Comments to the Board

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March 21, 2012 Board Meeting

February 15, 2013

Peter Lee, Executive Director
Covered California/California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814
Via E-mail: info@hbex.ca.gov

ICAN

Stronger Communities
Healthier Kids

Dear Mr. Lee, Covered California Board Members and staff:

I am writing to voice my concerns about the design of the Assister program which seems to favor larger, established agencies over smaller community-based organizations (CBOs) who are so much rooted in the LEP communities that they serve.

We are a community-based organization working with Vietnamese families and children in Santa Clara County. We were very involved in Census 2010 and have made great contribution to the success of Census 2010 in Santa Clara county in general, and in the Vietnamese community in Santa Clara County in particular. We know what it takes to reach out to Vietnamese and help guide them through the complicated system to get the much needed health coverage.

We were very disappointed to find out that the Assister program is not designed to encourage the participation of smaller CBOs. Below are some institutional barriers resulting from the way the program is designed:

1) We have no funding to support the umbrella public awareness campaign to attract potential clients

2) The compensation is only $58 per successful application. How can CBOs employ full time staff to focus on outreach and enrollment if the compensation is based only on successful application? Who pays for the rest of their time?

3) You emphasized that the target audience for Covered California is NOT Medi-Cal population, yet you also expect us to help those clients if we happen to come across them, & do that for free?

Asian Law Alliance also share many of our concerns, and we theirs. We urge you to rethink the design of the program so as to encourage and facilitate the participation of small CBOs who are in the trenches working with LEP communities. One suggestion is to require large agencies to partner with ethnic CBOs in implementing the program.

Thank you for your consideration to make Covered California more accessible to small ethnic community based organizations serving LEP populations.

Sincerely yours,

Quyen Vuong, Executive Director

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***Assisters Program* Comment Received via E-mail**

Subject: Background Checks for Assisters

Dear Mr. Lee,

We are writing in support of required background checks for Covered California enrollment assisters, which the Covered California Board of Directors is currently considering. Community members who will serve as assisters will play a critical role in ensuring that the greatest possible number of eligible Californians enroll in coverage. Further, trusted community members could be particularly effective in hard-to-reach communities where many individuals may have never previously been enrolled in coverage.

Some stakeholders have expressed concern that establishing background checks as a prerequisite for certification as an assister may decrease engagement of community members in the task of outreach and enrollment. While we recognize this concern, we nevertheless believe that required background checks are both prudent and necessary. Covered California should include in the background check any past offense related to fraud, identity theft, larceny, or other financial mismanagement that calls into question an individual's ability to responsibly handle and transfer applicants' confidential information. These offenses, both felonies and misdemeanors, should disqualify prospective assisters in order to protect consumers when they provide sensitive personal and tax information that is required to apply for subsidies for Covered California plans.

More than a few isolated cases of identity theft by assisters could also become a serious obstacle for Covered California. If potential applicants question the security of their personal and financial information, they may be dissuaded from enrolling in coverage through Covered California.

At the same time, Covered California should take steps to minimize the adverse effect that background checks may have on assister recruitment. We feel that many offenses should not prevent individuals from being certified as assisters. For example, convictions for drug offenses, driving under the influence of alcohol, or assault should not preclude interested individuals from being certified because these offenses are not directly relevant to an individual's ability to accept the responsibilities of an assister. Additionally, information about the offenses that will *not* disqualify an individual from assister certification should be explicitly stated in informational materials about the certification process.

In sum, we feel that a background check is an essential component of a successful assister program. Yet, we urge Covered California to develop a background check that is not overly onerous and only includes elements that directly relate to the responsibilities of paid assisters. We believe that this approach balances the need to protect consumers with the goal of recruiting the maximum number and diversity of assisters to expand coverage for all Californians.

Sincerely,

Lucien Wulsin and John Connolly

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State Data Elements		
Coalition Comments - March 15, 2013		
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Richard Konda, Asian Law Alliance Doreena Wong, Asian Pacific American Legal Center Kerry Birnback, California Food Policy Advocates Cary Sanders, California Pan Ethnic Health Network Michelle Stillwell-Parvensky, Childrens Defense Fund - California Mike Odeh, Children Now Sonya Vazquez, Community Health Councils, Inc. Julie Silas, Consumers Union Silvia Yee, Disability Rights, Education, and Defense Fund Marlene Bennett, Health Legal Services Lynn Kersey, Maternal and Child Health Access Kim Lewis, National Health Law Program Sonal Ambegaokar, National Immigration Law Center Katie Murphy, Neighborhood Legal Services of Los Angeles County Anne Donnelly, Project Inform Beth Morrow, The Children's Partnership Masen Davis, Transgender Law Center Elizabeth Landsberg, Western Center on Law and Poverty		
Application Section	**State proposal**	**Comments**
General	Additional	CA should adapt the Federal model application to meet California's needs (and include successful questions and wording of questions from Healthy Families Program and Medi-Cal applications?
	Additional	We hope to confirm that both the paper and online applications will include taglines in 15 different languages with an 800 number to call for assistance in any language

Application Section	State proposal	Comments
	Additional	Missing both privacy explanation and non-discrimination language (e.g. Section 1557 of the Patient Protection and Affordable Care Act prohibits California from discriminating against individuals on the basis of health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation), up front at the cover page of the application, including notice that people with disabilities can receive reasonable accommodations and policy modification in the application process. Also need, up front, communication that any information entered by the user will be kept confidential and not shared with immigration.
	Additional	Testing language - concern about some of the language identified in the minimum data elements - need to do consumer testing, including with different types of users - don't test scenarios pre-designed, but have people actually enter in their own experiences (For HHS testing, it is our understanding that they gave people scenarios to put into the application, rather than have people use their own real-life experiences).
	Additional	Important to consumer test the language proposed for the help text, pop-up boxes, roll overs, etc. at the same time developing and consumer testing of the application questions occurs. Also important to rely on consumer advocates who have experience with applications to review and comment on application questions and help language. Don't make the same mistake that HHS drafters made and postpone review of help text (which we have not yet been shown).
	Additional	Need to lead with cover sheet about free assistance applying for health insurance–see Federal paper application cover sheet, which has some good information (though some of us commented on some portions of the cover sheet that were unnecessary use of real estate, e.g., the list of documents someone needs for a paper application).
Getting Started	Do you want to apply for financial assistance?	This doesn't belong on the introductory page, but should be included later in the questions that are relevant to someone applying for coverage.

Application Section	State proposal	Comments
	Is this your initial houshold application for this year?	This question should not be in the Getting Started Section as it is duplicative of questions later about income and few people will answer household income accurately. Additionally, there are problems with the readability of the language - what is "initial"? What is "Household" - need to define. Duplicative of question asking how many members are in household several questions later. If this is intended to identify someone who may have already established an account, probably better to ask that more specifically.
	What is the life event causing you to apply/re-apply (e.g., specifically for special enrollment)	We recommend revising this to ask if the person is applying during open enrollment (just provide the dates) or other time - this question will only be relevent outside of open enrollment for Exchange folks, not Medicaid - otherwise they can and should skip - need the option. This is a good example of the need to have a dynamic application that targets the questions. If relevant, then the individual should have a chance to identify special circumstances, but otherwise should not be asked. And, its relevance can only be assessed toward the end of the application.
	Are you receiving assistance in filling out this application? (Recommend delete or rewording: "Is someone helping you with this application?")	Should remove this question altogether. Rather there should be a field at the end of the paper, modeled after IRS forms that ask at the end about the tax preparer, where the Assister identifies herself and provides her Assister number. For the online application, the Assister will be using their personal log-in to enter information into the application, so the system will know if there is an Assister involved online. If it is retained here, reword to say "Is someone helping you with this application?"
	Select the agent or assister helping with this application	This should be deleted, per our comments above.
	Who are you applying for?	This is very confusing. Should delete. Repetitive of self application questions and additional household member questions.

Application Section	State proposal	Comments
	How many members are in the household? (Recommended language: "How many people live in your household?")	Reword - "Who else lives in your household?" or "How many people live in your household?"
	How did you hear about the Exchange?	Delete - not minimally necessary and should save important real estate to ask essential questions necessary for determining eligibility. Can do post-enrollment follow-up for marketing questions. Or could ask as an optional question at the end of the entire application.
	Source of application	Remove - not minimally necessary and should save important real estate to ask essential questions necessary for determining eligibility. Can do post-enrollment follow-up for marketing questions.
	Date of application?	Won't the system automatically do this online - so just needed for paper application.
	I agree to consent for verification	It is unclear what this means? What is the proposed language about consent to verification - Advocates would need to review, since this will be very important language. The language that we saw on the wire frame in the first draft PPT on Usability would need to be revised considerably. Instead, would need clear language explaining specific information that is being verified (income, immigration, date of birth?) and that the verification of immigration status will not be used for immigration enforcement. Need to provide clear information about the purpose of the verification and when it will take place, to build trust and transparency. Also, it was presented to us that the verification consent would last for five years which we have serious concerns with; that is too long a period.
	Additional	If there is someone who is an official authorized representative, need contact information, permissions, signature or legal proxy. Information about authorized representatives should be at the end, alongside questions about Assisters, including clear information to distinguish an Assister from an authorized representative. Should also include language notifying consumers that they have the right to change their authorized representative along with information about how they can remove or change an authorized representative from their case.

Application Section	State proposal	Comments
	Additional	Communication preferences and language preferences. Adopt "Healthy Families" application questions on written and spoken language preference as referenced in consumer advocate recommendations dated May 3, 2012. Add an additional question on language proficiency as referenced in consumer advocate recommendations dated May 3, 2012. Add additional question on disability access that relates to alternative formats for communications (see below).
	Additional	Missing information based on new proposed regulations about people without homes. See example on Federal paper application (Appendix C)
	Additional	Should ask for contact information FIRST - then ask the questions above in the general section (though some of those should wait until the end) - change the order of I Getting Started and II Personal Information.
Primary Contact Information	First name	Change to "person filling out application". Perhaps use the Federal "Tell us about yourself" or just "Your information"
	Middle name	
	Last Name	
	Suffix	Delete - not needed
	Home phone	Format to ask for primary and secondary phone and then box to click what type (home, work, cell, etc.)
	Work phone	
	Extension	
	Cell phone	
	email	May need an explanation if e-mail address is provided, that notices will only be sent to that address if the applicant chooses to have her notices received that way.
	home street address	
	Home city and state	
	Home county and zip	If possible we would recommend that the system pull county based on zip or do some zip codes cross county lines rather than make the applicant identify their county. Some people do not know what county they live in.
	Mailing address same as home address	
	Mailing street	
	Mailing city and state	

Application Section	State proposal	Comments
	Mailing county and zip	
	What is the preferred method of communication? (Recommended rewording: "How do you want to get information and notices about your health coverage?")	If this is supposed to be how they want to be communicated with via e-mail, snail mail, text, etc., there should be check boxes or a pull down menu with choices. Reword as "How do you want to get information and notices about your health coverage?"
	What is the preferred written language of communication?	Glad to see this close to the front! See recommendation above and consumer advocate recommendations dated 5/3/12 for how to word this question. Refer to California's Healthy Families application for how to ask questions about preferred written and spoken language and include a third question measuring language proficiency, which will result in a more accurate measurement of primary language. At this stage of the application, it might be good to remind an applicant who has issues such as language or other challenges using this application that they can get free help that meets their needs, with information about how to access the help.
	What is the preferred spoken language of communication?	See above
	Additional	Add additional question, "What alternative format do you need for your written communications?" Could have an accessible pull-down menu that lists options like Braille, electronic disc, secure electronic mail or website, large font print, or audio-recording, but there needs to be some kind of blank space that allows an applicant to specify something like 18 or 24 font, because s14 font can be just as inaccessible as standard print to some applicants. This question should be close to the front, since the application process will be meaningless if someone can't use the application. The additional question should come before the "preferred method of communication" so someone isn't confused that answering that question takes care of their alternative format needs.

Application Section	State proposal	Comments
	Additional	Missing race and ethnicity questions - and explanation of why collecting data. See the Federal model application and our combined recommendations for how to ask about ethnicity in the simplest way possible. Provide clarification that the state is planning to expand the categories of race in the paper application to include at a minimum the new categories approved by HHS which include additional granularity for Hispanic (4) and Asian (7) subpopulations as well as the three additional categories included in our original combined recommendations. For the online question please use the suggested drop-down list included in the May 3, 2012 recommendations.
	Additional	Missing questions on disability status (e.g., the 6 questions from the American Community Survey) as included in our original combined May 3, 2012 recommendations.
	Additional	Ask questions about sexual orientation and gender identity as requested in our combined recommendations and further delineated below. The ACA prohibits discrimination on the basis of race, ethnicity, national origin, disability status, sexual orientation and gender identity. Although we learned that Covered California is planning to conduct follow-up calls to consumers where these types of questions will be asked, DHCS could not make a similar guarantee, making it impossible for the state to claim it is measuring disparities in access to care as required by law. We also learned at both the May 3, 2012 and March 8, 2013 meetings, that the lack of a data field on gender identity has caused technical problems for eligibility workers attempting to reconcile applicant data for Male-to-Female or Female-to-Male applicants.
	Additional	Missing space for homeless or domestic violence as articulated in new regulations. Issue of applicants who don't need to have an address. See model Federal paper application.
Tell us about Yourself	Are you applying for coverage?	
	If so, ask questions included for anyone applying for coverage (pre-populate with information entered above)	This is the first time where SSN should be asked - if the primary contact is applying, will need it with option for another identification number if no SSN - see also federal application where applicant is provided contact information for obtaining a SSN if the person doesn't have one. If she is not applying, you will need explanation that SSN is optional for non-applicants.

Application Section	State proposal	Comments
Additional Household Members	First name	
	Middle name	
	Last name	
	Suffix	Delete - not needed
	Is this person applying for health coverage at this time?	Move this question to the top - all the additional questions should only be asked if the answer to this question is yes. If answer is no, they should be told (or directed via dynamic questioning online) to skip this section of the application.
	Gender	Only needed for applicants - should not be asked of non-applicants.
	Date of birth	
	Does this person have a SSN	Need to be clear that this is optional for non-applicants and provide reassuring language about how it will be used. Should be skipped for all non-applicants. For applicants, include proper privacy notice of SSN use, as well as instructions for what an applicant should do when they do not have an SSN - Note also that CA should opt to use a Medi-Cal ID instead of an SSN for individuals who are only eligible for non-work SSNs, as permitted under the Federal regulations.
	Reason for no SSN	Delete this question altogether and instead add in explanatory text to the SSN question above explaining that if someone doesn't have an SSN, call 1-800-XXX-XXXX or visit www.???. gov to get help.
	Adoption taxpayer ID #, Individual Tax payer ID #	This question should be asked in the income section when SSN is used to verify income with an explanation of why they are being asked to submit the information and specific consent to having their tax information "obtained." See federal model application.
	Is this person a US citizen or national?	Need additional questions when the person responds to this question with "No," asking them whether the applicant is an eligible immigrant or non-ciitizen.
	Is this person a naturalized citizen?	Delete this question. Naturalized citizens can be verified by SSN so there is no need for this unnecessary additional information.
	Document type	Delete this question. Naturalized citizens can be verified by SSN so there is no need for this unnecessary additional information.

