CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD
April 23, 2013
California Secretary of State Auditorium
1500 11th St.
Sacramento, CA 95814

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

Chairwoman Dooley called the meeting to order at 9:00 a.m.

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

Board members en route during roll call:
Paul Fearer

Board members absent:
Susan Kennedy

Agenda Item II: Closed Session

Chairwoman Dooley reconvened the open session at 12:15 p.m. A conflict disclosure was performed; there were no conflicts from the Board members that needed to be disclosed.

Agenda Item III: Approval of Prior Board Meeting Minutes

After asking if there were any changes to be made, Chairwoman Dooley asked for a motion to approve the minutes from the meeting held March 21, 2013.

Presentation: March 21, 2013, Minutes

Discussion: none

Public Comments: none

Motion/Action: Board Member Ross moved to approve the March 21, 2013, minutes. Board Member Fearer seconded the motion.

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

Agenda Item IV: Health Disparities Public Comment
The comments from the prior month's panelists and this meeting's stakeholder comments will be built into a report on health disparities.

Public comment:
Doreena Wong, Project Director of the Health Access Project, Asian Pacific American Legal Center and the Health Justice Network, expressed that the concerns of the Asian American, Native Hawaiian, and Pacific Islander community are not being addressed. She noted that they were not included in the panel, and their needs must be incorporated into any plans and reporting on health disparities.

Cary Sanders, Director of Policy Analysis and the Having Our Say Coalition, California Pan-Ethnic Health Network, focused on measures that would ensure Covered California is welcoming and accessible to a diverse community: data collection, plain language, translation, asking only for necessary information when enrolling family members, diverse provider networks, and adequate staff training.

Cassandra Kramp, of the Having Our Say Coalition, suggested steps to make Covered California a welcoming system, including providing online and in-print language translation services, training staff and providers, and sharing information with public systems like CalWORKs.

Jongran Kim, Korean Resource Center and the Having Our Say Coalition, stated that both translated materials and interpretation must be available to applicants and assisters in the case of complicated applications, noting that state- and county-level assistance must be available.

Connie Mitchell, Public Health Medical Officer, California Department of Public Health's Office of Health Equity, noted that lack of insurance has the largest impact on preventable mortality, especially in minority and vulnerable populations. There are physical barriers to care, literacy issues, and stigmas that must be addressed. Data on educational attainment and disability status should be collected. Services designed with attention to community needs and desires are more likely to be used.

Adeola Adeseun, mother of two, Chair of California Families for Access to Midwives, suggested that licensed midwives provide cost-effective, quality care that, by reducing maternal morbidity, prematurity, and low birth weights, helps eliminate race- and class-based disparities. A pregnant African-American woman is three times more likely to die of pregnancy-related complications than her white counterpart.

JoAnne Belisle, fellow, Young Invincibles and the Having Our Say Coalition, noted that young adults are more uninsured than other groups, particularly in low-income communities of color. Age must be considered as a key component of health care reform.

Jonathan Tran, California Policy and Program manager, Southeast Asia Resource Action Center, reiterated Ms. Wong's comments about the lack of inclusion of the Asian American, Native Hawaiian, and Pacific Islander community, which is very diverse and experiences significant disparities, often tied to immigration status and geographic location.

On phone: Chiquita Tuttle, president and CEO, Marketing, Management, & Health Care Consulting, would like to see data published proving what kind of impact exchanges will have on decreasing disparities and hear how data will be collected and published by participating plans. She would like to know what evaluation process is being designed to demonstrate that access to care and prevention can reduce disparities by positively impacting clinical outcomes.

On phone: Scott William, Men's Health Network, described men's and boys' health issues as a public health crisis, as men are 100 percent less likely to seek preventative health care than women and die an average of five years younger. This is a family health issue, as more than half of women living in poverty were not in poverty before being widowed, and it will require focused strategies for males.

On phone: Racha Tahani Lawler, clinical director and licensed midwife, Community Birth Center, serves a low-income clientele reliant upon a variety of social service programs, and though the community has great need for culturally competent providers of color to help with its disparately poor maternal and infant health outcomes, they are unable to pay for these services.

Agenda Item V: Executive Director's Report

Presentation: Executive Director's Report

A: Announcement of Closed Session Actions

Discussion: Covered California has posted a notice of intent to award a competitive training-support contract to Maximus. Maximus will develop training for Covered California staff and county workers to ensure that those providing customer services do it right.

