CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD
December 18, 2012
East End Complex Auditorium
1500 Capitol Ave.
Sacramento, CA 95814

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

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

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

Board members absent:
Susan Kennedy

Agenda Item II: Closed Session

A. Consideration of Contract-Related Matters per Government Code Section 100500(j)
B. Consideration of Personnel Issues per Government Code Sections 11126(a) and 100500(j)

Chairwoman Dooley reconvened the meeting in open session at 12:16 p.m.

Chairwoman Dooley announced when roll was taken at the start of the closed session that Board Member Kennedy was not present due to a conflict of interest disclosed earlier in the year. Chairwoman Dooley stated Board members present were requested to disclose conflicts prior to the start of the meeting. None were disclosed.

Agenda Item III: Announcement of Closed Session Actions

Mr. Lee announced that the Board took up several contractual matters including approving an extension of the engagement with PricewaterhouseCoopers to support Qualified Health Plan contracting. The Board also reviewed the status of outside vendor contracting for SHOP operations and for the Service Center.

On personnel matters, Mr. Lee announced an offer has been extended to a candidate for a new exempt position that would be announced once offer is confirmed with the candidate. Covered California is now at 66 full time staff with 36 in the hiring process, bringing anticipated staffing to around 100 by the end of January, 2013.

Agenda Item IV: Approval of Prior Meeting Minutes
Chairwoman Dooley called for a motion to approve the minutes for Board meetings of October 30 and November 14, 2012.

Presentation: October 30, 2012, Minutes

Presentation: November 14, 2012, Minutes

Discussion: None

Public Comments: None

Motion/Action: Board Member Fearer moved to approve the minutes from the prior meetings. Board Member Ross seconded the motion.

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

Agenda Item V: Executive Director's Report

Presentation: Executive Director's Report

A. Exchange Planning Calendar

Mr. Lee reviewed the 2013 Board meeting calendar and items expected to come before the Board during the first six meetings of 2013. He noted the new Covered California website will launch in January, 2013.

B. Establishment Support and Blueprint Update

Mr. Lee reported the Level II Establishment Grant application was submitted and an award decision from the federal government is expected in January. The final Blueprint application was submitted on December 14 and Covered California anticipates certification by the end of this year.

C. Legislative Update

David Panush, Director of External Relations, gave a brief legislative update. The legislature is not yet back in session. The budget will come out on January 10, and the Governor will likely declare a special session of the Legislature around that time. The Senate and Assembly Health Committee Chairs have each introduced individual market reform bills that are very critical for Covered California and it is hoped these bills move forward expeditiously as well as legislation on Medi-Cal expansion that affects CalHEERS programming.

D. CalHEERS Update

Jim Brown, CalHEERS Project Director, provided on update on CalHEERS implementation.

Presentation: Executive Director's Report, cont'd

Discussion:
Board Member Belshé asked Mr. Brown to discuss the functionality of and timing the various eligibility and enrollment functions to meet the October 1, 2013 pre-enrollment launch date.

Mr. Brown clarified that Covered California must be able to determine eligibility and enroll someone in the program on October 1. People cannot be pre-enrolled in Medi-Cal, though they can be for Covered California since current Medi-Cal rules will still be in effect in October, 2013. In order to support both of those dates there will be additional testing and additional guidance will be forthcoming from CMS. An eligibility rules engine that includes the MAGI rules will be available on October 1.

Mr. Lee clarified that for Medi-Cal, CalHEERS must work with eligibility and enrollment rules in effect October 1, 2013 and not those that will be in effect January 1, 2014. Staff will be working very closely the DHCS regarding this interim period.

Board Member Belshé asked about CalHEERS's capacity for enabling consumers to provide an online consumer account to allow access and management of their personal data.

Mr. Brown replied that by October 1, 2013, customers would be able to create an account, input their information, and check their status. Both Medi-Cal consumers and tax-credit Covered California consumers will have access to managing their information, and all will have online accounts.

Board Member Ross asked what will happen if the eligibility system isn't ready until April 2014, to which Mr. Brown replied that a number of contingency plans are being mapped out.

Board Member Fearer addressed the term "release," and described it as the date the functionality will be ready to go, useable, and tested. Behind the release dates, with Covered California staff itself, hundreds of people will need to know how to use these systems and be trained in them. Board Member Fearer asked about the earliest date training could occur.

