**CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD**
**June 19, 2014**
**East End Complex Auditorium**
**1500 Capitol Ave.**
**Sacramento, CA 95814**

## Agenda Item I: Call to Order, Roll Call, and Welcome

Chairwoman Dooley called the meeting to order at 10:00 a.m.

Board members present during roll call:
Diana S. Dooley, Chair
Susan Kennedy
Kimberly Belshé
Paul Fearer
Robert Ross, MD

Board members absent: None

## Agenda Item II: Closed Session

Chairwoman Dooley called the meeting to order at 12:00 p.m. A conflict disclosure was performed; there were no conflicts from the Board Members that needed to be disclosed.

## Agenda Item III: Approval of Board Meeting Minutes

After asking if there were any changes to be made, Chairwoman Dooley asked for a motion to approve the minutes from the meeting held May 22, 2014.

**Presentation:** May 22, 2014, Minutes

**Discussion:** None

**Public Comments:** None

**Motion/Action:** Board Member Ross moved to approve the May 22, 2014, minutes. Board Member Fearer seconded the motion.

**Vote:** Roll was called, and the motion was approved by a unanimous vote.

## Agenda Item IV: Executive Director's Report

**Discussion: Announcement of Closed Session Actions**
The Board approved bringing Jim Lombard on board as Chief Financial Officer. It also approved extending the contract with Ana Matosantos. Santiago Lucero will be leaving, as will Gabriel Ravel. Mr. Ravel is leaving to be General Counsel at the Department of Managed Health Care.

The Board approved an amendment to the contract with Pinnacle to allow for third party administrative services which include: IT, enrollment and billing. This will smooth out some problems agents are encountering with the SHOP. The Board updated the contract with the Pacific Business Group on Health relating to their eValu8 data. It also approved an amendment with Pacific Consulting Group which will help with the renewal process. It approved an engagement with the Taylor Feldman Group to manage the analytics RFP.

There is a wide range of reports in the Board materials on the web. Peter Lee, Executive Director, specifically mentioned the one issued by California State University on their experience of helping Covered California enroll students. They were an outreach and enrollment grantee. The percentage of uninsured students went way down across all demographics. This data provides information for strategizing and leads to new questions.

There is no July meeting, but the August meeting will be held in the new offices at 1601 Exposition Blvd.

There is no major discussion regarding continued evaluation because Covered California is keeping up with the strategies and best practices set forth in a previous Board meeting.

**Discussion: Executive Director's Update**

**Presentation:** Executive Director's Report
Mr. Lee shared slides about continuing analysis of open enrollment. They included data currently available to Covered California, and initial findings.

i. **QHP and SHOP Contracting and Planning Update**
Last year, along with a number of other policy determinations, the Board decided if Qualified Health Plans (QHPs) were not ready to commit, they would not be allowed to join this year. It also made an effort to partner with Medi-Cal plans to promote continuity of care. Contra Costa Health Plan will not be recertifying this year due to federal policy. It has always put consumers first. Covered California has appreciated their partnership.

Leesa Tori, Interim Director, Plan Management, presented on the current contracting status and where Covered California is in the process. Plan Management is currently in the midst of Certification, Recertification and Decertification of Qualified Health Plans. Covered California's Guiding Principles are still very important going in to this year's contracting. Stability, consistency and predictability program principles are a main

focus for the 2015 partners. There is a continuous need for Covered California to support a policy to have standard benefit designs.

All carriers bid 10.0 embedded benefits. In early August, the rates and carriers will be available to the public.

Although Covered California and its partners have not been able to meet the performance guarantees for this first period, the 2015 year will bring more data collection, newly established benchmarks, and stability. This will lead to better tracked performance guarantees. Although there will not be a substantial number of changes in 2015, there will be a reworking of the contract model for 2016.

Patricia Tanquary from Contra Costa Health Plan spoke. She shared that her plan felt honored to participate in the Affordable Care Act programs. It has been an HMO for forty years, serving low-income and vulnerable populations. Its numbers have grown from Medi-Cal and Covered California. It also built its own bridge plan to help those churning between Medi-Cal and the Exchange. Contra Costa Health Plan exited the individual market and assisted those members to choose either it or another QHP in their county. The offerings were satisfactory and she feels disappointed that it must exit for next year. The final regulatory guidance from CMS would not be consistent with the Contra Costa Health Plan mission and would require extreme expenses that would have gone into building those same plans at the same rates in the market that it exited a year ago. CMS and CCIIO were not able to change the final regulation. It's an issue for many Medicaid plans entering the Exchanges across the country. Her plan will continue its high-touch assistance and will help members transition. The vast majority of its members (92 percent) are subsidized.

Ms. Tanquary strongly recommended that Covered California continue to work with CMS to implement the bridge. Her health plan and other Medi-Cal plans would like to participate with creating some appropriate rules that don't require plans addressing these populations to build and compete in the open market when that is not their mission. They want to help and participate. They regret leaving.

Chairwoman Dooley also regrets that the Contra Costa Health Plan left the market. She noted that the Exchange is still in a period of transformational change. Churn is a big issue. Those bridges will have to be evaluated from many angles. The commitment and integrity of the Contra Costa Health Plan is a model to work toward. Covered California will still work with the plan.

Ms. Tori presented on Small Business Health Options Program (SHOP). There are about 10 thousand people enrolled in the program as either employees or dependents. SHOP will require a different administrative platform based on the differences in technology needs between the individual and the SHOP markets. Ms. Tori apologized for the delayed commission payments and assured the Board these payments would be going out the following week. She also mentioned that Agents are going to be part of several activities in the coming months in the form of focus groups, training, and roadshows.

SHOP will include some new features for 2015 in Alternate Benefit Designs and the Family Dental Option.

The Contiguous Tiers Plan allows employers to pick two tiers that are contiguous to offer to their employees.

Mr. Lee noted that California is at the cutting edge on offering more choice.

**ii. Potential Operational Implications of the Insurance Rate Public Justification and Accountability Act**

Mr. Lee noted that Covered California has not completed its analysis of the Insurance Rate Public Justification and Accountability Act. Staff will share what the questions are.

Ms. Tori noted that Covered California must always plan toward the future. The Insurance Rate Public Justification and Accountability Act will be on the ballot in November. Mr. Lee will be testifying at a hearing on this topic in early July as well. Ms. Tori mentioned that they will be meeting with interested parties to go over the questions that Covered California will address and ask at the hearing.in July. A list of questions that staff is looking into is posted on the board materials page.

The prior legislation that is related to this new initiative was Prop 103, which related to rate approval for other insurance industries (automobile etc.). This would allow the commissioner to provide final approval for rates. The new initiative extends to health rates. We need more details on this legislation before Covered California can have a clearer picture on how this will affect the organization and its consumers. There are a lot of questions about the operational issues this could create.

Right now, some questions surrounding how this initiative would affect timeliness are: What would the timeline look like if they: Review the rates without a review hearing? Review the rates with a review hearing? Review the rates and disapprove them?

Significant time would be added to the timeframe under the last two scenarios. Ms. Tori noted that the main focus should be the consumers, especially the subsidized enrollees.

