Comments to the Board

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From: Marc Mullendore [mailto:mmullendore@OCASF.org]
Sent: Friday, February 15, 2013 2:46 PM
To: Info (HBEX)
Subject: Questions re: Assisters Program

Good afternoon,

I participated in the Webinar on February 7 but have some questions:

1. Can an organization apply for the In Person Assistance Program initially and then apply for the Navigator Program? I understand an organization can't be both, but want to confirm you can apply only for one and not for both.
2. Will the In Person Assistance Program continue along with the Navigator Program or will it be phased out over time?
3. For the In Person Assistance Program, is an Assister Enrollment Entity reimbursed for a successful application that leads to enrollment or is reimbursement dependent on the enrolled individual making the first premium payment?

Thank you for your assistance with these questions.

Sincerely,

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February 15, 2013

Peter Lee, Executive Director
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560 J Street, Suite 290
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Via E-mail: info@hbex.ca.gov

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

The Asian Law Alliance (ALA) and the Asian Pacific American Legal Center (APALC) are submitting these comments in response to Covered California's proposed Assister Program. Our organizations seek to advance a pro-active agenda on health disparities and the right to affordable, quality health services, including implementation of health care reform in California. We are members of the Health Justice Network (HJN), a statewide collaborative comprised of over 30 community-based organization, health care providers, and small business groups. HJN seeks to address the health care needs of the Asian American, Native Hawaiian and Pacific Islander (AANHPIs) communities, to ensure culturally and linguistically competent health care services to AANHPI patients, and to increase access to affordable, quality health care for AANHPIs through outreach, education, and advocacy.

On February 7, 2013, we attended the Assister Program webinar and were deeply concerned with the many barriers posed by the Program's requirements on community-based organizations (CBOs) in order to participate in the Individual Assister Program. In order to recruit culturally and linguistically appropriate Individual Assisters, Covered California will have to seek the participation of CBOs who work in the hard-to-reach, immigrant, LEP communities. Unfortunately, many of the CBOs in HJN may not be able to meet the current requirements to become Assisters. Although these small CBOs have the ability to reach out to the limited-English proficient (LEP) communities, they may lack the infrastructure and/or the financial means to participate in this program.

As you may know, both ALA and APALC are non-profit community legal services offices which serve many of the low-income, LEP immigrant community in Santa Clara and Los Angeles Counties. We work with many of the small AANHPI CBOS that assist the LEP communities. These CBOs have a proven track record of reaching out to the hard to reach communities because they have the trust of their

clients. For example, in Census 2010, many of the CBOs serving the LEP community had a late start (early February) to do Census outreach to their communities due to the late funding of their efforts. Despite this barrier, the City of San Jose achieved a Mail Back Participation rate of 74% while Santa Clara County had a 75% rate – second only to Inyo County in California. Why are we mentioning the Census? Because the Census is a much more foreign concept to convey than health care (though the new health care system will be much more complicated) to people who may be fearful of the government. Yet, these CBOs were able to achieve much with very little time due to the trust they have with their community.

Some of the barriers that prevent small CBOs from participating in the Assister program are:

1) **Lack of Infrastructure** - Many of the CBOs operate on a very small and tight budget. They may not have a dedicated staff person to simply conduct enrollment all day. They also may not be able to afford the Errors and Omission Insurance (E & O Insurance) or personnel to provide training on ethics or meet the stringent monitoring requirements presented in the webinar.

2) **Lack of Financial Resources** – In order to have personnel to take time off from work to study and pass the certification test, the CBO must have enough resources to pay their employees to study and pass the test, as well as, provide the fees for the criminal background check.

3) **Low reimbursement for applications** - As we have pointed out before, the maximum compensation paid per successful application is $58, regardless of the number of individuals enrolled from each application. We strongly belief that $58 is not enough to adequately compensate for all of the time involved in assisting individuals with eligibility and enrollment. According to one of HJN's direct service partners, Special Services for Groups, it could take up to 3-5 hours or more to do a single application. Staff may have to conduct field-based services because some people cannot get to the enrollment location and incur mileage expenses and time driving. Often, additional time is needed to assist LEP clients, especially if interpreter services are needed, a bilingual staff person is not available, or the LEP client has to return with needed documents. It can take more time to sort through various forms and photocopy the relevant required information before filling out the application. Moreover, if the client is a recent immigrant and unfamiliar with our health care system, it takes additional time to explain the options to the client. For some applications, there is a denial and/or follow-up process that may require further assistance for the clients, which can involve several hours of sitting on the telephone trying to persuade agencies to help, answer questions, or gather additional required documents. Therefore the estimated time used by Covered California of approximately one hour to complete the application is insufficient considering the experience of many CBOs who assist people enrolling into current existing programs.

4) **Payment only provided per application, not per enrollee** - We continue to be troubled by the decision limiting the maximum payment per application to $58,

regardless of the number of individuals enrolled. The time it takes to enroll a family will most likely take longer than it would for one person. For example, if a family of four applies on one application, the Assister must determine eligibility and enrollment for four individuals into possibly four different programs, depending on each person's circumstances. Each may require different documentation and additional time to collect such documentation. This is particularly true for mixed-immigration status families so there is much more work involved than if only one person was applying for health coverage.

5) **Payment only for successful Covered California application** - From our experience with Medi-Cal eligible clients, many LEP applicants are denied health care coverage because their applications fall through the cracks. Many of the LEP clients can not appeal this denial without assistance. This is more likely to happen for those in Covered California who have problems since applicants would not be assigned a specific eligibility worker to assist them with their cases. The responsibility of assisting these clients to appeal decisions regarding their premium tax credits or other subsidies may fall upon the small CBOs that provide language assistance. These CBOs may help the client appeal or refer them to our offices. However, again, there is no mechanism in which they would be paid for their efforts if they assist the clients to apply but through no fault of their own, the application process is not successful. Therefore, they must conduct follow-up and/or appeal Covered California's final determination of any tax credits.

6) **Requirement to provide free application assistance to Medi-Cal and LIHP (Low-Income Health Program) is unfair.** While these CBOs wish they had the funds to provide free work, in reality, small CBOs struggle to make ends meet while doing the much needed work for their communities. Moreover, many of their low-income clients may be eligible for Medi-Cal and/LIHP, in addition to Covered California. The requirement to assist these clients, but not be paid for these efforts is a great deterrent to small CBOs whose employees still need to pay the rent and feed their families.

Recommendations:

Reduce the barriers which prevent small CBOs from participating in the Assister Program by:

- Pairing small CBOs with larger CBOs that have resources to provide the E & O Insurance and trainings on ethics as well as the oversee quality assurance.
- Increasing the amount paid per application and paying for each enrollee, and not just per application
- Paying for the training of Certified Enrollment Assisters (CEAs) who belong to small CBOs to compensate their staff for the extra time and effort spent to learn and pass the certification process or at least a stipend for their time to offset the time to train and certify staff.
- Having Covered California pay for criminal background checks for those who successfully obtain certification, not only for the first year (at a minimum Option #2) but every year for CBOs with small budgets.

- Supplementing funding for those small CBOs with language ability that can provide language and application assistance, regardless which program consumers are found eligible for.
- Providing the Navigator grants beginning at the same time as the CEAs to ensure that all CBOS can become CEAs and provide needed assistance for immigrants and LEP applicants

Covered California should work together with the Center for Medicaid and Medicare Services (CMS) to provide seamless services to the low-income, limited English proficient (LEP) community. The best way to do this is to coordinate funding so that CBOs, especially smaller ones, with language capability may be funded to provide Medi-Cal and LIHP application assistance, and be paid to refer those higher income LEP clients to CEAs who provide help to complete the Covered California application.

In addition to the above recommendations, we would recommend that the training be offered in additional languages than English and Spanish. At a minimum, we would add at least Chinese (both Mandarin and Cantonese), Korean, Vietnamese, Hmong, Khmer, and other Medi-Cal threshold languages. Covered California can work with CBOs to "train" Certified Eligibility Assisters in additional languages.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Doreena Wong, Esq.
Director, Health Access Project
Asian Pacific American Legal Center

Jacquelyn Maruhasi, Esq.
Managing Attorney
Asian Law Alliance

From: Heather Woodruff [mailto:HeatherW@barneyandbarney.com]
Sent: Thursday, February 07, 2013 3:28 PM
To: Info (HBEX)
Subject: Stakeholder Feedback/Input

It is my recommendation that you please consider waiving the requirement for background checks and fingerprints for licensed agents who go through the training & certification to be an Assister. All California licensed agents have already have gone through extensive training on Compliance Standards through CMS and clearly understand the ramifications of PHI and HIPAA laws. If we did not properly handle PHI, HIPAA and Financial & Tax information we would be fined and/or loose our license.

Thank you.

Kind Regards,

Heather Woodruff
Client Executive

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From: Stefan Luesse [mailto:sluesse@smcgov.org]
Sent: Thursday, February 07, 2013 4:24 PM
To: Info (HBEX)
Subject: Feedback - Covered California Assisters Program Webinar

Hi -

I had a question similar to the one raised during today's webinar by the Health Services representative from Santa Cruz County.

Currently our Agency - Behavioral Health and Recovery Services which is part of our County's Health Services - employs a team of approx. 10 in-house Certified Application Assisters who assist our clients and family members with enrollment into the Targeted Low Income Children's Program, the Pre-Existing Condition Insurance Program and other public insurance programs through the Health-E-App and One-E-App systems. The same team would facilitate the enrollment of BHRS clients into Covered California-products if certified as assisters.

The team is currently associated with the Children's Health Initiative as an enrollment entity which in its early days was a separate non-profit entity partially funded by the County and other private and public donors, but not affiliated with any County government agency. Over the years, this entity has merged into a hybrid organization partially housed at the Health Plan of San Mateo and the Health Services' community clinics and partially funded as part of the Health Services' administrative workforce under its new name - Health Coverage Unit.

Neither the Health Coverage unit, nor the CAA-trained BHRS staff are currently directly involved in the provision of clinical client services at any of our County's public community or Mental Health clinics, yet without these two teams most of the non-Medi-Cal eligible low income population in our County would go without insurance coverage.

Per the slides provided in today's webinar it appears that eligibility worker employed by our County's Human Services Agency (who are currently not involved in any CAA-related enrollment activities and do not have access to the One-E-Application system) would be able to receive compensation for successful Covered California-enrollments, yet the Health Coverage unit as well as the BHRS staff would not receive compensation.

Would there be any possibility that these two entities could be reclassified as being able to receive compensation due to the unique CAA network already currently in place in San Mateo in order to keep the current successful outreach and enrollment infrastructure in place?

Also, even though the assisters will not be facilitating any active enrollment into these programs it would still be good to include a basic overview over Medicare and the SHOP in the training curriculum as any potential leads that might be forwarded to the in-person assister might require redirection to these programs at the point of actual enrollment engagement. From my personal experience of 13 years with public health insurance programs oftentimes consumers only identify their actual eligibility linkage to various programs at the time of actual enrollment and not in the context of any pre-discussion or pre-screening that leads up to the set up of enrollment appointments and it would be good if assisters would have some basic knowledge or resources at hand to facilitate the appropriate redirection of consumers potentially eligible for these insurance coverages.

Thank you very much,

Stefan Luesse

Stefan Luesse
Manager for Health Insurance Outreach and Coordination
Behavioral Health & Recovery Services

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Thank you for the opportunity to submit comments/questions on the Covered California Assisters Program: In-Person Assistance and Navigators".

1. "Navigator" vs. "Assisters"
   What is the state's goal in only allowing Navigator Program grantees to conduct "public education activities"? Why won't Assisters and Assister Entities (AEs) be allowed to conduct public education activities? Example: A church decides to give an evening education presentation to its congregation on the options under Covered California. In that the church is an approved AE, is this scenario unacceptable?

   Are Navigator grantees required to undergo the same training, background, fingerprinting and insurance requirements as Assisters? If yes, why would the state require Navigators to pass leads to the state for follow-up when the Navigator could handle the application process immediately? Passing leads to the state will increase the staffing and burden on the state to handle applications, when they could be focusing on processing enrollment.

   The Outreach & Education Grant Program: Bidder's Conference document states, "Grantees will be required to provide Covered California with **leads** for follow up with consumers or small businesses that are **potentially eligible** and interested in receiving more information about enrolling." Everyone in California is potentially eligible before proven ineligible, and developing a grant program that credits delivery of "any lead" will burden the system and result in wasted dollars that will delay enrollment for legitimate enrollees. What is the incentive for Navigators to pass only qualified, legitimate leads, rather than passing illegitimate leads that will allow them to reach quotas and burden the state with illegitimate leads that must be worked?

2. Organizations Eligible for Compensation.
   It is unclear as to how the state is determining which agencies/organization types can be compensated as Assisters/AEs, and which cannot. For example, community clinics can receive compensation as Assisters/AEs, but not other "providers", such as county health departments and hospitals. Also, what is the state's definition of "provider"? Does it include pharmacies, specialty physicians, Planned Parenthood, outpatient labs, chiropractors, acupuncturists, mental health professionals, optometrists/ophthalmologists, and dentists?

3. Concerns Regarding Training & Certification Requirements
   Reaching the projected assisters network capacity of over 21,000 Assisters is a daunting task. Our concerns include:
   - The potential Assistor has to take up to three days off of work, potentially losing pay, and incurring travel, meals and lodging costs as well. Then, existing Assisters will be required to undergo annual refresher requirements. We are concerned about the numbers of current or former Certified Application Assistors in the Healthy Families Program that would be able to do this.
   - There is no discussion of what level of training and other requirements will be required of Navigators.
   - The Certified Application Assistants (CAAs) in the Healthy Families Program were never required to undergo background checks or fingerprinting. Why would Assisters in Covered California be different? They are not dealing with any information that wasn't dealt with under the CAA program in the HFP.

- Background checks, fingerprinting and the proposed insurances add tremendous costs into the program regardless of who bears the burden – the AEs/Navigators or the state.
- Insurance agents are not required to carry negligence and liability insurance.

4. Concerns Regarding Lack of Plans for Master Trainers
   The state envisions that new Assisters will be made through direct training, until computer-based training is developed, at which time, new Assisters will undergo computer-based training. On the webinar, the state used the Healthy Families Program (HFP) as a model. However, the reality of the HFP's continued CAA training was that computer-based training was not sufficient to educate CAAs enough to perform application assistance. In most cases, those CAAs then underwent face-to-face training with a Master Trainer who was recognized by the MRMIB as qualified to certify both the public and health plan personnel. To develop a self-sustaining model that continues to provide an adequate pool of Assisters in future years, there must be a Master Training program developed.

   Although health plans were not addressed in this webinar, we feel strongly that health plans must be able to have Master Trainers on staff to train their Sales and Customer Service staff – staff the plan cannot allow to leave for offsite trainings.

   Additionally, If the state determines where trainings are held, and health plans do not have a Master Trainer that they can send at their own expense to reach certain targeted populations, then the health plan's membership growth is at risk. For example, the state may not find it cost-effective to have training in many counties. However, a health plan participating in Del Norte has a vested interest in having Assisters. It could result in a region having unfavorable risk that would jeopardize health plan participation (and therefore coverage and choice) in certain regions and/or counties.

5. Additional Types of Entities That Should be Considered
   - Property and Casualty insurance agencies
   - State agencies (OSHA, DMV, etc.)
   - Libraries
   - Unemployment offices

6. Retail Partnerships
   We support the idea of partnerships with retail organizations with paid Assisters as an especially great way to reach the masses, but also specific ethnic communities. For example, partnerships with grocery stores (e.g., Asian, Latino, middle Eastern, etc.).

7. Suggested Recruitment Strategies.
   Allow health plans to help recruit Assisters. Health plans participating in HFP and Medi-Cal have deep community ties and can help recruit. Blue Shield's Master Trainers have certified thousands of CAAs in the HFP over the existence of the program.

8. Suggestions on Steering Policies
   The state needs to come up with a definition of "steering" as any "activity that seems to promote one health plan choice over another." The definition of "steering" must be connected to activities of the Assisters or AEs.
   Some examples of what should NOT be considered steering:

- A doctor's office tells a current patient which health plans to choose from if the patient wants to enroll and continue seeing that doctor.
- A health plan taking a call from a prospect who wants to sign up for that plan.
- A health plan paying for a booth at a fair, Branded as the health plan, using Assisters to help applicants, provided that the Assisters write applications regardless of which health plan is chosen.

The most important thing to focus on when considering what constitutes "steering" is whether the applicant understands and acknowledges that they had choices and weren't given any monetary incentive (or any gift) to sign with a particular health plan.

In order to ensure that health plan marketing dollars can be spent to direct benefit of enrollment, health plans should be allowed to purchase or sponsor booths, tables, sponsorships, health fairs, etc., that while clearly identifying the specific health plan as the sponsor, should be allowed to use Assisters or Navigators to staff these events. This ensures that AEs have an abundance of opportunity to reach applicants and maximize enrollments.

What **should** be considered "steering?

- An AE or Assister who favors one health plan over others in enrollment.
- An Assister who accepts monetary remuneration incentives from health plans.
- An Assister or AE who doesn't inform all applicants of their health plan and metal level choices.
- An Assister or AE who disparages any particular health plan.
- An Assister or AE who offers any kind of incentive to the applicant for enrolling in any plan.

9. Suggestions on Monitoring Standards
   We support the monitoring of the AEs and Navigators to ensure Californians are informed of their choices accurately. We believe that monitoring of the Assisters and Navigators is placing the appropriate emphasis in the appropriate place.

10. What Additional Factors Should Covered California Consider?
    Every decision regarding assistance of any kind should take into consideration that ultimately, Covered California must be self-sustainable. Therefore, any Assister program must become self-sustaining. New Assisters must be made continuously and they must receive some kind of payment.

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February 15, 2013

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VIA ELECTRONIC MAIL: info@hbex.ca.gov

Re: Assisters Program Webinar Feedback

Dear Mr. Lee:

The California Association of Health Plans ("CAHP") represents 39 public and private health care service plans that collectively provide coverage to over 21 million Californians. We appreciate the opportunity to provide feedback on the Assisters Program presented via webinar on February 7th. We support Covered California in its goal to develop a robust eligibility and enrollment network and CAHP looks forward to working with you as the roles of Assisters and plans are further defined.

CAHP would appreciate additional information on the partnership between the Qualified Health Plans (QHPs) and Service Center and Assisters/Navigators. For example, it is not clear what will happen when a call goes directly to a QHP and how Covered California expects QHP direct sales team staff to interact with Covered California staff/service centers. Based on the information presented during the Assister's webinar, Covered California appears to imply that internal sales teams at the QHP will be not be considered Assisters.

CAHP believes that all plans should be given the opportunity to utilize their extensive expertise and positioning in the marketplace to ensure that Covered California rapidly expands its membership. We believe no other outreach strategy is as important as the partnership Covered California can establish with health plans as Assisters.

In addition to the role of QHPs, CAHP requests additional clarification on the specific role of Medi-Cal plans in the eligibility and enrollment process. Covered California has previously proposed to allow health plans to conduct education, eligibility, and enrollment starting in early summer 2012. However, we do not see this recommendation in your current Assister Program. We request that the Exchange confirm the policy to allow Medi-Cal health plans that currently provide Medi-Cal/Healthy Families application assistance to conduct these activities with no compensation by Covered California. Currently, Medi-Cal health plans provide application assistance to thousands of uninsured families to apply for Medi-Cal/Healthy Families. Permitting these health plans to provide education and application assistance for Covered California will allow health plans to help the children and their parents (who may be eligible for the Exchange products) and ensure that the entire family gets the coverage to which they are entitled. This

strategy would also support Covered California's enrollment and outreach goal to have "one-stop-shopping" for application assistance.

Eligibility and enrollment assistance by Medi-Cal plans is also a critical outreach and enrollment assistance component for the Medicaid Bridge Option. The new proposed federal regulation on "Application Counselors" allows Covered California flexibility to utilize organizations (for the Exchange application assistance) that currently provide Medi-Cal/Healthy Families application assistance and do not fit into the In-person Assistance Program and Health Navigator categories. We encourage Covered California to build on the existing resources and expertise of plans to ensure that consumers have a simplified eligibility and enrollment process that can be completed regardless of where they enter the system.

CAHP's member plans encourage the Exchange to reconsider the master trainer model. Plans have received feedback from many community partners and agencies that it is preferable to have a classroom format/ in-person training. This provides participants with the opportunity to ask questions and receive immediate answers. These community partners have urged health plans to ask Covered California to reconsider this master trainer model proposed in the webinar and to instead rely on the traditional in-person training program, which has been very successful for the Healthy Families Program. We believe that given the complexity of the new marketplace it is important to ensure that all Assisters get the opportunity to engage in-person training.

Additionally, plans will need to be prepared to provide training on the calculator and to develop the phone queue that will be designated for QHPs to call Covered California teams. The process must be clear so there is no interruption of the service to the consumer. The first impression a consumer has of Covered California is the most important and we want to work with you to ensure that it is a pleasant and informative experience for the consumer.

Again, we appreciate your consideration of our input and hope we can be of assistance as you move forward with the development of the Assister Program. Please contact me if you would like to discuss any of the items in this letter. We look forward to a continued partnership with Covered California.

Sincerely,

Athena Chapman
Director of Regulatory Affairs

cc: Andrea Rosen, Interim Health Plan Management Director
Ken Woods, Senior Advisor for Products, Marketing, and Health Plan Relationships

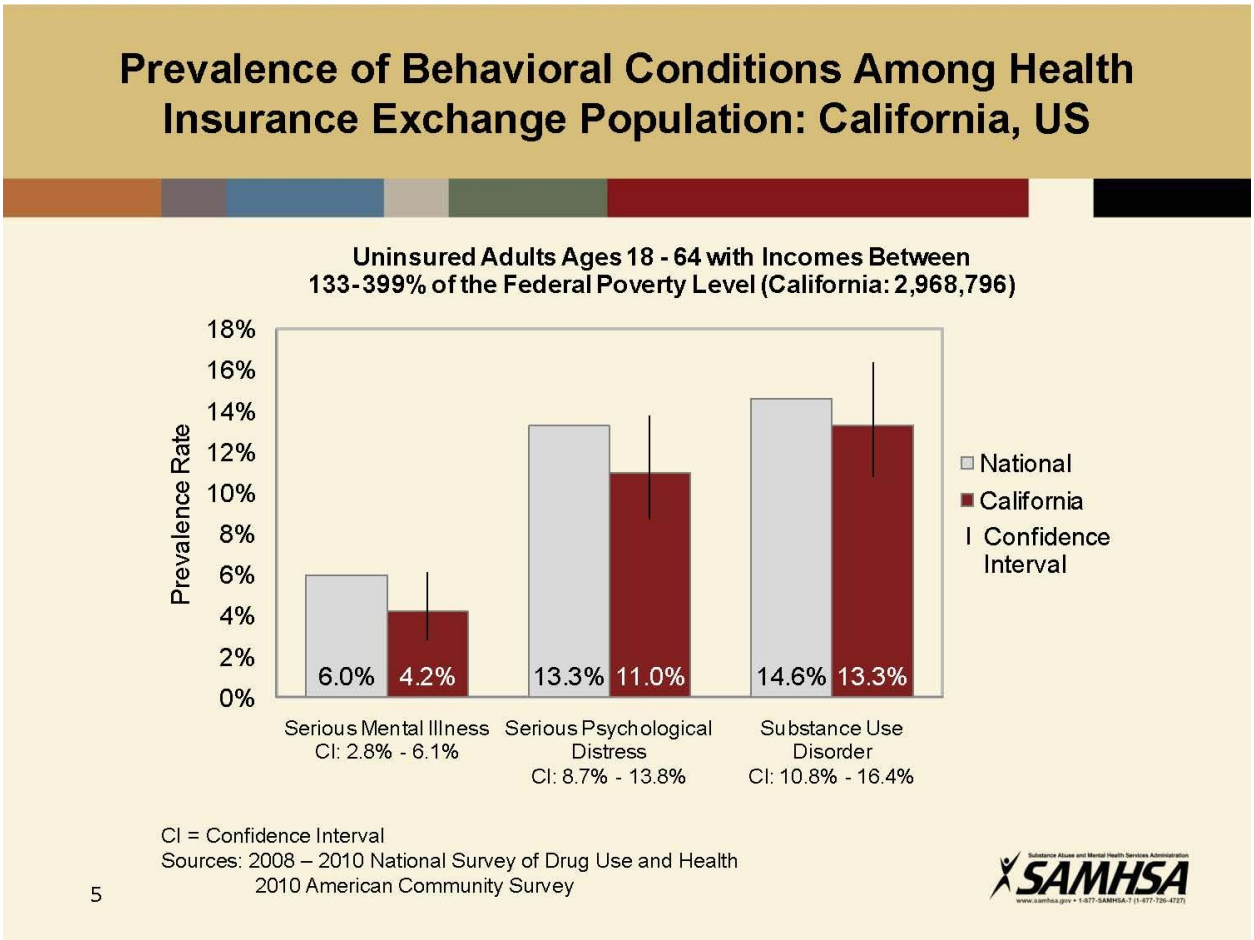
The Unique Needs of Individuals with Mental Health and/or Substance Use Disorders

Prevalence of mental health and substance use disorders

An estimated 26.2 percent of American adults over age 18 – or one in four – has a diagnosable mental health disorder, and mental health disorders are the leading cause of disability for those aged 15-44. An estimated 22.2 million Americans over age 12 have an addiction to alcohol and drugs. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2010 National Survey on Drug Use and Health, one in five (20%) of people with a serious mental health condition are uninsured. A study published in the October 2011 issue of the journal *Psychiatric Services* indicates that 22.6 percent of people with frequent mental distress (indicative of mental illness) were uninsured, compared with 17.7 percent of those with frequent physical distress (indicative of chronic disease).

High Rates of Uninsured Among Health Insurance Exchange Population with MH/SU Disorders in California

In California, according to the 2009 California Health Interview Survey (CHIS), 13.5% of the population with incomes between 138% and 200% of FPL indicated that they had mental health problems or drug/alcohol problems. Of those, 12% were uninsured. For the population with incomes between 201% and 400% of FPL, 15.5 % indicated a mental health or substance use problem. Of those, 19.9% were uninsured. (See table, below). According to the SAMHSA 2010 National Survey on Drug Use and Health, among uninsured adults ages 18-64 with incomes between 133-399% of FPL in California, 4.2% had serious mental illness, 11% had serious psychological distress and 13.3% had substance use disorder. (See graph, below).



California population with mental health/substance use disorders who were uninsured in 2009, by FPL

Federal Poverty Level	Percentage of CA population with mental health or substance use disorders	Percentage of MH/SUD population who were uninsured
138-200%	13.5%	12%
201-400%	15.5%	19.9%

2009 California Health Interview Survey

Unique Needs of This Population in Securing Insurance and Treatment

It is highly likely that targeted and appropriate eligibility, outreach, and enrollment services will be needed to ensure that this population is enrolled in newly available health benefits provided under the Affordable Care Act. A collection of evidence from states that have begun implementing health care reform suggests that consumers with behavioral health or substance use disorders are not well equipped to navigate the health insurance enrollment and reenrollment process or to make choices from among a large set of health plans on their own.

Why This Population Has Unique Needs

Because of cognitive deficits or co-morbid conditions, individuals with mental illness may be more reliant on assistance than others in navigating the health benefits exchange and enrollment process. Because some people with behavioral health and substance use disorders are difficult to reach and engage, and because many of the uninsured are not connected to family, to permanent places of employment or to primary care physicians or clinics, targeted outreach and enrollment is necessary for this population.

Evidence From Other States' Experience

Research confirms that enrollment processes are difficult for those with behavioral health problems. In Massachusetts after health care reform, only 2.6% of the population was still uninsured, but 22% of the uninsured had mental health or substance use disorders. Behavioral health patients in Massachusetts described the process for applying, completing information requests, and reapplying to MassHealth and Commonwealth Care as complex, burdensome and confusing. These patients described the experience taking between 45 minutes to 2 hours to complete the eligibility determination and enrollment forms, not including time for gathering, copying, and mailing supplemental verification documents like pay stubs, birth certificates, and proof of identity.

What Are The Consequences Of Not Fully Enrolling This Population

Without treatment, individuals with a serious mental illness are at an increased risk of hospitalization, poor social and clinical functioning, and diminished quality of life. If an individual is uninsured, he or she is more likely to rely on expensive emergency services. Untreated mental illness can interrupt careers, resulting in disability, poverty, and long-term dependence, all of which are costly and unnecessary. Additionally, extensive data conclusively demonstrate the association between mental illness and other chronic disorders such as cardiovascular disease, diabetes, cancer, asthma and obesity. According to the Centers for Disease Control and Prevention, the occurrence, course and outcomes of chronic disease are affected by a co-occurring mental illness. Those who have a co-occurring mental illness tend to experience worse outcomes than others and their poorer health status correlates with higher healthcare costs.

COMPETENCIES, SKILLS AND QUALITIES FOR COVERED CALIFORNIA ENROLLMENT/CALL CENTER STAFF: HOW BEST TO SERVE UNDERSERVED AND VULNERABLE POPULATIONS

We are proposing four sets of core/essential competencies for persons Covered California Navigators, Assisters and Customer Service Center staff; within each set there are more specific skills and qualities that are described. While some are general competencies that apply broadly, others are specific to the needs of individuals/families with substance use and mental health treatment needs. (see attached "MH/SUD Unique Needs"). We suggest that the training curriculum for Navigators/Assisters and Call Center staff include components of all of the following:

Basic Knowledge of Mental Health and Substance Use Disorders

Enrollment staff should be able to

- understand the prevalence of various mental health disorders and substance use disorders in the U.S. and the impact of stigma in their communities;
- understand that mental illness is a real organic disease from which recovery is possible;
- understand the etiology of substance use disorders and their classification as a treatable brain disorder from which one can recover.
- appreciate the complexity inherent in understanding mental illness and addiction along with other co-occurring conditions;
- explain simply how mental health and substance use disorder parity and equity laws as they apply to qualified health plans;
- explain simply the scope of mental health and substance use disorder benefits typically available to consumers by QHPs and public coverage option;
- work with the eligibility requirements, exceptions, and processes, for multiple insurance product lines that patients may be moving between;

Ability to Reach Out and Engage Clients

Enrollment staff should be able to

- listen nonjudgmentally using active listening skills that include confirming understanding;
- create a comfortable, safe and respectful environment where the individual feels free to divulge sensitive or difficult personal information;
- utilize approaches to outreach that have been found to be effective in engaging hard to reach populations;
- work in non-traditional settings as guided by leaders of diverse communities;

Sensitivity to the Role of Culture/Diversity in the population seeking help

Enrollment staff should be able to

- be respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse and vulnerable populations
- consider the role of cultural, social, and behavioral factors in the accessibility, availability, acceptability and delivery of benefits enrollment services.
- know the cultural and linguistic composition of the communities they serve;
- recognize community linkages and relationships among multiple factors affecting health;

Generalized Work Skills

Enrollment staff should be able to

- respect the ability and right of individuals to make their own decisions;
- understand complex topics and communicate the information in plain language;
- solve problems quickly and capably;
- practice good judgment and be willing to ask for help and/or advice with complex issues from supervisor;
- be patient with complex processes and procedures, and persistent with processes that are redundant;
- innovate, and develop rationales for assisting exceptional circumstances into traditional processes;
- direct and assist the applicant in gathering needed documentation.

California Labor Federation | AFL-CIO **www.workingcalifornia.org**

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February 15, 2013

Secretary Diana Dooley, Chair
Peter Lee, Executive Director
California Health Benefit Exchange Board
2535 Capitol Oaks Drive, Suite 120
Sacramento, CA 95833

Re: Partnerships with Retail Stores and Roles as Assistors

Dear Secretary Dooley and Mr. Lee:

The California Labor Federation would like to offer comments regarding the proposed Partnerships with Retail Stores and Roles as Assistors. We understand that the proposal is based on the goal of enrolling the maximum number of people in affordable health coverage through the Exchange by January 1, 2014. The Labor Federation shares that goal and is committed to maximizing enrollment.

That said, we strongly oppose the proposed partnership with retail stores as written. One of the key factors under consideration in the proposal is whether the retail store shares "similar core values as Covered California." Given that Covered California's mission is to "increase the number of insured Californians" we do not believe that any non-union retailer in California shares that goal.

Walmart, the largest retailer in the country, is instituting a policy to deny health benefits to any employee that works less than 30 hours a week. This policy comes on the heels of Wal-mart eliminating health benefits for workers with fewer than 24 hours a week. According to the Kaiser Family Foundation, in 2011 only 47 percent of Walmart employees received health care benefits, and dropping benefits for workers will further decrease that number.

An employer that denies health benefits to more than half of their over employees, and has recently announced they plan to stop offering benefits clearly does not share Covered California's mission of increasing number of insured Californians. In fact, Walmart is the driving force behind taking insurance away from Californians. This is not a partnership that Covered California could possibly be proud of forging.

We also oppose Covered California's proposal to offer any payment, co-branding, joint marketing or other economic or PR benefit to retailers. Walmart already benefits tremendously from the taxpayers of California since their model of low-wage, part-time employment dumps many employees onto public assistance. A 2004 study by the UC Berkeley Labor Center found that Walmart workers' reliance on public health care programs like Medi-Cal and Healthy Families cost taxpayers $32 million annually. The families of Walmart workers used 40 percent more taxpayer-funded health care programs the families of employees of other large retailers.

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The Affordable Care Act will only exacerbate the trend of retailers, especially Walmart, shifting the cost of health care coverage onto the public. The structure of the employer responsibility penalty in the ACA allows retailers like Walmart to dump workers onto public subsidies but avoid the penalty to reimburse the public for the cost. Part-time workers on subsidized coverage in the Exchange or Medi-Cal do not trigger an employer penalty. The retail industry, and Walmart in particular, rely heavily on part-time labor and closely control workers' schedules. These employers have the ability to reduce their liability for employer penalties by reducing worker hours, in addition to the huge numbers of low-wage, part-time workers they already employ.

Walmart workers may very well be the largest consumers of subsidized coverage in the Exchange because their employer pays low-wages, does not provide benefits and limits hours to part-time. Why would Covered California give Walmart even more public money to make them the face of Exchange outreach?

A partnership with retailers like Walmart would not only tarnish the image of Covered California, it would send a message to other employers that it is acceptable to abdicate their responsibility for health coverage. This partnership would reward Walmart for decades of shifting the cost of health coverage onto the public, a trend that has only increased after the passage of the ACA.

For these reasons, the Labor Federation strongly opposes the proposed partnerships with retailers.

We believe that the most effective strategy for enrollment in the Exchange is to run enrollment like a campaign. Political campaigns post-2008 have harnessed technology to become more targeted, effective and cost-efficient. Micro-targeting is a tool successfully used by the Obama campaign and most recently deployed by the labor movement. It's part of a cutting-edge strategy to precisely target and mobilize target audiences. Using this tool would allow the Exchange to target and reach retailers' consumer base without having to partner or pay those retailers. We look forward to working with the Exchange to develop these tools.

Sincerely,

Sara Flocks
Public Policy Coordinator
SF: sm
OPEIU 3 AFL CIO (31)

CPCA
California Primary Care Association
Health Care Access for All

February 19, 2013

Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: Covered California's Assisters Program: In-Person Assistance (IPA) and Navigators

To Whom It May Concern,

The California Primary Care Association (CPCA) respectfully submits comments on Covered California's (CC) Assisters Program, presented during the Stakeholder Webinar on February 7, 2013. CPCA represents over 900 not-for-profit community clinics and health centers (CCHCs) in California that provide comprehensive quality health care services to low-income, uninsured, and underserved Californians. CCHCs are one of the few providers who open their doors to anyone regardless of their ability to pay. By design, CCHCs are located in medically underserved, low-income rural and urban communities and serve as the primary point of care for California's uninsured and Medi-Cal populations.

Comments

I. Background checks

Covered California requested information on whether or not to require background checks for Assisters and in addition whether or not to require that the Assisters or the Assister Enrollment Entity (AEE) pay the fees for the background checks. We appreciate that CC needs to maintain program integrity and ensure consumer rights and safety are protected, but we believe there is a better option than the one proposed during the webinar.

Many CCHCs already conduct background checks on their employees and we propose that these background checks count towards this requirement for CC. Organizations that would like to be AEE's would provide CC with information about the process they conduct on their employees and the results of the background checks for the individuals that will be trained and certified as Assisters. While the process and breadth of the background checks will vary by organization the intent upholds the Assister Program's integrity and is flexible enough to not create a barrier to entry for AEEs. We also recommend that for those organizations that do not currently conduct background checks, CC pay for the first year of background checks and then evaluate the effectiveness of the policy before requiring that the AEEs cover the costs. The enrollment targets are high enough that CC needs every AEE and Assister possible to participate. Any cost barrier that can be eliminated should be eliminated.

CPCA
California Primary Care Association
Health Care Access for All

II. Recruitment strategies

CPCA would like to offer and suggest that CC work closely with CPCA and our 18 regional consortia to connect with the nearly 300 community clinic and health center corporations in California that can serve as the AEEs. The corporations represent over 900 sites who are serving over 5 million individuals, 1.8 million of whom have incomes over 100% FPL, a subset of whom will be eligible for CC. CPCA and the regional consortia look forward to offering any assistance necessary to ensure all of the willing and interested CCHCs become AEEs.

III. Steering policies and Monitoring standards

CPCA recommends that CC enhance the proposed code of conduct with the current CAA agreement MRMIB requires that the CAAs sign. The agreement can be found here: http://www.healthyfamilies.ca.gov/Publications/EEs_CAAs/CAAAgreementForm_en.pdf. The CAA agreement includes a code of conduct that addresses steering as well as a release of liability so that the state is not liable for the CAA's conduct. This agreement has served MRMIB and the Healthy Families Program effectively, and as this is a proven simple model, we recommend CC adopt it.

In regards to monitoring, the MRMIB Enrollment Entity and CAA monitoring process has been effective and CPCA would recommend that CC adopt a similar program. MRMIB monitors the EE and CAA through the application process, welcome call survey and the Healthy Families Program toll-free number. They have the ability to revoke the status of an EE or CAA should there be any violations to the agreement. They also have the statutory authority to impose a civil penalty of $500 per occurrence if a CAA is caught charging for his/her services.

Building the Assister Program to mirror the MRMIB CAA Program will help to expedite the enrollment process and ensure that CC can quickly achieve its targets.

V. Training Curriculum

The proposed training curriculum is very comprehensive and will serve as a strong foundation for the Assister Program. The curriculum would be stronger, however, if CC added a module on immigrant eligibility. The rules for immigrants in public programs and QHPs are very complicated and worthy of their own module.

