CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD
November 14, 2012
Department of Consumer Affairs
1747 North Market Blvd.
Sacramento, CA 95834

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

Board Members absent:
Robert Ross, MD

Agenda Item II: Closed Session

Chairwoman Dooley reconvened the meeting in open session at 12:06 p.m. Roll was taken. Board Member Kennedy was not present; Chairwoman Dooley announced Board Member Kennedy would be joining the meeting later. Chairwoman Dooley also announced Board Member Ross had another meeting today and could not be present.

Chairwoman Dooley asked Board Members if any conflicts relative to agenda items require disclosure. No conflicts were disclosed by Board Members.

Chairwoman Dooley announced she received a letter from the Speaker of the Assembly reappointing Paul Fearer to the Board for the term January 1, 2013 to January 1, 2017.

Agenda Item III. Announcement of Closed Session Actions

Agenda Item IV: Executive Director's Report
Note: This agenda item was taken up ahead of the Agenda Item III.

Presentation: Executive Director's Report

Mr. Lee noted the outcome of last week's election removed a distraction and that the Exchange has been moving full steam ahead for over a year and would continue to do so. He announced the federal government extended the deadline for states to submit their Blueprint applications from the original date of November 16 to December 14.

Mr. Lee also discussed the importance of the Exchange's Level II Establishment Grant

funding request to be submitted this week providing funding through 2014, as well as the proposed sustainability plan to fund the Exchange in 2015 and beyond.

Mr. Lee noted the Board received copies of a letter sent to Gary Cohen at the Center for Consumer Information and Insurance Oversight (CCIIO). The letter requests guidance on the Exchange's intent to offer standalone vision and dental as benefits in the individual market and as supplemental offerings in the SHOP.

Mr. Lee called attention to two reports: the results of focus groups conducted by the Robert Wood Johnson Foundation on consumers' understanding of costs and the Let's Get Healthy California Task Force draft report. Covered California is well represented in the Let's Get Healthy Task Force. Chairwoman Dooley is co-chair and Dr. Ross is chair of the advisory committee. Covered California seeks to actively partner with other agencies and groups to create a healthier California. Let's Get Healthy's framework is linked to Exchange goals insofar as it seeks to achieve the "triple aim" of better care, better health and lower costs as well as health equity.

Chairwoman Dooley noted the Let's Get Healthy document on the website is a draft report. The final report will be issued December 19.

Agenda Item III: Announcement of Closed Session Actions
(This item was taken up as part of Item IV, Executive Director's Report)

Mr. Lee announced the following actions taken in closed session:

1. The Board approved exercising an option under the CalHEERS contract with Accenture to contract for Service Center IT support.
2. The Board also approved amending the contract with Eventus for Service Center planning to assist Exchange staff in oversight of the Service Centers.

On personnel matters, Mr. Lee announced staffing is currently at about 60. New hires are expected to bring staffing to 78 by the December 18, 2012 Board meeting. The Board also approved a reorganization of the senior leadership team, naming David Maxwell-Jolly Chief Deputy Executive Director for Strategy and Yolanda Richardson Chief Deputy Executive Director for Operations.

A. CalHEERS Update

Jim Brown, IT Project Director, gave the CalHEERS update and noted that stakeholders would have an opportunity to comment on business requirements.

Presentation: Executive Director's Report cont'd

B. Service Center Update

Juli Baker, Chief Technology Officer, presented on the status of the Service Center.

Presentation: Executive Director's Report cont'd

Discussion:
Board Member Belshé asked if the Board would get a more detailed timeline of when key decisions need to be made relating to protocols and processes. The warm handoff is critical to a seamless, real-time eligibility and enrollment process, but there also must be a contingency plan in place.

Ms. Baker noted that the staff is working on the timelines and critical path for making those decisions that will be brought to the next Board meeting.

Board Member Belshé noted many of the key decisions are not made by the Exchange but must be made by the counties and other key partners critical to the success of reaching the Exchange's population.

Agenda Item VIII: Exchange Evaluation Plan
This item was taken out of order, moved up as a discussion item. Larry Bye of NORC presented an overview of the Exchange's evaluation planning work.