B: Covered California Planning Overview

Discussion: A special Board meeting will be held May 7.

Mr. Lee announced that Kathy Keeshen has been hired as General Counsel, Karen Ruiz as CalHEERS Project Manager, and Carene Carolan as Service Center Deputy Director.

Sarah Soto-Taylor provided an update on the outreach and education grant program.

Board Member Fearer asked if there will be a future opportunity for organizations to be included who do not receive grants in this Cycle 1 round.

Mr. Lee responded that most of the monies will be awarded. Some will be held for a second cycle. Mr. Lee noted that the future direction will be based on performance; further funding is not currently in the budget.

C: Service Center Update

Discussion: Juli Baker, Chief Technology Officer, presented a timeline for the service center. CWDA reports that the counties are ready.

A webinar planned for the last week in April will focus on the key elements of service-level agreements, options for the Quick Sort Transfer Memorandum of Understanding (MOU), and monitoring the warm handoff.

Board Member Belshé was pleased to hear that data will be gathered and contingency plans discussed. Stakeholders need time to provide input on these items.

D: CalHEERS Update

Discussion: Juli Baker and Keith Ketcher from Accenture presented jointly on the CalHEERS project status. It is on schedule with a few exceptions.

Mr. Lee pointed out the importance of CalHEERS's interface with all the federal systems that it needs to work with. The testing is not done, but it is going well.

Board Member Ross asked what the single biggest threat to the timeline is currently.

Ms. Baker said the timeline itself is a challenge. The schedule is already full, and additional requests for functionality add to the pressure. Getting policy decisions locked down and excluding excessive scope are the two biggest challenges.

E: Federal Proposed Rules

Discussion: Katie Ravel, Director of Program Policy, presented an update on federal proposed regulations. Covered California is seeking clarification on whether the training materials and schedule require federal approval. Federal clarification is also needed on the role of assisters involved in SHOP as well as authority to make appropriate referrals to help applicants in unique situations.

F: Supplemental Benefits

Discussion: This was not an action item. David Panush, Director of External Affairs, provided a presentation on the revision of federal policy relating to supplemental benefits. Staff has determined that federal funds cannot be used to support non-exchange

activities, including ancillary benefits, and exchange user fees and assessments may not be used to support them.

Board Member Fearer noted Covered California is currently receiving qualified health plan (QHP) bids, and asked whether the rules about ancillary benefits change anything for them, or whether their bids consistent with this? He further inquired whether the major plans were assuming they must include these benefits or that there would be stand-alone alternatives.

Mr. Panush explained there is no change for QHPs. There is a change in terms of supplemental vision benefits for adults, and the policy will need to be revised. The impact for dental benefits is smaller.

Mr. Lee noted that the plans that submitted bids had to bid on all ten essential health benefits, including pediatric dental and vision. The existing QHP bids are in good shape. Covered California is determining if and in what way the policy for supplemental benefits might need to be revised.

Comments are due by May 3, not May 10.

G: Legislative Update

Discussion: David Panush provided an update on legislation. The Medi-Cal expansion and MAGI changes are in opposite houses. The Individual Market Reform package is on the floor in both houses. The Bridge Plan bill passed the Senate with no dissenting votes.

Mr. Panush also discussed the details of the background check/fingerprinting bills, noting that one offered an approach similar to the Board's position which allows the Department of Justice to handle background checks and share the appropriate information. The other two bills offered a different approach that is closely aligns to the Department of Insurance approach for its agents.

The dental plan legislation clarifies rules on stand-alone dental plans. The legislation about cancer treatment cost-sharing caps could impact standard benefit design.

Board Member Belshé asked if the California Health Benefits Review Program (CHBRP) has looked at AB 219.

Mr. Panush responded that CHBRP has looked at the bill. There are specific issues relating to how it affects standard benefit design and its impact on actuarial value.

Board Member Belshé expressed that we're entering a new world in terms of the potential for state-mandated changes exceeding the federal minimum. If that were to happen, she is concerned that a general fund cost could potentially be created.

Mr. Panush responded that the CHBRP process may need to include additional analysis to guide the public, the legislature, and Covered California on how AB 219 might affect the values that are being used to create the benefit design.