VI. Errors & Omissions insurance requirement

CPCA would recommend against CC requiring that Assisters or the AEEs carry Errors & Omissions insurance. We are very concerned that requiring this insurance would effectively bar many organizations from participating because of the significant cost associated with carrying such a policy. The barriers created by requiring E & O insurance is part of the basis for the Department of Health and Human Services prohibiting States and Exchanges from adopting the requirement for Navigators (see Federal Register Section 155.210, Vol. 77, No. 59). This rationale was further enforced in Secretary Sebelius' letter to Representative Kinzinger dated

July 11, 2012 in which she writes that "requiring errors and omission coverage may serve as a significant barrier to entry for entities that may otherwise be well-qualified." In her letter Navigators are both agents and brokers and community and consumer-focused nonprofits. The CCHCs that would like to become the AEEs already operate on very thin margins. While some of the larger corporations would be better financially positioned to carry E & O coverage, the smaller ones, particularly in remote parts of California, would not be able to, and it is these sole provider CCHCs that will find it difficult to participate.

Covered California's success is predicated on large numbers of Californian's enrolling and securing health coverage, and the only way that can happen is if there are thousands of AEEs covering all sections of California. Developing an Assister Program that mirrors an already successful, well-respected program like MRMIB's is CC's best chance of success. The CCHCs in California are very familiar with the CAA model, outreach and enrollment generally, and are ready and able to assist CC in achieving its goals.

Thank you for the opportunity to respond to the above-referenced solicitation. Please do not hesitate to contact Andie Patterson at apatterson@cpca.org or Meaghan McCamman at mmccamman@cpca.org if you have any questions or comments, or if you require any clarification on the comments presented herein.

From: Jan Wolf [mailto:JanW@ccah-alliance.org]
Sent: Thursday, February 07, 2013 3:39 PM
To: Info (HBEX)
Subject: Questions from Covered California Assisters Webinar on Feb. 7, 2013

Good afternoon,

I am the Member Services Director for Central California Alliance for Health. We are a non-profit, public County Organized Health System (COHS) health plan. We are the Medi-Cal managed care health plan for Santa Cruz, Monterey and Merced counties and are also a Healthy Families Program health plan in Santa Cruz and Monterey counties. As a County Organized Health System, we are the only Medi-Cal managed care plan in the counties we serve. This means that all Medi-Cal beneficiaries in our three-county service area become our plan members when they enroll into Medi-Cal. There is no choice of health plan, as there is in counties that have the two-plan or geographic care model of Medi-Cal managed care. COHS counties have mandatory enrollment of Medi-Cal beneficiaries into the one plan that serves that county.

We have not submitted a bid to participate in the Exchange as a Qualified Health Plan for exchange products. My question is whether we would be allowed to have staff be trained and certified to be assisters, given that we will not be providing an exchange product. Our interest would be in assisting individuals and families who might be eligible for Medi-Cal.

Thank you.
Jan

Jan Wolf
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ConsumersUnion
POLICY & ACTION FROM CONSUMER REPORTS

CPEHN
California Pan-Ethnic Health Network

WESTERN CENTER ON LAW & POVERTY

February 15, 2013

Peter Lee, Executive Director
Covered California

Ms. Kim Belshé, Board Member
Secretary Diana Dooley, Board Member
Mr. Paul Fearer, Board Member
Ms. Susan Kennedy, Board Member
Dr. Bob Ross, Board Member

Re: Covered California—Assisters Program: In-Person Assistance and Navigator Webinar

Dear Mr. Lee and Board Members:

We offer comments below on the Assisters Program, as it was presented in the February 7, 2013 webinar. In addition to the webinar materials, we include in our comments our response to the Board Recommendation Brief on "Partnerships with Retail Stores and Roles as Assisters," dated January 17, 2013.

General

Consumers Union, California Pan-Ethnic Health Network, and Western Center on Law and Poverty appreciate many aspects of the proposal as presented on the February 7th webinar. In particular we applaud the Exchange's commitment to establish a trusted network that reflects the cultural and linguistic diversity of the targeted population; ensure a well-trained and knowledgeable cadre of assisters, provide a robust evaluation and measurement of the impact of assisters on awareness and enrollment, and establish important quality assurance standards and protocols.

We applaud the goal of identifying 3,600 assister enrollment entities with more than 21,000 individual assisters ready and able to provide help to millions of Californians eligible for Exchange coverage. We would appreciate more information about how the Exchange arrived at the moderate production goal that identifies that each assister will produce 4 completed and successful applications per month. In particular, does this assumption accurately reflect the experience of assisters in the HICAP and CHIP programs who undertake these types of activities for different populations?

Partnerships with Retail Stores

We fully appreciate that to accomplish the Exchange's bold ambition to help millions of people (1.4 million in the first year) access health coverage, a wide range of entities and a multi-faceted marketing and mobilization effort will be needed. However, we believe the recommendation in the policy brief for partnerships with retail stores with monetary compensation is misguided and potentially counter-productive. Overall, we support having retailers promote Covered California and afford space for certified assisters to enroll, but not to make payments to such retailers for that purpose. Our more detailed comments are set forth below.

"Key Factors"

It makes sense for Covered California to take into account the factors shown in the webinar slides and Brief, e.g. how many people the partnership has the potential to reach, including the composition of the Exchange's targeted population that shops at the retail store. Most importantly, Covered California should ensure that for-profit retail stores share similar core values with the Exchange.

As for-profit "partners" who stand to benefit monetarily from their association with the Exchange (see "Co-Branding" below), we strongly believe these stores should be held to the highest standards. Partner retail stores, at a minimum, should be those that provide comprehensive and affordable coverage to their workers. Surely large chains that do not provide coverage for their workers, or provide only the skimpiest coverage, cannot be viewed as sharing similar values with Covered California.

We also would like to hear more from staff regarding the standards used to judge whether or not the core values are aligned. Will the Exchange require evidence of alignment in documentation or some other transparent means? If not, what will the standards be to judge whether the retail store has similar core values to the Exchange?

An additional key factor should be added to the standards to include "No Conflicts of Interest," ensuring that retail partners do not have relationships with, issuers, drug companies, retail clinics and others in the health care sector that will benefit from Exchange business and could create steering or other bias concerns in the application and enrollment process.

Co-Branding

We urge the utmost care in allowing others to use the Covered California brand, logos, etc. Your brand will have significant value in the years to come and will be an indicator to the public of quality products and an institution to trust. Allowing others to use it creates an aura of goodwill that Covered California must not squander.

The standards you have proposed to determine the health plans you will contract with are rigorous. If Covered California undertakes co-branding with retail stores, we believe

that there should be similarly strong criteria for such partnerships, review of partnership proposals, and rigorous monitoring to protect the integrity of your brand. Without such standards and oversight, your legal staff will be forced to spend time monitoring the brand's proper use, and once the "genie is out of the bottle," it will be likely impossible to put it back in, to correct mistaken uses or repair erroneous impressions.

If Covered California moves forward with co-branding, we recommend that the Exchange only allow retailers to use pre-approved print messages, including for the use of the logo (e.g. on paper bags and receipts), public service announcements, and ads on in-store television and audio systems.

Monetary Compensation for In-person Assistance

A high quality partnership with appropriate retailers need not involve money changing hands. In fact, some of the most successful partnerships are those based on core value alignment and mutual self-interest. While retailers such as Target and Walmart and other businesses with in-store pharmacies will certainly have access to the diverse populations the Exchange will need to reach, we are concerned about the proposal recommended by staff (Tier 1) that would allow retail stores to be paid for using their employees as in-person assisters.

By analogy, in June 2012, after careful consideration the Board adopted the policy that those entities that derive a direct benefit in providing health care to individuals with coverage (e.g., clinics, hospitals and physicians) should not be compensated by the Exchange. The rationale was that those entities are self-interested, would likely help anyway with enrollment, and would find it difficult to be unbiased. Consumers Union supported the decision not to use the Exchange's consumer assistance funds on those entities that already had an interest in enrolling consumers without compensation.

The same holds true for retail establishments with pharmacies and optical departments, and those that don't have in-house pharmacies or optical departments but may have relationships with issuers, retail clinics, or other industry stakeholders. The Exchange's limited consumer assistance funds should be saved for non-profit groups that would otherwise be unable to provide enrollment assistance without these important dollars.

The potential convenience for consumers to enroll when doing their family errands should be considered, but if in-person assistance is provided on-site at a retail store we urge adoption of one of alternative proposal Tier 2, allowing stores to host certified assisters at booths in their stores, to refer consumers to the Service Center or certified assisters, and to disseminate material on Covered California.("Partnerships with Retail Stores…" slide 7 states that "no enrollment activities will be performed", but the bullets reference hosting in-person assistance from Certified Assisters approved by Covered California). However, we support this with the caveat that the retail store has provided evidence that it offers comprehensive and affordable health insurance to its employees. In addition, Tier 3 would be an acceptable option to us, with the caveats noted above under "Co-Branding."

Code of Conduct and Ethics Policies

We very much appreciate aspects of the code of conduct as it was presented in the webinar ("Assisters Slide" 27). It is important to identify from the outset that Assisters are obligated not to steer consumers to (or away from) any specific health plan or provider. Just as important is the policy that prevents Assisters from inviting or influencing an employee or her dependents to separate from employer-based insurance.

The code of conduct provision that prevents Assisters from intentionally providing false, deceptive, misleading or confusing information is too narrow. As drafted, it only prohibits *intentional* actions by an Assister, a difficult standard to prove and narrower than the usual standard aimed at curbing deceptive practices. Although we believe most Assisters will be well intentioned, they should be held to a higher standard than just intentional activity. One possibility is bar "Provid[ing] false, deceptive or misleading information in an effort to influence a consumer's enrollment decision."

Avoiding conflicts of interest is referred to on "Assisters" slide 28, but we have not seen Covered California's "conflict of interest policy" for the Assister program entities and individual Assisters. The Federal rules require the Exchange to develop such a policy for navigators and we have yet to see this. With the proposal to begin soliciting applications for Assisters in a few short months, we request an update and copy of the conflict of interest policy and opportunity for public comment as soon as possible.

Monitoring Requirements

It is vital that Covered California and all Assister partner entities undertake rigorous monitoring of Assisters. Any Assister enrollment entity will need the capacity and commitment to evaluate the performance of Assisters, including reporting the underlying data back to the Exchange.

We do not suggest that the Exchange should delegate its primary monitoring responsibility to the entities, but should simultaneously be monitoring, tracking, reporting, auditing, and reviewing Assisters directly to ensure compliance with federal and state rules and policies. For example, the Exchange should not delegate to Assister entities identification and reporting of conflicts of interest, fraud, and other issues. While the entities should be accountable to the Exchange, so should each individual Assister who is trained and certified by the Exchange.

Any monitoring that is also done by an Assister entity must be reportable in a format that includes a specific Assister identification number that can be tracked in the IT system, audit trail, etc. We did not see anything in the webinar that establishes these requirements and urge that they be added.

We agree that Covered California and consumers will need to have the utmost confidence in the trustworthiness of Assisters. To that end, we understand the likely

need for background checks, but we are concerned that, particularly for non-profits, finding the resources to pay for them will be difficult. The $63 per application fee may well be insufficient and could keep some individuals and entities from applying to be Assisters, with this added responsibility. We encourage the Exchange to explore other options for funding community-based entities for background checks, if in fact they are found warranted. The option for Covered California to take care of those costs in the first year could alleviate this burden.

Training and Curriculum

Considering that Maryland's Exchange will require at least 120 hours of training for their assister program, we are wondering if Covered California's proposal for just 2-3 days (24 hours maximum) per year is sufficient to ensure Assisters understand the intricacies of the insurance world, as well as employer coverage issues, tax implications, etc. We would appreciate further information about the thinking behind the length of training and also about whether the Exchange will consider providing this training in other languages, at a minimum in Spanish.

In addition to the items on "Assister Slides" 31-34, there are a number of topics that should be on the list for the Assister curriculum, including

- The rules and requirements associated with changes in circumstances;
- Tax reconciliation implications around eligibility for advance premium tax credits;
- Reasonable compatibility standards;
- Informal resolution process;
- Due process and appeals rights, including a bifurcated appeals system;
- Marketing and advertising rules and prohibitions;
- Nondiscrimination provisions, including Sec. 1557 in the ACA;
- Access standards for Limited English Proficient individuals; and
- Exchange requirements for reporting of demographic data on race, ethnicity and primary language of Exchange enrollees as it pertains to the Exchange's mission of eliminating health disparities.

Leads from Outreach and Education Grants

It is important to follow up with each and every individual who has learned about Covered California through the outreach and education grants and expressed a potential interest in coverage so that they can be matched up with a trained and certified Assister to help them apply for coverage in Covered California, CHIP, or Medicaid.

We believe these leads, however, should not result in referrals to just any Assister. Rather, leads should be directed to Covered California's Service Center or to nonprofit entities, such as Navigator Entities. We do not think that those Assisters who are positioned to derive substantial direct financial benefit from Covered California coverage should be eligible to receive leads generated by the nonprofit organizations taking on outreach and education.

Conclusion

We look forward to reviewing a more detailed proposal and set of recommendations than the webinar provided last week, and as always will appreciate the opportunity to review and comment upon them.

Sincerely,

Julie Silas
Consumers Union

Cary Sanders
California Pan-Ethnic Health Network

Vanessa Cajina
Western Center on Law & Poverty

From: Phil Daigle [mailto:phildaigle6@gmail.com]
Sent: Saturday, February 09, 2013 8:50 AM
To: Info (HBEX)
Subject: Fwd: Health Insurance Exchange - agent training

Begin forwarded message:

From: Cindy Davidson <Cindy.Davidson@examfx.com>
Subject: Health Insurance Exchange - agent training
Date: February 6, 2013 9:50:40 AM PST
To: "info@cahba.com" <info@cahba.com>

Wondering if you have any idea where the producer training is going to come from for the Health Insurance Exchange. The California Insurance Department Curriculum Advisory Board is meeting tomorrow and I'm sure there will be a discussion about how agents might best receive (and demonstrate completion of) this instruction. I saw in your website's Q&A that Assisters et. al. are expected to complete 2 days of training, but there does not appear to be a curriculum outline or any other details about the content/nature of the training and certification that will be required. Do you have any idea who will deliver the training and/or which agency will be charged with validating completions? (As far as I can tell it's not the Insurance Department.)

My company, ExamFX, is a national education provider of insurance licensing and continuing education, so we have some expertise in developing certification and training courses for insurance producers, and we have an excellent platform for delivering this type of training. Of course we would be interested in learning more about this opportunity.

Best,
Cynthia Davidson, CIC

ExamFX
Cynthia Davidson
Director, Insurance Products
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Thank you for inviting feedback on your planning for the Assister Program. I hope that you will consider the following issues:

Small counties may only have one or two entities and these entities may only hire 1 Assister (or, more likely, reassign work and have one or more staff member train as an Assister). With the funding tied to successful applications, and the estimate of an Assister enrolling a limited number of families per month, this is the only feasible way for an entity to approach this.

In geographic areas where the enrollment will be relatively low, the costs carried by entities should be carefully considered. For example, if an entity has only a few Assisters (e.g. <2 FTE), Covered CA should cover costs of background checks and fingerprinting. If staff have already gone through this process as part of the hiring process it should not have to be repeated.

For this reason, also, you should consider a Train the Trainer model for small, rural counties. Travel costs are expensive, as is dedicating staff to a computer training for 3 days, with no grant funding to pay for this. Better yet, training costs should be fully funded, whatever the model used.

If you go forward with working with retail stores as partners, you should focus on quality control issues. Minimum wage retail employees may not be the best equipped to learn the complicated ins and outs of health plans, nor should they expected to be. Perhaps the certification will cover this, but it does come to mind. Non profits and government entities have a history of "demystifying" complex regulations for citizens, WalMart does not. If a store cannot dedicate an employee to that booth on full time basis (because the reimbursement rate would not cover the costs), then the plan would be to pull someone off the floor - and the logistics of that for a retail store are even more complicated than for a non-profit service provider.

Clarity regarding the ability of Public Health Depts to become Assisters would be welcome -- many small county Depts of Public Health do not have full health clinics, but only offer services such as immunizations, etc.

Thank you,
Sheila Kruse

--
Sheila Kruse
First 5 Tuolumne County
20111 Cedar Rd. North
Sonora, CA 95370
209 588-8067
sheilamkruse@gmail.com

Hello,
I realize I missed the deadline to submit written comments (the timing for this initiative is really bad for grant writers working with health centers, since the long-awaited and highly competitive federal New Access Point applications for Federally Qualified Health Center [FQHC] funding are in full swing), but here is my comment:

I see from the PowerPoint presentation for the Assister's Webinar that the example given to illustrate how Assisters will interact with the public is for retail stores. As someone who works with a number of FQHCs and other community clinics, I'm wondering if that same model is being planned for the health center network. As far as I can tell, so far, no health center administrators are clear about what their role in this effort will be, and it seems obvious to me that FQHCs are much more appropriate Assister Entities than retail stores.

I didn't attend the webinar, so maybe I'm missing something.

As an aside, the Outreach and Education funding, requiring 33,000 contacts over 20 months is being seen as too ambitious for most of the clinics I work with, and some are scrambling to see if they can collaborate with larger coalitions to be part of the effort. Many, however, are just writing it off as beyond their capabilities, so I fear we may lose this excellent resource for outreach, and I hope we don't lose it for the Assisters program.

Thank you for your consideration of these thoughts,
Susan Dobra

Susan Dobra, Ph.D.
Lead Grant Writer
Gary Bess Associates
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Paradise, CA 95969
530.877.3426 ext 104

-----Original Message-----
From: Shannon.R.Borges@healthnet.com [mailto:Shannon.R.Borges@healthnet.com]
Sent: Wednesday, February 06, 2013 6:43 PM
To: WebConferencing1
Subject: Assister Questions

Hello,

The following questions are directed towards: The Assisters Webinar set for: Thursday February 7th from 1-3 pm.

Enclosed are only a few "filtered" questions from many of our Brokers and a couple for our Sales Operations team:

It seems the Non-Health & Life Licensed Assisters can offer service for all the Covered California programs and also be compensated as well, but an Agent/Broker which also must become Certified by Covered California and become an Assister will only be compensated for placing business into either the SHOP or the Individual Exchange within the portfolio of program options within Covered California, and NOT be compensated for any of the other Covered California Programs, is that right?

I understand the Fed's have stipulated in the PPACA ruling any money they have given the State to help fund the "Assisters" program; Agents/Brokers, Hospitals, Providers, etc... cannot be compensated, but if a group is submitted into the exchange and one of the applicants child is eligible for Medical and the exchange transfers the child to Medical for submission, the broker will not be compensated, but a non-licensed Health and Life Agent Assister would, right? If this is so, I would recommend working with your Issuers to figure out a way to compensate the Agents when a case is submitted into the exchange and a child is transferred to Medical, so the broker does not loose commissions. Might seem little money to some people to loose, but if a broker submits 20 cases into the SHOP program with an average of only 3 children per group which qualifies for Medical benefits, that add up.... 60 kids at $58 / $25 is a chunk of change.

Once the Non-Licensed Health and Life Assister is accredited by the SHOP, who trains the Assisters on the Issuers Product Portfolio, their Navigator?

I am assuming that an Issuer will be able to contact the Assisters or the Navigators and offer them some education about their plans like issuers conducted education workshops for CAA's when providing service for products like Health Families, right?

Can issuers create a C.E. course program to help/further educate the Assisters / Navigators "Best Practices" how to provide the Service of Excellence as an Assister when helping Californian's figure out the best plan for their clients needs? If so, who should the Issuers submit their training materials to?

If a carrier/issuer decided to pay Agent (Assisters) for placing Medical Business with them, is there a legal way to do so? I understand within the ACA, the Fed's do not want the State or the Issuers to pay the Agent (Assisters) for Medical business, but does that preclude issuers from

paying Agent (Assisters) a certain type of bonus to help the Agent (Assister) become compensated for the entire group, verse becoming a charity agent for 5 % of his book of business?

As an issuer, if the case is submitted and commissions are paid to the agent and within 90, 120 days or even 6 months (for some issuers) the groups leaves, the issuer will ask for their commissions back, will the SHOP conduct the same way? If so, how many days?

What is your Broker of Record Policy between Assisters?

Exchange Distribution systems: IPA (Assisters) Program and Navigators. If an Agent/Broker would like to sell into the SHOP and Individual Exchange, what is the first step?
Find an IPA Program looking for Assisters? Sign up through the IPA, and they train you.... then the Agent goes to a physical location and show their ID to take a test to become Assister Certified for the State of California.

I understand that anyone can sign up for a two day Assister credential course, take the Assisters Certification Test, pass it and become certified to Assist Californian's to choose the best product and plan design within the Covered California portfolio that meets the needs. Must this Assister work for an IPA Program or can they work independently? Same question for an agent which becomes a Certified Assister for the State.

Navigator Assister Program: I have seen how the Navigator is compensated because all the litriture I have read states the State will come up with a production number of enrollees per the amount of the grant. So, high-level.... Is the Navigator acting like an IPA program in respects to cultivating Assisters to go out sell people into the exchange and on the application they would put down the Navigators Covered California Producer Number, then the State would "credit" the Navigator the application. Is it up to the Navigator how they want to compensate the Assister placing business through their Navigator ID number?

From what I have read, the State is leaning towards only allowing 3 to 4 GA's become a GA for the exchange..... if a GA in the State does not become chosen as one of the 3 or 4 GA's, can a General Agent that represents Health Insurance companies participating in the CA. SHOP and Individual exchange become a Navigator or an IPA Assister?

Do you reply to my email answering each question individually, or do I check the website daily to see if they got posted?

Thanks.

Shannon Borges
Regional Vice President of Tactical Sales, Western Region
Health Net, Inc. | 7755 Center Ave. #800, Huntington Beach , CA 92647 | Mailstop: CA-123-08-02
Phone: (714) 934-3306 | Mobile: (714) 916-2311
shannon.borges@healthnet.com | www.healthnet.com

Good afternoon:

Thank you for giving us an opportunity to provide feedback on the proposed Assister Program. Following are our two recommendations:

1) We encourage the Exchange to re-consider the master trainer model. This model will not replace the Exchange's proposed training models, but it will create another training format for many entities and individuals who prefer the classroom format with in-person questions and answers. This model has been very successful for the Healthy Families Program. We have received many feedback from our community partners and agencies, urging us to request the Exchange to re-consider this master trainer model.

2) In early Summer 2012, the Exchange proposed to allow health plans to conduct education, eligibility and enrollment. However, we do not see this recommendation in your current Assister Program. We respectfully request that the Exchange re-considers to allow Medi-Cal health plans that currently provide Medi-Cal/Healthy Families application assistance to conduct these activities (and they will not be eligible for compensation.) Currently, Medi-Cal health plans provide application assistance to thousands of uninsured families to apply for Medi-Cal/Healthy Families for their children. By permitting these health plans to provide the Exchange education and application assistance, it will allow health plans to help the children and their parents (who will be eligible for the Exchange products) at the same time, and not turn away the parents. This strategy supports one of the Exchange's enrollment and outreach strategies, which is one-stop-shop for application assistance. It is also a critical outreach and enrollment assistance component for the Bridge Option. The new proposed federal regulation on "Application Counselors" allows the Exchange to utilize organizations (for the Exchange application assistance) that currently provide Medi-Cal/Healthy Families application assistance and not fit in to the In-person Assistance Program and Health Navigator categories.

Please contact me if you have any questions about our recommendations. And again, thank you for your consideration.

Thomas Pham
Director of Marketing & Product Management
Inland Empire Health Plan (IEHP)
303 East Vanderbilt Way
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☎ 909-890-2176
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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

Insure the Uninsured Project
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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

International Children Assistance Network
532 Valley Way, Milpitas, CA 95035, Tel: 408.509.8788, Fax: 408.935.9657
Website: www.ican2.org, Email: info@ican2.org

From: Reuben, Joanie [mailto:Joanie.Reuben@wellpoint.com]
Sent: Friday, February 08, 2013 8:04 AM
To: WebConferencing1
Subject: Feedback

A very well organized and informative webinar!

As you heard, there are lots of questions about the Agent's role and where he/she fits in. Can Agent be an Assister, Navigator AND receive commissions for sales through carriers? I'm hoping there's a future session to discuss the Agent's role with Covered California.

Also, can you confirm what we have heard – that Covered California will NOT allow premium rateups for tobacco use? As you know, where such rateups are allowed, the rateup portion of premium is to be excluded from any tax credit/subsidy.

Thank you!

Joanie Reuben
Individual Sales Development
Ph: 805-557-5054
BB: 805-208-8495

CA Insurance License 0G30171

From: Christopher Kirkland [mailto:cskirkland@live.com]
Sent: Thursday, February 07, 2013 3:31 PM
To: Info (HBEX)
Subject: Assistors and agents

Covered California,

I have a question about Compensation for insurance agents: If they help someone enroll as an assistor their not paid, but then are they then paid by the insurance company whose plan they enrolled the enrollee in?

On another note, It is very demeaning to agents to assert that they would not be impartial and fair and therefore not paid for this reason. As agents we would like to know very specifically what factual information was used to come to this conclusion or if the conclusion was solely conjecture based.

Sincerely,

Christopher Kirkland
Licensed Insurance Agent
CA Lic # 0E91569 : AZ Lic # 1016608

From: Ashley Spindler [mailto:aspindler@lbcc.edu]
Sent: Thursday, February 07, 2013 3:43 PM
To: Info (HBEX)
Subject: Question Regarding Assisters and SHOP

Good afternoon,

After listening to the bidder's webinar yesterday and the Assister's webinar today I have a question about the Outreach and Education's SHOP program and the role of Assisters. I believe the in Q&A portion of today's webinar someone asked if Assisters are able to enroll SHOP clients and the answer was no. Who will be responsible for enrolling leads generated by SHOP grantees?

My organization is interested in becoming an Assister; we have received a number of inquiries about the Covered California program from local small businesses. I realize neither programs are up and running but I would like to give them a general sense of who will be able to help enroll them once the process has begun.

Thank you in advance for your assistance.

Cordially,

Ashley A. Spindler, MPH
Institutional Resource Development
Long Beach City College
(562) 938-4756

Hello:
I was glad to be on the Webinar presentation last week. I found it informative and wish I'd been on the Webinar for the education and outreach program the day before. I am eager to participate in the education and outreach efforts on behalf of the Exchange and also the assister training programs. I attended the webinar to learn how these marketing elements were all going to hang together. I still have more to learn by reviewing the slides of both presentations and listening to the webinar again. And I've read the marketing plan Ogilvy and Mather prepared, but as I proceed to see how and where I might find a way to contribute, I still find it difficult to see a clear path through all the moving parts.

I live in Marin County and have been conducting my own information interviews to learn what and who is getting ready for health reform and the implementation of California Covered. So far I have not found much preparation. There is some pessimism about whether the constituencies without insurance are going to be able to afford what will be available on the Exchange, and since many of the clients of our Health and Human Services Department, our public health clinics, are not U.S. citizens, and will not be eligible for coverage on the Exchange, there was doubt and concern about their role in outreach programs. I also learned that there is fear and trepidation among small business owners about the their costs for offering mandated health coverage to their employees. Perhaps there are organizations applying for the education and outreach grants that I have yet to identify in my area, but I see gaps and voids that need to be filled, a significant need for education and outreach where I live.

I also wondered about your estimates for the numbers of people an individual assister will enroll per month. I believe I heard an estimate of four. That seems unrealistic to me. Did I not hear correctly, and the estimate is really 4 a day? Regarding retail outlets, it occurred to me that Costco stores might be likely places to set up kiosks to enroll prospective customers for California Covered. Perhaps also Safeway pharmacies. I am thinking of companies whose values align with the goals of the Exchange.

I look forward to learning much more and achieving a clearer understanding in the days ahead.
Kind regards,
Margaret Ballou

From: Max H Herr [mailto:max.herr@verizon.net]
Sent: Thursday, February 07, 2013 3:31 PM
To: Info (HBEX)
Subject: Training Curriculum and other topics

As concerns Assister Training curriculum . . .

Assisters will be "guiding" persons to health plans intended to meet their needs. How will they do this if they have no knowledge of how health insurance works? The training curriculum does not provide even a basic overview of insurance. This is a serious flaw in the training of assisters. Licensed insurance agents have this training but are foreclosed from acting as an assister. It appears that no consideration has been given to how will unknowledgeable assisters guide persons to the most appropriate plan for their personal needs?

Who will be responsible for testing assisters for competency? How much will this cost? Who will pay that cost?

It seems that too many costs associated with the program have not been adequately addressed. Training will be free. Testing obviously will not be. Will CA taxpayers have to foot the bill for this?

As concerns Errors & Omissions insurance, it is not available to persons such as assisters -- E&O is otherwise known as "professional liability insurance" and assisters are not "professionals" in any sense of the word. E&O insurance for licensed insurance agents costs $450 or more per year. Who's going to cover this cost?

As concerns background checks, inundating the federal and state departments of justice with livescan process requests will completely overload those systems. Has any thought been given to how will this impact background checks for persons applying for other professional licenses in CA and across the US?

When it comes to fraud and abuse, will there be any third party monitors who will perform as "secret shoppers"?

How can individual in-person assisters possibly represent multiple Assister Agencies? What addresses the conflict of interest that could potentially drive compensation to one agency over another if the agency compensation to the assister is higher at Agency A compared to Agency B? This is a blatant example of a policy that has not been well thought out and is potentially very hazardous to consumers. Individual Assisters must be limited to representing only one agency in one region. Only if an individual assister works in more than one region where the same Agency does not operate would this be a proper thing.

--
MAX H HERR, MA
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From: Linda Carpenter [mailto:linda@mojo-navigator.com]
Sent: Thursday, February 07, 2013 5:06 PM
To: Info (HBEX)
Subject: RE: Assisters Program: In-Person Assistance and Navigator Webinar

Hello,

I attended today's webinar, and already submitted a few questions during the presentation, which I will be looking for answers to on the web site later.

I have one more question, about Assisters being employed by or affiliated with enrollment entities.

I completely understand that Covered California, for quality assurance purposes, would want its IPAs to have "affiliations" with appropriate and vetted enrollment entities. I want to make sure that this reasonable parameter does not become a barrier to my goal of becoming part of the success of Covered California.

What is the definition of "affiliated with"? I intend to pursue affiliations with as many enrollment entities as I can, but before I do, I need to know how to establish these "affiliations" within the requirements of Covered California.

The specific population market I intend to reach out to is employees and employers in Sonoma County. I hope to develop a reputation in my community of being a highly competent, go-to person, who is also an alternative to health insurance agent IPAs for those people who would prefer a non-agent's assistance, for employees and employers seeking information about their options within the Covered California QHPs.

The specific components of the Community Outreach Network that will likely reap the greatest enrollees within this population market will probably include: (1) trade associations; (2) unions; (3) private companies; and (4) advocacy organizations.

The entity types that I will likely be seeking "affiliations" with are ones with direct access to the population market of Sonoma County employers and employees, and include: (1) attorneys; (2) chambers of commerce; (3) labor unions; (4) tax preparers; and (5) trade, industry, and professional organizations.

I have provided you with some context for my question, to demonstrate the scope of what I am seeking to accomplish through Covered California IPA-certification, and so that you will provide me with the clarity I need to proceed.

Thank-you.

Linda Carpenter
Healthcare Navigator
Private Patient Advocate
Northern California Healthcare Navigators

707-478-2103

From: Linda Carpenter [mailto:linda@mojo-navigator.com]
Sent: Friday, February 08, 2013 10:22 AM
To: Info (HBEX)
Subject: RE: Assisters Program: IPA & Navigator Webinar

I participated in the Feb. 7 webinar, and submitted a few questions during the presentation for which I will be checking in for answers on the HBEX web site.

I have one more question, plus a suggestion. My question has to do with IPAs being "affiliated with" enrollment entities.

I completely understand that Covered California would want its IPAs to have "affiliations" with appropriate and vetted enrollment entities. I want to make sure this requirement does not become a barrier to my goal of becoming part of the success of Covered California.

What has Covered California determined to be the parameters of an "affiliation" between its certified IPAs and enrollment entities? As someone who is pursuing Covered California IPA-certification, I need some insight into how I might best go about meeting this "affiliation" requirement. At this point in the development of Covered California, I'm not even sure if potential enrollment entities understand how to affiliate themselves with IPAs outside of an employment relationship.

I asked and received an answer during the webinar about whether IPAs can be affiliated with multiple enrollment entities. The answer we received was "yes". So, that answer indicates that there will be/are relationships outside of employment that are/will be available to IPAs seeking enrollment entity-affiliations.

The specific market I intend to reach out to is employees and employers in Sonoma County. I hope to develop a reputation in my community as a highly qualified, go-to person, one who is an alternative to health insurance agents for those who would rather get assistance from non-agent IPAs, for employees and employers to contact for information about their options within the Covered California QHPs. I am providing this context to you so that you have a clearer picture of what I am trying to accomplish within Covered California, so that the "affiliation" requirement does not become an insurmountable barrier for me.

My suggestion has to do with Covered California business cards for IPAs. If I am successful at becoming certified to be a Covered California IPA, and in developing affiliations with enrollment entities, it would greatly enhance my ability to reach out to the employer/employee population if I had business cards identifying me as a Covered California-certified IPA, and carrying the Covered California logo.

Thanks for all your good work. My question is detailed, because I am trying to avoid having to go back and forth with you on this point of what determines an enrollment entity "affiliation" from the perspective of an IPA.

Linda Carpenter
Healthcare Navigator
Private Patient Advocate
Northern California Healthcare Navigators
707-478-2103

From: Linda Carpenter [mailto:linda@mojo-navigator.com]
Sent: Saturday, February 09, 2013 1:04 PM
To: Info (HBEX)
Subject: RE: Assisters Program: IPA & Navigator Webinar

I have yet another comment to add to the mix in the wake of the Feb. 7 webinar re the assister program.

Fingerprint checks.
My experience with fingerprint checks is that, even with the best fingerprint technician performing the test, this technology is lacking. A a result, I question the wisdom of spending money on this.

When my daughter was in 4-H, I was required to undergo a fingerprint check in order to volunteer for 4-H activities. I went in for a fingerprint check on three different occasions, because my fingerprints could not be read. Because I work out in the yard with my hands in the dirt, and because I have naturally dry skin, the fingerprint machine as administered by someone who appeared to me to be knowledgable and competent was unable on any of the three occasions to read my prints. What ultimately happened is that I was waived from having to have a fingerprint test.

Meanwhile, someone paid the bill for these three tests, and I had to take time out of my day to drive to and from these testing events.

If there are other technologies out there to verify background information for Assisters and Navigators, then I would like to encourage Covered California to explore them as an alternative.

Thanks.

Linda Carpenter
Healthcare Navigator
Private Patient Advocate
Northern California Healthcare Navigators
707-478-2103

San Francisco Community Clinic Consortium

1550 Bryant Street, Suite 450 • San Francisco, CA 94103 • Phone 415/355-2222 • Fax 415/865-9960 • www.sfccc.org

February 15, 2013

Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: Covered California's Assisters Program

To Whom It May Concern,

The San Francisco Community Clinic Consortium (SFCCC) respectfully submits comments on Covered California's (CC) Assisters Program, presented during the Stakeholder Webinar on February 7, 2013. SFCCC represents 11 community-based primary care clinics with 19 clinic sites strategically located across the City to meet the health care needs of our most vulnerable residents. SFCCC partner clinics care for more than 94,000 low-income, uninsured and under-insured San Franciscans, more than 10% of the City's population. SFCCC partners offer services in over 20 languages and multiple dialects and employ over 500 health care professionals, including more than 50 trained Certified Application Assistors.

Our partners have been serving their communities for decades, and have built strong and trusting relationships with both their patients and their larger communities. It is common for third and fourth generations in a family to continue to attend the same clinic. The clinics care for the entire family, from newborns to seniors. Our partner clinics are in an ideal position to educate both their existing uninsured patients and the larger community about the benefits of enrolling in the Exchange, and to assist them to enroll.

I. Background checks

Covered California (CC) requested information on whether or not to require background checks for Assisters and whether or not to require that the Assister Enrollment Entity (AEE) pay the fees for the background checks. We appreciate that CC needs to maintain program integrity and ensure consumer rights and safety are protected, but we have some concerns with the options proposed during the webinar.

SFCCC has encountered State law limitations when background checks are required for our AmeriCorps Program members. Therefore, SFCCC highly recommends that CC assure that any required background checks do not violate any State rules governing when employers can require background checks and how the information is shared and stored. Depending on what State law allows, CC may need or prefer to conduct the background checks itself, which could also simplify the entire process. The enrollment targets are high enough that CC needs every AEE and Assister possible to participate. Any AEE cost or administrative barrier that can be eliminated should be eliminated.

II. Steering Policies and Monitoring Standards

SFCCC appreciates the importance of the steering policies and monitoring standards in CC's Assister Program, and we encourage CC to mirror the Managed Risk Medical Insurance Board's (MRMIB) Certified Application Assistant (CAA) Program whenever possible. Developing a similar program will help expedite the enrollment process and ensure that CC can quickly achieve its targets. We recommend that CC enhance the proposed code of conduct with the current CAA agreement that MRMIB requires their CAAs to sign in order to participate in the Healthy Families Program. The agreement can be found on their website: http://www.healthyfamilies.ca.gov/Publications/EEs_CAAs/CAAAgreementForm_en.pdf.

The CAA agreement includes a code of conduct that addresses steering as well as a release of liability so that the state is not liable for the CAA's conduct. We believe that this agreement has served MRMIB and the Healthy Families Program effectively. Since this is a proven and fairly simple model, we recommend that CC adopt it.

In regards to monitoring, we believe that the MRMIB Enrollment Entity (EE) and CAA monitoring processes have been effective, and SFCCC recommends that CC adopt a similar program. MRMIB monitors the EE and CAA through the application process, welcome call survey and the Healthy Families Program toll-free number. They have the ability to revoke the status of an EE or CAA should there be any violations to the agreement. They also have the statutory authority to impose a civil penalty of $500 per occurrence if a CAA is caught charging for his/her services.

III. Training Curriculum

The proposed training curriculum is comprehensive and will serve as a strong foundation for the Assister Program. However, the curriculum is lacking a module on the eligibility rules for immigrants in public programs. These rules are complicated but crucial for Assisters to understand in order to explain the eligibility rules for all of California's potentially eligible populations. We strongly urge CC to add such a section to the curriculum.

IV. Errors & Omissions Insurance Requirement

SFCCC understands the potential benefit that could occur if AEEs carry Errors & Omissions insurance. However, we recommend that CC not make it a requirement, since the cost and administrative burden to obtain such a policy might keep some smaller and potentially important organizations from participating in the program. We recommend that CC work with insurance companies to make certain that appropriate and affordable policies are available for AEEs, and publicize their availability. CC could strongly recommend that AEEs obtain such insurance, but a requirement to obtain a policy might limit potential organizations from participating in the program, which may limit enrollment of important segments of California's populations.

Thank you for the opportunity to respond to the above-referenced solicitation. Please do not hesitate to contact Merrill Buice at mbuice@sfccc.org or 415-355-2234 if you have any questions, or if you require any clarification on these comments.

