CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD MINUTES
Thursday, February 18, 2016
Covered California Tahoe Auditorium
1601 Exposition Blvd.
Sacramento, CA 95815

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

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

Board members present during roll call:
Diana S. Dooley, Chair
Marty Morgenstern
Paul Fearer

Board members en route during roll call:
Art Torres
Genoveva Islas

Agenda Item II: Closed Session

Discussion: Announcement of Closed Session Actions
The Board convened to discuss personnel and contracting matters and noted there was nothing to report on these matters at this time.

A conflict disclosure was performed and there were no conflicts from the board members that needed to be disclosed. Chairwoman Dooley called the Open Session to order at 12:00 pm.

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 January 21, 2016 meeting minutes.

Presentation: January 21, 2016, Minutes

Discussion: None.

Public Comment: None

Motion/Action: Board Member Morgenstern moved to approve the January 21, 2016, minutes. Board Member Islas seconded the motion.

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

Agenda Item IV: Executive Director's Report

Announcement of Closed Session Actions

Peter V. Lee, Executive Director, noted that there was nothing to report from closed session.

Executive Director's Update

Discussion: Press and Media

Mr. Lee referred the board to the media clips about Covered California, including the release of Covered California's launch in vision services.

Discussion: Reports and Research

Mr. Lee called attention to the several reports and research articles included in the Board material. Federal reports included a HHS ASPE report on premiums after the tax credit. There is also a report on the changes in the uninsurance rates nationally, based on the National Health Interview Survey. The third report is from the Congressional Budget Office (CBO) on private premiums and federal policy.

Reports about Covered California included a report from the California State Auditor. Mr. Lee went over the three main findings and Covered California's reactions to them. In the first finding, the auditor noted concern that Covered California used non-competitive bids too much. Mr. Lee agreed and noted that in January, the Board adopted a procurement manual. The second finding was the need to ensure Covered California is rigorously assessing the reserves needed. He strongly agreed and noted that detailed review of enrollment estimates and appropriate reserves will be provided to the Board in the coming months. Additionally, Covered California has retained Pricewaterhouse Coopers to look at enrollment projections and ensure they are accurate. The final observation was with regard to Covered California's use of independent review of CalHeers development. They noted the importance of having independent verification and validation (IV&V). Mr. Lee noted that Covered California had an independent firm provide that in the first years of CalHeers, prior to contracting to the Office of System Integration (OSI), independent from Covered California. Mr. Lee agreed that independent review of Accenture and its subcontractors is critical, but has a difference in opinion with the state auditor in how best to do that independent review.

Additional reports specific to Covered California included the California Health Care Foundation's report on improving the online experience of consumers, two reports from Massachusetts on their consideration of 1332 Waivers, a report from Avalere looking at standard benefit designs, a Robert Wood Johnson Foundation report on the best regional hospitals in exchanges, a Commonwealth Fund report on the Affordable Care Act and the U.S. economy, with a five-year perspective. And finally, a Peterson-Kaiser report looking at social determinants of health in the U.S. versus other countries.

Mr. Lee shared that the Board received many comments from specific to special enrollment period issues, contracting, and Medi-Cal to Covered California transitions.

Discussion: Open Enrollment Update

Mr. Lee indicated that open enrollment closed on January 31st and reported that enrollment was strong, with nearly 440,000 new enrollees in Covered California. 88% of consumers stayed where they were when they renewed. With regards to enrollment by race/ethnicity, Mr. Lee also noted that take-up among Latinos, African Americans, and Asian Pacific Islanders was very similar to open enrollment two. The total percentage of subsidy-eligible consumers remained similar to last year at 90%. In terms of age, enrollment for consumers between ages 18–34 increased to 38%, up from last year's 34%, and 29% in 2014. The good risk pool has resulted in premium increases of 4%. Enrollment by gender was 50/50 female to male. In terms of enrollment by service channel, nearly 45% of enrollment came through certified agent, 32% of enrollment was through self-service online. The next largest source of enrollment is service center representatives. Lastly, there was a decline on individuals enrolling through the navigator program, with 6%, versus 10% last year.

With regards to enrollment by region, enrollment continues to be concentrated in the four major plans. However, this concentration is less than it was due to Molina's substantial growth in the last year. Mr. Lee shared that a press release went out that provides a breakdown of enrollment by region, by plan. Mr. Lee noted that Covered California has created a marketplace where in every region of the state, 99.3%, enrollees had at least three health plans to choose. In terms of enrollment by metal tier, there was a slight increase in the percentage of newly enrolled individuals that selected bronze, 31%. Additionally, there is a continued decline in subsidy eligible individuals enrolling in gold and platinum. Enrollment data by unsubsidized enrollees remained similar to prior years.

Discussion: 1332 Waiver Process Update

Mr. Lee announced that Covered California is exploring options for pursuing a 1332 State Innovation Waiver and will be having a public forum on Tuesday, February 25 at 8:30 am. Expert panelists as well as advocates will discuss the process, federal requirements, guardrails, and options Covered California should consider. He welcomed comments ahead of time to 1332@coveredca.gov and encouraged everyone to also look at the Covered California website on items posted and watch the broadcast live.

Discussion: Vision Program Update

Mr. Lee reported that as of February 16th, Covered California launched a link where vision plan carriers can enroll consumers that are in Covered California directly. VSP Vision Care is the first carrier to be added, and other carriers may be added in the future. There are no standard benefits in vision. Covered California we will be monitoring and reporting back regularly. He noted that applicants had to pay a fee and provide Covered California with 5% commission on sales made.

Discussion: Covered California Board Calendar

Mr. Lee announced that there will not be a March board meeting. The next meeting is scheduled for April 7th.

Discussion: Service Center

Mr. Lee commended the service center for their good work over this open enrollment period. The average speed to answer in the month of January was three minutes, with

over 50% of the calls answered within 30 seconds. As the new fiscal year approaches, service level will be an important budget issue that will be looked at closely. He also commended Covered California's partners in the counties.

Public Comment

Elizabeth Landsberg, Western Center on Law and Poverty (WCLP) and the Health Consumer Alliance (HCA) is concerned about ongoing problems with consumers who are moving from Medi-Cal to Covered California. This is an issue that they have been talking to staff about for quite some time, but nothing has been issued telling either consumers or people helping them that people do have to pick a plan by the end of their last month on Medi-Cal or they will be uninsured. The current notice to consumers indicates they have 60 days to pick a plan, but consumers will uninsured if that happens. She requested that the board instruct staff to take this more seriously and noted a contrast between how the special enrollment period issue has been raised and handled and how this has been handled. She explained that Covered California is making allegations that, as far as she knows, are unsubstantiated about wrongdoing in SEPs. She believes the proposal to deal with this is radical. And yet with the former issue, there's still not basic information going out to consumers. She went on to explain they are part of in a work group. However, the last two meetings were canceled and staff has not issued anything concrete.