Mr. Brown replied that training will start early on to ensure everything will sync up the way it needs to as system components become available.

Mr. Lee noted that training is foundational. Staff has been meeting with the Department of Health Care Services (DHCS) to determine how to talk about the benefits, the IT system, etc., and noted that training must be multilayered.

E. Service Center Update

Juli Baker, Chief Technology Officer, presented an update on the Service Center. Ms. Baker noted two "very good" offers from two counties to run service center locations.

Presentation: Executive Director's Report, cont'd

Discussion:

Board Member Ross asked whether there would be a single point of accountability for the quality of the quick sort/warm handoff for potential Medi-Cal eligibles.

Ms. Baker replied that staff is engaged in discussions with a number of agencies that would need to be involved, but presumed this would be included in an inter-agency agreement with DHCS and the counties.

Mr. Brown noted industry best practices will determine protocol and staffing for the Service Center. There is no federal standard as one has not yet been promulgated.

Board Member Ross asked about plans in case the Medi-Cal eligibility and enrollment process isn't ready in time.

Mr. Brown noted a number of contingency plans are being mapped out and finalized.

Board Member Belshé, addressing Mr. Brown and Mr. Lee, asked if the Board would obtain information regarding continuing questions related to the role of the Service Center relative to the Medi-Cal eligible population.

Mr. Lee noted staff is engaged in an interactive process and discussions with CMS and CCIIO, and more detail on protocols will emerge as it's developed by staff. He further stated that staff will bring more clarity to the Board relative to processing mixed families and eligibility.

Chairwoman Dooley commented there will be a continuous learning and improvement process over the next 4-5 years. What's critical is the Exchange does not fail at the outset.

F. Stakeholder Advisory Groups

Presentation: Executive Director's Report, cont'd

Mr. Lee presented an update on the stakeholder advisory groups to be formally organized in January, 2013. He noted the meetings of the groups would be open to the public, and

suggested that one or two board members participate. Membership of each of the three new advisory groups – health plan management and delivery reform; outreach, education, and marketing; and the Small Employer Health Options Program – will be announced later this week.

Agenda Item VI: Federal Proposed Rules

Presentation: Federal Proposed Rules

David Panush, Director of External Affairs, presented on several federal rulemakings that affect Covered California, in connection with a proposed resolution authorizing staff to develop comments on the proposed rules on behalf of Covered California to be submitted in conjunction with the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).

Motion/Action: Board Member Ross moved to adopt Resolution 2012-72 authorizing staff to submit comments. Board Member Belshé seconded the motion.

Discussion:
Board Member Belshé asked if guidance on Multi-State Plans was part of this set of rules, or if that is still to be determined.

Mr. Panush replied that the Multi-State Plan Program (MSPP) is one of the rulemakings. He added staff is very concerned about the proposed rules and whether or not the multistate plans will have to meet the same standards as the other plans.

Mr. Lee noted comment on the proposed MSPP rules must be submitted by January 4, 2013.

Public comment:
Beth Capell, Health Access California, is pleased to note that the proposed rules prohibit benefit substitution but is troubled by the idea of Multi-State Plans having essential health benefits set by the Office of Personnel Management rather than complying with state essential health benefit rules.

Brett Johnson, Associate Director of Medical and Regulatory Policy, California Medical Association, said the MSPP rule preempts state law and tramples the efforts of Covered California. The Multi-State Plans wouldn't have to adhere to standardized cost-sharing structures and would follow broad, loosely defined network adequacy standards, while state qualified health plans would have to follow the more prescriptive state standards, in including the timely access rule.

Chairwoman Dooley asked that stakeholders let Covered California know of their comments and concerns relative to the proposed rules.

Cary Sanders, Director of Policy Analysis, CPEHN, reiterated Ms. Capell's comments about the Multi-State Plans. California has the strongest language access laws in the nation.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans (CAHP), expressed support for Covered California and the regulators commenting on the rating regions rules. A lot of work has been done to get to the 19 regions established in the 2012 legislative session and CAHP's member plans have started preparing bids accordingly.

Discussion:

Board Member Ross expressed concern over the MSPP. It exists to solve a problem California does not have and suggested the Covered California voice concern about the potential marketplace disruption it could cause.

