_Minutes_061511/Agenda_Item_11.a_HFP_May_2011_Summary.pdf



May 21, 2014

Peter Lee
Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Dear Mr. Lee and Covered California Board:

On behalf of the Health Justice Network (HJN) and as the Covered California Outreach and Education Grant Program lead agency for HJN, Asian Americans Advancing Justice – Los Angeles (Advancing Justice-LA) is writing to provide input to Covered California’s proposal to incorporate enrollment activities into its Outreach and Education Grants Program and change it into a “Navigator” grants program. Advancing Justice-LA is dedicated to providing the growing Asian American, Native Hawaiian and Pacific Islander (AANHPI) communities with multilingual and culturally sensitive legal services, education, leadership development, and public policy and advocacy support. Its Health Access Project (HAP) seeks to address the health care needs of our communities and coordinates the HJN, a statewide collaborative comprised of over 50 community-based organization, health care providers, and small business groups which promotes culturally and linguistically competent health care services for AANHPI populations and increased access to affordable, quality health care for AANHPIs through outreach, education, enrollment and advocacy.

Need for more community and stakeholder engagement

Given the limited information about the proposed grant program and the importance of developing an effective, integrated outreach, education and enrollment program, we need a comprehensive stakeholder engagement process, rather than a rushed process to redesign the current Outreach and Education program.

We have not had an opportunity to see the breakdown of funding allocated in Covered California’s 2014-2015 budget for Outreach, Education and Communications or for Eligibility and Enrollment efforts. But we think that the amount of proposed funding for the proposed new navigator grant program, which appears to be around \$5 million, is far too little to support the spectrum of activities expected by navigators to undertake for the second open enrollment period. We also believe that one of the major reasons for the successful enrollment numbers for the initial Open Enrollment Period was due to the investment of over \$43 million for Covered California’s Outreach and Education Grant Program. We would urge the Board to continue this

grant program and to increase the funding dedicated to the effective, one-on-one support that is provided by the existing Outreach and Education grantees, as well as Certified Enrollment Entities and Counselors (CEEs/CECs). Moreover, those who have enrolled were persistent enough to navigate through the complicated and spotty Covered California website and were predominantly English-speakers, or those considered the “low-lying fruit.” To reach the remaining uninsured in the second Open Enrollment Period will require more outreach and education to a “harder-to-reach” and likely more limited-English speaking population. At a minimum, funding for the existing Outreach and Education Program must be maintained on an ongoing basis for the current Outreach and Education grantees who have established an effective, successful foundation for future outreach, education and enrollment. For example, we believe that the coordinated efforts of our Health Justice Network have contributed to the success of the relatively high enrollment numbers of the AANHPI communities.

We therefore strongly recommend that Covered California does not make any changes until the end of the next open enrollment period but rather, use this period to seek broader input from existing community partners, other stakeholders and consumers. The additional time will allow more strategic planning to create a more comprehensive and effective program after a thorough evaluation of its current programs.

Navigator Program Structure

Although HJN generally supports the move towards a more integrated outreach, education and enrollment program rather than a bifurcated grants program, we strongly believe that any grant program should be flexible, especially since we have established an effective outreach and education program with our current HJN partners. Moreover, after discussing the proposed new navigator grant program with our collaborative partners, some have expressed reservations about the proposed changes and asked for more clarity. As trusted community sources of information for the AANHPI communities, our partners have successfully conducted outreach and education activities but may not have the capacity to expand their outreach and education responsibilities to include enrollment. Others are unsure if they want to engage in enrollment activities because of the administrative burdens imposed by becoming a Certified Enrollment Entity (CEE) and should be allowed the option to continue their current outreach and education efforts.

Moreover, most of our HJN partners have been collaborating with other HJN CEE partners and have assisted community members to enroll through joint events and referrals and should be allowed to continue to work and to refer to other CEE partners. We would not support a Navigator grant model where all of the Outreach and Education subcontractors would be required to conduct outreach, education, and enrollment.

Therefore, we strongly recommend a hybrid model that would allow some HJN partner organizations to continue to conduct outreach and education while other HJN partners choose to serve the “full spectrum” of navigator functions so each can decide the most appropriate activities according to their organizational capacities. We would not support a Navigator grant model where all of the Outreach and Education subcontractors would be required to conduct outreach, education, and enrollment. Those HJN partners who choose to conduct enrollment activities would be eligible for the additional funds.

Reimbursement Structure and Funding of Navigator Grants

We have been informed that CEEs receiving navigator grants cannot receive the reimbursement/application fee, which will be phased out after the end of the second enrollment period. We have also been told that the estimated amount provided for each enrollment is estimated to be about \$100/successful application, which is an increase over the current \$58 reimbursement fee, but still is not enough, given the requirement to conduct the full spectrum of navigator activities, which often includes case management for our community members. As mentioned in a prior board meeting we agree that the current CEE reimbursement rate should be increased.

Although the \$58 reimbursement per successful application does not fully compensate for the time needed to enroll and to conduct follow-up support for applicants, we do not support the elimination of the reimbursement fee after the second Open Enrollment Period. Since the final federal rule on navigator standards, which was released on May 16, 2014, allow states to continue their “fee per application” reimbursement system, we would support continuation of this model to ensure that those CEEs, particularly those who do not receive any navigators funds, such as most of our smaller HJN partners, will continue to have some supplemental funding to sustain their enrollment activities.

Moreover, it is not clear if funding would be taken away from current outreach and education activities and used for enrollment efforts. We would not support the transfer of any current outreach and education funding towards enrollment activities since all of the funding must continue to be used to target hard-to-reach populations, including those in the AANHPI that continue to be underrepresented, such as the Cambodian, Hmong and Pacific Islander communities, immigrants, and limited-English proficient populations.

Therefore, regardless of whether the Outreach and Education Grant Program will be merged into the Navigator Grant Program, CEEs should continue to be reimbursed on a “fee per application” basis.

We appreciate the opportunity to provide these comments and will be submitting additional recommendations regarding our lessons learned from the first Open Enrollment Period at a later time. We hope that the staff and Board find our comments helpful and we look forward to working with the staff to create the most effective and efficient outreach, education and enrollment program to reach all of the remaining uninsured and to retain all of its current enrollees. Please do not hesitate to contact me at (213) 241-0271 or dwong@advancingjustice-la.org if you have any questions or need additional information.

Sincerely,



Doreena Wong
Project Director, Health Access Project
Asian Americans Advancing Justice – Los Angeles

cc: Sarah Soto-Taylor



May 19, 2014

Mr. Peter V. Lee, Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: Comments and Recommendations on Proposal to Modify Enrollment Programs

Dear Mr. Lee,

California Coverage & Health Initiatives, a coalition of Children's/Community Health Initiatives and outreach and enrollment entities across the state, writes to comment on the proposal to modify the Enrollment Assistance Programs. Your comments at the last board meeting, in media reports, and our conversations with Covered California staff, indicate that you are planning to make staff recommendations on May 22nd that would constitute a major shift in policy for the Enrollment Assistance Programs. In anticipation of the proposal, we offer the following perspectives on the enrollment data presented at the last board meeting, as well as comments on the proposed recommendations.

Data on plan selection by service channel provides an incomplete picture.

We applaud your release of the data and hope that further context and analysis will present a more complete picture of the contribution Certified Enrollment Counselors (CECs) played in the success of Qualified Health Plan (QHP) enrollment. The data indicated that Agents were responsible for 41% of enrollments, Service Centers 9%, CECs 9%, and Self-Enrollments 41%. However, these data do not show the complete picture for the following reasons:

- The glitches and slow ramp up of the CEC program are the primary cause of the fewer than expected enrollments by CECs. Difficulties with the ramp up of the CEC program, training, and registration process have been well documented; we will not reiterate them here, as they are known. Covered California focused heavily on agent certification and training prior to open enrollment at the expense of creating a more robust CEC program. The result was that thousands of agents were ready to enroll by October 1st, 2013 while a mere 500 CECs were trained and prepared to enroll early in open enrollment. Throughout open enrollment the numbers of CECs continued to lag far behind those of Certified Agents – by a ratio of at least 3 to 1 for the majority of open enrollment. There should be no surprise that CECs enrolled fewer Californians. CECs enrolled roughly one quarter as many Californians as did agents during this period. Once Medi-Cal enrollment

data is released, it should show that combined QHP and Medi-Cal enrollment show that CECs are a highly efficient and cost effective enrollment channel.

- A significant portion of the “Self-Enrolled” were actually assisted by a CEC in completing their application. Many Certified Enrollment Entities (CEE) report that in their role helping consumers successfully complete online applications, their organizations fielded hundreds of calls and expended thousands of uncompensated staff hours helping residents who were not able to access the Service Center for assistance. In most cases, the CECs did not receive a delegation and thus were not credited with providing assistance. As a result, a sizable portion of the “Self-Enrolled” did seek and receive help from CEEs/CECs.
- CEEs/CECs are most suited to enroll Covered California’s primary target population of Latino Californians, and other communities. Covered California data show that CECs are the channel best equipped to assist Latino’s with enrollment. A full 58% of CECs are bi-lingual in Spanish, while only 15% of agents are able to provide assistance in Spanish. Moreover, Covered California data reveal that Latinos are very comfortable with assistance provided through Enrollment Counselors, seeking out their assistance at double the rate of any other ethnic group. CEEs/CECs typically serve a large percentage of the hardest-to-move/hardest-to-reach populations such as mixed status families, families with low English proficiency, or families with multiple enrollment barriers. These enrollments are both complex and time consuming, but crucial to reaching Covered California’s enrollment goals. Serving a high percentage of these types of cases may explain in part the lower percentage enrollments completed by CECs.

Taken as a whole, these facts provide a more comprehensive picture of the role CECs played and will play in meeting the enrollment goals into QHPs. Rather than simply seeking to maximize enrollment numbers, any change in policy direction should be toward greater support and resources for enrollers who grapple with the most complex enrollment and are most equipped to serve California’s hardest to reach consumers.

Responses and Comments on Expected Staff Recommendation.

Covered California’s staff is expected to make a set of recommendations to fundamentally alter the direction of the Enrollment Assistance programs. We anticipate staff to recommend an increased reliance on agents as a primary channel into QHPs. It appears that there will be a recommendation to move toward unification of Enrollment Assistance programs (Outreach & Education, In-Person Assistance/CEE/CEC, and Navigator Program) under a Navigator Program model that provides a broad spectrum of services to clients (outreach, education, enrollment and potentially post enrollment services like utilization and retention) and reduces siloing and duplication. There will also be a recommendation to continue the Outreach and Education program and CEE/CEC programs in “status quo” mode during open enrollment 2014-2015 but encourage entities to apply for Phase II navigator funding in summer 2014. However, there would be eventual phasing out of CEE/CEC program in 2015, with possible continuation of CEE/CEC work unpaid under the Certified Application Counselor (CAC) program. Recommendations will be made about a Phase II of navigator grants in summer 2014 with

expanded funding for the navigator program. There have also been suggestions that there may be a recommendation to develop a pool of funding focused on smaller non-profit organizations to support navigator activities with smaller grants, likely between \$50,000 and \$100,000.

In response to the proposed recommendations, CCHI provides the following comments and recommendations:

- No broad policy shifts should be made until after open enrollment 2014-15 data is analyzed. We support the broad policy of moving toward more integrated enrollment programs and a comprehensive scope of services to consumers, including health literacy education, utilization, and retention services. However, in the current context, having just completed the first open enrollment period and with the Navigator Program yet to start, no large policy decisions should be made until they can be grounded in data comparing the success of both the Navigator and CEC programs. Furthermore, we propose waiting to make significant policy decisions until stakeholders have ample time to meet with Covered California staff and discuss the implications. We urge Covered California to convene a comprehensive stakeholder group to analyze enrollment results and develop and vet proposals to reorganize the Enrollment Assistance Programs. Minimally, we suggest that the Marketing, Outreach and Enrollment Assistance Advisory Group have an opportunity to provide meaningful input in the development of any such proposals. Given that the recent Final Federal Rule does not impose limitations on state exchanges compensating on a per application basis, there is no hurry to make such a broad sweeping policy change.
- Ensure that CEEs/CECs are not driven away from Covered California work. Our greatest concern with this newly proposed policy direction is the threat of losing a notable number of the 5500+ CECs who have finally been fully trained and are contributing to the success of Covered California. These individuals and entities have met many resource consuming requirements and administrative hurdles to participate in enrolling in QHPs. A wholesale policy change now would send a message that their work is not valued or important to the long term success of Covered California. The goal of any policy change should be to more fully support and utilize those enrolling Californians into coverage, especially those with the experience and linguistic capacity that the job requires, while working to retain all CECs actively engaged in enrollment.
- Fully and fairly fund the Navigator Program. Whether it remains status quo or is expanded and broadened, the Navigator Program must be adequately funded to fairly compensate entities in providing excellent customer service and a full scope of services to consumers. The success of the Navigator Program will be largely dependent upon how well resourced entities are to accomplish their goals. We recommend fair and appropriate compensation that fully compensates navigator entities for the work they do. We also recommend including CEEs and Outreach and Education (O & E) grantees in developing a financial model for compensation so their experience guides the policy development on compensation. (This was not done for the CEE/CEC program or the existing Navigator Program).

- Provide support for small grants focused on smaller Community Based Organizations (CBO) who are disadvantaged in Navigator competition. We support the concept of a pool of navigator funds to address the needs of small CBOs who are disadvantaged by the Navigator Program structure. Offering grants of a minimum of \$50,000 and up to \$100,000 for such entities is appropriate and will encourage increased participation in enrollment efforts by these CBOs, therefore better leveraging the existing relationships they have with the communities they serve. We also believe that the program should encourage applicants to partner with other entities to bring more CECs into their framework.
- Develop umbrella Navigators to prevent the loss of CECs. Consider developing a structure that funds some entities to act as an “umbrella organization” that can bring together CECs/navigators who will otherwise not continue enrollments either because they are unaffiliated or because their CEE does not become a navigator entity.

