Comments to the Board

Table of Contents

May 23rd, 2013 Board Meeting

Assisters Program

- Asian Pacific American Legal Center
- California Hospital Association
- California Pan-Ethnic Health Network, Consumers Union, and Health Access
- California Primary Care Association
- Coalition
- Coalition
- Greenlining Institute and National Employment Law Project
- Health Consumer Alliance
- Local Health Plans of California
- Multiple Organization Comments by Regulation Number (Spreadsheet)
- National Health Law Program
- San Francisco Community Clinic Consortium
- San Luis Obispo County Public Health Department
- Stephen Young
- Transgender Law Center
- United Way
- Yolo County Community Health Initiative

Eligibility and Enrollment

- Coalition
- Social Interest Solutions & The Children's Partnership

General Comments

- Alliance for Boys and Men of Color
- Asian Pacific American Legal Center
- California Pan-Ethnic Health Network
- Dave Schmitt
- James Wisdom
- Ken Alan
- Stephen Benveniste

Marketing
- Inland Empire Health Plan

National Voter Registration Act
- Asian Pacific American Legal Center
- California Forward
- Communications Workers of America
- County of Santa Cruz
- Greenlining Institute
- Rock the Vote
- UAW Local 4123
- UAW Local 5810

Outreach and Education
- Latino Coalition for a Healthy California

Service Center
- Consumers Union

Supplemental Benefits
- VSP Global

QHP
- California Optometric Association
- Transgender Law Center
- United Concordia Dental

April 30, 2013

Via: info@hbex.ca.gov

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

Dear Mr. Lee and Covered California Staff:

The Asian Pacific American Legal Center (APALC) is writing in response to your request to provide feedback to Covered California's (CC's) proposed comments to the Center for Medicare and Medicaid Services' (CMS') Proposed Rules on Navigators and Non-Navigator Assistance Personnel. APALC, a member of the Asian American Center for Advancing Justice, is dedicated to providing the growing AANHPI communities with multilingual and culturally sensitive legal services, education, leadership development, and public policy and advocacy support. As the coordinator of HJN, APALC's Health Access Project seeks to address the health care needs of the AANHPI 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.

The three areas that we would like to provide input on are the following:

1) Training standards for Navigators and non-Navigator Assistance Personnel carrying out consumer assistance function under 155.205(d) and (e) and 155.210.
1. Certification and recertification standards.

We work with the Asian Americans and NHPI small business community, which has expressed a strong interest in ensuring policies that promote maximum enrollment in and utilization of SHOP Exchanges by small business owners and their employees. It is well known that many small businesses do not currently provide health insurance for their employees.[1] While it is unclear how many Asian American and NHPI small business owners are uninsured, owning a small business is a likely indicator of also being uninsured.[2] There are about 350,000 Asian-

[1] U.S. GOV'T ACCOUNTABILITY OFFICE, SMALL EMPLOYER HEALTH TAX CREDIT: FACTORS CONTRIBUTING TO LOW USE AND COMPLEXITY 1 (2012), http://www.gao.gov/assets/600/590832.pdf.
[2] ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM (APIAHF), OPPORTUNITIES AND CHALLENGES IN THE AFFORDABLE CARE ACT FOR ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER SMALL BUSINESSES 6 (2012), http://www.apiahf.org/sites/default/files/PA-brief07-12.pdf.APIAHF report. For example, "[a]ccording to a 2009 survey conducted of Korean owned small businesses in Koreatown, Los Angeles, 52% of respondents were

owned businesses that may be qualified to insure their employees through SHOP Exchanges.[3] Overall, Asian Americans own 5.7% of businesses in the United States and employ 2.8 million people.[4] SHOP Exchanges are expected to make a significant impact among Asian American and NHPI small business owners who will soon have access to affordable health insurance.

Asian American and NHPI small business owners are a part of the fastest growing racial group[5] in the United States with dozens of different cultures and languages. Approximately 71% of Asian Americans speak a language other than English at home.[6] Approximately 32% of Asian Americans are limited-English proficient (LEP) and experience some difficulty communicating in English.[7] Approximately 21% of Asian American households are linguistically isolated, meaning that all members 14 years old and older speak English less than "very well"[8] and would be considered LEP.[9] Decisions to reduce enrollment or make program provisions more complex have real consequences for LEP individuals by deterring them from participating altogether.

CC makes the following recommendation:

> b)(1)(v) Covered California does not agree with the proposed requirement that non-Navigator assistance personnel be required to serve the SHOP market. Consistent with current market practice, Covered California intends to use certified agents to facilitate enrollment in the SHOP. While we intend to train non-Navigator assistance personnel in basic elements of the SHOP, providing the training necessary for them to complete a group enrollment would be both costly and duplicative of services provided today by agents. We request that this requirement be removed from the final regulation.

We disagree with CC's claim that the SHOP market should rely on certified agents to facilitate enrollment in the SHOP. We have repeatedly noted that in the Asian American, Native Hawaiian and Pacific Islander communities there are many LEP small businesses who are not served by certified agents and do not rely on them for obtaining health

---

uninsured and 30% replied that their dependents were also uninsured. Only 10% reported that all of their dependents had health care coverage." *Id.*

[3] U.S. CENSUS BUREAU, 2007 Survey of Business Owners (adding numbers of self-identified Asian-owned businesses with one to 99 employees).

[4] APIAHF, ASIAN AMERICAN AND NHPI SMALL BUSINESSES, at 5.

[5] "Between 2000 and 2010, the Asian American population grew faster than another other racial group, at a rate of 46%." KARTHICK RAMAKRISHNAN, UNIVERSITY OF CALIFORNIA RIVERSIDE & TAEKU LEE, UNIVERSITY OF CALIFORNIA BERKELEY, PUBLIC OPINION OF A GROWING ELECTORATE: ASIAN AMERICANS AND PACIFIC ISLANDERS IN 2012, NATIONAL ASIAN AMERICAN SURVEY 3 (2012), http://naasurvey.com/resources/Home/NAAS12-sep25-election.pdf.

[6] ASIAN PACIFIC AMERICAN LEGAL CTR. (APALC) & ASIAN AMERICAN JUSTICE CTR. (AAJC), MEMBERS OF ASIAN AMERICAN CTR. FOR ADVANCING JUSTICE, A COMMUNITY OF CONTRASTS ASIAN AMERICANS IN THE UNITED STATES: 2011, at 25 (2011), *available at* http://www.advancingjustice.org/pdf/Community_of_Contrast.pdf.

[7] *Id.* at 27.

[8] *Id.* at 29.

[9] Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311, 47313 (Aug. 8, 2003), *available at* http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html ("Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be limited English proficient, or 'LEP,' and may be eligible to receive language assistance with respect to a particular type of service, benefit, or encounter.").

insurance for their employees. They often are not able to provide insurance information in a culturally and linguistically competent manner and that the small business community will be a new market which probably does not have an existing relationship with certified agents. Rather, small businesses turn to more trusted community-based organizations for assistance. Therefore, we believe with the federally proposed rule that would require that Navigators and non-Navigator personnel; "[b]e prepared to serve both the SHOP and the individual Exchange."

2) Training standards for Navigators and non-Navigator Assistance Personnel carrying out consumer assistance function under 155.205(d) and (e) and 155.210.
2. Training Module Content

Although CC does not comment on the content of the training, we would recommend that it include training on other insurance programs, including Medicaid, Children's Health Insurance Program and other publicly funded and safety net programs, similar to its recognition of such programs in its proposed Assister training.