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

Public comment:
Betsy Imholz, Director of Special Projects, Consumers Union, noted that the service center decisions are absolutely critical to the success of Covered California. It would be logical to have assessments done for simple MAGI Medi-Cal cases using CalHEERS. The counties' deep expertise may be warranted in the case of dual eligibility families or making non-MAGI Medi-Cal eligibility determinations.

Vanessa Cajina, Legislative Advocate, Western Center on Law and Poverty, expressed appreciation that the CalHEERS timeline will be affected by the fact that there is a Medi-Cal population that will exist January 1, 2014, but not before. Mixed-coverage families or people who don't understand the application timelines might be applying to the service center, so there should be some sort of repository for their information.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), asked about people with limited English proficiency in the quick-sort system, noting it's not just about the number enrolled, but also ease of access. It won't reflect well on the service center if people fall off.

Micah Weinberg, Senior Policy Advisor, Bay Area Council, noted timeline for processing enrollments and the backlog for Medi-Cal eligibility and enrollment is currently measured in months. The Covered California may need to be more realistic about how efficient the current eligibility pathways into public programs are.

Ken Doyle, Executive Director of Sales and Marketing, LISI, noted its brokers have seen approximately 85 percent or more with $3500 deductibles or higher. In Southern California, split between HMOs and PPOs, it's 45–50 percent. Covered California should consider this and how California has always had flexibility in innovation.

Kathleen Hamilton, Director, the Children's Partnership, noted her organization and the 100% Campaign have expressed concerns about the quick sort option. She said she is dismayed to hear that may be the path that Covered California is going down and is concerned about accuracy and unreliable referrals.

Lucy Streett, Social Interest Solutions, shares Consumers Union's and the Children's Partnership's concerns regarding the quick sort and the commitment to prompt customer service and accurate transfers of complex Medi-Cal cases to the county level. They recommend using the federal streamlined application and note CALHEERS is building in the capacity to use that assessment.

Sara Nichols, Government Relations Advocate, SEIU California, said state and county workers are excited about participating in the Service Center. County workers are trained and ready, and with simplifications that will be made during this coming year, they'll have an easy time enrolling the large numbers of new customers as they did during the recession.

Cathy Senderling-McDonald, Deputy Executive Director, County Welfare Directors Association of California, testified her organization supports the quick sort and warm handoff is the most effective way to proceed. With regards to revised CalHEERS schedule, the SAWS system has not changed and they are working to get things ready by October.

Gil Ojeda, Director, California Program on Access to Care, UC Berkeley, was impressed by the complexity of what has been laid out. It will be crucial to determine that something is going slightly wrong before there is a major catastrophe.

Doreena Wong, Project Director of the Health Access Project, Asian Pacific American Legal Center, reiterated concern about the quick sort. Some of the counties' service centers are able to provide good services to limited English proficient populations, but others have challenges. It's important to ensure customer service reps can provide some of the services and screening. Limited English proficient customers need to be able to speak directly to Service Center staff, not through an interpreter.

Beth Capell, Health Access California, pointed out that one challenge is that people don't know their income. Ms. Capell also noted potential privacy violations with a SHOP requirement that employers screen their employees for Medi-Cal.

Agenda Item VII: Focus Groups to Inform Marketing and Outreach

Presentation: Market Study Focus Group Findings

Larry Bye of NORC presented the results of consumer interviews to gauge interest in Covered California.

Discussion:

Mr. Lee noted that staff is designing marketing and outreach based on its understanding of Californians' attitudes and desires for coverage. The results are generally good news, although there is general ignorance about the details. Many expressed interest and curiosity when they heard more about 80 percent said they would want to buy through Covered California and 10 percent said they might want to. Most of the people in the target population want to hear about Covered California.

Mr. Bye noted the straightforwardness with which people viewed the whole transaction was striking. The drivers are, for the most part, simple and straightforward. While there has been a low level of understanding about the Affordable Care Act (ACA), there is more sophistication about insurance than he had expected. People know what insurance is, and many have shopped for it. People don't need "Insurance 101" as much as was expected. The likelihood of enrollment numbers varies according to ethnicity, from around 60 percent to around 80 percent.

Board Member Belshé noted the presentation builds upon work Mr. Bye shared in a previous presentation. People's definition of affordability is now more realistic and encouraging.