Presentation: Executive Director's Report cont'd

Discussion:
Board Member Belshé asked if staff is far enough along in their work to know where there are data gaps or limitations that will impede their ability to answer key questions.

Mr. Bye explained they have more work to do on data sources. There will be data gaps in a number of areas; it may take some time to get the various data collection systems into alignment.

C. Exchange Naming and Branding

Mr. Lee noted that the taglines are still under development. The color scheme for the logo has been decided.

Public comment:
Beth Capell, Health Access California, looks forward to providing comments on the CalHEERS process and appreciates the inclusion of stakeholder involvement. Health Access has particular concern about all data elements being consistent with state and federal laws and looks forward to commenting on the evaluation component.

Gary Passmore, Congress of California Seniors, noted the process for dual-eligible Californians is under way. A number of state agencies are working with CMS, looking at a list of over a hundred data elements, and he hopes the Exchange will become involved, so the same plans aren't trying to generate data for two different processes.

Darryl Burton, CMS, congratulated the staff on their work, especially the webcasts, and complimented them on the high quality information they are producing. Regarding the evaluation process, Burton suggested using language in terms of the metal tier plan actuarial value system.

Suely Ngouy, Policy Advocate, Asian Pacific American Legal Center and the Health Justice Network, expressed support for the brand name CaliHealth because it is easy to translate and had "health" as part of it, signifying health care and health insurance. The translation for Covered California doesn't have the word for health attached, so the tagline will be very important to convey the meaning of the name, especially for people with limited English proficiency.

Nicette Short, California Dental Association, noted that the letter sent to CCIIO contained references to standalone dental care, and they don't want to miss an opportunity to support the Exchange's work toward offering dental, especially standalone dental.

Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law and Poverty, expressed concern about the CalHEERS build going on with no public input. Their organization is committed to ensuring the design works for consumers and hopes for transparency moving forward.

Alice Kessler, Transgender Law Center, noted that the cornerstone of evaluation is promoting health equity and identifying disparities, and staff has identified that separate analyses will be needed for different population segments. Race, ethnicity, and language have been identified; she asked that the Board separately evaluate the outcomes for lesbian, gay, bisexual, and transgender (LGBT) enrollees.

Julie Silas, Senior Policy Analyst, Consumers Union, echoed Mr. Passmore's and Ms. Landsberg's comments. They appreciate being able to give feedback and that Covered California has opened up the process.

Laura Lopez, Executive Director, Street Level Health Project, noted Covered California doesn't mean much when translated into Spanish. When they do outreach, they will need a brief description to help people understand this name. The Board should think about what type of information should be expressed in marketing efforts, and it is really important to say something about health.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), echoed the prior comments about the CalHEERS process and making room and time to listen to different groups. They appreciate the stratification of data in the evaluation and the attention Covered California is giving to evaluating health disparities.

John Connolly, Insure the Uninsured Project, feels the enrollment goals should be both quantitative and qualitative. It's also important to know if Californians understand the coverage they're getting through Covered California, and what the differences are among the plans.

Gilbert Ojeda, Director, California Program on Access to Care, UC Berkeley, brought the Board's attention to a CPAC initiative on males of color. A committee is dedicated to research their needs, with a specific health component; a report was drafted in August. He noted that this population is hard to reach and hard to serve.

Carmella Gutierrez, Californians for Patient Care, noted that health literacy should be included as a core evaluation metric. It's also important to consider people's literacy level, especially as it relates to creating an easy to use web-based portal.

Darcel Lee, California Black Health Network, voiced appreciation for the work that the Exchange is doing to be inclusive and to address health disparities. They would like to ensure, as they look at separate analysis across all the domains, that the Exchange is talking to those who can provide information on data gaps, limitations, and sources.

Agenda Item V: Qualified Health Plans Solicitation and Regulations

Mr. Lee noted both the QHP solicitation and the proposed regulations governing the QHP selection process are presented as action items.