Sincerely,

Allen Meyer

Allen Meyer
Vice President of Programs

From: Tangerine Brigham [mailto:Tangerine.Brigham@sfdph.org]
Sent: Thursday, February 14, 2013 8:48 AM
To: Info (HBEX)
Cc: Jenine Smith; Raul Alarcon; Diana Guevara
Subject: Covered California Assisters Program: In-Person Assistance and Navigator Webinar

To Whom It May Concern

The San Francisco Department of Public Health has the following questions regarding the Assister Program based on the February 7, 2013 webinar.

1. On slide 18 of the Assister Program presentation, it indicates that county health departments that provide health care services to consumers are not eligible for compensation but that community clinics are eligible for compensation. What is the rationale (programmatic, policy and/or regulatory) for allowing one type of provider of health care services to receive compensation for enrollment and not another? If there are perceived conflicts with having county health departments that provide health care services to consumers receive compensation, then why would those conflicts not also exist for community clinics which provide health care services to consumers?

2. On slide 19 of the Assister Program presentation, it indicates that hospitals and providers are not eligible for compensation. However, a community clinic is by definition a provider. There appears to be inconsistency with the information contained on slides 18 and 19. Please explain the distinction between slides 18 and 19. What entities are classified as providers?

3.

Thanks
Tangerine Brigham

****

Tangerine M. Brigham
Deputy Director of Health
Director of Healthy San Francisco
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From: Srija Srinivasan [mailto:ssrinivasan@smcgov.org]
Sent: Tuesday, February 12, 2013 8:35 PM
To: Info (HBEX)
Subject: Feedback on Assistor Program from San Mateo County Health System

Dear Covered California colleagues,

The San Mateo County Health System urges you to allow Health Departments to be eligible to serve as Assistor entities. In listening in and reviewing the slides from the Assistor program webinar last week, Slide 19 is confusing and implies that Covered California may not allow Health Departments to serve as Assistor entities. Whether or not Health Departments deliver direct healthcare services, there are mechanisms to assure that the organizational units that perform Assistor functions maintain impartiality, avoid conflicts of interest and are responsible for maintaining program integrity.

For Health Departments that have invested in this capacity to offer "no wrong door" and "culture of coverage" service to consumers that we reach, it directly thwart's Covered California's goals of achieving maximum coverage to disqualify entities that have demonstrated expertise in this arena.

In San Mateo County, the Health System's Health Coverage Unit and Behavioral Health and Recovery Services division have a combined 51 Certified Application Assistors (designated by MRMIB) as part of their staffs. These staff can deliver assistance to consumers with ALL programs that they may qualify for, increasing the efficiency and quality of customer service provided. Collectively, the Health System's Certified Application Assistors represent more than 50% of the CAAs in San Mateo County, and these CAAs are well-positioned to serve as Assistors for Covered California. As one example, we have achieved 95% coverage of children in our community, in part through the work of the network of CAAs. Disqualifying the Health System will result in a need for greater ramp-up and training and, potentially, much reduced Assistor capacity to serve as community-based resources for San Mateo County residents. Training and/or redirection of current staff into different organizational entities would take time away from preparation for ACA implementation at a time when we can least afford to divert focus on our joint goals of maximum enrollment assistance for consumers who will need it.

Also, to the extent that Covered California wants trusted on-the-ground staff to connect with low-income, uninsured consumers, we hope that you consider Assistors working in local health departments as similar to those who work for community clinics or other community-based locations that are a resource for low-income uninsured residents seeking assistance or healthcare.

We also recommend that Covered California continue to consider the Master Trainer model to support online training offered by Covered California. In our experience, local expertise and training support, that can adapt statewide training to the local provider landscape, improves the level of customer service we can provide. The Health System is interested in continuing our role in this arena given the expertise and capacity that we have developed, as a local complement to Covered California's statewide responsibilities.

Thank you for your consideration.

Srija Srinivasan

PLEASE NOTE: My email address has changed to ssrinivasan@smcgov.org. Please add this new address as a trusted site to ensure that spam filtering software doesn't prevent the delivery of emails.

SEIU California

SEIU California
Stronger Together

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February 25, 2012

Members of the California Health Benefits Exchange Board:
Kimberly Belshé, Sec. Diana Dooley, Paul Fearer, Susan Kennedy, Dr. Robert Ross
California Health Benefits Exchange

Re: Assister's Program

As a major supporter of the Affordable Care Act (ACA), SEIU appreciates the opportunity to provide input on the implementation of Covered California, and specifically the Assister's Program. The successful implementation of the HBEX is a top priority for SEIU.

SEIU find Covered California's approach to be thoughtful, and appreciate the focus on ensuring that Assisters reflect the target population. We also appreciate the concerted effort made by Covered California to ensure that the Outreach & Education Grants complements the Assister's program and the statewide marketing program. These efforts will ensure that all eligible Californians will have the opportunity to engage in their health coverage. Specifically, SEIU would like to make the following recommendations:

1. **Assister Training.** It is clear that much thought has been put into the training curriculum and approach for assisters. Given the extremely tight timeframes the program is under to ensure the target number of assisters are reached, SEIU recommends the following:

    a. ***Training location.*** SEIU agrees that building on existing application assistance networks is critical to ensure the program meets its goals. However, if large numbers of assisters have to travel, that increases the cost of the program. Moreover, many organizations have local training facilities that can be leveraged. *SEIU recommends that Covered California be flexible on training locations and work with Eligible Entities to determine which training locations are most feasible and appropriate. We also suggest utilizing existing training space that many organizations have and make trainers available to come to locations identified by Eligible Entities.*

    b. ***Eligibility worker (EW) training.*** There are 15,000 EWs in the state who are trained to provide support and application assistance for public programs, in addition to their eligibility role. This is an important network of eligibility professionals who already play a critical role and can support Covered California on the ground. As with agents and brokers who will receive specialized agent training, *SEIU recommends that Covered California work with stakeholders, including SEIU and counties, to develop a training for EWs that builds on the assister training and adds any necessary detail to recognize the enhanced role our eligibility professionals will play.*

c. ***Post enrollment training and consumer assistance.*** Many consumers purchasing coverage through Covered California may have difficulty navigating the system and accessing care for which they now have coverage. As trusted messengers, Assisters may be asked for help. *SEIU recommends that the post enrollment training module include training on consumer assistance/ombudsman support programs in the state or by the insurer.*

d. **Flow of funds.** It is unclear how funding would flow from Covered California to eligible entities and then to assisters. *Would it vary based on the type of entity? What are the fiscal and operational requirements of eligible entities for managing the flow of funds?*

2. **Background Check & Fingerprinting.** SEIU agrees that building on the existing application assisters is critical to ensure the program meets its goals. However, Assister organizations will incur costs to participate. These costs may make participation unfeasible for many local community based organizations that have strong ties to target populations. Covering the cost of background checks and fingerprinting could help defray those costs. Additionally, it is unclear how the background checks will be used and if certain exclusion applies. *SEIU supports Option #2 to defray the cost of becoming assisters in year one, and requests that Covered California provide additional details regarding any potential exclusions that being considered when flagged by background checks.*

3. **Partnerships with Retail Stores.** Covered California should ensure that large retail partners are providing its own employees with coverage and continue to do so. Such partnership arrangements should serve to add to the total number of insured Californians. It is also unclear in the proposal if store employees conducting in-person assistance must also undergo same Assisters training. *SEIU recommends that retail store employees providing any such assistance undergo the same training to ensure consistent messaging across the state. We also recommend retailers be required to provide affordable health care coverage to its work force as of January 2012 and continue to provide coverage to its employees throughout the duration of its involvement with Covered California.*

We believe that consumer engagement is critical to the successful implementation of the ACA and California's Exchange. SEIU members and organizers reflect California's diversity and have a track record of delivering complex messages and campaigns, and continue to see ourselves as a key partner ensuring Covered California's success. We appreciate the thoroughness of the Exchange Board.

Sincerely,

Tia Orr
Sr. Government Advocate
SEIU – California

From: steve@signaturehealthinsurance [mailto:Steve@signaturehealthinsurance.com]
Sent: Thursday, February 07, 2013 3:57 PM
To: Info (HBEX)
Subject: Webinar Questions

Thank you for the presentation.

There are many brokers out here that are very excited about the ACA and Covered California. Several agents had questions regarding the agent/brokers involvement, however the answers didn't seem to hit the nail on the head. I understand that agents/brokers will not be compensated by the exchange but by the carrier. But I still have a couple questions.

Who will be giving the required training for agents and brokers to get certified?
When will we be able to sign up for the training?
If the applications for training are available, where are they located?
Will the agent/broker compensation be set at $58 per successful application or will it be different?
Is the SHOP training going to be separate?

Thank you,

Steve Sauer

THE GREENLINING INSTITUTE
1918 UNIVERSITY AVENUE, 2ND FLOOR
BERKELEY, CA 94704
GREENLINING.ORG

February 15, 2013

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

Comments to the Board on the Proposed Assisters Program

Dear Mr. Lee:

The Greenlining Institute is writing to provide comments on the Assisters Program presented on the Covered California webinar on February 7, 2013. As an organization also dedicated to diversifying health workforce opportunities for California's diverse communities, we are pleased that the Board is seeking Assisters that know their respective geography and communities intimately, to promote maximum enrollment into the Exchange. We believe that enlisting Assisters that reflect the communities they serve will improve the Exchange's reach to California's diverse uninsured population through a culturally and linguistically sensitive approach. While we support the intent and purpose of the program, we do have some concerns that some proposed details will not achieve the intended goals of employing Assisters that have no conflict of interest or mirror the population who need coverage for smooth enrollment into the Exchange.

Retailers as Covered California as Assister Enrollment Entities

We support the Board in pursuing options to enlist Assister Entities that build on existing networks and channels to reach eligible people where they live, work, and play. However, as outlined in the webinar, we believe that Retailers as Assisters enters a gray area regarding conflict of interest as entities that may gain direct benefit from enrolling community members. We urge the Board to consider the following in developing their final ruling:

- Develop comprehensive conflict of interest policies to prevent retailers from potentially steering consumers exclusively towards health plans that contract with their business, e.g. pharmacy services.
- Consider whether retail employees truly serve as a trusted resource for consumers, and can move them from an informed to an enrolled individual. Although retailers provide goods and services to diverse consumers, the trust needed for enrolling someone previously uninsured may be lacking in the retailer-consumer dynamic.
- Even if the retail employee establishes trust with the uninsured, there is no guarantee that a consumer will enroll upon first contact in a retail store. Thus, if the retail Assister does not work at the store 24 hours, seven days a week, and the interested consumer returns at a

later date then the process could begin anew. This potentially inefficient process will not achieve the Board's goal of smooth and cost-effective enrollment for the Assisters Program.

- It is unclear what the buy-in is for the retail worker to serve as an Assister for Covered California. Unlike other proposed Assister Entities who are more traditional stakeholders of their communities, retailers as Assister Entities may have little incentive or purpose for their employees to serve as Assisters outside of the payment for successful employment applications.

In addition, retailers identify locations primarily based on the presence or lack of a profitable market.[1][2] The significance of community purchasing power in determining where retailers exist could decrease the efficacy of using them as Assister Entities to target California's uninsured populations, as they could have limited reach in California's rural and low-income areas which are less densely populated or have less disposable income, respectively.

Option #1 & #2- Background Clearance and Fingerprinting Requirements for Individual Assisters

We support the Board in ensuring consumer protections and disqualifying dishonest individuals from being Assisters, but we do not agree that proposed clearance requirements will achieve both goals of protecting consumers and enlisting Assisters that reflect the communities they serve. Although details for this process are unclear at this point, 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" as certified Assisters.

Research at the national level generally finds that 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 and the Department of Justice have both found that approximately 30 percent of the adult U.S. population has a criminal record.[3][4] This can severely limit the Assisters 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] The U.S. Equal Employment Opportunity Commission's (EEOC) Enforcement Guidance also found that one in six Latino men, and one in three black men are likely to be incarcerated during his lifetime, disparately larger rates compared to the white male incarceration rate of one in seventeen.[6]

CalSIM modeling predicts that of the four million uninsured in 2019, 66 percent are Latino, and approximately 60 percent are limited English proficient.[7] However, should background check requirements be overly restrictive, it will limit the Assister Program's ability to provide culturally

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[1] Strother SC, Strother BL, Martin BL. (2009). Retail market estimation for strategic economic development. *Journal of Retail & Leisure Property*; 8(2):139-52.
[2] Mushinski D and Weiler S. (2002). A Note on the Geographic Interdependencies of Retail Market Areas. *Journal of Regional Science*; 42(1):75-86.
[3] Rodriguez MN and Emsellem M. (2011). *65 Million Need Not Apply: The Case for Reforming Criminal Background Checks for Employment*. National Employment Law Project.
[4] Schmitt J and Warner K. (2010). *Ex-offenders and the Labor Market*. Center for Economic and Policy Research.
[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] 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.
[7] 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).

and linguistically appropriate enrollment services to communities of color that are at higher risk of remaining uninsured.

We propose the Board consider the following to reach a suitable solution that is appropriate and fair, based on evidence and on workforce expertise:

- Incorporate best practices for background checks recommended by entities such as the U.S. EEOC and the National Employment Law Project. For instance, the EEOC provides guidance that background checks must consider the nature of the crime, the time elapsed since the conviction, and the nature of the job.[8]
- Ban requests for criminal histories on initial job applications, delaying the background check until the final stages of the application process; nine California city and county jurisdictions implement some form of a "ban-the-box" policy.[9]
- Drug and DUI offenses should be excluded from the background check as they are unrelated to the work of a Covered California Assister.
- 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. In addition, if an Assister Entity has their own background check policies, they should be eligible for a waiver to Covered California's security clearance requirements to streamline the process.
- Regardless of the final security clearance guidelines, there should be an appeals process for an applicant if their background check contains errors, and a special appeals process for applicants whose records show convictions for select offenses that would not endanger consumer protections.

We would be happy to work with the Board to develop language on background checks that mitigates risk but does not inequitably disqualify certain candidates, and can provide more data on this issue upon request.

Best,

Carla Saporta, MPH
Health Policy Director
Bridges to Health

cc: Covered California Board Members
Thien Lam, Deputy Director of Eligibility and Enrollment

[8] 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.
[9] National Employment Law Project. (2012). *Ban the Box: Major U.S. Cities and Counties Adopt Fair Hiring Policies to Remove Unfair Barriers to Employment of People with Criminal Records. Resource Guide.*

From: Doren Martin [mailto:dorensf@msn.com]
Sent: Saturday, February 09, 2013 5:16 PM
To: Info (HBEX)
Subject: Background check comments

Fingerprinting background checks: how we make hiring decisions from the information received. Do we classify candidates?
- eligible for hire
- eligible for hire with conditions
- ineligible for hire

The Latino Commission is committed to being a vital participant/partner of Covered California. We are also committed to helping our clients, volunteers, staff and residents in the communities we serve. We are a Recovery Community Organization in that many of our staff are people in recovery who have turned their lives around, and are now providing services to clients in our recovery programs. For Covered California, we will be utilizing staff and perhaps hiring from clients graduating from our programs, who potentially have bad background checks and considered “unemployable”. We want to give them an opportunity to work and become proud productive citizens and taxpayers.

For worthy candidates with a bad background, we suggest a person can be "eligible for hire with conditions". In our case, the condition is an 'official professional recommendation' provided by The Latino Commission, a state-licensed service provider.

For decreasing potential harm to innocent applicants:
-Furnish the applicant with a copy of the report before it is given to the employer, so that any inaccuracies can be addressed beforehand; and
-Allow only conviction (not arrest) records to be reported.

Concerns with the validity of background check information (web database vs official records):
As a general rule, employers may not take adverse action against an applicant or employee (not hiring or terminating them), solely on the basis of results obtained through a database search. Database searches, as opposed to source records searches (search of actual county courthouse records), are notoriously inaccurate, contain incomplete or outdated information, and should only be used as an added safety net when conducting a background check. Failure by employers to follow FCRA guidelines can result in hefty penalties.

Doren Martin, Board Member, The Latino Commission

UFCW
Western States Council
a VOICE for working California

United Food & Commercial Workers Union
James Araby, Executive Director · William Lathrop, President · Ronal Lind, Secretary-Treasurer · Rick Eiden, Recorder

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February 15, 2013

Peter Lee, Executive Director
Ken Wood, Senior Advisor for Products, Marketing and Health Plan Relationships
Thien Lam, Deputy Director, Eligibility and Enrollment

California Health Benefits Exchange
560 J St., Ste. 200
Sacramento, CA 95814

Re: Exchange Partnerships with Retail Stores

Dear Mr. Lee, Mr. Wood and Ms. Lam,

The Western States Council of the United Food and Commercial Workers strongly opposes the proposal for the California Health Benefits Exchange to partner with retail stores as assisters and locations for outreach.

Our union represents the workers in retail stores in California and elsewhere in the country: we are proud to have done so for many years. We are disappointed that the staff of the California Health Benefits Exchange has been in conversation with management of retail stores without reaching out to us as the representatives of the workers in these stores. The first we knew of the possibility of the Exchange working with retail stores was when the materials for the January 17, 2013 meeting were posted after 3PM on January 16, 2013.

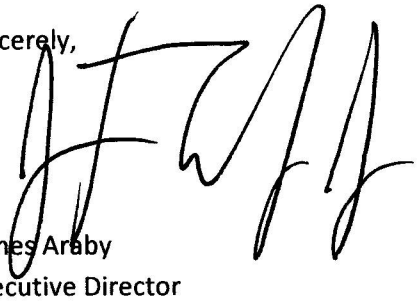
We oppose the compensation of retail stores as assisters. In our view, these large, for-profit enterprises will benefit from health reform in much the same manner as health insurers, hospitals or other providers. This is especially true of those retail stores that offer pharmacy or optical services: consumers with health insurance will be better able to afford prescription drugs and eye glasses when these are covered benefits. The same questions of conflict of interest and steering of consumers arise in the retail context that arises in the context of a hospital or other provider steering consumers to a particular carrier or a specific product whether or not that carrier and that product is the best fit for a consumer. The Exchange does not propose to permit insurance agents, hospitals, insurers, or other providers to be paid assisters: the same standards should apply to retail stores.

Our union provides good health benefits to our members and our members value those benefits. We are appalled and offended that the Exchange would contemplate partnering with retail stores notorious for failing to provide health benefits to many of their workers and providing substandard benefits to the workers who do qualify for benefits. Some of these retailers are already redesigning work hours in order to evade the employer responsibility requirements of the Affordable Care Act. One of these retailers has informed investors that the health benefit it provides meets a minimum

value of 60%, exposing its minimum wage workers to 40% of costs of health care. ASPE found that 94% of American employers provide benefits with a minimum value of 80% or better. Co-branding would allow retailers to take credit for providing health benefits to consumers and presumably their own workers while shifting the cost of health benefits from the employer to the taxpayer.

The United Food and Commercial Workers Western States Council asks that the Exchange adopt a policy that it will contract with or employ as assister entities only those entities that provide decent health benefits to their employees. We would look forward to working with the Exchange on developing such a standard.

Sincerely,



James Araby
Executive Director

From: paul white [mailto:paulw@vantagebss.com]
Sent: Thursday, February 07, 2013 4:47 PM
To: Info (HBEX)
Subject: Covered California

I listened to the webinar conducted 2/6/2013. One of the slides showed the Assister being required to have General Liability, Negligence, and Errors and Omissions Insurance. There are many carriers that offer this coverage. But, it is for licensed insurance brokers who are required to have this coverage in order to be appointed by insurance companies – health, personal, or commercial. In addition, the brokers have to compete 30 units of continuing education every 2 years to maintain their license to continue they appointment with the companies.

I am troubled that Covered California is going to allow individuals giving insurance advice after 2-3 days of training. Frankly, I think this is a recipe for misguidance. I am all for getting everyone insurance coverage, but Assisters negligence will fall back on Covered California-I hope you have insurance. Think about it, you are requiring a non-licensed lay person/entity to purchase professional insurance errors and omissions coverage. You are asking an insurance company to provide errors and omission for a retail store. And, you are requiring the retail store to pay probably $1,500 minimum premium to acquire the coverage, if they find a company to insured them. Plus this premium will probably be more than their regular business insurance cost. Imagine what the cost for a store with many Assisters. This is naïve.

Please reconsider/revamp your distribution plans. Know I am a strong support of your goals and I want the program to be success. If you like some suggestions, let me know.

At Your Service,

Paul L. White
Principal/CEO
Vantage Business Support & Insurance Services
2363 Mariner Square Drive, Suite 240
Alameda, CA 94501
Ph. 510-595-0904 Fax. 510-522-1906
CA. Lic #0A10086
paulw@vantagebss.com

All March Stakeholder Feedback	3/14/13 Webinar
Anonymous	Submitted
Blue Shield of California	Submitted
Californians for Safety and Justice	Submitted
Farmers Insurance Agent	Submitted
Health Services Agency, County of Santa Cruz	Submitted
J.S. Tucker Insurance	Submitted
Kevin Knauss	Submitted
Licensed Agent	Submitted
Motion Picture and Television Fund	Submitted
Private Patient Advocate	Submitted
San Mateo County Health System	Submitted
Social Services Program Supervisor	Submitted
Unitus Insurance Services	Submitted

Covered California
In-Person Assisters Program comments
3/21/13

Payments to Assister Enrollment Entities (AEE)

- It is confusing trying to understand how Issuers will pay AEEs. In order for an Issuer to pay someone for enrollment, the California Insurance Code requires that the person/entity be a licensed agent/agency.
- If an In-Person Assister (IPA) is certified by Covered California and is affiliated with or employed by an AEE, for an Issuer to pay that AEE, the AEE needs to be a licensed Agent or Insurance Agency along with the corresponding individual producers (i.e. certified assisters) transacting insurance under the agency license.
- Has the Insurance Code been amended to allow Issuers to pay non-licensed agents (i.e. AEE and their certified IPAs)?

Large Group Employers

- Many large group employers will want onsite assistance to help enroll their employees who have an interest in Covered California.
- I don't see any plans for IPAs or AEEs to be able to facilitate enrollment for individuals who may be interested receiving information at the actual employer site. This is an ideal opportunity to reach many people during an Open Enrollment period.
- The majority of Large Group employers have 1/1 plan anniversary dates and therefore hold Open Enrollment meetings in October and November. That means, in Oct & Nov 2013, they will want assistance from people who can sit down at their business location during their Benefits Fair & Open Enrollment meetings to meet with the employees who have an interest in Covered California or who may be eligible for subsidies to enroll in Covered California. It seems like from your most recent presentation on 3/14/13, the only type of assistance that would be available for Large Group Employers is IPAs. Navigators would not yet be educated and certified and available to sit down at an employer site to help educate and enroll employees who want to participate in Covered California.
- For Large Employers, who want to help their employees choose the best option for the particular employee, the current IPA plans don't adequately provide the type of structure that would be needed to have an IPA force ready to assist large employers this upcoming October & November.

Training

- The training curriculum needs to include robust HIPAA Privacy and Security training since the IPAs will be handling Protected Health Information (PHI).
- It seems doubtful that a 2-3 day training can adequately cover the complexity of ACA, Covered California and HIPAA.

Liability Insurance

- It will be either impossible or cost prohibitive for AEE to obtain Liability and E&O insurance as an AEE.
- My first-hand experience has informed me that the Liability and E&O insurance marketplace does not know how to underwrite and insure anything other than a Life Agent or Health and Accident license. If certified AEEs employ or affiliate IPAs, and those individuals are not Agents

duly licensed, it will be impossible to find a carrier who can understand and affordably write a policy to cover the AEE and its employees. I don't even know if a Liability insurer will write a policy for someone who is "affiliated" with an AEE and not an "employee."

- As a licensed Life and Disability Insurance Analyst, a license type that has existed in California for approximately 50 years, I can tell you liability insurers do not know it exists or how to write a Liability policy or E&O insurance for that license type. I predict, with any new certificate class (i.e. AEEs) that may be able to transact insurance, it will be difficult, at best, to find a carrier who could write insurance for the new category. I recommend that Covered California explore which carriers might be willing to write such coverage and facilitate that relationship for all AEEs who will need the coverage.
- Similarly, in the current Life Agent and Accident and Health licensee marketplace, many carriers and industry trade associations offer a warm introduction to a carrier they have a relationship with to offer E&O coverage for the licensees who are able to transact business with the carrier or who are a member of the trade association.
- My experience in searching for E&O insurance as a Life and Disability Insurance Analyst was difficult and fraught with challenges. The first carrier, Avemco, incorrectly placed me into a policy for commissioned life insurance agents, even though I expressly told them I worked as a Life & Disability Insurance Analyst and, as such, was prohibited from accepting commissions and could only work on a consulting fee basis. The Avemco E&O policy cost me $884.00 annually. At the first renewal of my Avemco policy, I was non-renewed, because they realized they placed me in the wrong policy and did not have the ability to write me a policy for the manner in which I worked. Next, I found an E&O policy with National Union Fire Insurance Company of Pittsburgh, Pa which cost me $3,390 annually. It was a policy for Insurance Agents and Brokers Professional Liability, even though I again reiterated that I didn't work as an Agent because I did not accept commission, rather I worked as a Life and Disability Insurance Analyst and only accepted consulting fees. At renewal, I was non-renewed because National Union Fire decided to non-renew all of their Insurance Agents and Brokers Professional Liability Policies in the State of California. As I again started to look for a 3rd Liability carrier in 3 years, I could not find any admitted carriers and this presented a serious problem for me. Since I did work with public entities, I was required to have liability insurance with an admitted carrier. Finally, as an alternative to an admitted carrier, since none existed for me, I was told I could use a non-California admitted carrier but they had to have an A.M. Best rating of A-7. At this point, my only option was to go with Underwriters at Lloyds, London and the annual premium was $3,872.25. Obtaining E&O insurance for something other than a Life Agent license was very difficult and expensive. I fear that the same experience will be repeated when trying to obtain E&O insurance as an Assister Enrollment Entity, unless Covered California strikes a deal with an Insurance carrier in advance, for all the AEEs that will need liability coverage.

From: Brizendine, Verne [mailto:Verne.Brizendine@blueshieldca.com]
Sent: Friday, March 22, 2013 3:59 PM
To: Info (CoveredCA)
Subject: Comments on In-Person Assistance and Navigator Stakeholder Webinar March 14, 2013

Comments on In-Person Assistance and Navigator Stakeholder Webinar March 14, 2013

1. Regarding Kay Issue #4: Training

Master Trainer model is not recommended at this time as it does not guarantee that second generation trainees receive complete, consistent and accurate training. However we can further evaluate in Year 2.
First, it is unclear how this conclusion is reached. Second, there is a concern as to whether the state will have the capacity necessary to reach their training goal of 21,000 in Year 1. A Master Training program in Year 1 would significantly increase the bandwidth to reach this goal, in both rural and densely populated areas. Third, there is an issue as to whether there will be training monies in future years to establish to Master Trainer program. Why isn't a long-term sustainable training program rolled out from the beginning?
Finally, it is problematic to be relying on a computer-based training/certification program when the state estimates that 60% of assistors will be certified this way. Based upon our experience with the Master Training program, the majority of those CAAs that attended our Master Training classes in the last four years were already certified through the computer-based training, but could not successfully submit complete and accurate applications.
Regarding proper training of Year 1 assistors:
We would expect that all Trainers – including Master Trainers – would receive proper training and are skilled and qualified to train others. Covered California should be looking at what is in the best interest of sustainability of a qualified, trained Assistor program starting Year 1.
If the training vendor can train its employees to perform trainings, it can train Master Trainers to perform the same function – especially because there are already Master Trainers under the Healthy Families Program.

2. Regarding Key Issue #6: Compensation

The state has not made a clear list of what a "provider" is. Are dentists or vision providers eligible to be compensated? It is unclear as to why Community Clinics and County Health Departments that provide health care services to consumers are both eligible for compensation. Community Clinics are not necessarily not-for-profit. How can a retail store with a pharmacy be considered a provider and therefore uncompensated while a Community Clinic or CHD clinic that directly provides healthcare services (and in some cases, dispenses prescription drugs onsite as well) *not* be considered a provider and receive compensation?
The chart on page 24 does not match the chart on pages 35 and 36 in regards to "providers".

3. Regarding Interested Entities

It is concerning that there is no interest to date from entities covering approximately 600,000 eligibles. This is another reason that a Master Training program and allowing health plan staff to assist uncompensated, are essential to reach these populations, is essential to reach this large population and keep a "no wrong door" policy.

4. Health Plans as uncompensated assistors

Although not discussed in this slide deck, a determination must be made quickly as to whether to allow health plan staff to serve as uncompensated assistors in order to reach hard-to-reach populations and prevent the creation of a “wrong door”. Time is of the essence in order for health plans to make training plans.

Thank you for allowing us to provide comments.

Verne Brizendine
Director of State Programs
Blue Shield of California
6300 Canoga Ave
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818 228-2642
verne.brizendine@blueshieldca.com

From: Jenny Montoya Tansey [mailto:jenny@safeandjust.org]
Sent: Thursday, March 14, 2013 2:57 PM
To: Eligibility
Subject: webinar question

Hi there,

Thanks very much for putting together such an informative webinar this afternoon. I work for a new statewide organization called Californians for Safety and Justice. Part of what we do is provide direct support to counties to improve public safety and reduce costs in the justice system through health-based strategies like enrolling people in health care and connecting people to treatment.

You all didn't get a chance to respond to the question I submitted during the webinar, so I wanted to pose it again here. My question is: will county sheriffs or probation departments be eligible to become enrollment assistance entities?

Approximately 90% of people in jail and 75% of people on probation are uninsured, and many will be eligible for health plans on Covered California (as well as Medi-Cal.) If public safety agencies could access funds to help with costs, the justice system would be a fruitful site for enrollment. In addition, probation, in particular, also does a lot of vocational education and job placement. Training and certifying people on probation to enroll their communities in health plans could be a great way to connect people with employment when they are transitioning out of the justice system.

I am drafting a piece on the assisters program for the probation chiefs' association and the sheriff's association. If you could let me know whether they will be eligible to apply themselves, or whether they will need to partner with a community organization to apply, that would be most helpful.

Thanks very much,

Jenny

--
Jenny Montoya Tansey
Research and Information Director
Californians for Safety and Justice
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From: Michele Been [mailto:michele.gbeen@farmersagency.com]
Sent: Friday, March 15, 2013 2:10 PM
To: Eligibility
Subject: Covered California Assistors Webinar

Thank you for providing a very informative overview and time line for Covered California Exchange Insurance Plans. I am a fully licensed Property and Casualty and Life and Health Agent from California and plan on becoming certified with Covered California so I can provide the professional counseling to our community to make the best choice for their health care protection with Covered California or the traditional market. I have a couple of questions and suggestions. Will the Certified Insurance Agent with Covered California be required to align themselves with the Assister Enrollment Entity or will the agent be able to assist our prospective members from our insurance office? I would recommend considering individual insurance offices for certified agents as enrollment entities. I understand the agent will receive commission from the insurance plan for the Covered California enrollees. Please consider allowing the agents to hire trained assisters and receive compensation so the assisters and professional agents can partner in providing the highest level of professionalism and competency to our citizens. Most lay people do no have an understanding of health insurance terminology. Agents have a moral,legal and ethical obligation to provide competent service to our prospective clients. How will certified agents be notified of prospective client who may be eligible for the Covered California? Our agency has an website and we would be interested in partnering with Covered California to offer the exchange plans. More people are going to the Internet to search for their health insurance coverage. I look forward to hearing back from you.

Michele Been Life & Health Specialist License #0E96223

Office of Gary Been
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FARMERS

From: Maria Love [mailto:mlove@health.co.santa-cruz.ca.us]
Sent: Thursday, March 14, 2013 2:36 PM
To: Eligibility
Subject: Additional Questions

Covered California Staff,

There are a couple of follow up questions in regards to the webinar which just ended related to the Assistor and Navigator program that I am hoping someone from the staff could answer.

1. Will there be a Navigator Program webinar soon? If so when?
2. Because the Assistor program application and trainings will happen much sooner than the Navigator program application is released, can you let me know if becoming an assistor entity and having staff trained as assistors preclude you from applying for the Navigator grant? Or can an agency have both Assisters and Navigators in their staff?

Thank you

Maria Love, MPP | Healthcare Outreach Coalition Program Manager
Departmental Administrative Analyst
Health Services Agency, County of Santa Cruz
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(831)454-5431 (*Office)*
(831)454-4488 *(Fax)*

From: Kelley Irish [mailto:Kelley@jstuckerins.com]
Sent: Thursday, March 14, 2013 2:51 PM
To: Eligibility
Cc: Scott Tucker
Subject: Concerns/suggestions

I submitted these questions today via the Assisters webinar but would like to submit through this venue also for consideration:

- Will Assister entities or retailers be required to display the Certificates of their In-Person Assisters?
- Will these same entities be required to display their renewed In-Person Assister Certificates each year?

*My concern is that the public will not know otherwise, if an Assister is qualified and sufficiently trained.

- Can the public look up an Assister online to verify a current Certificate like they can through the DOI for licensed Agents right now?
- Will Agents be able to direct the public to their websites with a link to apply online and receive the credit?
- Will there be verbiage on the application requiring an Assister to sign that he/she has fully explained the plans to the Applicant, without bias and in a language that the applicant understands?
- Will a translator be required to sign if assisting the applicant?
- How will Agents know when they can submit Interest forms like Assisters are doing right now?

Thank you.

Kelley Irish, REBC
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From: Kevin Knauss [mailto:kevin@insuremekevin.com]
Sent: Thursday, March 14, 2013 3:04 PM
To: Eligibility
Subject: Assisters 2nd webinar

Nice overview of the progress on the Assister program.

You may have covered this in the first presentation, but I wanted to throw it out.

I would strongly encourage CoveredCA to prohibit Assister Entities, Assisters or Navigators from cross selling other insurance lines when meeting with someone to enroll them in either the Medi-Cal program or CoveredCA.

As you maybe aware, Medicare as strict rules on what an insurance agent can discuss with presenting information about tax payer subsidized Medicare Advantage health plans and Medicare Advantage Part D Prescription drug plans. This has developed over years of insurance agents using Medicare Advantage plans as a means to get their foot in the door to sell other insurance products.

While folks eligible for CoveredCA will be under 65, there may still be language and educational barriers that make them vulnerable to a hard cross sell pitch.

The only types of insurance that should be discussed during a one-on-one visit or in a group setting should be the insurance offered through CoveredCA: health, dental and vision. Agents authorized to sell other lines should be prohibited from talking about those lines or using their other lines to confuse the individual.

Other insurance lines prohibited would include, but not limited to:
Life
Accident
Hospital indemnity
Car
Home
Annuities

Call me a cynic, but I can see insurance agencies signing up to be Assister Entities, Assisters and Navigators as a means to pitch their other products. I can already see the marketing pitch "The CoveredCA plan is great, but what about an AFLAC plan to help cover the deductible?" or "Instead of buying the pricey Platinum Plan, get the less expensive bronze and buy hospital indemnity insurance to cover the deductible." or "Now that you have health insurance, don't you want to protect your family if you die?"

The financial incentive for the CoveredCA plan is negligible compared to the compensation the agent or agency would receive from the more lucrative indemnity plans or other lines of insurance.

Don't let the insurance guys game CoveredCA and turn it into a marketing tool to reach prospective clients for their other lines.

Thank you

Kevin Knauss
Walking with you | side by side | from start to finish.

From: Tim Rogan [mailto:timroganca@live.com]
Sent: Thursday, March 14, 2013 3:42 PM
To: Info (HBEX)
Subject: assisters webinair comments of March 14, 2014 1-2:30pm

Dear sir or madam,

I am a licensed life and health agent that specializes in small group health and individuals in the San Joaquin County (and neighboring areas). I would like to receive additional information on the assisters program and to be sent an application when available.

I have several businesses and non profits that have employees that make more money than is necessary to qualify for Medi Cal but need the health benefits. Possibly some of these individuals could qualify for Medi Cal but I am not trained in this area and generally recommend that they seek information from the County social services department.

My comments:

Background checks and fingerprinting. Exactly what threshold does the plan allow to become an assister? If you are convicted of a felony or a misdemeanor will this prevent you from assisting the person? Obviously we are trying to provide the same information and prevent fraud. I would suggest that the application fee that was mentioned be paid over 12 installments rather than at once. This would at least slow the fraud from filling out the names of the phone book and sending them to the state. While as an agent I cannot get these fees, I can work under an entity such as the Chamber of Commerce and be compensated under their agreement. Plus I could get compensation from the insurance company in the form of commissions.

If a person who qualifies for SSI or Medi Cal (welfare), and they decide on a company based plan, would the agent be compensated for this account? If so, then the assisters payment is not necessary but if no payment is made, then you might want to consider payment to the agent for the work rendered.

I am currently licensed for medicare supplemental plans. The web based training program is not a walk in the park and requires annual reading and refreshing of the rules governing supplemental retirement medical plans. The AHIP training is pretty rigorous yet allows for a comprehensive knowledge of the plans available to the consumer. Even with the training, we see a variety of information guiding people regarding plans.

Last, while the $58 first time and $25 renewal sounds fine, it sends the wrong message. I would have not given anything on the application but more to grants for general education.

I look forward to your future webinair broadcasts. If you need assistance in making a training program or need test subjects on the content, please include me on your meetings. I would

have a $100 fee for the training but if you submit 10 applications, the fee is refunded to you. If you do not pay for the education, you do not learn the information. Free education equals no comprehension.

Good luck with the program. It is needed in our community.

Sincerely yours,

Timothy A. Rogan
Ca license 0D72852

Re: Covered California Assisters Program

Dear Mr. Lee,

The Motion Picture and Television Fund ("MPTF") is a 91 year young California non-profit, public benefit corporation that offers safety net health and social services to entertainment industry workers. MPTF appreciates this opportunity to provide the California Health Benefits Exchange ("Covered California") with its feedback on the planned Assisters Program.

MPTF would appreciate additional information on the rules applicable to uncompensated Assister Enrollment Entities and individual Assisters. Based on the information presented at the February 7, 2013 webinar (slide 27), an Assister Enrollment Entity and affiliated Assisters would be prohibited from accepting "any consideration directly or indirectly, in cash or in-kind, from a health issuer as compensation or inducement for enrolling qualified individuals or employees into qualified or non-qualified health coverage." On the other hand, Covered California staff emphasized in the March 14, 2013 webinar that insurance agents and brokers serving as uncompensated assisters (i.e., uncompensated by Covered California) could nonetheless receive compensation from health plans for enrollment activities. MPTF recommends that Covered California consider revising the draft code of conduct to limit the prohibition on compensation of assisters by plans to only apply to assisters that are not otherwise compensated by Covered California.