3. (c) Providing Culturally and Linguistically Appropriate Services (CLAS Standards)

CC has made the following recommendation:

> (155.210)(c)(d)- Covered California seeks clarification on the requirements to provide services that meet CLAS standards in section (c) as well as the requirements to provide services that are accessible to persons with disabilities in section (d). Per the preamble, "Each Navigator and non-Navigator assistance personnel should have the ability to help any individual who presents him or herself for assistance. However, there may be some instances where a Navigator, or non-Navigator assistance personnel, does not have the immediate capacity to help an individual. In such cases, the Navigator or non-Navigator assistance personnel should be capable of providing assistance in a timely manner but should also refer consumers seeking assistance to other Exchange resources, such as the toll-free Exchange Call Center, or to another Navigator or non- Navigator assistance personnel in the same Exchange who might have better capacity to serve that individual more effectively". Accordingly, Covered California recommends that the final rule reflects the direction taken in the preamble in that assistance personnel may refer consumers to other resources in instances where that assister is not able to provide full enrollment services for a particular person with special language or disability needs. It would be inefficient, costly, and not lead to a first-class consumer experience if each individual Navigator or non-Navigator assistance personnel were (for example) required to provide interpreter services. We seek confirmation that this approach would be compliant with the regulation.

As noted in the preamble, we believe there is the flexibility for Navigators and non-Navigators to refer applicants to other Navigators and non-Navigator entities who could provide more appropriate assistance, whether in-language or for the disability

community, including other community-based entities or the Service Center for further enrollment assistance. We think that all Navigators and non-Navigators must comply with all federal and state non-discrimination requirements, including the ability to provide culturally and linguistically accessible information and assistance. We would not want certain large entities to simply refer applicants who are limited-English or disabled to other entities or the Service Center. Therefore, we do not believe that further clarification is necessary.

We hope that you find our comments helpful and if you have any questions, please do not hesitate to contact me at dwong@apalc.org or (213) 241-0271. Thank you for the opportunity to provide our comments.

Sincerely,

Doreena Wong

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

Providing Leadership in Health Policy and Advocacy

May 14, 2013

Peter V. Lee
Covered California
Executive Director
info@covered.ca.gov

Subject: Assisters Program Draft Proposed State Regulations

Dear Mr. Lee:

The California Hospital Association, which represents more than 400 hospitals in California, is pleased to provide comments on the Assisters Program draft proposed state regulations. We appreciate the opportunity Covered California has provided to hospitals and other stakeholders to engage in this process.

We are very supportive of Covered California's "no wrong door" approach to enrollment assistance in which, through a variety of settings, Californians will be assisted to enroll in any insurance affordability program for which they are eligible. In consideration of the many "doors" by which Californians will enter, we encourage Covered California to consider how elderly and low-income individuals located in rural, medically underserved areas will enter – through the doors of hospital-based clinics. Due to the unique characteristics of hospital-based clinics and the populations they serve, we ask that Covered California include these clinics as Assister Enrollment Entities eligible for compensation.

As we shared with Covered California in our June 14, 2012 letter and June 26, 2012 e-mail correspondence, many hospital-based clinics are located miles from the nearest inpatient facility and are oftentimes not supported by hospital-based eligibility and enrollment activities (more typically an emergency room and inpatient activity). Many of these clinics self-identify as being very financially unstable, citing costs and limited resources as their biggest challenge. Hospital-based clinics in rural areas have access to target populations that may otherwise escape Covered California's most robust outreach and enrollment activities and should be seen as vital partners in enrolling medically underserved populations into Covered California and the expanded Medi-Cal program.

In recognition of the vital role hospital-based clinics will play in achieving Covered California's ambitious enrollment goals, and of the elderly and low-income individuals in rural areas that would benefit by additional outreach and enrollment activities, we urge Covered California to include hospital-based clinics as Assister Enrollment Entities eligible for compensation. While there are various forms of clinic licensing, designations, ownership and association membership, patients – particularly those in rural areas – are likely unaware of these differences and only

focus on where care is available for them. Therefore, we encourage Covered California to treat all clinics equal in terms of their eligibility for compensation under the Assisters Program.

Thank you for your time and consideration. We look forward to our continued partnership to improve the health of all Californians by assuring their access to affordable, high-quality care.

Sincerely,

Amber Kemp
Vice President, Health Care Coverage

cc: David Panush

May 6, 2013

Mr. Peter Lee, Director
Ms. Katie Ravel, Director, Program Policy
Ms. Thien Lam, Deputy Director, Eligibility and Enrollment
Covered California

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

We write today to support the proposal, as presented in the Board Recommendation Brief entitled, "Agent and Enrollment Entity Relationships," which prohibits enrollment entities from receiving financial compensation from agents for referrals or enrollment services and prohibits agents from compensating grantees.

We strongly urge the Board to adopt the staff proposal. We would further support the staff's identification that would require Covered California to add the prohibitions explicitly into grantee, agent and QHP contracts (including a requirement in the Model Contract that QHPs incorporate these prohibitions into their contracts or QHP appointments with agents), and training materials and certification curriculum. And we encourage Covered California to build into its budget and staffing the resources to enable adequate monitoring and enforcement of the policy position.

Sincerely,

Julie Silas
Consumers Union

Cary Sanders
CPEHN

Anthony Wright
Health Access

May 14, 2013

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

RE: Assister Regulations

To Whom It May Concern,

The California Primary Care Association (CPCA) respectfully submits comments on Covered California's Proposed Assisters Regulations. 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.

Background

On June 19, 2012, The Covered California Board of Directors adopted the *Statewide Assisters Program Design Options and Recommendations* to guide Covered California staff in the creation of an in-person assisters program that will aid in education, enrollment and ongoing use of public and qualified private health plans that will be offered through California's new Individual Health Benefits Marketplace. This document was carefully crafted and revised to reflect the careful judgment of the Covered California Board and was subject to an extensive vetting process to ensure that the policies adopted represent the best path forward for Covered California.

CPCA understands that the Assisters Regulations promulgated by Covered California are required to reflect the policies adopted by the Board as written in the *Statewide Assisters Program Design Options and Recommendations.* While Covered California staff may retain some latitude in implementation, it is not appropriate for the Assisters Regulations to directly contradict the clearly defined policy goals included within the Board-approved document. Our comments below are meant to aid Covered California staff in revising the proposed Assisters Regulations to reflect the clear intent of the Covered California board.

Comments

§ 6574. In-Person Assistance Program

CPCA respectfully points out a significant error included within §6574 of the draft Assister Regulations. This section contains a list of the types of organizations which are ineligible for compensation by the Exchange for functions performed as Assister Enrollment Entities. Subsection (a)(5) includes "providers, including, but no limited to, Hospitals, Clinics, and County Health Departments that provide health care services" as entities ineligible for compensation.

By including "clinics" in the list of entities ineligible for compensation, and not creating an exception for "community clinics," §6574 directly contradicts the clear intent of the Covered California Board of Directors as stated within the *Statewide Assisters Program Design Options and Recommendations.* In

fact, the Board-approved document specifically lists “community clinics” as entities eligible to serve as enrollment assisters and be compensated by the Exchange.

CPCA recognizes that there is a distinct difference between “community clinics” and “clinics” as listed in §6574. However, the regulation as currently written does not reflect this differentiation nor allow for the participation and compensation of “community clinics” per the clear intent of the Covered California Board.

It is necessary to revise this proposed regulation to reflect the Board-adopted *Statewide Assisters Program Design Options and Recommendations.* CPCA recommends that the regulation be revised to include both a definition of “community clinic” within §6570, and a clarification that entities classified as “community clinics” are specifically eligible for compensation for functions performed as Assister Enrollment Entities.

§6570 should be revised to include:

<u>Community Clinics:</u> Community clinics or health centers licensed as either a “community clinic or “free clinic”, by the state of California under Health and Safety Code section 1204(a) and (2), or is a community clinic or free clinic exempt from licensure under Section 1206(c).

§6574(a) should be revised to include:

5) Providers, including, but not limited to, Hospitals, Clinics not designated as “community clinics”, and County Health Departments that provide health care services. Community clinics are eligible for compensation by the Exchange for functions performed as Assister Enrollment Entities.”