Application Section	State proposal	Comments
	Naturalization #	Delete this question. Naturalized citizens can be verified by SSN so there is no need for this unnecessary additional information.
	Alien #	Only should be asked of those who are not naturalized citizens, so should only be asked of a person who says "no" to the question "is this person a US citizen or national."
	Citizenship certificate #	Do not ask this question
	Document type	Delete - document ID is not necessary for a SAVE inquiry.
	Alien #	Ask only after the applicant indicates she is an eligible immigrant.
	First name as per document	Not necessary - can be y/n answer - is name on document different from name reported above - if so, add name here. Applicants should not be required to provide any documentation for this unless there is a problem with electronic verification using just the alien registration number.
	Middle name as per document	Delete
	Last name as per document	Delete
	Suffix per document	Delete
	Date of entry	Delete or move to later and apply only to those eligible for Medi-Cal. At that time, this field can likely be pre-populated online through a SAVE inquiry.
	Does this person have eligible immigration status	Move to right after "Are you a US citizen or national?"
	Additional	Family relationship (daughter, spouse, etc.)

Application Section	State proposal	Comments
	Additional	We recommend that you collect additional information to adequately assess eligibility based on the Breast and Cervical Cancer Treatment Program (BCCTP), the potential to qualify as medically needy, limited-scope family planning, medical frailty where the person might need different treatment (either becuase existing income threshholds exceed 133% of FPL, e.g., BCCTP, there are different eligibility rules, e.g., medically needy), or because the person may qualify as an exception to the Alternative Health Benefit Plan, e.g, medically frail), and foster youth who are eligible (those in foster care on their 18th birthday and children and young adults in foster care who are not automatically linked to Medi-Cal though cash assistance).
	Additional	Missing race, ethnicity and primary language questions (which should be asked of each enrollee) and explanation of why collecting this data. See advocate recommendations from 5/3/12.
	Additional	Many of the questions listed in other sections should be moved up to this section. See our comments below: "Move up to general section on additional household members."
Additional Household Members - Address and Contact	Is this person's residence address the same as the household primary contact's address?	This seems unnecessary - why would someone fill this out for someone not in their household? If there is another reason to ask this question, would need to be reworded. If this is about dependents living somewhere else, then should specifically frame the question that way. The person by person approach of the federal application may work better, where each person can identify if they are applying for coverage and answer only relevant questions. For instance, every person applying for coverage needs to be asked about whether they are blind/disabled.
	Home address	Same as above
	Home city and state	Same as above
	Home county and zip	Same as above
	Home phone	Same as above
	Work phone	
	Extension	
	Cell phone	
	email address	
	Business name	Delete

Application Section	State proposal	Comments
	Enrollment PIN	Delete
	Date of hire	Delete
	What is this person's marital status	Delete - we don't know of any insurance affordability program that requires this as minimally necessary information.
	Is this person blind and/or disabled?	Move up to general section on additional household members. Use ACS 6 survey questions to ask specific questions to identify disability
	Does this person have a medical expense in the last three months?	Move up to general section on additional household members. Only applies to applicants and only in Medicaid program.
	Is this person pregnant?	Move up to general section on additional household members. Online version should only ask this of females within certain age range
	What is the expected date of delivery?	Not asked on federal model application and unlcear why it is included. Please delete.
	Number of babies expected?	Move up to general section on additional household members.Yes, important for household size
	Is this person a member of Federally-recognized Indian Tribe?	Federal model application has a separate paper form for this.
	Do you want to apply for the Indian-only cost-sharing reduction?	See above.
	Is this person attending school full-time?	This should only be asked of 19 and 20 year olds. We support the Administration's proposal to take the federal option of covering 19 and 20 year old full time students in the "children" bucket, but this information in not needed for others.
Additional Household Members - personal tax information	Was this person in the foster care or out of home placement or were they on their 18th birthday?	Move to general section on additional household members. Add wording to capture out of home placement care for foster youth and also children and young adults in foster care who are not automatically linked to Medi-Cal through case assistance.. Can use drop-down menu for this question or y/n for each person.
	Is this person the primary tax filer?	Ask for ANN/ITIN/ATIN of the primary tax filer only. Other members of the household should not have to provide this information.
	Did this person file taxes last year?	
	What was this person's tax filing status last year?	Not necessary - ask a different way - See federal application questions

Application Section	State proposal	Comments
	Is this person planning on filing taxes this year?	
	What is this peron's expected filing status for the benefit year?	Delete - not a minimally necessary question for determining eligiblity.
	Who claims this person as a tax dependent?	Ask above in federal model application.
	Is this person expected to be required to file taxes this year?	Delete - as both redundant and unclear.
Applying Members - Other Health Coverage Information	Does this person currently have or been offered heatlh insurance?	This should only be about employer-sponsored coverage for the Exchange - no one is barred from joining Medi-Cal or the Exchange if they already have non-group coverage - needs to be specific to ESI and later asked "other insurance" questions (See federal paper application - Appendix C)
	What is the name of the employer?	Not necessary for Medi-Cal
	What is the enrollment status?	This should not be asked on the application, but can be a post-eligibility follow-up question.
	How much does the person pay in monthly premiums?	Not specific enough - for that portion of the premiums attributed to that individual, right - not a family plan, etc.? This should be a post-eligiblity follow-up question.
	Does the health plan meet the "minimum standard value"?	Delete and instead use the federal Employer Health Coverage form by sending it directly to the employer to fill-out, based on minimal contact information for the employer, gathered through above data elements.
	Does this person need help with long-term or home and community-based services (HCBS) Waiver Services?	Move to general section on additional household members. How is an applicant supposed to know the answer? Should use six questions from ACS survey, rather than ask this here.
	Does this person receive Medicare benefits.	Delete and replace with "Other insurance." SSA database should identify if the applicant is on Medicare. This should be asked as a "Other health insurance" question to obtain information about all kinds of other insurance, including COBRA, VA, etc. See Federal paper application.

Application Section	State proposal	Comments
Applying Members - Referrals	Would anyone in the household like a referral to the local Health and Human Services agency for any of the following programs (CalWORKS, CalFresh, etc.)	Should be reworded to say "there may be other programs your family is eligible for. Please check here if you would like additional information" - see Health e-App for examples.
Optional information	Additional	Need to add Explanation for collection of optional data. The explanation for why this optional data is being collected should also inform consumers that the data is confidential and will not be used to determine eligibility per consumer advocate recommendations dated 5/3/12.
	What is this person's preferred written language of communication?	Should all be moved up front for each applicant - mark as optional but include with all other information requests - Also need to reword. See our suggested wording above.
	What is this person's preferred spoken language of communication?	Should all be moved up front for each applicant - mark as optional but include with all other information requests - Also need to reword. See our suggested wording above.
	Is this person Hispanic, Latino or Spanish origin?	Should all be moved up front for each applicant - mark as optional but include with all other information requests. See the Federal model application and our combined recommendations for how to ask about ethnicity in the simplest way possible. Reword into one question as done in consumer advocate recommendations dated 5/3/12 and on federal form: Is this person of Hispanic, Latino, or Spanish origin? □ No, not of Hispanic, Latino, or Spanish origin □ Yes, Mexican, Mexican Am., Chicano □ Yes, Puerto Rican □ Yes, Cuban □ Yes, another Hispanic, Latino, or Spanish origin
	Is this person Hispanic or Latino?	This question is duplicative and should be stricken.

Application Section	State proposal	Comments
	What is this person's ethnicity?	Reword to ask for the person's race. Provide clarification that the state is planning to expand the categories of race in the paper application to include at a minimum the new categories approved by HHS which include additional granularity for Hispanic (4) and Asian (7) subpopulations as well as the three additional Asian Pacific Islander categories included in our original combined recommendations dated 5/3/12. Drop-down menus accessible to screen readers with more granular categories should be included, particularly in the online application.
	Is this person a member of a Federally-recognized Indian Tribe?	This question could also be asked as part of the question on race above and as worded in the consumer advocate recommendations dated 5/3/12, along with the ability to write-in the name of the tribe.
	To which State does the tribe belong to?	
	What is the name of the Tribe?	
	Additional	Additional question on "Ancestry or ethnic origin" We recommend an additional question on Ancestry or Ethnic Origin as stated in the consumer advocate recommendations dated 5/3/12. This is useful information for understanding how well the state is serving emerging immigrant populations, e.g. Russian, a group that is reflective of one of the Medi-Cal Managed Care threshold populations and already recognized by the state as a significant population.

Application Section	State proposal	Comments
	Additional	"Gender identity and sexual orientation" Section 1557 prohibits discrimination on the basis of gender identity or sexual orientation. To ensure equal access to state programs, California must adopt additional questions on sexual orientation and gender identity as mentioned in the consumer stakeholder recommendations dated 5/3/12. Note: In 2013 the HHS Data Council and the National Center for Health Statistics released the following suggested wording for the question on sexual orientation which we urge California to adopt (ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2013/english/qadult.pdf): Which of the following best represents how you think of yourself? 1 Gay 2 Straight, that is, not gay 3 Bisexual 4 Something else 5 I don't know the answer 7 Refused
Income pages	Income type/income source	Income needs to be asked earlier, in order to start targeting the relevant questions where it is clear that a person is Medi-Cal eligible or likely APTC eligible, in order to benefit most from dynamic questioning for an online application. Need to be more clear what kind of income information is needed so as to ensure that reported income is clearly MAGI and not income that should not be counted toward MAGI - including self-employment, wages, SS benefits, child support, unemployment beneftis, etc.? Income questions should be integrated with questions on each separate member of the household. Need to be able to determine whether children or tax dependents in the household are expected to file tax returns, so that their income will be excluded, if not. (This determination may be built into the CalHEERS rules engine, so a separate question may not be necessary.) Need to provide instructions for those who do not have tax information (undocumented immigrants) as to how they can provide tax information for determining their legal immigrant family members' income.

Application Section	State proposal	Comments
	Amount	Applicant should be able to indicate if she is a seasonal worker or whether current employment is temporary, so that annual income can be properly determined for APTC eligibility. Also, applicant should be able to indicate otherwise whether current income is not consistent with expected income or is otherwise fluctuating, so that income can be prorated for Medi-Cal eligibility purposes.
	Frequency	Applicant must be able to clearly indentify frequency of reported income, i.e., weekly, bi-weekly, twice per month, monthly or annually. It may be helpful to achieve this through a drop-down menu accessible to screen readers.
	Additional	Data elements are missing the discrepancy questions - that will help anticipate inconsistencies; questions around any changes in income over the last six months, loss of job, decrease in hours, changes in job (see federal data elements and model application).
Income summary	Enter the projected annual household income if different from above	This will require significant help, and a calculator, in order for a relevant projection to come out of this, especially if a person is paid other than annually and needs help taking their hourly, weekly, or other income into annual format.

March 18, 2013

Ms. Thien Lam, Deputy Director Eligibility and Enrollment
Covered California

Mr. Len Finocchio, Associate Director
Department of Health Care Services

Re: AB1296 Meeting on Single Streamlined Application – State Minimum Data Elements

Dear Ms. Lam and Mr. Finocchio:

Thank you for providing us the opportunity to review and comment on the State's proposed minimum data elements for the single streamlined application for health coverage. On behalf of the undersigned, we submit these group comments.

We appreciate the work of the Department of Health Care Services (DHCS) and Covered California in developing the list of minimum data elements, as well as identifying the manner by which applications will be processed through a new "no wrong door" approach. While we are grateful for the detail provided and realize that a list of data elements does not convey the electronic logic for the electronic application or things such as pull-down lists, there are a number of areas where we continue to have concerns. These include the minimum data elements discussed during the meeting and outlined in greater detail below, as well as concerns further highlighted during our stakeholder meeting with you on March 8, 2013 regarding the policy decisions accompanying the application, eligibility and enrollment processes. This is especially important given the different portals and the variation in process steps depending on which door an applicant arrives at (online through the CalHEERS portal, online through a county portal, in-person, on the telephone, by fax, or through the mail).

Based on the meeting on March 8th, we anticipate sending a separate letter identifying a series of clarifications we hope to get from you all regarding the application, eligibility and enrollment process, including questions with respect to how "real time" eligibility of all MAGI cases (both Covered California and Medi-Cal) will be determined. We hope Covered California and DHCS's responses will help us to better understand and obtain assurances that no matter what door an applicant enters, the individual will get the same high quality customer service and the same standards for promptly processing her/his application and determining eligibility.

General comments

Overall, we seek to achieve the ACA goal of a truly streamlined application that is as concise as possible and minimizes the data elements required. We were gratified to hear at the meeting on March 8th, a number of decisions that DHCS and Covered California have made to benefit consumers. In particular, we applaud the design of a CalHEERS interface to be able to transfer applicant data obtained online through CalHEERS to SAWS for CalWorks and CalFresh eligibility determinations, when applicants consent to it. We also appreciate the decision to retain accelerated enrollment for children, which will be built into the new CalHEERS rules engine.

At our in-person meeting, we identified a number of overarching issues that require comprehensive and thoughtful consideration in developing the application data elements and specific application questions and flow to ensure a smooth, fair and accessible application process. Our comments below focus on the following areas, which are further delineated in the attached spreadsheet:

- Overall approach, tone, and feel of the application;
- Treatment of immigrants and immigration status;
- Collection of optional demographic information;
- Method for collecting and verifying income information;
- Identification and process for handling non-MAGI groups; and

- Other health care information.

Approach to the Application

We understand from our meeting on March 8th that there will be background or context information that will be provided to applicants before beginning an application, whether it be online or a paper application. From what was provided to us in the minimum data elements, concise explanations are missing about what kind of application and financial assistance is available, as well as important reassurances about non-discrimination, privacy and confidentiality, and general explanations regarding what information will be asked of applicants and why. The draft federal model paper application cover sheet provides a good start at draft language that welcomes and reassures consumers. We would like to see, as soon as possible, what the state proposes for such language in California.

Moreover, we understand that the state is developing draft questions for each of the data elements and explanatory language that will appear throughout the application to help guide consumers through the application process. Given our extensive experience working with or assisting consumers applying for coverage, we are anxious to review the language you are proposing, to ensure it is understandable and succinct.

After a cover page, the "getting started" section will be the first place where consumers are introduced to Covered California, Medi-Cal, AIM and the single, streamlined application process. Applicants should be asked some basic information about themselves and then offered a brief explanation about the rest of the application process. The federal proposed paper application provides a good model for how to approach this section. This section should not be used to ask detailed and sometimes unnecessary or repetitive questions that are not directly relevant to the eligibility determination process. In the attached chart, we have noted questions that we think should be removed from the "getting started" section that are not minimally necessary and have suggested moving until later or deleting altogether some of the optional questions, including those about Covered California marketing, which are optional and should be categorized as such.

Treatment of immigrants and immigration status issues

We greatly appreciate DHCS and Covered California's commitment to ensure eligible individuals in California's immigrant families are able to easily apply and enroll. Almost all of California's existing application questions, procedures, and instructions regarding citizenship or immigration status are considered best practices and should be incorporated in any newly designed application, so as to not start from scratch. It is critical that the application be designed from the perspective of a parent in a mixed-status family, with all their fears and reluctance in seeking benefits, to ensure only the questions that are strictly necessary to determine eligibility are asked of non-applicants and applicants and that the questions for non-applicants are clear and specific in order to obtain only necessary information.

We recommend eliminating questions that could be more easily and accurately obtained via electronic databases such as SSA or SAVE and shifting the burden of proof away from the applicants. This will help streamline enrollment for immigrant families and not deter eligible individuals. Finally, we recommend no distinction in the application process from the consumer perspective be made between naturalized and U.S. born citizens as they must be treated equally under the law.

We would greatly appreciate having a separate meeting to hone in on the specific immigration/citizenship recommendations raised in the attached for our mutual education and understanding of what information is absolutely necessary to conduct an accurate eligibility determination and to develop the best solutions for all Californians.