We hope our insight and experience as an association with over a decade of statewide experience engaging in outreach and enrollment can assist Covered California as you prepare for the future and continue to improve the consumer enrollment experience. Thank you for your consideration of these comments. If you have follow-up questions, please contact Suzie Shupe at sshupe@cchi4families.org or (707) 527-9213.

Sincerely,



Suzie Shupe
Executive Director
California Coverage & Health Initiatives

Cc: Covered California Board
Sara Soto-Taylor
Katie Ravel
Elsa Ruiz-Duran
Mary Watanabe
Thien Lam
Rene Mollow



May 16, 2014

Sarah Soto-Taylor
Deputy Director of Community Relations
Covered California
1601 Exposition Blvd
Sacramento, CA 95815

RE: Outreach and Enrollment Program Changes

Dear Ms. Soto-Taylor,

On behalf of our nearly 1,000 not-for-profit community clinics and health centers (CCHCs), the California Primary Care Association (CPCA) is submitting comments to reiterate our commitment to outreach and enrollment and provide recommendations for programmatic changes. As one of the few providers that open their doors to all regardless of their ability to pay, CCHCs play a critical role in assuring access to health care services in California and serve over 5 million patients each year. Since one in three California certified enrollment counselors (CECs) are based at CCHCs, we are committed to achieving successful outreach and enrollment efforts across the state.

CPCA appreciates that Covered California's staff met with our staff as well as representatives from regional clinic consortia and CCHCs on May 8th to discuss the future of the state marketplace's outreach and enrollment infrastructure. Adept in providing a trusting enrollment environment in local communities, CCHCs have truly emerged as leaders in our state's historic open enrollment success. A simple snapshot of 125 health centers assisting nearly 900,000 persons through outreach, application technical assistance, and enrollment education, and submitting over 250,000 applications for programs of coverage does not even begin to accurately reflect CCHCs' unique attention to assisting and enrolling Californians, including those persons eligible for Medi-Cal. In many rural north, Central Valley, Central Coast, and Imperial Valley communities, our health centers are often the only place to get timely, informed, in-person assistance. By providing culturally sensitive and linguistically appropriate enrollment assistance, we also play a critical role in enrolling immigrant and Latino communities.

CPCA is hopeful that future outreach and enrollment programming will include trusted organizations like CCHCs that are uniquely positioned to provide education, outreach, and enrollment assistance not only for those first enrolling but also for those looking to learn how to best use their new coverage, stay in coverage, and renew.

Covered California should be incredibly proud of the infrastructure it has built and see it as groundwork for the future. CPCA agrees with Covered California's sentiment that, with improvements, this critical enrollment workforce can be maximized not only for enrolling other community members, but also for assisting individuals in staying in coverage, accessing care, navigating renewals, and providing education.

Building on the collective success we have shared to assist all Californians, CPCA recommends the following:

- **Maximize CCHC Involvement in all Future Programs:** All future outreach and enrollment programs should continue to support an infrastructure that includes CCHCs. All program opportunities and funding applications should explicitly indicate that licensed health care clinics including, but not limited

to 1204(a) clinics, FQHC, FQHC look-a-likes, Urban Indian Health Centers, and entities funded by the Indian Health Services, are eligible for funding and encouraged to participate.

- **Continue Payment Systems for Existing Certified Enrollment Entity Workforce:** While we appreciate the capacity of the Navigator program to seamlessly combine education, outreach and enrollment, we know that a grant –based program is not the right fit for all organization types. We support a hybrid program that allows CEE/CEC infrastructure to exist side-by-side with the Navigator program so that meaningful partnerships can be built between navigators and experienced CEE/CECs. By maintaining this structure, current Certified Enrollment Entities that are not good candidates or do not desire to become Navigators can maintain their enrollment functions and continue to receive financial support to incentivize their outreach and enrollment activities.

There are a number of additional reasons why a funded CEE/CEC infrastructure should be maintained. With 48% of Latino Covered CA enrollees enrolled via this in-person assistance structure, we know that enrollment counselors played a critical role in the massive uptake of enrollment in the second half of open enrollment. This same workforce will be critical to keeping Latinos enrolled in their program of care. More broadly, considering the many unknowns regarding future outreach, enrollment, and retention needs, the CEE/CEC infrastructure, coupled with the Navigators program, will allow for greatest overall program flexibility and the greatest number of CECs able to assist Californians enrolling in health coverage. With proper training, CECs may prove critical in minimizing program “churning” or movement between programs of coverage and avoidable loss of coverage. CECs are already providing extensive on-going support to consumers with continuing to make their premium payments, staying enrolled in their plan of choice, learning how to access care with their new coverage, and assisting with renewals for all programs. As we evolve the program, we recommend that the pay-per-application system continue with financial support that reflects the complexity of the work and need for retention assistance.

- **Restructure the Navigator Program for Success and Issue a Second Request for Applications:** With a second round of funding, and thoughtful expansion, Covered California’s Navigator Program could be an even greater outreach, education, and enrollment asset. Thoughtfully expanding the program can assure no “gaps” in regions and maximize the ability to touch target communities.

We recommend creating a new funding pool that would add “Local” navigators to the Regional and Targeted funding pools that already exist. Instead of having a statewide population-specific reach like the Targeted funding pool, or a multi-county broad approach like the Regional funding pool, this new “Local” funding pool would provide grants to small community level institutions that, at most, would cover a city or local region. Applicants to the local funding pool should be permitted to apply as single entities *or* as partnerships or coalitions on joint applications. The program should not be structured in such a way as to all but require joint applications, as were the Regional and Targeted pools in the original Navigator RFA. By creating the “Local” navigator, we will gain participation from trusted institutions that reflect their local community, such as community clinics and health centers. This will better incorporate CEE institutions looking to be an active part of the long-term enrollment infrastructure into the Navigator Program.

This new “Local” funding pool described above would alleviate many of the other issues clinics and health centers encountered with the original Navigator RFA. Under the original Navigator RFA the number of grants being awarded in each “funding pool” was very small – just one per region – and a range of 2-8 grants total in the targeting funding pool. For smaller entities, it was not worth investing

the time and resources to apply when the chances of receiving funding were so slim and the proposed structure essentially required participation in joint applications. For entities with limited resources, forging the necessary relationships, writing joint applications, and performing activities under a partnership structure can be administratively and operationally burdensome.

The structure of the “regional” funding pool also presented problems. For example, the Los Angeles/Orange County region is prohibitively large – with regard to both geography and population. Organizations were not inclined to form the extensive coalitions that would be required to serve such a large geographic area, and the population density in Los Angeles is such that it makes little sense for most organizations to invest resources in reaching beyond their local cities and communities within the county. There is enough need at the local level, and by focusing on smaller regions, entities can avoid encroaching on the traditional services areas of other CCHCs and community institutions.

When considering the structure of a second round Navigator RFA, we also recommend Covered California rethink the way the “target population” is specified in the RFA. The target population for Navigators was clearly stated as 138% FPL and over, subsidized and unsubsidized Covered CA health plans. Since CECs are required to assist with enrolling in both Covered CA health plans and in Medi-Cal, being supported financially to enroll in one or the other is administratively difficult and served as a deterrent to the participation of CCHCs whose mission is to serve everyone, and turn no one away. We recommend that the second round Navigator RFA state that funding is being provided to support enrollment throughout the year and in ALL of the insurance affordability programs and products available through coveredca.com, including both subsidized and un-subsidized health insurance plans and Medi-Cal.

We respectfully request a second round Navigator RFA be issued in summer 2014 to ensure that the expanded Navigator program is implemented prior to the start of the 2nd open enrollment period. We also recommend that the grant application be modified and application assistance be provided to maximize applications from small institutions, such as free and community clinics and cultural and ethnic organizations. Lastly, we recommend that overall funding and funding period be extended to support the Navigator infrastructure into 2015.

- **Additional Support and Marketing for Rural and Hard-to-Reach Populations:** As we discuss improvements to the outreach and enrollment infrastructure, it is important that we acknowledge that not all assistance has the same costs. Of particular note, our rural health centers’ outreach and enrollment programs often cover distances the size of some states. Recognizing that each consumer touch costs more money, we recommend that Covered California revisit the level of financial support that is provided to Navigators and Certified Enrollment Entities that serve primarily rural areas. Additionally, we recommended that Covered CA invest in rural targeted marketing that recognizes that a message that works in California’s urban centers may not be best for our rural community members.
- **Transition Support for Outreach and Education Grantees:** Recognizing that Outreach and Education Grantees have played an important role in our outreach and enrollment infrastructure, we support plans to assist Outreach and Education Grantees in transitioning to Navigators. In addition to reallocating their remaining Outreach and Education Grant dollars to be used for Navigator activities, we request additional resources be provided to these institutions to support their work through the end of the 2nd open enrollment period and beyond. Lastly, to maximize ongoing participation by Outreach and Education Grantees, we request that the Navigator transition not be mandatory. Respecting that some institutions are proud to focus their efforts on outreach and education, we ask that institutions that do

not want to transition into the Navigator program be allowed to maintain their Outreach and Education Grantee status and continue with their outreach and education activities through the 2nd open enrollment period.

- **Expand Upon Current Efforts to Build Relationships and Partnerships:** For the 2nd open enrollment period, we also recommend that a pilot be launched in selected rural and urban communities to designate and support an institution responsible for building partnerships between navigators, certified enrollment entities, and other organizations committed to community health. These coordinating organizations would be responsible for hosting and facilitating regular convenings and provide ongoing support, which would help to maximize opportunities and create dynamic interplay between these programs.
- **Revisit Provider Education Program:** In 2015, we also recommend that Covered California examine the benefits of this program, and consider implementing a more robust, second round of this program. Modeled after the 1st program, this program would assist providers in supporting patients to stay enrolled in programs of coverage.

As we consider the future vision and funding for the outreach and enrollment infrastructure, it is important to keep in mind Director Peter Lee's own reflection on the first open enrollment period: it is "just the beginning." To create an enduring culture of coverage and build on our tremendous enrollment momentum, we must consider what resources and programs we need to have in place.

We appreciate your time and attention to our program recommendations. We recognize, as we hope you do to, that this is just the beginning of what we believe are critical stakeholder conversations regarding the future of the outreach and enrollment program. We strongly recommend that Covered CA host a series of webinars and meetings with all outreach and enrollment stakeholders before formal proposals are brought to the board for approval. CPCA and our member institutions look forward to working with Covered California on the recommendations we submitted, discussing the feasibility of these program components, timing of their implementation, and necessary funding, to make sure we have an outreach, enrollment, and retention infrastructure that works for our communities.

Please feel free to email Beth Malinowski at bmalinowski@cpc.org with any questions or to continue this important dialog.

Sincerely,

Beth Malinowski
Associate Director of Policy

CC:
David Panush, Covered CA
Thien Lam, Covered CA
Elsa Ruiz-Duran, Covered CA
Mary Watanabe, Covered CA
Carmela Castellano-Garcia, California Primary Care Association



Community Health Councils, Inc.



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May 21, 2014

Peter Lee, Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Dear Mr. Lee,

Community Health Councils (CHC), on behalf of the undersigned and our Covering Kids and Families (CKF) and LA Access to Health Coverage Coalitions, writes to provide input on the proposal to consolidate outreach, education and enrollment. CKF and LA Access combined represent more than 100 organizations across California and Los Angeles County. Many partners are current Covered CA Outreach and Education (O/E) grantees and Certified Enrollment Entities (CEEs) with years of experience who touch the lives of thousands of Californians.