Public Comments:
Beth Cappell, Health Access California, expressed dismay that the Board has allowed seven discussion items to be presented without asking for public comments and hoped that more time will be set aside in future meetings for frequent public commenting. She stated that dental legislation has been deferred due to a lack of clarity. They are concerned about the implications of CalHEERS and the service center on the Medi-Cal side and excited to hear about the outreach grants.

Vanessa Cajina, Legislative Advocate, Western Center on Law and Poverty, explained that they are sponsoring AB 617, the bill on the appeals process. They are open to some amendments, but due process belongs in statute, not in exchange regulations.

Betsy Imholz, Director of Special Projects, Consumers Union, appreciates all the progress on the Service Centers, and seconds Board Member Belshé's request that contingency plans be included in the webinar. They are not aware of conflict of interest standards affecting navigators, and they want to keep working with the legislature to find the right balance between protecting consumer privacy and having diverse representation.

Kathleen Hamilton, Director, The Children's Partnership, wanted contingency plans in the webinar. They do not want pediatric dental benefits to disadvantage families.

David Chase, California Outreach Director, Small Business Majority, wondered if the new federal guidance on ancillary benefits affects the other types of benefits available in SHOP, such as COBRA administration, health savings accounts, or wellness plans.

Lisa Klinger, Health Care Reform Consultant and Attorney, the Leavitt Group, asked if she would be able to serve as both a church navigator and an insurance firm employee.

Kate Burch, Legislative and Policy Assistant, California LGBT Health and Health Services Network, voiced a need for cultural-competency as well as technical-details training on how things will work for the LGBT community. If service center employees don't respond appropriately, it will turn people off from enrolling in health insurance.

Kathy Chao Rothberg, Executive Director, Lao Family Community Development Corporation, voiced concern about the very small number of applicants applying to work at the Contra Costa service center who spoke languages other than English; only 10 percent even spoke Spanish. She suggested that legislation should allow some organizations to offer very small group assistance because of language, technology, and literacy issues.

John Valencia, Leukemia and Lymphoma Society, expressed that CHBRP has reviewed AB219, which they support, and described its impact as being one penny per person per

month. Covered California and CHBRP should do further analysis and consult with other states and then include specialty medications in essential health benefit designs.

Charles Bacchi, Executive Vice President, California Association of Health Plans, opposed Mr. Valencia's comments.

Board Member Ross would like to see a dedicated panel on the impact of Covered California on children's health. At some point, he would like to see an organized discussion of the greatest opportunities and concerns.

Agenda Item VI: Qualified Health Plan Contracting

A. Plan Contracting Update

Mr. Lee noted that Covered California is moving quickly to select plans and enter into contracts with them. He appreciated the staff and consultants for their hard work, but also all of the stakeholders providing input.

Mr. Lee introduced Bob Cosway, Principal and Consulting Actuary, Milliman, who prepared a report on potential rate changes in 2014. Milliman is also providing support for the bidding process.

Prior to yielding the floor to Mr. Cosway, Mr. Lee reminded everyone that the Quality Health Plans and the bidding must be evidence-based. Rates should be as low as possible, but not so low that they can't cover the care they are underwriting.

Mr. Lee highly praised the Milliman report, commissioned by Covered California, saying that the report doesn't oversimplify the matter or imply that everyone will have the same rates. Many factors will affect rates, including where you live, who you are, whether or not you qualify for a subsidy, and more.

B. Actuarial Report on 2014 Potential Rate Changes (Milliman)

Presentation: Covered California Plan Model Contract Options and Recommendations

Robert Cosway offered a presentation on the factors affecting individual premium rates in 2014 and the adjustments due to the Affordable Care Act market changes.

Discussion: Mr. Lee noted Covered California thinks that having standard benefit designs will have significant cost savings for providers. Over time, this could take administrative burden out of the system so more money can be spent on health care.

Mr. Lee asked Mr. Cosway to comment on people's belief that premiums will go up because they will have to buy more benefits.

Mr. Cosway noted that they call that "buying more coverage," and that it is one of the many reasons they forecast a rise in premiums. Some services that are not usually covered right now will be covered in 2014, including pediatric dental and vision benefits. There will also be less cost-sharing. Most plans out there right now have a 60 percent actuarial value, meaning the plan pays 60 percent of the cost, and the consumer pays 40 percent. Because silver will be such a popular tier, people will pay more and be buying better coverage.