Ms. Landsberg appreciated Mr. Lee noting the CHCF report about CalHeers in his Executive Director's report. She also shared that advocates will be participating in user exceptions testing at the end of this month, There has been progress made on a number of points. She looks forward to some of the issues in the CHCF report, which we are also working with you on being addressed. The report noted that people are cycling through Shop and Compare, confused and thinking they are applying. So that's something that Covered California can fix itself without reliance on the vendor. Lastly, Ms. Landsberg noted that there are still a lot of ongoing problems with how income is calculated and how people are explained, what their income is. Some of those are slated for CalHeers releases and some are not, so she hopes those will be accelerated.

Michelle Lilienfeld, National Health Law Program (NHLP) echoed Ms. Landsberg concerns regarding transitions, and the minimal progress that has occurred since this issue was last brought to the board's attention in November. As Ms. Landsberg noted, one of the issues has been the inability to produce legally sufficient notice that meets basic due process requirements and includes crucial information to consumers about how to avoid loss of coverage. We also in the past have asked that Covered California says service staff be trained to assist these consumers. And as of now, even tentative changes do not have scheduled dates, and greater changes will not happen until September. With an absence of clear policy guidance, training, and legally sufficient notice, both the Department of Health Care Services and Covered California are not upholding the obligation to ensure transition without a break in coverage for enrollees as required by law.

Michael Lujan, California Association of Health Underwriters (CAHU) was pleased to see the data that provides a lot more clarity around what is happening by ethnicity, by location, by plan, and channel.

He is pleased with the role agents are playing and to see that they are growing and maintaining their involvement and engagement and requested having more metrics shared that might help inform them on how they are performing around retention. Some of the areas that might inform them of how they might prepare during the off season to get better next year. He said they are also very big supporters of allowing agents to continue their work outside of open enrollment. Those comments have been shared at ITUP and they'll continue to share those comments through 1332 and other opportunities.

Lastly, Mr. Lujan complimented the work of the California Health Care Foundation and their insight and seeing it as an opportunity for work to happen to improve the CalHeers experience.

Dorena Wong, Advancing Justice LA stated there were several factors that might have contributed to the decline in enrollment by navigators. First, there was reduction in the number of grants and the amount allocated for the navigator program. Additionally, the CEC assistance line does not have the same hours as the customer service line. There are also some issues with the delegation codes. There was a change in policy where consumers could not change the delegation code and the CECs would go through the consumer line to help the enrollee, without changing the code. Ms. Wong shared that their navigators are working very hard and taking as many calls and enrollments as they have in the past. She also supports Ms. Lilienfeld's comments about the issues with gaps in coverage. Lastly, she also requested to see some disaggregated race, ethnicity, and data. The data book that comes out in the summer and fall comes out too late for planning purposes.

Mr. Lee responded that Covered California has been working closely with DHCS and that many of the notice issues and the conversion issues are primarily DHCS issues and hand offs to Covered California. He asserted that Covered California will continue to work closely with Jennifer Kent to try to facilitate those and have them be as clear, smooth, and rapid as possible.

With regard to the request on obtaining more data, sooner, Mr. Lee responded that he agreed and stated that Covered California would do what it could.

Agenda Item V: Covered California Policy and Action Items

2017 Qualified Health Plans: Recertification, New Entrants, Standard Benefit designs and Quality Framework

Anne Price, Director of Plan Management, reviewed the certification timeline and proposed dates and deadlines included in the Board materials and indicated the areas where changes have been made since the January presentation.

Ms. Price reviewed the criteria for plan selection. Covered California is looking for plans that offer that value based on quality, service and price, competition throughout the state, integrated health care delivery systems and administrative capacity.

Ms. Price provided a 2017 certification update. She indicated there were no significant comments received from what was presented in January. The two changes being made to the recommendations include a change related to the participation fee, changing it from a flat fee to a percentage fee. The percentage fee recommendation will be presented in April, with final approval sought in May. Staff will be providing a guidance figure of 3.5% in the initial 2017 rates submitted on May 2nd, with the understanding that that value can be updated and the rate will be reviewed annually and adjusted as necessary. With regards to small business applications, there will be a small change that we will allow new carrier entrants off annual certification cycle. The participation fee guidance also applies to dental. Small group rates are not due until late July, so the small group participation fee will be going along with the board direction.

Ms. Price reported that the actuarial value calculator was released with no significant changes. Ms. Price also presented a list of changes that resulted from comments received related to clean up and end notes.

There were two changes with dental standard benefit design. One is clarifies that the exclusion of tooth whitening, adult orthodontia and implants is subject to adult benefits only. On the employer-sponsored adult coinsurance plan design, adult endodontic services are included in basic services.

Board Member Torres requested clarification on orthodontics. Ms. Price clarified that plans are now standardized, and adult orthodontia is not covered. She said she would double check this for pediatric dental, which is imbedded in the health plan and provides some level of pediatric orthodonture related to necessity, and not cosmetic reasons. Mr. Torres asked if cosmetic reasons implied the elimination of braces and requested clarification on how essential/medically necessary orthodontia. Ms. Taylor Priestley, in Plan Management, responded it is defined by the requirements of the benchmark plan design for pediatrics. She added that medically necessary meant as deemed by an orthodontist following a scheduled requirement, defined by California Children's Services (CCS). Ms. Price responded that she would follow up with Mr. Torres with the actual language.

Ms. Price shared some appendix documents related to an aggregation of the comments received.

Chair Dooley thanked Ms. Price and presented two resolutions dealing with the certification policies and improving the issuance of the application, and a second resolution to adopt a standard benefit design. She took them both together and asked if there were questions from the board before opening for public comment.

Mr. Lee clarified that public comment is not on the broader issue of the quality of delivery in the contract, but on whole package of standard designs.

Ms. Price added that there is a side-by-side comparison of the benefits by metal tier that includes all of the things that were changed.

Discussion: None.

> **Motion/Action:** Board Member Torres moved to pass Resolution 2016-03. Board Member Islas seconded the motion.
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> **Motion/Action:** Board Member Torres moved to pass Resolution 2016-04. Board Member Islas seconded the motion.

Public Comment

Beth Capell, Health Access California, added her support for the adoption of the standard benefit designs. This has been a multi-year effort, in which Covered California has been able to adjust and adapt and to do really landmark work, for example on prescription drug cost sharing as well as on incentivizing primary care in outpatient care. This proposal would adjust copays slightly higher, but there will be no surprise deductibles weeks after getting care. Ms. Capell agreed with Mr. Lee that the landmark work that the board has done over the last several years would not have been possible without a collaborative, iterative process and a consultative process.

Betsy Imholz, Consumers Union, echoed Ms. Capell's remarks and commented that it provides an apples-to-apples comparison basis that no other state has, and the federal government is even looking at it now as a model.

Jen Flory, Western Center on Law and Poverty and the Health Consumer Alliance, reiterated Betsy and Beth's comments. She pointed out the silver 73 plan, which is a population that gets extra subsidies. In addition to the roughly 6% of their income that consumers pay in premiums, they are looking at 20% of their income in out-of-pocket costs if they have a catastrophe. The actuarial value calculator is the tough task master. That is still what consumers are paying, even in the best of circumstances. A lot of work still needs to be done outside of this process on affordability in general.