Mr. Bye pointed out there's a difference between asking people what they can spend and asking them to choose from among real prices for what they are getting. It's better to give real prices.

Public Comment:
Beth Capell, Health Access California, is pleased Covered California is doing this qualitative research first, rather than quantitative research based on assumptions about consumers. They have sat through many focus groups, and have found that most consumers view coverage provided by large employers as the benchmark.

Gary Passmore, Congress of California Seniors, wondered where the report is, and what NORC stands for.

Mr. Lee noted the report will be posted on Covered California.

Betsy Imholz, Director of Special Projects, Consumers Union, hoped that basic knowledge of health insurance isn't needed by consumers. But research has clearly shown that there's a lot of education to be done on terminology.

Al Hernandez-Santana, California State Rural Health Association suggested for the larger survey, looking at affordability barriers as well as market segment differences based on demographics and lifestyle such as rural vs. urban. Unemployment in rural areas is at least 2 percent more than in urban areas. Also, people may be "connected" in different ways.

Cary Sanders, Director of Policy Analysis, CPEHN, applauded Covered California for the twelve languages represented in the focus groups.

Christina Dorame, Pacific Islander Cancer Survivor's Network and the Having Our Say Coalition, noted many Pacific Islanders speak English and many don't understand the insurance terminology, such as coinsurance. The Pacific Islanders are not the same as Asian Pacific people. It's a cultural difference that should be considered.

Doreena Wong, Project Director of the Health Access Project, Asian Pacific American Legal Center, noted the focus groups confirm what they have found: there is a lack of knowledge about health insurance, but strong interest in getting coverage. She agreed with the suggestion of looking at the barriers, access to insurance, and access to health care services.

Gil Ojeda, Director, California Program on Access to Care, UC Berkeley, mentioned a study about to be issued by Ken Jacobs on the role of the individual responsibility tax penalty and asked how various income groups might view it.

Jonathan Tran, California Policy Advocate, Southeast Asia Resource Action Center, asked for more evaluation of potential differences between rural and urban populations.

Mr. Lee noted that these were technically interviews using open ended questions, not focus groups. Focus groups will also be conducted in multiple languages. The full report has not been posted on the website, but it will be by the end of the week.

On phone: Silvia Yee, Senior Attorney, Disability Rights Education & Defense Fund, asked if the individual interviews included those with vision problems or is blind or deaf. Information about insurance and health care is lacking in those communities.

Mr. Bye clarified in terms of "Insurance 101" knowledge, he meant people who lack very basic knowledge. He can get the race-ethnic composition of the English speakers. The Chinese interviews were done in Mandarin. They did not try to look at urban-rural

differences or disabilities—those are good suggestions. Quantitative surveys will tease out some of that information.

Agenda Item VIII: Qualified Health Plan Contract and Benefit Design

A. Standardized Benefit Design
B. Model Contract

Presentation: QHP Contract and Benefit Designs

Andrea Rosen, Interim Health Plan Management Director, presented on standardized benefit plan designs, out-of-network benefit policies and the QHP model contract outline.

David Maxwell-Jolly, Chief Deputy Director, presented on plan participation fees. Mr. Maxwell-Jolly noted that Covered California plans to assess a 3 percent fee on participating health plans in 2014 to 2017. The level of the fee is subject to change starting in 2014 based on enrollment and costs in order to ensure the financial sustainability of the Exchange.

Mr. Lee noted that plans should not be surprised by contract terms since staff has already outlined many elements with them. Comment is invited on the benefit design and model contract provisions. Email should be sent to qhp@hbex.ca.gov. In response to a question from Board Member Fearer, Mr. Lee noted every plan will be clearly required to distinguish and describe their out of network benefits, but such benefits won't be standardized.

Ms. Rosen noted plan descriptions of out-of-network benefits are currently wholly inadequate and misleading, and most consumers are shocked when they see bills. It's not uncommon for someone to end up paying 80 percent of the bill instead of 20 percent. If Covered California adopts a transparency standard, that might prevent frustration.

Mr. Lee noted policy adopted by the Board in August would require plans to inform consumers prior to their use of non-emergent care in language that is standard as much as technically possible.