**Discussion:**
Board Member Kennedy said it feels like the analysis is focused on operations, and not on the impact on consumers. The impact could be huge and negative, and any inability for Covered California will trickle down to risk being padded into rates.

Ms. Tori noted that Covered California can't be seen as lobbying one way or another. The hearing that Mr. Lee will testify at is on July 2nd.

Mr. Lee stated that staff sees every operational issue as a consumer issue. Staff has not yet determined what the ultimate effect would be on rates.

Ms. Tori noted that there could be a lot of time spent waiting for rates to be approved. In that case, the impact on the consumer will be evaluated.

Board Member Kennedy felt that the definition of "benefits" in the bill is very broad. What if the insurance commissioner's definition of fair or adequate differs from Covered California's? This statute may last through multiple commissioners, and eventually one could be hostile to the Affordable Care Act. If the commissioner disagrees with a policy decision that the Board has made, what carries? Is there an appeal, or is the insurance commissioner's office able to just say it is unfair and Covered California must change?

Mr. Lee said staff will answer questions as quickly and clearly as they can. There are down-the-road uncertainties about how a court or a future regulator might interpret the law.

Board Member Kennedy asked what would happen if the commissioner said the current rates are deemed unfair.

Ms. Tori stated that there is not a lot of information yet. She will ensure those questions are first on the list of what needs to be answered in the staff's analysis.

Board Member Kennedy noted that Covered California must clearly explain what the impacts will be if it passes. The alarm level should be raised.

Mr. Lee noted that staff wants to understand the impact on Covered California, but staff won't have all answers in two weeks, and it must

continue fleshing it out. They would like to find out what questions they should make sure are on the list. He hears Board Member Kennedy's feelings of urgency.

Board Member Dooley asked that staff distinguish between questions the organization currently knows the answers to, ones that can be answered later, and ones we cannot know the answers to.

Board Member Fearer noted that many of his questions are already on the list. It seems that this rate review is by region and by product, which adds layers of complexity. The current process overview is serial, not parallel. Is there a parallel process? That makes contention possible.

Ms. Tori noted that there are already some flow charts showing the fastest route to approval and the longest route to approval. Different plans may or may not be approved.

Board Member Fearer noted that "rate" is not well defined. The Board would want it be consistent with the fulfillment of Covered California's mission; not only price but also value is considered.

Board Member Belshé stated that this is a very timely analysis, albeit incomplete. These are reasonable questions. It's Covered California's responsibility to research them. The California landscape is not the same as in other states. California has two regulators, unlike other states. All of the landscape has huge implications for these operational questions, which affect consumers. She commended the staff for beginning the important work.

Board Member Ross would like to know how the intervener has worked elsewhere. He also wondered if any external entity is commissioning a consumer perspective analysis of the benefits and concerns relating to this ballot measure. He hoped the stakeholders would weigh in.

Ms. Tori hears a sense of urgency to get the consumer impact questions up front so that they have an opportunity to inform the discussions and debates. Some elements can be examined in other states with laws like this. The intervener process has been active in California under Proposition 103, just not in the health insurance market.

Board Member Belshé worries about looking at things that work in other states, because California is unique.

Board Member Kennedy asked what "premium financing" is. She wants to know how all the what-ifs might impact the Exchange.

Mr. Lee noted that staff should follow up on that. Staff is seeking to do an analysis of the facts and of what is uncertain or unknown. He is not aware of any other entity analyzing this yet. Staff is framing its questions and analysis of what this could mean for the Exchange and its consumers.

Board Member Dooley did not like the terminology being used in the discussion ("passionate" versus "dispassionate" evaluation), because it implies bias. Covered California has come to be a trusted resource. It does have an interest, and that is protecting consumers. It also has an obligation to communicate what the intended and unintended consequences of this measure could be. She has no bias except a commitment to the continued success of Covered California.

Staff will move forward with its analysis as quickly as possible.

Mr. Lee noted that they have been discussing ways plans can improve product and network designs. Staff is not bound to absolutely no change. There are some rule issues that will be part of the negotiations.

Chairwoman Dooley and Board Member Kennedy will form a Board subcommittee.

**Public Comment:**
1:12:05 Gary Passmore, Congress of California Seniors, appreciated the concern for consumers' interest. He asked that the Board nuance its comments to recognize that there are different segments of consumers that will be affected differently. His organization still hears concerns and questions about the higher rates for older people. This initiative includes things other than rates. Network adequacy is a particular concern to older consumers who are frequent users who need specialists. As the Board considers the what-ifs, the most serious threat is a situation where rates are out of control. Consider the threat to the program with uncontrolled rates and how else to address them.

1:15:02 Betsy Imholz, Director of Special Projects, Consumers Union, asked about the alternative benefit designs for the SHOP plan. Close scrutiny of rates is important. Proposition 103 has worked for the benefit of consumers and made for a more fair rate-making process. Consumers Union has not taken a position yet. They are looking at the goal as well as the particular language. In other states it has been helpful and effective in lowering rates, but California is different with multiple regulators, an active purchaser, and health insurance may be different than other kinds. We are in new territory. Intervention can be a very effective tool.

1:17:07 Emily Rusch, Executive Director, CALPIRG, noted they have supported rate review in other states and have been active in the rate

review process. There's no question that increased scrutiny of rates is a good thing for consumers. There are some outstanding issues that would have to be addressed. They found that increased oversight by the regulators has reduced premiums. There were a million California consumers who had rates that were determined to be unreasonable but the rate still went forward. She encouraged the Board to think about potential answers and sketch out some solutions.

Cornelius Burke, Bay Area Counsel, voiced serious concerns with the act and potential negative impact on Exchange operations. Bureaucratic conflict will create chaos and confusion instead of transparency. This is an enormous gamble. No other state has a regulatory scheme like this. Open enrollment is on a tight timeline already, and we can't afford further delays.

Julianne Broyles, California Association of Health Underwriters, appreciated the sorting-out of SHOP issues. The questions that Covered California is asking are what they are asking too. Anything that delays open enrollment is going to cause chaos and create barriers such as immovable open enrollment periods in statute that can't be changed. There is no limit on intervener actions once Covered California resolves one, another may crop up. Service levels and network adequacy may cause a delay, but also Covered California must determine what such a determination might do to subsidies. There could be great cost to plans and the Exchange. There are so many elements that go into a quote; even age of family members would be an intervener issue. They would like to participate in working through the issue.

Kathleen Hamilton, Director, The Children's Partnership and the California Children's Health Coalition, thanked the Board for its commitment to making sure children have maximum access to dental care. Getting embedded plans is a huge achievement. They get so many questions nationally on how pediatric dental evolved and how we got there and if it will work. California is leading on this issue.

Gil Ojeda, Director, California Program on Access to Care (CPAC), UC Berkeley, noted they have been observing all along. They have also watched the initiative as it has developed. At the time, they thought it was a modest initiative compared with some in other states. Some states do have multiple regulators. Two UC groups (Berkeley and UCLA) are doing work in this arena. They commend the Board Chair's comments on the Exchange not being immersed in the public political process. CPAC believes it will pass. There must be a strong working group between the insurance commissioner and the Exchange to work out the elements. The commissioner is supposed to be a stated partner.