Cary Sanders, California Pan-Ethnic Health Network (CP-EHN), appreciated staff for working through the various ideas and proposals and for coming up with a way to really encourage the use of preventative care and to make care affordable for enrollees.

Michelle Lilienfeld, National Health Law Program (NHLP), echoed the sentiments shared by other advocates and appreciates the plan management process.

Juli Broyles, California Association of Health Underwriters, appreciates the time and effort that went into putting the benefit designs in. The clearer they are, the more explainable they are to the consumer. All of the updates made will lead to good results in

the marketplace, especially the requirement that the cost of that emergency room visit will not have surprise bill at the end of it.

On resolution 2016-13, related to the approval of the certification requirements and the issuance of the qualified health plan applications.

Vote: roll was called and the motion was approved by a unanimous vote.

On number 2016-04, approval of the standard benefit design plans.

Vote: roll was called and the motion was approved by a unanimous vote.

Quality and Delivery System Reform

Mr. Lee thanked all participants, the benefit design working group, and the representatives from the health plans. He explained that goal was to create benefit designs that are about minimizing burdens and barriers to consumers.

Mr. Lee reported that the model contract will be a new, three year contract that applies lessons learned over the past two and a half years, and a better vision of how Covered California can both assure a good risk mix, and affecting the delivery system robustly. In an effort to ensure that board has a chance to fully hear comments, concerns and suggestions, action will be held at the April board meeting. Mr. Lee added specific measures will be part of attachments that will be revised on an ongoing basis. The proposed contract is providing the broad guidance for what the plans will be responding to starting March 1. If major terms change, plans would need to amend their application.

Ms. Price provided an overview of revisions made to the 2017 recommended contract requirements that are not related to Attachment 7. Some of the base contract changes include a requirement for QHPs to identify when members are eligible for subsidy and forward them to the Exchange; updated appeals language to ensure health plan and Covered California working together to implement appeals decisions in a timely manner; updated language regarding agent commissions to ensure all products are being offered consistently throughout the market; the addition of an operational requirements and liquidated damages section, to ensure timely and accurate submission of QHP filings and documents to the Exchange; expanded remedies in case of a QHP issuer default or breach. Lastly, on Attachment 14 the penalty increased from 5% to 10% for QHP issuer failure to submit timely reconciliation reports.

Dr. Lance Lang, Chief Medical Officer, expressed his appreciation for the level of participation from all on the proposal. He indicated that meetings were held with all of the health plans starting in July. Advisory committee meetings were held as well as additional meetings with advocates. There has been ongoing dialogue, and the delay reflects the need to continue that robust exchange. It’s really been about detail that there has been disagreement on.

Dr. Lang went over the guiding principles for raising the bar on quality requirements, which are reemphasized in response to comments. He noted that independent but not isolated practice is respected, therefore collaborative and coordinated efforts on performance improvement are necessary within the PPO. There will be alignment among the major purchasers in the state which will result requirements across all business. Requirements will focus on tracking, trending, and improving health care disparities in care of for chronic disease. Enrollees will have tools needed to be active consumers. Payment reforms will be aligned with value and proven delivery models. Lastly, variation in delivery of quality care will be reduced so that all contracted providers meet minimum standards.

Dr. Lang presented an overview of updates to Attachment 7 based on stakeholder input. Under Article 3, he clarified that disparity measures refer to all lines of business, excluding Medicare. On Article 4, he clarified that the standards apply to Covered California lives only.

Dr. Lang provided clarification on Article 1. With regards to assuring networks are based on value, the process started in developing this requirement will be continued after the board adopts the contract in Attachment 7. He also indicated that outlier poor performance has not been defined and won't be until national benchmarks and variation across networks are evaluated. He noted that on all the quality targets, there is support available for providers. Lastly, health plans exclude poor performing providers by 2019. This would provide a rationale for continuing to contract with the provider, as long as the provider is undertaking efforts to improve performance. It doesn't include specifics on what actions should be taken, except by 2019, outliers need to be addressed.

One area that was thought to be missing was this focus on action on high-cost pharmaceuticals. This will also be a reporting requirement. Specifics aren't included on how, but staff is looking for best practices and may add requirements at a later date that would help bring pharmaceuticals under control.

With regards to data exchange with providers, much of the requirements included in later articles require more data than either health plans or providers have in their possession at this time. Managing clinical data to track, trend, and improve requires more than sample collection on a once-a-year basis for HEDIS. Examples were provided where exchange between providers and plans and among providers will be critical. Existing initiatives were outlined for electronic health information exchanges.

For data aggregation across health plans, there are a number of benchmark tools that report on aggregated data on provider performance. There is proposals now for an all claims database. Covered California would like reports on what the best practices are.

Dr. Lang explained that the next steps include establishing standards and specifications in collaboration with stakeholders based on best science and benchmarks, as well as understanding variation within California.

Dr. Lang reviewed an appendix with some 25 areas of comment that was outlined. With regards to disparities there's a lot of concern that some quality initiatives may have the unintended consequence of aggravating disparities. As a result, balancing measures will be used to alert Covered CA for unintended consequences. Also in collecting self-reported racial and ethnic identity, the target was reduced to 80%. There were also comments stating the pace of the disparities measurement was too slow, and too fast by others. Dr. Lang indicated they will try to find the right balance, and that there will be some flexibility on how requirements are fulfilled.

With regards to data for all lines of business, there was concern that only Covered California enrollees should be addressed. Dr. Lang responded that data is needed for comparison, the across plan. That will be an accountability and a requirement.

For payment reform, Dr. Lang indicated it may not be fully developed 16, so the due date could be advanced to the third quarter if necessary.

Article 5, relating to Hospital Acquired Conditions (HACs) received a lot of push back that adverse drug events (ADEs) are not ready for prime time as a measure. Dr. Lang stated that although ADEs have been one of the target HACs designated by CMMI as part of Partnership for Patient program, there was flexibility in the program and few hospitals have experience with the measure. The proposal has been modified and Covered California will be starting with Opioid Overdose in 2017 and defer the other measures to future years. Dr. Lang reported that the feedback from the stakeholders indicated it's a reasonable compromise.

There was a lot of concern in the hospital incentive program was structured, where 6% of payments were based on a plan's priorities around how they defined quality. There is some evidence that readmissions may be beyond the control of the health care delivery system, or resources that could be provided at the time of discharge because of social determinants. Revisions were made to say that if readmissions are part of the mix, it not be the only measure.

Lastly, Dr. Lang stated that both providers and some plans raised concerns about the confidentiality of their contracts as relates to pricing. Covered California's does not plan on modifying that the requirement. When as much as $6800 may be a patient's responsibility out of pocket, Covered California need to know what it's going to cost an enrollee when they get care. And because contracts vary by provider, they need to be able to include that variation as part of their decision making.