Mr. Lee underscored that there could be 17 percent increase in premium, but that will be offset on average by people spending less in cost-sharing or benefits that are not covered. They hope that consumers will understand that they will know what they are buying, know what they are getting, and avoid the nasty surprise of later out-of-pocket costs. Even those not benefitting from tax credits will have less to spend at the point of service.

Board Member Fearer asked if slide 2 could be updated with the real numbers once the bids come in.

Mr. Cosway noted that the health status assumption makes that more complicated. They based their estimate of the increase on assumptions about enrollees' current health status. Each carrier tried to estimate their own health statuses effectively in 2014. However, they can probably come up with some version of that.

Mr. Lee said Covered California will have to look at how to package information about bids. Once the bids go to the regulators, they are public. It's part of Covered California's job to clarify what those bids mean.

Chairwoman Dooley noted that so many things are changing in the delivery system and financing system and individual behavior that it's difficult to get a fair calculation. The more standardized Covered California can make the complex information, resulting in apples to apples comparison, the more helpful it will be.

Board Member Ross said a Los Angeles *Times* headline said prices will go up, while its article said premium prices will go up for some and down for others. He asked Mr. Lee to be clear as to what will happen for the typical consumer.

Mr. Lee noted that there was a lot of press coverage included in the materials. It was mostly good coverage. The headlines were less accurate and more sensational. The reporters got that, depending on where you are, rates will be very different. They also point out that it's important to consider the better coverage that people will be getting. The specific plans that will be offered in each community will vary. Covered California should be able to give more information soon.

Board Member Ross hoped they can share transparent facts soon. Covered California must work upstream against so much misinformation and political posturing.

C. Model Contract Approval

Although the agenda lists this as an action item, Mr. Lee noted that no action is being taken at this time on Model Contract Approval. However, he shared that both clean and redlined versions of the Model Contract were posted online on April 22, and comments are requested by April 26.

Mr. Lee reported that Covered California invited Plans to submit alternate designs for consideration and many interesting and innovative designs were received. However, the current recommendation is to only offer standard benefit designs and wait to learn from the 2014 market before changing tack. Plans can offer alternate designs outside of Covered California.

Covered California is concerned that health spending account (HSA) silver plans may be the lowest-cost or the second-lowest-cost silver plan. In that case, the tax subsidy would be available for that product, but not cost-sharing subsidies, as those are only available in combination with non-HSA plans. Comments and suggestions are welcomed on this matter through April 26. If this issue arises, Covered California will seek federal guidance since they have implied HSA plans may be excluded relative to cost-sharing. Another consideration may be to "negotiate the goal" to ensure that HSA products are not the lowest or second-lowest cost or exclude them from the silver tier. Silver is the only actuarial tier for cost-sharing subsidies.

Presentation (continued): Covered California Plan Model Contract Options and Recommendations

Andrea Rosen, Interim Director, Health Plan Management, followed with a presentation on options and recommendations, contract development, and the review process.
She explained that the model contract is very important because Covered California wants all QHPs to sign one standardized contract. The Exchange considers the Plans as its partners, and works to balance consumer expectations with what the plans can do Ms. Rosen then reviewed the Plan selection and contracting timeline as well as the fourteen major issues, along with corresponding staff recommendations, that were brought up in comments received on Model Contract Version 3.0.
Covered California would like QHP issuers to agree to discontinue selling or maintaining plans not compliant with the Affordable Care Act by March 2014. This does not bind issuers not selling through the Exchange—thus a legislative solution would be better. Staff recommends influencing the California market as much as possible through this provision.

Ms. Rosen further noted that during plan negotiations, Covered California received a lot of provider concerns about the federal grace period during which individuals would remain covered even if they have not paid their premiums. Under federal law, the subsidized population is allowed a ninety-day grace period before they can be terminated by an issuer. During the first thirty days, the issuer is required to pay claims, and in the next sixty days, they can pend claims. The Department of Health and Human Services

requires that issuers notify providers submitting claims during the second period, but it still doesn't sit well with providers. Covered California is considering requiring that QHP providers be notified at the start of the second month if an enrollee's claim may be pended.

Chairwoman Dooley inquired about what the providers' options are once they are notified. Ms. Rosen noted the federal government will not pay its portion during that grace period.