Brett Johnson, Associate Director of Medical and Regulatory Policy, California Medical Association, noted that they were disappointed that there was no timely access update. A lot is going on in that arena right now and that would have been helpful. He echoed the comments of Board Member Kennedy, especially looking at the patient/consumer impact of the initiative, and Mr. Passmore's comments about network adequacy as well.

Emily Lam, Vice President of Health Care, the Silicon Valley Leadership Group, thanked Mr. Lee and staff for moving forward on contiguous levels for the SHOP. That will make the SHOP more competitive. She echoed all the concerns about the rate regulation initiative which could muddle or undermine a lot of the work that has already been done. Their members are concerned about an increase in rate premiums. This is not a good way to address that.

David Chase, California Director, Small Business Majority, appreciated the expansion for employer and employee choice. California is expanding choice and moving forward, not backward. They are still reviewing the measure. They don't have an opinion yet but they have many concerns. They don't want to see anything undermine Covered California's ability to be an active purchaser.

Vanessa Hernandez, Policy Coordinator, California Youth Connection, noted that she is a former foster youth. They are excited about the expansion of Medi-Cal to the former foster youth population, but they are finding barriers to enrollment in this program. Former foster youth are already vulnerable and have suffered abuse and neglect. Adulthood is difficult enough to navigate without having trouble with finding insurance to cover medical needs. Currently, the process is unclear and hard to navigate.

Elizabeth Garcia, former foster youth and college graduate, expressed gratitude for the extension of medical coverage up to the age of twenty-six. Although she has overcome struggles and considers herself resourceful, this is not the case for all foster youth. They have a hard time accessing the right resources. It needs to be an easier process.

Sherri Walker, former foster youth, noted that her population is vulnerable to sex trafficking, incarceration, and homelessness. Keeping them on track is better for society. She is an outreach counselor for foster youth. This extension is important and extends coverage to foster youth the way it does other youth. Many foster youth get discouraged by the application system's problems. County workers are not trained on the issue.

Jessica Haspel, Senior Associate, Children Now, said it's not just about the child welfare system, it's also about Covered California and Medi-Cal. It is about there being no wrong door to coverage. This current door is incredibly difficult to navigate. The former foster youth should actually wind up in coverage if they contact the Exchange. Some text changes will be made to the portal to alert former foster youth that the website is not the best way to apply yet. They also need to be able to apply online. The notification is a good step for now. The functionality changes have been pushed further back. This needs to be a higher priority. The other change they have been requesting is for Covered California to create a mechanism on phone calls to identify this population and give them the correct information. There is not a question in the script, and there has not been any training.

On Phone: Henry Abrons, All Care Alliance, emphasized that Covered California must look at the operational impact if the initiative passes. While staff has listed many details, the primary impact that needs to be considered is the triad of access, cost, and quality for consumers. What will the impact be if the rate regulation does not go through? If there is not rate regulation, it's clear from precedent that rates will continue to become unaffordable. The Board has a responsibility to ensure that rates are affordable going forward. The Wall Street Journal reported on premium rises by insurers in the ten states where they have already submitted filings. The prospective rate increases are frightening.

On Phone: Jeri Field, Small Group and Individual Markets, voiced that her husband saw a 40 percent rate increase. He could not hire more employees because he had to use his money on the rate increase. Small businesses will be hurt by rising costs, and they won't be able to hire, and this will adversely impact Covered California. If this does not pass, there is no recourse if there are high rates. The strength of Covered California is dependent on the strength of the whole insurance market. These double-digit increases impact the population in general, and thus Covered California.

On Phone: Jamie Court, President, Consumer Watchdog, voiced that he is a proponent of the initiative. This initiative won't slow down Covered California. We must make sure that insurance policies are affordable and also help the millions insured outside of the Exchange, who have no one to negotiate for them. The most important question that was not asked during the meeting is why health insurance premiums increased more than five times faster than inflation over the last decade. There is no regulatory recourse for unreasonable rate hikes. Nobody can reject rate hikes right now, though one million people faced unreasonable ones this year. Despite the generous subsidies, four in ten of those who bought a plan said they had difficulty paying their monthly premiums. This was more pronounced

among the self-employed and small businesses. There is a difference between rate regulations and rate negotiations. Negotiations are secret and not subject to the Public Records Act. Rate regulation is public. The public and the commissioner can examine what they do, and insurers have to justify what they charge. The health insurers have put $24.5 million into defeating this proposition. They are happy to answer questions and help allay fears. There are not many rates to review. This is about translating one of the most successful reforms in the history of America to health insurance. Auto insurance rates in 1988 were higher in real dollars than they are now.

Janice Rocco, Deputy Commissioner of Health Policy and Reform, California Department of Insurance, offered to have her department work with staff to discuss the twenty-five-year history with Proposition 103 and how it would work for health insurance. They welcome the opportunity to help Covered California work through this. Both CDI and DMHC were able to get excessive rates lowered for the first set of QHPs offered for 2014, and plan to do that again this year. They are confident that they can accomplish things in time for open enrollment deadlines if it passes. The Board has so many questions and has not had time to discuss this with the most experienced stakeholders. The July 2nd hearing is very early for a ballot measure. They are often held in September.

On Phone: Deborah Burger, President, California Nurses Association and National Nurses United, noted that they have endorsed the measure to regulate health insurance rates in California like auto and home rates are regulated. They support public rate justification and accountability because they see what the lack of accountability has done to patients. California's registered nurses struggle to get patients the care they need without causing financial ruin. Their struggles are over what the insurance companies will pay instead of the best care options. They want to reign in the out of control price hikes. Covered California has no power to reign in rate hikes. Health insurance companies not required to lower rates will hike them further. California's consumers deserve the same rate regulation that 35 states have. We need to do right by our patients. Covered California is already projecting that this initiative will be bad for California. That sounded like a clear bias in favor of the insurance industry.

On Phone: Quyen Vuong, Executive Director, ICAN, noted that they are a grant recipient. She would like to urge Covered California to delay abolishing the navigator grants and collect more information from stakeholders to create a win-win situation. Many community-based organizations do not get sufficient funding to hire dedicated staff. They talk to communities to convince them to buy health insurance. Many Vietnamese families don't dare to apply for insurance. They must sign an

affidavit saying they can afford to support a family member coming to live in the United States. Receiving assistance makes them fear they won't meet that requirement. Enrollment should not be the only focus.

**iii. Web-Based Entities Solicitation Update**

Mr. Lee thanked those who provided thoughtful feedback. The recommendation is that Covered California not move forward with an RFP for 2015. This is not for lack of interest, but because of the need to focus on core mission elements and renewal. Web-based agents might have them for 2016.

Dan Frey, Policy Advisor, SHOP, presented on web-based entities. They are online insurance agencies that are open to consumers and online engines. A Request for Information released in March 2014 received eleven responses. The responses received represented both the consumer driven and online agent community. The full analysis is not yet complete, but Mr. Frey will report back when it is. He recommends getting through the next open enrollment period before moving forward with completing this analysis.

Mr. Lee noted that all of the web-based entities and agents were concerned about the I-Frame. There are a lot of IT issues that must be fixed first.