Kindest regards,

Sharon Siefert
Vice President, Legal Affairs
Legal Affairs Department
MPTF
MOTION PICTURE & TELEVISION FUND
23388 Mulholland Drive
Woodland Hills, CA 91364
(818) 876-1775

From: Linda Carpenter [mailto:linda@mojo-navigator.com]
Sent: Friday, March 22, 2013 12:50 PM
To: Eligibility (CoveredCA)
Subject: RE: comments after 3/21 Board mtg

I have some comments/questions after reading Thien Lam's 3/21 powerpoint slides on the Assister Program Update, that were not discussed at yesterday's CoveredCA Board meeting.

I continue to see barriers to CoveredCAs problem of training a healthy-sized "army" of "boots-on-the-ground" IPAs to fan out over our state & provide in-person information about & enrollment in the plans offered through our Exchange, not just to our most-vulnerable populations, but also to those populations which will become the primary funding apparatus for the subsidies/tax credits provided to those most-vulnerable individuals. If we dedicate a too-high proportion of our IPA-training/certifying efforts at targeting the most vulnerable & at-risk in our state, without dedicating a proportional amount of our efforts at making sure there are adequate numbers of qualified, certified IPAs to assist employers/employees, both in SHOP and in the individual program, who will be transitioning from/out of the pre-2014 health insurance environment, and who request in-person help from a non-agent, then we will have a problem that may worsen exponentially by 2016.

The main barrier I see is the one having to do with having an affiliation with an AEE. Presented in the 3/14 Assisters webinar was a slide that stated that: (1) IPAs will be "**employed**, trained, certified, & linked" to AEEs; (2) it will be up to the AEE to decide whether an individual will become affiliated with them; and (3) an individual must be affiliated with an AEE in order to begin the IPA certification process.

During the post-webinar discussion, it was stated that the relationships between AEEs & IPAs "will in many cases **look like** an employer-employee relationship", which leads me to conclude that I may be able to become CoveredCA-certified as an IPA, if I first become affiliated with (not necessarily employed by) an AEE.

Question: If I am not employed by an AEE, but I have a relationship with one that "looks like" an employer-employee relationship, what exactly would that relationship be?
Possible answer: An AEE/IPA relationship that does not involve employment, must be one in which there is an appropriate level of vetting and oversight of the IPA by the AEE. I don't know what that vetting and oversight would look like, just that it needs to be. Also, the problem of liability insurance for AEE/IPA relationships outside of employment presents itself.

Currently, I am pursuing a possible affiliation with one of the grantee organizations that filed a letter of intent to become an AEE, one that also happens to have on its staff one of the members of the advisory committee for Marketing & Outreach. However, they already have staff who will be the ones to provide enrollment assistance to their target population (one that is characterized as vulnerable/at-risk). This organization does not need to affiliate with someone in their community, like me, who intends to provide enrollment information for employees/employers. If I were to pursue an affiliation with a licensed agent, there is no incentive for them to affiliate with me, as I would be providing 100% unbiased-toward-any-particular-insurance-company information to people who they would prefer to remain/become policyholders within their

company. No matter what agents may tell you about their capacity to be nonbiased, it is unreasonable to expect them to not provide information in ways that will enhance their income stream. This is just a fact-of-life.

I realize that this barrier may not have been anticipated by CoveredCA, while designing safeguards to make sure that all IPAs are vetted & qualified to do this work.

I will continue to try to convince the potential grantee in my community to establish an affiliation with me, and I hope to speak with them again about what that affiliation may look like, but from their perspective, I am unable to see why they would do this. So, effectively, the AEE affiliation requirement, as it stands at this moment in time, poses a barrier to those potential IPAs, like myself, who want to provide information to & enroll people who are not necessarily in the most-vulnerable target populations, outside of the licensed agent community.

Thank-you. I hope to see this barrier addressed in time for me to position myself to become CoveredCA-certified in the first wave of IPA trainings. I have already established a relationship (outside of employment) with a private firm that provides essential services to employers statewide, and that wants to have people under its umbrella who are NOT licensed agents and who are authorized to provide in-person information about CoveredCA alongside or instead of that being provided by agents. This firm, however, does not see itself as a CoveredCA grantee. It will be assisting its clients to transition into the new CoveredCA environment on its own, without grant assistance, and wants to be able to affiliate with me as a certified IPA.

Linda Carpenter
Healthcare Navigator
Private Patient Advocate
Northern California Healthcare Navigators
707-478-2103

From: Srija Srinivasan [mailto:ssrinivasan@smcgov.org]
Sent: Monday, March 25, 2013 3:32 PM
To: Eligibility (CoveredCA)
Subject: Feedback on Assisters Program

Hello Thien/Covered California Colleagues:

I provided some feedback after our Outreach and Education Advisory Group meeting on February 28th and wanted to again reiterate my concern that Covered California not over-estimate the Assister capacity that will be available based on the Assister interest form and tabulation of interest among potential Assistor entities. For many of these entities, they may have several individuals prepared to perform Assistor roles but the proportion of time of these staff available for Covered California in-person Assistance may be much less than 100% of the time of such staff. For Assister entities that have strong ties to the healthcare safety net and the needs of the lowest-income, uninsured Californians, in-person assistance for enrollment in Medi-Cal will be the highest priority. It is not clear how much capacity will remain to provide in-person Assistance to Covered California-eligible consumers.

I hope that Covered California will continue to consider any strategies that make Covered California enrollment an "easy-as-possible" add-on to work that is targeting Medi-cal eligible residents across the State.

Should you have any questions or wish to discuss this further, please let me know.

thank you and regards for all that you are doing to advance the important work in this arena.
Srija

PLEASE NOTE: My email address has changed to ssrinivasan@smcgov.org. Please add this new address as a trusted site to ensure that spam filtering software doesn't prevent the delivery of emails.

Srija Srinivasan
Director of Strategic Operations
San Mateo County Health System
225 37th Ave. Room 178.8
San Mateo, CA 94403
650.573.2095

Good Afternoon
I participated in the Assistors Program: In Person Assistance and Navigator Stakeholder webinar this afternoon, a lot of good information was shared. I submitted a question through the panel on the right hand side of my screen. I chose to use the type my question rather than raise my hand and the question was not addressed so I just want to make sure it has been received.

Will individual counties who will have eligibility workers assist client's with their enrollment into a health care plan be required to submit an interest application to be an assistor? Also will current county staff have to be certified to become an assistor and will they have to undergo the fingerprint and background check?

Thank you and look forward to hearing a response.

Angie De Los Santos, EBFF
Social Services Program Supervisor
Program Integrity - Quality Assurance
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email: adelossantos@co.fresno.ca.us

From: unitushealth@verizon.net [mailto:unitushealth@verizon.net]
Sent: Thursday, March 14, 2013 2:18 PM
To: Eligibility
Subject: Question

Covered CA,

I understand that a licensed agent cannot receive an enrollment fee because they are paid by commission. As a licensed agent with a large book of business that I need to service during open enrollment, once I determine if my client should enroll through Covered California can I be the broker of record AND then turn them over to an assister open enrollment entity to complete the enrollment into Covered California to speed up my servicing of my clients?

thank-you

Jim Warner
Unitus Insurance Services
39823 Payton Court
Murrieta CA 92563
License #0F35740
951-813-6536

March 29, 2013

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

RE: CCHI and Children Now Comments on Initial Eligibility & Enrollment Policy Recommendations and Assister Program Update from March 21, 2013 Board Meeting

Dear Mr. Lee,

California Coverage & Health Initiatives and Children Now write to provide input to Covered California on both the Initial Eligibility & Enrollment Policy Recommendations and the Assister Program Update presented at the March 21, 2013 board meeting. We appreciate the opportunity to provide this input. CCHI's network of children's and community health initiatives and partner outreach organizations is present in 54 of California's 58 counties doing on-the-ground outreach and enrollment for Californians into health coverage. We hope the experience of the children's coverage coalition's experience over the past decade plus enrolling California's children and families can be of help in ensuring the success of Covered California's enrollment efforts.

Comments on Initial Eligibility & Enrollment Policy Recommendations

Periodic Data Matching Process

We are in support of the staff recommendation related to the "periodic data matching process" and the option proposed to extend periodic data matching to include household income. Helping consumers understand and navigate the implications of the advance premium tax credits (APTC) on household finances will be one of the biggest challenges Covered California and Assisters face in educating consumers and getting them enrolled in coverage. A change in household income (or tax filing status) can have very significant ramifications for consumers and is rife with opportunity to create confusion among consumers and possibly generate frustration in Covered California's target populations. Covered California and all Assisters should take every opportunity to educate eligible populations about the link between household income (and tax filing status), eligibility for the APTC, year end reconciliation, and the considerable fiscal and eligibility ramifications for consumers. The staff proposal to match household income data on at least a semi-annual basis and use the opportunity to inform consumers of the new income information and

projected eligibility will be an important step in helping educate consumers about this complicated but important issue.

Self-Reporting of Changes

For similar reasons, we support the staff recommendation to require consumers to report a change of income that might result in a change in the amount of the APTC or cost sharing reduction. Covered California and its partner Department of Health Care Services (DHCS) will best serve the public by promoting full information to consumers about the complete range of programs and options available to them and clear information about the next steps consumers should take to ensure continued coverage. CCHI and CN recommend that when consumers voluntarily report a change in income as proposed in the staff recommendation, a notification to the consumer be automatically generated containing information about any potential eligibility changes and the next steps consumers must take to ensure continuation of coverage.

Authorized Representative Process

The staff recommendation proposes to expand the federal requirements for a consumer designated Authorized Representative to give Covered California the flexibility to allow consumers to designate a more limited role for the Authorized Representative. This recommendation is reasonable and provides consumers with greater choice in how to involve others in their sensitive health coverage enrollment process while providing greater flexibility in maintaining the privacy of their personal information.

We also note that the staff recommendation does not address the interplay or overlap between the Authorized Representative Process and what access Certified Assisters will have to these enrollment and retention processes by virtue of their role as Assisters. Will consumers need to fill out an authorization form allowing an Assister access to some or all of their information? If so, will this authorization be similar or overlapping with the Authorized Representative Process outlined in the staff recommendation? We look forward to further clarity on the interactions between the Authorized Representative Process and Assister authorizations.

Appeals Process

With respect to appeals of eligibility determinations or APTC levels, CCHI recommends that if an appeal is resolved in favor of the consumer, the eligibility determination or correct amount of APTC should be retroactive. In other words, the consumer should be entitled to coverage or the correct APTC amount retroactive to the date of the original application.

Comments on Assister Update and Recommendations

Reducing Barriers to Broad Participation by Assister Entities

Success of the endeavor Covered California has taken on, and to some extent even the success of health reform nationally, hinges on Covered California meeting or exceeding the aggressive enrollment targets it has set out for itself. Thus, Covered California is powerfully motivated to encourage broad participation by vast numbers of Assisters and Assister Entities (both paid and unpaid) to engage in this process with as

much organizational capacity as they can muster. As Covered California has in the last six months rapidly rolled out policy decisions related to the Assister program(s), CCHI and its member organizations have become increasingly concerned that the Assister program(s) are being burdened with costs, bureaucratic barriers, and impediments to the broad participation Covered California is envisioning. With each additional requirement, complexity, or cost imposed on participating Assister organizations (whether paid or unpaid), Covered California will potentially discourage groups from engaging as its partner.

To the extent that Covered California hopes to build on the successful Certified Application Assister (CAA) infrastructure embedded in some of California's lowest income communities, many of the entities and individuals with the potential to assist Covered California target customers will also be providing in-person assistance for enrollment into Medi-Cal. As you can appreciate, the proportion of time devoted by these entities and individuals to Covered California responsibilities will be influenced by the relative costs and burdens of the Covered California Assistor program. This is especially relevant to the small community-based groups, faith-based organizations, community resource centers, health centers, etc. who hold the trust of California's uninsured. It is these small, trusted community organizations who are most likely to be discouraged by additional requirements, costs and complexity.

We offer as one example of the types of barriers that would keep such organizations from participating the extreme length and complexity of the Request for Proposal process for the Education and Outreach grant program. Many potential grantees with excellent local relationships and deep trust in communities and others with potentially useful statewide infrastructure declined to respond to the RFP due to the extent of detail and corresponding staff burden to complete the RFP and the proposal process, as well as the monthly reporting requirements. Many who did apply can attest to the vast amount of administrative and staff time and funding it took to respond. In the spirit of working together to ensure the success of health reform in California, we look forward to working with Covered California to find ways to minimize barriers to engagement and develop Assister policies that actively encourage participation.

Insurance Requirements for Assister Entities

In the presentation made available to the Covered California board in the materials for the March 21, 2013 meeting, Key Issue #1 addresses proposed insurance requirements for Assister entities. The recommendation reiterates the earlier recommendation to require Assister entities to hold general liability, auto and workers compensation insurance. This recommendation is reasonable and will support a strong Assister program. However, the proposal also reiterates the recommendation that Assister entities be required to hold errors and omissions insurance "if allowed by federal regulations." We continue to be quite concerned about this requirement and the very significant cost and institutional barriers this will pose for small community-based organizations and their willingness to partner in either a paid or unpaid capacity with Covered California.

We continue to believe that such a requirement is contrary to the spirit, if not the word, of the federal regulations and Secretary Sebelius' own words in a letter to Representative Kinzinger, dated July 11, 2012. The preamble to Section 155.210 (Federal Register, Vol. 77, No. 59, 18331) clearly prohibited state exchanges from requiring Navigators from carrying E & O insurance (this rule was promulgated prior to the development of the In-Person Assister and Certified Application Counselor concepts). "[W]e clarify that

States or Exchanges are prohibited from adopting such a standard, including errors and omissions coverage." Secretary Sebelius makes this point in her letter through the following language: ". . . requiring errors and omission coverage may serve as a significant barrier to entry for entities that may otherwise be well-qualified." We again urge Covered California to find a balance that protects consumers without putting unnecessary and prohibitive burdens on Assister entities.

Thank you for the opportunity to comment on these important policy issues. If you would like to discuss these matters further, please contact Suzie Shupe, Executive Director, California Coverage & Health Initiatives at sshupe@cchi4families.org or 707-527-9213.

Sincerely,

Suzie Shupe
Executive Director
CCHI

Ted Lempert
President
Children Now

Assisters Program Comment Received via E-mail

Subject: Comment on In-Person Assistance and Navigator Stakeholder Webinar March 14, 2013

1. Regarding Kay Issue #4: Training

Master Trainer model is not recommended at this time as it does not guarantee that second generation trainees receive complete, consistent and accurate training. However we can further evaluate in Year 2.
First, it is unclear how this conclusion is reached. Second, there is a concern as to whether the state will have the capacity necessary to reach their training goal of 21,000 in Year 1. A Master Training program in Year 1 would significantly increase the bandwidth to reach this goal, in both rural and densely populated areas. Third, there is an issue as to whether there will be training monies in future years to establish to Master Trainer program. Why isn't a long-term sustainable training program rolled out from the beginning?
Finally, it is problematic to be relying on a computer-based training/certification program when the state estimates that 60% of assistors will be certified this way. Based upon our experience with the Master Training program, the majority of those CAAs that attended our Master Training classes in the last four years were already certified through the computer-based training, but could not successfully submit complete and accurate applications.
Regarding proper training of Year 1 assistors:
We would expect that all Trainers – including Master Trainers – would receive proper training and are skilled and qualified to train others. Covered California should be looking at what is in the best interest of sustainability of a qualified, trained Assistor program starting Year 1.
If the training vendor can train its employees to perform trainings, it can train Master Trainers to perform the same function – especially because there are already Master Trainers under the Healthy Families Program.

2. Regarding Key Issue #6: Compensation

The state has not made a clear list of what a "provider" is. Are dentists or vision providers eligible to be compensated? It is unclear as to why Community Clinics and County Health Departments that provide health care services to consumers are both eligible for compensation. Community Clinics are not necessarily not-for-profit. How can a retail store with a pharmacy be considered a provider and therefore uncompensated while a Community Clinic or CHD clinic that directly provides healthcare services (and in some cases, dispenses prescription drugs onsite as well) *not* be considered a provider and receive compensation?
The chart on page 24 does not match the chart on pages 35 and 36 in regards to "providers".

3. Regarding Interested Entities

It is concerning that there is no interest to date from entities covering approximately 600,000 eligibles. This is another reason that a Master Training program and allowing health plan staff to assist uncompensated, are essential to reach these populations, is essential to reach this large population and keep a "no wrong door" policy.

(Continued on next page)

4. Health Plans as uncompensated assistors

Although not discussed in this slide deck, a determination must be made quickly as to whether to allow health plan staff to serve as uncompensated assistors in order to reach hard-to-reach populations and prevent the creation of a “wrong door”. Time is of the essence in order for health plans to make training plans.

Thank you for allowing us to provide comments.

Verne Brizendine
Director of State Programs
Blue Shield of California
6300 Canoga Ave
Woodland Hills, CA 91367
818 228-2642
verne.brizendine@blueshieldca.com

ALLIANCE FOR
Boys and Men of Color

Invest in the Health and Success
of California's Future

April 19, 2013

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

Re: Support for Greenlining and NELP's Recommendations for Covered California's Criminal Record Check

Dear Mr. Lee:

As partners and supporters of the Alliance for Boys and Men of Color, we write regarding the progress made on the emergency statute and draft regulations on criminal record checks for Covered California. Because background checks tend to create unfair biases against people of color, African American and Latino men in particular, we are completely committed to creating a policy that promotes equity and diversity rather than discriminating, inadvertently or otherwise, against workers of color, while also protecting consumers.

We appreciate the efforts of your staff to work with stakeholders, namely The Greenlining Institute (Greenlining) and the National Employment Law Project (NELP). This collaborative effort has made a huge difference in advancing a more reasonable policy. We have complete confidence in the expertise of our partners and their recommendations including, but not limited to, the following:

- Applying best practices established by the Department of Justice and other experts.
- Including language that helps ensure that disqualifying offenses are substantially related to the position in question.
- Excluding crimes of moral turpitude as the standard for determining which offenses will disqualify an applicant.
- Providing potentially disqualified workers with a copy of the record and notification of the reasons for disqualification.
- Ensuring there is an appeals process that provides potentially disqualified workers an opportunity to correct any error on their records.
- Ensuring there is a process that provides potentially disqualified workers an opportunity to provide evidence of special circumstances surrounding a potentially disqualifying offense and efforts to rehabilitate.
- Including a grandfather clause for current employees of Covered California.

Covered California deserves a model policy that makes sense and does not discriminate against qualified workers. The BMoC Alliance supports what Greenlining and NELP have put forward and worked out with the Covered California staff. We look forward to seeing more progress.

Sincerely,

Ruben Lizardo on behalf of the Alliance for Boys and Men of Color and:

PolicyLink
Urban Strategies Council
Children's Defense Fund
Latino Coalition for a Healthy California
Liberty Hill Foundation
Community Coalition
California Pan-Ethnic Health Network
Brown Boi project
Young Men's Empowerment Program & Khmer Girls in Action

CC: Covered California Board Members
Diane Stanton, External Relations
David Panush, Director, Government Relations

***CalHEERS* Comment Received via E-mail**

Subject: CalHEERS Webinar

Great webinar on the progress of the Covered Ca web portal.

Not to overload you with suggestions for the smart sort features, but as an independent health agent, I get asked specific questions on what people are looking for. Some of these might be applicable to the sort features as folks have strong opinions around some of these items.

Type of Network
PPO or HMO: some people will not consider a HMO style plan at all.

Physician, Physician Group or Hospital network
People want to know that the plan they select will allow them to keep seeing their current personal of family physician. Selecting an insurance plan that doesn't include their current physician, which has happened, leads to a really unhappy member.

Standard or HSA: many people still don't know what an HSA is and have gotten stung when they opt for the less expensive HSA only to find out that no office visits are included at a set copayment.

Insurance company: While it is nice to see all the options, so people have had experiences with certain insurance companies, good and bad, and wish not to even consider insurance through a specific carrier.

Thank you.
Kevin Knauss
Walking with you | side by side | from start to finish.

My pledge to you:
1. I will respect your time and decisions.
2. I will not try to sell you something you do not want or need.
3. I will not call you after 5pm unless you ask me to.

Ph: 916-521-7216
kevin@insuremekevin.com
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KEVIN KNAUSS
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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-CaI. 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.

Other health care information

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
Beth Abbott, Health Access
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

April 3, 2013

Mr. Peter Lee, Director
Ms. Thien Lam, Deputy Director Eligibility and Enrollment
Mr. David Panush, Director of Government Relations
Covered California

Re: Proposed regulations governing eligibility and enrollment for the Individual Exchange

Dear Mr. Lee, Ms. Lam and Mr. Panush:

Thank you for the opportunity to review and comment on the Exchange's proposed eligibility and enrollment regulations for the Individual Exchange (Covered California) dated March 21, 2013. On behalf of the undersigned, we submit these group comments, which are attached.

While we have a number of comments to the draft proposed regulations, we wanted to call to your attention two areas that we believe violate federal law:

- Requiring an applicant to pay premiums to the QHP before enrollment is effectuated (§6500(b)); and
- Allowing an insurer to assist with eligibility, which would give insurers private information about income and health status that should be kept out of the hands of insurers until after people are enrolled (§6500(g)).

In addition, there are a number of provisions that are of concern, including:

- Preventing someone eligible for traditional Medi-Cal from being enrolled in MAGI Medi-Cal and having Exchange emergency regulations govern Medi-Cal eligibility rules (§6486);
- Creating barriers for non-applicants, such as requiring them to provide SSNs; and
- Providing for electronic verification of residency instead of just relying on self-attestation (§6478).

We look forward to seeing a revised draft that addresses our comments and would welcome the opportunity to meet with you regarding these important regulations. We also note that several sections are marked as "reserved" and look forward to having the opportunity to review language in these areas as well.

Thank you for your consideration of our comments. For further information, contact Elizabeth Landsberg (916) 282-5118 or Julie Silas (415) 431-6747.

Sincerely,

Richard Konda, Asian Law Alliance
Doreena Wong, Asian Pacific American Legal Center
Cary Sanders, California Pan Ethnic Health Network
James Crouch, California Rural Indian Health Board
Deven McGraw, Center for Democracy & Technology
Michelle Stillwell-Parvensky, Childrens Defense Fund - California
Mike Odeh, Children Now
Kevin Aslanan, Coalition for California Welfare Rights Organizations
Sonya Vazquez, Community Health Councils, Inc.
Julie Silas, Consumers Union
Silvia Yee, Disability Rights, Education, and Defense Fund
Carla Saporta, Greenlining Institute
Beth Capell, Health Access
Lynn Kersey, Maternal and Child Health Access
Kim Lewis, National Health Law Program
Sonal Ambegaokar, National Immigration Law Center
Anne Donnelly, Project Inform
Beth Morrow, The Children's Partnership
Masen Davis, Transgender Law Center
Elizabeth Landsberg, Western Center on Law and Poverty

Consumer Advocate Comments on the Proposed Exchange Eligibility and Enrollment Regulations

April 3, 2013

Section and Issue	Comments
§ 6410. Definitions	The proposed definition of Authorized Representative requires designation in writing. This should be broadened to allow an online signature to be sufficient to designate an AR. We appreciate the definition of "reasonable compatibility" to state that information is compatible when the difference or discrepancy between applicant's attestation and the Exchange's records does not impact the eligibility of the applicant. The definition of CalHEERS should include a reference to California Welfare and Institutions Code §15926. Add to this section a definition for LEP that states, "Limited-English-Proficient (LEP) means a person who speaks English less than very well." The Definition of non-citizen is the same as the one in the proposed federal rule at § 155.300. Since HHS has not issued the final rule on definitions, we recommend California's regulations include reference to 155.300 in case there are any changes. Similarly, the definition of special enrollment period should include a citation to the federal definition. We recommend you add a definition of "TAX IDENTIFICATION NUMBER (TIN)" to include SSN, ITIN, ATIN.
§ 6452. Accessibility and Readability Standards	The readability level identified in (b) for the eligibility and enrollment system should be set no higher than a 6th grade level, not a 9th grade level as proposed. 6th grade is the level used by Medi-Cal and there will be many with low literacy levels applying for coverage and receiving notices. Overall, we are concerned that these regulations appear to confine the broader legal right to accommodations and accessibility to purely a matter of receiving information, and we want to make sure that they address reasonable accommodations and the operation of non-discrimination in the context of

	redeterminations, appeals, applicable timelines, etc. ALL of the Exchange's and QHPs' policies and procedures could be the subject of a request for a reasonable modification by a person with a disability or Limited-English-Proficiency if the policy or procedure constitutes a barrier for that individual. We recommend the following specific changes: (a) All applications, including <u>but not limited to</u> the single streamlined application described in Section 6470 of Article 5 of this chapter, forms, notices, <u>correspondence, outreach and education materials, appeals, redeterminations or applicable timelines</u> provided to the applicants and enrollees by the Exchange and QHP issuers shall conform to the standards outlined in paragraphs (b) and (c) of this section in accordance with 45 C.F.R. 155.205(c), 155.230, and 156.250. (c) should specify that "Information shall be provided to, <u>and collected</u> from, applicants and enrollees in a manner that is accessible and timely" since people will have to interact with the Exchange and QHPs and not just passively receive information. (c)(1) is overly narrow and tracks the language of federal disability rights laws only with respect to communication access. Moreover, it does not make sense to mention accessible web sites and then omit mention of section 508 of the Rehabilitation Act. Instead, we urge the following language: "Individuals with disabilities through the provision of r<u>easonable accommodations and policy modifications, including</u> auxiliary aids and services, at no cost to the individual, including accessible Web sites in accordance with the Americans with Disabilities Act <u>of 1990</u> and Sections 504 <u>and 508</u> of the Rehabilitation Act <u>and applicable provisions of state law</u>." (c)(2) Individuals who are Limited-English-Proficient through the provision of language services at no cost to the individual i<u>n accordance with Title VI of the Office of Civil Rights 1964 and all other relevant provisions of federal and state law.</u> (A) Oral interpretation <u>in any language</u> or written translations a<u>t a minimum in the Medi-Cal Managed Care threshold languages;</u> and (B) Taglines in <u>at least 15</u> non-English languages indicating the availability of language services. We believe subsection (c)(3) should refer to the services "described in paragraphs (**<u>c</u>**)(1) and (2) rather than (**b**)(1) and (2).

	We also urge that these accessibility and readability standards be monitored and enforced over time and that the regulations address the method of enforcement.
§ 6470. Application	We are concerned about (a) defining the "single streamlined application" to exclude non-MAGI. While federal law allows the state to create a "supplemental" or "alternative" form for those potentially eligible for non-MAGI Medi-Cal, we would prefer to have non-MAGI populations addressed in this provision as having their information collected and eligibility determined by the single, streamlined application and supplemented with additional information, as needed. Though this provision is about the Exchange determination since the Exchange will be doing a screen for non-MAGI Medi-Cal along with doing an assessment for MAGI Medi-Cal, that should be acknowledged here. We are concerned about codifying the penalty of perjury language in regulation. Any proposed language that describes what it means to sign something under the penalty of perjury should be evaluated for readability and tested with consumers. Moreover, the language as proposed is unclear - are applicants/enrollees required to notify of ***any*** changes or just changes that are relevant to eligibility? As it is currently drafted, applicants/enrollees have a legal obligation to report any changes, which could be quite onerous. Section (b) should be revised to allow partial applications to be submitted. As currently drafted, it requires applicants to submit "all" information required on a single, streamlined application. We understood that applicants will be able to fill out a partial application and get follow-up assistance, which would not be allowed under the proposed rules as drafted. Subsection (d) should add the following specifics about the channels for application: (2) Telephone <u>through the Exchange call center or an assister</u> (4) In person <u>at a county office or with an assister</u>
§ 6472. Eligibility Requirements for Enrollment in a QHP through the Exchange	In subsection (a), it does not work to say an applicant is an individual "seeking enrollment in a QHP." As Exchange staff has pointed out, consumers don't walk around with a sign that they are at 137% or 139% FPL. Anyone applying for subsidized coverage, whether they think they are eligible for Medi-Cal or an Exchange QHP should be considered an applicant. Subsection (c) refers to lawfully present eligibility. We recommend striking the phrase "is reasonably

	expected to be a" and "for the entire period for which enrollment is sought." This is the statutory definition but it is unnecessary as individuals with lawful status don't lose the status from month to month and also rarely from year to year. Any change in status can be reported as part of normal change reporting requirements or at annual redetermination. If lawfully present at time of application, the applicant should be provided continuous eligibility for that period unless there is information to the contrary from the beneficiary or from the Department of Homeland Security. NILC provided similar comments to HHS for the federal definition. Since HHS's proposed rule is the same, we recommend adding a cite to 45 CFR 155.305(a)(1) for this eligibility rule which may change when HHS's final rule comes out. Subsection (e) sets forth the residency requirements and appears to mirror the federal regulation at 45 CFR 155.305(a)(3). However, (e)(2), describing certain individuals under 21 for whom alternate requirements apply, omits the phrase "is not emancipated." We assume this is an oversight and request that it be added in.
§ 6474. Eligibility Requirements for APTC and CSR	We recognize that the language in 6474(c)(1) mirrors language in 45 CFR 155.305(f), but have some concerns about the use of the term "tax filer" instead of "applicant" in (c)(1)(A), wherein it states that the "tax filer" must have household income of 100%-400% to be eligible for APTC. With all the possible permutations of families and households, we believe that there are situations where the focus should be on the "applicant's" income, rather than the income of the tax filer's household. We believe the language here may warrant further clarification. Subsections (c)(2) and (c)(2)(C) provide that lawfully present immigrants may not be excluded from the Exchange if ineligible for Medi-Cal. Both provisions should be changed to "not eligible for <u>full-scope</u> Medi-Cal" because people can get "limited scope" Medi-Cal (i.e., emergency and pregnancy-related care). (c)(2)(B): revise 100% FPL to 138% FPL. Immigrants ineligible for Medicaid due to immigration status should be eligible for APTC if their income is below the Medi-Cal income rule of 138% FPL. The calculation for APTC starts at 100% FPL and so there is a special rule for immigrants whose income is below 100% FPL for actual calculation of the APTC. However, as this is the eligibility rule section, income of tax filer should be at 138% FPL or below. As drafted subsection (c)(5) requires the applicant to give the SSN of the non-applicant tax filer if the filer has an SSN and filed for the relevant tax year. Wouldn't the SSN of the applicant be sufficient to find the tax

	filer's SSN? The concern here is that making the applicant provide the SSN of the non- applicant filer could create barriers for many applicants, e.g. applicants who don't know what the SSN is, would experience significant delay in trying to get it, or who can't get the non-app filer's SSN, or for whom requesting it could be dangerous due to domestic violence, etc. If (c)(5) continues to request the non-applicant's SSN, there should be a requirement that the application filer be notified that his/her SSN will be used ONLY for purposes of income verification and cannot be shared for any other purposes other than eligibility determination. See 1411(g) of the ACA and WIC § 10850 (confidentiality).
§ 6476 Eligibility Determination Process	If subsection (a) is meant that an applicant may apply only for unsubsidized coverage in a QHP that is fine but should be more clearly stated and specifically say "unsubsidized" or something similar. If, on the other hand, this subsection is meant to say that an applicant can request an eligibility determination for a QHP and not for Medi-Cal, that is not permissible because people are only eligible for Exchange subsidies if they are not eligible for Medi-Cal. An applicant could conceivably decide after receiving an eligibility determination not to enroll in Medi-Cal, but they must have an eligibility determination for both Medi-Cal and APTC. We support subsection (b) which says that an application for an IAP should be deemed a request for all IAPs. This is important as most consumers will not know when they apply what they are eligible for. We also support in (c)(1) that an enrollee can accept less than the full amount of APTC. Applicants should be informed of this at the time of application and redetermination and we urge that this disclosure be included in the regulations. Subsection (d) governs transmittal of information when the Exchange makes a Medi-Cal or CHIP eligibility determination. We recommend several changes. First, this should include transmittal of potential eligibility for non-MAGI Medi-Cal in addition to MAGI Medi-Cal and CHIP since the application will have questions to screen for non-MAGI Medi-Cal. Second, those consumers determined eligible for MAGI Medi-Cal or CHIP through the Exchange should actually be enrolled in coverage and be able to choose and enroll into a plan and that information as well as the eligibility record should be transferred. Lastly, we seek

	clarification whether the information will actually be transferred to the counties or to MEDS. We recommend the following changes to the language: (d) If the Exchange determines an applicant eligible for MAGI Medi-Cal or CHIP,or potentially eligible for non-MAGI Medi-Cal, the Exchange shall enroll the applicant eligible for MAGI Medi-Cal or CHIP, as applicable and notify DHCS and the county and transmit all information from the records of the Exchange to DHCS and the county, promptly and without undue delay [placeholder for data/records transmittal timeline], that is necessary for DHCS to provide the applicant with coverage. In subsection (e) and other places where there are processing timeframes we recommend that the language read, "(e) An applicant's eligibility shall be granted in real time, meaning within minutes." In subsection (g), consistent with federal regulations, this should be a combined notice that advises about eligibility for all MAGI IAPs as well as potential eligibility for non-MAGI Medi-Cal. In terms of timeframe for the notice we urge that if issued electronically, the notices be issued realtime and if issued through regular mail, it be sent the same business day. Subsection (g) refers to provision of timely "*written* notice." We urge that there be a separate section of the regulations regarding notices and that consumers be able to select their preferred method(s) of communication, including being able to get communication through secure email, regular mail or both. We also hope CalHEERS will include the ability to send text reminders.
§ 6478 Verification Process Related to Eligibility Requirements for Enrollment in a QHP through the Exchange (b) verification of SSN (c) verification of citizenship or lawful presence (d) verification of	We recommend revising "any individual" to "applicant" in 6478(b)(1). SSNs should only be required and verified of APPLICANTS. Use of SSN for an application filer for income verification purposes should not be subject to the general verification of SSN as it's not being provided for any other purpose (such as ID). Also, verification of SSN as proposed by HHS in the recent proposed rule lacks sufficient due process protections so we recommend waiting until HHS issues the final rule on this before adding it to California's guidance. Subsection (c)(2) seems to assume that all lawfully present immigrants will have to present paper documentation which will then be verified with DHS. The ACA, however, permits verification using the immigrant's A number instead. Sub (c)(2) should be amended accordingly. Paper documentations should be required only if the A# verification process is not successful.

residency (e) verification of incarceration	We recommend revising (c)(2)to read as follows: "For an applicant who attests to being a non-citizen or national with lawful presence and for applicants attesting citizenship who cannot be verified through SSA, the Exchange shall request from the applicant only the information that is strictly necessary to verify status through DHS. Verification of status can be electronically done without requiring the applicant to provide paper documentation of status. Only the information strictly necessary to perform verification of status shall be transmitted by the Exchange to DHS. If the Exchange cannot verify status through SSA or DHS, the Exchange shall follow the inconsistencies procedures at Section 6492." We recommend adding a procedure in 6478(c) where citizenship status is verified by California vital statistics if the first match by SSA is unsuccessful and BEFORE going to inconsistency procedure at (c)(3). We recommend ensuring there is a procedure for obtaining paper documentation of citizenship/immigration status as part of verification procedure BEFORE getting to inconsistency procedures. There will be lawfully present immigrants who do not have an A# to provide but can provide documents at the time of application to document their status. The verification process should allow for that before moving to inconsistency procedure. In (c)(3) if an applicant provides proof of immigration status/attests to lawful presence and is in the inconsistency process, Section 1137d of the SSA and Ruiz v. Kizer as well as California Welfare and Institutions Code § 15926 (f)(6) require the applicant be aided (aid paid pending) during the reasonable opportunity period. This may need to work differently in terms of enrollment in the Exchange, but if there are medical bills between date of application and during the reasonable opportunity period for immigration status, there should be clarification about who will pay for those expenses. We support the acceptance of self-attestation for proof of residency, which is allowable under federal regulations. However, as written, the regulation is ambiguous in this regard. To make it clear, paragraph 6478(d)(1)(B) should be eliminated altogether, and the "or" after paragraph (d)(1)(A) should be deleted. Further, verification beyond attestation of residency should only be necessary if other information in the record is not reasonably compatible with the attestation, as set forth in (d)(2) and (d)(3). It would also help clarify if the same framing for the reference to 6492 were framed the same in all 3 subparagraphs of (d). We prefer the framing in (d)(3), i.e., "the inconsistencies procedures specified in section 6492."

	We support the portion of (d)(3) which states that evidence of immigration status may not be used to determine residency. These are two distinct criteria and it is important to clarify that immigration status information is not determinative of residency. We recommend making that a separate subsection to make it clear that it is not an eligibility requirement in determining residency. We recommend striking "evidence of immigration status" and revising requirement as follows: "Any evidence related to immigration status cannot be used to determine an applicant's residency consistent with 45 CFR 435.956(c)(2)."
§ 6480 Verification of Eligibility for MEC other than through an Eligible Employer-Sponsored Plan Related to Eligibility Determination for APTC and CSR	
§ 6482 Verification of Family Size and Household Income Related to Eligibility Determination for APTC and CSR	The intended verification process for family size, as set forth in paragraphs (b) and (d), is not clear. As written, it appears that an applicant will have to attest to current family size [(d)(1)] and then attest again to the information that is obtained by the Exchange from the HHS data hub, from past tax returns, represents an accurate projection for the future [(d)(2)]. We believe that a second attestation is not necessary if the family's original attestation is consistent with the verification data (i.e., there has been no change from the prior tax return). There would only be the necessity for further inquiries if there is some inconsistency, in which case the procedures in (3)(B) and (4) could then be followed. We recommend adding an explicit reference to allowing self-declaration of income if the applicant attests there are no data sources available BEFORE moving into the inconsistency process.
§ 6484 Verification Process for Increases in Household Income Related to Eligibility Determination for APTC and CSR	While this section rightly refers to the inconsistency process in 6492, it is missing an important provision that is stated in 6492. As currently drafted, section 6484 would allow the Exchange to immediately require documentation when there is an inconsistency ("the application shall provide additional documentation..."). This provision should follow the federal rules (Section 155.315(f)(1)) to state that the Exchange must first make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, <u>by contacting the application filer to confirm the accuracy</u> of the information submitted by the application filer. Additional language should be added to reflect the federal rules.