We agree that consumers need to engage with enrollment assistance entities that are able to provide a full spectrum of services, not just outreach and enrollment but utilization and retention. However, we are concerned by the rushed process to redesign the existing program and want to share three overarching concerns:

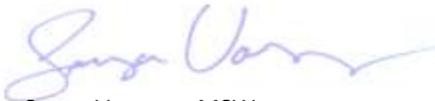
- 1. The process is moving too quickly without comprehensive stakeholder engagement.** While we understand the need to make improvements, we feel that more time is required to consider all options. For example, concerns exist that rural communities would not receive the localized support they need if the current Navigator program is the model. A lot of time and effort has gone into developing the current programs and they should not be easily dismissed. Staff have discussed this proposal at regional CEE and O/E grantee meetings; however, there wasn't a formal engagement process as in the past. At a minimum, the Marketing, Outreach, and Enrollment Assistance Advisory Group should be convened to vet the recommendations. It is no longer necessary to make rush decisions given the recent federal rule that only bars Federally Facilitated Marketplaces from providing per application fees. ***We urge Covered CA not to make any changes at this time, but to engage in comprehensive planning that includes broad based stakeholder and consumer input and reviews data through the next open enrollment period.***
- 2. Coordination between Covered CA and the Department of Health Care Services (DHCS) is lacking.** It was clear from the beginning of the initial open enrollment that consumers would seek out enrollment assistance regardless of the program for which they were eligible. Both agencies worked in concert to create the initial Statewide Marketing, Outreach & Education Program design. Yet with this decision, there is no such joint deliberation. If one of the goals is to provide a seamless health coverage system, enrollment assistance designed to support that system must also be seamless. ***We urge both agencies to work together again in the redesign of the enrollment assistance program so that it meets the needs of all consumers.***
- 3. Recent data on the usage of Certified Enrollment Counselors (CECs) does not provide the full picture.** Recent data show that only 9% of those who enrolled did so with help from a CEC. We feel this not an accurate picture. We are aware of many CECs who prior to being certified were helping consumers complete their applications (these would appear as self-enrolled). Some CECs found it simpler to make a correction (some of which occurred in other service channels) in a consumer's existing application instead of going through the delegation process. Whereas agents assisted the most consumers, in the Asian and perhaps other communities many consumers may have gone to agents given the limited number of CECs who spoke their language. Finally, these data do not show the number of Medi-Cal applications completed by CECs or the amount of troubleshooting CECs offered. ***We recommend that additional data be provided or collected that could offer a better understanding of how the CEC service channel was utilized.***

If and when the consolidation of the O/E grants and the CEE program moves forward, we offer the following as an initial set of recommendations:

- 1. Funding for the program must be adequate.** The \$5 million that is set aside for the current Navigator program is insufficient. There are still Californians who need help enrolling into coverage, many of whom will have obtained coverage but dropped off due to financial or other barriers. We believe that community-based enrollment assistance can play a critical role in helping consumers maintain and utilize their coverage. ***Therefore, we recommend that Covered CA and DHCS conduct a full analysis of how much funding would be needed to provide comprehensive services, taking into account regional concerns such as the number of uninsured and "hard to reach" populations.***
- 2. Organizations/ Collaborations need flexibility in providing services.** Many O/E grantees and CEE groups were naturally working together even before Covered CA identified the need for this. In addition, many O/E collaborations chose partners who may not have had the capacity to conduct enrollment but had expertise in outreaching and educating eligible populations. We believe that agencies/ collaborations can best determine which of their staff or partners are best suited to conduct all services or to conduct only outreach and education. We are glad to hear that Covered CA staff are in agreement on this issue. ***We want to underscore this point by recommending that agencies/ collaborations be allowed to have some staff or partners only conduct outreach and education as long as they work with CEC staff/partner.***
- 3. Counselor/ Educator Trainings need improvement.** We along with other advocates and CEE groups have already expressed concerns with the current trainings. We are most concerned about the limited information available on Medi-Cal http://www.chc-inc.org/downloads/IB_CECcurriculum020714.pdf. We are also concerned that CECs might be unable to adequately explain the copay/co-insurance structure and lack knowledge about other health-plan specific information to fully inform consumer choice. ***As the programs become consolidated, we urge both Covered CA and DHCS to work together to enhance trainings so that Education and Enrollment staff are fully equipped to support consumers.***
- 4. Organizations/ Collaborations should have the option of transitioning to the new program.** We understand the desire to move all current O/E grantees and CEES to this new program; however, groups conducted an extensive assessment in determining their engagement in these opportunities. They spent time developing the design of their partnerships and the strategies they would use. It may not be feasible for groups to transition into this new program, at least not using their existing collaboration or staffing. We are glad to be in agreement with Covered CA staff on this issue. ***We want to reinforce this point by recommending that existing agencies/ collaborations keep their current O/E grants or CEE agreements in place at least through the next open enrollment period.***

Thank you for this opportunity to provide our recommendations. We look forward to working with you to provide more input on the program when further details are provided. Should you require additional information, have any questions or would like to meet with our coalition partners, please feel free to contact me at 323.295.9372 ext. 235 or sonya@chc-inc.org.

Respectfully submitted,



Sonya Vasquez, MSW
Policy Director

cc:

Covered California Board
Sarah Soto-Taylor, Covered California
Mary Watanabe, Covered California
Rene Mollow, Department of Health Care Services
Tara Naisbitt, Department of Health Care Services
Crystal Haswell, Department of Health Care Services
Cynthia Bruno, Richard Heath and Associates

Covering Kids & Families and LA Access Coalition Partners

Doreena Wong, Project Director – Health Access
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Long Beach Department of Health and Human Services
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Kelly Bennett-Wofford, Executive Director
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Valley Community Clinic

Luis Pardo, Executive Director
Worksite Wellness

May 20, 2014



Peter Lee, Executive Director
Covered California
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Sacramento, CA 95814

Dear Mr. Lee:

Thank you for taking the time to meet with us in April to review the successes and challenges we have faced as outreach and enrollment grantees, and to discuss the policy issues we have identified as priorities for the next several months.

We are writing to share some of our experience with both the Outreach and Education grant and the Enrollment Entity program and hopefully provide some helpful feedback and recommendations. We will first share our outcomes to date, then address the areas of: effective partnerships; administrative, training and marketing concerns that prevent us from even greater success; social media and other “push” outreach strategies; and suggestions on active outreach for utilization and retention. Finally, we will share some consumer feedback we have received.

A. Strategy and Progress to Date

Our strategies for reaching the target populations include (partial list):

- United Way programmatic work including:
 - Volunteer Income Tax Assistance (VITA) sites;
 - Schools/colleges/universities;
 - Corporate workplace campaigns,
 - 211 call center;
 - Migrant program presentations.
- Key Partnerships:
 - Enrollment entities and counselors;
 - County-level collaboratives and work groups
 - Public service offices, including Mexican Consular offices;
 - Community based organizations such as employment and housing centers;
 - Migrant worker programs;
 - School districts;
 - Clinics and provider offices;
 - Churches, temples, and other faith-based organizations;
 - Colleges and universities and student groups affiliated therewith;

As of May 10, 2014, United Ways of California (UWCA) and our 11 United Way subgrantees employ 20 certified educators (CEs), equivalent to 8 FTEs, and use the talents of additional certified volunteer educators to accomplish our goals. To date we have conducted: 860 events, 295,406 outreach exchanges, 29,562 education sessions, and made 14,504 referrals, 44% percent of our original goals. In addition, other UWCA-member local United Ways not participating in our grant are part of regional grants or part of the community outreach network.

Also, UWCA has become a Certified Enrollment Entity (CEE) and currently has 9 Certified Enrollment Counselors (CECs) located in Stanislaus, Merced, Fresno, Tulare, Ventura, Kern and San Diego counties.

B. Partnerships

We have found working with partners to be a particularly effective strategy for achieving our goals. Most counties meet together with other grantees to plan events and share the work. In addition we have successfully coordinated with Young Invincibles around social media outreach. Teams consisting of certified educators, certified enrollment counselors, and certified county workers attend events together to educate and enroll people in an “assembly line” type of support. For example, our certified educators in Riverside attend weekly events at the Mexican Consulate and educate more than 1,300 people on average per week. Another example is in Tulare County where our United Way staff has developed strong relationships with CECs who they can seamlessly do a soft handoff to for enrollment. Consumers have been appreciative of being given a name and even hours and helped with connecting to them.

However, it took time to cement these partnerships. Had grantee meetings facilitated by Covered California happened earlier in the grant period as we were told they would, partnerships likely would have developed earlier. Partnership is a strategy to encourage more as we all proceed.

Going forward, we would recommend RHA and Covered California help encourage such partnerships and ask their grantees to show evidence of how they are working with others in the same geographic regions.

C. Administration: Training, GPAS, Marketing Outreach Materials

We are very impressed with Richard Heath & Associates (RHA) and the level of support they have provided. RHA staff is responsive and comfortable dealing with the change. They actively work to improve systems, and are good problem solvers.

Although all of us - Covered CA, RHA and grantees - were working with a nearly impossible timeline to create a new program with multiple elements, many necessary changes have been made that help grantees be more successful. Both the GPAS & IPAS systems are evolving but still need much more work to consistently and efficiently track and manage activities and outcomes. Further changes to streamline systems will be required, as we however, to enable grantees to be more effective while still maintaining accountability.

Challenges and recommendations:

1. Training: The first rounds of O&E training lacked an accurate, meaningful component on Medi-Cal and how to handle consumers who could be eligible for it. While we continue to be focused on QHP outreach and enrollment, the dynamics of dealing with real families and requirements of good customer service demand our staff be able to answer specific Medi-Cal questions and serve the whole family.

Recertification is due to begin this summer. The certification process needs to be available online or by webinar for new staff and volunteers, especially in the absence of additional funding for travel to in-person trainings. UWCA has identified several areas that need enhancement:

- a. More focus is needed on the availability and importance of selecting pediatric dental coverage.

- b. A section on the CalHEERS application process would benefit all certified staff, no matter what role they play. Even though some do not conduct enrollments, an abbreviated version of the training enrollment counselors receive would be beneficial and should be included.

Finally, as the training material is finalized, health policy experts should vet all materials before they are distributed to ensure accuracy. In the initial training this did not happen and there were several errors.

2. **GPAS:** Though we foresaw that we would need to add events and activities to our plan, we did not anticipate such a high number of requests. (Many additional community events and requests for presentations could not have been included in the original workplans, and we work to be responsive and attend as many events as possible.) We did not anticipate, however, how the peculiarities of GPAS would so greatly add to our administrative burden, which detracts from the effort to connect people to coverage. GPAS should add an Excel upload function to streamline reporting, and also add a recurring activities function so that activities can be more quickly and easily added. Additional upgrades to make GPAS more efficient and require less time for data entry would be helpful in allowing grantees to put more effort into increasing production while still complying with grant reporting requirements.
3. **CEE Program:** We have nine CECs with some starting to submit applications in February. As of May 15th, we had received our first reimbursement check for what we assume are eight enrollments. Not documentation accompanied the check and as of this writing we have RHA investigating the specifics. The lack of funds for administration of the CEE program was problematic as there were no upfront funding to get the CECs and program up and running. The IPAS system was cumbersome and inaccurate at best in the initial stages. This will hopefully be solved with a different, more integrated approach in 2015.
4. **Materials in Print Store:** With the close of open enrollment, we need new outreach materials reflecting the current eligibility rules. Producing new resources quickly as changes happen is critical for our effective outreach. (i.e. FAQs; fact sheets) The Print Store needs updated material on non-open (special) enrollment, former foster youth, future open enrollment, and other changing or important messaging.

D. Social Media, Web/Phone Conferencing and SMS “Push” Outreach

We are concerned that Covered California may be underestimating the potential for social media to catalyze enrollments. More narrowly, we are concerned that our reach is understated in the way it is permitted to be counted. Every month, UWCA creates an editorial calendar for daily social media that we share with local United Ways. When our entire network sends the same message, we conservatively estimate that our collective reach through Facebook, Twitter and Instagram totals over one million people, though some may be duplicated. We estimate our social media messages about Covered California reach an average of 100,000 views each month, just with UWCA and the 11 local United Ways (LUWs) serving as subgrantees, and many more when the messaging is posted by our other United Way members.

Challenges and recommendations:

1. Social Media Reach: We are currently reaching more people on social media than we are able to report in GPAS. Our reach exceeds 100,000 per month, but counting only the number of link clicks and followers, as instructed, does not reflect the true reach and impact of our social media efforts. Counting only user link clicks, followers and shares/retweets does not give an accurate picture of the total impressions or reach, as evidenced by the Sprout Social report uploaded in GPAS monthly. We are willing to work with Covered California to determine a more accurate method of tracking social media outreach.
2. Accurate Tracking: Activities have sometimes reached a larger number of people than the limits of the reporting requirements indicated. For example the number of people educated during our tele-town hall with Representative Sanchez would have been more accurately reported as the total 3000 people on the phone, rather than only 1500 of the participants. Our CE was invited into the Congresswoman's office and asked to present for 15 minutes and then answer questions. Thirteen people asked questions that helped educate the entire 3000. The Congresswoman's office carefully tracks and documents exactly how many constituents are listening on the phone. We feel the total participants on the call would be the accurate number to use for outreach and education.
3. SMS Text Messaging: UWCA has begun pilot testing an SMS text messaging system with existing programmatic clients at one United Way. The pilot includes both in-reach to current United Way programs and outreach about additional resources the recipients may find helpful, with no more than two text messages per month. In the first two months, the program has had a very low "opt out" rate of only 3%. Our outreach staff is starting to gather information for new contacts separately from our Covered California outreach, using a separate, voluntary "opt-in" form. This will allow us to easily follow up and ensure families are successfully enrolled and educate them about utilization.

Based on our experience so far, and the sound research about SMS strategies, SMS text messaging appears to be a powerful strategy, and one we recommend be used not just for outreach, but also for promoting utilization and retention, and ensuring leads convert to enrollments.

D. Consumer Education on Utilization and Retention

Covered California and its grantees have learned that many consumers require numerous touches in order to enroll. A similar level of consistent and regular effort likely will be needed after enrollment to encourage utilization and retention. While the health plans are charged and contracted to do this, we know that many who have used health coverage rarely or not at all in the past, will need consistent reminders and education about preventive care, choosing a doctor, and even how to utilize their coverage. We believe it would be a mistake to rely solely on the health plans to drive renewal and utilization.

Challenges and recommendations:

1. Renewal: From our experience with the Healthy Families Program, we know that many consumers tended to return to same Certified Application Assistor that enrolled them initially when they received their renewal notices in the mail. We feel that CEs and CECs should be encouraged to provide outreach and education on utilization, which will lead to higher rates of renewal. If consumers use their

coverage and take advantage of preventive care, we know they will be more likely to find value in the coverage and renew.

2. Customer Service: Consumers are already returning to our CEs/CECs for support, including questions regarding the application or enrollment process and even technical support, such as cases where they find themselves locked out of online application. We hope future expectations of and support for CEs and CECs will acknowledge the time spent on this customer service.