Mr. Frey noted that staff learned from the RFI, and also learned that it is a very involved process and more time is needed.

**Public Comment:**

Betsy Imholz, Director of Special Projects, Consumers Union, said to clarify that they commented. It has been suggested for a long time. Without the I-Frame, they were concerned about cross marketing and the consumer experience. I-Frames are by far the preferred approach. They appreciate its deferment and the focus on CalHEERS and the consumer experience.

Emily Lam, Vice President of Health Care, the Silicon Valley Leadership Group, thanked staff and the Board. She expressed disappointment that it can't be done for this enrollment period, but emphasized that web-based entities can really help. She has heard reservations and they can be addressed with policies.

Brian Poger, CEO, Benefitter, voiced that they contract with federal states, but they are not afforded that privilege in the state where they are domiciled. The Exchange is looking for only three to five web-based partners which would be a terrible mistake. This would result in an oligopoly. It would sideline Silicon Valley innovators who believe they can change the trajectory of health insurance costs. This would also leave

agents on the sidelines, because the existing projects and contenders are inadequate for today's demands. It would be a bad financial decision by the state by artificially limiting entities that can have a profound impact on enrollment and efficiency California should do the same as the federal government. If limiting the number of people who can help with enrollment was smart, we'd cap the number of assisters. Opening up the market to an unlimited number of contenders would be a win-win situation.

On Phone: Chad Hogan, Senior Vice President, QUOTIT Corporation, represents online agents. Independent community based agents can pool their resources and afford an advanced, fully compliant system they couldn't afford on their own. Agents using QUOTIT technology enrolled many into Covered California during the open enrollment period. They worked closely with CCIIO and were one of the first granted web-based-agent status by CMS for the federal marketplace. Many consumers prefer to choose a health plan with an agent. The web-based agent approach has been effective in empowering independent agents to better and more efficiently service and assist their clients. This should be carefully considered as a model. They encourage the adoption of policies in alignment with federal regulation. They must meet strict security standards. Covered California should be open to as many independent, certified, web-based agents as possible.

Beth Capell, Health Access California, noted that active purchasing distinguishes the Board from their federal colleagues who use any willing vendor. What is referred to as "requirements" or "principles" are mostly statutory requirements, not just desired elements. They trust that the Board will assure that any vendor meets the statutory requirements. They are pleased to hear that all the plans that previously contracted with the Exchange will do so again except Contra Costa.

Juliann Broyles, California Association of Health Underwriters, voiced that their issues with the web-based entity approach is not saying that the process should halt. They do want to see the continued ability of community-based certified agents to act as the sales force and not be supplanted by a national call center.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), noted that they sponsored SB1313, requiring those marketing health insurance to provide information in the language in which products are marketed. There needs to be access to information in languages in which products are marketed.

**Discussion: 2015 Renewal Consumer Experience**
Katie Ravel, Director, Policy, presented on the Renewal Experience. The 2015 Renewal Principles focuses on the consumer experiences and on engaging Covered California's delegates, partners and plans. There is also a plan to maximize retention by giving consumers renewal options that allow for continuous coverage. Covered California is also continuing to encourage self-service options to enrollees.

Ms. Ravel discussed the Consumer Journey which is a pathway for consumers as they ready themselves for renewal. This includes redetermination, consent, and changes.

Mr. Lee noted that more communication will go out to members on not just renewal, but also on issues such as access.

**Discussion: Legislative Update**
David Panush, Director, External Affairs, presented. One bill relates to Enrollment Periods. Open enrollment will be November 15–February 15. One bill establishes the California Vision Care Access Council. It was amended to consolidate this council with the Covered California Board. Staff will look at the amendments and administrative structure. One bill would allow for an extension of non-grandfathered health plans in the small-group market.

The legislature passed the budget. The Health Budget Trailer Bill establishes a pregnancy wrap to allow women to choose to have Covered California coverage and Medi-Cal. It also extends Covered California's ability to extend emergency regulations for an additional year to give some flexibility.

Chairwoman Dooley stated that the governor will sign the budget.

Mr. Lee said there is an appendix on a range of issues, key website initiatives, and getting ready for the renewal process. He noted that in May, Covered California exceeded its service levels. There were a lot of calls, though fewer than in the heat of enrollment. They are fielding less confusion. The quick sort partnership continues to be effective and service levels exceeded.

**Public Comment:**
Beth Capell, Health Access California, appreciates that there will be regular communication with the enrollees. It would also be helpful to hear about their experiences via surveys. She encouraged the Board to give consumers the chance to stay where they are if they only have modest changes. She also encouraged the board to make it as easy as it currently is to stay in the same plan while also pointing out that alternative options are offered. She would like to begin to hear reports on the service provided by plan partners. The plans were also inundated for a while, but it would be good to hear about their service levels.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), noted that the signing of the budget means those who have been legal

residents for less than five years will be transitioning to Covered California as well. As we move into open enrollment and renewals, it will be important to ensure renewal materials are translated. She would like to hear why LEP callers represent such a low percentage of the calls. Some Spanish-language calls are getting dropped after the transfer. How is that portrayed in the current reporting structure? Is there a mechanism in place to record the number of dropped calls?

Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law & Poverty, is pleased that the wrap for pregnant women will be put in place. They look forward to the renewal process. It will be important to coordinate with Medi-Cal, since there are many families where parents are in Covered California and children in Medi-Cal. They would like for families to only need to do one set of reporting. They continue to have language access concerns regarding the service center. They have heard of people being transferred to Spanish-language lines that answer in English. Keep up bilingual recruitment.

Betsy Imholz, Director of Special Projects, Consumers Union, congratulated Covered California on meeting the performance goals. It should be easy for people to stay where they are, but also people will need to know how to continue their eligibility for the subsidy and know what the current best value is for them.

On Phone: Susan Pfeifer, Educator and Enrollment Counselor, Community Outreach, voiced concern about the ever-shrinking provider pool with some plans after people signed up. Some even checked with their physicians and were assured that the physicians were in the plan, but were later notified that their physicians had been dropped from the plan. Those who have moved are having a hard time finding a doctor. She inquired about how the dental add-on would work. People in middle income ranges are finding that the rates can be disappointingly high for them, especially if they haven't had insurance before. She gets asked about dental a lot. At what point would the ballot measure affect rates? Would it be retroactive or for 2016?

**Agenda Item V: Covered California Policy and Action Items**

Mr. Lee noted that many groups have provided feedback on the navigator program. In many cases, their comments are incorporated directly. In other cases, staff does not agree with comments. These are issues staff has wrestled with extensively. This program is funded from premium assessments. Covered California cannot be responsible for funding efforts to maximize Medi-Cal enrollment. Many groups will ask for more money. This proposal puts substantially more resources into outreach, education, and enrollment than the first round, by being more efficient. This will be far more efficient in terms of oversight and result in more money on the street. Staff is proposing to migrate the program after the second open enrollment period. Paid enrollment after this next period will only be through the navigator program. The organization is not stopping existing grantees, who can continue under their existing funds. They are encouraged to convert, too. Many have suggested that Covered California not act now. The initial grant program and enrollment program and partnership with agents were not perfect, but showed good returns. But pushing this down the road would hurt the 2015–2016 budget.