§ 6486 Alternate Verification Process for APTC and CSR Eligibility Determination for Decreases in Annual Household Income or If Tax Return Data Is Unavailable	We have grave concerns about subsection (c)(2)which states that an applicant is ineligible for APTC, CSR, MAGI Medi-Cal or CHIP if they haven't responded to the request for information within the 90 day period or the data sources indicate that an applicant in the tax filer's family is eligible for Medi-Cal or CHIP. First, we oppose Exchange regulations governing Medi-Cal or CHIP eligibility. While we understand that with the joint application the Exchange will sometimes make Medi-Cal eligibility determinations and counties will sometimes make eligibility determinations regarding APTCs and CSRs, and that the MAGI rules engine will reside in the CalHEERS system, Medi-Cal eligibility is governed by federal Medicaid law and state Medi-Cal law - NOT emergency regulations promulgated by the Exchange. Second, due to the drafting of this section it says in (2) that "the applicant shall not be eligible for . . . Medi-Cal or CHIP if: . . . (B) the data sources . . . indicate that an applicant in the tax filer's family is eligible for Medi-Cal or CHIP." This is nonsensical to say they are not eligible for Medi-Cal if they are eligible for Medi-Cal or CHIP. Perhaps it means non-MAGI Medi-Cal but this should be clarified. Once again, we recommend allowing self-declaration of household income for APT/CSR if the applicant attests there are no data sources available or tax return information is unavailable from the applicant or application filer, before moving into the inconsistency process.
§ 6488 Verification Process for MAGI-Based Medi-Cal and CHIP	The language regarding the Alternate verification plan in § 6486 refers to this section but it is currently "reserved" so we cannot review it.
§ 6490 Verifications of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-Sponsored Plan Related to Eligibility Determination for APTC and CSR	"Reserved"
§ 6492 Inconsistencies	Subsection (a)(1) rightly requires that the Exchange try to resolve any inconsistencies between what the applicant filled out in her or his application and what the data electronically verified showed – both by

	checking for typographical or other clerical errors and contacting the applicant. We urge that this be augmented in several ways. First, if the Exchange contacts the applicant who explained the discrepancy that should be sufficient to resolve the inconsistency. Further, this section should only apply to inconsistencies that are material to the eligibility determination or the administration of the case. Language should be included that specifies that an applicant shall be contacted and given an opportunity to resolve any inconsistencies during the course of completing their application, where ever possible, including during an online, service center, telephonic, or in person application. We urge that (a)(1) be amended as follows: (1) Shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer <u>to explain the alleged inconsistencies and</u> confirm the accuracy of the information submitted by the application filer; We urge that (a)(2) be amended to facilitate the applicant sending in information by offering to accept documents electronically or send a pre-paid envelope for the applicant to mail the needed document. We urge that (c) be revised to "An applicant shall not be required to provide information beyond <u>what is strictly</u> ~~the minimum~~ necessary to support the eligibility and enrollment processes of the Exchange, Medi-Cal, and CHIP."
§ 6494 Special Eligibility Standards and Verification Process for Indians	
§ 6496 Eligibility Redetermination during a Benefit Year	We see the Exchange proposes taking the federal option of using a 10% threshold income changes to determine what changes are reportable. We urge that the enrollee be given notice at the time their APTC is calculated as to what this 10% amount is for their family/the individual. It would be tailored to each account, based on the information that was used to determine eligibility. A more exact approach would be to tell the individual at eligibility determination the precise amount of income that would take them to a higher or lower level of APTC or CSR and require that they report the specific level of change.

	We support the approach in subsections (n) and (o) regarding APTC reconciliation and CSR changes. We agree that if the redetermination indicates a change in the APTC for the benefit year, the Exchange should calculate the new APTC level, taking into account what has already been paid out, so the applicant isn't stuck at reconciliation time owing back some of the tax credit. We would urge that this section also state that if it looks like the enrollee's annual income is going to require them to pay back some of the APTC they already received, they should be notified so they can plan ahead.
§ 6498 Annual Eligibility Redetermination	The proposed regulations would have an authorization from enrollees to obtain tax information for "up to five years" whereas the federal provision says they can authorize "for fewer than five years." We oppose requiring applicants and enrollees to give a five-year authorization in order to qualify for coverage. Rather, the Exchange should provide notice to enrollees yearly upon their redetermination that they have the right to terminate the authorization to obtain updated tax return information or to authorize it for less than five years. Subsection (c)(1) refers to requesting tax return information and (c)(2) refers to requesting data regarding MAGI-based income. As these overlap it would be helpful to more specifically lay out the difference. Again, we note a reference to section 6488 which we have not yet seen language for. It is not clear in subsection (d)(1) what the Exchange shall notify the enrollee regarding. This should be clarified. We support sending enrollees pre-populated redetermination forms. In (f), the redetermination notice should also include tailored information with the dollar amount for what 10% of income would be for this family and the duty to report increases in income. (g) requires an enrollee to report changes within 30 days, but this is not included as something required in the notice. This should be added to the notice to ensure enrollees understand it.
Administration of APTCs and CSRs	We note that the proposed California regulations do not include a section of the federal regulations that deal with administration of the APTCs and CSRs including the processes for notifying QHPs, applicant, etc. about APTCs and CSRs. Section 155.340. We think it would be useful for California to promulgate a parallel section.

§ 6500 Enrollment of Qualified Individuals into QHPs	§ 6500(b): The Federal rules on effective coverage dates for initial open enrollment and annual open enrollment make no mention of paying premiums to the QHP before enrollment is effectuated. Such a requirement violates federal law. The federal regulations base effective coverage dates for initial open enrollment and annual open enrollment from the time the ***enrollee selects a QHP.*** See Section 155.410(c) and Section 155.410(f), both of which tie "effective coverage dates" to the date when the QHP selection is received by the Exchange, not to the date when the premium is paid. Accordingly, effective coverage dates are "the first day of the following benefit year for a qualified individual who has ***made a QHP selection***..." Nowhere in the federal law do the rules permit enrollment to be conditioned on the "QHP issuer [receiving] the applicant's initial premium payment in full and by the due date." As currently drafted, the proposed California regulations would violate federal law. California cannot condition enrollment in the Exchange on proof of premium payment to the QHP issuer. Subsection 6500(b) should be deleted and replaced with language that reflects the federal rules: "For purposes of this section, enrollment shall be deemed complete when the applicant's coverage is effectuated, which shall occur when the qualified individual has made a QHP selection." All other language in (c)(1), (f)(4), and (f)(5) that reference initial premium payments as part of the enrollment effectuation process, should similarly be stricken. §6500(c)(3): Information submitted by an applicant to determine eligibility for the Exchange, APTCs, CRS, or insurance affordability programs should not be shared with the QHP (for example, income information, SSN, immigration status). Only information necessary for enrollment should be shared with the QHP. §6500(c)(3) should specify that only that information necessary to facilitate enrollment in the QHP should be sent. §6500(f): We are pleased to see language requiring QHP issuers to receive enrollment information consistent with federal Exchange regulations; however, it is critical that there be limits on the amount of enrollment information sent to QHP issuers, as noted in our comments to 6500(c)(3). Once information is in the hands of the QHP issuer, it will be much more difficult (if not impossible) to adequately protect it against subsequent inappropriate use. § 6500(g): The federal rules state that the QHP issuer has to: "(i) Direct the individual to file an application with the Exchange in accordance with § 155.310, or (ii) Ensure the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site. " (Section 156.265(b)(2)(i) and (ii). At no place in the federal rules is the QHP allowed to "assist the applicant" to apply for and receive an eligibility determination. As stated explicitly in the preamble to the federal rules, it

	is important that applicant's eligibility information is in no way shared with QHP issuers: "These provisions ensure that ***the applicant's information is collected only by the Exchange and thus firewalled from issuers*** and agents and brokers and accordingly protected." (Page 18425 of the Federal Rules.) [emphasis added] §6500(g)(2) should be deleted as proposed and revised to reflect what is permitted under the federal rules to read: "(ii) Ensure the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site." Moreover, the Exchange should expressly prohibit health plans from serving as assistors. Health plans who are contacted for information about applying for coverage should refer the individual to the Exchange.
§ 6502 Initial and Annual Open Enrollment Periods	
§ 6504 Special Enrollment Periods	While proposed "triggering events" leading to a special enrollment track the federal regulations, they must be modified to comply with state law by including domestic partnership in addition to marriage and the special enrollment periods required under AB 1083 of 2012 and SBx1 2/ABx1 2 of 2013, e.g. release from incarceration. We support the provision in (a)(7) whereby there is a special enrollment period if employer-sponsored coverage is no longer affordable or no longer provides minimum value. We urge that COBRA also be included in this so that if COBRA coverage becomes unaffordable or does not provide minimum coverage the individual could enroll in Exchange coverage. Subsection (c) would need to be amended to achieve this. We urge you to add losing AIM among the public program losses for qualifying for special enrollment in (b)(1)(B). Subsections (d) and (e) summarize the process for an individual to show they had a triggering event entitling them to a special enrollment period, i.e. present documentation of the event to the Exchange and they verify it. No timeframe for a decision is provided and under (f) and the individual only gets 60 days from the date of the triggering event to pick a QHP. To address this, we recommend either add a deadline for the Exchange's decision or amend (f) to say 60 days "<u>from the date the individual receives written notice that the Exchange concurs that the triggering event has occurred</u>."

	We commend the clear statement in (h)(1)(A) that coverage begins on the date of birth for newborn. But are very concerned about (B), which says the APTC/CSR don't begin until the following month. The subsidies should also be effective as of on the newborn's DOB. Newborns of mothers with Medi-Cal are covered – not just eligible – as of the DOB. AIM infants are also covered as of the DOB, and AIM is a program that uses health plans exclusively (no fee for service), and even though the newborn may eventually be enrolled into Medi-Cal (if family income in the birth month was at or below 250% FPL) or into the residual Healthy Families program (if family income in the birth month was 250-300% FPL). The infants of mothers with Exchange coverage should also be eligible for subsidized coverage as of the DOB. This is a critical time for coverage, especially for newborns with extensive health care needs (e.g., premature births) but also for healthy newborns, all of whom need well-baby visits and other preventive care in the birth month.
§ 6506 Termination of Coverage in a QHP	The regulations should require that notices of termination inform applicants/enrollees of the consequences of non-payment including the APTC being returned if the consumer does not pay during the grace period. We recommend that when an individual is terminated from coverage in a QHP, they be advised about eligibility for Medi-Cal or AIM. During transitions between programs including from Exchange to Medi-Cal or AIM, the Exchange must attempt to have such a transition occur without a break in coverage pursuant to California Welfare & Institutions Code §15926(h)(2).
§ 6508 Appeals of Eligibility Determinations for the Exchange Participation)	"Reserved"

March 29, 2013

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

RE: CCHI and Children Now Comments on Initial Eligibility & Enrollment Policy Recommendations and Assister Program Update from March 21, 2013 Board Meeting

Dear Mr. Lee,

California Coverage & Health Initiatives and Children Now write to provide input to Covered California on both the Initial Eligibility & Enrollment Policy Recommendations and the Assister Program Update presented at the March 21, 2013 board meeting. We appreciate the opportunity to provide this input. CCHI's network of children's and community health initiatives and partner outreach organizations is present in 54 of California's 58 counties doing on-the-ground outreach and enrollment for Californians into health coverage. We hope the experience of the children's coverage coalition's experience over the past decade plus enrolling California's children and families can be of help in ensuring the success of Covered California's enrollment efforts.

Comments on Initial Eligibility & Enrollment Policy Recommendations

Periodic Data Matching Process

We are in support of the staff recommendation related to the "periodic data matching process" and the option proposed to extend periodic data matching to include household income. Helping consumers understand and navigate the implications of the advance premium tax credits (APTC) on household finances will be one of the biggest challenges Covered California and Assisters face in educating consumers and getting them enrolled in coverage. A change in household income (or tax filing status) can have very significant ramifications for consumers and is rife with opportunity to create confusion among consumers and possibly generate frustration in Covered California's target populations. Covered California and all Assisters should take every opportunity to educate eligible populations about the link between household income (and tax filing status), eligibility for the APTC, year end reconciliation, and the considerable fiscal and eligibility ramifications for consumers. The staff proposal to match household income data on at least a semi-annual basis and use the opportunity to inform consumers of the new income information and

projected eligibility will be an important step in helping educate consumers about this complicated but important issue.

Self-Reporting of Changes

For similar reasons, we support the staff recommendation to require consumers to report a change of income that might result in a change in the amount of the APTC or cost sharing reduction. Covered California and its partner Department of Health Care Services (DHCS) will best serve the public by promoting full information to consumers about the complete range of programs and options available to them and clear information about the next steps consumers should take to ensure continued coverage. CCHI and CN recommend that when consumers voluntarily report a change in income as proposed in the staff recommendation, a notification to the consumer be automatically generated containing information about any potential eligibility changes and the next steps consumers must take to ensure continuation of coverage.

Authorized Representative Process

The staff recommendation proposes to expand the federal requirements for a consumer designated Authorized Representative to give Covered California the flexibility to allow consumers to designate a more limited role for the Authorized Representative. This recommendation is reasonable and provides consumers with greater choice in how to involve others in their sensitive health coverage enrollment process while providing greater flexibility in maintaining the privacy of their personal information.

We also note that the staff recommendation does not address the interplay or overlap between the Authorized Representative Process and what access Certified Assisters will have to these enrollment and retention processes by virtue of their role as Assisters. Will consumers need to fill out an authorization form allowing an Assister access to some or all of their information? If so, will this authorization be similar or overlapping with the Authorized Representative Process outlined in the staff recommendation? We look forward to further clarity on the interactions between the Authorized Representative Process and Assister authorizations.

Appeals Process

With respect to appeals of eligibility determinations or APTC levels, CCHI recommends that if an appeal is resolved in favor of the consumer, the eligibility determination or correct amount of APTC should be retroactive. In other words, the consumer should be entitled to coverage or the correct APTC amount retroactive to the date of the original application.

Comments on Assister Update and Recommendations

Reducing Barriers to Broad Participation by Assister Entities

Success of the endeavor Covered California has taken on, and to some extent even the success of health reform nationally, hinges on Covered California meeting or exceeding the aggressive enrollment targets it has set out for itself. Thus, Covered California is powerfully motivated to encourage broad participation by vast numbers of Assisters and Assister Entities (both paid and unpaid) to engage in this process with as

much organizational capacity as they can muster. As Covered California has in the last six months rapidly rolled out policy decisions related to the Assister program(s), CCHI and its member organizations have become increasingly concerned that the Assister program(s) are being burdened with costs, bureaucratic barriers, and impediments to the broad participation Covered California is envisioning. With each additional requirement, complexity, or cost imposed on participating Assister organizations (whether paid or unpaid), Covered California will potentially discourage groups from engaging as its partner.

To the extent that Covered California hopes to build on the successful Certified Application Assister (CAA) infrastructure embedded in some of California's lowest income communities, many of the entities and individuals with the potential to assist Covered California target customers will also be providing in-person assistance for enrollment into Medi-Cal. As you can appreciate, the proportion of time devoted by these entities and individuals to Covered California responsibilities will be influenced by the relative costs and burdens of the Covered California Assistor program. This is especially relevant to the small community-based groups, faith-based organizations, community resource centers, health centers, etc. who hold the trust of California's uninsured. It is these small, trusted community organizations who are most likely to be discouraged by additional requirements, costs and complexity.

We offer as one example of the types of barriers that would keep such organizations from participating the extreme length and complexity of the Request for Proposal process for the Education and Outreach grant program. Many potential grantees with excellent local relationships and deep trust in communities and others with potentially useful statewide infrastructure declined to respond to the RFP due to the extent of detail and corresponding staff burden to complete the RFP and the proposal process, as well as the monthly reporting requirements. Many who did apply can attest to the vast amount of administrative and staff time and funding it took to respond. In the spirit of working together to ensure the success of health reform in California, we look forward to working with Covered California to find ways to minimize barriers to engagement and develop Assister policies that actively encourage participation.

Insurance Requirements for Assister Entities

In the presentation made available to the Covered California board in the materials for the March 21, 2013 meeting, Key Issue #1 addresses proposed insurance requirements for Assister entities. The recommendation reiterates the earlier recommendation to require Assister entities to hold general liability, auto and workers compensation insurance. This recommendation is reasonable and will support a strong Assister program. However, the proposal also reiterates the recommendation that Assister entities be required to hold errors and omissions insurance "if allowed by federal regulations." We continue to be quite concerned about this requirement and the very significant cost and institutional barriers this will pose for small community-based organizations and their willingness to partner in either a paid or unpaid capacity with Covered California.

We continue to believe that such a requirement is contrary to the spirit, if not the word, of the federal regulations and Secretary Sebelius' own words in a letter to Representative Kinzinger, dated July 11, 2012. The preamble to Section 155.210 (Federal Register, Vol. 77, No. 59, 18331) clearly prohibited state exchanges from requiring Navigators from carrying E & O insurance (this rule was promulgated prior to the development of the In-Person Assister and Certified Application Counselor concepts). "[W]e clarify that

States or Exchanges are prohibited from adopting such a standard, including errors and omissions coverage." Secretary Sebelius makes this point in her letter through the following language: ". . . requiring errors and omission coverage may serve as a significant barrier to entry for entities that may otherwise be well-qualified." We again urge Covered California to find a balance that protects consumers without putting unnecessary and prohibitive burdens on Assister entities.

Thank you for the opportunity to comment on these important policy issues. If you would like to discuss these matters further, please contact Suzie Shupe, Executive Director, California Coverage & Health Initiatives at sshupe@cchi4families.org or 707-527-9213.

Sincerely,

Suzie Shupe
Executive Director
CCHI

Ted Lempert
President
Children Now

California LGBT Health & Human Services Network

March 29, 2013

Thien Lam
Deputy Directory, Eligibility and Enrollment
Covered California
560 J St., Suite 290
Sacramento, CA 95814

Re: Eligibility and Enrollment; Streamlined Application

Dear Ms. Lam,

The California Lesbian, Gay, Bisexual, and Transgender Health & Human Services Network is a coalition of more than 50 organizations throughout the state. We are advocates, providers, community centers, and researchers working together for the improved health and wellness of LGBT families and communities. We greatly appreciate your efforts to create an easy enrollment process that simplifies signing up for health insurance. Thank you for the opportunity to comment on the draft regulations and application elements.

Family Applications for LGBT Families

One major concern of ours is how Covered California will accommodate LGBT families. Under California law, people in same-sex marriages or Registered Domestic Partnerships are entitled to access health insurance the same as opposite-sex married couples. While the Affordable Care Act provides the opportunity for cost sharing reductions (CSR) and advance premium tax credits (APTC), they will be more complicated for people in same-sex unions to access because the federal government does not count people in same-sex unions as part of the same tax household.

The draft streamlined application developed by HHS was clearly for people in a tax household to apply together; one part of the instructions stated that adults who file taxes separately need to use separate applications. While we understand the utility of separate applications for separate tax households when it comes to APTC and CSR, we have not seen a way to combine separate applications for subsidies into one application for insurance, enabling same-sex couples to apply for family coverage.

We are pleased to see that Covered California's draft regulations on the Application, Eligibility, and Enrollment Process for the Individual Exchange seem to allow the possibility of two individuals in separate tax households to be on the same family application (§6474(d)(4)). However, there appears to be inconsistency in the draft regulations. The definition of "Application Filer" utilizes the federal definition of family, apparently precluding the possibility of same-sex couples being on the same application. We would greatly appreciate clarification about this critical issue.

Streamlined Application Elements

Additionally, we have several questions and recommendations for the streamlined application. We are concerned about the complexity of the application for same sex couples, potential delays for transgender people if their sex as listed with the Social Security Administration is different from their sex on other documents, and the apparent lack of data collection about sexual orientation and gender identity.

Simplifying the Application for Same-Sex Couples

As discussed above, we are unclear about how same-sex partners and spouses can apply individually for subsidies and then enroll in family coverage. Given the unique application needs of this population, the application instructions should include clear, extensive directions on how to fill out the application for the variety of family compositions that exist. In the online application, this can be done by including a question in the Getting Started section asking if the person is in a same-sex marriage, registered domestic partnership, or civil union. If the applicant answers yes, the application should provide specialized instructions on how to fill out the application taking into account both the federal definition of family and the fact that California allows families headed by same-sex couples to apply for insurance as a family. Additionally, in the information sections for each Additional Family Member, the list of options for Type of Relationship should include opposite-sex spouse, same-sex spouse, domestic partner, and civil union partner.

Data Matching for Transgender Individuals

While we support collecting data on the sex of applicants on all applications, we note that this question may be problematic 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, transgender individuals often have several forms of identification with difference sex markers. To make the question more clear, we recommend that the question read as follows:

> *What is your legal sex?*
> - *Male*
> - *Female*

We also recommend the inclusion of help text that will further clarify the question and specify that applicants should answer the question 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. We recommend that the help text reads as follows:

> *"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 Medi-Cal or for subsidies to help you purchase coverage through Covered California. Your answer to this question will not affect the benefits you receive and."*

Collecting demographic data on sexual orientation and gender identity

Comprehensive demographic data collection is indispensable to the effective operation of Covered California. These data will help Covered California with activities such as outreach planning, compliance with nondiscrimination requirements, and customer satisfaction evaluations. They will also

help Covered California 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 demographic data collection sections of the application collect a full range of demographic data, including sexual orientation and gender identity.

Numerous sources testify to the importance of sexual orientation and gender identity data.[1, 2, 3] In fact, Secretary Sebelius has committed the Department of Health and Human Services 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."[4]

While applicants may be uncomfortable sharing personal information on Covered California applications due to privacy concerns, the importance of these data justifies the inclusion of these questions as optional measures. Sexual orientation and gender identity are no different from race, ethnicity, and language in this respect. Moreover, the groundbreaking LGBT-inclusive nondiscrimination laws that apply to Exchanges 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 questions to the Optional Information section:

1. 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*
- *Queer*
- *Something else (write in)*_____

[1] Institute of Medicine, 2012. "Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records." Available from http://www.iom.edu/Reports/2012/Collecting-Sexual-Orientation-and-Gender-Identity-Data-in-Electronic-Health-Records.aspx

[2] Institute of Medicine, 2011. "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding." Available from: http://iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx

[3] The California LGBTQ Reducing Mental Health Disparities Project. 2012. "First, Do No Harm: Reducing Disparities for Lesbian, Gay Bisexual, Transgender, Queer, and Questioning Populations in California." Available from: http://www.health-access.org/files/providing/FIRST_DO_NO_HARM-LGBTQ_REPORT.PDF

[4] 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

2. 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 and 2009 indicate that 0.5% of 18 to 64-year-old adults answered yes to this question and were classified as transgender,[5] which is consistent with population-based estimates from two other states (California and Vermont).[6]

The creation of Covered California offers a historic opportunity to connect LGBT individuals and their families to affordable, comprehensive coverage, as well as to collect data about the experiences and needs of this population. As the draft regulations are finalized and the streamlined application is developed, are eager to work with Covered California in ensuring that the unique needs of LGBT families are addressed.

Sincerely,

Kate Burch

Kate Burch
Network Coordinator
California Lesbian, Gay, Bisexual, and Transgender Health & Human Services Network
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916-497-0923

[5] 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.
[6] Ibid.

State Data Elements		
Coalition Comments - March 15, 2013		
For further information, contact: Julie Silas , (415) 431-6747, Cary Sanders (510) 832-1160, or Elizabeth Landsberg (916) 282-5118		
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 Beth Abbott, Health Access 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.

social interest SOLUTIONS
Better Lives through Better Systems

March 19, 2013

Dear Dr. Finocchio and Ms. Lam:

Social Interest Solutions is submitting these comments in response to the Department of Health Care Services' and Covered California's proposed data elements and process for the single streamlined application for health coverage. Our organization seeks to promote an automated, streamlined, efficient and user-friendly application and enrollment process, and we appreciate the opportunity to provide input.

We attended the AB1296 Stakeholder Workgroup meeting on March 8 and participated on the Covered California Eligibility & Enrollment Key Policy Issue Stakeholder Webinar on March 14. At both meetings, the data elements and policy considerations related to the single streamlined application were presented and discussed. We were pleased by a number of policy decisions that will benefit consumers, in particular the intent to transfer applicant data electronically from CalHEERS to SAWS for CalFresh and CalWORKS determination, and the decision to build accelerated enrollment for children into the CalHEERS system.

However, we were concerned to learn that California will not be fully leveraging the real-time capabilities of the federal data services hub during the application in order to simplify the process, avoid unnecessary data entry, and maximize data accuracy. Instead, we understand that CalHEERs will use the hub to verify income data only after the applicant has submitted their application data. This will put a greater burden on the applicant and will significantly hinder the ability to build a dynamic application that can truly determine eligibility in real time. We believe that pre-populating fields with data from verified sources when feasible and asking applicants to confirm or modify that data (similar to the process California is proposing for renewal applications) is an important element of a truly first-class consumer experience. We were also concerned to hear the application experience – in particular the ability to have eligibility determined in real-time - may vary depending upon how applicants initially access the system.

To that end, we put forth the following recommendations.

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Recommendations:

- Wherever possible, pre-populate the application with data drawn from the federal data services hub and other available systems. Adopt the process modeled by the federal single streamlined application, which will pull income, citizenship and other data from the data services hub mid-application and present it to the applicant for verification. This could be handled in a manner similar to what the State is proposing for redetermination, whereby information previously provided will be presented to the applicant for verification or modification.
- Build a dynamic application that serves up questions to applicants based on data they have verified or provided. Pre-population of income information and a subsequent mid-application verification process will allow the system to tailor subsequent questions to the applicant based on their likely eligibility. This will avoid, for example, an individual who is clearly eligible for Medi-Cal from being put through the burdensome list of questions relevant only to the Insurance Affordability programs.
- Ensure that all applicants experience the same real-time, consumer friendly, expedited application process regardless of how they enter the system. With the exception of paper applications, eligibility should be determined in real-time for all programs for applicants coming in through all channels (phone, CalHEERS, SAWS consumer portals, in-person).
- In addition to facilitating a referral for CalWORKS and CalFresh, provide a mechanism to refer applicants (and electronically transfer their data where possible) for help in applying for other support programs such as Earned Income Tax Credit, other food and nutrition support, and indigent health programs (in the event that they don't qualify for health coverage via CalHEERS).

Finally, the list of data elements provided for input does not provide any context for process nor does it reflect the final application flow or language. So that we can provide comprehensive, thoughtful feedback on the single streamlined application and process, we would appreciate the opportunity to review an application mock-up that illustrates the interactive, dynamic environment that the applicant will experience, similar to the draft model paper and online applications that CMS has released for the federal single streamlined application.

Thank you again for the opportunity to comment.

Sincerely,

Lucy Street
Senior Policy Manager

Cc: Juli Baker, Chief Technology Officer, Covered California
Toby Douglas, Director, Department of Health Care Services
Peter Lee, Director, Covered California
David Panush, Director of External Affairs, Covered California

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).

CHCC California Health Care Coalition

March 20, 2013

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

Dear Peter,

The California Health Benefit Exchange (Exchange) will be an enormous purchaser in the California healthcare market and has the potential to affect the marketplace in positive or negative terms.

The members of the CHCC are encouraged by the opportunity to have input as purchasers to bring positive changes to the California market.

Published studies place the amount of waste, abuse, fraud within the Health Industry at between $750 Billion and $900 Billion. Collectively as purchasers we spend enough money to have world class care, and yet as a country we are woefully behind other nations in realizing quality. There are many special interests determined to maintain the status quo and continue to waste health care dollars. We need help. We need to find ways to bend the trend to be more in line with general CPI rather than multiples above. The only way to accomplish this is to say no to selfish efforts to maintain the status quo.

We offer the following recommendations:

In contracts negotiated by the Exchange we recommend the inclusion of language that actively pursues bio-similar drugs without rewarding big pharma by unfairly discouraging competition.

Monitor and control waste, fraud and abuse and require severe penalties to pill mills, fraudulent claim filing scams, up coding charges, and unreported medical errors.

Require hospitals and other providers to only refer patients to other in network providers and if they fail to do so, protect the patient from overcharges or balance billing by requiring the referring entity to accept responsibility for the difference in cost.

4371 Latham St., Suite 101
Riverside, CA 92501
P.O. Box 5345
www.hubinternational.com
(951) 788-8500

CALIFORNIA HEALTH CARE COALITION

Build incentives into hospital contracts that reward or penalize hospitals based on their incidents of hospital acquired infections readmissions, and ensure that no patient or payer is ever financially responsible for injuries, infections, or abuse caused by a doctor or in a facility. No condition that was not Present On Admission should be chargeable.

The practice of doctors referring patients to imaging centers, laboratories, surgery centers or other facilities in which they have a financial relationship should be prohibited.

The Exchange should support the prohibition of direct-to-consumer advertising by pharma, and pharma detailing to doctors and/or staff. Furthermore, if a doctor receives any financial payment from a medical devise or pharmaceutical company, that doctor should be prohibited from prescribing those products.

The Exchange should require that Charge Masters and all provider and facility charges be posted online and available to patients and purchasers for comparison and the ability to shop.

The Exchange should include coverage for payment of Medical Directive Counseling. Currently there is little incentive for physicians to educate patients on choices for late stage disease or end of life treatment. The incentives currently in place allow the suffering of patients who prefer the dignity of passing peacefully. In addition to such counseling palliative care and hospice must be easily accessible and broadly available.

Regards,

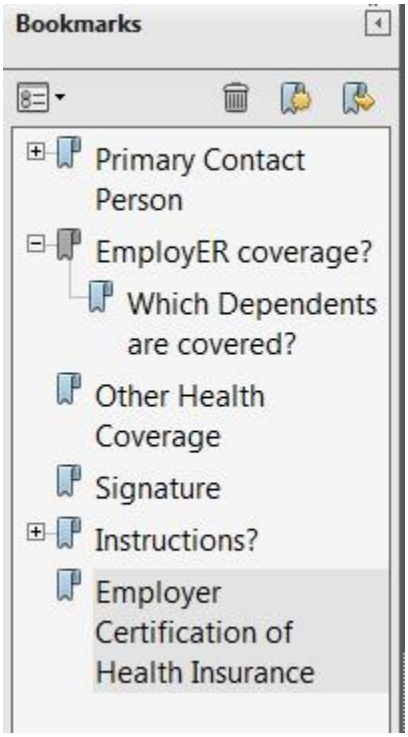
John Stenerson
CHCC Chair

4371 Latham St., Suite 101
Riverside, CA 92501
P.O. Box 5345
www.hubinternational.com
(951) 788-8500

***General* Comment Received via E-mail**

Subject: Application Form

I guess the biggest comment would be to add bookmarks and let people know they can use an agent. I think it will be a big "pain" to get all the income and employer coverage from the average consumer, let alone those who never had coverage before. The rest of my comments are in the application itself.



www.SteveShorr.com
Instant ONLINE Health and Life Insurance Proposals
We are paid by the Insurance Companies, there is no extra charge for our expertise, as mandated by law.

Telephone (310) 519-1335, Fax (310) 519.1359
1027 W. 11th Street # 3, San Pedro, CA 90731-3558

Application for Health Insurance

(and to find out if you can get help with costs)

THINGS TO KNOW

Use this application to see what insurance choices you qualify for

- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)
- A new tax credit that can help pay your health insurance premiums
- Private health insurance plans

You may qualify for a free or low-cost program even if you earn as much as $92,000 a year (for a family of 4).

Who can use this application?

You can use this application to apply for anyone in your family, even if they already have insurance now.

You can still apply even if you don't file a federal income tax return.

Apply faster online

Apply faster online at www.placeholder.gov.

What you may need to apply

- Social Security numbers (or document numbers for any legal immigrants who need insurance)
- Birth dates
- Employer & income information for everyone in your family (for example, from paystubs or Forms W-2, Wage and Tax Statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for so much information?

We ask about income and other information to make sure you and your family get the most benefits possible. **We'll keep all the information you provide private, as required by law.**

What happens next?

Send your complete, signed application to the address on page 19. **If you don't have all the information we ask for, you should sign and submit your application anyway.**

We'll let you know what programs you might be eligible for within 1–2 weeks.

Get help with this application

- **Online:** www.placeholder.gov
- **Phone:** Call our Help Center at **1-800-XXX-XXXX**
- **In person:** Visit our website or call **1-800-XXX-XXXX** for a list of places near where you live
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-XXX-XXXX**

STEP 1

Tell us about yourself.

(We will need to contact an adult member of the family.)

First Name, Middle Name, Last Name & Suffix

Home Address	Apartment Number

City	State	Zip Code	County

Mailing Address (if different from home address)	Apartment Number

City	State	Zip Code	County

☐ Check here if you don't have a home address. You still need to give a mailing address.

Phone Number	Other Phone Number
( ) –	( ) –

I would like to get information about this application by:

Email: ☐ Yes ☐ No Email Address: _____

Text: ☐ Yes ☐ No Cell Phone Number: ( ) – _____

Preferred Language Spoken (if not English)	Preferred Language Read (if not English)

STEP 2

Tell us about your family.

Your income and family size help us decide what programs you qualify for. With this information, we can make sure everyone gets the most coverage possible.

Here's who you need to include on this application:

- Your spouse, if married
- Your children who live with you
- Your partner who lives with you (but only if you have children together who need health insurance)
- Anyone you include on your federal income tax return

Anyone else who lives with you will need to file their own application if they want insurance. You don't need to file taxes to apply for health insurance.

Complete one page (front and back) for each person in your family. Start with yourself!
If you have more than 6 people in your family to include, you'll need to make a copy of the next 2 pages and complete.

Your information is private.

- We'll keep your information private as required by law.
- We'll use the information on this form only to see if you qualify for health insurance.

STEP 2: PERSON 1

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you. **Start with yourself!**

First Name, Middle Name, Last Name & Suffix			Relationship to you? **SELF**
Social Security Number **OPTIONAL** ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Date of birth (month/day/year)	Sex ☐ Male ☐ Female	Pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected: ____

We need Social Security Numbers (SSNs) for everyone applying for health insurance who has one. An SSN is optional for people not applying for insurance, but providing an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with insurance. If someone doesn't have an SSN, call 1-800-XXX-XXXX or visit **www.placeholder.gov**.

Does PERSON 1 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions 1–3. ☐ **NO. If no,** skip to question 3.

1. Will PERSON 1 file jointly with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Does PERSON 1 have any dependents? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Is PERSON 1 claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer: _____
   How is PERSON 1 related to the tax filer? _____

Is PERSON 1 applying for health insurance?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 4. Leave the rest of this page blank.

Social Security Number **REQUIRED** if you have one and if not listed above

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Have a disability? ☐ Yes ☐ No	Needs help with activities of daily living through personal assistance services or a medical facility? ☐ Yes ☐ No
U.S. citizen or national? ☐ Yes ☐ No	**If PERSON 1 isn't a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 20 for a list of eligible immigration statuses and add the information below. Document Type: _____ ID Number: _____ Has PERSON 1 lived in the U.S. since 1996? ☐ Yes ☐ No

Does PERSON 1 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

Does PERSON 1 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if PERSON 1 is 26 or younger:

Did PERSON 1 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

End date: _____ **Reason the insurance ended:** _____

Is PERSON 1 a full time student? ☐ Yes ☐ No	Was PERSON 1 ever in foster care? ☐ Yes ☐ No	Does PERSON 1 have a parent living outside the home? ☐ Yes ☐ No

If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

Race (OPTIONAL—check all that apply)

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other

NOW, tell us about any income from PERSON 1 on the back.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

STEP 2: PERSON 1

CURRENT JOB and INCOME INFORMATION

☐ **Not employed**—Skip to "Other Income" lower on this page.

CURRENT JOB 1:

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

In the past 6 months, did PERSON 1:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, please answer the following questions:

Type of Work

How much net income (profits once expenses are paid) will PERSON 1 get from this self-employment this month? See instructions on page 20 to see what could be counted.
$

OTHER INCOME: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement Accounts **$** _____ How often? _____

☐ Alimony **$** _____ How often? _____

☐ Capital Gains **$** _____ How often? _____

☐ Dividends/Interest **$** _____ How often? _____

☐ Net Farming/Fishing **$** _____ How often? _____

☐ Net Rental/Royalty **$** _____ How often? _____

☐ Other Income **$** _____ How often? _____
Type: _____

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 1 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

☐ Alimony **$** _____ How often? _____

☐ Student loan interest **$** _____ How often? _____

☐ Other deductions **$** _____ How often? _____
Type: _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year. If you don't expect changes to your monthly income, skip to Step 3.

PERSON 1's total income **this year**	PERSON 1's total income **next year**
$	**$**

THANKS! This is all we need to know about PERSON 1.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

STEP 2: PERSON 2

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First Name, Middle Name, Last Name & Suffix	Relationship to you?

Social Security Number **OPTIONAL**	Date of birth (month/day/year)	Sex	Pregnant?
___ ___ ___ - ___ ___ - ___ ___ ___ ___		☐ Male ☐ Female	☐ Yes ☐ No **If yes,** how many babies are expected: ___

Does this PERSON 2 live at the same address as you? ☐ Yes ☐ No **If no,** list address: _____

Does PERSON 2 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions 1–3. ☐ **NO. If no,** skip to question 3.

1. Will PERSON 2 file jointly with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Does PERSON 2 have any dependents? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Is PERSON 2 claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer: _____
   How is PERSON 2 related to the tax filer? _____

Is PERSON 2 applying for health insurance?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 6. Leave the rest of this page blank.

Social Security Number **REQUIRED** if you have one and if not listed above

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Have a disability?	Needs help with activities of daily living through personal assistance services or a medical facility?
☐ Yes ☐ No	☐ Yes ☐ No

U.S. citizen or national?	
☐ Yes ☐ No	**If PERSON 2 isn't a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 20 for a list of eligible immigration statuses and add the information below. Document Type: _____ ID Number: _____ Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No

Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

Does PERSON 2 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 26 or younger:

Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

End date: _____ **Reason the insurance ended:** _____

Is PERSON 2 a full time student?	Was PERSON 2 ever in foster care?	Does PERSON 2 have a parent living outside the home?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

Race (OPTIONAL—check all that apply)

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other

NOW, tell us about any income from PERSON 2 on the back.

STEP 2: PERSON 2

CURRENT JOB and INCOME INFORMATION

☐ **Not employed**—Skip to "Other Income" lower on this page.

CURRENT JOB 1:

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

In the past 6 months, did PERSON 2:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, please answer the following questions:

Type of Work

How much net income (profits once expenses are paid) will PERSON 2 get from this self-employment this month? See instructions on page 20 to see what could be counted.
$

OTHER INCOME: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement Accounts **$** _____ How often? _____

☐ Alimony **$** _____ How often? _____

☐ Capital Gains **$** _____ How often? _____

☐ Dividends/Interest **$** _____ How often? _____

☐ Net Farming/Fishing **$** _____ How often? _____

☐ Net Rental/Royalty **$** _____ How often? _____

☐ Other Income **$** _____ How often? _____
Type: _____

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

☐ Alimony **$** _____ How often? _____

☐ Student loan interest **$** _____ How often? _____

☐ Other deductions **$** _____ How often? _____
Type: _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year. If you don't expect changes to your monthly income, skip to Step 3.

PERSON 2's total income **this year**	PERSON 2's total income **next year**
$	**$**

THANKS! This is all we need to know about PERSON 2.

STEP 2: PERSON 3

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First Name, Middle Name, Last Name & Suffix	Relationship to you?

Social Security Number **OPTIONAL**	Date of birth (month/day/year)	Sex	Pregnant?
___ ___ ___ - ___ ___ - ___ ___ ___ ___		☐ Male ☐ Female	☐ Yes ☐ No **If yes,** how many babies are expected: ____

Does this PERSON 3 live at the same address as you? ☐ Yes ☐ No **If no,** list address: _____

Does PERSON 3 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions 1–3. ☐ **NO. If no,** skip to question 3.