Chair Dooley expressed her appreciation for everyone who has participated in the stakeholder process.

Mr. Lee noted that this is a very robust road map, where Covered California wants to ensure enrollees have the information and tools to get the right care at the right time. It is a big agenda that warrants holding the proposal for action until April.

Board Member Fearer requested clarification on modification to the contract after approval. Mr. Lee responded that the structure proposed to the board for approval in April will be a structure that we will then continue a collaborative working process to work out those details in the months and years to come.

Mr. Fearer asked if pharmaceuticals is that meant expansively to include scrip as well as inpatient, or is it just out patient? Mr. Lang responded that he believes it's both

Public Comment

Amber Kemp, California Hospital Association (CHA), shared that their members have a shared commitment to achieving the triple aim, as reflected on their February 8th and 16th comments. However, there are a number of questions that remain unanswered. And the lack of clarity regarding QHP and provider requirements in Attachment 7 remain a great concern. The current process has not supported the needs of Covered California for stakeholders, namely providers, in being able to fully vet and consider both the opportunities and the challenges of the proposed requirements in Attachment 7. And from reviewing comments of other stakeholders, it is clear that there is confusion amongst the field regarding the complex and often overlapping provisions. CHA has identified areas that if not addressed will lead to overly burdensome and costly data collection, multiple competing health plan priorities, and a downstream effect that will divert precious health care dollars away from direct patient care, which is contrary to the goals of Covered California. While the approval delay is appreciated, Ms. Kemp urged the Board to revisit the stakeholder engagement process to include providers more, so that the policies can be more fully vetted and the issues can be addressed in a way that accelerates improvement, reduces costs, and improves the health care of all Californians.

Cary Sanders, California Pan-Ethnic Health Network (CP-EHN), appreciates the stakeholder process which has been in place since last summer. Staff has really listened to stakeholders. Ms. Sanders is disappointed that there's no vote today and thinks that the proposal before the board is a very concrete set of proposals that are very well vetted, that have considered comments from stakeholders that have participated, including some landmark proposals really around health disparities reduction that will move the needle in Covered California from talking about disparities to actual improvements and reducing those disparities. The attention to some of CP-EHN's recent comments on the red line version are appreciated, including an acknowledgment and commitment ensuring that some of the quality improvement initiatives don't, unintentionally exacerbate health disparities. CP-EH is one of the groups that would like progress on disparities reduction move faster. Ms. Sanders urged the board to stand behind the work of staff and the work of the stakeholders group and acknowledged there are places where there could be some improvements.

Dorena Wong, Asian Americans Advancing Justice LA, supported Ms. Sanders' comments and the specific recommendations in the letter that they submitted. The recommendations, especially around the health disparities in section seven do show that California is leading other states in ensuring that health equity is integrated more closely in quality improvement. She supports a lot of what has been proposed and continues to recommend a uniform and also disaggregated data collection in reporting. Rather than the

use large categories like Asian American or native born pacific islanders, she would like a more disaggregated data on populations. The inclusion of language as one of the categories is appreciated and she hopes that it is integrated sooner rather than later, because it really relates to access issues. In conclusion, Ms. Wong hopes the Board approves the contract.

Wendy Soe, California Association of Health Plans (CAHP), thanked the Director and the Board for delaying action on the model contract. It really will allow the health plans and all of stakeholders more time for thoughtful review and comment to the terms. This contract is very important to the QHP's and it's worth taking the time to get it right. It's critical that time is taken to discuss the quality metrics set forth in the contract. They have to be aligned with the other quality initiatives that plans are doing for other state plans like Medi-Cal, as well as national efforts.

Stacy Wittorff, California Medical Association, appreciates the decision to postpone a vote on these items in order to allow for more discussion. CMA shares Covered California's commitment to the triple aim, and wants to ensure that efforts to make good on those commitments take into account all stakeholders, including physicians, who are an essential component of California's health care system. Attachment 7 and its appendices will have a significant impact on CMA members in terms of their ability to provide care to Covered California's enrollees. CMA has expressed concerns about Attachment 7 in submissions dated February 4th and 16th. CMA opposes the publication of any provider allowed charges as negotiated with plans, as they raise anti-trust issues, and is unsure how this information is useful to Covered California enrollees. With regard to physician quality rating, in order for these ratings to be useful to enrollees and fair for physicians, they must be accurate. Accordingly, physicians must have meaningful opportunity to review and correct their data prior to publication, and data collection efforts must be conducted in a way that does not place significant administrative burden on physicians, as time spent complying with these requirements takes time away from their ability to provide medical care. Physicians who become over burdened with administrative requirements may be forced into a decision not to participate in Covered California, which could have detrimental effects

Edie Burns, Private Essential Access Community Hospitals (PEACH), echoed the comments submitted by CHA. Mr. Burns also appreciates that more time is being allowed for more engagement and involvement by community safety net hospitals. Mr. Burns appreciates that the February 18th draft issued today includes some language that addresses the importance of establishing consistency across contractors and looks forward to working with Covered California to maximize uniformity of QHP quality measures, and cost factors that would determine potential exclusion of hospitals from networks. Mr. Burns thanked staff for adding the language that does acknowledge that QHP's need to support essential community provider hospitals in terms of achieving their performance quality goals and prevent unintended consequences in terms of access relative to the value-based payments for the safety hospitals and really takes into account the complex socio demographic needs of communities.

Bill Wehrle, Kaiser Permanente, indicated that on Attachment 7, there are a few items, that are unique to the Kaiser model and that should be addressed differently. For example, one section requires the QHP to list all of the hospitals that are available to the consumers in a particular region and how much it would cost if you go to each of them. For Kaiser it would be one or two hospitals, not ten, and it's going to cost the same. Second, Kaiser is philosophically not on board with the notion of individual physician ratings as a way to achieve quality improvements. Kaiser believes that that this is achieved by surrounding practitioners with a system that assures the right care is given at the right time. This is one area that needs further conversation. Lastly, Mr. Wehrle acknowledged that staff is listening to stakeholders. However, more work is still needed to get to an acceptable document.

Jen Flory, Western Center on Law and Poverty and the Health Consumer Alliance, appreciates the additional time to work through some of the comments. For example, with the appeals and getting appeals decisions acted on more quickly with plans, that was intended to be not just appeals decisions, because we don't want to force consumers to go through appeals needlessly. Some of the problems that happened, when they called Covered California they realized it was just a complete error and it doesn't necessitate an appeal. Ms. Flory would like those on a similar timeline to get the plan to reinstate people. Similarly, certain physicians do like to charge fees for certain services like e-mailing or refilling a prescription. Those are not non-covered services as they are described. They are the cost of doing business, and Covered California is in a unique position to stop some of those practices from happening, as DHCS was able to when certain Medi-Cal providers did the same thing. With regards to Attachment 7, Ms. Flory is happy to see Covered California moving on with some of the quality issues. She agreed with that this is moving too slow, but appreciates that it's happening. Ms. Flory would like to see a plan begin on the issue of disparities based on gender identity, sexual orientation, and disability status. She understands it may take some time, but questions need to start being asked so that measuring is possible.