E. Feedback from Consumers

Below are a few observations from Covered California customers:

1. In general, people are pleased with the subsidies available to them and they are happy that they can get the one-on-one local assistance. One story told by our outreach staff was of Maria Coleman from Irvine (Orange County), a previous cancer patient, was paying over \$1,400 per month for coverage, and now pays \$118 a month through a Covered California health plan.
2. While, luckily, complaints and objections about political opinions regarding the Affordable Care Act has lessened considerably, we now hear negative comments about the time it took to reach the call center for help. This has been alleviated somewhat by having the local, on the ground help.
3. Due to changes in some requirements and timeframes, some businesses are delaying choosing their options for providing health coverage for employees, creating employee confusion and unhappiness. Consumers are telling outreach staff that they were under the impression that they could shop on the CC marketplace and get a subsidy if they opted out of their employer sponsored health plan, which is true in only some cases. Much work needs to be done with companies so that employees have the correct information about what their options are and what they may be eligible for.

Two final notes on Open Enrollment 2014 and beyond: While we are aware that Covered California will be aligned with the federal open enrollment period, we hope that decisions on the next phase of outreach, education and enrollment efforts will be made no later than late summer 2014. We understand that Covered California is considering combining CEs and CECs into one cohesive program, and we support that. (Covered California has different programs today driven by different funding streams, federal versus state versus foundation, and the rules for each thus far have not supported an integrated program.) At a minimum, we hope going forward that all CEs and CECs are cross-trained, even if they don't perform both roles on a regular basis. This would serve the consumers best and be useful to the CEs and CECs. However, if a grantee wants to remain focused and is successful performing just one specific role, then Covered California could require evidence of partnerships at the local level to enable the consumer to be connected to enrollment assistance directly and seamlessly, such as through joint events with CEs and CECs or soft handoffs.

We understand Covered California is still in the planning stage of designing a next round of funding for an assisters program, and that an RFP likely will be issued late this summer. We encourage Coverage California to move as quickly as possible to ensure that those O&E grantees fortunate enough to continue to partner with Covered California, will not lose trained, experienced and certified CEs and CECs due to uncertainty about what may happen when their current funding ceases in December.

We hope that this feedback is helpful as Covered California plans for the future of the consumer assistance programs. As always, we would be pleased to discuss these ideas and comments further and assist with your planning efforts.

Very truly yours,

A handwritten signature in blue ink that reads "Peter Manzo". The signature is written in a cursive style with a large initial "P" and "M".

Peter Manzo, President and CEO
United Ways of California

C.C. Sarah Soto-Taylor
Dr. Robert Ross
Kimberly Belshé
Susan Kennedy
Paul Fearer
Secretary Diana S. Dooley



Nonprofit Publisher
of Consumer Reports



May 20, 2014

Diana Dooley, Chair
Covered California Board

Peter Lee, Executive Director
Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

Re: Proposed Regulation on Special Enrollment Periods: Oppose Unless Amended

Dear Ms. Dooley and Mr. Lee,

Health Access, Consumers Union, and Western Center on Law and Poverty are opposed to the proposed regulation on special enrollment periods unless further amended to continue to allow self-attestation until electronic verification is operational.

Our organizations have spent considerable time and effort working with your staff and with the health plans. We have met numerous times. We have also met with the Department of Managed Health Care. We have inquired of our colleagues in other states. We have consulted at the national level as well. We recognize and appreciate the work that Covered California and the contracting plans have committed to sorting out workable alternatives for consumers. We also recognize the shared commitment of all parties to maximizing enrollment in coverage and minimizing gaps in coverage.

Covered California Sole Judge of Eligibility of Consumer for Enrollment

We acknowledge that under both federal and state law, Covered California is the sole judge of whether an individual consumer is eligible to enroll in the individual exchange. We further acknowledge that Covered California may terminate eligibility for enrollment in a QHP if a consumer fails to meet the requirements for eligibility. We begin with these two critical points because there has been confusion about whether it is Covered California or its contracting carriers which are responsible for eligibility determinations: it is clear that Covered California has the sole responsibility for eligibility determinations, not contracting carriers.

Special Enrollment Periods Vital to Success of Covered California

Enrollment during special enrollment periods will be a significant source of new enrollment in exchanges. Estimates of income volatility indicate that about half of the new enrollment will occur at special enrollment periods. These estimates are based on income volatility which is strongly correlated with life change events that are the triggers for special enrollment periods. For this reason, the proposed regulations are important to the viability of Covered California: unduly impeding enrollment during special enrollment periods will unnecessarily undermine overall enrollment. Impeding enrollment will also worsen the risk mix because only those who need coverage most will persevere through an enrollment gauntlet. Young adults are more likely to experience special enrollment events than any other age group: more likely to move, get married, change jobs or have other life changes that trigger special enrollment events: disproportionately deterring the enrollment of young adults would also undermine the risk mix.

Existing Regulations: Consumer Attestation Sufficient

The existing Covered California regulations provide for attestation by the consumer for eligibility for special enrollment periods. We support these regulations. These regulations do not impose barriers to enrollment on consumers or impose administrative burdens on Covered California. The existing Covered California regulations are consistent with both federal regulations and the practice of the federal Marketplace which also relies on self-attestation.

Enrollees will need to reconcile whatever they told Covered California with what they tell the Internal Revenue Service. If a consumer tells Covered California they got married or divorced or lost their job or moved, that information will also be subject to audit by the Internal Revenue Service. This applies even more strongly to the 90% of enrollees in subsidized coverage since the Internal Revenue Service will "reconcile" the subsidy amount on the household tax return for the tax year. This fact means that another government agency uses its own processes to verify triggers for special enrollment periods. This separate verification by the Internal Revenue Service exists today and applies even in those instances in which Covered California relies on the self-attestation of the consumer.

Proposed Regulations: Oppose Unless Amended

The proposed regulations would create additional barriers to enrollment by requiring verification of the enrollee's self-attestation. The proposed regulations would also create significant additional administrative burden on Covered California.

We understand from speaking with Covered California staff that producing documentation would only be required where electronic data sources were insufficient to verify the asserted special enrollment period. Specifically this would apply only in the case of five specific types of special enrollment periods and we offer amendments to

clarify this point. We also appreciate that the proposed regulations would rightly allow an enrollee who has attested as qualifying for one of those five types of special enrollment periods to enroll upon attestation and then the regulation gives the consumer the 90-day period to produce documentation. However, as discussed below, this requirement should only begin when electronic data sources are available for the five types of special enrollment triggers listed in the proposed regulations and the electronic data sources fail to verify the event attested to by the consumer.

Use of Electronic Data Sources

We do not oppose the use of electronic data sources to verify the applicant's attestation. However, even the use of electronic data sources will impede and delay enrollment as well as create administrative burdens on Covered California.

As we know from Medi-Cal and other programs, matching of databases is harder in practice than in theory. Even when database matching works well, inevitably errors or mismatches occur which may appear to disqualify a consumer who is in fact qualified to enroll.

Time lags also occur: for example, reporting of deaths and marriages by counties to the state lags some weeks after the event. This is precisely why federal regulations and Covered California's own regulations provide for a reasonable opportunity period to reconcile and resolve discrepancies.

Some of the data sources to verify the information provided by individuals are anticipated to be available later this year. These include the California Department of Public Health vital statistics database which includes deaths and public marriages. In addition, CalHEERS is on track to link later this year to the Department of Motor Vehicles which uses the United States Postal Service database to verify permanent moves. The Employment Development Department has since 1935 collected information on wages paid in order to administer unemployment compensation: personal income tax withholding is administered by this department (along with other payroll taxes): for this reason, EDD is a data source for loss of employment. Our understanding is that EDD cannot verify data in real-time but does so on an overnight batch basis and that there are some reporting lags on wage data. Again, the reason why federal regulations and Covered California regulation provide for a reasonable opportunity period is so that people get coverage while the verification of eligibility proceeds. Because of the challenges faced by the judicial branch in developing statewide computer capacity, we do not anticipate that there will be electronic data sources for divorces or dissolution of domestic partnership in the foreseeable future. For the other four trigger events listed in the amended regulations, we anticipate that electronic data sources will be available sometime during 2014.

Documentation Requirement: Enrollment Grinds to a Halt?

While use of electronic data sources to verify an applicant's or enrollee's attestation is not our first choice, it can be a workable alternative. What is not workable is requiring enrollees to produce documents in order to apply for coverage. This could bring enrollment for special enrollment periods to a grinding halt. California has had recent experience with this as it required paper documents to verify residency for the Medi-Cal program: literally hundreds of thousands of cases were backlogged. Even with the suspension of this policy, as of this date the backlog has not yet been sorted through. We fear similar backlogs for Covered California if the proposed regulation moves forward as drafted, requiring documentation before electronic data sources are available.

Requiring applicants to produce documents is a barrier for applicants and an administrative burden for Covered California. Unlike the Medi-Cal program, Covered California does not have offices in every county in California. While an applicant for Medi-Cal can go to the county human services department, Covered California lacks this administrative capacity. Requiring applicants to convert documents to a PDF creates another hurdle for the applicant and administrative burden for Covered California to review the document to determine whether it matches the applicant's attestation.

Self-Attestation until Electronic Data Sources Available Later this Year

Our proposal is simple: Covered California should continue to accept self-attestation until electronic data sources are available. We reasonably anticipate that electronic data sources for four of the five listed trigger events will be available before the end of 2014 and perhaps earlier than that.

Signing up for health coverage is not a simple process. Customer service during the initial open enrollment period was not acceptable by anyone's standards, including your own. Creating barriers to enrollment by requiring documents will impede consumer participation and undermine Covered California's efforts to bring service to acceptable levels. Continuing self-attestation until electronic data matching can be brought on-line will give Covered California the opportunity to provide consumers the responsive and helpful service that we all agree consumers have a right to expect. Self-attestation would not continue indefinitely: indeed for several of the identified trigger events it would not last for even six months.

We are also mindful of the service backlogs at contracting carriers: these appear to have been considerable. Indeed one of us has directly experienced service backlogs now extending almost four months. In this context, allowing a few more months of self-attestation for trigger events seems like a sensible transition step while requiring documentation is counter-productive to the shared goals of Covered California, its contracting plans and the consumers who are rightly eligible for coverage.

For all of these reasons, we oppose requiring documentation and support continued reliance on attestation by the consumer until electronic data sources become available later this year.

Sincerely,

Consumers Union
Health Access California
Western Center on Law & Poverty

§ 6504. Special Enrollment Periods.

(a) A qualified individual may enroll in a QHP, or an enrollee may change from one QHP to another, during special enrollment periods only if one of the following triggering events occurs:

(1) A qualified individual or his or her dependent loses MEC, as specified in subdivision (b) of this section.

(A) If loss of MEC occurs due to a QHP decertification, the triggering event is the date of the notice of decertification as described in 45 CFR Section 155.1080(e)(2).

(B) In all other cases, the triggering event is the date the individual or dependent loses eligibility for MEC.

(2) A qualified individual gains a dependent or becomes a dependent through marriage or entry into domestic partnership, birth, adoption, placement for adoption, or placement in foster care.

(3) A qualified individual, or his or her dependent, who was not previously a citizen, national, or lawfully present individual gains such status.

(4) A qualified individual's, or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange shall, on a case-by-case basis, take necessary actions to correct or eliminate the effects of such error, misrepresentation, or inaction.

(5) An enrollee, or his or her dependent, adequately demonstrates to the Exchange, as determined by the Exchange on a case-by-case basis, that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

(6) An enrollee, or his or her dependent enrolled in the same QHP, is determined newly eligible or ineligible for APTC or has a change in eligibility for CSR.

(7) An individual, or his or her dependent, who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC because such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B-2(c)(3), including as a result of his or her employer discontinuing

or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage. The Exchange shall permit an individual who is enrolled in an eligible employer-sponsored plan and will lose eligibility for qualifying coverage in an eligible employer-sponsored plan within the next 60 days to access this special enrollment period prior to the end of his or her existing coverage, although he or she shall not be eligible for APTC until the end of his or her coverage in an eligible employer-sponsored plan.

- (8) A qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move. This event shall also apply to individuals who are released from incarceration.
- (9) A qualified individual who is an Indian, as defined in Section 6410 of Article 2 of this chapter, may enroll in a QHP or change from one QHP to another one time per month.
- (10) A qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS and as determined by the Exchange on a case-by-case basis, that the individual meets other exceptional circumstances. Such circumstances include, but are not limited to, the following:
 - (A) If an individual receives a certificate of exemption for hardship based on the eligibility standards described in 45 CFR Section 155.605(g)(1) for a month or months during the coverage year, and based on the circumstances of the hardship attested to, he or she is no longer eligible for a hardship exemption within a coverage year but outside of an open enrollment period described in Section 6502, the individual and his or her dependents shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.
 - (B) If an individual with a certificate of exemption reports a change regarding the eligibility standards for an exemption, as required under 45 CFR Section 155.620(b), and the change resulting from a redetermination is implemented, the certificate provided for the month in which the redetermination occurs, and for prior months, remains effective. If the individual is no longer eligible for an exemption, the individual and his or her dependents shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.
 - (C) If a child who has been determined ineligible for Medi-Cal and CHIP, and for whom a party other than the party who expects to claim him or her as a tax dependent is required by court order to provide health insurance coverage for the

child, the child shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

- (11) The Exchange determines on a case-by-case basis that a qualified individual or enrollee, or his or her dependent(s) was not enrolled in QHP coverage; was not enrolled in the QHP selected by the qualified individual or enrollee; or is eligible for but is not receiving APTC or CSR as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. For purposes of this provision, misconduct includes, but is not limited to, the failure of the non-Exchange entity to comply with applicable standards under this title, or other applicable Federal or State laws, as determined by the Exchange.
- (12) Any other triggering events listed in the Health and Safety Code Section 1399.849(d)(1) and the Insurance Code Section 10965.3(d)(1).