1. Will PERSON 3 file jointly with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Does PERSON 3 have any dependents? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Is PERSON 3 claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer: _____
   How is PERSON 3 related to the tax filer? _____

Is PERSON 3 applying for health insurance?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 8. Leave the rest of this page blank.

Social Security Number **REQUIRED** if you have one and if not listed above

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Have a disability?	Needs help with activities of daily living through personal assistance services or a medical facility?
☐ Yes ☐ No	☐ Yes ☐ No

U.S. citizen or national?	
☐ Yes ☐ No	**If PERSON 3 isn't a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 20 for a list of eligible immigration statuses and add the information below. Document Type: _____ ID Number: _____ Has PERSON 3 lived in the U.S. since 1996? ☐ Yes ☐ No

Does PERSON 3 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

Does PERSON 3 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if PERSON 3 is 26 or younger:

Did PERSON 3 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

End date: _____ **Reason the insurance ended:** _____

Is PERSON 3 a full time student?	Was PERSON 3 ever in foster care?	Does PERSON 3 have a parent living outside the home?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

Race (OPTIONAL—check all that apply)

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other

NOW, tell us about any income from PERSON 3 on the back.

STEP 2: PERSON 3

CURRENT JOB and INCOME INFORMATION

☐ **Not employed**—Skip to "Other Income" lower on this page.

CURRENT JOB 1:

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

In the past 6 months, did PERSON 3:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, please answer the following questions:

Type of Work

How much net income (profits once expenses are paid) will PERSON 3 get from this self-employment this month? See instructions on page 20 to see what could be counted.
$

OTHER INCOME: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement Accounts **$** _____ How often? _____

☐ Alimony **$** _____ How often? _____

☐ Capital Gains **$** _____ How often? _____

☐ Dividends/Interest **$** _____ How often? _____

☐ Net Farming/Fishing **$** _____ How often? _____

☐ Net Rental/Royalty **$** _____ How often? _____

☐ Other Income **$** _____ How often? _____
Type: _____

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

☐ Alimony **$** _____ How often? _____

☐ Student loan interest **$** _____ How often? _____

☐ Other deductions **$** _____ How often? _____
Type: _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year. If you don't expect changes to your monthly income, skip to Step 3.

PERSON 3's total income **this year**	PERSON 3's total income **next year**
$	**$**

THANKS! This is all we need to know about PERSON 3.

STEP 2: PERSON 4

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First Name, Middle Name, Last Name & Suffix	Relationship to you?

Social Security Number **OPTIONAL**	Date of birth (month/day/year)	Sex	Pregnant?
___ ___ ___ - ___ ___ - ___ ___ ___ ___		☐ Male ☐ Female	☐ Yes ☐ No **If yes,** how many babies are expected: ____

Does this PERSON 4 live at the same address as you? ☐ Yes ☐ No **If no,** list address: _____

Does PERSON 4 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions 1–3. ☐ **NO. If no,** skip to question 3.

1. Will PERSON 4 file jointly with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Does PERSON 4 have any dependents? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Is PERSON 4 claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer: _____
   How is PERSON 4 related to the tax filer? _____

Is PERSON 4 applying for health insurance?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 10. Leave the rest of this page blank.

Social Security Number **REQUIRED** if you have one and if not listed above

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Have a disability?	Needs help with activities of daily living through personal assistance services or a medical facility?
☐ Yes ☐ No	☐ Yes ☐ No

U.S. citizen or national?	
☐ Yes ☐ No	**If PERSON 4 isn't a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 20 for a list of eligible immigration statuses and add the information below. Document Type: _____ ID Number: _____ Has PERSON 4 lived in the U.S. since 1996? ☐ Yes ☐ No

Does PERSON 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

Does PERSON 4 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if PERSON 4 is 26 or younger:

Did PERSON 4 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

End date: _____ **Reason the insurance ended:** _____

Is PERSON 4 a full time student?	Was PERSON 4 ever in foster care?	Does PERSON 4 have a parent living outside the home?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

Race (OPTIONAL—check all that apply)

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other

NOW, tell us about any income from PERSON 4 on the back.

STEP 2: PERSON 4

CURRENT JOB and INCOME INFORMATION

☐ **Not employed**—Skip to "Other Income" lower on this page.

CURRENT JOB 1:

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

In the past 6 months, did PERSON 4:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, please answer the following questions:

Type of Work

How much net income (profits once expenses are paid) will PERSON 4 get from this self-employment this month? See instructions on page 20 to see what could be counted.
$

OTHER INCOME: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement Accounts **$** _____ How often? _____

☐ Alimony **$** _____ How often? _____

☐ Capital Gains **$** _____ How often? _____

☐ Dividends/Interest **$** _____ How often? _____

☐ Net Farming/Fishing **$** _____ How often? _____

☐ Net Rental/Royalty **$** _____ How often? _____

☐ Other Income **$** _____ How often? _____
Type: _____

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

☐ Alimony **$** _____ How often? _____

☐ Student loan interest **$** _____ How often? _____

☐ Other deductions **$** _____ How often? _____
Type: _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year. If you don't expect changes to your monthly income, skip to Step 3.

PERSON 4's total income **this year**	PERSON 4's total income **next year**
$	**$**

THANKS! This is all we need to know about PERSON 4.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

STEP 2: PERSON 5

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First Name, Middle Name, Last Name & Suffix	Relationship to you?

Social Security Number **OPTIONAL**	Date of birth (month/day/year)	Sex	Pregnant?
___ ___ ___ - ___ ___ - ___ ___ ___ ___		☐ Male ☐ Female	☐ Yes ☐ No **If yes,** how many babies are expected: ____

Does this PERSON 5 live at the same address as you? ☐ Yes ☐ No **If no,** list address: _____

Does PERSON 5 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions 1–3. ☐ **NO. If no,** skip to question 3.

1. Will PERSON 5 file jointly with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Does PERSON 5 have any dependents? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Is PERSON 5 claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer: _____
   How is PERSON 5 related to the tax filer? _____

Is PERSON 5 applying for health insurance?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 12. Leave the rest of this page blank.

Social Security Number **REQUIRED** if you have one and if not listed above

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Have a disability?	Needs help with activities of daily living through personal assistance services or a medical facility?
☐ Yes ☐ No	☐ Yes ☐ No

U.S. citizen or national?	
☐ Yes ☐ No	**If PERSON 5 isn't a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 20 for a list of eligible immigration statuses and add the information below. Document Type: _____ ID Number: _____ Has PERSON 5 lived in the U.S. since 1996? ☐ Yes ☐ No

Does PERSON 5 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

Does PERSON 5 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if PERSON 5 is 26 or younger:

Did PERSON 5 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

End date: _____ **Reason the insurance ended:** _____

Is PERSON 5 a full time student?	Was PERSON 5 ever in foster care?	Does PERSON 5 have a parent living outside the home?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

Race (OPTIONAL—check all that apply)

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other

NOW, tell us about any income from PERSON 5 on the back.

STEP 2: PERSON 5

CURRENT JOB and INCOME INFORMATION

☐ **Not employed**—Skip to "Other Income" lower on this page.

CURRENT JOB 1:

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

In the past 6 months, did PERSON 5:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, please answer the following questions:

Type of Work

How much net income (profits once expenses are paid) will PERSON 5 get from this self-employment this month? See instructions on page 20 to see what could be counted.
$

OTHER INCOME: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement Accounts **$** _____ How often? _____

☐ Alimony **$** _____ How often? _____

☐ Capital Gains **$** _____ How often? _____

☐ Dividends/Interest **$** _____ How often? _____

☐ Net Farming/Fishing **$** _____ How often? _____

☐ Net Rental/Royalty **$** _____ How often? _____

☐ Other Income **$** _____ How often? _____
Type: _____

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 5 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

☐ Alimony **$** _____ How often? _____

☐ Student loan interest **$** _____ How often? _____

☐ Other deductions **$** _____ How often? _____
Type: _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year. If you don't expect changes to your monthly income, skip to Step 3.

PERSON 5's total income **this year**	PERSON 5's total income **next year**
$	**$**

THANKS! This is all we need to know about PERSON 5.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

STEP 2: PERSON 6

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First Name, Middle Name, Last Name & Suffix	Relationship to you?

Social Security Number **OPTIONAL**	Date of birth (month/day/year)	Sex	Pregnant?
___ ___ ___ - ___ ___ - ___ ___ ___ ___		☐ Male ☐ Female	☐ Yes ☐ No **If yes,** how many babies are expected: ____

Does this PERSON 6 live at the same address as you? ☐ Yes ☐ No **If no,** list address: _____

Does PERSON 6 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions 1–3. ☐ **NO. If no,** skip to question 3.

1. Will PERSON 6 file jointly with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Does PERSON 6 have any dependents? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Is PERSON 6 claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer: _____
   How is PERSON 1 related to the tax filer? _____

Is PERSON 6 applying for health insurance?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 4. Leave the rest of this page blank.

Social Security Number **REQUIRED** if you have one and if not listed above

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Have a disability?	Needs help with activities of daily living through personal assistance services or a medical facility?
☐ Yes ☐ No	☐ Yes ☐ No

U.S. citizen or national?	
☐ Yes ☐ No	**If PERSON 6 isn't a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 20 for a list of eligible immigration statuses and add the information below. Document Type: _____ ID Number: _____ Has PERSON 6 lived in the U.S. since 1996? ☐ Yes ☐ No

Does PERSON 6 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

Does PERSON 6 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if PERSON 6 is 26 or younger:

Did PERSON 6 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

End date: _____ **Reason the insurance ended:** _____

Is PERSON 6 a full time student?	Was PERSON 6 ever in foster care?	Does PERSON 6 have a parent living outside the home?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

Race (OPTIONAL—check all that apply)

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other

NOW, tell us about any income from PERSON 6 on the back.

STEP 2: PERSON 6

CURRENT JOB and INCOME INFORMATION

☐ **Not employed**—Skip to "Other Income" lower on this page.

CURRENT JOB 1:

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

In the past 6 months, did PERSON 6:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, please answer the following questions:

Type of Work

How much net income (profits once expenses are paid) will PERSON 6 get from this self-employment this month? See instructions on page 20 to see what could be counted.
$

OTHER INCOME: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement Accounts **$** _____ How often? _____

☐ Alimony **$** _____ How often? _____

☐ Capital Gains **$** _____ How often? _____

☐ Dividends/Interest **$** _____ How often? _____

☐ Net Farming/Fishing **$** _____ How often? _____

☐ Net Rental/Royalty **$** _____ How often? _____

☐ Other Income **$** _____ How often? _____
Type: _____

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 6 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

☐ Alimony **$** _____ How often? _____

☐ Student loan interest **$** _____ How often? _____

☐ Other deductions **$** _____ How often? _____
Type: _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year. If you don't expect changes to your monthly income, skip to Step 3.

PERSON 6's total income **this year**	PERSON 6's total income **next year**
$	**$**

THANKS! This is all we need to know about PERSON 6.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

STEP 3

Your Family's Health Insurance

Answer these questions for everyone applying for help paying for health insurance.

INSURANCE FROM JOBS:

Is anyone offered health coverage from a job?

(This includes coverage from someone else's job, such as a parent or spouse, and includes private employer plans as well as TRICARE, federal or state employee plans, and Peace Corps plans.)

☐ **YES. If yes,** answer these questions. If there are plans offered by more than one employer and you need more space, attach another sheet of paper.

Is this a state health benefit plan? ☐ Yes ☐ No ☐ Don't know

☐ **NO. If no,** skip to "Other Health Insurance" on page 16.

Tell us about the job that offers coverage.

We need to know about any health coverage you could get through a job. You can use the Employer Coverage Form on page 21 to get information from the employer about health coverage this job offers to help you complete this section. If there is more than one job, copy this page.

Employee Name	Employee Social Security Number __ __ __ - __ __ - __ __ __ __
Employer Name	Employer Identification Number (EIN)*
Employer Address	Employer Phone Number ( ) –

City	State	Zip Code

Who can we contact about employee health coverage at this job?

Phone Number ( ) –	Email Address

*You can ask your employer for this information. See page 21.

What's the name of the lowest cost self-only health plan the employee listed above could enroll in at this job? (Only consider plans that meet the "minimum value standard" set by the Affordable Care Act.)

Name: _____

☐ No plans meet the "minimum value standard" ☐ Don't know

How much would the employee have to pay in premiums for that plan?

$ _____ How Often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other: _____

Do you think the employer's coverage is affordable? ☐ Yes ☐ No

STEP 3

Your Family's Health Insurance (Continued)

Who does this job offer coverage to?

PERSON NAME (First Name, Middle Name, Last Name)	ENROLLED NOW, PLANS TO ENROLL, OR NOT ENROLLED	CHANGES YOU PLAN TO MAKE NEXT YEAR
PERSON 1:	☐ Enrolled Now ☐ Plans to Enroll Start Date: _____ ☐ Not Enrolled	☐ Plans to drop coverage Date: _____ ☐ Will become eligible Start Date: _____
PERSON 2:	☐ Enrolled Now ☐ Plans to Enroll Start Date: _____ ☐ Not Enrolled	☐ Plans to drop coverage Date: _____ ☐ Will become eligible Start Date: _____
PERSON 3:	☐ Enrolled Now ☐ Plans to Enroll Start Date: _____ ☐ Not Enrolled	☐ Plans to drop coverage Date: _____ ☐ Will become eligible Start Date: _____
PERSON 4:	☐ Enrolled Now ☐ Plans to Enroll Start Date: _____ ☐ Not Enrolled	☐ Plans to drop coverage Date: _____ ☐ Will become eligible Start Date: _____
PERSON 5:	☐ Enrolled Now ☐ Plans to Enroll Start Date: _____ ☐ Not Enrolled	☐ Plans to drop coverage Date: _____ ☐ Will become eligible Start Date: _____
PERSON 6:	☐ Enrolled Now ☐ Plans to Enroll Start Date: _____ ☐ Not Enrolled	☐ Plans to drop coverage Date: _____ ☐ Will become eligible Start Date: _____

☐ Check here if this job will no longer offer health coverage next year.

☐ Check here if you think this health insurance will not be affordable next year.

OTHER HEALTH INSURANCE:

Does anyone have another health insurance now, including Veterans, Medicaid or CHIP, Medicare, COBRA, Private/ Other, Retiree Health Plan?

☐ Yes ☐ No **If no,** skip to step 4 on the next page.

WHO HAS OTHER HEALTH INSURANCE?	WHAT TYPE DO THEY HAVE?	NAME OF PLAN	POLICY NUMBER
Name:			
Name:			
Name:			

STEP 4

Is anyone in your family American Indian or Alaska Native (AI/AN)?

☐ **No, nobody in my family is American Indian or Alaska Native**. **If no,** skip to Step 5 on the next page.

☐ **Yes. If yes, continue.**

American Indians and Alaska Natives who enroll in Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplace can also get services from the Indian Health Services, tribal health programs, or urban Indian health programs.

If you or your family members are American Indian or Alaska Native, you may not have to pay cost sharing and may get special monthly enrollment periods. We are asking you to answer the following questions to make sure you and your family get the most help possible.

NOTE: If you need more space please attach another piece of paper.

	AI/AN PERSON 1	AI/AN PERSON 2	AI/AN PERSON 3
Name (First Name, Middle Name, Last Name)	First Middle Last	First Middle Last	First Middle Last
Member of a federally recognized tribe? **If yes**, give the name of the tribe.	☐ Yes _____ ☐ No	☐ Yes _____ ☐ No	☐ Yes _____ ☐ No
Did this person ever get a service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs or through a referral from one of these programs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Certain money received may not be counted for Medicaid or CHIP.

Does the income reported in Step 3, include money from any of the following sources?

☐ Yes ☐ No

If yes, how often and give amount below.

Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties?	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No
Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)?	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No
Money from selling things that have cultural significance?	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No

STEP 5

Please read and sign this application.

- I have provided true answers to all the questions on this form to the best of my knowledge. I know that there may be a penalty if I'm not truthful.
- I know that my information on this form will only be used to determine eligibility for health insurance and will be kept private as required by law. I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can call **1-800-XXX-XXXX** or visit www.placeholder.gov to report any changes.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I can confirm that no one applying for health insurance on this application is incarcerated (detained or jailed) or living in a medical facility.

Renewal of Coverage

I understand that if I'm eligible for help paying for health insurance, I may also be able to renew the coverage. During the renewal process, the Health Insurance Marketplace will use income data including information from tax returns of household members. This will determine yearly eligibility for help paying for health insurance for the next 5 years. The Marketplace will send me a notice and let me make changes. If I don't respond, the Marketplace will continue my eligibility at the level indicated by the data. I understand this renewal process will occur each year for the number of years that I check off below, but I may change my choice at any time by contacting the Marketplace.

☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Don't renew my eligibility for help paying for health insurance.

If anyone on this application is eligible for Medicaid:

- I know that if Medicaid pays for a medical expense, any money from other health insurance or legal settlements will go to Medicaid to reimburse for these services.
- *For parents who qualify for Medicaid:* I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I will not have to cooperate.
- I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me. I understand that a change in my status could affect the eligibility for a member(s) of my household.

Your right to appeal:

- If I think the Health Insurance Marketplace or Medicaid/CHIP has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/CHIP that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by (State description of process, including phone number). I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me. I understand that a change in my information could affect the eligibility for member(s) of my household.

Sign this application.

Signature	Date (month/day/year)
Signature	Date (month/day/year)

Congratulations, you're done! What happens next?

We'll let you know what programs you and your family qualify for within 1–2 weeks. You'll get instructions on how to take the next steps to get your health insurance. If you don't hear from us within 2 weeks, call **1-800-XXX-XXXX** or visit www.placeholder.gov. How about Agents?

Filling out this application doesn't obligate you to buy health insurance.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

You can choose an authorized representative.

You can give a trusted friend or partner permission to talk about this application with us, see your information and act for you on matters related to this application. This person is called an "authorized representative."

Do you want to name someone as your authorized representative?

☐ Yes ☐ No—Skip to Step 6

Name of Authorized Representative

Address	Apartment Number

City	State	Zip Code

Phone Number

( ) –

By signing, you allow this person to sign your application, to get official information about this application, and to act for you on all future matters with this agency.

Your Signature	Date

For certified application counselors and navigators only.

Complete this section if you're a certified application counselor or navigator filling out this application for somebody else.

Application Start Date

Counselor First Name, Middle Name, Last Name & Suffix

Organization Name	ID Number (if applicable)

STEP 6

Mail completed application.

Mail your signed application to:

Health Insurance Marketplace
1005 XYZ Drive
Washington, DC 20005

Did you remember to:

- ☐ Tell us about everyone in your family & household, even if they don't need insurance? (see page 2 for the list of who to include)
- ☐ Ask your employer about any job-related insurance?
- ☐ Sign this application on page 18.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Instructions for the Immigration Status and Self-Employment Questions

Eligible Immigration Status list:

Use to answer question about eligible immigration status.

- Lawful Permanent Resident (LPR/Greencard holder)
- Asylee
- Refugee
- Cuban/Haitian Entrant
- Paroled into the U.S.
- Conditional Entrant Granted before 1980
- Battered Spouse, Child and Parent
- Victim of Trafficking and his/her Spouse, Child, Sibling or Parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws and under the Convention against Torture (CAT)
- Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS) and Applicant for Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred Action Status
- Applicant for Special Immigrant Juvenile Status
- Applicant for Adjustment to LPR Status, with Approved Visa Petition
- Applicant for Asylum
- Applicant for Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Registry Applicants (with EAD)
- Order of Supervision (with EAD)
- Applicant for Cancellation of Removal or Suspension of Deportation (with EAD)
- Applicant for Legalization under IRCA (with EAD)
- Legalization under the LIFE Act (with EAD)
- Lawful Temporary Resident

For people who are self-employed:

You can subtract the costs below from your gross income to get an amount for your net self-employment income. For more information, see "Instructions for Schedule C" at www.irs.gov.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals

EMPLOYER COVERAGE FORM

Applying for help with health insurance costs from the Health Insurance Marketplace?

The Health Insurance Marketplace application asks questions about any health coverage available through a current job (even if it's from another person's job, like a parent or spouse) to figure out if you might be able to get help paying for health insurance. Use this form to get the information you need from the employer who offers health coverage. We'll verify this information, so it's important to be accurate. If you have more than one job that offers health coverage, use a separate form for each employer.

EMPLOYEE Information

The **employee** needs to fill out this section. Write down the employee's information then you may request the information below from the employer. Use this completed form when you fill out a Health Insurance Marketplace application.

Employee Name (First, Middle, Last)	Social Security Number
	__ __ __ - __ __ - __ __ __ __

EMPLOYER Information

Ask the **employer** for this information.

Employer Name	Employer Identification Number (EIN)
	__ __ - __ __ __ __ __ __ __
Employer Address	Employer Phone Number ( ) –
City	State / Zip Code
Who can we contact about employee health coverage at this job?	
Phone Number ( ) –	Email Address

Tell us about the **health plan** offered by this **employer**.

☐ This employee isn't eligible for coverage under this employer's plan.

The employee is eligible for coverage under this employer's plan on _____ (Start Date).

What's the name of the **lowest** cost self-only health plan this employee could enroll in at this job? (Only consider plans that meet the "minimum value standard" set by the Affordable Care Act.)*

Name: _____

☐ No plans meet the "minimum value standard"

How much would the employee have to pay in premiums for that plan?

$ _____ How Often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other: _____

*According to the standards set by the Affordable Care Act of 2010. If you're not sure, ask your employer or health insurance issuer.

***When and if I elect to be certified

Use the information in this form to complete your Health Insurance Marketplace application.

Apply online at **www.placeholder.gov**, or call us at 1-800-XXX-XXXX to get started.

QHP Model Contract Comment Received via E-mail

Subject: HEDIS and CAHPS Reporting / Promoting Care Coordination

Andrea and team-

Thanks for the opportunity to provide feedback on the redlined version of the model contract. In the last plan management advisory group call I heard strong pushback from plan representatives about key elements of the quality management and performance standards sections of the contract. While recognizing that the Exchange is asking plans to collect a robust set of information on quality and performance, this information is critical to the Exchange's ability to be an active purchaser and to drive health system change. The Exchange should not delay or forgo this role simply to ease the burden on plans. All of us should work harder to build the foundation of information we need to provide better and more affordable care for Californians.

Specifically there are two sections I wanted to address.

Section 2: HEDIS AND CAHPS Reporting
By eliminating the timeline for when QHP-level scores will be reported, the Exchange risks having less useful information for beneficiaries to use when selecting plans. If the Exchange plans to encourage consumers to choose higher quality, more affordable plans and providers, consumers will need quality and cost information at the most granular level possible. If the timeline cannot be reinserted into the contract language we hope this will still be reflected in the Administrative Manual.

Section 7: Promoting Care Coordination
We strongly recommend reinserting language in section 7.01 around the Exchange accessing participating provider contracts. Provider contracts that include anti-transparency terms are extremely harmful to fostering a competitive health care market. To the extent the Exchange can use its purchasing power to make payment terms transparent, it should.

Similarly, we suggest reinserting language in section 7.07 regarding provider competition and standardized reimbursement. The need for better monitoring of market competitiveness in California is clear and the need will not be met unless the Exchange plays this role.

There are several places where the proposed redlines have weakened the detail around requirements for value-based payment and pricing – we would encourage the Exchange in its negotiations to do its utmost to keep the bar high as we cannot afford a delay in seeing visible improvements in health and health care.

Sincerely,
Alana Ketchel

Senior Manager
Pacific Business Group on Health

California Association of Health Plans

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April 15, 2013

Ms. Andrea Rosen
Covered California
Interim Health Plan Management Director
560 J Street, Suite 290
Sacramento, CA 95814

VIA ELECTRONIC MAIL: qhp@covered.ca.gov

Re: Second Draft Model Contract

Dear Ms. Rosen:

The California Association of Health Plans ("CAHP") represents 39 public and private health care service plans that collectively provide coverage to over 21 million Californians. On behalf of our member plans, we appreciate the opportunity to provide public comment on the second draft model contract released on April 2, 2013.

The model contract is essential to the goal of signing contracts with health plans who will offer coverage in Covered California. Through CAHP, the bidders express their common views on most provisions of the draft model contract.

The Exchange released its first draft on January 11, 2013 and invited written comments. CAHP responded with a letter and 30 pages of specific concerns on January 24, 2013.

Exchange staff entertained many verbal conversations with stakeholders, including plans and CAHP, but did not sit down to work through the contract line-by-line.

The second draft model contract addresses some of the bidders' concerns, but remains in need of substantial work:

1. There are major issues that are summarized in this letter.
2. There are discreet, specific provisions that require clarification, modification, or deletion.

This important model contract would benefit from the kind of discussion and drafting that is commonly done with complicated legislation and other state programs (e.g. Healthy Families, Medi-Cal managed care).

It would be a mistake to ask the Exchange board to approve a model contract that is currently unworkable. It is better to fix it now than to expect each bidder to negotiate multiple provisions with Covered California after Board approval of a product that is not complete.

We realize time is of the essence, but want to emphasize the importance of having a model

contract that focuses on what is important in the first year of Covered California: to provide affordable coverage for as many Californians as possible. We have suggested major revisions to this draft model contract to ensure that Covered California and its contracted Qualified Health Plan Issuers (QHP Issuers) can concentrate on meeting this very important goal.

These comments represent hours of work by CAHP staff and health plan contract attorneys to provide detailed and substantive comments that represent the collective concerns of our diverse membership. While we understand that Covered California may have individual discussions with bidders regarding the model contract there are many concerns that apply across bidders.

CAHP and our member plans provided Covered California with substantive comments on the first draft model contract. We thank you for taking the time to review those comments and for addressing some of the concerns related to fees on QHPs outside of the Exchange and the prohibitions on upstreaming/downstreaming of funds. Nevertheless, many of the same concerns remain with the second draft model contract. Per your request, we have provided a redline version of the model contract with our suggested changes and comments to help provide context.

We have outlined several key principles below that the Exchange should use to frame the model contract. While this letter highlights some of the most challenging issues in the draft of the model contract, it is not a comprehensive list of the concerns our member plans have with the contract. We request that Covered California engage in dialogue with CAHP and our member plans on the comments and suggestions in this letter and its attachments as soon as possible.

Covered California Must Focus on Key Responsibilities of Plans to Ensure Success in 2014

The most important challenge for the Exchange and QHP Issuers in 2014 is to get individuals who are eligible for subsidies in the door. We believe that too many provisions in the draft model contract and attachments are completely unrelated to this core mission. We urge that extraneous provisions be aggressively deleted. The strongest role the Exchange can play in shaping health care delivery will come once the Exchange is operating on a firm foundation. We suggest that the contract be scrutinized with this focus in mind. We have provided several redline edits to help achieve this goal.

While CAHP acknowledges that on April 12th Covered California announced that it will delay a decision by the Board on the Performance Measurements we have significant concerns with the current draft of the contract. We support the concept of performance guarantees and agree that there should be penalties for poor performance and credits for exceptional performance. However, we believe that the Performance Guarantees as outlined in Attachment #14 are too ambitious for the first year.

For example, Covered California should focus on operational metrics first and several of those metrics were included in the draft model contract. However, we suggest that there be a 6 month baseline period for operational and customer service measures. Particularly in the first year, a longer lead time will provide a better reflection of both the true longer term volume and longer term expected utilization.

CAHP's member plans fully intend to provide Covered California and QHP enrollees a similar level of operational and customer service standards as other purchasers receive. Unfortunately, the performance targets, as currently drafted, are not realistic and would require significant

additional costs for health plans thereby increasing premiums and adversely impacting enrollment.

We have provided some modifications in redline language to the targets that match them to performance guarantees with other large purchasers, such as CalPERS. Health Plans look forward to the opportunity to discuss this with you in more detail prior to release of the next draft of Attachment 14.

Covered California Should Also Take On Responsibilities

Covered California and QHP Issuers share common goals and responsibilities for enrolling consumers in coverage. However, the contract focuses almost exclusively on the obligations of QHP Issuers to achieve this goal, even though parallel requirements for the Covered California are equally crucial. Therefore we believe the contract should specify standards that Covered California will adhere to.

For example, we ask Covered California recognize that there is a joint responsibility for the operational performance of QHP Issuers to meet customer needs and expectations. We propose that QHP Issuers not be assessed penalties on operational results that have a direct corollary with Covered California operations (e.g. Call Center Operations), if its own performance on that metric for that time period is not better than that of the QHP Issuer. We have provided redline changes and comments to the model contract for your review.

Additionally, this model contract does not recognize the responsibility of Covered California to ensure that timely data is provided to plans and that plans are not left in financially unstable situations as a result of delays in payments from Covered California. We believe it is important to clearly outline standards to which Covered California will be held and to ensure that plans are not liable for delays, omissions, or mistakes that are a result of Covered California failing to meet its obligations under this partnership. We have provided several suggestions in redline throughout the contract to acknowledge this partnership.

We would also note that current state law imposes requirements that must be incorporated into the CalHEERS enrollment process, including those related to broker attestation and binding arbitration. Please see redline changes to model contract.

A Purchaser, Not a Regulator

We believe Covered California should think first like a purchaser, where it can add far more value through quality and service performance metrics, have a role as a secret shopper, analyze its own call data to provide feedback to contracting plans, and ensure consumers are connected to regulatory assistance when needed.

Unfortunately, there are numerous provisions in the draft model contract in which Covered California assumes the position of a regulator by placing provisions of the Knox Keene Act, pending legislative proposals, and regulatory provisions into the contract. The result is that Covered California is, in effect, setting up parallel processes to those in place at regulatory agencies. We would propose that Covered California focus on cases where requirements are unique to coverage offered through the Exchange.

Fortunately, there are robust reporting requirements in current state and federal law that Covered

California can rely on to ensure compliance with many of the requirements in the draft contract. It would be more cost effective for both Covered California and QHP Issuers to leverage existing reporting requirements rather re-create the wheel. Otherwise we will unnecessarily increase premiums and adversely impact affordability.

Following is a partial list of examples where we believe that Covered California has stepped beyond its role as a purchaser. Please see corresponding redline changes to the model contract and other redlines changes reflecting this principle.

Marketing Requirements: We are concerned that Covered California will not have sufficient time or resources to ensure that plan marketing materials can be reviewed and approved within 14 days as outlined in this contract. We note that marketing and communications materials for individual and small group market products are already subject to regulatory review.

As an alternative, we suggest that QHP Issuers file only those documents and materials that are specifically directed at the Exchange population with Covered California and that the appropriate regulator maintain responsibility for materials that are for the entire or non-Exchange marketplace. This will allow Covered California to have access to the files that are relevant to its operations, and to review as necessary, but will not cause delays in the marketing campaigns of QHP Issuers or overwhelm the Exchange with documents that it does not need to review, which will be vital to ensuring timely enrollment.

We also request that Covered California remove provisions of the contract that require the printing and mailing of documents and suggest that all materials, with the exception of the ID card, be available on-line with an option for consumers to request printed materials. We believe this will reduce unnecessary costs and administrative burden.

We are also concerned with the contract provisions that require QHP Issuers to submit their marketing plans/budgets for products both in and out of the Exchange. We believe that this exceeds the scope of Covered California's interests and we are not clear what value these documents will provide.

Co-Branding Requirements: The requirements for co-branding appear problematic for health plans and confuse the role of Covered California as a purchaser. Requiring the Covered California logo on ID cards and other plan documents will have large systems implications and costs at a time when the focus needs to be on the affordability of products. We are also concerned that this will confuse enrollees regarding who they should be contacting for help and may pull Covered California staff away from critical tasks. We suggest that the requirements for co-branding be minimal and that Covered California carefully weigh the anticipated benefits with the associated costs and possible downsides to such a policy.

Threshold Languages/Translation: There are existing requirements for threshold languages and translation in both state and federal law and all QHP Issuers will have to be in compliance with these standards. It is duplicative and confusing for the Exchange to have alternative standards. The requirements in the draft contract that both Issuer call centers and websites must be provided in all threshold languages are not realistic. For example, Covered California has opted to only provide its website in English and Spanish. The challenges that come with such a requirement are understandable. We respectfully request that Covered California delete these requirements

from the contract as compliance would be extremely difficult and prohibitively expensive.

Extensive Reporting Requirements: While we agree that robust monitoring and quality data reporting is important, Attachment #17 contains over 70 required reports from QHP Issuers. We believe that the administrative burden of completing all of these reports distracts QHP Issuers from a focus on the successful launch of Covered California. We suggest that Covered California carefully evaluate the importance of each requested report and determine if reporting beyond what is required by the regulators has an added benefit that outweighs the potential costs in time and resources.

PCP Assignment: The Exchange needs to ensure that the requirements in the contract are appropriate for all delivery models with which they are contracting. However, the contract would require network plans to assign a primary care physician even though network plans in the current market do not employ a gatekeeper model. Because of the significant system implications and potential market confusion that would result from this requirement, we believe that Covered California should remove any such requirement from the contract.

Focus on Individuals Not Already Connected to Care, and Identify and Connect High-Risk Individuals to Care

Covered California requirements regarding on-boarding should focus on those who can most benefit from early interaction with care providers. We believe these are individuals who are new to coverage and those who are identified as having high-risk or chronic conditions. We suggest allowing for flexibility in the approach plans take to accomplish the onboarding and identification of high risk individuals. Please see redline suggestions.

Focus On a Few Core Quality Improvement Strategies

To be successful in improving quality, we believe Covered California must focus on a very few high-value quality initiatives that 1) are backed by evidence, and 2) will improve health for large numbers of individuals. The Exchange must make choices and consider what two or three quality initiatives Covered California could undertake to have the most impact. In contrast, there are over 17 pages of quality improvement strategies in Attachment #7.

We also note that it is imperative to allow for flexibility in the approaches used in different plan models (e.g., PPOs, HMO network models, HMO dedicated provider models, etc.)

Covered California cannot attempt to promote every idea, no matter how meritorious they appear to be. We believe this is true in the third year as much as in the first year. We suggest that Covered California develop the elements of these strategies in conjunction with plan and provider experts and not enshrine detailed process elements in the contract. One approach that the Exchange may want to consider is collaborating with QHP Issuers on a particular area of interest and develop a three-year Quality Improvement Project, which is similar to what is done in both Medicaid managed care and Medicare. QHP Issuers would be rewarded at the end of the three-year period for demonstrated improvement or be subject to penalties.

Focus On What Is In the Market

In general, we urge the Exchange to focus on what is in the market today, and be highly selective in imposing new requirements. For example, the contract attempts to modify many contractual

provisions that govern relationships between plans and providers and plans and agents. The impact of such changes should not be understated.

While CAHP strongly supports the goals of transparency, accountability, and the need to deliver higher value in health care in several places the draft contract would require us to violate terms of our contractual agreements. These are a few examples:

Disclosing Contracted Rates: CAHP supports disclosure of cost and quality information to our members and the public that will assist individuals and employers in choosing healthcare providers. Disclosure of cost information at that level would have anti-competitive effects and could even be considered an antitrust violation by federal regulators. We appreciate the changes that were made in the revised red-line of the attachment, and want to make sure that those changes carry through to other sections of the contract.

Violating Agreements with Brokers: Section 3.28(c) appears to require QHPs to change broker or agent rates even if those rates are an obligation under existing contracts. In many cases, an agent has a vested right to renewal commissions at a particular rate and basis. QHP Issuers can only adjust commissions to the extent permitted in their contracts. We hope Covered California will acknowledge that limitation by accepting our redline suggestions

Plan Captive Agents and Staff: It has been the understanding of CAHP and our member plans that captive agents and health plan staff would not be required to market all QHP Issuers offered through Covered California so long as current/potential enrollees are informed that there are other options available. Several areas in the contract appear to require that health plan staff and/or captive agents will provide information on all QHP options available to an enrollee. We request that Covered California clearly state, as proposed in redline, that it will not require plan staff or captive agents to market all available QHP Issuers.

In addition, we do not believe it is the intent of Covered California to provide mandatory scripts for health plan staff/captive agents. Therefore, we would appreciate clarification in the model contract that QHP Issuers will be permitted to develop their own scripts, which would be subject to review and approval by Covered California.

The Contract Must Contain All Relevant Requirements

We are concerned that many crucial elements of the model contract are referenced in the contract yet to our knowledge they do not exist. For example, the Administrative Manual is referenced twenty six times in the contract and nine additional times in the attachments, yet this document is not scheduled to be released until after we have provided our comments on this second draft model contract. Several other documents are also included by reference, but have not been provided for review, including but not limited to: the Compliance Addendum, Exchange Protection and Information Policies, Covered California Brand Guide Book, and Change Control Procedures.

Clearly, the terms and conditions of this contract will be significantly impacted by policies and protocols in documents that have not even been released. We respectfully suggest that Covered California incorporate these items into the contract and provide plans with sufficient time to review and negotiate any language.

In conclusion, we appreciate your review of our comments and we request that Covered California meet with CAHP and its member plans prior to Board approval of this contract to discuss in detail the issues outlined in this letter and in the redline versions of the contract and its attachments.

Sincerely,

Charles Bacchi,
Executive Vice President

cc: Ken Wood, Senior Advisor for Products, Marketing, and Health Plan Relationships
cc: Peter Lee, Executive Director

California Association of Health Plans

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March 27, 2013

Mr. Brandon Ross
California Health Benefit Exchange
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Sacramento, CA 95814

VIA ELECTRONIC MAIL info@hbex.ca.gov and Brandon.Ross@covered.ca.gov

Re: Emergency Regulation 2013-0322-02E: Qualified Health Plans Standard Benefit Designs

Dear Mr. Ross:

The California Association of Health Plans ("CAHP") represents 39 public and private health care service plans that collectively provide coverage to over 21 million Californians. We appreciate the opportunity to comment on the **Emergency Regulation 2013-0322-02E: Qualified Health Plans Standard Benefit Designs** and look forward to working with you address the issues outlined in this letter. Please contact me if you have any questions or would like to discuss any of these items in more detail.

CAHP has both suggested changes to the language in the regulation, which are further explained and provided below, and several areas of the standardized plan benefit designs incorporated by reference that require clarification by the Exchange in order for plans to successfully implement the standardized plan benefit designs.

As it relates to our suggested changes to the regulation we recommend that Covered California have explicit authority to modify the standard benefit plan designs dated March 15, 2013 to comply with state or federal regulatory guidance. There are a number of areas with respect to the Essential Health Benefits (EHBs) and preventive care cost-sharing provisions of the federal Affordable Care Act (ACA) where current guidance is limited or open to differing interpretations. These areas may substantially affect the proposed standard benefit plan designs, since the designs must comply with these and all aspects of the ACA. Therefore, we believe it is imperative that Covered California have explicit authority to modify the proposed standard plan designs to comply with state or federal regulatory guidance.