Mr. Lee noted that a lot of the issues presented relate to care, not coverage. The mission of Covered California is to set plan rules so that consumers get care. Covered California's immediate success depends on achieving large enrollment in affordable products. Longer-term success requires changing the cost curve. Those aims must be balanced.

Board Member Fearer noted that the comment about Covered California being a shadow regulator resonated with him in that he would not like to see that happen. The Board does not wish to become a regulator, but the Exchange is a purchaser, and it wants to know what it is buying and if changes occur in terms of options like drug formularies and network. He thinks the staff is on the right track.

Board Member Fearer continued by noting that part of the Covered California mission and values is to be a catalyst of change. Its requests will require work from the plans, but these are part of the change that is fundamental to the Exchange's mission. The requests do need to be achievable, and there may be revisions, but Covered California will be aggressive in order to achieve the end goals of quality and affordable health care.

He then turned to the discussion by stakeholders of primary care physicians (PCPs). Assigning physicians helps enrollees access care, it facilitates identification of high-risk enrollees, and it ensures reasonable coordination of care. He is most concerned about these objectives. Perhaps Covered California could periodically meet with the plans to figure out how to accomplish this.

Board Member Ross appreciated the tone of the new document and agrees with Board Member Fearer. It is a partnership, and it's fair for the plans to want to get their footing. He does not mind taking the long view, but the health care industry also tends to be resistant to new requirements.

Board Member Ross wanted to make sure Covered California is at least not going backward in language requirements. That is a part of the values, and contracting plans are aware of that. He would like to hear from the plans about what they would like to do to address disparities and what data should be collected.

Ms. Rosen agreed that if Covered California does not require the plans to address disparities in year one, it should still lay a foundation. The eValue8 data set included in the solicitation will be included in the next round as well. The data set includes collection

of ethnicity and language, but Ms. Rosen does not believe it includes gender identity and disability status.

Board Member Ross inquired about translating the Covered California tagline into all thirteen threshold languages as a welcoming notice.

Mr. Lee felt that was reasonable. Staff is deciding who has what obligations. They have not yet determined what data they will collect or how they can appropriately share that information. They intend to have all key information in English and Spanish.

Board Member Belshé sees the presentation as an important narrowing of areas of disagreement. She shares Board Member Fearer's observations about assigning a primary care physician, and worries that could be a designation without meaning. She is not certain if Covered California encourages plans to assign them or if it requires plans to transition to that practice, regardless of model and noted that whatever is done should be grounded in evidence and in the end goals.

Addressing the many data reporting requirements, Board Member Belshé noted that, while there is a great opportunity to engage the plans as partners in driving for transformation, it is important to clarify what Covered California is asking for, when it is asking for it, and why. Tackling many priorities without sufficient evidence would be a challenge.

In terms of the model contract provision relating to plans not in compliance with the Affordable Care Act, Board Member Belshé voiced concern about Covered California acting unilaterally outside of legislation. She is also concerned about how the non-uniform application may affect plans who participate in the Exchange.

While the disagreements have narrowed, she wants the opportunity to engage stakeholders, especially plan partners, to resolve outstanding disagreements.

Mr. Lee expressed again that the model contract is important because they don't want multiple contracts. Staff is working through the stakeholder and bidder comments as they revise. Covered California is requiring physician assignment. It helps enrollees know how to use their coverage. If enrollees don't select one, they would be assigned one after 120 days. It does not include compensation requirements.

Board Member Belshé expressed great reservations about asking PPO plans to change their practice in the limited time available.

Chairwoman Dooley noted this contract will be revised again before the May 7 meeting.

Public Comments:
Beth Capell, Lobbyist/Policy Advocate, Health Access California, agreed with the Board members' observations, though many revisions seem like setbacks. Plans should be

prevented from shifting higher-risk enrollees to Covered California, and HSAs are not appropriate for those below 250 percent of the federal poverty level.

Cary Sanders, Director of Policy Analysis and the Having Our Say Coalition, California Pan-Ethnic Health Network, hoped for stronger language requirements, and would like references to existing laws, as well as asking plans to produce translated statements about the availability of oral translation. Health plans cannot discriminate based on sexual orientation or gender identity, and it will be important for them to figure out how to collect data on those categories.

Jongran Kim, Korean Resource Center and the Having Our Say Coalition, urged Covered California to monitor how well plans are complying with language access laws, making it possible for their members to visit providers who speak their languages.