(b) Loss of MEC, as specified in subdivision (a)(1) of this section, includes:

(1) Loss of eligibility for coverage, including but not limited to:

(A) Loss of eligibility for coverage as a result of:

1. Legal separation,
2. Divorce or dissolution of domestic partnership,
3. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan),
4. Death of an employee,
5. Termination of employment,
6. Reduction in the number of hours of employment, or
7. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) Loss of eligibility for coverage through Medicare, Medi-Cal, or other government-sponsored health care programs, other than programs specified as not MEC under 26 CFR Section 1.5000A-2(b)(1)(ii);

(C) In the case of coverage offered through an HMO or similar program in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

- (D) In the case of coverage offered through an HMO or similar program in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
 - (E) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
 - (F) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.
- (2) Termination of employer contributions toward the employee's or dependent's coverage that is not COBRA continuation coverage, including contributions by any current or former employer that was contributing to coverage for the employee or dependent; and
 - (3) Exhaustion of COBRA continuation coverage, meaning that such coverage ceases:
 - (A) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
 - (B) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or
 - (C) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.
- (c) Loss of MEC, as specified in subdivision (a)(1) of this section, does not include termination or loss due to:
 - (1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or
 - (2) Termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with a plan.

(d) A qualified individual or an enrollee shall attest that he or she meets at least one of the triggering events specified in subdivision (a) of this section. Unless otherwise specified in (e), the exchange shall accept a qualified individual's or an enrollee's attestation without further verification.

(e) For the events listed in (e) (3), The Exchange shall verify the ~~accept a~~ qualified individual's or ~~an the~~ enrollee's attestation provided in accordance with subdivision (d) of this section without further verification. in accordance with the following process:

(1) The Exchange shall use the data obtained through available electronic data sources to verify the applicant's or the enrollee's attestation. Until such time as electronic data sources are available to verify an attestation, the exchange shall accept the applicant or enrollee's attestation without further verification.

(2) The Exchange shall request the applicant or the enrollee to provide additional documentation to support the attestation, in accordance with the procedures specified in Section 6492, if The applicant's or the enrollee's attestation is not reasonably compatible with the information obtained through the data sources described in subdivision (e)(1) of this section, other information provided by the applicant or the enrollee, or other information in the records of the Exchange. or

(3) The verification process described in subdivision (e) shall only apply to the following triggering events for a special enrollment period: ~~The data sources described in subdivision (e)(1) of this section are unavailable to verify the applicant's or the enrollee's attestation regarding any of the following:~~

1. Marriage or entry into domestic partnership;
2. Loss of MEC due to death of the employee or the primary subscriber;
3. Loss of MEC due to divorce or dissolution of domestic partnership;
4. Loss of MEC due to termination of employment or reduction in the number of hours of employment; or
5. Permanent move into or within the State that results in gaining access to new QHPs.

(f) A qualified individual or enrollee shall have 60 days from the date of one of the triggering events specified in subdivision (a) of this section to select a QHP.

(g) Except as specified in subdivision (h) of this section, regular coverage effective dates for a special enrollment period for a QHP selection received by the Exchange from a qualified individual:

- (1) Between the first and fifteenth day of any month, shall be the first day of the following month; and
 - (2) Between the sixteenth and last day of any month, shall be the first day of the second following month.
- (h) Special coverage effective dates shall apply to the following situations.
- (1) In the case of birth, adoption, placement for adoption, or placement in foster care:
 - (A) The coverage shall be effective on the date of birth, adoption, placement for adoption, or placement in foster care; and
 - (B) APTC and CSR, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.
 - (2) In the case of marriage or entry into domestic partnership, or in the case where a qualified individual loses MEC, as described in subdivision (a)(1) of this section, the coverage and APTC and CSR, if applicable, shall be effective on the first day of the following month.
 - (3) In the case of a qualified individual or enrollee eligible for a special enrollment period described in subdivisions (a)(4), (a)(5), (a)(10), or (a)(11) of this section, the coverage shall be effective on an appropriate date determined by the Exchange on a case-by-case basis based on the circumstances of the special enrollment period and in accordance with guidelines issued by HHS. Such date shall be either:
 - (A) The date of the event that triggered the special enrollment period under subdivisions (a)(4), (a)(5), (a)(10), or (a)(11) of this section; or
 - (B) In accordance with the regular effective dates specified in subdivision (g) of this section.
- (i) A qualified individual's coverage shall be effectuated in accordance with the coverage effective dates specified in subdivisions (g) and (h) of this section if:

- (1) The individual makes his or her initial premium payment in full, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the premium payment due date, as defined in Section 6410 of Article 2 of this chapter; and
- (2) The applicable QHP issuer receives such payment on or before such due date.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.420.

§ 6506. Termination of Coverage in a QHP.

10 CA ADC § 6506 BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness

Title 10. Investment

Chapter 12. California Health Benefit Exchange

Article 5. Application, Eligibility, and Enrollment Process for the Individual Exchange

10 CCR § 6506

§ 6506. Termination of Coverage in a QHP.

(a) An enrollee may terminate his or her coverage in a QHP, including as a result of the enrollee obtaining other MEC, with at least a 14-day notice to the Exchange.

(b) The Exchange may initiate termination of an enrollee's coverage in a QHP, and shall permit a QHP issuer to terminate such coverage, provided that the issuer makes reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating coverage for such individuals, under the following circumstances:

(1) The enrollee is no longer eligible for coverage in a QHP through the Exchange;

(2) The enrollee fails to pay premiums for coverage, as specified in subdivision (c) of this section, and:

(A) The three-month grace period required for individuals receiving APTC specified in subdivision (c)(2) of this section has been exhausted, as described in subdivision (c)(4) of this section; or

(B) Any other grace period required under the State law not described in subdivision (b)(2)(A) of this section has been exhausted;

(3) The enrollee's coverage is rescinded by the QHP issuer because the enrollee has made a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan, in accordance with 45 CFR Section 147.128;

(4) The QHP terminates or is decertified as described in 45 CFR Section 155.1080; or

(5) The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period in accordance with Sections 6502 and 6504.

(6) The enrollee has exhausted the reasonable opportunity period provided under Section 6492 and has been determined by the Exchange to be ineligible for enrollment in a QHP through the Exchange.

(c) In the case of termination of enrollee's coverage due to non-payment of premium, as specified in subdivision (b)(2) of this section, a QHP issuer shall:

(1) Provide the enrollee, who is delinquent on premium payment, with notice of such payment delinquency;

(2) Provide a grace period of three consecutive months if an enrollee receiving APTC has previously paid at least one full month's premium during the benefit year;

(3) During the grace period specified in subdivision (c)(2) of this section:

- (A) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period;
 - (B) Notify the Exchange and HHS of such non-payment;
 - (C) Notify providers that the enrollee is in the grace period; and
 - (D) Continue to collect APTC on behalf of the enrollee from the IRS.
- (4) If an enrollee receiving APTC exhausts the three-month grace period specified in subdivision (c)(2) of this section without paying all outstanding premiums:
- (A) Terminate the enrollee's coverage on the effective date described in subdivision (d)(4) of this section, provided that the QHP issuer meets the notice requirements specified in subdivision (e)(1) and (2) of this section; and
 - (B) Return APTC paid on behalf of such enrollee for the second and third months of the grace period.
- (d) If an enrollee's coverage in a QHP is terminated for any reason, the following effective dates for termination of coverage shall apply.
- (1) For purposes of this subdivision, reasonable notice is defined as 14 days from the requested effective date of termination.
 - (2) In the case of a termination in accordance with subdivision (a) of this section, the last day of coverage shall be:
 - (A) The termination date specified by the enrollee, if the enrollee provides reasonable notice;
 - (B) Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice;
 - (C) On a date on or after the date on which the termination is requested by the enrollee, subject to the determination of the enrollee's QHP issuer, if the enrollee's QHP issuer agrees to effectuate termination in fewer than 14 days, and the enrollee requests an earlier termination effective date; or
 - (D) If the enrollee is newly eligible for Medi-Cal or CHIP, other than the restricted Medi-Cal coverage of pregnancy-related services specified in 26 CFR Section 1.5000A-2(b)(1)(ii)(C), the day before such coverage begins. For purposes of this paragraph, the enrollee's Medi-Cal or CHIP coverage shall begin no earlier than the first day of the first full calendar month beginning after the enrollee's approval for Medi-Cal or CHIP, in accordance with 26 CFR Section 1.36B-2(c)(2)(iv).
 - (3) In the case of a termination in accordance with subdivision (b)(1) of this section, the last day of QHP coverage shall be the last day of eligibility, as described in Section 6496(k) through (n) unless the individual requests an earlier termination effective date per subdivision (a) of this section.
 - (4) In the case of a termination in accordance with subdivision (b)(2)(A) of this section, the last day of coverage shall be the last day of the first month of the three-month grace period.
 - (5) In the case of a termination in accordance with subdivision (b)(2)(B) of this section, the last day of coverage shall be consistent with existing California laws regarding grace periods.
 - (6) In the case of a termination in accordance with subdivision (b)(5) of this section, the last day of coverage in an enrollee's prior QHP shall be the day before the effective date of coverage in his or her new QHP.

(7) In the case of a termination due to the enrollee's death, the last day of coverage is the date of death.

(e) If an enrollee's coverage in a QHP is terminated in accordance with subdivision (b)(1), (2), and (3) of this section, the QHP issuer shall:

(1) Provide the enrollee with a written notice of termination of coverage that includes the reason for termination and the notice of appeals right, in accordance with the requirements specified in Section 6604 of Article 7 of this chapter, within five business days from the date of the termination;

(2) Notify the Exchange of the termination effective date and reason for termination; and

(3) Maintain electronic records of termination of coverage, including audit trails and reason codes for termination, for a minimum of ten years.

(f) If an enrollee's coverage in a QHP is terminated for any reason, the Exchange shall:

(1) Send termination information to the QHP issuer within three business days from the date of the termination;

(2) Send termination information to HHS promptly and without undue delay, in the manner and timeframe specified by HHS; and

(3) Retain records of termination of coverage in order to facilitate audit functions.

(g) The Exchange shall provide an opportunity at the time of plan selection for an enrollee to choose to remain enrolled in a QHP if he or she becomes eligible for other MEC and the enrollee does not request termination in accordance with subdivision (a) of this section. If an enrollee does not choose to remain enrolled in a QHP in such a situation, the Exchange shall initiate termination of his or her coverage upon completion of the redetermination process specified in Section 6496.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 CFR Sections 155.430 and 156.270.

HISTORY

1. New section filed 9-30-2013 as a deemed emergency pursuant to Government Code section 100504(a)(6); operative 9-30-2013 (Register 2013, No. 40). A Certificate of Compliance must be transmitted to OAL by 4-1-2014 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 4-1-2014 as deemed emergency pursuant to Government Code section 100504(a)(6); operative 4-1-2014 (Register 2014, No. 14). A Certificate of Compliance must be transmitted to OAL by 6-30-2014 or emergency language will be repealed by operation of law on the following day.

This database is current through 5/2/14 Register 2014, No. 18

10 CCR § 6506, 10 CA ADC § 6506

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May 21, 2014

Secretary Diana Dooley

Peter Lee, Executive Director
Covered California
1601 Exposition Boulevard
Sacramento, CA 95815

Re: Identity Proofing

Dear Ms. Dooley and Mr. Lee:

Our organizations appreciate Covered California delaying the implementation of the additional identity proofing requirement and taking into account, to the extent possible, the potential barriers to accessing coverage for consumers who will struggle with this additional administrative layer. We recognize both the success of Covered California in enrolling close to 1.4 million Californians into Exchange health coverage and the challenges Covered California faced in reaching vulnerable populations including Latinos, Asian Americans, Native Hawaiians and Pacific Islanders and Limited English Proficient (LEP) consumers during the first open enrollment period.

In that spirit, and without knowledge of Covered California's recommendations and proposed action for tomorrow's Board meeting, we express our concerns and share our recommendations with you on best practices as you implement the identity (ID) proofing requirement in California.

Challenges Associated with Identity Proofing:

Preliminary reporting from national consumer advocates including the Asian Pacific Islander American Health Forum (APIAHF), the National Health Law Project (NHELP) and the National Immigration Law Center (NILC) demonstrates that federal and state identity proofing has caused delays for numerous consumers. However, those delays are exacerbated for those with limited or no credit history (particularly elderly individuals, recent immigrants, and young adults). That is

because Experian, the third-party entity contracted by the federal government to perform the identity proofing function, cannot generate identity verification questions for consumers about whom there is little or no information in its database. In addition, Experian and other major credit reporting agencies are notoriously inaccurate in their data; a recent FTC report found that one in five consumers have an error in at least one of the three major agencies' reports. <http://www.ftc.gov/news-events/press-releases/2013/02/ftc-study-five-percent-consumers-had-errors-their-credit-reports> As a result such consumers must resort to other means to verify their identities in order to move forward with their applications.

Additionally, Limited English Proficient (LEP) consumers have faced major barriers when using Experian because it does not have in-language support in multiple languages. As a result Experian service representatives use the federal Call Center language line in some cases, which has resulted in very inefficient "4-way" calls with consumers (and often in-person assister with consumer), Call Center Representatives, Call Center Interpreters, and Experian Service Representatives to go through the identity verification process. This is very inefficient and a major barrier for LEP consumers who were trying to have their identity verified through Experian.

General Recommendations

Given the additional application delays related to identity proofing snags documented at the federal level, before implementing this new requirement Covered California should heed the lessons learned at the national level and in other states before implementing this requirement. We urge Covered California to:

Preserve Eligibility:

- **Allow consumers to start their applications, attaining an application "effective date" early on**, then go through the identity verification process as time permits or requires; or at a minimum **preserve a consumer's effective date of coverage from when they start the application**, regardless of how they progress through the identity proofing process.