Collection of optional demographic information

California has a track record, as one of the most diverse states in the country, of collecting demographic data on race, ethnicity and primary language on both the Medi-Cal and Healthy Families Program (HFP) application forms. We were happy to see that DHCS and Covered California are planning to continue to collect this data. However, we have concerns about the scope and wording of certain questions and the omission of other demographic data questions that are important both for measuring health disparities and for ensuring accessibility for Limited English-Proficient (LEP) and disabled consumers who require alternative formats for communication, as summarized in the attached spreadsheet and delineated further in our combined recommendations dated May 3, 2012. We were particularly surprised and disappointed to hear at the March 8th meeting that neither DHCS nor Covered California were planning to collect optional data on sexual orientation and gender identity at the time of application. These data elements are not only critical to measuring disparities in access to care, but mandatory in order to make proper eligibility determinations and to reconcile patient data for example in cases where a person's gender has changed.

Additionally, we would appreciate clarification that the online application will include drop-down menus, accessible to screen readers, for each of the demographic categories above in order to capture more granular data on race, ethnicity, primary language, and disability and LGBTQ status. The application should include in its statement for why the optional data is being collected, an explanation that the data will help to ensure equal access to quality care, that it is confidential and that it will not be used to determine a person's eligibility for health programs (see the Federal model application and our recommendations for suggestions).

As with the immigration issues identified above, we are available to meet with you separately to discuss the appropriate optional demographic elements and wording of questions to ensure that the data elements collected and language used on the application form are accessible and understandable to applicants.

Income Information

We applaud the state's explanation at the March 8th meeting about the intent to include detailed questions for the income section, in recognition of the fact that certain types of income will have to be subtracted by the rules engine from gross income to align with MAGI standards. For example, pre-tax contributions to health insurance and child support payments are not counted toward MAGI.

We also appreciate your offer to share the detailed income questions with us when they are drafted for our review and comment. In the meantime, we are concerned that the income data elements appear as a separate section toward the end of the application. The income elements should be incorporated into the sections for each person in the household. If kept as a separate section, the person whose income is being listed must be added as a data element (See, the children's mail-in application).

We also recommend asking about how frequently the income is received, i.e., weekly, bi-weekly, monthly or annually and whether an applicant is a seasonal or temporary worker and, if so, how their income comes in throughout the year. This will be necessary to do the calculation of annual income for APTC/CSR purposes. Further, applicants should be able to indicate whether the amount of income in the month of application is unusually high in comparison to what is expected in coming months and whether or not the applicant is a seasonal worker, in order to establish a projected income to determine Medi-Cal eligibility when the applicant has fluctuating income.

Traditional Medi-Cal groups

While we recognize that the single streamlined application is not intended to collect all of the information necessary for a full "traditional" (non-MAGI) Medi-Cal determination, the information collected should go beyond information about disability and long term care needs to also identify other non-MAGI eligible applicants, such as the AFDC-MN group and current foster children. In addition, certain groups of MAGI Medi-Cal applicants, such as certain parents eligible for the Section 1931(b) program and the medically frail, are not required to accept the "Alternative Benefits Plan" (ABP) benefits package. Therefore, if there is a different ABP, these groups will need to be identified through the application to ensure they can receive existing state plan services. Finally, there may be adult applicants currently eligible for Medi-Cal at income levels above 133% FPL, such as women in the Breast and Cervical Cancer Treatment Program (BCCTP), who will need to be flagged so they can get coverage under Medi-Cal rather than be sent to the Exchange.

While we fully recognize that the final policy decision regarding what the package of benefits will be for the ABP, as well as other outstanding policy decisions about the traditional Medi-Cal programs have not been made yet, capturing information from applicants who may be eligible for non-MAGI Medi-Cal is nevertheless critical. The application needs to solicit enough

information to flag these individuals for real time MAGI enrollment and for follow-up as to non-MAGI eligibility.

We recommend that you collect additional information to adequately assess eligibility based on the Breast and Cervical Cancer Treatment Program (BCCTP), the potential to qualify as medically needy, limited-scope family planning, medical frailty, and foster youth who are eligible (those in foster care on their 18th birthday and children and young adults in foster care who are not automatically linked to Medi-Cal though cash assistance). We have not provided specific language on questions to be added at this time, but would be happy to do so once we discuss the larger issue with you further. For example, the question "Have you been diagnosed with breast or cervical cancer?" could be used. If specific questions are not added, some other way to notify the person or flag the programs they may be eligible for needs to be addressed at the time of application.

Finally, the streamlined application needs to capture older adults and persons with disabilities so that the Exchange does not assume individuals age 65 and older are ineligible for assistance, since they may be non-MAGI Medicaid eligible. Medicare-eligible individuals who are ineligible for assistance under the Medi-Cal Expansion or APTC may be eligible for non-MAGI Medi-Cal. The single application may also miss Medicare Savings Programs (such as QI-1) eligibility unless it collects the information necessary to make such assessments or determinations for applicants and for individuals with potential eligibility for Medicare Part D "Extra Help" (low-income subsidies). We would like more detail on how these individuals will be treated when they apply through the Exchange Service Centers, online, in-person, or by paper application.

<u>Other health care information</u>

We are concerned that there are unnecessary and duplicative questions regarding Other Health Coverage (OHC). While we understand that for the respective programs, each program needs certain information related to OHC, we want to ensure that Medi-Cal eligible persons are not asked questions regarding access to affordable employer sponsored coverage that are only relevant to Covered California eligibility. In addition, for Medi-Cal, OHC data are currently available through electronic data matching with commercial carriers. Having applicants answer questions about OHC is thus not only unnecessary for eligibility determinations, but also with respect to third party liability.

Additionally, for applicants for whom information about employer health coverage is relevant to eligibility, we are concerned with the amount of information that is being requested. The level of detailed information that is requested in this section is not information an employee should be expected to know about an employer, including things such as minimum standard value. We understand that many employers have agreed to fill-out the HHS designed Employer Coverage Form and make it available to their employees. We think that, in instances where the employee does not have readily available access to employer information through a pre-filled Employer Coverage Form, it should not be the obligation of the employee to provide that information.

Once again, we appreciate having the opportunity to review and comment on the state's proposed minimum data elements and the impact of these elements on California's ability to develop a single, streamlined, application, eligibility and enrollment process. We look forward to reviewing further documents, as they become available. For further information, contact Julie Silas (415) 431-6747, Cary Sanders (510) 832-1160, or Elizabeth Landsberg (916)282-5118.

Sincerely,

Richard Konda, Asian Law Alliance
Doreena Wong, Asian Pacific American Legal Center
Kerry Birnback, California Food Policy Advocates
Cary Sanders, California Pan Ethnic Health Network
Michelle Stillwell-Parvensky, Childrens Defense Fund - California
Mike Odeh, Children Now
Sonya Vazquez, Community Health Councils, Inc.
Julie Silas, Consumers Union
Silvia Yee, Disability Rights, Education, and Defense Fund
Marlene Bennett, Health Legal Services
Lynn Kersey, Maternal and Child Health Access
Kim Lewis, National Health Law Program
Sonal Ambegaokar, National Immigration Law Center
Katie Murphy, Neighborhood Legal Services of Los Angeles County
Anne Donnelly, Project Inform
Beth Morrow, The Children's Partnership
Masen Davis, Transgender Law Center
Elizabeth Landsberg, Western Center on Law and Poverty

Cc: Peter Lee, Director, Covered California
Toby Douglas, Director, Department of Health Care Services

***Eligibility and Enrollment* Comment Received via E-mail**

Subject: Tax Data Pre-Population for Eligibility

Hello, I would like to discuss how completed tax returns from consumers may be able to pre-populate the enrollment and subsidy determination engine with Covered California. Please have someone contact me.

Paul Jordan
Paul_Jordan@intuit.com
Business Development
Intuit Consumer Group
650.944.5585

Transgender Law Center

March 15, 2013

California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814

Re: Comments on Single Streamlined Application

Dear Exchange Board Members and Staff:

We greatly appreciate the efforts of the Covered California board and staff to develop a single streamlined application to facilitate enrollment in Medi-Cal, CHIP, and the health insurance Marketplace, all of which will be critical gateways to affordable health insurance coverage for consumers. We appreciate the opportunity to comment on these draft data elements, and we make the following recommendations to assist Covered California in appropriately serving a large and diverse consumer population:

- We strongly support the proposed addition of "partner" alongside spouse among the options for response to questions related to relationship status. This appropriately recognizes that forms of relationship recognized in California today. We further recommend that the application include help text partners and separate filing, that guidance for Navigators and Marketplace staff include information about how to assist individuals who have a same-sex spouse or partner in applying for subsidies and purchasing family coverage.
- The application should specify that the information being requested in the "gender" data element is on **legal** sex, and the online applications for individuals should include help text for the definition of "legal sex."
- Where appropriate, the application should collect a comprehensive range of demographic information, including sexual orientation and gender identity. This information is an important component of including the lesbian, gay, bisexual, and transgender (LGBT) population in Marketplace functions such as outreach planning, compliance with nondiscrimination requirements, and customer satisfaction evaluations.

Below, we discuss these recommendations in turn.

Recognition of same-sex partners and spouses

In order to accurately reflect the current realities of family structures in California, the single streamlined application must be able to capture information about these families. We therefore recommend that the "Type of Relationship" Data Element of the application allow respondents to indicate that they are in a domestic partnership or civil union, in addition to the option indicating marriage. As such, we recommend that this question read as follows on the application:[1]

What is your relationship status?

- Single
- Married to an opposite-sex spouse
- Married to a same-sex spouse
- In an opposite-sex domestic partnership
- In a same-sex domestic partnership
- Divorced
- Widowed

We also recommend that the application consistently use "Parent 1" and "Parent 2" instead of "Mother" and "Father," if these terms are used.[2]

We also note that there is potential that the application could be unclear about how same-sex partners and spouses can apply for subsidies and enroll in family coverage. Specifically, we understand that any couple whose relationship is not recognized under federal law, including same-sex spouses and partners, will need to apply individually for subsidies. To ensure that individuals who have a same-sex spouse or partner receive the assistance they need to correctly calculate their subsidies, guidance for Navigators and Marketplace staff should note that California extends relationship recognition to same-sex partners and (in limited contexts) spouses, even though federal law does not currently recognize these couples for federal tax purposes. Navigators and Marketplace staff should thus be prepared to competently and respectfully assist individuals with same-sex spouses or partners in filing the appropriate paperwork to apply for subsidies.

Questions about gender

We support collecting data on the gender of applicants on all applications. We note, however, that this question may not be straightforward for transgender individuals to answer, given the degree of difficulty frequently involved in changing the sex designation on various forms of identification such as driver's licenses, passports, birth certificates, and Social Security cards. As such, we recommend that this question read as follows on the application:

What is your legal sex?

- *Male*
- *Female*

To further assist individuals in answering this question accurately according to their records with the Social Security Administration, which is the form of identification most closely tied to taxpayer status and income eligibility testing, the online application should include the following help text:

"This question asks for your legal sex which, in this context, means the sex on your Social Security record. We need this information to check whether you are eligible for Medicaid in your state or for subsidies to help you purchase coverage through the Health Insurance Marketplace. Your answer to this question will not affect the benefits you receive through Medicaid or any Marketplace plan that you purchase."

Collecting demographic data on sexual orientation and gender identity

Comprehensive demographic data collection is indispensable to the effective operation of the Marketplace. These data will help the Marketplace with activities such as outreach planning, compliance with nondiscrimination requirements, and customer satisfaction evaluations. They will also help the Marketplaces understand and address health disparities related to personal identity factors that affect health status, access to health care and insurance, and health care outcomes. As such, we recommend that the optional information/demographic data collection section of the application collect a full range of demographic data, including sexual orientation and gender identity.

Numerous sources, including the Department of Health and Human Services itself and the Institute of Medicine reports *Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records* (2012) and *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), testify to the importance of sexual orientation and gender identity data. In fact, Secretary Sebelius has drawn on the authority granted under Section 4302 of the Affordable Care Act to commit the Department to developing sexual orientation and gender identity questions for federally supported health surveys. According to the "LGBT Data Progression Plan," which HHS released in 2011, "The [Affordable Care Act] also provides the Department of Health and Human Services the opportunity to collect additional demographic data to further improve our understanding of healthcare disparities. In the past, identifying disparities and effectively monitoring efforts to reduce them has been limited by a lack of specificity, uniformity, and quality in data collection and reporting procedures. Consistent methods for collecting and reporting health data will help us better understand the nature of health problems in the LGBT community."[3]

Respondents may be uncomfortable sharing personal information on the Marketplace application due to concerns about privacy. The inclusion of ethnicity, and language questions among the draft data elements, however, correctly indicates that the importance of these data justifies the inclusion of these questions as optional measures. Sexual orientation and gender identity data are no different. Moreover, the groundbreaking LGBT-inclusive nondiscrimination laws that apply to the Marketplace provide unprecedented protection for gay and transgender individuals and offer a major opportunity to move forward with data collection that can help identify and address a range of disparities, as envisioned by Section 4302 of the Affordable Care Act.

We therefore recommend the addition of the following **optional** questions to the application:

i. Sexual orientation

The following question was developed by the National Center for Health Statistics, and a version of it is now on the National Health Interview Survey:

Do you consider yourself to be:

- *Straight or heterosexual*
- *Gay or lesbian*
- *Bisexual*
- *Something else (write in)*_____

ii. Gender identity

The measure below has been used on state Behavioral Risk Factor Surveillance System surveys for several years:

> *Some people describe themselves as transgender when they experience a different gender identity from their sex at birth. For example, a person born into a male body, but who feels female or lives as a woman. Do you consider yourself to be transgender?*
>
> - *Yes, transgender, male to female*
> - *Yes, transgender, female to male*
> - *Yes, transgender, gender-nonconforming*
> - *No*

In research conducted around the use of this question in Massachusetts, the non-response rate (1.4%) was very low; in fact, it was much lower than the non-response rate for income. Analyses of MA-BRFSS data collected between 2007-2009 indicate that 0.5% of 18 to 64-year-old adults answered yes to this question and were classified as transgender,[4] which is consistent with population-based estimates from two other states (California and Vermont).[5]

Covered California offers a historic opportunity to collect data about the experiences and needs of LGBT Californians and their families, as well as to connect this population with affordable, comprehensive coverage. We urge Covered California to take the opportunity to include LGBT individuals and their families in the streamlined application to help ensure they fully benefit from the health reform effort.

Sincerely,

Masen Davis
Executive Director
Transgender Law Center

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[1] Adapted from Bates N and TJ DeMaio, "New Relationship and Marital Status Questions: A Reflection of Changes to the Social and Legal Recognition of Same-Sex Couples in the U.S." (Washington: Center for Survey Measurement Research and Methodology Directorate, U.S. Census Bureau, January 2012). Available from http://www.census.gov/srd/papers/pdf/rsm2012-02.pdf

[2] The State Department made a similar change in 2011. *See,* e.g., Sheridan MB and E O'Keefe. "Parent One, Parent Two to replace references to mother, father on passport forms." *Washington Post* 7 January 2011. Available from http://www.washingtonpost.com/wp-dyn/content/article/2011/01/07/AR2011010706741.html

[3] Department of Health and Human Services. 2011. "Plan for Health Data Collection on Lesbian, Gay, Bisexual, and Transgender (LGBT) Populations." Available from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=209

[4] 95% confidence interval [CI]=0.3%, 0.6%; Conron KJ, G Scott, GS Stowell, and SJ Landers. "Transgender health in Massachusetts: Results from a household probability sample of adults." *Am J Pub Health* 102 (2012):118-122.