Charles Bacchi, Executive Vice President, California Association of Health Plans, called out attachment 7 as problematic in that not all plans will be able to meet these obligations in time. Attachment 6, providing for the tracking claims via secure website, is also out of reach for some plans in the first year; they would like additional clarification on captive agents and small group rates. Attachment 14 is a major issue for the plans, and they would like an opportunity for negotiation prior to the May 7 meeting.

On phone: Abigail Coursolle, National Health Law Program, voiced concerns about leaving more responsibility to existing regulators and encouraged Covered California to continue to monitor and track important issues like network adequacy and formulary changes. They are concerned about the removal of language requirements and would like to see coordination with other programs not be limited to additional premium and cost-sharing subsidies but also additional benefits and legal protection for those programs.

Gilbert Ojeda, Director, California Program on Access to Care, UC Berkeley, encouraged Covered California to be cautious about getting involved in the debate about what will happen with state programs, including respected immigrant health and prenatal care programs. He also expressed concern about provisions relating to newly legal immigrants.

John Stenerson, California Health Care Coalition, speaking as a purchaser, voiced a need for transparency in the contracting between health plans and providers. Consumers and purchasers are not at the table, and it’s worse in regions with monopoly hospitals.

Wade LaPearl, Board Member, California Health Care Coalition; Trustee, Local 393’s health plan and a number of trustee plans in Northern California, feels lack of transparency impedes quality care and consumer/purchaser understanding. New requirements and checks and balances will make things better.

Betsy Imholz, Director of Special Projects, Consumers Union, two positives, supports standardizing benefit designs and gathering demographic information for tracking.

Provider contract information should be included, and with COBRA ending, Covered California must get its information out there.

Bill Wehrle, Vice President of Health Insurance Exchanges, Kaiser Permanente, pointed out that information requests require extensive computer system building and training, as does detailing and tracking preventative care information for each enrollee. They don't believe a health assessment tool that tracks health status over time exists yet; can Covered California take the same approach as it did with language, starting small and asking for more over time?

Jeff Shelton, Vice President of Government Relations, Regulatory Affairs, and Compliance, Health Net, seconded Mr. Wehrle's and Mr. Bacchi's comments. There needs to be more opportunity for discussion about the contract. They don't know how to begin meeting some of the reporting requirements, or the requirement about primary care physicians, since their PPO doesn't even include primary care physicians.

Brett Johnson, Associate Director, California Medical Association, expressed uncertainty about why so many definitions are given in the contract even though they are not actually used in the contract or attachments. Several of those are extremely controversial and should worry both providers and patients. He also questioned what the provider directories submitted in February are based on, as no agreements have been signed between Covered California plans and providers. This contract harms physicians and small practices.

Sarah Muller, Director of Public Affairs and Government Communications, California Association of Public Hospitals and Health Systems, strongly feels HSAs should be excluded from the silver tier, at least, since they don't work for low-income people and don't make a good basis for the bridge program. Providers don't want to see just any coverage, but comprehensive coverage that enables people to access the care they need.

Bill Barcelona, California Association of Physician Groups, voiced strong support for the document, which moves delivery system reform forward and incorporates concepts they have been talking about for years. These things are doable.

Ruth Liu, Blue Shield of California, while appreciating the significant improvements, has remaining concerns about attachment 7, and would like clarification and expanded information on attachment 14. Attachment 13 is important; all plans need to play on a level playing field, and the model contract will spur legislation.

Francene Mori, California Exchange Director, Anthem Blue Cross, noted they share both the appreciation and concerns of the other health plan partners. They hope to maintain constructive dialogue with Covered California.

John Glenn supports additional transparency in the model contract, noting that research shows increasing quality reduces the high cost of poor quality care. Clauses allowing carriers and providers to remain silent about poor quality care should be prohibited.

Deborah Kelch, Kelch Policy Group and the Health Insurance Alignment Project, voiced concern about Covered California determining plans' status with the regulators, in terms of statutory authority, increasing confusion, and being a potential conflict of interest.

Anne Eowan, Association of California Life and Health Insurance Companies, seconded Mr. Bacchi's endorsements and concerns. They are especially concerned about the assignment of primary care physicians in PPO plans.

Beth Cappell, Health Access California, suggested that consumer advocate partners should be involved in the discussions between health plans and Covered California.