§ 6576. Navigator Program

Section 6576 includes a drafting error similar to that in included in §6574 by including “clinics” within the list of the types of organizations which are ineligible to apply for the Navigator Program. Again, the regulation must clearly differentiate “community clinics” as entities which are eligible to apply in order to reflect the clear intent of the Covered California Board.

The *Statewide Assisters Program Design Options and Recommendations* clearly state that “The Exchange is still defining which classification of organizations will be eligible to serve as Navigator enrollment entities. However, at a minimum, non-profit organizations, community clinics, County Social Service offices employing Eligibility Workers, and labor unions will be eligible to serve as Navigator enrollment entities for purposes of Exchange enrollment.”

CPCA requests that §6576 of the proposed Assisters Regulations be revised to reflect the clear intent of the Board. The revision should include:

§ 6576. Navigator Program

(a) The following types of organizations are ineligible to apply for the Navigator Program:

5) Providers, including, but not limited to, Hospitals, Clinics not designated as “community clinics”, and County Health Departments that provide health care services. Community clinics are eligible to apply for the Navigator program.”

Additional Comments
CPCA is concerned about language included in both §6574(a)(4) and §6576(a)(4) that states that "recipients of any direct or indirect consideration from any health insurance issuer or stop loss insurance issuer in connection with the enrollment of any individuals or employees in a QHP" are prohibited from compensation for in-person assistance and from participating in the Navigator program.

CPCA believes that Covered California means for this exclusion to apply only to entities that receive funding *in connection with the enrollment* of individuals into health insurance. However, in order to clarify and explicitly allow for the participation of community clinics and health centers we ask that Covered California revise these sections to state that support for non-enrollment related functions, including reimbursement for health care services, does not prevent the participation of otherwise eligible entities in these programs.

CPCA recommends that §6574(a)(4) and §6576(a)(4) be revised to read:

4) Recipients of any direct or indirect consideration from any health insurance issuer or stop loss insurance issuer in connection with the enrollment of any individuals or employees in a QHP or non-QHP. This exclusion does not apply to organizations who receive consideration from health insurance issuers or stop loss insurance issuers for functions other than enrollment, or are reimbursed by insurance issuers for services rendered.

Thank you for the opportunity to comment on the draft Assister Regulations. Please do not hesitate to contact Meaghan McCamman by telephone at (916) 440-8170 or by e-mail at mmccamman@cpca.org if you have any questions about these Comments.

May 14, 2013

Thien Lam, Deputy Director Eligibility and Enrollment
Katie Ravel, Director, Program Policy
Covered California Board
560 J St., Suite 290
Sacramento, CA 95814
Submitted electronically to info@hbex.ca.gov

RE: Comments on Covered California's Assisters Program Update, Draft Regulations and Board Recommendation Brief

Dear Ms. Lam, Ms. Ravel and Members of the Board:

On behalf of the California Pan-Ethnic Health Network, Consumers Union, Health Access and Western Center on Law & Poverty we thank you for the opportunity to share our feedback regarding Covered California's Board Recommendation Brief, Program Update and Draft Regulations and outline our comments and recommendations below:

Assisters Program Update Exchange Board Meeting Presentation 5/7/13

Assister Training (slides 13 and 14):

We understand that many of the training issues have yet to be decided. We reiterate here our comments from February 2013, urging Covered California to develop the minimum hours required for certification based on the time it will take to adequately and effectively communicate the many important issues that Assisters will need to understand and be able to communicate to consumers. Two to three days may not be enough to thoroughly impart important information that Assisters will need to understand. For example, it is our understanding that Maryland's Exchange will require at least 120 hours of training for their assister program. The proposal for California is only 24 hours per year; this may not be enough to ensure Assisters understand the intricacies of the insurance world, as well as employer coverage issues, tax implications, etc.

In addition, there are a number of topics that should be on the list for the Assister training curriculum and we are very interested in participating with Covered California in suggesting and/or reviewing training curriculum topics and materials.

- 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, as well as the processes for raising violations with the appropriate state agencies; and
- ACA non-discrimination provisions and demographic data collection in support of the Exchange's mission to eliminate health disparities.

Consumers Union is soon to release a brochure (that has been tested with consumers via focus groups and cognitive interviews) that communicates to consumers and Assisters information about ACA tax credits for health insurance premiums, including a worksheet for Assisters. We would be happy to share the brochure with Covered California and to work with your team to help develop the training curriculum on this issue. Our organizations have significant expertise on many of these issues and would be interested in working with a small team of Covered California to think through and/or review the training and curriculum standards.

Assisters draft regulations
§ Section 6570. Definitions.

Definition of Consumer: change to "an individual or entity seeking information on eligibility and/or enrollment and/or seeking application assistance with a health insurance or health related product available through the Exchange or the state of California…" Consumers might look to Assisters for a myriad of functions and broadening the definition would ensure that consumers have a single place for which to get information or apply for coverage. Exchange Board and staff have indicated their support for assistance across programs per the true "no wrong door" entry perspective. Though the CalHEERs system might build into other programs such as Medi-Cal, we believe it is important to call out other programs available through the state.

Include reference to the federal definition of **Culturally and Linguistically Appropriate** as currently proposed in 45 C.F.R. §155.215, and required in §155.205 and §155.210 to ensure Assisters are aware of the federal requirements and proposed standards for meeting those requirements.

§ 6574. In Person Assistance Program.

(a)(5) We understand that community clinics will be eligible to be paid Assisters. This provision should be changed to reflect that some clinics will be able to participate in the in-person assistance program: "Providers, including, but not limited to Hospitals, Clinics (except community clinics), and County…"

(b)(2). We appreciate the Exchange providing IPA Program applicants an opportunity to reply to and submit additional information in their application for IPA Programs should the Exchange request it, though we would prefer to see a formal appeals process, such as those outlined for Individual Assisters. We urge Covered California to establish a formal appeals process for Enrollment Entities, not just individual Assisters.

We suggest being clear in (b)(4) that Assister Enrollment entities who pass the training will be not only registered but officially certified by Covered California and suggest the following addition: "… pass the training requirements established by the Exchange shall be certified and registered as Assister Enrollment Entities by the Exchange."

(c)(2)(vi) should be revised to reflect the Federal rules for Navigators, to include the following language: "Ability to provide information that is culturally and linguistically appropriate, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act."

(c) We appreciate the criteria used to select Enrollment Entities and would suggest a few additional criteria: (ix) Ability to conduct marketing and outreach that does not discriminate based on income, disability status, language, etc. (x) Ability to maintain expertise in eligibility, enrollment and program specifications; (xi) Ability to adhere to conflict of interest standards established by the Exchange on an ongoing basis.

§ 6576. Navigator Program. (a)(6) Similar to §6572(a)(5) above, this provision should be changed to reflect that some clinics will be able to participate in the in-person assistance program: "Providers, including, but not limited to Hospitals, Clinics (except community clinics), and County…"

(b)(4) Add language about certification as suggested in §6472(b)(4) above. "… pass the training requirements established by the Exchange shall be certified and registered as Assister Enrollment Entities by the Exchange."

(c)(6) Access to target markets should also include immigrants, persons with disabilities and LGBTQ communities. "Access to target markets including, but not limited to, factors such as geography, ethnicity, language, employment sector, income, age, disability, immigration status, sexual orientation and gender identity."

(c)(7) Should outline requirement to have the ability to provide Navigator services for all programs, including Medi-Cal. "Alignment with Exchange's mission and ~~complementary programs~~ other insurance affordability programs, including Medi-Cal and CHIP."

§ 6580. Assister Fingerprinting and Criminal Record Checks

Federal law requires, and prudence and consumer protection dictate, that Covered California set standards and establish safeguards for protecting the privacy of highly sensitive and confidential personal information that will be needed for applying for health insurance programs. Discussions are ongoing with Exchange and legislative staff to refine the kinds of positions for which background checks will reasonably be required as well as potentially disqualifying crimes.