Ms. Rosen agreed that, in today's market, out-of-network benefits are very deceptive. Covered California could require the bidding PPO plans to clearly define out of network benefits. If it's unacceptable or confusing, perhaps it could be renegotiated. She has heard out-of-network claims make up only 1–2 percent of claims in a given year. But if someone ends up at the wrong hospital, and it's not covered, it would be shocking to them. Staff has discussed asking PPOs to give them out-of-network data in the middle of

2014, so they can analyze the data and compare that to the 50th percentile of the FAIR Health database.

Motion/Action: Board Member Ross moved to adopt Resolution 2012-75 but suggested suspending the requirement that Covered California use 50 percent of the FAIR Health database as the basis for determination in payment of out-of-network benefits for Plan Year 2014. Board Member Fearer seconded the motion.

C. Affordability/Continuity of Care Options

David Panush, Director of External Relations, discussed the option of including Medi-Cal managed care plans as potential QHPs per federal guidance issued December 10, 2012 allowing Medicaid Managed Care Bridge plans to be certified by QHPs.

Presentation: Alternative Strategies to Promote Affordability and Safety Net Continuity

Mr. Lee noted agenda item IX on Health Disparities would be tabled to next month's meeting in January, noting the addition of Item VIII(C) to the agenda was necessary to allow opportunity for potential Board action in January 2013 to accommodate the QHP approval timeline and review process. Mr. Lee stated that stakeholder comment on the inclusion of Medicaid Managed Care Bridge plans as individual Exchange QHPs is requested by January 10.

Discussion:

Board Member Fearer expressed general support for investigating the Medicaid bridge option. He noted there could be unintended adverse consequences and requested staff to do their best to identify them as well as how to best differentiate these plans from other QHPs.

Mr. Panush noted Medi-Cal managed care plans would have to meet all of the Exchange's QHP requirements. Consumers wouldn't only have this plan as their choice. They could choose a more expensive option.

Board Member Belshé commented it's positive to see how Covered California could use its subcontracting abilities to address affordability and access issues. Continuity of care is critical. She noted the possibility of unintended consequences such as an unlevel playing field with other QHPs and the implications for the QHP solicitation process.

Public Comment:
Beth Capell, Health Access California, was pleased to see a presentation prioritizing affordability and appropriate recognition of the safety net. There are indeed a number of

issues to work through, but greater affordability for those with lower incomes is an important goal. This creates a viable option.

Monica Blanco-Etheridge, Executive Director, Latino Coalition for a Healthy California, expressed concern about the Latino population. Medical debt and medical costs are some of their biggest issues. There needs to be clear language so it's clear to them what they will be getting.

Vanessa Cajina, Legislative Advocate, Western Center on Law and Poverty, noted coinsurance is confusing, while co-pays are known. The Medi-Cal managed care option is a lot to take in. They appreciate that Covered California is considering options for those with low incomes.

Gary Passmore, Congress of California Seniors, said his organization hopes to further examine this concept. They have done a lot of work with regard to the coordinated care initiatives and proposals.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, appreciated the change relating to the standardization of out-of-network benefits. Related to the marketing budgets, a lot of the information being requested as part of the solicitation is not available. They also request that a confidentiality clause be put into QHP contracts.

Jeff Shelton, Vice President of Government Relations, Regulatory Affairs and Compliance, Health Net, was intrigued by the affordability and continuity proposal. In addition to Health Net, there are a number of commercial plans in this market. There are millions of enrollees in these commercial plans, and if churn is a concern, Covered California should include them.

Brett Johnson, Associate Director of Medical and Regulatory Policy, California Medical Association, asked that the Board strike the requirement that network providers be required to disclose the cost of non-network providers. This is rate-sharing in violation of antitrust protections that requires legal analysis.

Sara Nichols, Government Relations Advocate, SEIU California, expressed enthusiasm for the Medi-Cal managed care proposal. They have been very concerned about affordability and the safety net, despite major efforts, and this will go much further toward addressing those concerns. If it requires legislation, SEIU would help support it.

On phone: Abigale Coursolle, National Health Law Program, commented that with respect to the out-of-network policy change, they have seen problems with consumers using CDI products and having issues of adequacy and timely access. Standardizing the reimbursement rate might be one way to address those problems.

Micah Weinberg, Senior Fellow, Bay Area Council, noted that Council has not yet had time to consider the proposal. Taking advantage of an unintended loophole in the federal law runs the risk of unintended consequences.