Provide Training and Consumer Education:

- **Ensure education and outreach to applicants prior to and after opening an on-line account** clearly explaining a) the identity proofing process, b) where to go for help if they are not able to pass identity proofing and c) that there are other application portals to use if they do not have a credit history to use for identity proofing. Covered California should also **provide general information, such as FAQ's or help text, for how to get help with the identity proofing process in English or an applicant's primary language.**
- **Train assisters including Certified Enrollment Counselors (CECs), Service Center Representatives (SCRs), agents and brokers, as well as Medi-Cal eligibility staff in the counties on identity proofing**, what to do if there are problems, and which

applicants may have problems with electronic ID proofing, and what ID is allowed to prove identity.

- **Provide clear guidance and information to assisters and consumers regarding what the identity proofing process will look like for all enrollment channels:** We encourage Covered California to adopt the following protocols by application channel:
 - **By Paper:** a signature under penalty of perjury should be adequate.
 - **In-Person:** Certified Enrollment Counselors (CECs), agents and/or Plan Based Enrollers (PBEs) should be able to verify identity from the list of approved identity documents or state databases without the need for additional verification by Experian.
 - **By Phone:** Covered California Service Center Representatives (SCRs), CECs, agents or PBEs may transfer the applicant to Experian for identity proofing, but the applicant should be able to ask for SCRs to initiate a 3 way call if there were problems and otherwise be allowed to assist applicants with the identity proofing process if asked.
 - **Online:** Links to helpful FAQs or list of identification documents should be added to the first screens after account creation. An 800 number must be made available to applicants with questions. There also should be a link to an Ombudsperson to help resolve issues and complaints with the process that is language accessible. As above, **Covered California SCRs, CECs, agents and brokers should be allowed to act as intermediaries for all applicants throughout the process by phone if requested.**

Limit Barriers to Access:

- **Obtain and make public performance data on the percentages of applicants that are cleared through the Experian process and those that are not,** including disaggregated data by LEP status, before deciding whether Covered California will use the current federal process. Moving forward, Covered California should ensure there are clear metrics to gauge the success/fail rate of identity proofing of applicants and that data is shared with AB1296 stakeholders.
- **Ensure language access for ID proofing for LEP applicants.** Covered California must make sure Experian has bilingual call center staff in California's threshold languages and oral interpretation in any language. If Experian cannot guarantee language access then Covered California Service Center Representatives must be allowed to act as intermediaries throughout the process by phone or the consumer must be allowed to go to an in-person assister that speaks their language to have their identity verified.

Implement Alternatives to Federal Processes:

- **Create a state fallback process for circumstances when the federal identity proofing does not work**, e.g. do an electronic check of state data sources (such as DMV, EDD, TANF, FTB, etc.) before requiring consumers to resort to in-person identity verification.
- **Join advocates in urging HHS to expand the list of documents that consumers can use to verify identity** beyond Government issued IDs, foreign passports and ID cards to include secondary documents such as notices from public benefit programs etc. (see Appendix A from the National Immigration Law Center).

Troubleshoot Problems:

- **Ensure there is a rapid response protocol in place to make adjustments to identity proofing** where IT problems are the main barriers.
- **Create a rapid response team to address problems** that consists of consumer advocates (both health and immigrant rights organizations), representatives for the CEC, agent, and broker community.

Thank you for your consideration of these recommendations to ensure all applicants for coverage through Covered California do not suffer undue delay in effectuating coverage due to identity proofing complications.

Sincerely,

Asian Americans Advancing Justice – Los Angeles
California Pan-Ethnic Health Network
Consumers Union
Health Access
National Health Law Program
National Immigration Law Center
Western Center on Law & Poverty

Appendix A

Proof of Identity

Documents that, presented alone, are sufficient to establish identity:

- a valid unexpired US or foreign passport or passport card;
- a valid unexpired consular identification document issued by a consulate from the applicant's country of citizenship;
- a driver's license issued by a U.S. state or territory;
- an identification card issued by a federal, state or local government, including a school identification card or voter identification card;
- a U.S. military identification document, including a military dependent's identification card, a draft card or draft record, or report of military separation;
- a Certificate of Naturalization (Form N-550 or N-570) or Certificate of U.S. Citizenship (Form N-560 or N-561);
- A U.S. Coast Guard Merchant Mariner card;
- a Permanent Resident Card or Alien Registration Receipt Card (Form 1-551);
- an employment authorization document that includes a photograph (Form 1-766);
- a notice from a public benefits agency;
- a certificate of degree of Indian blood issued by United States; or
- any document issued by a foreign government that the Department determines is substantially similar to a consular identification card or otherwise establishes identity.

Documents that, in combination of two or more, are sufficient to establish identity. At least one of the documents must contain a photo:

- a foreign passport that expired within the previous 5 years;
- a consular identification document issued by a consulate from the applicant's country of citizenship that expired within the previous 5 years;
- an original or certified copy of a birth certificate;
- a marriage license or divorce decree;
- an adoption decree for the adoptee;
- a foreign federal electoral photo card
- a foreign driver's license;
- an official school or college transcript that includes the applicant's date of birth;
- a foreign school record that includes a photograph of the applicant at the age the record was issued;
- a social security card;
- an employee ID card;
- a union or worker center ID card;
- a signed lease agreement with an address that conforms to the address shown on a photo ID;
- a baptismal certificate; or
- multiple documents relating to a child but listing the applicant as the parent of a child, such as an original or certified copy of a birth certificate, adoption, school, church (e.g. baptismal),

insurance, legal, or medical records showing the applicant listed as the child's parent, as long as the document(s) provided are sufficient to show an ongoing parent or guardian relationship between the applicant and the child and include at least one document issued in the last 12 months.

Exercise of Discretion by Covered California: for individuals who, based on their individual circumstances and/or country of origin, lack the above documents:

Covered California has discretion to accept a written explanation of why the applicant is unable to provide the documents above, including the reasons why the above-described evidence of identity is not reasonably available to the applicant, along with other documents that—considered together—establish the applicant's identity.

Dear Peter V. Lee and Covered California Board,

I am writing to you regarding some of my major concerns about the 2014 increased costs of individually paid for insurance and the upcoming 2015 recalculations of these costs. Let me begin by saying that I have been (and continue to be) a big supporter of insurance for all Californians.

Determination of Premium Costs

My own insurance premiums increased by 61 percent this year. This is not only a huge increase - but from an “affordability” standpoint - the Bronze Plan is now far above the “affordable 8%” of my total income.

When I sought alternatives, such as Catastrophic Insurance, the premiums were even higher and the deductibles significantly more than the least expensive Bronze Plan. When I formally applied for a Letter of Exemption From Insurance (based on both the original cancellation and the above 8% premium costs) I never received a reply. Covered California representatives told me that I could simply take it up with the IRS at the end of the year. This did not inform me if a penalty would be exacted so I could weigh this against the financial costs of purchasing insurance.

Income, Population Density and Affordability

My first concern has been the calculation factors used to determine premium costs. Since my costs were so very high, I spoke with Covered California representatives to see if my area zip code area included some of the wealthier areas in my county - and if the average household income for the county had been skewing the premium costs upwards. I was told, “no, population density had determined this - so that the insurance companies could insure profitability based on how many people lived in the zip code”. Since I live in a lower population farming community, my premiums were higher than if I lived in a city. This algorithm for costs calculations was further confirmed by a recent discussion on the KQED News Hour about the ACA premium costs in general - where it was pointed out, that “citizens of Beverly Hills were paying lower rates than those in rural Kentucky”.

My other concern is that the cost calculator - which had a sliding scale of assistance for those “below the poverty level up to X4” – did not seem to have one for those above the poverty level. Seemingly - those who applied for insurance whose incomes were just above the cutoff mark would pay substantially higher percentages of their income than those well above it. This seemed to run counter to the original indication that the law was to provide “affordable” premiums based on the definition of an income-ratio of 8 percent to premium costs. I support subsidizing insurance for those who cannot afford insurance. I question the middle-class subsidizing insurance for those who are significantly wealthier as this uncouples the definition of “affordability” from income.

Out-of-Network Deductibles

I tried to justify that there was at least some silver-lining to the ACA as I could no longer possibly go bankrupt as there were clear ceilings on deductibles. Lately I have been following the discussion that out-of-network providers may be considered a separate deductible well above the one specified in the basic policy framework. I can certainly attempt in case of health procedures requiring teams of specialists, to try and find out if they are in-network prior to the procedure - but I worry that in case of a severe accident I may be brought to out-of-network teams of medical specialists and wake up bankrupt. This may seem extreme, but in California’s earthquake riddled environment, I may not be alone in this worry and wonder if a disclaimer bracelet could prevent administered out-of-network medical care without my express consent.

Unseen Costs

I have spoken to many “individually insured” who now have the high-premium and high-deductible insurance now considered by the industry as normal. The common thought amongst us is “do not

go to the doctor unless you are extremely ill". Even the free tests require a pre-visit and post visit - so have costs attached. Once the bottom line is looked at, those of us who have put off medical care will for sure make the program appear to be a cost effective win. But after having paid such a large portion of our income to premiums – we are in essence, without basic care. I hope you will track how many insured customers decide to put off medical attention based on the thought they have no income left to invest in care once they have paid their premiums.

Representation

On the last interview I saw President Obama speak on the Affordable Care act, he said without equivocation that "Premiums will be going up next year". Those of us who purchase our own insurance clearly have little representation in Washington. We have no lobbyists -as the businesses who buy insurance for their employees do.

It can be argued that politically, financially, and from the cost-effectiveness viewpoint - there is no reason to keep premiums at a rate closer to 8 percent for individual purchasers and deductibles reasonable so they do not trigger bankruptcies. So I ask you, since you are my most direct representatives, to consider these cost points from a fairness and moral point of view. The very name "The Affordable Care Act" should provide "affordable care" for all of its citizens. Please do not increase premiums for those of us who buy our own insurance policies in 2015. Please require of the insurance companies a more transparent interpretation of deductibles.

Respectfully,

Jane Pray-Silver

El Granada, CA 94018

May 21, 2014

Insurance Premiums Comment Received via E-mail

Subject: No out of pocket maximum on health "insurance"

May 21, 2014

Dear Covered California Board Members:

My family has purchased health insurance privately for years because my husband and I are self-employed. Anthem Blue Cross cancelled our policy because they stated it was not ACA-compliant. They offered us a compliant policy with a monthly charge of \$1417 as opposed to our old family plan of \$632. That was a no go for us.

So I purchased a Blue Shield bronze family plan from CoveredCA, making sure (the joke's on me I guess) that my son, who attends college in another county, would be covered. When I inquired about this in February to Blue Shield because my son had been hit by a car while bicycling to campus, I was surprised to learn that he was considered "out of network." This was not the information I relied upon from the plan's description on the CoveredCA website last fall.

Blue Shield then followed up with this 4/18/2014 letter that states in part:

"Thank you for choosing Blue Shield. We recently identified an error in the Exclusive Provider Organization (EPO) plan benefit summary that you may have received prior to applying for coverage.

The Benefit summary indicated that BlueCard out-of-area coverage when travelling outside of the service area was included for both non-emergency and emergency services. This is incorrect; only coverage for emergency services is covered when outside of the service area in an EPO plan.

The benefit description in your contract (Evidence of Coverage) is correct. ...

We apologize for this error. We thank you for the opportunity to serve you."

So, I am now in a position of a son at college who is completely without health insurance, except for medical emergencies AS DEFINED BY BLUE SHIELD. Our family has no right to move to a Kaiser policy until November (which seems the only way to avoid out of network costs) and I am stuck with a completely useless policy that exposes me and my family to potentially infinite medical bills because there is NO out of pocket maximum for out of network costs on Blue Shield Bronze EPO plans. Meanwhile Blue Shield is allowed to change the terms of the policies they offer after the fact. Policy holders have no protection from Blue Shield arbitrarily changing policy terms, network participants, or definitions of medical emergencies.

It's ridiculous to call the Blue Shield Bronze EPO policy health insurance. It exposes policy holders to potentially infinite costs, the very thing insurance is supposed to prevent. I don't believe I've ever seen such a glaring example of a public policy disaster that could have been avoided with the application of due diligence, intelligence, and an actual desire to regulate and reform health care in California.

Sincerely,

Maureen Burke
peonygarden@comcast.net



May 15, 2014

Peter Lee, Director
Covered California

Submitted electronically to *info@hbex.ca.gov*.

RE: Physicians' Experiences with the New Individual Market Provider Networks and Contracting Practices of Certain QHP Issuers

Dear Mr. Lee and Members of the Board:

On behalf of our more than 39,000 members, the California Medical Association (CMA) would like to congratulate you on the successes of this inaugural open enrollment period. The tireless efforts of Covered California staff and the Board have not gone unnoticed and are truly commendable. As we transition into helping more than a million Californians use their new coverage, we anticipate that Covered California will maintain this level of gusto as we approach this new phase of implementation.

In an effort to aid Covered California and its partner qualified health plan (QHP) issuers in the critical task of ensuring Californians are able to use their new coverage, CMA would like to share information on the experiences of our member physicians with the new networks and the contracting processes used to build those networks, as well as make recommendations as to how these aspects may be improved in advance of the next benefit year.

As networks become smaller and more exclusive to a particularly payor, issues with directory accuracy and network adequacy are amplified, and the standards, monitoring, and enforcement here should adjust accordingly. Since new coverage became active on January 1, 2014, CMA has logged a rather steady stream of concerns and complaints from its members regarding the networks. Concerns from members regarding the contracts and contracting processes used to build these networks, however, began in 2012. These concerns and complaints have almost exclusively been confined to two QHP issuers, Anthem Blue Cross and Blue Shield.