**Presentation:** Covered California Policy and Action Items

**Discussion: Covered California Enrollment Assistance Policy**
Sarah Soto-Taylor, Deputy Director, Community Relations, presented on Enrollment Assistance Programs. Specifically, she talked about feedback to the Navigator Program and the integration of the education and enrollment model. A summary of comments includes: The impact to current outreach efforts, continuation of Certified Enrollment Entity Payments, integration with Medi-Cal, the needs of rural populations, and the payment schedule.

The staff recommendation is a performance measure against effectuation of coverage with an emphasis on outreach, participation, and retention activities. There are concerns about the transition to the Navigator Model. However, there is a plan to parallel the existing programs to aid in the effort. The outreach is flexible and covers a wide range of areas.

Ms. Soto-Taylor is requesting the Board to approve $16.9 million to award to the Navigator Grantees that will include a bonus pool. There is concern with a prescriptive budget, so applicants have been asked to describe their target populations. There will be flexibility in the budgets based on this information.

As part of the performance measures, Covered California will offer to extend agreements for one year for organizations that meet their goals at the end of the agreement.

Ms. Soto-Taylor requests that the Board approve their pending timeline and outline the considerations informing their recommendations.

**Discussion:**
Mr. Lee noted that these are tough issues. Some populations may cost more to enroll, but staff also wants to maximize enrollment. They want to get more people in for the dollar. They want applicants to put forward why their outreach will be effective. The existing grants will continue through open enrollment. Many enrollment entities enrolled relatively few members. Staff has been evaluating how to build an efficient system.

Board Member Ross feels this is generally a step forward and demonstrates learning from first-year experience. He is concerned about feedback received about a lack of time for public engagement. If the Board wanted to try to find more dollars for the outreach grants, where would it come from?

**Public Comment:**
Autumn Ogden, Policy Analyst, California Coverage & Health Initiatives, agreed with the staff comments about allowing for flexibility for subcontracting, smaller grant amounts to help smaller organizations, and the change in the compensation structure. They understand and agree with consolidating these programs. They still disagree with discontinuing the certified enrollment counselor (CEC) program at this point, without

time for sufficient stakeholder feedback. They were invited to one engagement and there was less than ten minutes for comments. They understand the budget concerns. More time would allow for more options. Covered California could offer a scaled-back CEC program. There is no need to rush the elimination of the CEC program.

Sonya Vasquez, Policy Director, Community Health Councils, supported Ms. Ogden's comments. There will be a number of people who they worked just as hard to get through the process but who won't pay their premiums. They encourage other models where final payments could be made at a minimum of 75 percent of payment into the plan. That would allow Covered California to use that money to do outreach and retention. Everyone wants to strive for 100 percent but that's not reality. It's hard to tell how much money is allotted to what activities in the budget. Do we need to spend more in media and marketing when people need more assistance?

Doreena Wong, Project Director of the Health Access Project, Asian Pacific American Legal Center, supported the previous two speakers' comments. She does not think people understand what the effects of this proposal will be. Those grantees who have existing funds will get no additional funding. Organizations such as hers have no incentive to do additional work for no additional money. All of her partners have made detailed work plans; they have planned for that. So it's not fair for them to change their program midstream. Organizations such as hers may have enrolled some people, but that was not their primary focus, so they are not on the list of top enrollers. There should be more time. If organizations are going to go forward, they should have a separate opportunity to apply without taking away from original grant.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN) pointed out that a lot of these organizations are not big grantees. Doing enrollment is already an add-on to their outreach work. Who is going to go to the libraries in Chinatown or the community colleges or stadiums? It's unrealistic and inappropriate to think providers will have the capacity or incentive to go where people live, work, and play. She would like to see a list of the top lead generators. What will happen to those important structures that have been created to reach vulnerable populations? There are limited funds and we need to move forward, but she would like to know what will happen with them.

Beth Malinowski, Associate Director of Policy, California Primary Care Association, also voiced concern about the rate of change. Stakeholder engagement needs to be continued. They are appreciative of some of the proposals, especially renewal and retention support. They appreciate the local support approach. They remain concerned that this could have a negative effect on Medi-Cal enrollment. They encourage increased engagement with DHCS. They have operational concerns they already shared with staff. The $16.9 million is insufficient, especially for retention.

Brian Burrell, Young Invincibles, appreciated the adjustment of proposals. He seconded a lot of comments. He is concerned about awarding success on the effectuation of coverage, because it does not reflect the work that on-the-ground navigators are doing. A

lot of further things must happen For example, the premiums must be paid and the insurance companies must approve the members. That could delay service and navigators' ability to continue their work. It is important to get people to that point of coverage, but different approaches could be taken.

Carla Saporta, Health Policy Director, The Greenlining Institute, voiced that they have been engaging with a lot of CECs and navigators to find out what's working. There are limited funds, but there needs to be an actual dialogue with the grantees and CECs about how much applications actually cost and if the allocations are accurate. They think distributing funds once 25% of enrollments are met is a good step forward. Those who are harder to reach are the limited-English-proficient communities. They did not enroll last time, and they are more expensive to enroll.

Fiona Lavelle, Program Manager, California Family Resource Association, stated that they are a grantee and represent several hundred smaller CECs. She agreed with the other stakeholders who signed on to the letter. She asked that Covered California take the time to assess communities and their needs and look at how these decisions will impact which assisters remain part of this program. A lot of CECs will withdraw from this program because of these impacts. It will particularly impact the communities who need additional assistance the most (those who have the most barriers to enrollment). While they appreciate being able to come to regional grantee meetings and the Board meetings, and being able to submit written comments, there is not an actual dialogue happening. They would like to have some deeper conversations with their partners across the state. They appreciate that the compensation is more in line with the flow of work over time.

On Phone: Kevin Knauss, Certified Insurance Agent, voiced concern that the navigator program essentially creates an unlicensed agency. Nobody has to take tests or have insurance, and they are allowed to advertise (which you normally must have a license to do). Navigators will put their efforts into where they can get bonuses. Every household they enroll is a household that a carrier doesn't have to pay commission on. Why don't carriers just pay navigators to fund their operations? He does not like the idea, but right now the carriers are paying commissions when households pay premiums. Carriers should fund the navigator program. That is not Covered California's responsibility except when it comes to vulnerable populations and Medi-Cal enrollment.

David Chase, California Director, Small Business Majority, hopes to hear what an outreach program will look like for the SHOP in 2015, as that will be an important year to be out doing that work. SHOP may be a tougher sell than the individual Exchange, so greater education is needed. Changes being made include the IT system migration from CalHEERS to Pinnacle and the expanded employee/employer choice. All of those changes need to be communicated to the employer community as 2015 is likely the year when small employers will be migrating to Affordable Care Act compliant plans.

Waynee Lucero, Program Manager, California Hispanic Chamber of Commerce, noted that they are a SHOP grantee. She echoed Mr. Chase's comments about continued outreach to the small-business community. The SHOP is unique. It has a perpetual

enrollment period, it's not mandatory, and it has a competitor. SHOP grantees have different experiences than those working in the individual market. Small employers need to understand the changes. They are excited about the SHOP and improving the product as well.