Michelle Lilienfeld, National Health Law Program (NHLP), and also on behalf of the Health Consumer Alliance supports the quality initiatives, and the comments made by Ms. Sanders. With regards to Article 2, Section 2.1 on contractor responsibility, Ms. Lilienfeld appreciated the inclusion of informal resolutions resulting from an appeal in section 2.1.2b. She recommends that it also include other informal resolutions that Covered California's customer service or research and resolution teams may create. She also recommended that QHP's be required to report, within a set time frame, the status completion of appeals decisions, informal resolutions, and written directives from Covered California. Furthermore, she recommended that there be a penalty for QHP's that do not fully and fail to implement appeals decisions or written case directives and should be considered a default on the contract and subject to remedies outlined in the section 7.2.4 of the contract. Finally, recording section 2.1.2d, Ms. Lilienfeld recommended requiring insurers to be responsible for verifying eligibility, that it gets established or reestablished as a result of an appeal. This goes to a common consumer problem that HCA local sees, where Covered California says that an enrollee has coverage restored, but the QHP doesn't have a record it. Ms. Lilienfeld recommends that

QHP's issue a confirmation in writing to both Covered California and the enrollees and that coverage be restored after an appeal.

Jerry Jeffe, California Chronic Care Coalition, commented on two areas. With regards to high-cost pharmaceuticals, he requested that information to be made public, as long as it doesn't violate confidentiality or proprietary elements. There is a lot of interest in transparency and how much drugs cost. Earlier this year, and also last year, Assemblyman Chu had a bill that would provide for transparency. It didn't even come up for a vote. This is another approach for transparency, and it's not as comprehensive, but it's still a good approach for providing information. With regards to data, this is a very complex area, and Mr. Jeffe is glad to see the delay in the contract and more work being done in this area.

Chair Dooley paused on the comments to allow Mr. John Bertko to make his presentation on special enrollment.

Consideration of Special Enrollment Period Policies

Emerging Potential Trends for Covered California Special Enrollment Period (SEP) Enrollees

Mr. Lee pointed out that two years ago, the board adopted a policy that would rely on self-attestation from consumers confirming a qualified event took place during SEP. At the time, the health plans were concerned that it wasn't adequate and more documentation should be required. The Board decided to wait, then assess in going forward. Mr. Bertko will be reviewing information that gives staff reason to recommend that this policy be changed. Chair Dooley indicated that Mr. Bertko will have access to all comments and be responsive before the board makes a decision at the April meeting.

John Bertko, Chief Actuary at Covered California shared that 2017 will be a big transition year. He pointed out that premium increases were low, at 4.2% and 4%, in 2015 and 2016. Mr. Bertko reviewed some of the major factors impacting rates in 2017. He also remarked that Special Enrollment is becoming increasingly important, making up 13% of effectuated 2015 memberships, versus 11% in 2014. Some of the plans have reported that it's getting closer to 20%.

He pointed out that credible sources indicate the risk mix of SEP enrollment is higher cost than open enrollment. Additionally, the California big four health plans believe that having documentation requirements would reduce SEP enrollment. Mr. Bertko shared that he has had access to several hundred thousand people's worth of claims for 2014 and 2015. The spread between SEP and OEP is that SEP is somewhere between 5-10% higher as they measured it with good data. While lower income enrollees are largely protected from premium increases by income-based subsidies, middle income, non-subsidized enrollees pay the entire premium. Additionally, the Federal Treasury premium tax credits are impacted by the increases for subsidized individuals. Mr. Bertko reviewed his sources of information and cautioned that data is still emerging. Although nothing is proven yet, it is some number that is big enough.

Mr. Bertko shared several observations based on proprietary data that has been provided by the big four health plans. The first observation is that SEP enrollees have a higher per member per month cost than OEP enrollees. Secondly, SEP members are about two years younger than OEP members, which exacerbates the cost difference. Third, health plans are reporting their strong belief that substantial SEP enrollment does not meet requirements of SEP criteria. When comparing the SEP cost difference between their off exchange and on exchange, the cost difference between SEP and OEP drops at least 50%. Fourth, it's unclear whether SEP enrollees are dropping coverage after use of care or are dropping because they have little need for services. There is some evidence that there is very high use by SEP enrollees in the first month or two of services. Fifth, SEP will be an increasing portion of the open enrollment mix of exchanges, with all carriers indicating a trend over time for larger impact of SEP members. He remarked in addition to SEP enrollees, Covered California is also responsible for the 1.3-1.4 million non-SEP people who also need affordable premiums. A rate increase could mean enrollees terminate their coverage because it is unaffordable. Lastly Mr. Bertko indicated that Covered California and the individual markets now are becoming a good alternative to Cobra for younger people, increasing average enrollment cost.

Chair Dooley asked Mr. Bertko to share more information on why there is increased cost to SEP enrollees, versus open OEP enrollees. Mr. Bertko responded that he does not have a clear picture on that yet, but explained there is a large national database, which covers 30 or so states in detail, that shows SEP enrollee costs are 5% to 10% higher costs. He added that they also looked at babies and that was one of the issues. However, there was no on/off exchange comparisons.

Chair Dooley asked if both a mother and baby could be enrolled after the birth of the child. Mr. Lee confirmed that was correct and added that birth is an event that is easy to validate. But the national data is that childbirth is a reason that, without an issue of documentation, there may be somewhat higher.

Mr. Fearer commented that one reasonable hypothesis concerning those people that do have proper documentation, and why they are more expensive, is a combination of risk taking behavior and affordability issues, which would give a bias, even among those who are truly eligible, that they are going to be more expensive. Mr. Bertko agreed.

Mr. Lee asked Mr. Bertko if the plan actuaries' belief that they would need to raise premiums 2%–5% was a credible argument. Mr. Bertko agreed that would be the case if no changes were made to the current attestation process. Mr. Lee asked Mr. Bertko if a 2%-5% premium increase could have significant, but not a huge impact on people paying premiums that we could lose. Mr. Bertko agreed that although it is not an end-of-the-world scenario, it's important to keep premium increases for a year to a reasonable number.

Mr. Fearer asked if it was only the increased number of SEP people that would lead to a premium increase. Mr. Bertko said it was true for 2014 and less true for 2015 because the experience for 2015 is just now emerging and actuaries setting their rates for 2017 based

on 2015. Mr. Lee clarified that when actuaries do their rates for 2017, they are looking not just at what happened in 2015, but continued degradation or impact to the risk pool going forward. Mr. Bertko agreed.

Board Member Morgenstern asked when numbers would be available that the actuaries would be confident with. Mr. Bertko responded that they have until May 2nd to submit proposals, which will be the basis for calculating their 2017 rate proposals.