In an attempt to quantify the issues being raised by our members, we conducted the attached survey, receiving over 2,300 responses in less than 48 hours – nearly doubling our previous record response rate. Notable results include the following:

- Eighty (80) percent of physicians reported confusion about their participation status in the new networks at some point;
- Fifty-five (55) percent of physicians reported difficulties in finding an in-network physician or hospital for referral of Covered California patients;
- Seventy-seven (77) percent of physicians believed that network adequacy challenges were having a potentially negative impact on patient care in their practice;
- Fifty (50) percent of those physicians participating in the new products planned to continue participating, while thirty-nine (39) percent were not sure; and

- Fifty-one (51) percent of physicians reported losing patients as a result of the new individual and small group products.

These survey results and the descriptive comments from survey respondents were consistent with CMA's trends in logged complaints and concerns, and, while we encourage members to also submit complaints to the appropriate regulator, we are unclear as to what proportion of these complaints have been formally submitted to a regulator. Covered California no longer has a dedicated channel for physicians to submit formal complaints, though we understand that Covered California's customer service team is actively managing 40-50 access issues daily.

As our survey suggests, inaccurate provider directories are having a negative impact on enrollees. Of the more than half of our survey respondents who reported losing patients, seventy-one (71) percent of those attributed that loss to patients choosing a certain QHP with the incorrect belief that the physician participated in that QHP. This translates into many patients being forced to find a new physician or seeing his or her current physician out-of-network – a frustration that appears to have spilled even into the courts. It also results in an unfair advantage by those QHPs with narrow networks over those QHPs with more robust networks and accurate directories. Though we support Covered California's policy of allowing enrollees to change plans during the open enrollment period where erroneous provider listings led to an unintended QHP selection, CMA is concerned that, once an enrollee chooses the QHP, the harm can prove difficult to resolve. An enrollee, for instance, might not have discovered that she lost access to specific providers until after open enrollment closed, or, even if she knew of the ability to switch QHPs, be willing or able to navigate the selection process once again. Furthermore, while state continuity of care provisions may provide temporary relief in some cases, this still means a transition in care to a new physician with no history with the patient and who may not best suit his or her needs. An accurate and straightforward provider directory on the front end saves patients a great deal of difficulty later.

We remain particularly concerned with indications of disruptions in longstanding doctor-patient relationships, as well as the prevalence of difficulties in finding in-network referrals for patients in these new individual and small group products. While we understand that the intentionally smaller networks of certain health plans account for some level of expected disruption, we believe other factors, which can be addressed by Covered California and regulators, are contributing to a significant proportion of reported network difficulties:

- An inability of currently used network adequacy monitoring and enforcement tools to keep pace with the rapidity with which networks are evolving;
- The lack of a reliable cross-plan provider directory;
- Inaccuracies and complexities in certain QHP issuers' searchable directories;
- The difficulties for physician practice staff to promptly identify whether a patient is covered by a mirror product (i.e., off-exchange QHP-equivalents) and whether the physician participates in that product's network;
- The use of physician group contracts to selectively contract with a fraction of the group; and
- Vague contract terms and the automatic opting-in of physicians into new networks.

To address the impact of these factors on the current state of networks in Covered California and in the broader individual and small group markets, CMA recommends:

- A regular agenda item dedicated to the topic of enrollees' access to care, network adequacy, and provider directories at future Board meetings;
- A resolution from the Board to adopt the "Potential Additional Steps" on addressing timely access to care presented in the April 17, 2014, Executive Director's Report (see attached);
- An acceleration of the timeline for providing consumers with a reliable, cross-plan provider directory to aid in the selection of QHPs;
- The development and adoption of new requirements to clearly identify mirror products and other individual and small group insurance products utilizing the QHP networks on patient identification cards and otherwise;
- Development of regulations to formalize Covered California policy allowing an enrollee to change plans when a QHP is chosen due to inaccurate directory information, as well as further regulatory provisions to require prompt corrections of erroneous directory data and to impose appropriate penalties on the QHP issuer; and
- A model contract requirement on QHP issuers that provider participation in networks used by QHPs be clearly communicated and obtained via a separate, affirmative assent.

Thank you for considering our input as we move into this critical phase of ensuring coverage means access. Dr. Rideout and his team have been very helpful in maintaining a channel of communication with the QHP issuers on the topic of networks and framing potential network issues and ways to address them. We look forward to continuing to work with the Board and staff to realize the vision of improving the health of all Californians by assuring access to affordable, high quality care.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Richard Thorp MD". The signature is fluid and cursive, with the letters "R", "T", and "M" being particularly prominent.

Richard Thorp, MD, President, CMA

Attachments: *Straightforward Contracting for a Stronger Health Care System* (9 pages); "Potential Additional Steps," *Executive Director's Report*, slide 30 (April 17, 2014).



Straightforward Contracting For a Stronger Health Care System

April 28, 2014

California's health care system is arguably undergoing its biggest period of transformation since the introduction of Medicare 50 years ago. Roughly 1.4 million Californians across the state are now covered under dozens of new health insurance products offered through the state's health benefit exchange, Covered California, and many more are now covered under new products in the broader individual market.

Coverage, however, means little without access to health care providers, and many patients covered under these new insurance products, as well as the physicians contracted with the issuers of these products, are finding it exceedingly difficult to verify which physicians and facilities are in or out of these products' networks. Since these products became active on January 1, 2014, rarely a week goes by without articles or other reports in the media about difficulties with the exchange products' provider networks.

The integrity of California's health care delivery system is being threatened by the fact that patients cannot rely on certain major health plans' lists of participating providers and that many physicians have been or remain confused about whether or to what extent they are contracted to serve patients covered under the slew of new insurance products. Many Californians are signing up for one of these new products mistakenly believing that a certain physician or physicians are in the network when they are not, and many physicians are unknowingly seeing patients in these products as an out-of-network physician, incurring higher out of pocket expenses for their patients, because they are confused about their contracting status.

Much of this uncertainty over who is in and out of the narrow provider networks is due to intentionally vague or confusing contracting practices by certain health plans, and these health plans can force physicians to accept contracts on account of the overwhelming market power they possess in the substantial majority of California.

The most egregious of these practices is the forced acceptance of "all products clauses," which are intentionally vague contract provisions that can bind a provider to participating in unspecified current and future products offered by the health plan. In California, a loophole exists in law that allows preferred provider organization (PPO) health plans, which represent a significant percentage of the California market, to make unilateral changes to a provider's contract and consider a provider's lack of response to the contract as acceptance of the changes, also known as a "silent amendment." If the change is being made to a health maintenance organization (HMO) agreement, current law states the change must first be negotiated and agreed to by the provider.

This PPO loophole has created an uneven playing field where health plans can wield their overwhelming market power over many physicians with little to no concern over fairness in contracting and without even allowing contract negotiations. With the rollout of Covered California, certain major health plans used the loophole to push many physicians unknowingly into the addition of an all products clause to their contracts. The result of such contracting practices has been mass confusion for both patients and physicians about participation status in the new products, which has led to patient access issues, loss of patients and has negatively impacted patient care in California.

To help determine the scope of these problems and the degree to which health plan contracting practices were responsible, the California Medical Association (CMA), along with the county medical societies and several medical specialty societies, conducted a survey of physicians to obtain information about their experiences with contracting for the new Covered California and related insurance products. In a period of less than two days, over 2,300 physician practices responded to the survey.

The survey results suggest that health plan contracting practices, such as all products clauses and silent amendments, are the primary contributor to the current state of network confusion by patients and providers in California. Please see the survey summary below.

Survey Summary

- * The survey gathered data from 2,337 practices representing physicians from over 30 different specialties in 46 different counties within California over a period of 2 days.
- * Eighty percent (80%) of physicians report that they were, at some point, confused about their participation status in a Covered California plan.
- * Almost 20% of physicians are still unclear about how they became a participating provider in the plan network(s).
- * More than half of the physician respondents report that their confusion about participation status was because they were automatically opted into the network without their affirmative sign on. Another 41% report they never received notice that the plan was adding them to its exchange network and, moreover, 20% report the plan mistakenly listed them as participating in the exchange network.
- * One in five doctors remains confused about their participation status in a Covered California plan.
- * Due to confusion in participation status, more than half of these physicians report they lost patients. The number one reported reason for the loss was due to the patients believing the physician participated in the plan they selected.

- * More than half of physician respondents report they have experienced difficulties finding an in-network physician or hospital to which they can refer their Covered California patients.
- * Fifty percent (50%) of physician respondents believe accepting the discounted rates for exchange patients will endanger their patients' access to, or continuity of, care. Almost a quarter of physicians (23%) report that if forced to accept patients at a discounted rate, they will either have to sell or close the practice. Eleven percent (11%) report they will have to join a larger group, and 8% will have to move the practice to another geographic area.
- * Only 12% of physicians report they will not continue to participate in exchange products, while 50% report they do plan to continue to participate.

CMA Survey – April 25, 2014, Results

Survey Results – 2,337 practices representing physicians in 46 different counties and over 30 different specialties responded to the survey.

1. Are you a participating provider with any exchange (i.e., Covered California) plans?

Yes.....50%
 No.....29%
 Not sure.....21%

2. In which exchange plans are you participating? (please select all that apply)

Anthem Blue Cross.....64%
 Blue Shield of California.....63%
 Chinese Community Health Plan.....2%
 Contra Costa Health Services.....2%
 Health Net of California.....51%
 Kaiser-Permanente.....8%
 L.A. Care Health Plan.....3%
 Molina Health Plan.....8%
 Sharp Health Plan.....5%
 Valley Health Plan.....2%
 Western Health Advantage.....4%

3. How did you become a participating provider with this plan's exchange network? (please select all that apply)

Plan automatically opted me in under the same terms as my base commercial contract.....37%
 Plan automatically opted me under different terms than my base commercial contract.....15%

I chose to accept an offer to participate from the health plan.....	18%
I unknowingly became a participating provider due to a lack of clarity in the contract offer and/or amendment to my existing contract (e.g., ambiguous product name).....	18%
I knowingly became a participating provider via a physician group affiliation (e.g., IPA).....	14%
I unknowingly came to participate via a physician group contract (e.g., IPA).....	10%
I contacted the plan expressing an interest to join its exchange network.....	4%
I am unsure how I came to participate in the exchange network.....	19%

4. Do you plan to continue participating in the exchange products?

Yes.....	50%
No.....	12%
Not sure.....	39%

5. Are you willing and able to terminate your contract for all commercial business with the health plan in order to terminate your participation in the exchange product?

Yes.....	20%
No.....	36%
Not sure.....	44%

6. What are your reasons for not joining an exchange network? (please check all that apply)

Not invited to join by plan.....	22%
Lack of capacity to accept new patients in my Practice.....	11%
Limited panel of physicians in which to refer my patients and/or limited participation by area hospitals.....	19%
Unacceptable terms offered by the plan.....	74%
Unreasonable administrative burden and costs to comply with requirements.....	47%

Comments (sample)

- Concern that by accepting lower compensation for these plans will eventually drive down others plan/product reimbursement rates, as we have experienced previously.
- Reimbursement rates are too low and the 90-day grace period puts oncology practices at unacceptable financial risk due to potentially very high drug costs.
- Reimbursement is less than my overhead costs.
- Unable to be financially solvent with fee schedule
- Restricted specialist network making it difficult to refer and coordinate care of patients.
- Plan rates are less than what I received when I first started my private practice in 1994.

- Most disturbing of all, was the lack of communication on behalf of these insurances to educate physicians about the plans that they would not be a part of in 2014 and how to identify patients with those plans before their appointments not after.
- Reimbursement levels for some plans are too low for our practice to remain viable.
- I've heard of two hour on-hold times for a PCP office to request a referral.
- Inadequate terms and no decrease in administrative burden/costs.
- We joined because we wanted to give patients access but it's been a nightmare. We are unable to verify detailed benefits and patients do not understand their plans.
- Don't like the coercive style these plans have promoted. I can only anticipate a poor future relationship because of recent Blue Shield and Blue Cross threatening phone calls. They said they would restrict access if we did not cooperate.
- We would not survive if we were forced to accept that contract.

7. If you contacted the plan to express interest in joining its exchange network, did they allow you to join?

I do not wish to participate in an exchange network.....	58%
Yes, but I am still considering my options.....	20%
Yes, but the terms of participation were unacceptable.....	17%
No, I was told the panel was full at this time.....	4%
No, I was told I have to refer to a certain hospital in which I don't have privileges in order to participate in their exchange network.....	2%

8. Were you, at any time, confused about your participation status in a Covered California plan?

Yes.....80%
 No.....20%

9. Please indicate which of the following contributed to your confusion: (please check all that apply)

Plan didn't clearly identify its exchange product in contract materials.....	56%
I was automatically opted into the exchange network without my affirmative sign-on.....	50%
I was not aware that Anthem Blue Cross and Blue Shield of California were selling narrowed networks to Covered California patients. I assumed I was part of the exchange network if I was contracted for their PPO/EPO product.....	51%
Covered California's cross-plan directory listed my participation status incorrectly.....	26%
I was given conflicting information by plan representatives about my participation status.....	27%
I was mistakenly listed as participating in the plan's exchange provider directory.....	23%
I did not receive notice that the plan was adding me to its exchange network.....	41%
Other.....	9%

10. Did you lose patients with the implementation of the exchange?

Yes 51%

No 49%

11. What is the reason for losing patients? (check all that apply)

I do not wish to participate in the exchange product 50%

**Patients thought I participated in exchange product they chose,
but they were unaware it was a narrowed network** **71%**

Patients thought I participated in exchange product they chose, because the
Covered California cross- plan directory inaccurately listed me as participating 32%

Patients thought I participated in exchange product they chose
because the health plan erroneously represented me as participating 33%

12. How many patients do you estimate you lost?

1-10 22%

11-25 31%

26-50 23%

51-100 13%

100+ 10%

13. Have you experienced difficulties finding an in-network physician or hospitals to which you can refer your exchange patients?