Because of the disproportionate impact on communities of color, particularly on men of color, of arrests and convictions, unjust and unjustified discriminatory impact could result if the parameters for background checks and potential job disqualifications are not carefully developed. For example, many crimes are wholly unrelated to the job duties that involve handling personal financial or medical information. On the other hand,

felonies involving fraud, dishonesty or breach of trust may very reasonably be considered substantially related to positions with Covered California, its vendors, sub-contractors and Assisters with access to such sensitive personal information. This will need to be carefully defined in regulations or statute, a task that is underway.

This proposed regulation sets forth another essential element: an appeal route for job applicants so that erroneous information can be corrected and individual background circumstances can be considered. For example, if identity is mistaken or if someone with a relevant felony conviction at a very young age has for several years been ably performing the duties which they propose to perform for Covered California, an opportunity should be provided to correct the erroneous information and consider an exception where the evidence warrants it. We appreciate the intent of the proposed regulation and offer specific suggested edits below to strengthen it, and comport with best practices, including EEOC guidelines. We have the following line edits to these provisions:

> (a)(1) "Except for Agents and Brokers with a current and valid license from the California Department of Insurance, all Individual Assisters must submit fingerprint images and associated criminal history information pursuant to Title 10, California Code of Regulations, Section 6456(b).
>
> (b)(2) If the Exchange finds that an individual whose duties require fingerprinting under paragraph (a) has a potentially disqualifying criminal record under Title 10, California Code of Regulations, Section 6456(d)-(e), the Exchange shall promptly provide the individual with a copy of his or her criminal record pursuant to Penal Code Section 11105(t), notify the individual of the specific reasons for the interim determination, and provide the individual information on how to request an appeal through the Exchange to dispute the accuracy and relevancy of the criminal record.
>
> (c)(1) If the individual believes that his or her criminal record is inaccurate or incomplete, within 60 days of receiving the notice set forth in paragraph (b)(2), the individual may provide information to the Exchange, including supporting documentation, identifying and correcting the incomplete or inaccurate criminal history information. Upon receipt of said information, the Exchange shall re-evaluate the interim fitness determination. ~~seek to correct or complete the response through processes established by the California Department of Justice, the Federal Bureau of Investigation, or agencies reporting information to the California Department of Justice or Federal Bureau of Investigation. If the individual successfully challenges the accuracy or completeness of the response, the individual may request a new criminal record check and reevaluation of the interim fitness determination by the Exchange.~~ The Exchange, within 60 calendar days, shall respond to the individual with a final determination.
>
> (c)(2) If the individual determines that his or her criminal record is accurate, within 60 days from the notice of interim determination the individual may dispute the ~~substantial relatedness of a disqualifying offense by producing any additional written evidence of circumstances~~ interim determination by producing evidence of rehabilitation and any other mitigating circumstances, related to any potentially disqualifying offense ~~and/or rehabilitation~~. The Exchange, within 60 calendar days, shall respond to the individual with a final determination.

(c)(2)(A) For purposes of ~~reconsidering the weight of disqualifying offense, the Exchange shall take into account any and all of the following~~ evaluating mitigating circumstances and evidence of rehabilitation, the Exchange shall take into account the following information provided by the individual:

(i) Whether the individual has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed against the individual;

(ii) Any evidence that the individual performed the same or similar type of work, post conviction, with the same or a different employer, with no known incidents of criminal conduct on the job;

(iii) Whether the individual has a history of prior discipline for the same or similar type of conduct;

(iv) Any evidence of participation in education, training, or treatment programs;

(v) References from employers, probation officers, parole officers, clergy and others who can attest to the individual's fitness and character; and

(vi) Any other evidence of rehabilitation or participation in treatment programs.

§ 6582. Training Standards. This section has not yet been developed and our undersigned organizations would like the opportunity to provide further comments on these regulations as mentioned above.

§ 6584. Appeals Process. (b) (1) (a). The Exchange shall, on the correspondence to applicants, provide a clear language reason for disqualification and the contact information of an ombuds-like resource so that applicants may appeal his or her adverse decision. This is particularly important for applicants who are not represented in a collective bargaining situation or place of employment.

§ 6586. Roles and Responsibilities. We urge the Exchange to reference the non-discrimination provisions in the ACA, Section 1557 which prohibits discrimination on the basis of race, ethnicity, primary language, disability status, sexual orientation and gender identity so Assisters are clear about the requirements of the ACA: (b) 3) Not discriminate on the basis of age, gender, race, ethnicity, primary language, disability status, sexual orientation or gender identity in accordance with Section 1557 of the ACA. ~~Comply with any applicable federal or state laws and regulations.~~
4) Comply with any other applicable federal or state laws and regulations.

Agent and Enrollment Entity Relationships Board Recommendation Brief
We have been consistently supportive of the Exchange's commitment to a "no wrong door" enrollment assistance approach and appreciate the Exchange's inclusion of basic knowledge about Medi-Cal as part of the criteria consideration for applicants of the In-Person Assistance Program (IPA) even though under federal guidance assisters cannot be compensated for Medi-Cal enrollment.

We accept the use of insurance agents to sell and market QHPs in both the individual and SHOP Exchange but we remain troubled by the much higher compensation to be paid to

insurance agents than assisters. This remains inequitable and may result in slower enrollment than would otherwise occur.

We agree that relationships should be developed across different types of Enrollment Entities, and that there should be standards for those formal relationships. As such, we support the recommendation to prohibit Navigator grantees and Individual Assisters from accepting payment or valuable consideration from agents, as well as a prohibition on certified agents from providing payment or other valuable consideration to grantees or assisters. We ask that this be amended to include examples of "other valuable consideration". We suggest that examples of other valuable consideration include office space at no cost or cost below actual costs, funding for travel expenses or reduced travel costs, marketing or co-marketing, and production of materials at no cost or below actual cost. Entertainment of assisters by insurance agents may be another area the Exchange wishes to consider.

Thank you for the opportunity to provide input. We look forward to continuing to work with you to ensure Covered California's Assisters program is a success. Please contact us if you have any questions about these comments.

Sincerely,

Julie Silas
Consumers Union
(415) 431-6747
bimholz@consumer.org

Cary Sanders
CPEHN
(510) 832-1160
ewu@cpehn.org

Anthony Wright
Health Access
(916) 497-0923
awright@health-access.org

Elizabeth Landsberg
Western Center on Law & Poverty
(916) 282-5118
elandsberg@wclp.org

May 9, 2013

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

RE: Comments to Covered California's Draft Regulations for the Assisters Program

Dear Mr. Lee,

We, the undersigned organizations, are writing to provide comments on the Draft Regulations for the Assisters Program as propose by Covered California. We appreciate the work Covered California staff has put into drafting the regulations and appreciate the opportunity to comment.

We would like to highlight in these comments ways we have identified that the Assister Program (including the In-Person Assister and Navigator programs) can be strengthened, as well as providing some specific comments on the proposed regulation.