Pallavi Shimoda, Director of Programs, California Asian Chamber of Commerce, noted that they are also a grantee. She echoed Mr. Chase's and Ms. Lucero's comments. She asked that Covered California consider discrepancies between the SHOP marketplace and the individual marketplace. The SHOP mandate has been extended, and 2015 will be a crucial year for the small business community which has been confused and misinformed.

Kathleen Hamilton, Director, The Children's Partnership, agreed with Ms. Ogden and the comment letter. She hoped that the Board would take the opportunity to not move forward with these major policy considerations that could undermine the availability of CECs to serve the needs of underserved populations. We are just beginning to see the data. Another year to observe would help inform the need to make changes.

Kate Burch, Network Director, California LGBT Health and Human Services Network, noted that they are a grantee and their subcontractors do enrollment. They are glad to see some of the changes. Streamlining the reporting process will help a lot. There is no outreach goal, only enrollment. No measurement of retention is mentioned either. It would be great to see some mention of LBGT-specific topics discussed during the navigator program.

Betty Williams, CEO, 1 Solution, voiced that they are also a grantee. She echoed the comments of others who spoke about not eliminating the CEE and CEC program. They are worth the investment. Covered California should listen and have more time for the stakeholders to share what they do. She encouraged the Board to pay the CECs in a more timely fashion. If you applied as a subcontractor for the navigator 1, would that preclude you from applying for the navigator 2 program? What are CECs supposed to do if someone comes that's a Medi-Cal-eligible person? You don't want to turn away anyone, but it creates a conflict if someone from Medi-Cal comes in (which you don't know right away).

Sonal Ambegaokar, Senior Attorney, National Health Law Program and the Health Consumer Alliance, noted that they work with CECs. They are able to provide more legal assistance and troubleshooting because of the CECs. Before, they were doing the work of CECs, which was very time intensive and not a good use of paralegals and attorneys. Having more CECs in the community builds the capacity of other community-based organizations. They also learned the importance of low-touch, and it was time to invest in CECs. She was not sure some of the assumptions and data out there about agents being the best channel for the API community were correct. They have heard more stories from API consumers that CECs played that role because of language access and community trust. Their role was downplayed. They were concerned that there wasn't enough stakeholder process for them. She would really like to request more time in the future.

Gil Ojeda, Director, California Program on Access to Care, UC Berkeley, stated that in late May, rumors about redoing of the program were spread, and there were a lot of concerns about the abrupt elimination of contracts. This plan seems to reflect a lot of reengineering. What happens to those organizations that submitted a proposal last navigator cycle for what was going to be $5 million? Is that still going, or has that been terminated? The governor chose not to match a substantial California Endowment contribution that would have led to money for Medi-Cal enrollment. These populations are integrated, not separate. Is there an impact on the outreach and enrollment process because of his rejection of the funds?

Anthony Wright, Executive Director, Health Access California, appreciates the complexity of the issue, but wants to make sure we have these additional resources for year two. This is not the time to let up momentum. While decisions are being made, he hopes that they won't be solidified yet. The experiences of those on the ground should inform what year three looks like. He appreciates the direction of the proposal, as it alters the performance-based funding. However, while that part of the proposal sounds good, they are concerned about only including top enrollers. Performance-based methods are important, but outreach and education are important too.

Kathy Ochoa, SEIU, UHW, and We Care Enough to Act, voiced that they have been playing by the rules. They are excited about the programs they implemented, and are #10 in both Medi-Cal and Covered California enrollments. Their success is due to their partnerships around the state. They share many of the concerns voiced about stakeholder engagement. They are fanatical about data and they know what is working. They would like to test what works in the new environment. They are appreciative of all of the compromises that must be made, but staff has delayed implementation by another month. The start date was going to be September 1, and now they have announced it will be October 1. This harms their ability to sustain momentum and explore what works. It harms their ability to leverage other sources of funding to retain current staff and recruit, train, and credential new staff. All outstanding organizers or canvassers will be poached or sign on to electoral campaigns. They can only contribute to the ongoing success if Covered California is a good partner too.

On Phone: Mari Lopez, Policy Director, Visión y Compromiso, agreed with other consumer advocacy groups that we need to slow down this process. They agree with a lot of this direction, but it's moving too fast. There is a dearth of information out there. Communities of color need more outreach and education.

On Phone: Iyan John, Asian and Pacific Islander American Health Forum, works with Ms. Wong's organization to provide outreach and enrollment assistance. As Covered California makes this move, it should ensure that it remains accessible to smaller community based organizations that are better at reaching some populations.

**Motion/Action:** Board Member Kennedy moved to pass Resolution 2014-51, to implement the Navigator Program as presented by staff and release the Request for Application for the Navigator Program. Board Member Ross seconded the motion.

Mr. Lee stated that he wished there was more time. They have been having dialogues with stakeholders for over two years. The question is exactly how to structure the program. If we don't move ahead, we will not be doing it for this next round of open enrollment. Staff is seeking Board approval on an overall budget. In August, they will come back with details on media spend, etc., but that has never been a Board decision. This investment that they recommend is on top of the approximately 20 million in existing grants, and on top of the $58 per application. Are there great grants? Is there a really strong case to be made for more money? This is a matter of deciding what your target is. The applicant can frame their target. The concerns around existing outreach and education grantees not losing their existing funds are well founded. They commit to work on a structure wherein grantees would not lose their grants if they attempt to become navigators. SHOP is different and this is not how the SHOP will work. The challenge is that Covered California needs to spend less on administration. Effectuated enrollment is easier to measure than outreach and education. Is there a way to measure outreach and education? We need to take the lessons from what we have, and create a new vision for round three. Navigator 1 has been completely put on hold. Those who applied already can reuse their application materials if they want. Those that did the work want to carry those grants forward. But the 16.9 million is not in addition to the 5 million.

Board Member Belshé would like context on how the $16.9 million fits into the larger budget.

Mr. Lee said the recommended budget includes $168 million for the full range of enrollment activities, including: Paid advertising, already-funded grants, CEE/CEC payments, this additional 16.9 million, and the administration of all of those grant programs. It's lower than it was in prior budgets. If Covered California were to have more grantees on an ongoing basis, it would have to ramp up administration costs. Generally speaking, the state was successful because of the multifaceted approach. Staff is not proposing a dramatic adjustment of downward media. Media was an important piece, as was community outreach.

Board Member Belshé questioned which budget year this was going to be included in.

Mr. Lee explained that this navigator initiative is in the recommended budget for 2014–15. The administration cost has been scaled to assume that Covered California would not have ongoing management of payment systems, but still have a CEC system.

Board Member Belshé noted that a number of comments had been made about the rush to eliminate the CEC program.

Mr. Lee clarified that they are changing the payment methodology, not eliminating the CEC program. Many entities will convert to CACs, to be uncompensated. Many are

doing that because it is mission-consistent, but Covered California will maintain the certification process. Covered California would be eliminating the $58 payment per application after this second round of open enrollment.