Yes 55%

No 45%

14. Have the challenges with network adequacy had a potentially negative impact on patient care in your practice (e.g. health complications due to lack of timely care, etc.)?

Yes 77%

No 23%

Personal stories (sample)

- Some of my patients are also undergoing cancer treatment or surveillance. They are unable to continue with their current doctors even on an out of network basis because some exchange plans do not offer out of network benefits even they are labeled as "PPO" and not "EPO". The other doctor in our office asked to be part of the exchange network and was told that they have to be invited in. He is the only specialist in the county who accepts insurance for the specific conditions he treats and his patients knew that, thus were already calling in November to see if he would be in network. Because we were not told either way, we were not able to advise them.
- Massive delay in care is hurting patients. It almost seems the network is designed to be confusing, narrow...

- Pts I have seen for years suddenly cannot see me anymore without any notification to patients. Recent surgical patients can no longer come to me as I am no longer on their plans. Prospective surgical pts are now scurrying around trying to find a participating doctor. I have no idea where to send these patients!
- Unable to find spine surgeon.
- It takes forever to get a specialist referral for some of the plans. I've had patients who couldn't get timely follow-up for rule-out ectopic, fracture care, and kidney stones.
- Difficulty finding specialists to accept my patients. I am family practice in rural area and specialists are already limited.
- Patients have to travel great distance, i.e. > 100 miles to find accepting provider.
- We have several patients each day calling to schedule appointments with our doctors as the exchange has told them we are contracted. We tried to get contracted with Blue Cross but they won't take our practice. Our current patients who had to switch Blue Cross PPO plans at the beginning of the year had no idea we would not be a preferred provider, neither did we. Very misleading. Our patients are NOT happy. Blaming our practice for not being contracted when Blue Cross would not take us.
- A patient with a distal humerus fracture had trouble finding an orthopedic surgeon who was in-network, I finally saw her almost 2 weeks after the injury and had to operate on her pro bono because waiting longer would have caused many complications, in addition, to the pain that she was having from the fracture.
- A 31 week premature baby came to my office for newborn check after recently discharged from hospital on 4/21/14. The family said they have "regular Blue Cross PPO," not a plan from Covered CA. The staff noticed the card states pathway PPO. When we called Blue Cross after waiting on the phone for over 40 minutes, Blue Cross told us we are not in-network. Family did not know what to do. We asked them to fax a provider list for this infant so we could help this family. Blue Cross rep said it would take them 2-3 days to do so. This is not acceptable! The insurance companies are selling these products without clearly telling consumers what physicians are on the provider list! Many of my established patients switched plan not aware of the "narrow network" plans. They are now responsible for the balance that health plans did not pay.
- Plans have over enrolled new patients without adequate provider networks or hospitals to care for their enrollees-it is a bait and switch.
- Patients are commenting and walking away from us, assuming it is the provider's issue, that the health plans are stating we are contracted, when we are not. Patients are insisting that because they are off the exchange (and the health plans are telling them this) that they are not covered CA and can be seen by us.
- Delays in assessments due to lack of facilities in network and confusion by plans of where to have us send patients.
- A have a number of complicated patients who may well have gaps in there care or who have had to pay out of pocket for care while they try to figure out to who they may go.
- Poor online reviews from angry patients blaming my office for not educating them enough about CC plans.
- Often patients return to emergency because they cannot get follow up appointments in a timely fashion after emergency visits or after hospital discharge. My last shift I had somebody return with CHF exacerbation that had to wait 6 weeks for a follow up after acute hospitalization for CHF.
- A cancer patient of mine who I had operated on several years ago now has a large recurrent neck cancer and was told by Blue Cross that I was a provider for his exchange plan. However I was not. This has delayed his treatment as he seeks to find another head and neck surgeon who will remove his cancerous tumor.
- These are not "narrow networks" for specialists they are "non-networks."

- Especially difficult for those in need of mental health services.
- I had a patient with breast cancer who we thought had regular PPO insurance and when we went to schedule we were told "Covered California." We had to find another facility to do surgery in. In the meantime, we were informed by the broker of the patient's insurance that it was NOT Covered California. Her surgery for breast cancer was delayed an additional month because of this.
- A child in our practice with complex congenital heart disease was forced to find a new pediatrician and had limited options for cardiology and cardiac surgery, due to the Blue Shield narrow network.

15. If you are forced to accept exchange patients or be part of the exchange network at discounted rates, how is this likely to impact your practice? (Check all that apply.)

I believe accepting the discounted rates for exchange patients will endanger my patients' access to, or continuity of, care.....	50%
I will likely have to sell or close my practice.....	23%
I will seek to integrate with or join a larger group, such as an IPA.....	11%
I will likely have to move my practice to another geographic area.....	8%
I will seek to hire non-physicians to handle a higher patient volume.....	13%
Unsure at this time.....	42%
Does not apply.....	13%
Other.....	12%

Specialty

Allergy.....	2%
Anesthesiology.....	3%
Cardiology.....	3%
Dermatology.....	4%
Emergency medicine/Trauma/Urgent Care.....	1%
Endocrinology.....	1%
Gastroenterology.....	3%
General surgery.....	3%
Infectious disease.....	1%
Internal medicine, Family Practice, General Practice.....	23%
Neurology.....	5%
Nephrology.....	1%
OB/GYN.....	5%
Oncology.....	2%
Ophthalmology.....	8%

Orthopedic surgery.....	4%
Orthopedics.....	2%
Other.....	3%
Otolaryngology.....	2%
Pain medicine.....	1%
Pathology.....	1%
Pediatrics.....	6%
Plastic & reconstructive surgery.....	1%
Psychiatry.....	3%
Pulmonary.....	2%
Radiology.....	6%
Rheumatology.....	1%
Surgery.....	1%
Urology.....	2%
Vascular surgery.....	1%

Number of physicians in practice

1.....	38%
2-5.....	29%
6-10.....	12%
11-25.....	10%
26-50.....	3%
51-100.....	2%
100+.....	5%

POTENTIAL ADDITIONAL STEPS

- Accelerate contractually required reporting regarding PCP and/or first visit status, use of preventive services and identification of at risk enrollees to Q3 2014
- Require plan demonstration of accuracy of In-Network status or enrollee access satisfaction
- Sponsor 3rd party “secret shopper” survey
- Covered California enrollee access satisfaction survey ahead of 2015 CAHPS QRS
- Standardize benefits regarding in and out of network rules and cost sharing for PPO and EPO plans; eliminate physician/hospital mismatches or require more prominent enrollee alerts

April 21, 2014

Mr. Peter Lee
Executive Director
California Health Benefit Exchange
560 J St., Suite 290
Sacramento, CA 95814

SUBJECT: 2015 Covered California Essential Community Provider Network Adequacy Standards

Dear Mr. Lee:

On behalf of Private Essential Access Community Hospitals (PEACH), I am writing to urge Covered California to seize upon an opportunity strengthen its 2015 Essential Community Provider (ECP) network adequacy standard to better ensure access to care in low-income communities statewide. PEACH remains generally supportive of Covered California's approach for the 2015 QHP recertification process, which will build on the rigorous 2013 QHP selection process and utilize the 2014 QHP solicitation as a continuing foundation for the 2015 new entrant application.

However, we believe that the March 14, 2014 Centers for Medicare & Medicaid Services' Final 2015 Letter to issuers in the Federally-facilitated Marketplaces, which established stronger ECP network adequacy standards for federally-facilitated marketplaces, provides an opportunity for Covered California to also strengthen its 2015 ECP network adequacy standard to better ensure access to care in California's low-income communities.

As the organization that represents California's community safety net hospitals, PEACH members have an average patient base that is 70 percent uninsured and government-sponsored and play a critical role in Medi-Cal managed care and Covered California plan networks.

As Covered California continues to make unprecedented inroads to expand health coverage to millions of Californians under the Affordable Care Act, community safety net hospitals will continue to be integral to California's health care safety net and provide a significant portion of care to millions of new Medi-Cal beneficiaries, serve as ECPs in Covered California plan products, and to help serve the 3-4 million remaining uninsured Californians in 2014.

In light of the March 14, 2014 federal ECP network adequacy standards, PEACH offers the following comments and recommendations for consideration by Covered California:

1) Strengthening the ECP Network Adequacy Standard

CMS's new 2015 ECP network adequacy guideline requires that plans demonstrate that "at least 30 percent of available ECPs in each plan's service area participate in the provider network" (March 14, 2014 "2015 Letter to Issuers in the Federally-facilitated Marketplaces," page 19). Issuers are also required to offer contracts in good faith to all available Indian health providers in the service area and at least one ECP in each ECP category in each county in the service area, to the extent that ECPs in each category are available.

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Private
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Hospitals,
Inc.

In contrast, Covered California’s current ECP network adequacy requirements comprise of at least 15 percent of entities in each applicable geographic region that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B); the inclusion of at least one ECP hospital in each region; and the inclusion of Federally Qualified Health Centers, school-based health centers and county hospitals (Source: Section 3.06 of the Final 2013 Covered California QHP Solicitation).

The new federal ECP standard encompasses 27 federally-facilitated exchanges with one set of guidelines to fit the diverse population and geography spanning Alaska to Maine; Florida to Montana; and Texas to Pennsylvania, and calls for ECP participation of at least 30 percent of all available ECPs in exchange plan service areas.

We urge Covered California to look to the new 2015 federal exchange standard—which increased the minimum ECP requirement threefold from its 2014 “Minimum Expectation” standard of at least 10 percent of available ECPs (April 5, 2013 “Letter to Issuers on Federally-facilitated and State Partnership Exchanges,” Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services)—as an example of how it can greatly improve upon Covered California’s ECP network adequacy standard and help ensure sufficient access to ECP providers.

Given California's extremely large population of 3-4 million remaining uninsured; 8 million Medi-Cal beneficiaries; the significant population density in urban and metropolitan areas; the number of large rural geographic regions; and the long-standing partnership between the state and safety net hospitals and their physicians and affiliated clinics to ensure access to care, we believe that Covered California should establish stronger ECP network adequacy guidelines than the new federal standard.

PEACH acknowledges and greatly appreciates Covered California’s efforts to ensure that the Exchange’s current plan networks include more than the minimum required participation of ECPs. However, the Exchange’s inadequate requirement to include at least one ECP hospital in each region continues to raise concerns about whether low-income communities will have adequate and timely access to their local safety net hospital providers. As we have noted previously, this is especially true in geographically vast counties such as Los Angeles where only two ECP hospitals are technically required in an Exchange plan network based on the minimum requirement.

We are also concerned that the Exchange plans’ tiered networks may result in ECPs having a contract but being denied the opportunity to provide care to covered Californians in their communities because they have been deemed a lower tier provider. Therefore, PEACH urges Covered California ensure that Exchange plans offer all ECPs a contract based on commercial rates, and establish higher standards for QHP network participation of ECPs.

It is critical that all residents, especially in low-income communities, have access to safety net hospitals that are their providers of choice in their community. Strengthening Covered California’s currently inadequate ECP network adequacy standards will be an important step to ensure timely and equitable access to high-quality and medically necessary services for all Californians.

PEACH Recommendation: Modify the 2015 Covered California ECP network adequacy standard to require that all available ECPs in an Exchange plan’s service area are offered contracts at prevailing commercial rates.

2) Providing Transparency of Covered California ECP Networks

We appreciate that Covered California is diligently working with its Exchange plans to resolve the numerous challenges to providing an accurate, comprehensive and consumer-friendly directory of Covered California's network providers so consumers can accurately determine if they will have access to their providers of choice in a plan's network. As part of this important work, PEACH urges Covered California to make the Exchange's ECP provider network information available to the statewide organizations that represent ECPs to help ensure accuracy of the provider information.

We greatly appreciate Dr. Jeff Rideout's April 17 presentation to the Covered California Board of Directors indicating that the exchange is further undertaking a review of network adequacy in the low-income communities our hospitals serve by assessing provider availability by zip code in vulnerable communities and "cross walking" these data with individual plan networks. As the Exchange undertakes this critical analysis and additional network adequacy evaluation, we urge you to make this information available to the statewide organizations that represent ECPs and engage them in helping communicate provider network changes and help dispel the confusion that providers have had about their own network standing. PEACH welcomes the opportunity to help Covered California provide consumers with accurate provider network information so they can make informed choices and have access to their providers of choice.

PEACH Recommendation: Engage the statewide organizations that represent ECPs in the assessment of network adequacy in low-income communities and engage them in helping to dispel ECP provider confusion about their network standing. Additionally, once they are verified, make ECP provider lists publically available by region to promote transparency of ECP networks.

Thank you for your consideration of our comments and recommendations. PEACH looks forward to continuing to work with Covered California to ensure all Californians have access to the health care they deserve. Please feel free to contact me at (916) 446-6000 should you have any questions.

Sincerely,



Catherine K. Douglas
President and CEO

CC: Diana Dooley, Chair, California Health Benefit Exchange Board
Kimberly Belshé, California Health Benefit Exchange Board
Paul Fearer, California Health Benefit Exchange Board
Susan Kennedy, California Health Benefit Exchange Board
Robert Ross, MD, California Health Benefit Exchange Board
Jeff Rideout, MD, Senior Medical Advisor, California Health Benefit Exchange