Presentation: Qualified Health Plan Solicitation

Brandon Ross, staff counsel, presented an update on the QHP solicitation and draft regulations. He noted that the regulations and solicitation are closely intertwined. Once the emergency regulations are in place, staff will return with permanent regulations, following the usual rulemaking process.

Discussion:
Mr. Lee noted that the solicitation is the product of engagement by hundreds of people. The Exchange will use a multiyear contracting process and will not be open for new plans in 2015 other than Medi-Cal managed care plans.

Mr. Lee underscored the Board would not be acting today on specifics of standardized benefit designs or model contract requirements as there will be follow on elements and additional stakeholder meetings. The action today would be the QHP solicitation only. This is a very good starting point and robust solicitation that will deliver value, quality and cost for millions of Californians.

Board Member Fearer expressed comfort with the general approach of using multiyear contracts, but noted that when many plans first bid they will have to create products that they don't currently have, and will have to renegotiate. He expressed concern about plans not having all their products ready in time, but believed they could by year two and therefore doesn't want to close the door on them.

Mr. Lee suggested that many plans will start out with one set of networks in year one, and will produce refined networks later. Covered California is open to new plans and new innovations, but the goal is to start with the best possible pool.

Board Member Kennedy asked about standalone dental plan participation. Mr. Lee responded that the plan is to allow for consumers to have standalone or integrated dental and vision, and to lay it out so that they understand the price differences. The solicitation will allow consumers to distinguish the difference in price if a standalone plan is included or a dental plan is incorporated into the major health plan.

Board Member Belshé expressed concern that the timeline shows contracts being executed with QHPs no later than the end of June 2013. She noted regulators are supposed to have at least 60 days to review new plans, and asked how that will affect the timeline for testing of the Covered California web portal.

Mr. Ross responded that the timeline will consist of a phased approach. The plans will be filing their networks and other details with the appropriate regulator along the way, and will then file their rates with regulators.

Mr. Lee noted staff has had good discussions with the California Department of Insurance and the Department of Managed Health Care. Covered California has 60 days to negotiate rates with plans. The rates then go to the regulators, each of whom has agreed to review them faster than normal recognizing Covered California's need to have plan rates listed on the web portal.

Board Member Belshé noted the need for sufficient clarity on who's responsible for key activities so that time is available to test the site. She also emphasized there must be capacity for ensuring people with specialty care needs get access the services they need, regardless of the health plans they select.

Public Comment:
Beth Capell, Health Access California, appreciates the recognition of clinics and hospitals as essential community providers, and highlighted importance of language access. Health Access appreciates the challenges Medi-Cal managed care plans face in the new world, and importance of including them because of churning and the important role they play for the safety net.

Micah Weinberg, Bay Area Council, asked if Covered California is backing off standardizing out of network reimbursement for the first round of contracts. He also asked what covered Covered California's role would be in renegotiating rates if regulators dislike them.

Katie Murphy, Supervising Attorney, Neighborhood Legal Services of Los Angeles County, echoed Board Member Belshé's comments about the importance of access to the specialty care network. When discussing out-of-network care, it's important to

understand what is happening within the plans, in terms of oversight of their independent practice associations (IPAs).

Francene Mori, California Exchange Director, Anthem Blue Cross, supports the new direction with regards to out-of-network benefits. Adverse selection could arise in developing out of network benefits.

Ruth Liu, Blue Shield of California, noted Covered California is considering eliminating standardization of out-of-network benefits and using FAIR Health as a basis for reimbursement. This is critical because if those changes aren't made, it will invite adverse selection against Covered California and Blue Shield will not be able to offer an affordable PPO in the Covered California.

Alice Ricks, Senior Policy Analyst, California School Health Centers Association, is pleased to see school-based health centers included as essential community providers, but noted that the request for proposal does not count school-based health centers toward the 15 percent threshold of 340B providers. She urged the Board to clarify that school-based health centers that are satellites of 340Bs or are 340B will be counted toward the threshold to ensure equity.