Covered California can take the following steps in the proposed regulations to better clarify, support and strengthen the availability of assistance:

1. Inclusion of Direct Benefit Assisters (DBAs). The proposed regulations have given a relatively detailed description of Individual Assisters and Individual Navigators but they do not define or provide a process for those intending to become DBAs who will conduct enrollments without compensation by the Exchange. In previous board meetings, Covered California discussed the role and importance of the DBAs but the proposed regulations do not offer any guidance on how to become a DBA or what the training standards will be. It will be beneficial and clarifying to include a definition of DBAs, regulations on the application process for becoming a DBA and, and outline training requirements and standards.
2. Inclusion of Certified Application Counselors (CACs). In a proposed rule (42 CFR Section 425.908 and 45 CFR Section 155.215) the Centers on Medicaid and Medicare Services (CMS) articulated a new category of application assister the "Certified Application Counselor" (CAC) who will assist with enrollment as well as managing cases between eligibility determination and regularly scheduled renewals. While the rule is not final, the proposed rule indicates that each state exchange will be required to have a CAC program. At the point that the federal rule becomes final, it will be helpful for Covered California to consider and articulate how CACs can be active in the California market to supplement and complement DBAs, IPAs and Navigators. Key issues will be whether: (1) CACs will be available both in Covered California and through California's Medicaid agency (Department of Health Care Services(DHCS)), (2) what the training

requirements will be for CACs and how coordination for training will occur between DHCS and Covered California, (3) whether there will be payment for CAC work for the valuable service they will provide in enrolling Californians in coverage including Medi-Cal, (4) how Covered California and DHCS will ensure that CACs provide equal access to individuals with limited English proficiency and individuals with disabilities, and (5) a web portal in CalHEERS will be provided for CACs.

Comments specific to the Covered California proposed Assister regulations:

§ 6570. Definitions.
Covered California has defined Assister Enrollment Entities as, "Organizations eligible to be trained and registered by the Exchange in order to provide one-on-one consumer assistance. Assister Enrollment Entities shall be registered either in the Navigator Program or the In-Person Assistance Program, but not both." This definition places organizations into one of two categories, either as a Navigator entity who receives compensation through a grant or as an IPA entity through IPA program who receives compensation of $58 per enrollment. Once 2014 approaches and Enrollment Entities begin to engage in outreach and enrollment and become familiar with the new landscape, the models that worked for Enrollment Entities before 2014 may shift and change and thus become less effective for them. Given the uncertainty of the changing enrollment landscape over the coming 18 months, it is likely that organizations will need to rethink their selected enrollment models and may need to change the Assister program they are registered in. We seek clarification as to whether organizations are obligated to operate under their original registration (as a Navigator or IPA Program) or whether they will have the ability to adjust and shift programs as appropriate once enrollments begin. If they will be permitted change, a process for changing registration between the Navigator Program and the IPA Program should be outlined in the regulations.

Thank you for your consideration of these comments. If you have follow-up questions, please contact Suzie Shupe, Executive Director, at SShupe@CCHI4Families.org or (707) 527-9213.

Sincerely,

California Coverage & Health Initiatives
California School Health Centers Association
Children Defense Fund – California
Children Now
The Children's Partnership

May 6, 2013

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

Re: Comments on the Draft Regulations on Fingerprinting for Assisters

Dear Mr. Lee:

The Greenlining Institute (Greenlining) and the National Employment Law Project (NELP) are writing to express our appreciation for the work of the Exchange to develop fair and effective regulations defining the scope of criminal background checks for Assisters, and to summarize our recommendations for revisions to the proposed draft regulations.

To date, the draft regulations developed by the Exchange staff reflect several key concerns discussed with our organizations. Thus, the draft regulations require any disqualifying offenses to have a substantial relationship to the qualifications, functions, or duties of the specific employment sought, and they provide for a defined appeal and interim determination process for the individual to challenge the accuracy of the criminal records and produce evidence of rehabilitation

However, there remain three additional issues that require additional clarification. First, it is not clear that all workers who perform "any Service Center or County Center duties or functions" should be required to submit to the new regime of FBI and state background checks. (Emphasis added). Second, when an applicant has identified incorrect information on the record, the applicant should be able to provide the corrected information to the Exchange, not be diverted instead to the state DOJ or FBI. Third, in order for an individual to effectively challenge the interim determination of a potentially disqualifying offense, the regulations should incorporate additional indicia of mitigating circumstances and evidence of rehabilitation.

We hope this letter helps Covered California to better understand our concerns. Again, we appreciate the commitment the Exchange has put forward in getting these regulations right. Please contact us with any questions.

Sincerely,

Carla Saporta
Health Policy Director
Greenlining Institute

Maurice Emsellem
Policy-Co Director
National Employment Law Project

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

The **Health Consumer Alliance**

3701 Wilshire Blvd., Suite 750 • Los Angeles, CA 90010
Phone 310-204-6010 • Fax 213-368-0774

May 14, 2013

Thien Lam, Deputy Director Eligibility and Enrollment
Katie Ravel, Director, Program Policy
Covered California Board
560 J St., Suite 290
Sacramento, CA 95814
Submitted electronically to info@hbex.ca.gov

RE: Comments on Covered California's Assisters Program Update, Draft Regulations and Board Recommendation Brief

Dear Ms. Lam, Ms. Ravel and Members of the Board:

We are writing on behalf of the Health Consumer Alliance (HCA), a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, which includes: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Greater Bakersfield Legal Assistance, Legal Aid Society of Orange County, Legal Aid Society of San Diego, Legal Aid Society of San Mateo, Legal Services of Northern California, Neighborhood Legal Services of Los Angeles County, the Western Center on Law and Poverty, and the National Health Law Program. We are pleased to present our input on the latest version of Covered California's Assisters program guidelines. Our recommendations and comments address issues on draft regulations and Thien Lam's presentation.

Assisters Program Update Exchange Board Meeting Presentation 5/7/13

Assister Training (slides 13 and 14):
We understand that many of the training issues have yet to be decided. We urge Covered California to develop the minimum hours required for certification based on the time it will take to adequately and effectively communicate the many important issues that Assisters will need to understand and be able to communicate to consumers. Two to three days may not be enough to thoroughly impart important information that Assisters will need to understand. For example, it is our understanding that Maryland's Exchange will require at least 120 hours of training for their

assister program. The proposal for California is only 24 hours per year; this may not be enough to ensure Assisters understand the intricacies of the insurance world, as well as employer coverage issues, tax implications, etc.

In addition, there are a number of topics that should be on the list for the Assister training curriculum and we are very interested in participating with Covered California in suggesting and/or reviewing training curriculum topics and materials.

- Baseline education on Medi-Cal, both MAGI and non-MAGI eligibility. Assisters must provide assistance across programs, but Medi-Cal eligibility will continue to be determined by counties. Assisters must have basic training, as well as be admonished to not turn away those who appear eligible, as Assisters will not be compensated for Medi-Cal enrollments;
- 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; and
- Marketing and advertising rules and prohibitions, as well as the processes for raising violations with the appropriate state agencies.
- ACA non-discrimination provisions and demographic data collection in support of the Exchange's mission to eliminate health disparities

Our organizations have significant expertise on many of these issues and currently administer many Consumer Assistance Programs through the state. We have performed extensive trainings and believe our input is necessary in developing the training and curriculum standards.

Assisters draft regulations
§ Section 6570. Definitions.
Definition of Consumer: change to "an individual or entity seeking information on eligibility and/or enrollment and/or seeking application assistance with a health insurance or health related product available through the Exchange or the state of California…" Consumers might look to Assisters for a myriad of functions and broadening the definition would ensure that consumers have a single place for which to get information or apply for coverage. Exchange Board and staff have indicated their support for assistance across programs per the true "no wrong door" entry perspective. Though the CalHEERs system might build into other programs such as Medi-Cal, we believe it is important to call out other programs available through the state.

Include reference to the federal definition of **Culturally and Linguistically Appropriate** as currently proposed in 45 C.F.R. §155.215, and required in §155.205 and §155.210.

§ 6574. In Person Assistance Program.

(a)(5) We understand that community clinics will be eligible to be paid Assisters. This provision should be changed to reflect that some clinics will be able to participate in the in-person assistance program: "Providers, including, but not limited to Hospitals, Clinics (except community clinics), and County…"

(b)(2). We appreciate the Exchange providing IPA Program applicants an opportunity to reply to and submit additional information in their application for IPA Programs should the Exchange request it, though we would prefer to see a formal appeals process, such as those outlined for

Individual Assisters. We urge Covered California to establish a formal appeals process for Enrollment Entities, not just individual Assisters.