Chair Dooley asked if the Board's policy action at the April meeting will affect what rates the plans will come in with in May. Mr. Bertko agreed. Chair Dooley said the Board will need to make an informed judgement based on incomplete data.

Mr. Morgenstern asked if the Board's decision will affect the immediate contracts coming up. Mr. Bertko said yes.

Mr. Torres asked Mr. Bertko what he meant when he said cobra enrollees have a 20-plus years' experience. Mr. Bertko clarified that Cobra has been around since the late 80's, hence 20+ years of experience. He added that they are about 150% of the cost of an average person because they made a selection to actually buy that coverage at relatively high cost. Mr. Torres asked if that's why we are seeing that increase in that age group towards Covered California. Mr. Bertko agreed.

Public Comment (on QHP cont.)

Betsy Imholz, Consumers Union, commended the collaborative approach on Attachment 7, as well as on the contract. Leveraging the active purchaser role to really realize the full promise of the affordable care act really is ground breaking. The improvement of safety, quality, and value being sought through this comprehensive proposal is essential to sustaining the reforms as well as the entire health care system. Ms. Imholz appreciates the focus on reducing disparities, particularly the addition of the limited English proficiency measure. She also emphasized the importance of getting the definitions set up.

Michael Lujan, California Association of Health Underwriters (CAHU), is proud to see the efforts to reduce disparities in health. Regarding the model contract, Section 1.17, Mr. Lujan hopes that information to consumers about their access to in-person enrollment can be included. Enrollment is getting more and more difficult and that message is still being missed. When referring to "in-person enrollment," Mr. Lujan clarified that he meant everyone, not just agents. On Section 2.26, Mr. Lujan appreciates the concern and watchful eye on compensation related to SEP and the impact that it has on agents. He indicated there is also a differential payment that happens in other states. It's not pervasive in California, but anything that would act as steering on the QHP side that attempts to guide enrollment in one plan versus another would not be good for anyone, especially consumers. CAHU is very concerned around the trend of shrinking compensation, SEP and tiered compensation.

Beth Abbott, Office of the Patient Advocate (OPA), urged Dr. Lang to include the OPA to the sources of data aggregation across health plans. OPA has more than 2,000, 2100 data points that aggregate data across plans and make comparisons and judgment calls in

terms of quality. And in about two weeks they are adding cost data to the quality data of their report card, which will have indications for medical groups, whether or not they have higher costs than usual, average costs, or lower costs. Ms. Abbott also mentioned that there is a lot of quality data in the Department of Managed Health Care's (DMHC), Right Care Initiatives. Ms. Abbot said she has had discussions with Covered California staff about re-establishing the link to the OPA quality report cards on OPA on the Covered California website. She also shared that OPA was just named the number one report card in the nation. She urged Covered California to have a link to the OPA's report card while they are building up their report card.

Beth Capell, Health Access California, was delighted to see the many quality measures and appreciate the collaborative and iterative process. She understands that expecting both plans and providers to improve quality while controlling cost and while not worsening disparities is a reinvention of how health care is delivered and will take time. Ms. Capell would like for more to be done sooner.

Mr. Lee responded to comments made. With regards to comments about cost information, Mr. Lee noted there are requirements in the contract that make best efforts to make the actual costs that consumers face from their providers available. It's Covered California's mission statement to create a marketplace that works for and is driven by consumers. A key element of that is that consumers understand what health care will cost them, and having health plans that are able to share what a consumer will experience is a core tool. Second, there's a number of questions and concerns with regard to providers not being surprised that health plans use data about them. Mr. Lee strongly agreed and pointed to the contract, we references the patient charter, which holds plans to accountable. Lastly, with regards to comments about moving too slow and too fast, Mr. Lee stated there needs to be a balance. The physician-hospital provider community has an array of daunting issues before them and they share Covered California's agenda to promote a triple aim.

Consideration of Special Enrollment Period Policies (cont.)

Discussion: Promoting Special Enrollment Periods

Mr. Lee highlighted a number things being done promote special enrollment periods, including collaborations with various groups. New advertisements that were also released on February 1st regarding special enrollment. Mr. Lee stated that Covered California wants to promote as much special enrollment as possible, but there is also an obligation to ensure people enrolling in special enrollment qualify. Mr. Lee added that as a result of the information presented by Mr. Bertko, staff is recommending that the verification process be altered to include documentation.

Discussion: Policy Considerations for Special Enrollment Verification

Ms. Price presented special enrollment policy considerations. Specifically, staff is proposing to move forward with requiring documentation with verification for SEP. She explained that SEP enrollee would receive a letter identifying the appropriate document that must be supplied to confirm eligibility. Members who were previously eligible for Medi-Cal but are no longer eligible due to an increase in income and are newly eligible

through Covered California will not be required to submit documents. Qualified health plans will use their existing processes to collect documentation and-or verify eligibility using electronic verification and pass all that documentation or verification information through to Covered California. Covered California will make all decisions related to final eligibility determination prior to coverage taking effect. Staff proposes continuing to work through the details of the process in consultation with health plans, advocates and the federal government. The final process will be presented to the board in April for action, with an anticipated start date of June 1st.

Mr. Lee added that staff is looking their own processes that could put in place to collect the documents directly. He would also like to minimize documentation by allowing electronic verification. Between now and April, there will be further discussion with stakeholders on documentation requirements. The goal is for this to be as clear, and minimally burdensome as possible. At the same time giving the assurance to both health plans and the public that the only qualified people getting enrolled in special enrollment.

Chair Dooley said her interest in the issue is around the integrity of the program. Rules about enrolling during open enrollment and spreading the risk over the entire base is fundamentally the tradeoff of no pre-existing conditions. In the private sector, there are requirements to show that you have a qualifying dependent. When PERS went through a process of requiring verification for dependents, they found thousands of people who are not eligible dependents, which adversely impacted rates for everybody else. In conclusion, Chair Dooley said she wants to assure integrity and assure that people play by the rules and that we are protecting the interests of the rule followers in the rate structure, and yet not overly burdening those people that have legitimate qualifying events that should be allowed to enroll.

Board Member Islas expressed her support of Chair Dooley's comments. She asked how staff will measure if and how consumers are being overburdened or slipping through the cracks. Mr. Lee responded that based on the health plan's experience, there will be around 10%-15% fewer people enrolled by having a documentation requirement; some of which will truly be eligible and some will not. He remarked that we will need to come back and set up a process to see how that is assessed.

Mr. Fearer echoed his support of the comments made. He added that in his experience in dealing with group purchasing, underwriters are inherently conservative. In the absence of good data, they are going to assume worst case scenario. Mr. Fearer believes that Mr. Bertko's sense of the risks for higher premiums is a very real risk.