Edie Ernst, Private Essential Access Community Hospitals, opposed the concept of Covered California including Medicaid managed care plans if they would reduce provider rates. The ACA does intend that the influx of newly commercially insured Americans (not lower Medicaid or Medicare rates) would ensure the stability of essential community providers.

Bill Wherle, Vice President of Health Insurance Exchanges, Kaiser Permanente, expressed appreciation for the movement toward per member, per month fees. He hoped the board will consider in-kind services in 2014. Kaiser can get a lot of people in employer groups into Covered California, and that would be worth a lot to Covered California.

Steffanie Watkins, Legislative and Regulatory Advocate of Health Policy, Association of California Life and Health Insurance Companies, thanked staff for suspending the requirements regarding the FAIR Health database. They are also concerned about the unintended consequences, especially those given the encouragement of utilizing out-of-network benefits.

Stephen Francis, Office of Assembly Member Perea, noted some oral medications are deemed "specialty pharmaceuticals," and often require coinsurance and cost many thousands of dollars. Coinsurance for oral drugs can result in unaffordable treatments for those already suffering with a life-threatening condition. Assembly Member Perea hoped Covered California will at least include a maximum payment for these drugs to improve coverage.

Sarah Muller, Director of Public Affairs and Government Communications, California Association of Public Hospitals and Health Systems, acknowledged Covered California's efforts to address challenges around affordability. Even after full implementation, which will take three to five years, under a best-case scenario, 3–4 million will remain uninsured. It is essential that California take steps minimize that number.

Ruth Liu, Blue Shield of California, expressed appreciation for the staff recommendation regarding out-of-network benefits. This will be critical in maintaining the affordability of PPO plans. Some consideration should be given to an offset for in-kind marketing when discussing plan fees, but this disadvantages plans with smaller marketing budgets, and this would also be hard to track.

Jim Novello, Molina Healthcare, thanked staff for recognizing the challenges confronting the Medi-Cal plans in the next twelve months. Any plan that involves continuity of care needs to include all of the Medi-Cal plans, not just some of them.

John Ramey, Executive Director, Local Health Plans of California, appreciated and applauded the staff and Board's efforts and consideration of a mechanism to make premiums more affordable. Clinics and public hospital provider networks are currently serving uninsured patients without receiving revenue for that care.

Eric Payne, Fresno Metro Black Chamber of Commerce, hoped to spread awareness about Covered California's friends in the Central Valley. He noted that they hoped their voices will be heard as they seek to engage a cultural sensitivity.

Betsy Imholz, Director of Special Projects, Consumers Union, was surprised to hear that out-of-network claims make up only 1–2 percent of claims. They make up a far larger percent of their inquiries. Consumers Union appreciates the effort to find a bridge type plan for affordability and continuity.

Carla Saporta, Health Policy Director, the Greenlining Institute, is excited to see options on the table in terms of an affordable plan. The biggest concern of Greenling Institute is affordability and access to safety net providers.

Kathy Ochoa, SEIU, noted that one of the remarks she made early on was that aggregation could prove to be a driver of delivery system reformation. Covered California can use its power to catalyze and move systems.

Discussion:
Board Member Belshé noted that much analysis of the Medicaid Managed Care Bridge Plan and the implications for the QHP RFP process remains to be done.

Mr. Lee said staff needs to bring this back for potential action as soon as January, which would allow time for local initiatives or other Medi-Cal plans that had not previously submitted applications to meet the review timelines thereafter.

Board Member Fearer asked if it is possible that the presence or absence of this alternative would influence the bids of commercial health plans.

Mr. Lee replied that Ms. Rosen went through the different elements of the timing. The premium rates are not brought in until March 21. It is possible that, if this alternative were part of the bidding, it could complicate things and affect how bidders bid, but it would be known by all parties by then. He noted initial staff review indicates new state legislation to implement the Medical Managed Care Bridge Plan would be required and would move forward parallel to the QHP solicitation process.

Mr. Lee affirmed how confusing out-of-network benefits can be. Even if they are just 1–2 percent of claims, that's hundreds of thousands of people. Mr. Lee also noted that it's important that consumers are given as clear information as possible. Plans need to

answer the question, “If you do use out of network services, what are the rules?” so that people can make informed decisions.

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

Agenda Item X: Adjournment
The meeting was adjourned at 4:43 p.m.