We suggest being clear in (b)(4) that Assister Enrollment entities who pass the training will be not only registered but officially certified by Covered California and suggest the following addition: "… pass the training requirements established by the Exchange shall be certified and registered as Assister Enrollment Entities by the Exchange."

(c)(2)(vi) should be revised to reflect the Federal rules for Navigators, to include the following language: "Ability to provide information that is culturally and linguistically appropriate, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act."

(c) We appreciate the criteria used to select Enrollment Entities and would suggest a few additional criteria: (ix) Ability to conduct marketing and outreach that does not discriminate based on income, disability status, language, etc. (x) Ability to maintain expertise in eligibility, enrollment and program specifications; (xi) Ability to adhere to conflict of interest standards established by the Exchange on an ongoing basis.

§ 6576. Navigator Program. (a)(6) Similar to §6572(a)(5) above, this provision should be changed to reflect that some clinics will be able to participate in the in-person assistance program: "Providers, including, but not limited to Hospitals, Clinics (except community clinics), and County…"

(b)(4) Add language about certification as suggested in §6472(b)(4) above. "… pass the training requirements established by the Exchange shall be certified and registered as Assister Enrollment Entities by the Exchange."

(c)(6) Access to target markets should also include immigrants, persons with disabilities and LGBTQ communities. "Access to target markets including, but not limited to, factors such as geography, ethnicity, language, employment sector, income, age, disability, immigration status, sexual orientation and gender identity."

(c)(7) Should outline requirement to have the ability to provide Navigator services for all programs, including Medi-Cal. "Alignment with Exchange's mission and ~~complementary programs~~ other insurance affordability programs, including Medi-Cal and CHIP."

§ 6580. Assister Fingerprinting and Criminal Record Checks

Federal law requires, and prudence and consumer protection dictate, that Covered California set standards and establish safeguards for protecting the privacy of highly sensitive and confidential personal information that will be needed for applying for health insurance programs. Discussions are ongoing with Exchange and legislative staff to refine the kinds of positions for which background checks will reasonably be required as well as potentially disqualifying crimes. Because of the disproportionate impact on communities of color, particularly on men of color, of arrests and convictions, unjust and unjustified discriminatory impact could result if the parameters for background checks and potential job disqualifications are not carefully developed. For example, many crimes are wholly unrelated to the job duties that involve handling personal financial or medical information. On the other hand, felonies involving fraud, dishonesty or breach of trust may very reasonably be considered substantially related to positions with Covered

California, its vendors, sub-contractors and Assisters with access to such sensitive personal information. This will need to be carefully defined in regulations or statute, a task that is underway.

This proposed regulation sets forth another essential element: an appeal route for job applicants so that erroneous information can be corrected and individual background circumstances can be considered. For example, if identity is mistaken or if someone with a relevant felony conviction at a very young age has for several years been ably performing the duties which they propose to perform for Covered California, an opportunity should be provided to correct the erroneous information and consider an exception where the evidence warrants it. We appreciate the intent of the proposed regulation and offer specific suggested edits below to strengthen it, and comport with best practices, including EEOC guidelines. We have the following line edits to these provisions:

(a)(1) "Except for Agents and Brokers with a current and valid license from the California Department of Insurance, all Individual Assisters must submit fingerprint images and associated criminal history information pursuant to Title 10, California Code of Regulations, Section 6456(b).

(b)(2) If the Exchange finds that an individual whose duties require fingerprinting under paragraph (a) has a potentially disqualifying criminal record under Title 10, California Code of Regulations, Section 6456(d)-(e), the Exchange shall promptly provide the individual with a copy of his or her criminal record pursuant to Penal Code Section 11105(t), notify the individual of the specific reasons for the interim determination, and provide the individual information on how to request an appeal through the Exchange to dispute the accuracy and relevancy of the criminal record.

(c)(1) If the individual believes that his or her criminal record is inaccurate or incomplete, within 60 days of receiving the notice set forth in paragraph (b)(2), the individual may provide information to the Exchange, including supporting documentation, identifying and correcting the incomplete or inaccurate criminal history information. Upon receipt of said information, the Exchange shall re-evaluate the interim fitness determination. ~~seek to correct or complete the response through processes established by the California Department of Justice, the Federal Bureau of Investigation, or agencies reporting information to the California Department of Justice or Federal Bureau of Investigation. If the individual successfully challenges the accuracy or completeness of the response, the individual may request a new criminal record check and reevaluation of the interim fitness determination by the Exchange.~~ The Exchange, within 60 calendar days, shall respond to the individual with a final determination.

(c)(2) If the individual determines that his or her criminal record is accurate, within 60 days from the notice of interim determination the individual may dispute the ~~substantial relatedness of a disqualifying offense by producing any additional written evidence of circumstances~~ interim determination by producing evidence of rehabilitation and any other mitigating circumstances, related to any potentially disqualifying offense ~~and/or rehabilitation~~. The Exchange, within 60 calendar days, shall respond to the individual with a final determination.

(c)(2)(A) For purposes of ~~reconsidering the weight of disqualifying offense, the Exchange shall take into account any and all of the following~~ evaluating mitigating circumstances and evidence of rehabilitation, the Exchange shall take into account the following information provided by the individual:

(i) Whether the individual has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed against the individual;

(ii) Any evidence that the individual performed the same or similar type of work, post conviction, with the same or a different employer, with no known incidents of criminal

conduct on the job;
(iii) Whether the individual has a history of prior discipline for the same or similar type of conduct;
(iv) Any evidence of participation in education, training, or treatment programs;
(v) References from employers, probation officers, parole officers, clergy and others who can attest to the individual's fitness and character; and
(vi) Any other evidence of rehabilitation or participation in treatment programs.

§ 6582. Training Standards. This section has not yet been developed and our undersigned organizations would like the opportunity to provide further comments on these regulations as mentioned above.

§ 6584. Appeals Process. (b) (1) (a). The Exchange shall, on the correspondence to applicants, provide a clear language reason for disqualification and the contact information of an ombuds-like resource so that applicants may appeal his or her adverse decision. This is particularly important for applicants who are not represented in a collective bargaining situation or place of employment.

§ 6586. Roles and Responsibilities. We urge the Exchange to include non-discrimination language (cite Sec. 1557 which includes race, ethnicity, primary language, disability status, sexual orientation and gender identity) so Assisters are clear about the requirements of the ACA.
(b) 3) Not discriminate on the basis of age, gender, race, ethnicity, primary language, disability status, sexual orientation or gender identity in accordance with Section 1557 of the ACA. ~~Comply with any applicable federal or state laws and regulations.~~
4) Comply with any other applicable federal or state laws and regulations.

Agent and Enrollment Entity Relationships Board Recommendation Brief
We have been consistently supportive of the Exchange's commitment to a "no wrong door" enrollment assistance approach and appreciate the Exchange's inclusion of basic knowledge about Medi-Cal as part of the criteria consideration for applicants of the In-Person Assistance Program (IPA) even though under federal guidance assisters cannot be compensated for Medi-Cal enrollment.

We accept the use of insurance agents to sell and market QHPs in both the individual and SHOP Exchange but we remain troubled by the much higher compensation to be paid to insurance agents than assisters. This remains inequitable and may result in slower enrollment than would otherwise occur.

We agree that relationships should be developed across different types of Enrollment Entities, and that there should be standards for those formal relationships. As such, we support the recommendation to prohibit Navigator grantees and Individual Assisters from accepting payment or valuable consideration from agents, as well as a prohibition on certified agents from providing payment or other valuable consideration to grantees or assisters. We ask that this be amended to include examples of "other valuable consideration". We suggest that examples of other valuable consideration include office space at no cost or cost below actual costs, funding for travel expenses or reduced travel costs, marketing or co-marketing, and production of materials at no cost or below actual cost. Entertainment of assisters by insurance agents may be another area the Exchange wishes to consider.