Board Member Ross noted that the stakeholder feedback has been so constructively supportive, that he would like to reassure them that there will be continued, structured opportunities for feedback. He would like to ensure that we continue in that spirit going forward; between now and the enrollment period coming up.

Mr. Lee made that commitment. He said staff will look at the timeline to see if we can buy ourselves a week here or there. When they evaluate existing certified enrollment counselors and entities, there are not that many large enrollers. They will allow for consortia of organizations working together. It is striking if you look at the data of how some enrollment counselors enroll hundreds. Covered California does not need to start from scratch. Some organizations may say they want to bring in counselors. That certification process will take time. Nobody will think any program is perfect.

Board Member Belshé agrees it will not be perfect, but Covered California needs to do the best it can within the timeframe that has been allowed. She tends to favor a performance-based payment system, but can step back and support a more integrated approach. She thinks post-enrollment and retention is also very important. She hopes for continued stakeholder engagement as well.

**Vote:** Roll was called, and the motion was approved by a unanimous vote.

**Discussion: 2014-15 Covered California Budget**
Mr. Lee thanked Joe Munzo and Ana Matosantos, and Dora Mejia, the finance team and staff. Covered California is not seeking approval for the small scale details.

Sue Johnsrud, Chief Deputy Executive Director, Operations, presented on the 2014-15 Covered California Budget, specifically on: The changes from the April recommendation, highlights/changes from 2013-14 to 2014-15, and a preview of 2015-16. The major changes from 2013-14 to 2014-15 are the Service Center funding, the CalHEERS budget, and enrollment activities.

Covered California is preparing to enter into its sustainability phase. The major assumptions revolve heavily on Federal approval to certain cost allocation and grant activities. Risks faced are: Lower enrollment than expected, delays in federal approval, and higher than expected costs.

**Discussion:**
Mr. Lee noted that they take sustainability and efficiency very seriously. Federal funds will continue into 2015. Then they will spend less. Every dollar spent means an extra dollar in premiums. Renewals are critical. Marketing and correctly staffing service centers are important. The assessment will be adjusted as necessary in the future.

Board Member Belshé said slide 16 shows an increase for enrollment activities. She got clarification from Ms. Johnsrud that the balance just reflects the payments Covered California will receive from DHCS to pay certified enrollment counselors.

Board Member Fearer said the core here is not the $250 million balance at the end of the 2015-16. The real driver here is the relationship between income and expense. In 2015-2016, income and expenses are getting pretty close. We need to be careful, even if we want to adjust the assessment. Reducing the balance is one-time money. Sustainability is about careful management of income and expenses. Any adjustment must be sustainable.

Mr. Lee agrees with that.

Board Member Fearer said he also has quite a bit of experience with employer plans. He feels that requiring documentation for change is ultimately important in the right direction. He understands a lot of the stakeholder concerns. If Covered California is going to require documentation, it must not be too onerous to deal with. We must also determine what evidence is appropriate or not. There needs to be appropriate support. He would like to set a direction, though he is not sure about timing.

**Public Comment:**
Beth Capell, Health Access California, voiced that they are pleased to see increased funding for the service center and the continued commitment to service, as well as the increased funding for enrollment activities.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), stated that they are pleased to see that there will be funding for hiring a diversity officer in this budget.

**Motion/Action:** Board Member Belshé moved to pass Resolution 2014-52 to adopt the 2014-15 budget as presented by staff. Board Member Ross seconded the motion.

**Vote:** Roll was called, and the motion was approved by a unanimous vote.

**Discussion: Covered California Regulation Readoptions**

**i. Eligibility and Enrollment Process for the Individual Exchange**

Katie Ravel presented on the Special Enrollment Period Verification. The Board was asked to move away from self-attestation and move toward a 90-day policy within the recommended eligibility allowances. This policy will not be ready for the 2015 Open Enrollment period, but staff will continue to work through this issue for the following year.

The trailer bill mentioned earlier would enable staff to keep extending the emergency regulations without them becoming permanent regulations. Eligibility and Enrollment and Enrollment Assistance would expire before the trailer bill went into effect.

**Motion/Action:** Board Member Ross moved to pass Resolution 2014-53 as amended by Board Member Belshé. This resolution is regarding the readoption of the regulations for the Eligibility and Enrollment Process for the Individual Exchange. Board Member Belshé seconded the motion

**Vote:** Roll was called, and the motion was passed by a vote. Board Member Fearer was absent. Board Member Kennedy voted no.

**Discussion:**
Chairwoman Dooley asked if asking for verification for the next special enrollment period is not feasible.

Ms. Ravel explained that staff is considering the various options on the table, including electronic verification with documentation up front, before allowing people to enroll, or conditional verification process. We are currently only using self-attestation. Staff will come back with a proposal for the 2015 special enrollment period.

Board Member Kennedy asked if paper verification (as an interim) was being considered.

Ms. Ravel said it was considered. They heard concerns about the 90-day conditional enrollment, and staff also presented concerns about the staff's ability to support that. If there is still no electronic process available for 2015, paper verification would still be considered.

Chairwoman Dooley does not want self-attestation indefinitely.

Board Member Kennedy does not understand why paper verification, despite its challenges, would not be considered if the electronic verification system is not up and running. She does not want to get comfortable with self-attestation.

Ms. Ravel explained that that would have to be built into the system, for it to receive that verification.

Board Member Ross wondered how many they are expecting to enroll during the special enrollment period. Mr. Lee voiced that they expect 100,000–200,000 people. Staff looked closely at what they could require now and the staff recommendation is to have operationalized verification for 2015, which would be paper or other.

Chairwoman Dooley asked if there is any indication that people are cheating the system.

Mr. Lee said they have no reason to be concerned at this point. They are doing sample audits and phone calls. However, in the off-Exchange market, plans are doing other verification. Covered California wants to be clear that it is not easier to game than other outlets.

Board Member Belshé is unsure how Covered California will know if people are eligible for special enrollment. What are we doing on the consumer side to inform consumers that misrepresentations will have consequences? And to the extent QHPs are hearing anecdotally, or have evidence that not every person is being forthright, where does that information go?

Ms. Ravel said that on communications, they will be rolling out a separate signature under penalty of perjury on the page explaining the special enrollment reason. These regulations also incorporate an affirmative duty on the Exchange to notify individuals that they may be subject to penalties of up to $25,000 if they misrepresent their circumstances. Thus consumers will be informed that, under penalty of perjury, they have the obligation to tell the Exchange the truth about special enrollment events. Covered California can also take action if someone willfully misrepresented their application.

Chairwoman Dooley asked if the plans have the ability to take action if someone wrongfully enrolls.

Ms. Ravel said that Covered California makes the eligibility determination, so she is not sure that the plans have that authority.

Board Member Belshé expressed that she would feel better about the resolution if it included specific language about the policy direction we are headed in, stating that Covered California is going to operationalize a verification process for the 2015 plan year.

Chairwoman Dooley voiced that the resolutions are broad. They are delegating to the staff to finalize and submit an emergency regulation package.