Public Comment

Betsy Imholz, Consumers Union, stated that Staff's recommendation to require documents to verify SEP is an unnecessary restriction on access to coverage. More fundamentally, the factual basis for the abuse the proposal is aimed at correcting is not evident. The basis to date has been assertions by carriers, in some cases implying malfeasance by consumers. In relation to Federal regulations on the same topic, the major carriers did provide comment. Ms. Imholz's colleagues went through those comments in depth, but saw no empirical data. Ms. Imholz asked what specific problems the carriers

are seeing. What are the specific categories that are problematic? The proposed sweeping change to policy without those specific answers is ill advised. Documentation will mean people will drop out. We know this partly from the Washington experience, where they have allowed documentation for special enrollment categories. Documents may not be readily available for low-wage workers, especially things like loss of job. In conclusion, short enrollments in Covered California are not necessarily an indicator of abuse. Prior to the ACA, 62% of enrollees dropped out within five months. That wasn't because of fraud, it was because it's a stopgap measure. Individual coverage is not meant to be long-term coverage.

Elizabeth Landsberg of the Western Center on Law and Poverty (WCLP), and the Health Consumer Alliance echoed Ms. Imholz' comments that the staff proposal is not well founded and expressed her dismay with the rush to judgement without real evidence, in a way that will harm consumers in need of care as well as the risk mix. She stated that any time a consumer is required to submit another piece of paper, people will drop off.

This proposal veers dramatically from other procedures that Covered California uses today. For example, self-attestation is accepted on most things. Income and immigration information are first verified electronically and documentation is only required if there's a discrepancy between what the electronic verification shows and what the person has said. Furthermore, consumers currently have 95 days to provide documentation, and in a variety of ways. Consumers remain enrolled and have coverage during that 95-day period. Here, staff is proposing a 10-day window of time. They are also proposing that consumers have to send the document to the health plan, which Ms. Landsberg believes is an inappropriate role for the health plan. Also, there would be no conditional eligibility during that period.

Ms. Landsberg explained that applicants do not always have documents to prove eligibility for a special enrollment period. For instance, people fleeing domestic violence or who have been evicted from their homes and are sleeping on a friend's couch do not have a utility bill to prove they are living where they are. Ms. Landsberg went on to say that WCLP represents a lot of people who neither own their homes nor have a formal rental agreement. They also represent a lot of workers who don't get termination documents or documentation that their hours have been cut when they lose their jobs or have their hours cut.

In closing, Ms. Landsberg urged staff to reconsider this proposal, and urged the board to apply strict scrutiny as they look at it.

Mr. Torres asked Ms. Landsberg for clarification on the specific provisions of the proposal that she would like to see improved. Ms. Landsberg responded that WCLP is not convinced that there is a problem. For instance, one reason that special enrollment enrollees may have higher cost is because they are more likely to lose a job or move when they are sick. She indicated that WCLP has asked to see the data and encouraged Covered California staff to verify it. Additionally, they have asked to be in a room with the health plans and Covered California staff. In conclusion, Ms. Landsberg is not

convinced there is a problem. If there is a problem, though, she doesn't understand why people would be given 10 days instead of 95 days to provide verification.

Mr. Torres then asked if all the groups that signed on to the letter shared her position. Ms. Landsberg said the letter represents a deep concern over what was presented to last Thursday, but the proposal seems to be evolving.

Mr. Torres said this is a serious issue and asked Mr. Lee if staff is moving forward to reconcile some of the issues to come up with a solution that can be acceptable. Mr. Lee responded staff will continue to meet with the stakeholder groups and come back with a proposal.

Michelle Lilienfeld, National Health Law Program (NHLP) stated that while affordability is important, they do not support controlling costs by making it difficult for consumers to enroll in coverage which they are eligible for. They too have serious concerns with the staff proposal to require consumers to produce a paper document to demonstrate eligibility for special enrollment.

There's a lot of evidence, as is outlined in the advocates letter that was submitted to the board, but reliance to paper documents will serve as a barrier to enrollment. The documentation that would be required in many instances may not even exist.

And federal rules also state a strong preference for allowing applicants to self-attest eligibility, particularly when electronic verification is not available. The federal law and regulations recognize that verification and documentation pose significant burden to enrollment and should be minimized to the greatest extent possible. For this reason the federally facilitated marketplace allows applicants to self-attest.

Dorena Wong, Asian Americans Advancing Justice LA, supports a lot of the points made in the letter from the consumer groups. The proposal would make it more difficult to enroll eligible consumers. It is already very hard to enroll eligible consumers as during SEP due to confusion about what constitutes as qualifying event. This proposal would cause additional confusion and discourage people from applying for coverage during SEP. This proposal would be especially harmful for limited-English speaking populations, who already don't have much information in their languages. In response to the fraud allegations, Ms. Wong has not witnessed fraud in hear dealings with consumers. Relying on the health plans to collect the documents might also be problematic because the current dealings with the health plans are not necessarily smooth now; the plans lose documents when Ms. Wong's organization is trying to resolve billing and other kinds of issues for clients. In conclusion the requirement to have enrollees provide documentation during the SEP runs contrary to Covered California's goal to increase access to health coverage for consumers, and it places the burden on eligible enrollees.

Betzabel Estudillo, California Immigrant Policy Center, echoed all the comments made from previous speakers. The staff proposal for self-attestation for the special enrollment period is very concerning for communities of color and immigrant communities. A lot of

immigrant communities who are low-wage workers do not have documentation to prove that they have been terminated or other documentation that they can provide for special enrollment period. She urged for the proposal to be reconsidered

Cary Sanders, California Pan-Ethnic Health Network (CP-EHN), reiterated her support for the previous comments. She was taken by surprise that this proposal had come so far without much notification, on a three-day weekend. The concerns raised are understandable, but there is not a lot of information showing this is a problem. For the communities CP-EHN represents – limited English proficient, low income communities – documentation can be very difficult to come by, as is information about the special enrollment period. Ms. Sanders would like Covered California to educate people about their ability to access health care in SEP and not add additional barriers.

Wendy Soe, California Association of Health Plans (CAHP), expressed her support for the staff proposal for SEP. Their qualified health plans believe that the documentation will help prevent adverse selection for Covered California and help ensure the data integrity and appropriate use of special enrollment periods.

Linda Brown, Health Net, supports the staff recommendation to require documentation and believes it's prudent. She looks forward to understanding the advocates' concerns and working with advocates and staff to come up with something that is not an undue barrier to people enrolling in Covered California.

Michael Lujan, California Association of Health Underwriters (CAHU), stated that the diversity task force is working with this topic and provided anecdotal feedback around what they are finding. It is concerning to have stories in the media and some of them closer to home that are citing specific example of provider fraud. It's concerning with regard to the adverse selection. On one hand, it's reasonable, the example that cited. Even CalPERS had a defendant eligibility verification process that saved millions. Also concerning is the remedy that this would all go through Covered California, if its estimated 200-250,000 verification would all have to funnel through this agency, that might be an undue burden on Covered California if it comes through this channel as opposed to the carriers. In conclusion, Mr. Lujan wants to note that the issue is complex. Mr. Lujan agreed with a lot of the stakeholders who also said a lot of that verification just can't be delivered. And that was especially true in the findings working with diverse communities.