Brett Johnson, Associate Director, California Medical Association, echoed the concerns already expressed regarding Covered California allowing a two-tier network. This will add another complicating factor on top of serious network adequacy concerns.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans (CAHP), appreciates the clarification on essential community providers and multiyear contracting, and would like further clarification in terms of when data needs to be submitted on plan marketing budgets and the requirements for health risk assessments. CAHP are concerned about the solicitation being incorporated into the proposed regulation by reference.

On phone: Meaghan McCamman, Associate Director of Policy, California Primary Care Association. Qualified health plans must abide by federal rules, which they appreciate, but the burden is on Federally Qualified Health Centers (FQHCs) to pursue payment from plans. Ms. McCamman requested that Covered California reinsert the attestation requirement for non-contract payment and take the burden of policing plans off safety net providers.

Laura Lopez, Executive Director, Street Level Health Project, asked if there would be a stakeholder process for the development of specialty care protocols so they can give feedback about their own community's needs and issues.

Motion/Action: Board Member Kennedy moved to adopt Resolution 2012-63, to allow for the development of emergency regulations that will codify the QHP solicitation. Board Member Fearer seconded the motion.

Discussion:
Mr. Lee pointed out that the Board was not acting on standard benefit designs; there is a wide range of views regarding out-of-network benefits, and staff wants to follow-up on this issue. He added the resolution allows for fine tuning on matters such as nondiscrimination, LGBT issues, and payment issues for qualified health centers in the model contract provisions. Staff will follow up with timelines. Incorporating the RFP by reference is the same as a regulation.

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

Agenda Item VI: Exchange Tribal Consultation Policy
Mr. Lee thanked California's Tribal community who helped to create this policy. It sets a very good process in place.

Discussion: None

Public Comment:
Kristine Smith, California Consortium for Urban Indian Health, thanked the staff and looks forward to working with Covered California.

Motion/Action: Board Member Belshé moved to adopt Resolution 2012-68, to adopt the Tribal Consultation Policy dated November 5, 2012. Board Member Kennedy seconded the motion.

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

Agenda Item VII: Consumer Assistance/Ombudsman Program

Katie Marcellus, Director of Program Policy, presented the staff recommendation for consumer assistance and ombudsman support for problem resolution. She noted that initial recommendation presented in September proposed $2 million be allocated for independent community-based support. The recommendation now calls for $3.4 million of support over a two-year period for independent consumer assistance, back loaded for the period from October 2013 through December 2014 with startup support for the first nine months of 2013.

Presentation: Board Recommendation Brief—Consumer Assistance/Ombudsman Program

Discussion:
Board Member Belshé noted that Covered California should ensure that this program is not duplicative of other capacity. It will be important to try to push complaint calls to the lowest level of resolution possible; the health plan complaint unit or to the regulators, who have capacity and expertise. Redundancy should be avoided.

Ms. Marcellus noted that staff will clarify the processes for handing enrollee issues as Covered California works with the regulators in the coming months.

Mr. Lee stated that the Level II Establishment Grant funding request includes both this program as well as additional funding for the DMHC Help Center. Covered California will be providing a number of staff as transition staff for DMHC via interagency agreement. Over time, the increased enrollment in DMHC products will fund expansion of the DMHC Help Center.

Public Comment:
Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law and Poverty and the Health Consumer Alliance, recognized the different kinds of consumer assistance and urged the Board to support this proposal and the $3.4 million funding.

Katie Murphy, Supervising Attorney, Neighborhood Legal Services of Los Angeles County, described consumer assistance groups as holding a role in the middle to back end of the process. Outreach informs people about programs, navigators help people figure out how to get in, and the independent consumer assistance help people when something goes wrong.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, voiced concerns about redundancy. Once Covered California is self-sustaining, some of the costs currently covered by federal grants will impact affordability. It's important to avoid duplication between groups, the call center, and the plans.

Beth Capell, Health Access California, said the ombudsman program is not redundant or costly. Navigators, regulators, and plans should be able to help most people, but the record of the Health Rights Hotline and the Health Consumer Alliance proves there is an important role to play for tertiary consumer assistance.