In addition, the Covered California Board established as Board policy that it may, in its discretion, allow minor variation (as allowed under federal law) to the proposed standard benefit plan designs at the request of a bidder. We strongly recommend that the proposed regulation reflect this discretionary authority. Absent this change, carriers may be forced to bid standard benefit designs without even minor variations. This result would be contrary to the Board's intent, and would undermine the effective operation of the Exchange on behalf of California consumers.

We have provided updated language below that reflects these requested changes.

SECTION 6426: STANDARD BENEFIT PLAN DESIGNS

(a) In responding to the Qualified Health Plan Solicitation, Bidders must use the Standard Benefit Plan Designs established by the Exchange. The Standard Benefit Plan Designs are identified in the Standard Benefit Plan Designs -FINAL, dated March 15, 2013, which is hereby incorporated by reference. The Exchange may modify the Standard Benefit Plan Designs to comply with state or federal regulatory guidance.

(b) Bidders must submit either the co-pay or co-insurance plans in the Standard Benefit Plan Designs - FINAL, dated March 15, 2013, or a combination of the co-pay and co-insurance plans in order to offer coverage at all four levels of coverage and the catastrophic level of coverage in Bidders' proposed geographic service areas. However, Bidders for plans in the SHOP are prohibited from submitting bids for the catastrophic coverage level. The Exchange may, in its discretion, allow minor variation from the proposed standard designs by a participating carrier. Bidders must submit their plans and premium bids pursuant to this section no later than 5:00 pm Pacific Time on April 2, 2013.

Other areas of concern related to the standardized plan benefit designs, incorporated by reference in these regulations, are summarized in the following paragraphs. CAHP believes there are still several areas where additional clarification on the standardized plan benefit designs is necessary to prevent confusion and allow plans to operate as Covered California intended.

For example, the Bronze benefit design includes both a member cost share of $300 and a deductible for Emergency room services and a $300 cost share and deductible for the Emergency Transportation benefit. It is not clear if it is the intent of Covered California for this to be a one-time cost share of $300, (e.g. works like an additional deductible of $300 just for the Emergency & Emergency Transportation) or a co-pay after the deductible has been met, or some other arrangement entirely. With issues such as this still outstanding we believe it is important that Covered California not put something into regulation that it does not have the flexibility to clarify and update as necessary.

CAHP's member plans also believe that reasonable flexibility should be provided to plans when administering certain benefits in order to avoid any last minute administrative complexities or process changes. For instance, some plans have advised Covered California that they would prefer for the co-pays to include all services that might occur during an office visit such as Lab and X-ray - as this is how their systems are administered. While other carriers advised that services such as lab and x-ray needed to be aligned with the appropriate benefit category and cost sharing (i.e. it is separate and distinct from an OV co-pay.) These minor differences among plans exist in the market today, and we believe that Covered California should continue to allow such differences to exist in the standardized plan benefit design structure.

In conclusion, we would like to thank you for your time and we appreciate your review of these issues. Again, we are available at your convenience to discuss any of the issues outlined in this letter.

Sincerely,

Athena Chapman
Director of Regulatory Affairs

cc: Andrea Rosen, Interim Health Plan Management Director

California Association of Physician Groups

April 15, 2013

Peter V. Lee
Executive Director
Covered California 560 J Street
Suite 290
Sacramento CA 95814

Via Email and U.S. Mail

Dear Peter,

Based upon our reading of the Covered California QHP Contract Discussion Draft dated April 3, 2013, we want to applaud your effort to bring coordinated care to PPO products. We, therefore, generally support this second draft contract.

We must, however, reserve final comment and judgment until we have had the opportunity to thoroughly review the second draft with our members. Unfortunately, the twelve calendar days between publication of this draft and today's comment period deadline was not sufficient to permit us to disseminate, review and discuss it with our membership. We will get our substantive comments to you as soon as possible.

Best regards,

Donald H. Crane
President/CEO

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CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

April 15, 2013

Peter V. Lee
Covered California
Executive Director
QHP@hbex.ca.gov

Subject: Second Draft, Qualified Health Plan Model Contract

Dear Mr. Lee:

The California Hospital Association, which represents more than 400 hospitals in California, is pleased to provide comments on the second draft of the qualified health plan (QHP) model contract ("Draft") released April 3, 2013, and the redline of the attachments to the QHP model contract released on April 12, 2013. We appreciate the opportunity Covered California has provided to hospitals and other stakeholders to engage in this process.

Before providing specific comments, we generally note that the Draft in many cases unnecessarily duplicates regulatory agencies and imposes requirements that conflict with existing law. The California Department of Insurance and the California Department of Managed Health Care, as well as other state and federal agencies, regulate licensed insurance companies and health care service plans that will be participating in Covered California as health insurance issuers. For example, grievance processes, quality of care requirements and termination processes and notices are already heavily regulated or involve nationally accepted standards by accrediting agencies or professional associations. Covered California should not become a third regulator because it will lead to duplicative requirements, ambiguity, added administrative costs and liability risks.

Section 2.03 requires plans to submit a complete data set, inclusive of all claims, encounter and pharmacy data, on a quarterly basis to Covered California or their designated recipient. This section does not specifically address the confidentiality of that production. The information contained in a data set (claims, etc.) could include information regarding rates and other highly proprietary information. A strict confidentiality provision should be included to address this claims data.

Section 3.09(f) requires plans to provide Covered California with provider contracts, including payment terms. Provider contracts and payment terms are proprietary, confidential and competitive. There is no policy reason for Covered California to have this detailed information since it is negotiating with the health plan issuer on premium rates – detailed proprietary contract information from specific providers is not necessary for the purpose of negotiating premiums. In addition, Covered California may obtain aggregated information from its contracted health plan issuers, which is sufficient to satisfy any legitimate policy purpose without needing to access individual proprietary provider contracts. Therefore, we are concerned this sensitive information will not remain confidential and that it could be used by other parties inappropriately or for anti-competitive reasons.

Section 3.15 requires plans to disclose to enrollees all costs associated with non-emergent out-of-network costs and require that providers inform enrollees, in a manner that allows them the opportunity to act upon

a recommendation regarding the use of an out-of-network provider, and disclose if the plan of care requires the use of an out-of-network provider. There are several practical considerations regarding implementation of this section regarding out-of-network services. While we appreciate the policy considerations in providing notice to enrollees about the possibility of out-of-network care, existing California law makes it difficult, and in some cases impossible, for a hospital to provide the required notice. Existing law regarding the ban on the corporate practice of medicine prohibits most hospitals from employing physicians. Physicians that are hospital based (e.g., radiologists, anesthesiologists, pathologists, etc.) make their own business arrangements and are often "out-of-network" even when the hospital is contracted. These relationships are continuously changing, and thus it is impossible for the hospital or medical group to have real-time information on the contracting status of other independent parties. We suggest that contracting health plan issuers provide the notices because they are in the best position to know who their contracting providers are and have utilization management programs in place to address these issues.

Sections 10.01-.03 require participating providers to accurately keep clinical and financial records for at least seven years; however, the policy is open-ended if there is any "research, evaluation or other action." These terms are ambiguous. Given the sensitive nature of clinical records, we recommend that Covered California avoid establishing ambiguous standards that conflict with comprehensive state and federal law governing clinical records.

Section 13.02 indicates that, in addition to the requirements in existing law and the Draft, there will be additional policies and procedures set forth in the Administrative Manual. These policies and procedures will likely impose significant additional obligations on health plan issuers and their contracting providers. Accordingly, the Administrative Manual must be available at the time of contracting. This definition additionally provides that the Administrative Manual will be updated "as needed," which could result in frequent *ad hoc* changes that must be immediately implemented without stakeholder review and comment. We recommend that routine changes to the Administrative Manual be carried out on an annual basis and prior to contract renewal with advance notice and the opportunity for stakeholders to review and comment. This will prevent what often is a steady stream of administrative changes that are conflicting, difficult to implement and carry significant unintended consequences.

The following comments relate to *Attachment 7. Quality, Network Management and Delivery System Standards*:

> Article 2.02 requires plans to report the percentage of providers participating in various quality initiatives, including those developed by the plan. We appreciate that Covered California revised this section to so that quality initiatives are not limited to only those listed in this section, and appreciate that quality initiatives developed by hospitals may also be included.
>
> Article 6.01 requires plans to make provider-specific cost and quality information available by region. Article 6.02 requires plans to make available pricing information to both plan enrollees and contracted providers. While we support Covered California's effort to provide transparency around provider quality and beneficiary cost, we are not supportive of plans being required to provide detailed proprietary contract information, as we are concerned this sensitive information will not remain confidential and that it could be used by other parties inappropriately or for anti-competitive reasons.
>
> Article 7.01 would have required plans to provide Covered California with access to any and all provider contracts, including payment terms. We appreciate that Covered California has omitted

this section, as this is proprietary information. We request that the language in Attachment 5 that references Article 7.01 also be omitted.

Thank you for the opportunity to provide comments on the second draft qualified health plan model contract. We prepared comments quickly to meet Covered California's compressed timeframe. Should we identify other areas of concern, we will submit our comments to Covered California in an expeditious manner. We look forward to working with Covered California regarding further revisions to the Draft.

Sincerely,

Amber Kemp
Vice President, Health Care Coverage

cc: Andrea Rosen

California Medical Association
Physicians dedicated to the health of Californians

April 15, 2013

Peter Lee, Director
Covered California Board
560 J Street, Suite 290
Sacramento, California 95814

Submitted electronically to *QHP@hbex.ca.gov*.

RE: Comments on Covered California QHP Model Contract – Second Draft

Dear Mr. Lee and Members of the Board:

On behalf of the California Medical Association (CMA) and its more than 37,000 member physicians, we want to thank you for considering our input on the Covered California Qualified Health Plan Model Contract – Second Draft (issued April 4, 2013; redlines issued April 12, 2013). We believe this is the keystone document to determining the success of Covered California in 2014.

Our comments, concerns, and requests for clarity regarding the California Qualified Health Plan (QHP) Model Contract – Second Draft (hereinafter "Model Contract"), are provided below.

General Remarks

First, CMA is encouraged by Covered California's increased attention to critical tasks in the Model Contract like ensuring there are adequate networks awaiting enrollees in 2014. We are hopeful that Covered California efforts such as spot-checking networks will be effective in assuring enrollees that they will have the access to providers they need under the coverage they purchase. We further believe that more stringent provider directory standards and procedures will benefit both patients and physicians.

Recent events illustrate the importance of monitoring and enforcing network adequacy, such as the Los Angeles civil trial of *Dr. Jeffrey Nordella v. Anthem Blue Cross*. At this trial, which resulted in compensatory damages of $3.8 million to Dr. Nordella, Anthem could only produce a verified list of 7 physicians after originally contending it had 137 family practice physicians within 10 miles of Porter Ranch – roughly 5 percent of the original list. CMA has found an approximately 50 percent accuracy rating in its own review of a PPO's specialist provider directory for Humboldt County. Furthermore, regarding HMOs, California's Office of the Patient Advocate (OPA) gave 7 of the 10 HMOs it reviewed a rating of "poor" on patient access – with the remaining 3 only rated as "fair."

Insufficient network adequacy monitoring and enforcement have contributed to the current situation. California's regulators rarely, if ever, attempt to verify the directories submitted to them by insurers and health plans. In general, the insurers and health plans simply attest that the

directory is accurate at the time of licensing, and the regulators generally accept this without independent verification unless they receive a significant volume of patient complaints regarding access. The average patient, unfortunately, does not call the regulator when a physician says the practice no longer accepts that insurance or when no appointments are available within a reasonable timeframe. The patient often simply goes on to the next physician on the list and bears any added inconveniences, allowing network adequacy and directory accuracy issues to persist.

Because of the prevalence of provider directory inaccuracies and network inadequacy, we are also concerned with the deletion of important patient protections from the first draft of the Model Contract. The clear requirements on QHPs to provide alternate care arrangements where network providers are not available can be a valuable incentive in encouraging QHPs to maintain adequate networks. We recommend that Section 51 of the first draft of the Model Contract be incorporated into current Section 7.08 of the Model Contract.

Second, physicians should be spending more time caring for patients and less time on administrative tasks. It is no secret that physicians are at their breaking point in terms of the myriad administrative demands being put on practices, which is one reason why bills were passed like SB 866 (Hernandez, 2011) to bring uniform medication prior authorization forms. Reducing administrative burdens across QHPs could serve as a huge selling point to physicians on participation in Covered California and, more importantly, allow more physician practices to invest more time and focus on caring for patients.

Recommendations for administrative simplification were adopted this past August by the Covered California Board in the QHP Policies and Strategies Recommendations Brief. However, much of the requirements in Attachment 7 of the Model Contract, among others, will run contrary to those recommendations. A number of the new monitoring and reporting requirements on QHPs in the Model Contract will be borne ultimately by the delivery system and will offer little in the way of improving care, as well as result in potentially significant administrative costs.

Finally, CMA is still gravely concerned about the impact of the federal 90-day grace period on patient access, especially access to specialists and sub-specialists. The federal grace period would potentially leave many providers and federally subsidized patients with huge financial liabilities. Under federal law, QHPs are provided with the option of how they treat claims submitted during the last 60 days of the 90-day grace period, while state licensing laws generally require that payors honor authorized claims for services provided in good faith. Covered California should take all necessary steps to protect patients and providers from the potential negative impacts of federal grace period provisions. The uncertainty on this issue is serving as a further deterrent to physicians, especially specialists, from signing onto QHP products.

CMA's more specific comments, concerns, and requests for clarity regarding the Model Contract are provided below.

Specific CMA Comments by Section	
Section	**CMA Comments**
3.02: Licensure and Good Standing	Although we remain concerned about basing "material" on industry-defined standards, **CMA supports the use of Attachment 3 and the specificity with which Covered California has outlined the definition of "good standing" therein**. We very much hope that Covered California and the regulators will rigorously monitor and enforce this standard.
3.05: Network Requirements	**CMA supports the enhanced requirements on provider directory accuracy and believes significant potential exists in the maintenance of a centralized Covered California provider directory**. We, however, are concerned with the termination of the more prescriptive consumer protections at Section 51 of the previous draft of the Model Contract and accordingly recommend reinsertion of those provisions either at Section 3.05 or Section 7.08. The Section 51 provisions for reinsertion in the Model Contract are in relevant part: • QHP issuers must "make a reasonable effort to secure alternate arrangements for the provision of care by another Participating Provider without additional expense to the Enrollee" if: (1) The network provider's contract is terminated; or (2) the network provider is unable or unwilling to provide care to "any Enrollee." • If the alternate arrangements are unavailable or deemed unsatisfactory by the Exchange due to access or quality issues, the QHP issuer must cover the affected enrollees' services on a fee-for-service basis, ensuring that enrollees pay in-network cost-sharing for any out-of-network services received. • Under a fee-for-service arrangement, any affected treatment plan shall continue until completion or until the patient (1) agrees to see another network provider, (2) is no longer covered, or (3) is transferred to another QHP, whichever occurs first. These protections would serve as a more effective means to ensure issuers maintain policies and procedures to preserve and enhance network development, as stated in Section 3.05(d).
3.10: Transparency in Coverage	**CMA recommends the following amended language to the first sentence of Section 3.10:** Contractor shall provide the Exchange, *Participating Providers,*

	and Enrollees with information reasonably necessary to provide transparency in Contractor's coverage . . . Providers must have the means to be kept current on issuers' coverage policies pursuant to state law.
3.15: Enrollee's Out-of-Network and Other Costs; Network Requirements	CMA opposes the imposition of unduly burdensome disclosure requirements on providers regarding the use of out-of-network providers or facilities. **CMA consequently recommends that reasonable knowledge requirements be included in subsection 3.15(ii), such that physicians are provided safe harbors for reasonable reliance on a QHP's provider directory.** Provider directories are commonly found to contain inaccuracies. As stated above, recent examples have included PPO provider directories that were up to 95 percent inaccurate. CMA recommends adding the following language to the end of subsection 3.15(ii): *Participating Providers may reasonably rely on the Contractor's publicly available provider information regarding contracting status*.
3.17: Utilization Review and Appeals Process	**We strongly support the ability of a participating provider to challenge a pre-service utilization review decision on the enrollee's behalf**. This allowance for an additional patient advocate will serve as a key protection for enrollees, as their participating providers will have a greater understanding of many issues facing patients in the health care system.
3.22: Termination of Coverage	As stated in the general remarks above, the possibility of having 60 days of submitted claims denied for a federally-subsidized patient is acting as a significant deterrent to participating in Covered California products for many physicians, particularly specialists. Though federal law requires that a grace period of 90 days apply to federally subsidized enrollees, flexibility exists for QHPs in how they treat enrollee claims submitted during this grace period. **CMA strongly recommends that Covered California utilize its powers as an active purchaser to prohibit or discourage to the fullest extent possible the suspension and denial of provider claims during the last 60 days of the federal 90-day grace period**. CMA and our partner stakeholders on this issue would very much like to work with Covered California on how to eliminate or reduce the negative consequences of this wholesale ability to deny claims.

	Please see the attached comment letter, *Impact of the Final Federal Exchange Rule's Grace Period Revision (45 CFR § 156.270) on Qualified Health Plan Enrollees and Providers*, dated August 6, 2012, for further information on this issue.
4.03: Contractor Quality Management Program	As stated above, administrative simplification and the general reduction of waste in the health care delivery system due to unnecessary administrative burdens could be one of Covered California's biggest selling points to providers and significantly increase access to care for many patients. Unfortunately, the Model Contract appears to pay little attention to the need for administrative simplification – outside of broad strokes such as the "reduce inefficiencies of the current system" in Section 4.01. That being said, **CMA recommends the addition of the following language to Section 4.03**: *Contractor shall seek to reduce to the greatest extent possible the administrative burdens on Participating Providers related to Contractor's quality management program*.
7.06: Contractor Insolvency	**CMA recommends adding language to make it explicit that disclosures related to financial distress should be made as soon as possible and pursuant to regulators' financial solvency standards, as opposed to waiting until a bankruptcy action.**
7.08: Effect of Termination	**CMA recommends reinsertion of the consumer protection measures from Section 51 of the Model Contract's previous draft at either Section 7.08 or Section 3.05**. We believe these are critical deterrents to network overstatements and inaccuracies, such as those described in this letter's introduction. Covered California enrollees will be purchasing coverage with the expectation of meaningful access. Section 51's protections held significant promise towards ensuring coverage would mean access in 2014 and that the 95 percent directory inaccuracy of the *Nordella* case would be a thing of the past. These Section 51 provisions for reinsertion in the Model Contract are in relevant part: • QHP issuers must "make a reasonable effort to secure alternate arrangements for the provision of care by another Participating Provider without additional expense to the Enrollee" if: (1) The network provider's contract is terminated; or (2) the network provider is unable or unwilling to provide care to "any Enrollee."

	• If the alternate arrangements are unavailable or deemed unsatisfactory by the Exchange due to access or quality issues, the QHP issuer must cover the affected enrollees' services on a fee-for-service basis, ensuring that enrollees pay in-network cost-sharing for any out-of-network services received. • Under a fee-for-service arrangement, any affected treatment plan shall continue until completion or until the patient (1) agrees to see another network provider, (2) is no longer covered, or (3) is transferred to another QHP, whichever occurs first.
Article 13: Definitions	**All terms not used in the Model Contract or its attachments should be deleted, especially "medically necessary" and "medically appropriate."** The introductory paragraph to Article 13 expressly states that "capitalized terms used in the Agreement and/or Attachments shall have the meaning set forth below," which leads to confusion for stakeholders when the terms do not appear and takes the Model Contract into murky legal territory. If the terms are intended to be used in forthcoming documents or attachments, they should be defined at that time. Until such time, Covered California is asking stakeholders to accept definitions for which there is no context. Furthermore, many of these unassociated terms have a significant impact on the operations of providers, health plans, and insurers and consequently create considerable ambiguity due to these definitions' considerable variance with industry definitions. Finally, the definitions provided by Covered California for terms like "medical necessity" and "medically appropriate" could be viewed as controversial by those concerned with the possibility of aggressive care rationing.
13.11: Case Management	<u>Recommended language</u>: Contractor's medical utilization and oversight systems that attempt to optimize ~~the most effective~~ available benefit coverage and resources *for the maximum health benefit to* Enrollees with complex and exceptional needs due to chronic or catastrophic illness or injury. The deleted language is redundant. The added language seeks to address a noticeably absent focus on achieving the best health outcomes for complex patients, as the definition currently reads like an insurers' fiscal management standard.

13.17: Covered Services	Recommended language: **The Health Care Services ~~that are Medically Necessary~~ that are covered benefits under the applicable QHP and described in the EOC.** The use of "Medically Necessary" here is unneeded and inconsistent with Covered California's encouragement of wellness and preventive services elsewhere in the Model Contract (e.g., Section 3.02 of Attachment 7). The deletion of "that are Medically Necessary" also allows Covered California to delete the unused term "Medically Necessary" from Article 13 while keeping the used term "Covered Services."
13.36: Grace Period:	Recommended language: A specified time following the premium due date during which coverage remains in force and ~~an Enrollee or Employer may pay~~ the premium *may be paid* without penalty. Circumstances may arise necessitating the payment of an outstanding premium balance by a party other than the enrollee or employer. Changing the clause to passive voice eliminates any unnecessary restriction on parties that may pay an outstanding premium balance and may be inconsistent with current law.
13.53: Medical Necessity (Medically Necessary Services)	**For the reasons outlined above at Article 13, we recommend deletion of this term from the definitions list.** The term is not used in the Model Contract or its attachments, outside of the "Covered Services" definition example above for which we recommend deletion of the "Medically Necessary" language. The term's "as determined through the Plan's review process" language appears to be inconsistent with California's bar on the corporate practice of medicine. Additionally, the proposed definition does not appear to account for wellness and preventive services, which other areas of the Model Contract appear to encourage (e.g., Section 3.02 of Attachment 7). If Covered California is intent on keeping the term in Article 13, we recommend the following substitute language: ~~Health Care Services as determined through the Plan's review process to be reasonable, necessary, appropriate, and established~~

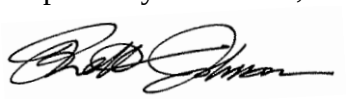
	~~as safe and effective for the diagnosis and/or treatment of a Enrollee's illness, injury, or condition. The Plan's review processes are consistent with Contractor's medical policy and the definition of medical necessity contained in the Plan's EOC.~~ *Health Care Services that a prudent treating physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site and duration; and (3) not primarily for the convenience of the patient, physicians, other health care provider, or for the financial benefit of the health plan or insurer.*
13.55: Medically Appropriate:	**For the reasons outlined above at Article 13, we recommend deletion of this term from the definitions list.** The term is not used in the Model Contract or its attachments, and commonly used definitions of the term in industry are much less prescriptive than that found at Section 13.55, which could result in harm to both patients and providers. Furthermore, the definition's cost-effectiveness requirement could result in significantly negative unintended consequences and fuel the rationing concerns of some. Medical appropriateness and fiscal appropriateness are independent concepts and should remain as such. For example, in the Los Angeles area, Kaiser-Permanente protocol calls for the administration of thrombolytics to ST segment myocardial infarction (STEMI) patients overnight instead of taking them to the catheter lab for primary percutaneous coronary intervention (PCI), because the former is more cost-effective than having a catheter lab team on-call. While the former may be more cost-effective, few, if any, cardiologists would agree it is the most medically optimal or appropriate course of treatment for these patients. Similarly, the Veterans Administration and Los Angeles County use stool samples to screen for colon cancer instead of colonoscopies, because this is more cost-effective. Again, few would argue that the former is the most medically appropriate option. If Covered California is intent on keeping the term in Article 13, <u>we recommend the following substitute language:</u> Health Care Services that are Medically Necessary and that are: (1) consistent with the symptoms of a health condition or treatment of a health condition, illness, or injury; (2) appropriate with regard to ~~the most current standard of practice for~~ the safe

	and effective assessment, treatment, or management of the applicable health condition, illness~~, or injury as determined by the relevant scientific community and professional bodies~~ *in accordance with current standards of good medical practice in the service area of the State*; (3) not solely for convenience of a*n* Enrollee or the Health Care Professional providing the Health Care Services; and (4) ~~more cost-effective than alternative services or supplies that could be employed for the safe and effective assessment, treatment, or management of the applicable health condition, illness, or injury under prevailing standards of scientific knowledge and clinical practice among practitioners with like credentials providing Health Care Services in the State~~ *the most appropriate level or type of Covered Service which can safely be provided to the Enrollee*.
Attachment 6 ***G: Enrollee Materials***	If Enrollees will be expected to promptly select a PCP or patient-centered medical home (PCMH), it is critical that provider directory and selection information be included in the new enrollee enrollment packet. For instance, those enrollees who may need a hard copy provider directory will need prompt direction on how to request such a directory, and many enrollees may not understand the significance of selecting the best provider for their needs before one is assigned under current Model Contract provisions. For this reason, **CMA recommends adding the following item to the list at subsection (iii) on page Attachment 6-3**: *Provider directory access and PCP selection information*.
Attachment 7 ***3.01: Benefit Plan Designs Requiring Primary Care Provider Assignments***	CMA supports the Kaiser-Permanente model of enrollee PCP selection and assignment for all products. Enrollees should be encouraged from the moment of enrollment to select an appropriate PCP and provided the necessary tools to do so, which begins with an accurate online provider directory. An enrollee, however, should be free to change his or her assigned PCP and visit any provider covered under the QHP. Enrollees often need assistance in being connected to care before circumstances necessitate it. A prompt connection and establishment of a PCP relationship can reduce the likelihood of inefficient care utilization, such as that involving emergent and urgent care.

Conclusion

Thank you again for the opportunity to provide input on this critical component leading us into the October 2013 pre-enrollment efforts and beyond. We look forward to continuing to work with the Covered California Board and staff to realize the vision of improving the health of all Californians by assuring access to affordable, high quality care.

Respectfully Submitted,



Brett Johnson, Associate Director, Medical & Regulatory Policy, CMA

Cc: David Panush, Director of Government Relations, California Health Benefit Exchange
Francisco Silva, Chief Counsel, CMA
Lisa Folberg, VP of Medical & Regulatory Policy, CMA

April 15, 2013

Peter Lee, Executive Director
Andrea Rosen, Health Plan Management Director
Jeffrey Rideout, Medical Director
Ken Wood, Senior Advisor for Products, Marketing and Health Plan Relationships
Covered California

Re: April 11, 2013 meeting of the Plan Management and Delivery System Reform Stakeholder Advisory Group and comments to the draft Model Contract released on April 3 and April 12

Via qhp@hbex.ca.gov

Dear Mr. Lee, Ms. Rosen, Dr. Rideout, and Mr. Wood:

We write today to offer comments on substantive topics addressed at the Plan Management Advisory Group meeting of April 11, 2013, including some comments to selected portions of the Model Contract and Attachments provided on April 3 and April 12.

Given the short time frame, we are unable to address the Model Contract in its entirety. However, we have some comments on overarching topics. More specific comments are set forth below.

Alternative Health Benefits

We applaud and support the idea, discussed at the Advisory Group meeting, to postpone including Alternative Health Benefit designs in the first year of the Exchange's operation. California has taken a huge step in support of standardizing benefit plans and think that the decision to stay solely with standard plans is the right one at this important juncture.

Customer Service Standards

Overall, we support the Customer Service Standards in Attachment 6. For example, the requirements for extended call center hours and warm hand-offs when transfers are needed between the Exchange and the Contractors support a positive consumer experience. Regarding the electronic listing of providers (Attachment 6-4), we suggest adding language to ensure currency. For example: "Contractor shall create and maintain a continually updated ~~an~~ electronic listing of all Participating Providers…."

Regarding "Exchange Training of Staff" (Attachment 6-5), we find the wording confusing and scope perhaps too narrow. We suggest the following language:

K. ~~Exchange~~ Training of Staff on the Exchange
(i) Contractor shall arrange for and conduct ~~the Exchange~~ staff training regarding the relevant laws, mission, administrative functions and operations of the Exchange including the systems used for the program in accordance with federal and state requirements and using training materials developed by the Exchange, where applicable.

Personal Health Information

We are pleased to see many important provisions to secure privacy and security embodied in this version of the contract and urge that they will remain in the final version, including:

Section 3.27(b):
- Obligates the Contractor to provide to the Exchange, upon request, a copy of any information the Contractor plans to mail or send to enrollees and to maintain a file of all such mailings for inspection by the Exchange for a (unspecified) period of time.

Section 3.34:
- Obligates the Contractor to maintain a disaster recovery plan and to specify how it will safeguard enrollees' records after a disaster.

Section 7.08:
- Requires that should the contract be terminated by either party, information of the other party in possession will be returned or destroyed on request of the party owning the information. Should both parties agree that return or destruction is not feasible, then the party in possession of the information will continue to be held to the protection standard outlined in the contract.

Section 9.01:
- Expressly recognizes that a Contractor will be a "HIPAA covered entity"; the contract requires them to follow HIPAA (the Privacy and Security Rule, as well as all of the other Administrative Simplification Provisions), and also HITECH amendments. The contractor is also expressly obligated to follow Exchange privacy and security requirements;
- Binds the Contractor to all applicable California privacy legislation (i.e. - CMIA, IIPPA and IPA);
- Contract is interpreted such that when a conflict arises between federal and state legislation in terms of the permissibility of use and/or disclosure of PHI or PII, the more stringent privacy and/or security standard applies;
- Contractor is obligated to apply fair information practices including: right to access; right to amend records; and implement administrative, physical and technical safeguards. In many respects, the timeframes for exercising these rights are more generous for consumers and patients than is the case in HIPAA. (For example, contractors are obligated to respond to an individual's request for Personal Health Information within 10 calendar days; the HIPAA Privacy Rule allows for up to 30 days, with the possibility of a 30 day extension for information stored offsite.);
- Contractor is obligated to report breaches to the Exchange no later than 3 days after discovery;
- Contractor agrees to use minimum necessary PHI to perform its services; and

- Should an instance arise where the Exchange acts as a HIPAA covered entity, then the Contractor shall become a Business Associate.

Plan-based Enrollment – Transition Plan

We agree it is important to maximize moving the large number of enrollees currently in the private, individual market into the Exchange. Making insurance more affordable through Advanced Premium Tax Credits and cost-sharing subsidies will ensure these consumers' ability to maintain coverage and also will enlarge the Exchange pool. We are concerned, however, that the transition through issuers, as currently proposed, lacks sufficient consumer protections and could result in enrollee dumping or cherry picking.

First and foremost, we suggest that targeting subsidy-eligible non-group incumbents would require Contractors to gather sensitive information (such as income, SSN and citizenship status) that is prohibited under federal law. It is our understanding that the ACA regulations require that such eligibility information should be kept private from Contractors vis-a-vis eligibility determinations. Similarly, the Transition Plan should respect that barrier. However, in order to achieve the transition goals we suggest that Contractors should reach out to the entire population of non-group and COBRA incumbents, similar to those terminating coverage.

Moreover, a transition plan must ensure that issuers do not use the process to cherry pick. Issuers will have claims information showing enrollees' use of services. It would be possible for issuers to focus on transitioning healthier enrollees to their Exchange (or other) plan, steering higher use enrollees off their Exchange health plans. We are also concerned that the proposal, as articulated in the Model Contract, does not sufficiently establish marketing restrictions that would prevent cherry picking of healthy lives. We suggest, specifically, prior approval of marketing materials, including both verbal presentations as well as documents and we also suggest a retrospective analysis of the individual market lives to determine whether there are subsidy-eligible, healthy individuals in the outside market. We understand staff will be examining the marketing restrictions in both Medicare and Medi-Cal Managed Care contracts to determine whether there are other relevant restrictions to engraft onto QHPs. Due to the shortness of time, we do not address those restrictions here.

We offer the following redline changes to the Model Contract:

3.36 – Transition Plan. On or before August 1, 2013, Contractor shall submit to the Exchange a ~~Transition~~ transition plan for facilitating the transition of Contractor's current enrollees in individual coverage who may be eligible for subsidies in the Exchange. The plan shall include, without limitation, a description of Contractor's plan with respect to the following:

(a) Targeting specific populations, including (i) ~~subsidy-eligible~~ non-group incumbents, (ii) ~~subsidy-eligible~~ COBRA incumbents and (iii) all incumbents terminating coverage, including 25-year-old dependents

(b) Processes for identification, outreach and enrollment of ~~subsidy-eligible~~ individuals who respond to their normal marketing efforts.

(c) Estimates of the number of incumbent members in each target population category above and the number of incumbent individuals in each grandfathered and non-grandfathered plan.

(d) Deployment of the subsidy calculator provided by the Exchange for marketing purposes so consumers can ~~as to~~ estimate the level of Federal subsidies that may be available to Enrollees.

(e) Plan for educating incumbents, minimizing market confusion, and easing the seamless transition of subsidy-eligible incumbents into Qualified Health Plans in the Exchange, along with customer service scripts and website presentations that inform subsidy-eligible incumbents of their options under the Affordable Care Act and in the Exchange. The Exchange will have prior approval of marketing materials, including customer service scripts.

(f) Plans for assuring and implementing a process required to enable Contractor to attest to its commitment to fairly and affirmatively offer, market, and sell all products made available to all eligible Enrollees and Employees both inside and outside the Exchange.

Definitions

It is factually inaccurate to characterize all issuers regulated by the Department of Managed Health Care as HMOs, since DMHC regulates HMOs, PPOs, and other limited network products. Section 1343 specifically does not in any way define HMO. Our redlined suggestion is below:

13.43 ~~Health Maintenance Organization (HMO):~~ A Health Care Service Plan: (as that term is defined in California Health and Safety Code Section 1345) holding a current license and in good standing with DMHC means a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) or Point of Service plan regulated by the Department of Managed Health Care.

Performance Measures

We are concerned by several proposals that weaken health plan performance reporting requirements and thus undermine the mission of Covered California to be a catalyst for change. We understand the Exchange has to walk a fine line of being able to attract health plans while balancing the needs of consumers for better quality information. To that end, we are not opposed to phasing in requirements and/or re-thinking how prescriptive the Exchange should be on some requirements.

However, in other areas, the consequences of not requiring certain performance measures at all will have a much larger impact on the Exchange's ability to meet its goals of improving health care quality and promoting better health and health equity. In particular, we are concerned about Covered California's intent to not require health plans to collect and report QHP-specific HEDIS measures, as well as to not require health plans to stratify claims and quality data by demographic characteristics. Without these requirements, Covered California will be severely handicapped in terms of its ability to adequately measure the quality of care provided to its enrollees.

We recommend the following changes to Attachment 7: Article 2. "Quality of Care":

- **2.01 HEDIS and CAHPS Reporting:** We understand there are cost implications for requiring health plans to report QHP-specific HEDIS measures and that these should be carefully weighed against other needs of the Exchange. However, without this

data it is not clear to us how Covered California plans to measure and compare the quality provided for QHP enrollees with non-QHP enrollees. We appreciate that the Exchange will have encounter and claims data on QHP enrollees, but this will not allow the Exchange to do a direct comparison of QHP enrollees to non-QHP enrollees or answer the evaluation question posed in the evaluation plan, "Do Covered California health plan choices offer as good or better quality for consumers compared to those offered outside the Exchange?" In addition, ideally the quality rating system used by consumers to select a health plan would include information about health plans' quality performance among QHP enrollees, rather than just commercial and Medi-Cal lines of business. We urge Covered California to reconsider requiring health plans to report on QHP-specific HEDIS measures or to explain how it plans to measure and compare quality for QHP enrollees with non-QHP enrollees. We suggest the Exchange use similar language to that used to refer to the use of CAHPs survey data: "(v) Contractor may be required to collect and report QHP LOB HEDIS measurement and reporting effective MY 2016 and annually thereafter."

- **2.03 Data Submission Requirements to the Exchange:** We support and thank Covered California for requiring health plans to collect demographic data on race, ethnicity, gender, primary language, disability status, and sexual orientation by 2015. This is especially important as Exchanges are subject to the non-discrimination provisions of Section 1557 of the Affordable Care Act (referenced in 3.32). We are especially appreciative given that for many health plans, some of these data elements (e.g. sexual orientation) may be new requirements in terms of data collection, thus it may take some time for Contractors to develop their capacity to collect this data. However, we were disappointed to learn that Exchange will not be requiring health plans to stratify their claims and quality data based on these demographic characteristics. While we appreciate that the Exchange will be able to conduct its own analysis of quality data by demographic characteristics with the information submitted by the health plans, it is important that the health plans be required to conduct their own analysis to identify and address disparities in access, utilization, and outcome among their enrollees. The U.S. Department of Health and Human Services in its September 2011 report "Approaches for Identifying, Collecting, and Evaluating Data on Health Care Disparities in Medicaid and CHIP," recommends stratification of HEDIS and CAHPs data as an important strategy in identifying health disparities and implementing quality improvement projects to eliminate them. Requiring health plans to analyze their quality data by demographic variables will help to protect against discrimination, while ensuring the Exchange is able to meet its mission of eliminating health disparities.

  Additionally, while we are happy to see the inclusion of sexual orientation as a data category, we urge Covered California to consider requiring plans to ask a question about gender identity as gender identity is also covered under Section 1557 and referenced in 3.32 of the Model Contract. We thus urge you to make the following changes: "By 2015, Contractor shall collect on a ~~voluntary~~ basis voluntary to the enrollee, the following enrollee data, and should be capable of stratifying claims and quality data whenever possible based on these ~~the following~~ characteristics:

  a. Race
  b. Ethnicity
  c. Gender
  d. Primary language

e. Disability status
f. Sexual orientation
g. Gender identity

- **2.05 eValue8 Submission:** We appreciate Covered California's plans to move forward with the requirement that Contractors complete certain sections of the eValue8 reporting system including Module 1.7 Health Disparities Reduction.

- **3.01 Benefit Plan Designs Requiring Primary Care Provider Assignments:** We support the Exchange's proposal to require Contractors to encourage Plan Enrollees to make a primary care selection. We also support the Exchange's proposal with respect to auto-assignment that it be consistent with an Enrollee's stated gender, and language preference as well as to consider geographic accessibility and existing family member assignment. Additionally, we urge the Exchange to require Contractors to ensure new members have the opportunity to select in addition to a primary care provider, a community clinic or a medical home and that auto-assignment also include this criteria. We recommend the following revisions:

  "Contractor will encourage Plan Enrollees to make a primary care selection, including as an option the selection of a community clinic or a medical home. In the event the Enrollee does not select a primary care provider (PCP) within the allotted timeframe, ~~the Enrollee may be auto-assigned to a PCP and the assignment shall be communicated to the Plan Enrollee.~~ if the Enrollee has previously received care from a PCP or medical home within the Contractor's network, initial automatic assignment shall default to that provider who the patient has last seen. If an Enrollee has not selected a provider and has not previously received care from any contracted provider, PCP assignment will be consistent with an Enrollee's stated gender, ~~and~~ language preferences, availability of traditional and safety-net providers, provider capacity, ~~and will consider~~ geographic accessibility and existing family member assignment."