Agenda Item VII: Eligibility and Enrollment
Thien Lam, Deputy Director, Eligibility and Enrollment, presented an update on concepts, policies, regulations, and single streamlined elements.

Presentation: Eligibility and Enrollment

A: Eligibility and Enrollment Policy Options

Discussion: Draft Regulations
As this relates to regulations, it will come before the board for action on May 23.

Responding to Board Member Belshé's question, Ms. Lam noted that these regulations are exclusively related to the Covered California population. The Department of Health Care Services (DHCS) has been around longer, so they already have many things in place. Covered California is trying to be more transparent, but whenever it is appropriate, it learns from DHCS's example and aligns itself to create consistency.

Board Member Belshé requested clarification on and reconciliation of differences in policy.

Ms. Lam agreed that some tensions are created in the differences. CalHEERS is the single business-rules engine for insurance affordability programs, but there are some large verification differences between programs. They will bring some comparisons to the board. For example, Medi-Cal requires verification of state residency, but Covered California does not. They have been working closely with DHCS through the process.

Mr. Lee noted that the CalHEERS system needs to be able to handle differences.

B: Single Application Update

Discussion: Board Member Belshé solicited the opinions of consumer advocates and others on key issue 1, regarding prepopulated application data. Staff and DHCS have concerns about confidentiality, but it seems like it would simply the enrollment process.

Mr. Lee noted they have worked closely with DHCS on eligibility and enrollment, and everything is subject to federal review. The federal government has issued a single streamlined application that states can use, or states can create their own, subject to federal approval. There will be a webinar on the topic.

Public Comment:
Cary Sanders, Director of Policy Analysis and the Having Our Say Coalition, California Pan-Ethnic Health Network, would like better definition for readability standards since plain language is required to help people understand the complex issues. While they appreciate many of the comments relating to language access, they would like to see data collected out of the gates.

Betsy Imholz, Director of Special Projects, Consumers Union, noted some areas of disagreement: ninety days should be long enough for appeals, eligibility should precede premium payment in case payments are received after the open-enrollment period, requiring the social security numbers of nonapplicants could have a chilling effect, and a ninth-grade reading level is too high.

Kate Burch, Legislative and Policy Assistant, California LGBT Health and Health Services Network, expressed the importance of clarifying terms like "household," and "gender." Anywhere the application asks for race and ethnicity, it should ask for gender identity and sexual orientation. California law requires that same-sex couples be allowed to purchase the same family plans that opposite-sex couples have access to.

Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law and Poverty, agreed with the preceding speakers and expressed concern about asking for nonapplicants' social security numbers, paper application processing times, and putting off collection of sex and gender identity data, creating barriers to getting coverage.

Beth Cappell, Health Access California, seconded the comments of their colleagues. For enrollment and eligibility, all public-facing materials must be at a sixth grade or lower level, with materials at a higher level for use by the service center and other experts assisting the public with complicated matters.

Kathy Chao Rothberg, Executive Director, Lao Family Community Development Corporation, stressed the importance of helping people understand the term "household." She suggested connecting with the Workforce Investment Act one-stop centers, and connecting CalHEERS with CalWIN, speeding up the process by using preexisting data.

Beth Abbott, Director of Administrative Advocacy, Health Access California, noted that when the Centers for Medicare and Medicaid Services changed their materials from an eighth-grade to a sixth-grade reading level, they received considerable positive feedback and got fewer calls for assistance.

On phone: Byron Gross, counsel, National Health Law Program, agreed with Ms. Landsberg about paper application processing time and added that there should be a built-in way for consumers to explain inconsistencies in the interest of quick resolutions. The original language applying to people who are not emancipated minors should be added back in.

On phone: Claudia Page, Social Interest Solutions, expressed that it was hard to tell from the usability webinar what things would look like for the consumer, and is unsure how the process will work considering the delay in establishment between SAWS and CalHEERS. Based on their focus tests, consumers are less confused by questions when prepopulation is used and they only have to confirm or change data.

Doreena Wong, Project Director of the Health Access Project, Asian Pacific American Legal Center, suggested materials should be at the fifth-grade reading level, and supported the suggestion about web portal taglines in different languages. They would like to hear an update about the threshold language decisions, adding that the inclusion of Chinese on the website would enable access for an additional 120,000 people.

Agenda Item IX: Adjournment
The meeting was adjourned at 4:23 p.m.