[5] Ibid.

Transgender Law Center

March 15, 2013

California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814

Re: Comments on Enrollment and Eligibility

Dear Exchange Board Members and Staff:

Transgender Law Center is pleased to have the opportunity to comment on the key policies related to enrollment in and eligibility for plans offered through Covered California.

We would also like to take this opportunity to provide input related to eligibility and enrollment for family plans, to help ensure that policies adopted by Covered California will adequately serve families in California. In particular, policies related to the recognition of diverse family structures are of great importance to lesbian, gay, bisexual, and transgender (LGBT) communities.

According to data from the 2010 census, California is home to over 98,000 same-sex couples, and over 15,000 of these couples are raising children.[i] Recognizing the importance of insurance coverage for these families, the state of California has affirmatively required carriers in the individual and small group markets to extend family coverage to same-sex partners and their children.[ii] Additionally, the Department of Health and Human Services has made note of the diversity of state relationship recognition laws, and has expressly stated that "states have the flexibility to require issuers to include specific types of individuals on a family policy, and nothing in [federal] rules precludes this ability."[iii] Thus, as a matter of sensible policy, and as a matter of state law, same-sex partners and their families must thus be eligible to enroll in Qualified Health Plans that are offered through Covered California.

To facilitate enrollment and eligibility determinations for families headed by same-sex couples, Covered California should provide guidance to issuers offering Qualified Health Plans to ensure that family covered offered through a QHP complies with state law.

Additionally, while regulations issued by the Treasury Department make clear that the federal Defense of Marriage Act (DOMA) prohibits same-sex couples from applying jointly for advance premium tax credits to purchase coverage through the Covered California, families headed by same-sex couples should be able to apply any individually-calculated credits to purchase any family coverage offered by QHPs. Thus, policies developed by Covered California related to the application of tax credits toward the purchase of QHP coverage must account for the reconciliation between the individually calculated credits and their joint application for the purchase of QHP-based family coverage. Navigators, Assisters, Covered California staff, and other individuals or entities charged with providing assistance to consumers in the application

and enrollment process should be provided with guidance in guiding these consumers through the subsidy and application process.

Finally, the streamlined application, and any other forms utilized for the purposes of eligibility or enrollment, should include response options that permit same-sex couples to accurately report their relationship status.

Sincerely,

Masen Davis
Executive Director
Transgender Law Center

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[i] http://williamsinstitute.law.ucla.edu/wp-content/uploads/Census2010Snapshot_California_v2.pdf
[ii] *See* Cal Ins Code § 381.5; Cal Health & Saf Code § 1374.58.
[iii] Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Final Rule (Feb 27, 2013).

March 18, 2013

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

Comments to the Board on the Draft Regulations on Background Checks

Dear Mr. Lee:

We, the undersigned organizations, are writing to provide comments on the Draft Regulations for Background Checks for Assisters and Covered California employees presented at the February 26, 2013 board meeting. As organizations dedicated to improving the life chances of California's Boys and Men of Color (BMOC), we are deeply concerned that the staff's proposed regulations for background checks are overly restrictive.

As the criminal justice system - from initial stops to arrests to convictions – has a disparate impact on communities of color, the stringent criminal background check regulations put forth by Covered California will have detrimental and disproportionate consequences for the employment opportunities of boys and men of color. Furthermore, the regulations drafted run counter to Covered California's stated principle of employing Assisters and other staff who mirror "the cultural and linguistic diversity"[1]of the 5.3 million Californians expected to lack insurance and/or qualify for tax credit subsidies in 2014. Therefore, we fear that if the background check policy is implemented as drafted, those whose healthcare access has historically been unduly limited will once again be excluded from the solution.

There are several reasons why overly stringent background checks do not make sense. First, research at the national level generally finds that background checks do not improve an employer's ability to identify risk, and result in the exclusion of many eligible candidates from employment opportunities. Second, overly stringent background checks disproportionately impact blacks and Hispanics. Finally, the proposed overly stringent regulations could severely limit Covered California's ability to hire a diverse workforce that can adequately respond to consumers' linguistic and cultural needs. Below, we have

[1] Covered California. (February 2013). Covered California Assisters Program: In-Person Assistance and Navigator Webinar. [PowerPoint]. Retreived from http://www.healthexchange.ca.gov/StakeHolders/Documents/Assisters%20Webinar%20FINAL02072013.pdf.

included the justification for our concerns and recommendations to make the regulations fair.

Background Checks Do Not Improve an Employer's Ability to Identify Risk, and Exclude Many Eligible Candidates from Employment Opportunities

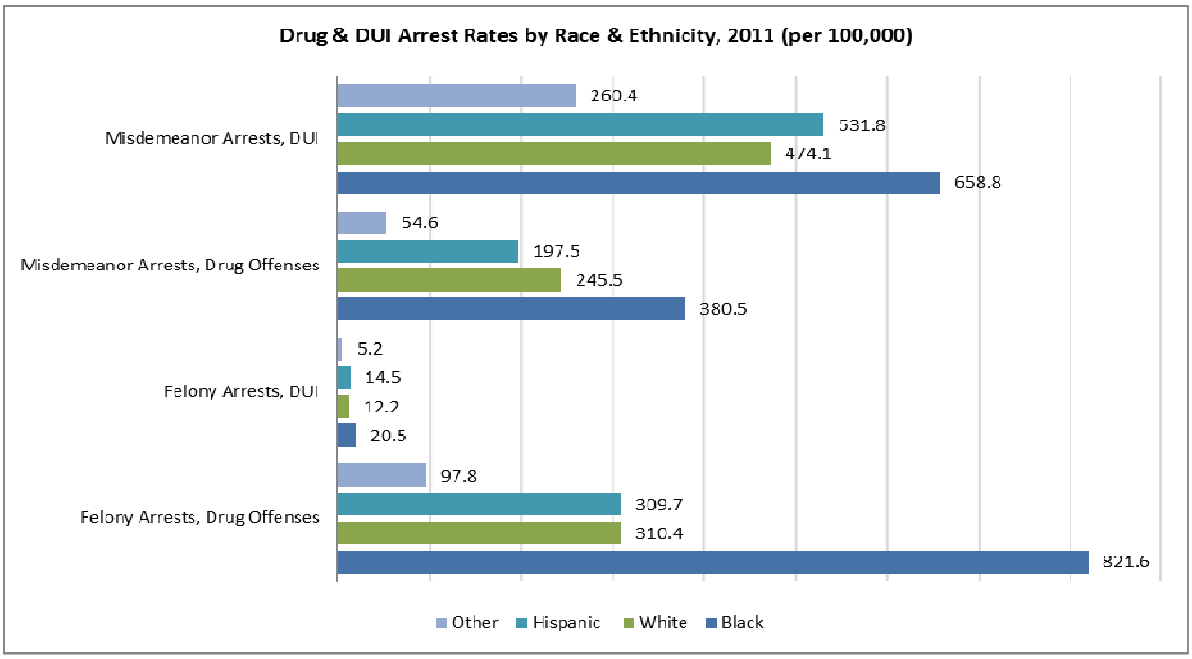
The National Employment Law Project (NELP) and the Department of Justice have both found that approximately 30 percent of the adult U.S. population has a criminal record.[2,3] In fact, as of December 31, 2010, California had 10,641,300 subjects in its state criminal history files. This indicates that up to 28 percent of all California residents have a criminal record.[4] This can severely limit the applicant pool, since a criminal record reduces the likelihood of a job callback or offer by almost 50 percent, an effect inequitably greater for black men versus white men.[5]

Blacks and Hispanics Are Disproportionately Impacted by Overly Stringent Background Checks

California's racial and ethnic minorities make up the majority of the prison population, with blacks and Hispanics comprising a full 70 percent of those in state institutions. Though the share of the prison population blacks and Hispanics represent is startling, their rate of incarceration gives a better picture of the disparate impact the criminal justice system confers on racial and ethnic minorities: Blacks are 7.7 times more likely to be incarcerated than whites, and Hispanics have almost double the incarceration rate of whites.[6] If these trends continue, one in six Hispanic men, and one in three black men will be incarcerated during their lifetime, disparately larger rates compared to the white male incarceration rate of one in seventeen.[7]

In terms of drug and DUI enforcement, blacks are disproportionately arrested compared to other population groups in California.[8] Even though data indicate that racial and ethnic groups use and sell drugs at similar rates,[9] blacks are arrested at significantly higher rates than other groups, indicating a significant disparity.[10] Taking into consideration arrest information for drug offenses in the employee selection process would have a disparate impact on blacks in California, as demonstrated in the graph below: [11]

[2] Rodriguez MN and Emsellem M. (2011). 65 Million Need Not Apply: The Case for Reforming Criminal Background Checks for Employment. National Employment Law Project.
[3] Schmitt J and Warner K. (2010). Ex-offenders and the Labor Market. Center for Economic and Policy Research.
[4] Bureau of Justice Statistics. (2011). Survey of State Criminal History Information Systems. Washington, D.C.
[5] Pager D, Western B, and Sugie N. (2007). Sequencing Disadvantage: Barriers to Employment Facing Young Black and White Men with Criminal Records. The Annals of the American Academy; 623(1):195-99.
[6] Bureau of Justice Statistics. (2011). Survey of State Criminal History Information Systems. Washington, D.C.
[7] Bonczar, T.P. (2003). Prevalence of Imprisonment in the U.S. Population, 1974-2001. Washington, DC: Bureau of Justice Statistics.
[8] Harris, K.D. (2011). Crime in California, 2011. Sacramento, CA: California Department of Justice, Office of the Attorney General.
[9] SAMHSA (2011). Results from the 2010 and 2011 National Survey on Drug Use and Health: Detailed Tables. Prevalence Estimates, Standard Errors, and Sample Sizes.
[10] Harris, K.D. (2011). Crime in California, 2011. Sacramento, CA: California Department of Justice, Office of the Attorney General.
[11] Harris, K.D. (2011). Crime in California, 2011. Sacramento, CA: California Department of Justice, Office of the Attorney General.



Source: Harris, K.D. (2011). Crime in California, 2011. Sacramento, CA: California Department of Justice, Office of the Attorney General.

Proposed Regulations Could Limit Covered California's Ability to Hire A Diverse Workforce

CalSIM modeling predicts that of the Covered California individual subsidy eligible population in 2014, approximately 171,000[12] or 21 percent[13] will be boys and young men of color; and of that population, 64 percent will be Latino, 6.6 percent Asian-Pacific Islanders, and 3 percent African American.[14] As stated in the Board's Report by the Exchange to the Governor and Legislature, Latinos, low-income African-Americans, Asian and Pacific Islanders, and young adult males are priority outreach populations in Covered California's marketing, outreach and education strategy.[15] Should background check requirements be overly restrictive, leading to the large-scale exclusion of populations disproportionately impacted by the criminal justice system, Covered California's ability to provide culturally and linguistically appropriate enrollment services will be severely stymied.

We believe the proposed regulations cast too wide a net and will disproportionately impact black and Hispanic applicants. Instead, the background check policy should be more narrowly tailored. While we support the intent and purpose of the background check

[12] Ojeda, Gil. (February 2013). *BMoC: Socio-demographics and Health Indicators. [*Presentation PowerPoint]. Berkeley, CA: California Programo n Access to Care , US Berkeley School of Public Health

[13] Calculated by taking the base number of the subsidy eligible population and dividing that by the male 19-26 subsidy eligible population. CalSIM. Lucia L, Jacobs K, Dietz M, et al. (September 2012). *After Millions of Californians Gain health Coverage Under the Affordable Care Act, Who Will Remain Uninsured?* UC Berkeley Center for Labor Research and Education & UCLA Center for Health Policy Research (Note: CalSIM "base" estimate used); Ojeda, Gil. (February 2013). *BMoC: Socio-demographics and Health Indicators. [*Presentation PowerPoint]. Berkeley, CA: California Programo n Access to Care , US Berkeley School of Public Health

[14] Ojeda, Gil. (February 2013). *BMoC: Socio-demographics and Health Indicators. [*Presentation PowerPoint]. Berkeley, CA: California Programo n Access to Care , US Berkeley School of Public Health. (Total Covered California Individual Subsidy Eligible, age 19-26, equals 226,000; Latino: 145,000; Asian-Pacific Islanders: 15,000; African American: 7,000; White/Non-Latino: 55,000; Other: 4,000).

[15] Covered California. (January, 2013). Covered California: Report by the California Health Exchange to the Governor and Legislature. Retrieved from http://www.healthexchange.ca.gov/Documents/CoveredCA-AnnualReport-01-08-2013.pdf.

policy, we have serious concerns with the proposed draft regulations. We support Covered California in ensuring consumer protections and disqualifying dishonest individuals from being Assisters and employees of Covered California, but we do not agree that proposed clearance requirements will achieve both goals of protecting consumers and enlisting workers that reflect the communities they serve. We urge the Board to develop security clearance guidelines that do not adversely select out Californians who are disproportionately incarcerated and represent valuable "boots on the ground."

Recommendations

For the aforementioned reasons, we submit the following recommendations to implement fair background checks, based on evidence and on workforce expertise:

- Incorporate best practices for background checks recommended by entities such as the Equal Employment Opportunity Commission (EEOC) and NELP. For instance, the EEOC's Guidance emphasizes that background checks must consider the nature of the crime, the time elapsed since the conviction, and the nature of the job.[16]
- Limit the list of potentially disqualifying offenses to felonies and misdemeanors that are substantially related to the job. For example, drug and DUI offenses should be excluded from the background check because they are unrelated to the work of a Covered California Assister or service center employee.
- Eliminate all arrests and pending charges as potentially disqualifying offenses. In the U.S., it is a fundamental right that all people are innocent until proven guilty. Additionally, many people, and those from low-income communities and communities of color, in particular are arrested for reasons other than being guilty.
- If a background check is conducted, at minimum, legal requirements of the Fair Credit Reporting Act and California's Consumer Credit Reporting Agencies Act should be met. The nation's federal consumer protection law (the Fair Credit Reporting Act) requires accuracy in background checks conducted by private screening firms, and mandates that employers provide a copy of background check reports to workers before any adverse employment decision is taken.[17] Additionally, California Penal Code Section 11105(t) requires all government and private parties requesting a state or federal criminal background check to promptly provide the worker with a copy of the DOJ criminal record response when that information is a basis for an adverse employment licensing or certification decision. That way, as with a credit check, the individual has an opportunity to question the accuracy of the determination without delay.
- Include an appeals process that allows an individual to determine whether there is an error in that individual's record because background checks often contain incomplete or inaccurate information. In fact, of the more than 10.5 million subjects with criminal records in California's criminal history information system, only 57 percent of all arrests in the database have the final disposition recorded, and only 11 percent of arrests in the past five years provide disposition information.[18]

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[16] U.S. Equal Employment Opportunity Commission. (2012). EEOC Enforcement Guidance. Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964. No. 915.002.

[17] Fair Credit Reporting Act. 15 U.S.C. Section 1681. (Updated September 2011). Retrieved from: http://www.ftc.gov/os/statutes/031224fcra.pdf

[18] Bureau of Justice Statistics. (2011). *Survey of State Criminal History Information Systems.* Washington, D.C

- Include an individual assessment in conjunction with the appeals process for individuals whose criminal history includes a potentially disqualifying offense. The individualized assessment will provide the Exchange an opportunity to waive the potentially disqualifying offense by allowing the individual to explain the special circumstances relevant to the potentially disqualifying offense and provide information about subsequent efforts to rehabilitate.
- Clearly define the evidence of rehabilitation that can enable an individual with a potentially disqualifying record to become an Application Assisters or Service Center employees. Documentation of rehabilitation or good faith effort to address past criminal history should include factors such as the following:
    - Participation in a work training program;
    - Participation in a counseling program;
    - Involvement in a community group; and
    - Letters of support from community leaders, parole, probation, case worker, clergy.