Laura Lopez, Executive Director, Street Level Health Project, agreed that this program is not duplication. This is a big need in the community, especially the need to have someone close by who speaks your language, understands your problems, and knows your community.

Motion/Action: Board Member Belshé moved to adopt Resolution 2012-69. Board Member Kennedy seconded the motion.

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

Agenda Item IX: Federal Establishment Support and Blueprint Application

Chairwoman Dooley noted that it is a tremendous relief that Proposition 30 passed, but stated that the Legislative Analyst's Office has predicted that a large deficit remains. She noted that everyone must continue to show fiscal restraint.

Presentation: Building Covered California—Blueprint Overview and Establishment Grant

A. **Budget, Organizational Overview and Core Application Elements**

Mr. Lee noted this agenda item contains two action items: Board approval of the Covered California Blueprint, as well as the Level II Establishment Grant plan covering the period through 2014. Mr. Lee provided a detailed overview of Exchange operations and budgeting going forward through 2017, including Covered California's Long-Term Sustainability Plan that begins in 2015 when it must be financially self-sufficient. He noted that the Board was not being asked to adopt the potential plan assessment levels presented in the Long-Term Sustainability Plan.

David Maxwell-Jolly, Chief Deputy Executive Director for Strategy, presented budget alternatives for the individual and SHOP Exchanges under various enrollment level scenarios and allowing for a three-month operational reserve. He reviewed the financial sustainability plan including potential plan assessment levels.

Discussion:
Board Member Belshé appreciated the clarification that the Board was not taking action on the plan assessment. She urged adherence to the principles, with affordability being the first, and scrutiny of the expenditures. There is a potential tension between assessing fees on non-Covered California qualified health plans and Covered California's interest in advancing standard products. The concern raised was about plan assessments creating an incentive for plans to move away from standard products to make sure they don't have to pay the fees.

B. Marketing, Outreach and Education
Oscar Hidalgo, Director of Communications and Publication Relations, provided an overview of the Covered California marketing and outreach plan and goals. He noted the plan will touch every Californian in some way.

Discussion:
Board Member Belshé noted that the marketing and outreach budget is a large amount of money, even considering the large, diverse state. She asked about the assumptions relative to what health plans will be investing in marketing to the subsidy-eligible population.

Mr. Lee said noted the QHP solicitation asks the plans about their investment in marketing. The goal is to determine where Covered California can reduce its investment in order to be as frugal as possible while achieving maximum enrollment.

Public comment:
Darryl Burton, CMS, asked about the modeling used to come up with the potential enrollees and whether the California Simulation of Insurance Markets (CalSIM) model was used for the financial modeling as well as the enrollment modeling.

Dolores Duran-Flores, Legislative Advocate, California School Employees Association, expressed concern about allocating responsibility for managing reinsurance and risk adjustment to the federal government, and urged Covered California to consider providing this function at the state level.

Ruth Liu, Blue Shield of California, expressed support for having the federal government handle reinsurance and risk adjustment.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, said a 3 percent assessment level is an improvement, but expressed support for a 2 to 2.5 percent plan assessment level range.

Bill Wherle, Vice President of Health Insurance Exchanges, Kaiser Permanente, pointed out that the administrative activities of the Exchange are tied to enrollment numbers, not premiums, but the funding base is per premium rather than per person. Covered California should look at a per member, per month flat fee.

Beth Capell, Health Access California, expressed concern that Covered California be adequately financed and able to provide the necessary level of service on an ongoing basis.

Motion/Action: Board Member Fearer moved to adopt Resolution 2012-70, to submit the Level II establishment grant application to the federal government with two-person Board committee for final review and review of budget narrative (Chairwoman Dooley and Board Member Belshé). Board Member Belshé seconded the motion.

Motion/Action: Board Member Fearer moved to adopt Resolution, 2012-71, to authorize the submission of the blueprint application for California to operate as state-based Exchange. Board Member Belshé seconded the motion.

Discussion: None

Public Comments: None

Vote: Roll was called, and both motions were approved by a unanimous vote.

Agenda Item IX: Adjournment
The meeting was adjourned at 3:29 p.m.