Rob Spector, Blue Shield of California, shared that they are working really hard to help expand enrollment and make a stable and affordable market. If action is not taken on this proposal, the net result will be a rate increase. This is also a unique opportunity for the plans to work with all the stakeholders to really figure out a process that works for everyone, is innovative, and reduces the burden.

Bill Wehrle, Kaiser Permanente, supports staff's recommendation and agreed with the way Chair Dooley laid out the issue. Mr. Wehrle pointed out that this issue was brought up a couple of years prior. At that time, those concerned about the policy said to wait

until there is data. Fast forward to today, and data is available. It may not be as robust as people would like, but there is actual data. Kaiser looked at their own experience, and compared people SEP to SEP, Covered California versus not and saw a dramatic difference in utilization when they looked at whether there was documentation. With regards to the point that other advocates have made about starting with an attestation, verification and providing 90 days, Mr. Wehrle responded that State and Federal law doesn't allow plans to take action if eligibility was inappropriate after enrollment is complete. That is why this uniquely has to be up front. Mr. Wehrle stated they have a very strong interest in getting as many enrollees as they can, but because of that element of the law, this issue has to be approached differently.

Kate Burch, California LGBT Health & Human Services Network, echoed the comments made by the consumer advocates. When people have a special enrollment period, they are going through a huge life event. Documents are hard to find. Signing up for insurance in general is hard. You have to find your old documentation. Doing that during a time where there's a lot going on in your life is extra difficult. It is not surprising that more sick people sign up during special enrollment periods than people who are healthy because the people who are sick are the ones who are going to actually prioritize that with everything else that is also going on. This policy, as presented is not a good idea. It would keep a lot of sick people out of coverage who are eligible and need coverage. If Covered California really insists on going forward with income verification, there should be a way to use a waiver to get around the law that says you can't do it. . Ms. Burch suggested that Covered California can use a 1332 waiver to do that sort of a switch around if there are problems with the legality.

With regards to the model contract, Ms. Burch said she was glad that sexual orientation and gender identity are included.

Beth Capell, Health Access California, stated she appreciated there was further thinking on the staff recommendation presented last Thursday. This arises from a fundamental disagreement about the prevalence of SEP triggers, of the life events and work transitions that result in special enrollment eligibility, as well as a fundamental misunderstanding of the prevalence of short bouts of uninsurance. There is a blog post from *Health Affairs* in the research documents of the agenda packet that summarizes the peer reviewed, academic literature on which comments are rested. It appears the plan actuaries are operating on the assumption that if special enrollment is more than 10-12%, it's somehow inherently fraudulent. Instead, based on the academic literature on changes in life circumstances, there are closer to a third to a half of enrollment should arise from special enrollment periods, and that much of it should be for brief periods of time. The fact that people have short bouts of coverage is a sign the system is working, not that it's a problem. Several other advocates have commented on the lack of documentation. The staff proposal is that if a person cannot produce a document, they will be denied coverage, even if no document exists. That seemed really harsh. There are a number of readily available data sources that appear not to have been contemplated. For example, each and every health plan knows who has been terminated from coverage. They can check their records when a job is lost or coverage is terminated after a divorce.

Mr. Torres pointed out a time when he was the director of Department of Personnel Administration and he refused crack down on state employees, because some of them were insuring their neighbors. Mr. Torres did not believe people were doing that, but Cal-PERS has now demonstrated that he was negligent in his duty. Mr. Torres noted the position taken by all of the consumer groups was very moving and would be taken into consideration. He encouraged everybody who is in the negotiations to understand there are two sides to this story. The basis of the ACA is that in order to insure with previous health conditions, everyone needs to sign up. He noted that staff's position was understandable. However, he finds it difficult to come up with documents in 10 days. He encouraged everyone work hard to come up with the best possible solution.

Mr. Lee noted that he wants to minimize what consumers have to do to verify status. He added that the self-interest of the health plans is to enroll more people at better risk. Staff's concern is that actuaries set rates with conservative base and we need to respond on a credible basis of what health plans will do for 2017. A 5% premium increase will result in tens of thousands of unsubsidized, middle class individuals will go without health insurance because it's unaffordable. We all need to be looking at have a system where we can insure as many people as possible.

Covered California Regulations

Discussion: Individual Eligibility and Enrollment Regulations Emergency Readoption

Bahara Hosseini covered the proposed changes to the Covered California Individual Eligibility and Enrollment and Appeals regulations. Changes included updating the definition of a Qualified Health Plan to include a Qualified Dental Plan (QDP), revising the definition of a (QDP) and removing the definition of stand-alone dental, family dental, and children's dental plans. Eligibility requirements are also being added for enrollment in a QDP. Language has also been added to support the verification of a qualifying life event. Language regarding the binder payments is also being amended to allow for the premium threshold to be applied to initial payments as well as the subsequent premium payments. And finally, the language regarding verbal unconditional withdrawal of an appeal has been amended to make the regulations consistent with our current processes.

Mr. Lee shared that this item will be coming back for action at the next meeting.

Public Comment

Jen Flory, Western Center on Law and Poverty and the Health Consumer Alliance, commented that she received the regulations language last night including what happens with the verbal unconditional withdrawal process. She stated that they do appreciate the efforts to make sure people are getting a written statement when that has happened. It will improve the process. Ms. Flory also stated her appreciation on the attempt to allow for partial premium payments. Lastly, Ms. Flory added that there are some real problems with the special enrollment language. For example, it's not clear how the timelines actually work for the special enrollments periods now. This is the exact thing they have

been working on with the Medi-Cal transitions that is required by federal regulation. It's not clear how the back and forth with the plan and the documentation works into that and if that will impermissibly extend people's gaps in coverage. Similarly, Ms. Flory believes the Exchange is a full arbiter of eligibility, and while the use of processing vendors is understandable, she has concerns about health plans processing this type of information and having access to claims data on consumers. Lastly, Ms. Flory noted that the current special enrollment regulations already provide a rather large warning of what happens if you commit fraud. This is a better way to deal the issue, then going back and forth between the plans and Covered California.

Chair Dooley asked Ms. Flory to clarify if she was commenting on the changes to eligibility or special enrollment. Ms. Flory responded that the changes to eligibility include how you verify the special enrollment period. Ms. Flory added that she was not talking about the global moral issue, but rather talking about the things that she thinks actually violate federal regulation.

Discussion: Permanent Plan-Based Enrollment Regulations Adoption

Drew Kyler reported that in March of last year the Board approved the beginning of the permanent rule-making process for the Plan-Based Enrollment (PBE) program. That was approved by the Office of Administrative Law in April. Technical and non-substantive changes were made in January and no comments were received. Mr. Kyler requested that the board approve filing the permanent regulations for the PBE program.

Discussion: None.

Public Comment: None

Motion/Action: Board Member Torres moved to pass Resolution 2016-05. Board Member Morgenstern seconded the motion.

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

Agenda Item VI: Adjournment

The meeting was adjourned at 3:41 p.m.