Thank you for the consideration of our comments.

Sincerely,

Jamila Edwards
Northern California Director
Children's Defense Fund—California

Ellen Wu
Executive Director
CPEHN

Carla Saporta
Health Policy Director
The Greenlining Institute

Judith Bell
President
PolicyLink

CC: Covered California Board Members
Thien Lam, Deputy Director, Eligibility and Enrollment
Diane Stanton, External Relations
David Panush, Director, Government Relations
Willie Walton, Manager, Eligibility and Enrollment

March 18, 2013

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

Re: Comments on the Draft Regulations on Background Checks

Dear Mr. Lee:

The Greenlining Institute (Greenlining) and the National Employment Law Project (NELP) are writing to summarize our recommendations for revisions to the proposed draft regulations on criminal background checks presented at the February 26th Covered California board meeting. (Attached, please find our specific recommended language.)

More than one in four U.S. adults in California has a criminal record on file with the state, thus the expansion of criminal background checks for employment has a major impact on hiring decisions.[1] As the U.S. Equal Employment Opportunity Commission (EEOC) recently made clear in guidance regulating criminal background checks, the impact is especially severe on people of color and other communities that are disproportionately impacted by the criminal justice system. EEOC, "Enforcement Guidance on Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964" (No. 915.002, adopted April 25, 2012).

At the same time, we recognize the importance of screening and vetting workers and assisters who will be utilizing the CalHEERs system to determine eligibility and subsequently enroll consumers into coverage through Covered California. The safety of consumers is paramount, and it is essential that workers hired into these positions do not pose any safety or security risks to the consumer. Thus, our goal in commenting on the draft regulations is to balance the need for safety and security with the rights of qualified workers to a fair process that properly takes into account the age and severity of a criminal offense, the relationship of the offense to the job, and evidence of rehabilitation. As currently proposed, however, the overly broad regulations will exclude many qualified applicants and bias the selection process against African American and Latino workers in particular—both applicants and those who are currently employed by Assister Entities. Overall, it is not a policy that will ensure fairness and it will significantly impede diversity in the workforce.

By adopting the attached recommendations developed by Greenlining and NELP, Covered California will have an opportunity to be a model employer that passes a forward-thinking policy. As a model employer, Covered California will benefit by limiting its liability under federal and state civil rights laws; increasing access to the most qualified candidates; promoting diversity in the workplace; creating a capable workforce; increasing the efficiency of the hiring process; and contributing to safe communities. Most importantly,

[1] John Schmitt & Kris Warner, Ctr. For Econ. & Policy Research, *Ex-offenders and the Labor Market* 12 (2010)

our communities will view Covered California, and the Assister Entities it contracts with, as a model employer committed to considering all qualified candidates and building a diverse workforce.

Greenlining and NELP's recommendations are based on our collective expertise and history advocating for low-income communities and communities of color; the legal requirements of Title VII of the Civil Rights Act of 1964 and the best practices endorsed by the EEOC, and the legal mandates regulating most of the California licensing boards under the Business and Professions Code. Generally, the EEOC guidance requires that employers "eliminate policies or practices that exclude people from employment based on any criminal record."[2] (Emphasis added). Thus, blanket disqualifications that include arrests, pending charges, and unrelated convictions unfairly exclude many qualified applicants of color from gainful employment opportunities. The EEOC specifically noted that 1 in 6 Latino men is likely to be incarcerated during his lifetime and that 1 in 3 African American men will likely be incarcerated in his lifetime.[3] Additionally, the Center on Juvenile and Criminal Justice found that California's African American population is 12 times more likely to be imprisoned for a marijuana felony arrest than any other racial group.

Thus, a blanket ban on all felonies and many misdemeanors, as proposed by the draft regulations, will exclude and unfairly discriminate against many otherwise eligible candidates who are predominantly African American and Latino. In addition, the draft regulations conflict with the requirements of the EEOC by failing to take into account whether the disqualifying offenses are "job related", while focusing instead on an individual's prior convictions and arrests regardless of their relevance to the specific responsibilities of the job. Additionally, the draft regulations do not ensure individual assessments that take into consideration rehabilitation and other special circumstances nor do they provide an adequate process to appeal the results of an erroneous background check.

Greenlining and NELP's Recommendations:

As set forth in the attached revisions to the draft regulations, our position and recommendations cover the following key points:

Given the disparate impact of criminal background checks on people of color, the EEOC requires employers to demonstrate that the background checks are job-related and consistent with business necessity. Thus, according to the EEOC, the check must specifically consider the nature of the crime; the time elapsed since the conviction; the nature of the job; and an individual assessment taking into account rehabilitation and other special circumstances.

a. *Nature of the Crime & Relation to the Job* - Because the concern with employment in Covered California positions primarily relates to abuse of sensitive financial and personnel information, the background check should not focus on drug convictions and DUIs and other crimes not related to fraud or theft. These crimes are not related to the work that applicants and workers would perform, and have no bearing on performance. Further, using

[2] EEOC Enforcement Guidance. Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964. No. 915.002.
[3] Id.

crimes of moral turpitude as the indicator for offenses that may disqualify an applicant provides too vague of a definition of offenses that may qualify. Indeed, the California Supreme Court has recognized that moral turpitude "is an elusive concept incapable of precise general definition."[4] By limiting the crimes to those that are substantially related to the employment processing sensitive financial and personal information, our recommendations seek to protect the information of consumers while not excluding otherwise qualified applicants.

b. *Time Elapsed* – The amount of time since conviction is an important factor to consider because the risk of coming into contact with the criminal justice system for individuals with criminal records and those without criminal records is largely comparable with the passage of time.[5] Further, a number of studies indicate that the likelihood of an offender reoffending is at its highest point in the immediate 1-2 years after release and declines over time.[6] California data confirms that after 1-2 years following release, there is a large decline in recidivism rates across offense types.[7] Therefore, we recommend that applicants who have had any felony convictions in the last 5 years or multiple misdemeanor convictions in the last 2 years will not be automatically excluded from consideration.

c. *Consideration of Arrests* - Including arrests is inconsistent with Title VII of the Civil Rights Act of 1964 because, as the EEOC states, "The fact of an arrest does not establish that criminal conduct has occurred, and an exclusion based on an arrest, in itself, is not job related and consistent with business necessity."[8] In fact, the U.S. Supreme Court has ruled that, "The mere fact that a [person] has been arrested has very little, if any, probative value in showing that he has engaged in any misconduct."[9]

Further, California Labor Code Section 432.7, states that no employer "shall ask an applicant for employment to disclose, through any written form or verbally, information concerning an arrest or detention that did not result in conviction, or information concerning a referral to, and participation in, any pretrial or posttrial diversion program, nor shall any employer seek from any source whatsoever, or utilize, as a factor in determining any condition of employment including hiring, promotion, termination, or any apprenticeship training program or any other training program leading to employment, any record of arrest or detention that did not result in conviction, or any record regarding a referral to, and participation in, any pretrial or posttrial diversion program."[10]

Last, African Americans and Latinos are arrested in numbers

[4] *See* In re Higbie 6 Cal.3d 562, 565 (1972) [state bar discipline]
[5] Kurlychek, M.C. Megan C., Brame, R. & Bushway, S.D. (2007). Enduring Risk? Old Criminal Records and Predictions of Future Criminal Involvement, Crime & Delinguency, 53:64.
[6] Greenberg, D. F. (1978). Recidivism as radioactive decay. Journal of Research in Crime and Delinquency, 15, 124-125.
[7] California Department of Corrections. 2011. Annual Report: Corrections, Year as a Glance. Sacramento, CA: CDCR.
[8] EEOC Enforcement Guidance. Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964. No. 915.002.
[9] Schware v. Bd. of Bar Exam'rs, 353 U.S. 232, 241 (1957)
[10] Cal. Lab. Code 432.7

disproportionate to their representation in the general population.[11] By using arrests as a determining factor to disqualify an applicant from working at the service center or as an assister, Covered California would potentially be excluding quality applicants that would otherwise be considered highly employable.

d. *Individual Assessment (Waiver & Appeal Process)*: The EEOC criminal records guidance and most of the California occupational licensing laws also ensure that even those applicants with a disqualifying criminal record are provided an opportunity to present evidence of rehabilitation and other information that takes into account compelling individual circumstances, not just their criminal record.

   Thus, based on other model occupational licensing laws, our recommendation provides for a "waiver" process that applies to applicants who are determined to have a disqualifying record. Specifically, we recommend that the applicants receive an "interim determination" requiring the the Exchange to first notify the applicant of the specific disqualifying conviction(s), and provide the applicant with a copy of his/her review and information on how to request a waiver. The individual then should have 60 days to present evidence of rehabilitation and other compelling information indicating that the individual is a suitable candidate for employment and a waiver of the disqualifying offense(s).

   Similarly, the applicant found to have a disqualifying offense would be provided an opportunity to appeal the interim determination by presenting information that indicates the criminal record information is inaccurate or incomplete. The "interim" determination will become final after a determination is made on the merits of the applicant's appeal or waiver or the 60-day deadline has passed to request an appeal or waiver.

We hope this letter and the revised draft regulations help Covered California not only to better understand Greenlining and NELP's concerns, but also serve to clarify how Covered California can become a model employer that maintains a fair background check process that also promotes consumer safety and privacy. We look forward to hearing your response and discussing this further with you. Please contact us with any questions.

Sincerely,

Carla Saporta	Maurice Emsellem	Noemi Gallardo
Health Policy Director	Policy-Co Director	Legal Fellow
Greenlining Institute	National Employment Law Project	Greenlining Institute

CC: Covered California Board Members
Thien Lam, Deputy Director, Eligibility and Enrollment
Diane Stanton, External Relations
David Panush, Director, Government Relations

[11] EEOC Enforcement Guidance. Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964. No. 915.002.

Willie Walton, Manager, Eligibility and Enrollment
Adopt Article 4, Fingerprinting and Criminal Record Checks, Section 6460

(a) Definitions.

For purposes of this section, the following terms shall have the following associated meanings:

(1) Federal Tax Information or FTI: return or return information as defined in 26 U.S.C. § 6103(b)(1)-(2).
(2) Personal Identifying Information or PII: information which can be used to distinguish or trace an individual's identity such as their name, social security number, biometric records, etc. alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc., consistent with the definition in Office of Management and Budget Circular M-07-16.
(3) Personal Health Information or PHI: protected health information or individually identifiable health information as defined in 45 C.F.R. 160.103.
(4) Service Center: to be defined
(5) County Center: to be defined

(b) Duties Requiring Fingerprinting.

The California Health Benefit Exchange (Exchange or Covered California) shall require fingerprint images and relevant criminal history information from individuals whose duties include any of the following:

(1) Access to Federal Tax Information.
(2) Access to Personal Identifying Information.
(3) Access to Personal Health Information.
(4) Access to confidential or sensitive information provided by a member of the public including, but not limited to, a credit card account number or social security number.
(5) Access to cash, checks, or other forms of payment and accountable items.
(6) Responsibility for the development or maintenance of the CalHEERS system and other critical automated systems of the Exchange.
(7) Access to information technology systems of the Exchange that permit access to information described in sections 1-5, above.
(8) Responsibility for the performance of any Service Center or County Center duties or functions, where those duties or functions include access to information described in sections 1-5, above.

Individuals whose duties require fingerprinting under paragraph (b) shall submit fingerprint images and all related information to the Department of Justice for the purpose of obtaining criminal history maintained by the state or the Federal Bureau of Investigation.
As a condition of appointment, an individual whose duties require fingerprinting under paragraph (b) shall certify whether his or her fingerprints have been furnished to the Department of Justice in compliance with this section. Proof of fingerprint submission can be met as follows:

(1) Electronic fingerprint submissions. A notarized copy of the Request for Live Scan Services form # BCIA 8016 (January 2011) shall be provided as proof of fingerprint submission. If a notarized copy cannot be provided, the individual shall be manually fingerprinted.
(2) Manual fingerprint submission. If an individual initially used the manual method of fingerprinting, the individual shall be deemed fingerprinted.

(c) Costs.

The Exchange shall pay all costs directly incurred for furnishing fingerprints and other costs associated with criminal history assessments of all current and prospective employees. The Exchange shall pay the costs incurred by third party vendors such as community based organizations working with the Exchange. No later than [Date], the Exchange will contract with a qualified Live Scan Fingerprinting center in each county in the State of California to provide for Live Scan Fingerprinting services paid for by the Exchange and at no cost to the applicant.

(d) Maintenance of Criminal History Records.

Criminal history records shall be considered confidential information, and shall be maintained in the same manner that the Exchange maintains protected health information. An applicant's criminal history record will be destroyed:

(1) Within 30 days of a final determination that an applicant is ineligible for employment after exhaustion of appeal and waiver options; or
(2) Within 60 days of a determination not to hire an applicant not based on ineligibility under this section; or
(3) Within 90 days of an employee's voluntary or involuntary termination.

Notwithstanding section (1) of this subsection, any documents containing information regarding the decision whether to hire an applicant shall be retained by the Exchange for no less than two years from the date of a final determination that an applicant would or would not be hired.

(e) Substantially Related Offenses.

For purposes of denial or suspension of employment, crimes must be substantially related to the qualifications, functions or duties of the specific employment sought by the applicant/employee. Subject to the special circumstances review of section (g), denial or suspension of employment may be based on whether an individual has received a felony for one of the crimes listed in this section within five years prior to the application date or multiple misdemeanors within two years prior to the application date. The following is a complete list of crimes that are substantially related to the qualifications, functions or duties of an applicant/employee whose duties require fingerprinting under paragraph (b):

(1) A felony conviction for conduct related to fraud, theft, or the abuse of sensitive financial, personal identity, or personal health information;

(2) A misdemeanor conviction which evidences present unfitness to perform the duties listed under paragraph (b) including crimes involving the following:
    (i) Fraud, theft, or the abuse of sensitive financial, personal identity, or personal health information;
    (ii) Any conviction arising out of acts performed in the business of tax preparation, personal health or other related business or profession requiring a license or certification;
    (iii) Theft such as embezzlement, false pretenses, and larceny by trick;
    (v) Any act or offense wherein the person willfully causes injury to the person or property of another;
    (vi) Violation of a relation of trust or confidence, or a breach of fiduciary duty;
    (vii) Any act which demonstrates a willful attempt to derive a personal financial benefit through the nonpayment or underpayment of taxes, assessments or levies duly imposed upon the applicant/employee by federal, state or local government or a willful failure to comply with a court order; and
    (viii) Any violation of Penal Code section 502 or 502.01 or 18 U.S.C. §1030, subdivision (a).
(3) Conviction. A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere. Any conviction for which a certificate of rehabilitation has been received or which has been dismissed from an individual's record pursuant to Penal Code section 1203.4 shall not adversely impact an individual's employment or application.
(4) Under want, warrant, or indictment. An applicant who is wanted, or under indictment for a felony listed in this section, is subject to a potential disqualification until the want or warrant is released or the indictment is dismissed.

(f) Interim Determination and Final Disqualification.