Thank you for the opportunity to provide input. We look forward to continuing to work with you to ensure Covered California's Assisters program is a success. Please contact us if you have any

questions about these comments.

Sincerely,

Vanessa Cajina
Legislative Advocate

Board Chair
Maya Altman

Members
Alameda Alliance for Health
Ingrid Lamirault, CEO

Cal Optima
Michael Schrader, CEO

CalViva Health
Gregory Hund, CEO

CenCal Health
Bob Freeman, CEO

Community Health Group
Norma Diaz, CEO

Contra Costa Health Plan
Patricia Tanquary, PhD, CEO

Gold Coast Health Plan
Michael Engelhard, CEO

Health Plan of San Mateo
Maya Altman, CEO

Health Plan of San Joaquin
John R. Hackworth, PhD, CEO

Inland Empire Health Plan
Bradley Gilbert, M.D., CEO

Kern Health Systems
Doug Hayward, CEO

L.A. Care Health Plan
Howard A. Kahn, CEO

San Francisco Health Plan
John Grgurina, CEO

Santa Clara Family Health Plan
Elizabeth Darrow, CEO

LHPC
John Ramey, Executive Director

Corky Oakes, Business/Logistics

Tim Smith, Policy Director

Lobbyist

James C. Gross
Nielsen-Merksamer et al

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

To Whom It May Concern;

The Local Health Plans of California represents 14 local initiative health plans and county operated health systems. The following comments concern the draft Assisters Regulations were recently released by Covered California. Although we are generally in agreement with the content of the regulations, we have one concern regarding their consistency with the model contract.

Essentially, these regulations would create plan-based enrollment entities that allow health plans to enroll individuals into the Exchange. However, this will only apply to QHPs since the Exchange has included this provision in the model contract. Non-QHPs would not be eligible to enroll people since they are not listed as an eligible entity in the draft regulations. While non-QHP commercial plans will likely not care, this is an issue for local health plans that have traditionally had robust enrollment services, particularly for Healthy Families and local coverage programs, and who are less likely to become QHP.

Thank you for reviewing our comments. We look forward to working with Exchange staff to draft regulations that are in the best interest of all Californians.

Regards,

Tim Smith
Policy Director

1225 Eighth Street, Suite 440 ★ Sacramento, CA 95814
Phone: (916) 448-8292 ★Fax: (916) 448-8293 ★ www.lhpc.org

Stakeholder(s)	Regulation	Issue	Comments	Recommendation(s) from Stakeholder
1. CA Coverage & Health Initiatives 2. CA School of Health Centers America 3. Children Defense Fund-CA 4. Children Now 5. The Children's Partnership	6570	Navigator vs. IPA Program	Seeking clarification as to whether organizations are obligated to operate under their original registration (Navigator or IPA program) or whether they will have the ability to adjust and shift programs as appropriate once enrollments begin.	Process should be developed to allow organizations to change programs.
	6574	IPA Program	1. Direct Benefit Assisters have not been addressed in the Proposed State Regulations. 2. Certified Application Assistants (CACs) proposed Federal regulations require CACs to be created to assist in enrollment and case management for Medicaid and Medicare.	1. Provide a definition of DBAs, regulations on the application process for becoming a DBA, and an outline of training requirements and standards. 2. Consider and articulate how CACs can be active in the California market to supplement and complement DBAs, IPAs and Navigators.
1. CA Primary Care Association 2. SFCCC, Community Clinic Consortium	6570	Community Clinics	Definition of Community Clinics is too limiting	Change the definition of community clinics to include, "community clinics or health centers licensed as either a 'community clinic or free clinic', by the State of CA under Health and Safety Code section 1204(a) and (2), or is a community clinic or free clinic exempt from licensure under section 1206 (c)."
	6574	IPA Program	(a)(5) "Providers, including, but not limited to Hospitals, Clinics, and County…" (a)(4) "recipients of any direct or indirect consideration from any health insurance issuer or stop loss insurance issuer in connection with the enrollment of any individuals or employees in a QHP"	(a)(5) exclude community clinics (a)(4) revise this section to state that support for non-enrollment related functions, including reimbursement for health care services, does not prevent the participation of otherwise eligible entities from receiving compensation from Covered California for enrollment.

Stakeholder(s)	Regulation	Issue	Comments	Recommendation(s) from Stakeholder
	6576	Navigator Program	(a)(6) "Providers, including, but not limited to Hospitals, Clinics, and County…" (a)(4) "recipients of any direct or indirect consideration from any health insurance issuer or stop loss insurance issuer in connection with the enrollment of any individuals or employees in a QHP"	(a)(6) exclude community clinics (a)(4) revise this section to state that support for non-enrollment related functions, including reimbursement for health care services, does not prevent the participation of otherwise eligible entities from receiving compensation from Covered California for enrollment.
1. National Employment Law Project 2. The Greenlining Institute	6580	Fingerprinting	Want to make sure that there is adequate clarification on the fingerprinting process and sufficient recourse if there are disqualifying issues that arise on an individual's record.	1. It is not clear that all workers who perform "**any**" Service Center or County Center duties or functions" should be required to submit to the new regime of FBI and state background checks. 2. When an applicant has identified incorrect information on the record, the applicant should be able to direct correction of the information to Covered California not the DOJ or FBI 3. The regulations should incorporate additional indicia of mitigating circumstances and evidence of rehabilitation.
United Way	6580	Fingerprinting	Agree with the fingerprinting policies. Glad to see Covered California covering the costs of the fingerprinting process.	n/a
	6590	Compensation	Agree with the proposed compensation amounts and timeline	n/a
	6582	Training	Appreciate the design of the training program (CBT and ILT). Agree train the trainer program is not realistic at this point.	1. Include in the training Market Abuse issues arising from fraudulent practices from non-

Stakeholder(s)	Regulation	Issue	Comments	Recommendation(s) from Stakeholder
				exchange certified persons and entities. 2. Provide on-going support to address difficult issues through Consumer Assistance Program or on-going training mechanism (FAQ or live person to help as issues arrive)
		Agents	Assisters should be independent from any Agent/Broker relationship	Prohibit co-locating Assisters in Agents' offices or other in-kind contributions
		Medi-Cal Enrollment Assistance	Strong support and thanks for The California Endowment's investment of funds for Medi-Cal enrollment	Advocating that Covered California should accept the contribution and draw down from the Federal match.
CA Hospital Association	6570	Clinics	Want Covered California to consider how elderly and low income individuals located in rural, medically underserved areas will enter-through the doors of hospital-based clinics.	Treat all clinics equal in terms of their eligibility for compensation under the Assisters Program.
Health Consumer Alliance	6570	Consumer	Consumers might look to Assisters for a myriad of functions and broadening the definition would ensure that consumers have a single place for which to get information or apply for coverage.	Change definition of consumer to "an individual or entity seeking information on eligibility and/or enrollment and/or seeking application assistance with a health insurance or health related product available through the exchange or the State of CA"
	6580	Fingerprinting	1. Disproportionate impact on communities of color, particularly on men of color. 2. Adequate appeals process in place for error correction.	1. All individual assisters must be fingerprinted 2. Provide copies to the individual if an issue arises, disqualifying them from participation so they can appeal if necessary 3. Give 60 days to dispute the