- **3.03 Community Health and Wellness Promotion:** We strongly support Covered California's requirement that Contractor's report annually the initiatives, programs and/or projects that it supports that promote wellness and better community health that specifically reach beyond the Contractor's enrollees. Studies show that investing in community-level health initiatives such as child safety-seats, tobacco cessation and/or biking and walking trails can result in huge savings through lower health care costs and better health outcomes.

- **3.04 Reporting Requirements:** We support the Exchange's efforts to require Contractors to *encourage* Plan Enrollee's access to preventive health and wellness services and participation in community health and wellness promotion.

- **4.02 Identification of At-Risk Patients**: While we share the goal of identifying and providing extra steps for coordinated care to those individuals with chronic conditions, we believe this responsibility should be shared between providers and plans. PCPs in particular should be ideally placed to identify such individuals and play a key role in their care coordination. In addition, certain provisions of current law, aim for this same goal. Thus, we suggest the following amendment to 4.02:

"In addition to the requirements of Sections 1373.95 and 1373.96 of the Health and Safety Code and section 10133.56 of the Insurance Code, Contractor agrees to work with providers, particularly primary care providers, to identify and proactively manage the Plan Enrollees with existing and newly diagnosed chronic conditions and who are most likely to benefit from well-coordinated care ("at-risk plan enrollees")…"

- **4.03 Reward-based Consumer Incentive Programs:** We strongly support and thank Covered California for its revised language in the Model Contract acknowledging the existence of legal limitations to reward-based consumer incentive programs.

- **5.04 Enrollee Health Assessment:** Given the lack of enrollee use of health assessments, we wonder whether section 5.04 should be contingent on the use of a health assessment or whether it should be a broader requirement to collect and report at both individual and aggregate levels changes in Plan Enrollees' health status.

- **6.04 Shared Decision-Making:** We appreciate Covered California's inclusion of efforts aimed at shared decision-making, including by way of example programs such as *Choosing Wisely*, a joint information effort by Consumer Reports and ABIMF.

Language Access

We appreciate Covered California's incorporation of some of our earlier comments to strengthen and make consistent references to language access requirements in the Model Contract. These changes will go a long way towards ensuring California's Limited English Proficient (LEP) consumers, who comprise 40% of those newly eligible for subsidies in Covered California, can get the care they need in a language they understand. In particular, we support and thank Covered California for requiring Contractors to include welcome messages in English, Spanish and the Contractor's threshold languages and to ensure that call center staff include representatives in Contractor's threshold languages. Additionally, we support and thank Covered California for explicitly stating QHP requirements to provide no-cost oral interpreter services for all non-English speaking Enrollees.

However, we remain concerned by several inconsistencies throughout the Contract and offer specific recommendations below to help ensure consistency throughout.

We offer the following redline changes to the Model Contract:

- **Section 3.05 (c) Participating Provide Directory:** We support Covered California's requirements that a Contractor make its provider directory electronically available to the Exchange and by paper to Plan Enrollees on request. We urge the Exchange to require that Contractors make available information regarding the languages spoken by physicians as well as staff.

- **3.07 Applications and Notices:** We support and thank Covered California for referencing Federal requirements that Contractors provide applications, forms and notices to applicants and enrollees in plain language and in a manner that is

accessible and timely to individuals living with disabilities and who are limited English proficient. We urge Covered California to specify the number of taglines in non-English languages; we recommend they be available in at least 15 different languages. We urge the Exchange to make the following changes:

"(2) who are limited English proficient through the provision of language services at no cost to the individual, including (i) oral interpretation, (ii) written translations; and (iii) taglines in fifteen (15) non-English languages indicating the availability of language services."

- **3.27 Enrollee Materials, (d) Marketing Materials:** We support Covered California's requirement that Contractors provide the Exchange with marketing materials on an annual basis as this will help ensure against inaccuracies, misinformation and other types of deceptive marketing practices. We encourage Covered California to make it clear that this provision applies to marketing materials in non-English languages as well.

- **3.32 Nondiscrimination:** We thank the Exchange for amending its nondiscrimination provision to include reference to the Affordable Care Act Section 1557 which prohibits discrimination on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. We urge the Exchange to consider referencing state nondiscrimination laws as well, in particular California Government Code Section 11135-11139.8.

We recommend the following changes to Attachment 6: Customer Service Standards (we are referring to the redline version updated 4/12/13)

Notices (D): The Model Contract requirements for written translations may be confusing. We recommend you revise the language in (D)(iv) as follows: "All legally required notices sent by Contractor to Enrollees shall be translated into and available in the Contractors' ~~all~~ threshold languages. ~~according to the following criteria:~~Thresholds are 3,000 of ~~the~~ ~~spoken~~ a language in a county ~~the service area~~, ~~or~~ 1,000 per ZIP code, and ~~or~~ 1,500 per two ZIP codes, or ~~as otherwise required under applicable State and Federal laws, rules and regulations, including,~~ the thresholds under Health and Safety Code 1367.04, whichever is lower, every three years as required by law.

Enrollee Materials (G): In order to simplify and make consistent the Contract language, we recommend the following changes to this section:

"(i) Such materials shall be made available in Contractor's threshold languages or as otherwise required by law…"

"(ii) Enrollee materials shall be available in English and Contractor's threshold languages, as previously referenced in Attachment 6. D. Notices."

The list of materials in (ii) should be amended to include: "h. Evidence of Coverage, i. Other materials as required by the Exchange."

"b. Contractor shall maintain access to enrollment packet materials, Plan Summaries, claim forms and other Plan-related documents in English and Contractor's threshold languages as required by law…"

"(iv) The Plan Summary Plan Description available online and the hard copy sent to Enrollees on request shall be available to Enrollees in English and Contractor's threshold languages as required by law…"
(ix) Secure Plan Website for Enrollees and Providers: We support and thank the Exchange for requiring Contractors to make available website content in English and Spanish and any other languages required by law. We urge the Exchange to restate the explicit requirement in the Model Contract: 3.07 Applications and Notices, that Contractors must provide taglines on their websites in non-English languages indicating the availability of language services. Specifically, "(ix) all content on the secure Enrollee website shall be available in English upon implementation of Plan and in Spanish within thirty (30) days after the Effective Date and any other languages required under applicable laws, rules or regulations. Contractor shall provide taglines in fifteen (15) non-English languages indicating the availability of no cost language services."

Thank you for the opportunity to provide input. We look forward to continuing to work with you to refine the Model Contract. Please contact us if you have any questions about these comments.

Sincerely,

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CPCA
California Primary Care Association

Health Care Access for All

April 15, 2013

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

RE: Qualified Health Plan Model Contract – Second Draft

To Whom It May Concern:

The California Primary Care Association (CPCA) represents nearly 900 not-for-profit community clinics and health centers in California that provide comprehensive quality health care services to primarily low-income, uninsured, and underserved Californians.

CPCA appreciates the opportunity to provide feedback on the second draft of the Qualified Health Plan Model Contract. We thank the Covered California staff and Board for their efforts to engage and respond to the concerns of stakeholders and look forward to continuing our work together to ensure that the promise of the Affordable Care Act is accessible to all Californians.

1. **3.05 Network Requirements**

Part (c): Participating Provider Directory

CPCA appreciates the Exchange's wish to collect participating provider information from each QHP and create a centralized directory to allow applicants to search for a specific provider. The accuracy and accessibility of the provider directory is critical to enable each member to make an informed choice of primary care provider and optimize continuity of care.

Community clinics and health centers cultivate relationships with patients on both a facility and individual-provider level. In many cases, a member may know that they receive care at a specific health center rather than a specific practitioner within the center. When those patients look at the Covered California provider directories to identify and select their medical home, they will be looking for the name of the health center. It's imperative that the name of the health center, and not just the name of the practitioner, be included within the directory.

The California Department of Medi-Cal Managed Care has recognized the importance of including the name of individual practitioners as well as the name of the health center within each participating health plan's provider directory. MMCD Policy Letter 00-02 clearly states that all participating health plans must include the primary care clinic name as well as the practitioner name within their directories. **Similarly, it is necessary that both health centers and individual providers employed by health centers be listed within the Covered California provider directory so that applicants can search by both provider name and facility name.**

This requirement must apply to both the Exchange's provider directory in CalHEERS, as stated above, as well as in the individual QHP's provider directory as addressed in Attachment 6, Part G(v): Electronic Listing of Participating Providers.

2. **3.15 Enrollee's Out-of-Network and Other Costs; Network Requirements**

CPCA remains concerned that Covered California's language regarding payment for non-contracted or out-of-network enrollees served by FQHCs fails to ensure payment of federally required PPS reimbursement. CPCA has consistently requested that Covered California issue guidelines that reflect the Center for Consumer Insurance Information and Oversight (CCIIO) guidance that states that "if a QHP issuer does not have a contract with an FQHC, the QHP issuer must pay the FQHC the Medicaid PPS rate for the items and services provided to the QHP enrollee."

Unfortunately, Covered California's latest model contract language does not provide the protection referenced in the federal guidance. **CPCA requests that Covered California add a section 3.15(iii) to the QHP Model Contract stating that the "Contractor shall comply with federal rules requiring that if a QHP issuer does not have a contract with an FQHC, the QHP issuer must pay the FQHC the relevant Medicaid PPS rate for the items and services provided to the QHP enrollee."**

3. **3.22(v) Enrollment: Termination of Coverage**

CPCA is extremely concerned about the negative financial impact resulting from the three month grace period provided for nonpayment of premiums to individuals receiving advance payments of the premium tax. The federal rule under 45 C.F.R. §156.270(d)(3) requires QHP issuers to allow a three month grace period for enrollees who have paid at least one month's premium during the benefit year. Upon termination of an enrollee for non-payment of premiums at the end of the three-month grace period, this rule allows issuers the option to pend and deny claims submitted in month two and three of the grace period, shifting the financial burden of the grace period onto the provider.

California state licensing laws prohibit a plan or issuer that authorizes treatment from rescinding or modifying the authorization after the provider renders the service in good faith (see Health & Safety Code §1371.8; Insurance Code §796.04). **CPCA encourages Covered California to include provisions in the Model Contract that bind the issuer to pay claims submitted in the second and third months of the grace period and adhere to state licensing requirements regarding the payment of claims rendered in good faith.**

At the very least, section 3.22(v) of the QHP Model Contract should require all QHPs to provide accurate, binding, and real-time notification to community clinics and health centers and other health care providers, so that they are aware that patients are entering the second month of the grace period and that claims submitted on their behalf will be pending and ultimately may be denied if the patient does not pay their premium. Real-time access to this information will allow providers to immediately assist enrollees who seek care during the grace period to retain their coverage.

CPCA
California Primary Care Association

Health Care Access for All

CPCA recommends that the Exchange ensure that the CalHEERS system or another easily accessible all-QHPs portal provide real-time eligibility status such that a provider can efficiently determine whether or not a patient is in the grace period.

ATTACHMENT 7: QUALITY, NETWORK MANAGEMENT AND DELIVERY SYSTEM STANDARDS

3.01: Benefit Plan Designs Requiring Primary Care Provider Assignments.

CPCA supports the Exchange's proposal to require all QHPs to ensure that all enrollees are assigned to a Primary Care Provider or Patient Centered Medical Home within 45 days of enrollment. However, CPCA encourages the Exchange to clarify that patient self-selection of a primary care provider, community health center, or patient-centered medical home during the enrollment process is preferred and will take precedence over an auto-assignment approach. In cases where enrollees do not select a primary care provider, health center, or patient-centered medical home on their own, **we propose that Covered California require QHPs to use the following approach to auto-assignment:**

Contractor shall demonstrate to the Exchange that all new Enrollees are assigned to a Primary Care Provider, Health Center, or a Patient-Centered Medical Home within 45 days of enrollment. Patient assignment shall be based upon the following criteria:

1. **Patient Choice: Contractor shall encourage member choice and member participation in health care services. Every new member shall have the opportunity to select his or her own Primary Care Provider (PCP), community health center, or medical home from the plan provider network at the time of enrollment. If members do not select a PCP, community health center, or medical home when they first enroll, the Member Services Department shall attempt to contact these members to help them choose.**

2. **Auto-Assignment: If Member Services is unable to contact a new member within the first month, the member is automatically assigned to a PCP, community health center, or medical home the first of the following month. The selection is confirmed in a welcome letter in a packet sent to the new member. The member may change his or her assignment simply by calling the Member Services Department.**

   When a member does not select a PCP, automatic assignment is designed to facilitate a good match between members and PCPs. If the member has previously received care from a primary care provider or medical home within the contractor's network, initial automatic assignment shall default to that provider which the patient has last seen.

   If a member has not selected a provider and has not previously received care from any contracted provider, PCP auto-assignment shall be based on the following criteria, in order:
   - **a. Language, culture, and ethnic background**
   - **b. Availability of traditional and safety-net providers**
   - **c. Provider capacity**
   - **d. Geographic accessibility based on members' home zip code**
   - **e. Existing family member assignment**

CPCA
California Primary Care Association

Health Care Access for All

7.02 – Promoting Care Coordination and Higher Value

CPCA commends the Exchange for requiring QHPs to actively promote the development of care models that promote care coordination and value. Community clinics and health centers in California are leading the nation in implementing innovative care delivery models and strongly support the transformation of the health care delivery system to reward "payment for value." **CPCA supports the Exchange's proposal to require QHPs to develop incentives programs that reward good clinical quality, patient experience, access and appropriate use of resources and in particular, payment methodologies that invest in primary care.**

Thank you for the opportunity to respond to the above-referenced solicitation. Please do not hesitate to contact Meaghan McCamman by telephone at (916) 440-8170 or mmccamman@cpca.org if you have any questions or comment or if you require any clarification on the comments presented herein.

DORIS O. MATSUI
6TH DISTRICT, CALIFORNIA

COMMITTEE ON ENERGY
AND COMMERCE

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April 17, 2013

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

Ms. Kimberly Belshé, Board Member
Ms. Diana S. Dooley, ex-officio
Mr. Paul Fearer, Board Member
Ms. Susan Kennedy, Board Member
Dr. Robert Ross, Board Member

Re: Covered California Standard Benefit Design

Dear Members of the California Covered Board:

As you know, I was a strong supporter of the Patient Protection and Affordable Care Act when we passed the law in 2010, and have a vested interest in our success as a state with the implementation of the law. I am pleased to see that you are moving so quickly in order to ensure that Californians have insurance coverage regardless of income or health status. However, I have some concerns with the standard benefit design which I would like to bring to your attention. While I know that the decisions regarding standard benefit design were approved in February, I urge you to study alternative designs that would fit the federal requirements but also achieve affordability for patients with high cost healthcare needs.

In reviewing the final standard benefits published by Covered California last month, I have some concerns regarding the standard benefit design's potential impact on patients with serious and often life-threatening illnesses, such as cancer, autoimmune disorders, hemophilia and other conditions. I am particularly concerned about the across the board patient co-insurance requirements for specialty medications in every metal tier, with patient out of pocket costs as high as 30% for specialty medications.

These co-insurance requirements could prevent many patients from receiving the lifesaving treatments they need because of prohibitively high cost. For example, Gleevec, a drug used to treat Chronic Myelogenous Leukemia (CML), would cost a patient on average approximately $2,500 a month if that patient was responsible for a 30% coinsurance payment.

Other states have taken an alternative approach, and the standard benefit designs in states such as New York have stable and affordable patient copays rather than high patient co-insurances. I know that we all share the same goal in ensuring access for patients through

the ACA and I want to ensure that this includes access to medications through reasonable patient copayments.

I would like to respectfully urge the Board to study alternatives to the standard benefit design that was approved in February and provide information regarding these alternatives to my office.

Sincerely,

Doris O. Matsui

DORIS O. MATSUI
Member of Congress

CC: Peter Lee, Executive Director, California Health Benefits Exchange

Comments
Qualified Health Plan Model Contract
Revised Draft (4-3-13) and Updated Redline (4-12-13)

The Health Insurance Alignment Project (Project) has reviewed the model Qualified Health Plan (QHP) contract proposed by the California Health Benefit Exchange (Covered California) to solicit health insurance issuers in providing health care coverage. The Project engages in independent policy research, analysis and strategic assistance to advance the goals of reducing duplication, improving transparency and maximizing consumer protections in health insurance oversight in California. Kelch Policy Group administers the Project through a grant from the California HealthCare Foundation. Deborah Kelch serves as a member of the Covered California Health Plan Management Advisory Work Group.

With that as background, the Project offers the following comments on the proposed QHP model contract for consideration by the Board and staff of the Exchange.

The revised contract addresses several of the comments we previously submitted and the overall format and structure is easier to follow and review. In that sense, the revised contract is an improvement to the previous versions.

We raise the following remaining questions and issues with the revised contract as are possible for us to identify and articulate given the extraordinary short timeline for review of major and sweeping changes some of which were just proposed late on the prior business day. We would be happy to discuss any of the comments provided directly with staff or through the Health Plan Management Advisory Group. For questions about these comments or the Health Insurance Alignment Project, please contact Deborah Kelch of the Kelch Policy Group at dk@kelchpolicy.com

SPECIFIC COMMENTS

Uniform Model Contract

As an overarching policy, we recommend that the model contract apply to all QHP issuers participating in the Exchange. Having one common contract will contribute to consistency, transparency and ultimately to the accountability needed to support informed consumer choice. The Exchange should not individually negotiate contract provisions with participating issuers except for those elements which are unique among issuers such provider network, service areas and rate provisions.

Licensed in Good Standing (§3.02, p. 7)

The model contract leaves room for interpretation that applicant issuer, or the Exchange, make the determination that the issuer is in good standing. As a definitional matter, under the ACA QHPs must be offered by an issuer that "is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage."[1] The federal regulations mirror, and do not

expand upon, this requirement.[2] According to CMS comments to the Final Rules implementing the Exchange statutes, CMS interprets "in good standing" to mean that an "issuer faces no outstanding sanctions imposed by a state's department of insurance." CMS did not prescribe how Exchanges would determine licensure and standing, but suggested that Exchanges could use a number of means such as "attestation or verifying the information directly with State departments of insurance." Given CMS' statements, it is reasonable to conclude that state regulators, not QHPs issuers or the Exchange, should verify the good standing requirement. To clarify this point we offer the following amendment:

> 3.02 Licensure and Good Standing.
>
> Contractor shall be licensed and in good standing to offer health insurance coverage through its Certified QHPs offered under this Agreement and its other health plans offered outside the Exchange. For purposes of this Agreement, "good standing" shall require, **subject to verification by the Contractor's respective health insurance regulator**: (i) Contractor to hold a certificate of authority from CDI or a health care service plan ("HCSP") license from DMHC, as applicable, and (ii) the absence of any material statutory or regulatory violations, including, penalties, during the last two years prior to the date of the Agreement and throughout the term of Agreement, with respect to the regulatory categories identified at Attachment 3 ("Good Standing**")**. For purposes of this Agreement, "material" violations shall represent a relevant and significant departure from normal business standards required to be adhered to by a Health Insurance Issuer.

Marketing

California has a history of challenges and marketing abuses dating back to the early days of Medi-Cal managed care and further consideration and discussion in this area is warranted. As discussed at the Health Plan Management Work Group, we recommend that the Exchange review state marketing regulations and contract requirements applicable to Medi-Cal managed care plans and the Healthy Families Program to identify specific provisions for possible application to QHP issuer marketing and enrollment assistance. For example, the Exchange may wish to mirror requirements that prohibit door-to-door marketing and in-home presentations by QHP issuers, limit issuer comparisons among Exchange offerings and require all issuer marketing materials and promotions to be approved by the Exchange prior to their use. The existing well-established and tested program rules and standards can easily form the basis for guidelines, expectations and standards applicable to the marketing plan now included in the model contract. We are available to provide background on the existing regulations and contract requirements in state law and programs that might be used to set uniform Exchange standards.

Primary Care Physicians

Section 3.01 would require the assignment of a primary care physician (PCP) for all enrollees regardless of coverage model type. Despite the positive intent, this provision may fail to ensure that QHP enrollees have access to a physician who is contractually obligated and compensated to coordinate and manage their health care. The model contract defines a PCP as follows:

> A California licensed doctor of medicine or osteopathy who is a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist or pediatrician who has a contract with Contractor as a primary care physician and who has the primary responsibility

for providing initial and primary Health Care Services to Enrollees, initiating referrals for specialist and hospital care, and maintaining the continuity of the Enrollee's medical care. (Para. 13.74, pg 67).

Despite this proposed comprehensive and appropriate role and definition of PCPs, the model contract requires the assignment of all enrollees to a PCP, even in coverage models based on fundamentally different contractual roles and responsibilities. For example, in PPOs, physicians in primary care specialty areas are, like other contracted physicians, typically paid for the medical services they provide during an office visit based on the applicable CPT billing code. Unlike the HMO context, they generally do not contract and are not compensated for care coordination, speaking to other specialists, enlisting family members as partners or any of the other activities required to manage care in a primary care medical home model. Existing fee-for service systems do not reimburse physicians for care coordination.[3]

Without additional changes, the proposed Exchange policy regarding PCP assignment could result in assignment of enrollees to physicians who are not contracted or compensated to actively serve as PCPs. Physicians will either be unable or unwilling to fully function as PCPs given their practice demands and payment structure or will do so outside the compensation structure generally regarded as appropriate for physicians who function as PCPs. Requiring assignment of enrollees to physicians who are not signed up to serve as primary care physicians devalues the comprehensive role of PCPs in integrated coverage models and could create unrealistic enrollee expectations of the role an assigned provider will play in the coordination of their health care.

In order to implement the Exchange goal of mandatory assignment of PCPs in all settings, the model contract should require that issuers assign enrollees only to physicians contracted to serve as PCPs. Alternatively, the model contract could require issuers to assign all enrollees to a contracted *physician* but not specifically imply or communicate with enrollees that those physicians will fully function as PCPs or primary care medical homes unless the physicians are contracted to do so.

Definitions

- **Exclusive Provider Organization (EPO).** The definition of EPOs cited (p. 64, 13.31) references a specific regulation for a defunct program, the Health Insurance Plan of California (HIPC). Rather than cite a definition that is not in active force and may be deleted at any time we recommend that the contract include the full text of the definition from the regulations. The Exchange may also wish to consider and seek guidance from CDI because it appears from our review that EPOs under the Insurance Code are only authorized for group coverage and not for individual coverage. See California Insurance Code (CIC) §10133 (c) which applies to EPO agreements between insurers and group policyholders.

- **Health Insurance Issuer.** In addition to referencing the federal definition of issuer, we continue to recommend the clarity afforded by defining for California purposes that issuers are entities appropriately licensed by either DMHC or CDI to sell health coverage (p. 65, 13.40).

- **Health Maintenance Organization**. This definition continues to be inaccurate (p. 65, 1343). All licensed health care service plans are not HMOs. Products offered by licensed health care service plans include Point of Service and PPO product plans. To continue to use this incorrect definition

is confusing for regulators and consumers and could affect later contract enforcement. There is a definition of HMOs included in the HIPC regulations that could help reduce confusion at California Code of Regulations ,Title 10, section 2699.6000 (x). Again, we do not believe this regulation should be cited for the reasons set forth above, but the text from the regulation rather used as the contract's definition as follows:

"Health maintenance organization" means [a health care service plan licensed pursuant to Health and Safety Code §1345] and either of the following:

(1) Comprehensive group practice prepayment plans which offer benefits, in whole or in substantial part, on a prepaid basis, with professional services thereunder provided by physicians or other providers of health services practicing as a group in a common center or centers. This group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

(2) Individual practice prepayment plans or network model prepayment plans which offer health services in whole or in part on a prepaid basis, with professional services thereunder provided by individual physicians or groups of physicians or other providers of health services who agree to accept the payment provided by the plans as full payment for covered services rendered by them."

- **Medical Necessity** and **Medically Appropriate** – ***We continue to have concerns with the inclusion of these definitions in the contract.*** Is the Exchange seeking to expand Exchange coverage beyond the statutory requirements in state and federal law relating to medically necessary essential health benefits and the state essential health benefit benchmark enacted in 2012 (See HSC §1367.005 and California Insurance Code (CIC) §10112.27)? Does the Exchange intend to standardize the definition of medical necessity among all participating plans and expect that state regulators will enforce the requirement? If so, what is the source of the proposed definition and what are the implications and goals for imposing it as a standard definition? What is the purpose and intended effect of including the definition of "medically appropriate"?

Quality Initiatives

The model contract and proposed quality changes in Attachment 7 still do not establish with clarity a set of specific and clear quality initiatives for the initial first year of the contract to promote uniformity and allow for reasonable monitoring and evaluation. Rather than trying to address many potential quality improvement activities and existing known strategies across a wide spectrum of topics, the Exchange has the opportunity to select a few quality initiatives based on emerging evidence, existing national benchmarks and the diverse needs of expected Exchange enrollees.

The most recent contract version appears to reduce the number of mandatory expectations and change them to primarily reporting and data collection, but fails to set forth a clear path for the Exchange related to quality improvement. A few specific quality initiatives in the first year, with a focus on the appropriate role of health plans as the locus of responsibility, along with uniform reporting on the additional models, initiatives and collaboratives issuers are implementing once 2014 open enrollment is completed, could

form the basis for deliberative staff and stakeholder work on further quality initiatives in 2015 and 2016. Clearly identified and specific first year initiatives, as well as clear and simple contract language requiring Contractors to help develop and implement additional quality initiatives in future contract years, could launch the Exchange as a leader in quality measurement and improvement while providing sufficient time to carefully consider year-to-year progress that is realistic, measureable, and achievable given the role the Exchange plays as a contractor with health plans.

[1] 42 USC §18021.
[2] 45 CFR §156.200.
[3] See Anne S. O'Malley et al. "Coordination of Care by Primary Care Practices: Strategies, Lessons and Implications," Center for Health Systems Change, Research Brief No. 12, April 2009.

March of Dimes Foundation

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April 15, 2013

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

Dear Mr. Lee:

Thank you for the opportunity to provide comments on the updated April 4 version of draft Qualified Health Plan Model Contract. We commend Covered California for its outreach and response to stakeholder feedback on the first version of the model contract.

We have several specific comments on this version of the model contract outlined below:

- Model Contract Attachments (2.01 HEDIS and CAHPS Reporting; section (c)) – Thank you for the inclusion of section (c) that outlines that the Exchange can add additional reporting requirements to the standard Health Plan Employer Data and Information Set (HEDIS) measures. We look forward to the opportunity to work with you on the inclusion of additional measures. As we have indicated in prior comments, the HEDIS measures do not include four of the priority measurers recommended by the March of Dimes: (1) Elective deliveries 37-39 weeks gestation; (2) cesarean rate for low risk first birth women; (3) percent of live births weighing less than 2500 grams; (4) pregnant women at risk of preterm delivery at 24-32 weeks gestation receiving antenatal corticosteroids prior to delivery.
- Model Contract Attachments (2.02 Participation in Quality Initiatives) – We are pleased to see the inclusion of participation in quality initiatives. For the list of specific collaborative initiatives, we commend you for the inclusion of the California Maternal Quality Care Collaborative as this is a critical initiative that works to improve maternity care services. We also commend the inclusion of Leapfrog and the CMMI Comprehensive Primary Care Initiative (CPC) on the list. Leapfrog, the employer-driven hospital quality watchdog group, is showing a decline in such key quality indicators as non-medically necessary elective deliveries. The CPC encourages primary care providers to redesign their practices in ways that will improve care for patients, while providing the payment support and alignment among public and private payers to make that change possible.
- Model Contract Attachments (Article 3. Preventive Health and Wellness Services for Enrollees and Article 4. Services for At Risk Enrollees) – While we commend what appears to be a comprehensive design for the model contract that will address the needs of women of childbearing age and children, we continue to underscore how important it is to ensure that all plans are required to maintain an adequate supply of available obstetric and gynecological, and pediatric providers to address their health care needs.

We appreciate this opportunity to provide input on the draft model contract. If you have any questions, please do not hesitate to contact me at 916-576-2836. Thank you for your consideration.

Sincerely,

Justin Garrett
State Director of Advocacy & Government Affairs
March of Dimes

march of dimes

August 6, 2012

Peter Lee, Director
California Health Benefit Exchange Board
2535 Capitol Oaks Drive, Suite 120
Sacramento, California 95833

Submitted electronically to *info@hbex.ca.gov*.

RE: Impact of the Final Federal Exchange Rule's Grace Period Revision (45 CFR § 156.270) on Qualified Health Plan Enrollees and Providers

Dear Mr. Lee and Members of the Board:

On behalf of the undersigned organizations, we want to thank you for considering stakeholder input throughout the Exchange's rapidly evolving development. Such engagement is particularly critical in the creation of standards for the selection and oversight of qualified health plans (QHP), as they will have a significant role in determining the success of California's Exchange.

We are extremely concerned about the potential impact of the final federal exchange rule's grace period provision[1] on access and the continuity of care for QHP enrollees. Under this significant change in the final exchange rule[2], providers would render services to delinquent, subsidy-eligible QHP enrollees for two months with no advance notice of the patient's delinquency, and, upon the patient's termination for unpaid premiums, issuers could choose not to pay the providers for those two months of services rendered in good faith. In other words, contracting with a QHP has become a risky proposition for providers.

Furthermore, this practice will lead to adverse selection due to relatively thinner networks in QHPs, strain rural and other providers who rely on predictable payments, saddle California's

[1] Codified at 45 C.F.R. § 156.270.
[2] Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310-18475 (March 27, 2012) (amending 45 C.F.R. Parts 155, 156, & 157).

delivery system with more bad debt, and add to the problem of medical bankruptcy among Californians – all of which are irreconcilable with the Exchange's vision statement and guiding principles.

We therefore ask that the Exchange formally provide its understanding of section 156.270's grace period. Specifically, we ask for clarification as to whether and to what extent this provision preempts state law. Should the Exchange see QHP issuers as having the option to pend 60 days of claims, we ask the Exchange to propose options and recommendations to minimize the impact of this change before the Exchange becomes operational.

The Grace Period as Described in the Final Federal Exchange Rule

The federal Department of Health and Human Services (HHS) revised its grace period provisions from the proposed exchange rule to the final rule. In the proposed exchange rule, Establishment of Exchanges and Qualified Health Plans[3], HHS required QHP issuers to pay all appropriate claims submitted on behalf of subsidy-eligible enrollees during the three month grace period for non-payment of premiums. In the final exchange rule, HHS reduced this issuer payment requirement to one month and allowed issuers the option to pend and deny claims upon termination of the enrollee at the end of the three-month grace period for non-payment of his or her share of the premium.

Understanding that this revision shifts the risk and burden to providers, HHS requires issuers to provide notice. Under 45 C.F.R. § 156.270(d)(3) and the comments and responses to the rule, HHS requires that "providers who submit claims for services rendered during the second and third months of the grace period" be notified of "the possibility for denied claims when an enrollee is in the second and third months of the grace period." The HHS responses imply that such notice would be after or upon claims submission, though the regulatory language itself does not specify when notice is expected to occur.

The final rule is also ambiguous regarding the grace period's preemption of state law. The HHS responses in the final rule state that "QHP issuers may still decide to pay claims for services rendered during that time period in accordance with company policy or State laws, but the option to pend claims exists." Yet, issuers must still be licensed in the state, which requires adherence to myriad laws, such as those prohibiting a plan or insurer that authorizes treatment from rescinding or modifying the authorization after the physician renders the service in good faith[4] and the significant statutory and case law requiring plan or insurer reimbursement for emergency care services.

The Pending and Denial of Claims by QHPs Will Result in Adverse Selection

Contrary to the Exchange's vision statement and guiding values, forcing California's health care delivery system to absorb the costs of 60 days of rendered services to some segment of the nearly 2.4 million estimated to be eligible for subsidies in 2016 will hinder "access to affordable, high

[3] Establishment of Exchanges and Qualified Health Plans; Proposed Rule. 76 Fed. Reg. 41866-41927 (July 15, 2011) (amending 45 C.F.R. Parts 155 and 156).
[4] Health & Safety Code §1371.8; Insurance Code §796.04.

quality care" for all Californians. Furthermore, by creating a major disincentive for providers to contract with QHPs, this practice of pending claims will lead to adverse selection as a result of provider networks outside of the Exchange being more comprehensive.

Providers in rural, disadvantaged, and/or provider shortage areas, especially solo and small practice physicians, no doubt would be disparately impacted. For the most part, these practices rely on relatively predictable fee-for-service payments and do not have the margins to absorb significant unpaid claims. Unfortunately, these are precisely the types of providers the Exchange should be encouraging to contract with QHPs, as they are the providers currently caring for much of the Exchange's anticipated enrollee population.

Providers of emergency services also would be particularly hard hit by such pending and claims denials. Many emergency physicians already are reimbursed at unreasonably low rates by non-contracted payers. Forcing these providers of emergency care services to further absorb the cost of these denied claims will jeopardize emergency care access for all Californians.

Networks of specialist physicians in QHPs, however, may be where the effects of the grace period policy would be most evident. Specialists tend to be reimbursed on a fee-for-service basis precisely because of the significant risks posed by patients with complications under a capitated rate. If QHPs are permitted to pend two months of claims, then fee-for-service also becomes risky, and consequently unappealing to specialists, under these plans.

Finally, because fee-for-service providers will be discouraged from contracting with QHPs, adverse selection will occur within the Exchange between QHPs with largely fee-for-service networks (e.g., PPO products) and those QHPs relying on capitation. This will occur as sicker individuals seek the more comprehensive networks of the capitation-based QHPs, avoiding the skimpier networks of fee-for-service-based QHPs in greater numbers.

Recommendations:

- Because of the broad impact of 45 C.F.R. § 156.270 on all Exchange stakeholders, as well as partners in state government, the Exchange should address its understanding and approach to this provision separate from other QHP selection and oversight issues, using the same discussion brief, options, and recommendation stages as with other major issues.
- Adopt QHP standards which require, penalize, and/or strongly encourage that issuers seeking QHP certification include provisions in their provider contracts that bind the issuer to pay claims submitted in the second and third months of the grace period.

Putting the Burden on Patients and Providers Negatively Affects Continuity of Care

Continuity of care will also suffer under QHPs' pending of claims. The physician-patient relationship often suffers when the physician is put in the position of creditor with no indication of whether or when any reimbursement for the services rendered might be paid.

Alternatively, as the California Medical Association learned through member polling around assignments of benefits, a patient put in the position of debtor often ceases communication with his or her physician and is often lost to follow-up. Similar behavior might be expected in instances where the patient is doubtful of his or her ability to pay the remaining premium balance and is thus fearful of being liable for the full cost of care.

In addition, for many physicians, outlays are such that just a few patients' worth of ultimately rejected claims under the grace period would threaten the practice's solvency and consequently jeopardize its ability to care for all other patients. For instance, an oncologist might pay $93,000 for a course of treatment of Provenge to be administered to a patient but only recoups that cost when the plan reimburses the practice for its administration. If the oncologist is not reimbursed for these services, other patients may also be impacted as the oncologist will not be able to provide these expensive treatments to other patients. The oncologist's patients are also more likely to suffer income disruptions as a result of the illness and treatment.

If the oncologist were to receive a notice of the patient's premium delinquency midway through a long-term treatment plan, it is unclear how HHS and the Exchange would expect the oncologist to proceed. More importantly, what about the patient who will be liable for the cost of services upon termination for inability to pay his or her premium share? What if the patient loses his or her job during the third month of delinquency and transitions into Medi-Cal, but is unable to pay the remaining premium balance?

Finally, as HHS acknowledges, patients may "game" the system by taking advantage of the grace period for the three months prior to open enrollment, then switching QHPs under the federal guaranteed issue requirements. HHS further acknowledged that it did not yet have a response to such gaming. In addition to driving a cost shift to other Californians, this policy gap encourages plan switching, preventing long-term patient-physician relationships where networks do not overlap.

Recommendations:

- The Exchange should maintain reinsurance for all QHPs to cover these uncompensated costs, at least until the potential scope of risk and its consequences are better understood. Such reinsurance also would remove disincentives to provider contracting with QHPs, help to spread the financial risks generally, and provide a mechanism through which the Exchange can address QHP insolvency or bankruptcy – so that individual physicians or small hospitals do not suffer the brunt of a potentially significant drain on the system.

- The Exchange should consider funding options for such reinsurance or for a special fund under Government Code § 100503(n) to help defray the cost of uncompensated care rendered in the grace period.

- As previously stated, the Exchange should also consider the use of its active purchasing power to drive QHPs to pay those claims submitted during an enrollee's grace period.

- In conjunction with the above, the Exchange should explore options pursuant to Government Code § 100504(a)(7), which provides for Exchange "[collaborations] with the State Department of Health Care Services and the Managed Risk Medical Insurance

Board, to the extent possible, to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a [change in eligibility status]," and may allow for the "seamless transitions between coverage" envisioned in Government Code § 100503(a).

If Such QHP Pending and Denial of Claims is Permitted, Then Enrollees' Real-Time Eligibility Status must be Available to Providers

For the reasons stated above, after-the-fact notice of delinquency would prove meaningless for many physicians seeing these grace period patients if QHPs are given the grace period denial option. Physicians must have access to the real-time eligibility status of QHP enrollees, which is something plans in California are capable of providing.

If the final rule is unaltered before exchange implementation, then HHS must ensure that exchanges require QHPs to provide accurate, binding, and real-time notification to physicians and other health care providers, so that they are aware that patients are entering the second month of the grace period and that claims submitted on their behalf may be pended and ultimately denied. HHS should also investigate with physicians, hospitals, and health insurance issuers the best ways to accomplish this, preferably through electronic transaction notifications and traditional routes, such as certified mail.

As mentioned above in the patient churn discussion, real-time, binding information from the QHPs would be the best solution to the churn issue and could help significantly with this problem as well. Physicians should also receive timely notification from issuers about patient terminations from QHPs.

While proper notification may mitigate some of the problems caused by this change in the final rule, it fails to address situations where the patient and the physician and/or hospital do not have a pre-existing relationship. Without accurate, binding, and real-time information and without notice, the physician or the hospital would not have any knowledge that the patient is in the grace period and that the QHP will pend his or her claims.

Recommendation:

- Ensure that the CalHEERS system or another easily accessible all-QHPs portal provides real-time eligibility status such that a provider can efficiently determine whether a patient is in the grace period.

Concluding Remarks

Thank you again for the opportunity to provide input on this key component of Exchange design at such an important stage of development. We look forward to continuing to work with the Exchange Board and staff to realize the vision of improving the health of all Californians by assuring access to affordable, high quality care.

Please direct any questions or comments to:

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Respectfully Submitted,

California Medical Association

California Hospital Association

California Academy of Family Physicians

California ACEP

American Congress of Obstetricians and Gynecologists, District IX

Medical Oncology Association of Southern California, Inc.

California Academy of Eye Physicians and Surgeons

Association of Northern California Oncologists