If the Exchange finds that an individual has a potentially disqualifying record based on a felony conviction or multiple misdemeanors of crimes listed in section (e), the applicant/employee will be subject to an interim determination until subsections (1) and/or (2), below, are satisfied. The Exchange shall promptly notify the applicant/employee of the reasons for the interim determination, including the specific disqualifying conviction(s), and provide the applicant/employee with a copy of the state and federal criminal record response from the Department of Justice for his or her review pursuant to Penal Code § 11105(t) and information on how to request an appeal or waiver.

(1) Appeal. If the applicant/employee determines that said record is inaccurate or incomplete, the Exchange shall provide the applicant/employee 60 days to provide information to correct or complete the record. The Exchange, within 60 days, shall respond to the request for appeal by the applicant/employee.
(2) Waiver. If the applicant/employee determines that said record is accurate, within 60 days applicant/employee can seek a waiver of the disqualifying offense by producing evidence of special circumstances related to any potentially disqualifying offense listed in section (e) and/or rehabilitation. The

Exchange, within 60 days, shall respond to the waiver request by the applicant/employee.

(3) Absent good cause for late filing of an appeal or waiver, the interim determination shall become final.

(g) Special Circumstances and Rehabilitation Review.

For purposes of evaluating special circumstances and rehabilitation pursuant to section (f)(2), the Exchange shall consider all evidence presented by the applicant/employee to determine whether the applicant/employee has sufficiently explained or been rehabilitated from the prior disqualifying conviction. When evaluating the rehabilitation of an applicant/employee, on the grounds of conviction of a crime, the Exchange shall consider criteria, including, but not limited to, the following:

(1) Nature and gravity of the offense or conduct;
(2) The time that has passed since the offense, conduct, and/or completion of the sentence;
(3) The nature of the job held or sought;
(4) The facts or circumstances surrounding the offense or conduct;
(5) The number of offenses for which the individual was convicted;
(6) Older age at the time of conviction, or release from prison;
(7) Participation in treatment programs or post-conviction education or training;
(8) Whether the individual is bonded under a federal, state, or local bonding program;
(9) Whether the applicant/employee has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against the applicant/employee;
(10) Whether the applicant/employee has made any restitution or done anything to recompense the injured party or to alleviate the wrong or damage caused by the act or misconduct;
(11) Evidence that the individual performed the same type of work, post conviction, with the same or a different employer, with no known incidents of criminal conduct on the job;
(12) The length and consistency of employment history before and after the offense or conduct;
(13) Employment or character references and any other information regarding fitness for the particular position in question;
(14) Membership in a community organization or letters of support from community leaders, parole, probation, case worker, and clergy;
(15) Involvement in community or privately-sponsored programs designed to provide social benefits or to ameliorate social problems; and
(16) Any other information provided by the applicant/employee.

(h) Exemption.

This section does not apply to individuals identified in paragraph (b) whose appointment occurred prior to [OAL Effective Date].

Authority: Government Code 100504
Reference: Government Code _____, Penal Code 11105

Stephen Downing

152 La Verne Ave• Long Beach, CA 90803• Phone: 562 433 4403 •
E-Mail: Stephen@leap.

Date: March 18, 2013

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

Dear Mr Lee:

Job opportunities have routinely been denied to non-violent drug offenders because of the scarlet letter assigned for life to even the most minor violators. Because of that, I write to express my deep concern regarding the actions of the California Health Benefit Exchange to implement overly restrictive background check requirements for service center employees and applicants of the Covered California Assisters program. I support the Greenlining Institute's recommendations for background check requirements, which seek to eliminate overly restrictive requirements and are more aligned with the goals of the Affordable Care Act to ensure full participation of minority, low income, and disadvantaged communities.

Restrictive policies will significantly limit opportunities for employment of those who have been swept up in what has become a devastating 40-year war on drugs. It is critical that the Exchange understand the extent of harm the drug war has imposed upon individuals, families and the social fabric of our communities and how you can help to remedy past injustices and provide a brighter economic future for our people and our communities.

Fortunately, we have reached that point in time where 82% of the American public sees the war on drugs is a failure and the "tough on crime" era of three strike laws and mandatory minimum sentencing is finally coming to an end. This past year President Obama recognized that drug abuse is a health rather than a criminal justice problem. That acknowledgement is good news for those who have been sidelined from employment because of bad law, rather than personal ability.

But, we as a society are now faced with repairing the undertow of the harm that has been produced by the 43 million drug arrests made over the past forty years, half of which were for minor possession of marijuana. While most drug users are white, people of color have been the primary target of the drug war and their mass incarceration has become its hallmark. Because of bad law, sentencing practices and the life-time label of a drug conviction, we have created a caste system in our society that is most tragically felt among the young and people of color.

It is time to reverse the tragic unintended consequences of these bad laws and as a public body, I ask that you make a contribution toward that end by recognizing that your actions can make a difference in breaking the cycle of joblessness and despair that has ruined so many lives and torn apart the fabric of so many of our communities.

We need to heal our communities, shrink the mass incarceration of our people, help families stay together, help keep more fathers in more homes and fewer children in foster homes while we replace arrest with treatment and stop trying to arrest our way out of a health problem. I can think of no better way to accomplish all of that than by doing everything in our power to fuel, rather than restrict, opportunities in the job market.

You have the power to do that. By supporting the Greenlining Institute's recommendations for background check requirements, which seek to eliminate overly restrictive requirements, you will not only contribute to the healing process but you will also contribute to the achievement of the goals of the Affordable Care Act to ensure that minority, low income, and disadvantaged communities fully participate in the program.

Thank you for taking the time to listen to the concerns of my community of 100,000 criminal justice professionals and supporters of Law Enforcement Against Prohibition (LEAP) and for understanding that overly restrictive background check policies will only contribute further to the abyss of unemployment that we so desperately need to reverse.

Sincerely,

Stephen Downing
Deputy Chief, LAPD (ret.)
Executive Board Member, Law Enforcement Against Prohibition (LEAP)

CDA
California Dietetic Association
7740 Manchester Ave., Suite 102
Playa del Rey, CA 90293-8499
eat right. an affiliate of the Academy of Nutrition and Dietetics

California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814

Attn: Peter Lee, CEP

Dear Mr. Lee,

On behalf of the California Dietetic Association, I am sending you two pieces of information, which illustrate the cost-effectiveness, and efficiency of medical care through the usage of Registered Dietitians (RDs) in health care. The first is a letter sent to Centers for Medicare/ Medicaid (CMS) by the Academy of Nutrition and Dietetics discussing these issues and the second is a study showing cost-effectiveness in a weight management study in North Carolina using Registered Dietitians as the providers.

There are many other studies showing cost effectiveness of medical nutrition therapy (MNT) provided by RDs in the health care arena.

The California Dietetic Association is made up of 7000 RDs, dietetic technicians, interns and students all who are trained and educated in evidence-based practice of nutrition.

There are many areas in the Essential Health Benefits mandated by the Affordable Care Act in which dietitians could play an important role – preventive care, chronic disease management, pre and post-natal care; ambulatory care and more.

We urge you to utilize and require medical nutrition therapy provided by Registered Dietitians to be part of Covered California policies.

Thank you for your attention to this and thank you for all of the work you and your team on the Health Benefit Exchange have done to make health care affordable for all in California.

Sincerely,
Michelle Wien, DrPH, RD, CDE
Michelle Wien, RD, CDE, DrPH
President
California Dietetic Association

Cc:
Kimberly Belshé
Diana S. Dooley
Paul Fearer
Susan Kennedy
Robert Ross, MD

Contact Lorri Holzberg, MA, RD at lorri@irvingholzberg.com or 650-868-7359 for further information.

March 7, 2013

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

Dear Mr. Lee:

On behalf of the California Dental Association, I would like to express our concerns with HBEX 15 - Supplemental Dental and Pediatric Dental Essential Health Benefit Solicitation ("Dental Plan Solicitation"). CDA represents over 24,000 California dentists who provide primary and specialty oral health care to infants, children, adolescents, adults and patients with special medical and developmental needs. They will be responsible for providing the pediatric dental component of the Essential Health Benefit and the adult supplemental dental benefit offered through the Individual and SHOP Exchanges.

Our concern with the solicitation is that it appears to have inadvertantly strayed from your goal of affordability. The DMHO benefit package for the Adult Supplemental benefit as currently proposed itemizes a broad range of dental services at no cost to the beneficiary at the time of service. In addition, the plan includes most other dental services and considers them "non-covered," yet caps the beneficiary co-payment requirement and, in virtually every case, at an exceptionally low level. While this may seem in line with your goal of affordability initially, to ensure a product such as this is fiscally sound and can deliver the care that is promised with its purchase, the Exchange will have to require a quite sizeable monthly premium, which will ultimately hinder access.

Experience shows that the DMHO option as proposed here may be a cost-effective product for some individuals that do not require more than periodic examinations or cleanings, but services that have high materials cost or are labor intensive strain the financial viability of this model, making it unsustainable. This will be particularly relevent for the Exchange to consider as many of the enrollees who will be accessing coverage through the Exchange will likely have been unserved or underserved for many years.

CDA believes that prior to the Exchange offering DMHO products, it is critical to ensure that they are based on sound underlying actuarial assumptions and are closely monitored for performance - especially if the product includes a comprehensive set of services and sets

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significant limitations on consumer contributions, as is the case with the product currently under consideration.

We submitted official comments to your office as well as the Office of Administrative Law to this Solicitation, which was included by reference to the recent Emergency Regulations regarding access to dental care in the Exchange. Please see our comments, attached.

CDA remains committed to the success of the Exchange and the dental products that will be offered to California consumers. Accordingly, CDA believes that before this solicitation is finalized, it will be important to have a broad discussion of these issues with expert stakeholders. CDA would like to serve as a resource for you on dental benefits issues as you tackle the work ahead. If I can provide you with any additional information, please feel free to contact me at (916) 554-4970.

Sincerely,

Nicette Short
Manager, Legislative Affairs

cc: Diana S. Dooley
Kim Belshe'
Paul Fearer
Susan Kennedy
Robert Ross, MD
Ken Wood
Andrea Rosen
David Panush
Michael Lujuan
Director Brent Barnhart

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cda.org

February 20, 2013

California Health Benefits Exchange
ATTN: Brandon Ross
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RE: Advance Notice of Intent to File Emergency Regulations

On behalf of the California Dental Association (CDA), I am pleased to offer our comments and thoughts on the **Advance Notice of Intent to File Emergency Regulations** distributed on February 8, 2013 and the **Solitication for Proposed Supplemental Standard Plan Designs** included by reference.

CDA represents over 24,000 California dentists who provide primary and specialty oral health care to infants, children, adolescents, adults and patients with special medical and developmental needs. They will be responsible for providing the pediatric dental component of the Essential Health Benefit and the adult supplemental dental benefit offered through the Individual and SHOP Exchanges.

Regarding the requirement in the **Emergency Regulations, Section (e)(2)** for Bidders to submit an Exchange adopted PPO or DMHO standardized benefit plan design in each region to encourage competition, CDA agrees that competition and multiple plan choices will benefit the marketplace and the consumer. Understanding that some dental plan companies have experience with and networks for one product or the other, but potentially not both and may not be able to bid both products, CDA strongly encourages the Exchange when approving bids to ensure the availability of both PPO and DMHO products. This is essential to ensure competition and provide choices that benefit consumers, entices their purchase, and supports healthy Exchange activity.

Further, CDA believes it is important for the Exchange to offer both PPO and DMHO products for purchase because the marketplace has been changing over the last decade, and the DMHO product has not fared well (eroding from 15% of the market in 2001 to only 8% of the market in 2010, according to statistics from the National Association of Dental Plans). We believe it will be critical for the Exchange to ensure they are offering the products that are most actively used and purchased in the overall market.

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Regarding the **Solitication for Proposed Supplemental Standard Plan Designs**, CDA has significant concerns regarding the viability of the DMHO plan design that has been selected.

The DMHO benefit package as presented in Attachment 16 and included by reference in the Emergency Regulations itemizes a broad range of dental services at no cost to the beneficiary. In addition, the plan includes several common services and considers them "non-covered," yet caps the beneficiary co-payment requirement, and in virtually every case, at an exceptionally low level.

Experience shows that the DMHO option may be a cost-effective product for some individuals that do not require more than periodic examinations or cleanings, but that labor-intensive or high material-cost services strain the financially viability of this model, making it unsustainable if a significant number of these servcies are required and the premium does not fully account for this utilization. This will be particularly relevent for the Exchange to consider as many of the enrollees that will be accesssing coverage through the Exchange will likely have been unserved or underserved for many years. Further, it must be understood that the DMHO model assumes a large portion of the enrollees will access no services, allowing unused premium dollars to subsidize the care of those who do. The model has been applied in dentistry in the group insurance and dental Medicaid markets where utilization rates are not high, and has struggled to perform well even in those marketplaces. To offer this product in a marketplace where people will intentionally purchase coverage, indicating an express desire to use it, throws a new dimension into the DMHO financial viability equation.

For these reasons, CDA believes that prior to *Covered California* offering DMHO products, it is critical for the Exchange to ensure that they be based on sound underlying actuarial assumptions - *especially* if the product includes a comprehensive set of services and sets significant limitations on consumer contributions, as is the case with the product described in Attachment 16. These assumptions must account for materials, laboratory and labor costs, and include realistic projections of actual use. Further, CDA urges the Exchange to keep close scrutiny on plan performance, so plans that fail to perform as intended are identified and can course correct or have their contracts terminated if need be.

Additionally, the Solicitation includes many of the same pediatric dental benefits that are required in the pediatric Essential Health Benefits benchmark selected by California. That benchmark includes most of the routine pediatric services children will require, with the exception of non-medically necessary orthodontia care. It is unclear why the Exchange

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would include pediatric dental services in this plan that are duplicative of the EHB in this supplemental benefit design.

Finally, CDA is concerned that this Solicitation and the Emergency Regulations, as well as many other of the critical issues impacting the dental component of the work of the Health Benefit Exchange have not had a public hearing or been actively discussed with key or public stakeholders. The Exchange has much work to do and getting support and assistance from knowledgeable stakeholders may improve the work product and shorten the time ultimately used to review and comment on such issues.

We are committed to the success of *Covered California* and the dental products that will be offered to California consumers. Accordingly, CDA believes that before these issues are finalized it will be improtant for the Exchange to discuss these issues further with expert stakeholders. CDA would like to serve as a resource for you on dental benefits issues as you refine these regulations and the dental solicitation.

For additional information regarding these comments or to schedule follow-up conversations on these or other issues, please feel free to contact Nicette Short at nicette.short@cda.org or 916-554-4970. Thank you.

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Response to CMS Request for Information Regarding Health Care Quality for Exchanges From CPEHN

The following response highlights the importance of integrating the reduction of racial and ethnic and other disparities into all quality improvement activities by Health Insurance Exchanges. We strongly recommend that this integration include the design, implementation, and evaluation of all quality improvement activities. We also strongly recommend that patients and advocates from communities of color, low-income communities, and other disparities populations are represented and included in the design, implementation, and evaluation of all quality improvement activities. Finally, we urge that these quality improvement activities, including disparities reduction, begin immediately rather than waiting for quality reporting requirements to become effective in 2016.

1. What quality improvement strategies do health insurance issuers currently use to drive health care quality improvement in the following categories: (1) Improving health outcomes; (2) preventing hospital readmissions; (3) improving patient safety and reducing medical errors; (4) implementing wellness and health promotion activities; and (5) reducing health disparities?