Mr. Lee noted that the resolution is to submit emergency regulations for a draft approved by the Board. The language can be modified to indicate that, as part of this approval, the Board wants an indication of the future policy direction, which is operationalizing a verification process beginning in 2015. That gives both plans and public certainty of the path Covered California is on. Staff must work through the specific details of how it will be done. Self-attestation is a real protection and the penalty of perjury is something people take seriously. This attestation is what the federal marketplace and other states are doing, but the concerns around risk selection are valid.

The resolution will be revised to reflect Board Member Belshé's suggestion.

Chairwoman Dooley stated that, in this first year, Covered California enrolled most of the high-risk individuals during open enrollment. At the end, the more ordinary purchasers started to funnel in more. Covered California does have to be clear that over time, we have to show that there's some verification required. This is a unique enough year that she's not too troubled by going forward with the staff recommendation.

Mr. Lee stated that the concerns that the plans have are that people with new events and diagnoses will enroll and affect the risk pool.

We have to be alert and that has to be part of our instructions for people who are enrolling.

Board Member Kennedy asked how many are expected to enroll during special enrollment period.

Mr. Lee stated that enrollment was expected to be between 100,000 and 200,000 (but closer to 200,000).

Board Member Kennedy asked if that number is small enough that it should not cause an actuarial impact or affect the premiums.

Mr. Lee noted that the plans submitted rates that will be negotiated based on their known reality. The known reality is self-attestation. Covered California can give the plans comfort that there are protections. And having a clear policy of operationalizing verification should give the plans more comfort.

Board Member Kennedy asked if Covered California will be able to go back and identify what happened during this open enrollment period. Can it be determined the determinations were correct or incorrect?

Mr. Lee stated that the organization will have to work with the health plans on determining that. If they see a higher number of people with cancer within a month of their enrollment, that would be a red flag.

Board Member Belshé voiced that it is Covered California's responsibility to maintain the integrity of open enrollment. She is comfortable with the resolution as amended.

**Public Comment:**
Beth Capell, Health Access California, stated that self-attestation is not the honor system. Most life events that trigger this will affect tax filing, and 90 percent of enrollees are receiving subsidies that are income tax subsidies. If you said you were married, and then filed as single, there would be consequences for that. She rejects that characterization of self-attestation as the honor system. They have worked with staff to achieve electronic verification. It is because of CalHEERS

difficulties that Covered California is currently unable to achieve that. The Board should ask the staff (if it is going to handle paper documents and actually verify them), how many more staff members would be needed and how much bigger the budget would be. What would that do to the cost of premiums? That would be a considerable staff burden. A 90-day period to reconcile is not optional; it's a matter of state law and federal guidance. The regulations regarding the grace period allow for cancellation if an eligibility requirement is not met.

Bill Wehrle, Vice President of Health Insurance Exchanges, Kaiser Permanente, noted that anecdotes are not data. They don't have data yet. A person can very easily say, even truthfully, "I thought I was doing the right thing." He is rarely pro-paperwork, but that will have to be what happens. The plans must prove a criminal standard of intent. At some point, we are going to have to rely on what happens in the job-based market.

Sonal Ambegaokar, Senior Attorney, National Health Law Program and the Health Consumer Alliance, understands the concerns. She noted that self-attestation is done federally and in many states, and they do not seem concerned. As Ms. Ravel pointed out, Covered California can rescind any enrollment if someone has committed fraud. Most people in special enrollment are young people with life changes, not fraudsters. Covered California can offer other protections as well, such as post-enrollment audits. There has been a change in culture. Before, we were worried about sick people defrauding the system. But now there is guaranteed issue and the individual mandate. It's a world where everyone should be covered. It's not the best system, but 90 percent of the people are honest and want coverage. They have legitimate reasons. You can deny people if you have reason to.

Ruth Liu, Blue Shield, voiced that they want people eligible for enrollment during the special enrollment period. The estimated 200,000 people constitute a lot of people, and it can impact premiums. It is real risk for the Exchange long-term, and it's not good stewardship of federal funds if Covered California gets audited in the future. Until the electronic verification system is possible, they ask that people be asked for documentation. They don't agree with what Ms. Capell said about the 90 days. They think 30 days of coverage to resolve inconsistencies is more reasonable.

Autumn Ogden, Policy Analyst, California Coverage & Health Initiatives, echoed Ms. Capell's comments. In regards to personally identifiable information, they are grateful for the regulations. They previously caused considerable problems for their membership and an inability to retain information and compromise their grant situation. This will be positive going forward to help them continue their work.

Brian Burrell, Young Invincibles, stated that a lot of special enrollment periods will affect young adults. In the past he would not have had documentation to verify a change in circumstances.

Betsy Imholz, Director of Special Projects, Consumers Union, expressed support for self-attestation, saying paperwork would be too much to handle. She suggested that Covered California not lock itself too far into any one system for verification. There will be some evidence in the future to base decisions on. They agree that the 90 days is state and federally required. For someone with a job who can't go to City Hall to get papers, 90 days is not unreasonable.

Kathleen Hamilton, Director, The Children's Partnership and the California Children's Health Coalition, appreciated the focus on the operational issues of how verification would occur. She is unsure if there's a way to build this into the resolution. Rather than including a notion of intent, it would make sense that that intent is conditional upon finding a workable, functioning system that is subject to stakeholder input and Board approval.

Carla Saporta, Health Policy Director, The Greenlining Institute, seconded the comments of Ms. Capell, though she is in support of the resolution.

Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law & Poverty, also concurred with the prior comments. They support moving forward but they are concerned about the proposed amendment that suggests that there will be a verification system (when we don't know what the system will be). They also believe that the law requires a 90-day reasonable opportunity period.

On Phone: Kevin Knauss, Certified Insurance Agent, voiced that he welcomes additional verification. When he tells clients that they need to verify their income, some adjust their income estimations. Having verification adds honesty to the system. Some just had a baby. That's a special enrollment period. There are issues with people changing jobs or moving. They say they just lost their coverage, and they should need to prove it. There are adverse selections out there. Covered California needs to show it cannot be gamed, and the health plans need to feel secure.

Board Member Kennedy stated that the Board is suggesting that this is an issue of integrity. It's about error as much as potentially gaming it. It's about protecting the 99 percent of members who are there rightfully. Most of them absolutely will be honest. It's not unreasonable to be able to expect even Young Invincibles to fax in a paper. Even if it's not verified by the staff, the effect of knowing you have to provide documentation has an impact. Otherwise, we're opening the door to something that could come back to bite us.

**Motion/Action:** Board Member Ross moved to pass Resolution 2014-53 as amended by Board Member Belshé. This resolution is regarding the readoption of

the regulations for the Eligibility and Enrollment Process for the Individual Exchange. Board Member Belshé seconded the motion

**Vote:** Roll was called, and the motion was passed by a vote. Board Member Fearer was absent. Board Member Kennedy voted no.

**ii. Enrollment Assistance Program**
Katie Ravel spoke briefly on Enrollment Assistance

**Motion/Action:** Board Member Belshé moved to pass Resolution 2014-54 to readopt the enrollment assistance program regulations. Board Member Ross seconded the motion.
**Discussion:** None

**Public Comment:** None

**Vote:** Roll was called, and the motion was approved by a unanimous vote.

**Agenda Item VI: Adjournment**
The meeting was adjourned at 4:30 p.m.