Unfortunately, very few health insurance issuers have explicitly integrated the reduction of health disparities into their quality improvement strategies.[1] The Institute of Medicine and commentators have recommended this integration.[2] The National Health Plan Collaborative to Reduce Disparities highlighted the need for collecting information on the race, ethnicity, and language of health plan members as a first step in identifying and addressing health care disparities.[3] America's Health Insurance Plans now provides administrative support for the National Health Plan Collaborative but unfortunately, there has been little activity by the health plan members of the Collaborative in the past few years.[4] For several years, the National Committee for Quality Assurance recognized health insurance plans for best practices in multicultural health[5] and has developed a Distinction in Multicultural Health Care program;[6]

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[1] Rosenthal MB, Landon BE, Normand SL, Ahmad TS, Epstein AM. Engagement of health plans and employers in addressing racial and ethnic disparities in health care. *Med Care Res Rev.* (2009;66(2):219-231

[2] Institute of Medicine, *Future Directions for the National Healthcare Quality and National Healthcare Disparities Reports* (2010), available at: http://www.iom.edu/Reports/2010/Future-Directions-for-the-National-Healthcare-Quality-and-Disparities-Reports.aspx; Beal AC. High-quality health care: The essential route to eliminating disparities and achieving health equity. *Health Aff.* (2011);30(10):1868-1871; Weinick RM, Hasnain-Wynia R. Quality improvement efforts under health reform: How to ensure that they help reduce disparities, not increase them. *Health Aff.* (2011);30(10):1837-1843; Green AR, Tan-McGrory A, Cervantes MC, Betancourt JR. Leveraging quality improvement to achieve equity in health care. *Joint Comm J Qual Pat Safety* (2010)36(10):435-442; University of California San Francisco Center for the Health Professions, *Bringing Equity into Quality Improvement* (2012), available at: http://futurehealth.ucsf.edu/Public/Publications-and-Resources/Content.aspx?topic=Bringing_Equity_Into_QI_1

[3] Lurie N, Fremont A, Somers SA, Coltin K, Gelzer A, Johnson R, Rawlins W, Ting G, Wong W, Zimmerman D. The National Health Plan Collaborative to Reduce Disparities and Improve Quality. *Jt Comm J Qual Patient Saf.* (2008);34(5):256-265

[4] http://www.nationalhealthplancollaborative.org/index.html

[5] http://www.ncqa.org/HEDISQualityMeasurement/Research/HealthCareDisparities.aspx

unfortunately, very few health plans have sought this recognition. The Center for Health Care Strategies has worked with Medicaid programs in several states on disparities reduction strategies and their lessons learned should be heeded.[7]

2. What challenges exist with quality improvement strategy metrics and tracking quality improvement over time (for example, measure selection criteria, data collection and reporting requirements)? What strategies (including those related to health information technology) could mitigate these challenges?

Since collecting patient demographic data is an essential first step to identifying health care disparities, Qualified Health Plans should be required to follow, as a minimum, the HITECH Act meaningful use requirements for patient demographic data collection, especially the collection of race, ethnicity, and language data.[8] We would further recommend the use of the Affordable Care section 4302 standards for race, ethnicity, language, sex, disability, sexual orientation, and gender identity demographic data by Health Insurance Exchanges and by Qualified Health Plans.[9] Ultimately, we would recommend that Health Insurance Exchanges and Qualified Health Plans fully implement the recommendations of the Institute of Medicine on granular categories for the collection of race, ethnicity, and language data[10], and for the collection of sexual orientation and gender identity data in electronic health records.[11]

3. Describe current public reporting or transparency efforts that states and private entities use to display health care quality information.

California has many public reporting and transparency efforts to display health care quality information. Our state Office of the Patient Advocate (OPA) annually publishes an on-line report card rating the quality of health plans and providers, which can be found at www.opa.ca.gov. Previous to 2012, OPA also included a report on the language services health plans had available (http://www.opa.ca.gov/rc2011/languageservices.aspx). In addition, the California HealthCare Foundation partnered with UC San Francisco to develop a voluntary reporting system on hospital quality, www.calhospitalcompare.org. Unfortunately, due to the voluntary nature of the project, not all hospitals participate. Hospital quality data can also be found at California Office of Statewide Health Planning and Development at http://www.oshpd.ca.gov/HID/DataFlow/HospQuality.html.

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[6] National Committee for Quality Assurance, *Distinction in Multicultural Health Care* (2011), available at: http://www.ncqa.org/tabid/1157/Default.aspx

[7] http://www.chcs.org/info-url_nocat5108/info-url_nocat_list.htm?attrib_id=18631

[8] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/7_Record_Demographics.pdf

[9] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[10] Institute of Medicine, *Race, Ethnicity, and Language Data : Standardization for Health Care Quality Improvement*. (2009), available at: http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx

[11] Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender Persons: Building a Foundation for Better Understanding* (2011), available at: http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx

Both the Department of Health Care Services and the Managed Care Medical Insurance Board publishes their quality reports for their Medi-Cal managed care health plans (http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx) and Healthy Families (California's Children's Health Insurance Program) health plans (http://www.mrmib.ca.gov/MRMIB/Reports.html), respectively.

Unfortunately, except for the Healthy Families quality report, none of the quality report listed above analyze or report on quality results by race, ethnicity, or language preference. We highlight recommend that regardless of which quality measures are selected for public reporting, all data should be stratified by patient demographic categories by the most granular categories available for race, ethnicity, language, sex, disability, sexual orientation, and gender identity.

4. How do health insurance issuers currently monitor the performance of hospitals and other providers with which they have relationships? Do health insurance issuers monitor patient safety statistics, such as hospital acquired conditions and mortality outcomes, and if so, how? Do health insurance issuers monitor care coordination activities, such as hospital discharge planning activities, and outcomes of care coordination activities, and if so, how?

Other than health plans that monitor their providers' quality performance through HEDIS measures and their hospital performance through calhospitalcompare.org, we are unaware of other efforts. Since every hospital is likely to try to meet meaningful use requirements because they will seek HITECH Act incentive payments, CMS should require all hospitals which are to be contracted by Qualified Health Plans through the Health Insurance Exchanges collect, analyze, and report all their quality data by race, ethnicity, and language by the most granular categories available.

5. What opportunities exist to further the goals of the National Quality Strategy through quality reporting requirements in the Exchange marketplace?

The Health Insurance Exchanges should not only seek to further the goals of the National Quality Strategy but also aim to further the goals of the National Stakeholder Strategy for Achieving Health Equity,[12] the National Prevention Plan,[13] and Healthy People 2020,[14] all of which highlight the priority of reducing disparities in health care and in health status among racial and ethnic minorities, and other disparities populations. To the extent that CMS sets federal standards for quality improvement and reporting for all Exchanges, it should also seek to further the goals of the Action Plan to Reduce Racial and Ethnic Health Disparities.[15]

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[12] U.S. Department of Health and Human Services, *National Stakeholder Strategy for Achieving Health Equity* (2011), available at: http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

[13] U.S. Department of Health and Human Services, *National Prevention Strategy* (2010), available at: http://www.healthcare.gov/prevention/nphpphc/final-intro.pdf

[14] U.S. Department of Health and Human Services, *Healthy People 2020*, available at: http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx

[15] U.S. Department of Health and Human Services, *Action Plan to Reduce Racial and Ethnic Health Disparities* (2011), available at: http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf;

6. What quality measures or measure sets currently required or recognized by states, accrediting entities, or CMS are most relevant to the Exchange marketplace?

In addition to the analysis recently recommended by the National Quality Forum for identifying "disparities-sensitive" quality measures,[16] there are opportunities within existing national quality standards and measures to highlight issues of health care disparities reduction. For example, standards for patient-centered medical homes present numerous opportunities to address health disparities.[17]

7. Are there any gaps in current clinical measure sets that may create challenges for capturing experience in the Exchange?

The National Quality Forum has recently endorsed quality measures which specifically address health care disparities.[18] There are supplemental cultural competency and health literacy items which have been developed for the Consumer Assessment of Health Providers and Systems (CAHPS).[19] However, while CAHPS has been translated in Spanish, Chinese, Korean, and Vietnamese, only our Healthy Families program (California's CHIP) uses the translated versions as NCQA has only certified the Spanish version. In order to solicit feedback from our diverse communities, CAHPS should be administered in the additional languages.

The National Committee for Quality Assurance has program for Distinction in Multicultural Health Care.[20] These measures and items should be used by the Health Insurance Exchanges and by Qualified Health Plans in all quality improvement activities.

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[16] National Quality Forum, *Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment Technical Report* (2012), available at: http://www.qualityforum.org/Publications/2012/09/Healthcare_Disparities_and_Cultural_Competency_Consensus_Standards_Technical_Report.aspx

[17] The Commonwealth Fund, *Closing the Divide: How Medical Homes Promote Equity in Health Care* (2007), available at: http://www.commonwealthfund.org/usr_doc/1035_Beal_closing_divide_medical_homes.pdf?section=4039; California Pan-Ethnic Health Network, *How Medical Homes Can Advance Health Equity* (2010), available at: http://www.cpehn.org/pdfs/Medical%20Homes.pdf; Connecticut Health Foundation, *Advancing Health Equity through Medical Homes* (2012), available at: http://www.cthealth.org/wp-content/uploads/2011/04/7-26-12-Advancing-Health-Equity-through-Medical-Homes.pdf

[18] National Quality Forum, Healthcare Disparities and Cultural Competency Measures (2012), available at: http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Healthcare_Disparities_and_Cultural_Competency_Measures.aspx; National Quality Forum, *National Voluntary Consensus Standards for Ambulatory Care: Measuring Healthcare Disparities* (2008), available at: http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care—Measuring_Healthcare_Disparities.aspx

[19] Consumer Assessment of Health Providers and Systems Cultural Competency Items (2012), available at: https://cahps.ahrq.gov/clinician_group/cgsurvey/aboutculturalcompetenceitemset.pdf; Consumer Assessment of Health Providers and Systems Health Literacy Items (2012), available at: https://cahps.ahrq.gov/clinician_group/cgsurvey/aboutitemsetaddressinghealthliteracy.pdf

[20] National Committee for Quality Assurance, *Distinction in Multicultural Health Care* (2011), available at: http://www.ncqa.org/tabid/1157/Default.aspx

8. What are some issues to consider in establishing requirements for an issuer's quality improvement strategy? How might an Exchange evaluate the effectiveness of quality improvement strategies across plans and issuers? What is the value in narrative reports to assess quality improvement strategies?

At a minimum, issuers should be required to document a quality improvement strategy that includes explicit elements that identify and address health disparities. At a minimum, the issuers should describe their demographic data collection activities (and strategies to improve the accuracy and completeness of such data), should publicly report all quality measures stratified by race, ethnicity, language, and other demographics with the greatest degree of granularity available, should identify specific disparities to be addressed, and should establish measureable, time-specific quality improvement goals to reduce those disparities. In future reports, the issuers should then report on their progress in achieving those specific disparities reduction goals.

9. What methods should be used to capture and display quality improvement activities? Which publicly and privately funded activities to promote data collection and transparency could be leveraged (for example, Meaningful Use Incentive Program) to inform these methods?

All quality improvement data that is publicly reported should be reported with the data stratified by race, ethnicity, language, and other demographics with the greatest degree of granularity available. For any measures for which such stratified data are not available, the issuers should be required to develop and implement corrective action plans to overcome the unavailability of such data.

In addition, all federally funded activities to improve quality of care, such as the Medicaid Adult Quality Grants and the State Innovation Model Design Grant, should require the collection and analysis of race, ethnicity, and language data, and the use of the data to identify and address racial and ethnic disparities.

10. What are the priority areas for the quality rating in the Exchange marketplace? (for example, delivery of specific preventive services, health plan performance and customer service)? Should these be similar to or different from the Medicare Advantage five-star quality rating system (for example, staying healthy: screenings, tests and vaccines; managing chronic (long-term) conditions; ratings of health plan responsiveness and care; health plan members' complaints and appeals; and health plan telephone customer service)?

Any quality rating system should include member/patient, family, and caregiver feedback about the experience of care, access to care, and the quality of care. Instruments to collect such feedback must be equally accessible by and inclusive of health plan members with limited English proficiency, with lower health literacy, and with disabilities. Issuers may need to either oversample these members or use additional methods to collect such feedback.

As a first step, California's Health Benefit Exchange will require Qualified Health Plans (QHPs) to complete portions of the eValue8 Health Plan RFI, Module 1.7 on cultural competency and disparities reduction. The collection of this data will allow the Exchange to access important

baseline data that can be used as part of the QHP selection process and a powerful catalyst for delivery system reform moving forward. The California's Exchange will also require QHPs to be NCQA certified.

11. What are effective ways to display quality ratings that would be meaningful for Exchange consumers and small employers, especially drawing on lessons learned from public reporting and transparency efforts that states and private entities use to display health care quality information?

Any information about quality ratings should be equally accessible by health plan members with limited English proficiency, with lower health literacy, and with disabilities. The information should be in plain English at appropriate reading levels, available in languages other than English, and in alternate formats accessible to individuals with disabilities. If the information is made available online, the websites must meet accessibility standards for individuals with visual and other disabilities.

12. What types of methodological challenges may exist with public reporting of quality data in an Exchange? What suggested strategies would facilitate addressing these issues?

[No response]

13. Describe any strategies that states are considering to align quality reporting requirements inside and outside the Exchange marketplace, such as creating a quality rating for commercial plans offered in the non-Exchange individual market.

[No response]

14. Are there methods or strategies that should be used to track the quality, impact and performance of services for those with accessibility and communication barriers, such as persons with disabilities or limited English proficiency?

It is very important to track the quality, impact, and performance of the Health Insurance Exchanges and of the Qualified Health Plans in meeting the comprehensive health care needs of persons with disabilities, individuals with limited English proficiency, and others with accessibility and communication barriers. Instruments to collect such feedback must be equally accessible by and inclusive of health plan members with limited English proficiency, with lower health literacy, and with disabilities. Issuers may need to either oversample these members or use additional methods to collect such feedback.

15. What factors should HHS consider in designing an approach to calculate health plan value that would be meaningful to consumers? What are potential benefits and limitations of these factors? How should Exchanges align their programs with value-based purchasing and other new payment models (for example, Accountable Care Organizations) being implemented by payers?

One unintended consequence from pay-for-performance,[21] value-based purchasing, and other payment reform models is that providers who currently serve disparities populations will be penalized for having more sicker and more complex patients. This is especially true if payment models are based primarily on ultimate health outcomes, as opposed to a combination of pay-for-reporting, pay-for-improvement, and some case mix adjustments. Several commentators have also cautioned that accountable care organizations may also have the unintended consequences of increasing health care disparities without explicit attention to the needs of disparities populations.[22]

[21] Chien AT, Chin MH, Davis AM, Casalino LP. Pay for performance, public reporting, and racial disparities in health care: how are programs being designed? *Med Care Res Rev.* (2007);64(5 Suppl):283S-304S; Chien AT, Chin MH. Incorporating disparity reduction into pay-for-performance. *J Gen Intern Med.* (2009);24(1):135-136; Weissman JS, Hasnain-Wynia R, Weinick RM, Kang R, Vogeli C, Iezzoni L, Landrum MB.
Pay-for-performance programs to reduce racial/ethnic disparities: what might different designs achieve? *J Health Care Poor Underserved.* (2012);23(1):144-160

[22] Lewis VA, Larson BK, McClurg AB, Boswell RG, Fisher ES. The promise and peril of accountable care for vulnerable populations: A framework for overcoming obstacles. *Health Aff.* (2012);31(8):1777-1785; Pollack CE, Armstrong K. Accountable care organizations and health care disparities. *JAMA.* (2011);305(16):1706-1707

WE CARE *for* CALIFORNIA

March 15, 2013

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We Care for California is a coalition of organizations that are directly involved in the delivery or financing of health care in the state. Implementing the Affordable Care Act in California in a responsive and responsible manner is our highest priority. The *We Care for California* coalition supports the goal that California should be the nations' health care leader in access, quality and affordability.

California has over 7 million uninsured people. As California aggressively pursues coverage expansion through the state exchange – *Covered California* – it is important that healthcare providers support the state's outreach efforts.

Ensuring that Californians understand the benefits of Covered California will be particularly critical in its success. As such, it is important the Covered California take advantage of its healthcare provider partners. Covered California estimates that 5.3 million Californians will be enrolled in subsidized or non-subsidized health care coverage through the exchange or in the open market. Also, another 2 million are expected to be eligible for Medi-Cal. Of the uninsured in California, an estimated 5 million are legal citizens. Based on the coverage goals – which include coverage for citizens and noncitizens – California hopes to substantially eliminate the number of eligible uninsured residents.

Despite the ambitious outreach and education campaign being launched by Covered California, more often than not, the first time someone has contact with the health care system is when they seek treatment when they are ill or when they are suffering from an urgent medical condition in a hospital emergency room. In its June 2012 presentation to the exchange, Ogilvy Public Relations recognized "current health care providers to the targets" as a key partnership to develop in the initial phase of the exchange's outreach, marketing, and education plan. Furthermore, Ogilvy's May 2012 report specifically recognizes providers as community influencers, trusted messengers, and natural partners in the outreach and education effort, going so far as to mention CMA, CHA, and CAPG by name as important partners to the exchange in coordination and outreach.

Providers are on the front lines of patient care. They are committed to helping the state achieve its enrollment goals for Covered California and for the Medi-Cal program. Many providers have eligibility screening mechanisms in place, though are not currently equipped to handle the impending surge in newly eligible individuals needing screening and enrollment services. Covered California, philanthropic organizations and the Medi-Cal program must support providers in their efforts to build or bolster their programs for outreach and enrollment. While we applaud the efforts of community-based organizations, grant funding must be accessible to the providers in the field to ensure they have the resources they need to effectively provide consumers with information about their coverage options.

California's healthcare providers can serve a significant role in helping Covered California reach hard-to-reach patient populations, and it would be a mistake not to take advantage of those partners willing to invest the time and resources in helping patients understand their coverage options. This is especially true for those private

practice physicians considered essential community providers, as data suggests that as much as 89 percent of safety-net primary care visits are handled by private physician practices. It is in Covered California's interest and the interest of Californians to ensure those providers interested enough to perform exchange outreach and education activities have the means to do so.

Even with the best outreach and education materials and instruction, the chance that an individual will follow through and complete the eligibility screening and enrollment process drops significantly once they leave the physician's office or the hospital. Physician offices and hospitals are a critical point of contact for a number of hard-to-reach patient populations that the exchange will be targeting, such as uninsured parents of insured children, expectant mothers who may be transitioning off of public insurance, and patients in a temporary or transitional employment situation.

An investment by Covered California would encourage these key providers to help patients understand how to enroll. As Ogilvy observed, outreach and education should work hand-in-hand with eligibility screening and enrollment.

The first grant application that was released by Covered California was structured in a way that made it challenging for providers to directly apply. We hope that Covered California will maximize all future grant opportunities to help educate Californians about the new coverage options available to them by working with us to ensure that providers are encouraged to be full partners in this effort.

On behalf of the *We Care for California* coalition, thank you for your time and your commitment to the implementation of health care reform. We will work with your office to schedule a meeting in the near future so we can share more information with you about the *We Care for California* coalition and the shared goals of the organizations involved.

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March 14, 2013

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Commissioner Dave Jones
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Director Brent Barnhart
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Subject: Continuing Concerns Regarding Children's Access to Higher Level Specialty Services in Covered California Products

Dear Mr. Lee, Commissioner Jones and Director Barnhart,

The California Children's Hospital Association appreciates the opportunity to submit comments regarding Covered California's certification process for QHP products and network adequacy review by the respective licensing departments. We are concerned that access to care for medically complex children for commercially insured children is increasingly at risk.

It is our understanding that network negotiations by the health plans should have largely concluded as of February 15th and that the networks remain under confidential review by the Covered California staff for compliance with standards for certification as qualified health plans. CCHA asks that the Covered California review process more explicitly condition certification as a QHP on affordable and timely access to hospitals uniquely focused on children's specialized care needs within product networks. As well, we ask that the approval of network adequacy by regulators be premised on the timely and affordable availability of specialty and subspecialty pediatric services.

CCHA is compelled to continue to raise the unintended but perhaps foreseeable consequences of contracting practices by QHPs that will marginalize safety net providers, such as children's hospitals, both in the Exchange and outside, despite status as Essential Community Providers. Our member hospitals' general experience with the contracting process to date has not been positive, either as to the outreach of health plans to initiate contract negotiations or, where initiated, as to the deeply discounted commercial rates being proposed by health plans.

The eight California Children's Hospitals provide, among their many services, unique services for acutely ill children that do not have options for treatment in lower level

facilities. Even if we are not explicitly in a plan's network, and thus not receiving any advantages of patient volume in exchange for rate discounts, we always 'keep the light on' as providers of last resort for California's sickest children, regardless of their ability to pay out of network penalties. That is our mission. Keeping that light on means that we have many services available, such as transplant services, that are unprofitable but that meet our mission to provide the full line of quality specialty health care services to all of California's children, so that they do not have to travel out of state to receive appropriate care.

It is for this reason, among others, that children's hospitals are specifically intended to be 'essential community providers'. Both from the standpoint of access to appropriate levels of care as well as patient affordability, the inclusion of children's hospitals in qualified health plan networks should be a high priority for plans contracting representatives.

Participation in QHP products must be financially sustainable to the hospital and financially feasible for the enrollee. If our children's hospitals end up out of network or in higher tiers with very significant cost-sharing or no benefits, the families that must have access to our hospitals for the critically specialized care their children need will bear the decision and financial expense that is properly borne by the QHP.

Simultaneously or following the Covered California certification process, the respective regulatory agencies, CDI or DMHC, will review the proposed networks for compliance with network adequacy standards as part of the licensing process. We ask that the approval of network adequacy by regulators be premised on the timely and affordable availability of specialty and subspecialty pediatric services. We understand that it may be difficult for plans to project the exact levels of need for specialty and subspecialty pediatric services; however, all can agree that access to these high level services must be available and affordable to the children of enrollees in Covered California products.

CCHA hospitals deeply appreciate the need to focus on affordability of premiums in the Exchange products and our hospitals are willing to play a role in achieving these critical price points. However, at the end of the day, the Exchange cannot, through unintended consequences, fundamentally disrupt traditional access to the highest quality pediatric services, including highly specialized services that few providers offer. While we respect the desire of Covered California to not interfere with network contracting, we do ask that the respective review processes more explicitly condition certification as a QHP on inclusion of a hospital that offers certified specialty and subspecialty care for children within product networks at affordable cost-sharing.

Thank you very much for your consideration of these views.

Best regards,

Cindy Ehnes

Cindy Ehnes, President and CEO
California Children's Hospital Association

Suggested Contract Language
Exchange Model Contract -- Primary Care Providers

Contractor shall demonstrate to the Exchange that it supports and provides the opportunity for every person enrolled in a QHP through the Exchange to establish an ongoing relationship with a primary care provider or Patient-centered Medical Home. Contractor shall, at a minimum, do the following:

1. Within 30 days of the effective date of coverage communicate in writing with all Exchange enrollees, consistent with language and access requirements in section ___ of this contract and applicable state law, encouraging enrollees to either: (1) select a primary care provider or patient-centered medical home using information on the process to make that selection provided by the Contractor in the same communication, or (2) continue an existing relationship with a primary care provider or Patient-centered primary care medical home if the enrollee is continuing coverage with the contractor and the enrollee's previously designated primary care provider is an eligible primary care provider in the QHP network;

2. Administer a process for enrollees to select a primary care provider within the QHP network;

3. In QHP coverage where the contractor requires enrollees to have a primary care provider, within 45 days of the effective date of coverage ensure that all enrollees have a designated primary care provider;

4. In the communication provided pursuant to (1) above, encourage enrollees to schedule an initial visit to establish a relationship with the primary care provider and to access appropriate preventive services, including notifying enrollees that the annual wellness visit is available to them with no cost sharing; and

5. Track and monitor the implementation of this requirement and report the results at least annually to the Exchange, in a form and manner determined by the Exchange.

CCWH

California Coalition for Whole Health

February 26, 2013

Peter Lee, Executive Director
Diana Dooley, Chair
Covered California
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SUBJECT: Customer Service Center – Comments in Response to Customer Service Center Updates Dated January 31, 2013

The California Coalition for Whole Health (CCWH) is a diverse group of behavioral health stakeholders concerned with informing the implementation of the Patient Protection and Affordable Care Act (ACA) to appropriately address mental health and substance use disorder treatment needs. CCWH hopes to serve as an important resource to the Covered California board and staff as it moves forward in implementing the Service Center to ensure that California consumers, including those with mental health and substance use disorder treatment needs, receive the assistance necessary to access essential health care coverage.

The ACA presents an unprecedented opportunity to expand coverage to tens of millions of Americans, and to ensure that coverage, both in the public and private markets, includes essential benefits. Of note to the mental health and substance use disorder community, the ACA explicitly includes mental health and substance use disorder services, including behavioral health treatment, as one of ten categories of service that must be covered as essential health benefits. Furthermore, the ACA mandates that mental health and substance use disorder benchmark coverage be provided at parity with other medical and surgical benefits offered by the health plan, pursuant to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA 2008).

Foremost, CCWH strongly urges Covered California to ensure that Service Center staff members are sufficiently knowledgeable about mental health and substance use disorder parity and equity laws as they apply to qualified health plans, and the scope of mental health and substance use benefits typically available to consumers by qualified health plans (including those required as essential health benefits) and public coverage options. CCWH has noted that too often consumers are misinformed about their mental health and substance use benefits, which can hinder them from accessing necessary services in a timely manner. Lack of timely access to appropriate, mental health and substance use disorder services can cause conditions to worsen and lead to costly emergency and inpatient care. It must be noted that the management and provision of mental health and substance use disorder services in today's small group and individual market varies significantly by health plan and insurance carrier. Many health plans and insurance carriers choose to "carve out" these benefits to partner behavioral health organizations. While this structure should, in theory, be seamless to the beneficiary, more often than not it can leave consumers confused and misinformed – and with services uncoordinated. It will be important for Service Center staff and other direct benefit assisters to

understand this structure in order to appropriately inform consumers about how to navigate this potential complexity, and to ensure their appropriate access to covered benefits.

California's mental health and substance use disorder community has been monitoring issues of consumer access and parity compliance for many years. There have been a number of consumer resources developed – some in partnership with the relevant regulatory bodies – to help consumers better understand their rights related to accessing necessary mental health and substance use disorder services. CCWH would very much like to work with Covered California to leverage existing resources to support the development and design of the Service Center.

Specifically, CCWH recommends the following:

1) Service center activities must take into consideration the unique needs of individuals with mental health and/or substance use disorder treatment needs. Activities and services provided should be based on the recovery principles that are the foundation for California's community mental health system.

2) Training for Services Center staff must include strategies for working with diverse populations with diverse health needs, including those with mental health and/or substance use disorder treatment needs. This includes strategies to prevent stigma and discrimination.

3) Given the complexity of how mental health and substance use disorder services are sometimes managed by health plans in the private market, Service Center staff should be well versed in these nuances in order to ensure seamless linkages to appropriate and needed care for individuals with mental health and/or substance use disorder treatment needs. Staff should be able to provide accurate information regarding the mental health and/or substance use disorder coverage options available to the consumer and accurately respond to questions related to benefits, particularly as they must be provided at parity. This includes the ability to provide comprehensive and accurate information regarding how benefits may be accessed after enrollment. For example, Service Center staff should be prepared and trained to respond to the following question: "Which plan allows me to continue to see my current psychiatrist?" Questions like these are likely to come up, and staff will need to be prepared to answer them accurately.

4) The training should be comprehensive and ongoing. In addition to material on eligibility policies, benefits and scope of health care options, the training should include information about the broader social service options available to consumers and their families.

5) Culturally appropriate communication must be an ongoing part of the training.

6) While completing calls quickly is an important goal, it should not be as important as assuring high consumer satisfaction. Beyond providing the technically correct information, good customer service means that staff must listen actively to the caller, empathize, and, if necessary, make appropriate referrals to more experienced staff or another source that could provide additional support and information. This type of assistance is especially needed for individuals with mental health and/or substance use disorders because they are more likely to have difficulties navigating a complicated system.

7) There should be a separate statewide number that can be accessed only by navigators and assisters in the field who have questions or encounter problems. The Service Center staff person who answers that separate line should receive a higher-level of training in order to respond to complex questions.

8) While initial eligibility and enrollment may be the Service Center's main function, staff should also be able to assist callers with interpretation and response to verification notices, reapplication and reenrollment processes, plan and provider selection, appeal and adjudication of eligibility determination decisions and transitions between plans. This range of customer assistance will be necessary to prevent consumers with mental health and/or substance use disorders from experiencing dangerous gaps in their treatment, which can cause conditions to worsen.

9) A mental health/substance use disorder benefit and network analysis of each health plan should be required.

10) CCWH strongly recommends that Service Center staff have access to Office of Patient Advocacy's "report card" which provides quality information for all of California's health plans. The behavioral health component is particularly relevant. This will allow Service Center staff to provide an objective quality rating without making "recommendations." The report card can be found here: http://www.opa.ca.gov/report_card/

11) Protocols must be implemented to address the possibility of a caller who is experiencing a psychiatric or other emergency. Special protocols should be developed and applied for mental health and substance use disorder emergencies, including suicide and substance overdose. CCWH recommends universal screening of all callers to identify a medical or psychiatric emergency so that an appropriate referral can be made. The Service Center may consider including the following question to the basic list of eligibility questions asked on every call: "Are you experiencing a psychiatric or medical emergency?" Service Center staff must be equipped with a comprehensive list of appropriate resources to which they can connect the customer immediately in the event that a caller is in crisis.

While mental health and substance use disorder services are required benefits, access to such essential benefits will heavily depend on plan compliance with mental health and substance use disorder parity and equity laws. Consumers facing challenges navigating mental health and/or substance use disorder benefits in the private market today often encounter significant stigma and discrimination in interactions with both the insurers and regulatory agencies, including the use of stigmatizing language regarding mental health and substance use conditions and treatment. In addition to stigma concerns, the level of expertise and knowledge at the insurance and state regulatory agencies about mental health and substance use disorder coverage has historically been inadequate. Due to misinformation and inadequate staff training, consumers are often transferred around to multiple departments and agencies for assistance. Given the significant challenges that consumers face in navigating their benefits, critical, medically necessary mental health and substance use disorder treatment is too often unattainable.

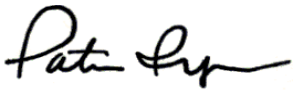
Thank you for your continued commitment to and leadership in the development and implementation of California's health benefits marketplace. We welcome the opportunity to discuss our comments and work collaboratively with Covered California to further strengthen the Service Center. Specifically, CCWH offers its support to Covered California to be a resource in the design and implementation process to ensure that issues related to mental health and

substance use disorder coverage are appropriately addressed. Any questions may be referred to Patricia Ryan at pryan@cmhda.org.

Sincerely,

Undersigned representatives of the California Coalition for Whole Health:

Sandra Naylor-Goodwin, PhD, MSW
President and Chief Executive Officer
California Institute for Mental Health



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