Stakeholder(s)	Regulation	Issue	Comments	Recommendation(s) from Stakeholder
				record 4. Covered California to take into account all mitigating circumstances.
	6584	Appeals Process	Concerned about applicants being disqualified without adequate appeals process in place.	Provide clear language for the reason for disqualification and the resources available to them for appeals.
	6586	Roles & Responsibilities	Include Non-Discrimination language so Assisters are clear about the requirement of the ACA.	Cite Section 1557 which includes race, ethnicity, primary language, disability status, sexual orientation, and gender identity.
	6582	Training	Perceived inadequate amount of time for training to cover the body of knowledge.	1. Baseline education on Medi-Cal, MAGI and non-MAGI eligibility. 2. Rules and requirements associated with changes in circumstances. 3. Tax reconciliation, advanced tax premium credits. 4. Compatibility standards. 5. Informal resolution process. 6. Due process and appeals rights, including bifurcated appeals system. 7. Marketing and advertising rules and prohibitions. 8. ACA non-discrimination provisions.
	6574	IPA Program	(a)(5) “Providers, including, but not limited to Hospitals, Clinics, and County…” (b)(2) Additional information (b)(4) AEE registration classification (c)(2)(vi) Language	(a)(5) exclude community clinics (b)(2) create a formal appeals process (b)(4) add certification to the

Stakeholder(s)	Regulation	Issue	Comments	Recommendation(s) from Stakeholder
			(c) Criteria for selection of AEEs	classification for AEEs (c)(2)(vi) revise to reflect Federal rules for Navigators, "ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the ADA Act and section 504 of the Rehabilitation Act. (c) add additional criteria: (ix) Ability to conduct marketing and outreach that does not discriminate, (x) Ability to maintain expertise in eligibility, enrollment and program specifications, (xi) Ability to adhere to conflict of interest standards
	6576	Navigator Program	(a)(6) "Providers, including, but not limited to Hospitals, Clinics, and County…" (b)(4) Navigator registration classification (c)(6) Access to target markets should be expanded (c)(7) Expand Navigator services to include Medi-Cal	(a)(6) exclude community clinics (b)(4) add certification to the classification of AEEs (c)(6) target markets should be expanded to include (immigrant status, disability, sexual orientation, and gender identity). (c)(7) add "other insurance affordability programs, including Medi-Cal and CHIP."

Stakeholder(s)	Regulation	Issue	Comments	Recommendation(s) from Stakeholder
		Agents	Troubled by the much higher compensation to be paid to insurance agents vs. Assisters	Expand the prohibition on agents providing valuable consideration to grantees and/or Assisters. Valuable consideration should also be defined as, “office space at no cost or cost below actual costs, funding for travel expenses, marketing or co-marketing, and/or production of materials at no cost or below actual cost.
San Luis Obispo County Public Health Dept.	6574	IPA Program	(a)(5) “County Health Departments that provide health care services”	1. Requesting clarification on the definition of “health care services”. 2. Exclusion of county health departments that provide “public health” services as opposed to primary, secondary, or tertiary care.
Local Health Plans of California	6574	IPA Program	Non-QHP not included as eligible to participate in the IPA Program.	Local Health Plans traditionally have had robust enrollment services, particularly for Healthy Families and local coverage programs, who are less likely to become QHP.
1. CA Pan-Ethnic Health Network 2. Consumers Union		Agents	Support the proposal to “prohibit enrollment entities from receiving financial compensation from agents for referrals or enrollment services and prohibits agents from compensating grantees.	1. Strongly urge Covered California to include this language in the contracts, training materials, and certification curriculum. 2. Provide adequate budget and staffing resources to enable adequate monitoring and enforcement of this prohibition.

Emily Spitzer
Executive Director

Board of Directors

Marc Fleischaker
Chair
Arent Fox, LLP

Ninez Ponce
Vice-Chair
UCLA School of Public Health

Jean Hemphill
Treasurer
Ballard Spahr Andrews & Ingersoll

Janet Varon
Secretary
Northwest Health Law Advocates

Elisabeth Benjamin
Community Service Society of New York

Daniel Cody
Reed Smith, LLP

Robert B. Greifinger, MD
John Jay College of Criminal Justice

Marilyn Holle
Protection & Advocacy Inc.

Andy Schneider
Washington, DC

Robert N. Weiner
Arnold & Porter, LLP

April 30, 2013

Peter V. Lee, Executive Director
Katie Ravel, Director of Program Policy
Covered California

Via E-mail: info@hbex.ca.gov

Re: Comments on CMS April 5, 2013 Proposed Rules on Standards for Navigators and Non-Navigator Assistance Personnel

Dear Mr. Lee and Ms. Ravel:

Founded in 1969, the National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP provides technical support to direct legal services programs, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or under-insured low income people.

This letter is in response to Covered California's request for input to staff and the Board regarding the proposed federal rule, dated April 5, 2013, regarding Standards for Navigators and Non-Navigator Assistance Personnel. NHeLP has carefully analyzed the proposed rule and will be submitting detailed comments. Enclosed with this cover letter, please find a **draft** of NHeLP's comments, which, though not final, reflect NHeLP's views on the issues presented in the proposed rule.

We would like particularly to bring your attention to our comments on "Referrals," at pp. 4-5 of the draft. We are very concerned about Covered California's intent to allow navigators and assisters to refer out enrollees who have special communication needs, whether linguistic or on account of disability. This would violate specific statutory requirements for culturally and linguistically appropriate care and longstanding civil rights laws prohibiting discrimination on the basis of language or disability. We strongly believe that all navigators and assisters

1444 I Street NW, Suite 1105 · Washington, DC 20005 · (202) 289-7661 · Fax (202) 289-7724
3701 Wilshire Boulevard, Suite 750 · Los Angeles, CA 90010 · (310) 204-6010 · Fax (213) 368-0774
101 East Weaver Street, Suite G-7 · Carrboro, NC 27510 · (919) 968-6308 · Fax (919) 968-8855
www.healthlaw.org

should be prepared to meet all communication needs, and our comments suggest efficient ways that can be accomplished.

Further, in regard to training of outreach and education grantees, we believe that training modules on enrollment requirements should be made available to such grantees, even if not required. Please see our comments at pp. 5- 6 on "Availability of Assister Training." We have concerns that based on Covered California's draft comment on Section 155.215(b)(2)(vii), the intent is to restrict the availability of such training.

We sincerely appreciate the opportunity to provide comments in advance of Covered California's finalization of its comments on these federal regulations.

Sincerely,

Byron Gross
Of Counsel

Encl.

Emily Spitzer
Executive Director

Board of Directors

Marc Fleischaker
Chair
Arent Fox, LLP

Ninez Ponce
Vice-Chair
UCLA School of Public Health

Jean Hemphill
Treasurer
Ballard Spahr Andrews & Ingersoll

Janet Varon
Secretary
Northwest Health Law Advocates

Elisabeth Benjamin
Community Service Society of New York

Daniel Cody
Reed Smith, LLP

Robert B. Greifinger, MD
John Jay College of Criminal Justice

Marilyn Holle
Protection & Advocacy Inc.

Andy Schneider
Washington, DC

Robert N. Weiner
Arnold & Porter, LLP

VIA ELECTRONIC SUBMISSION

May 6, 2013

Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 8010
Baltimore, MD 21244-1850

Re: CMS-9955-P
Standards for Navigators and Non-Navigator Assistance Personnel

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. NHeLP provides technical support to direct legal services programs, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people. We are pleased to submit the following comments in response to the proposed rule issued on April 5, 2013 regarding standards for navigators and non-navigator personnel.

As an overarching comment, we recognize that three types of individuals may potentially provide information and enrollment assistance to consumers – navigators, non-navigator assistance personnel, and certified application counselors. Throughout these comments, we use the general term "assisters" to include all three types. When we wish to address comments to only one or two of the types, we will use the specific terminology.

We commend HHS on reiterating the requirement throughout the preamble that all assisters provide fair, accurate and impartial information. This is a critical protection to ensure consumers can rely on assisters without concern about an assisters' potential conflict of

1444 I Street NW, Suite 1105 · Washington, DC 20005 · (202) 289-7661 · Fax (202) 289-7724
3701 Wilshire Boulevard, Suite 750 · Los Angeles, CA 90010 · (310) 204-6010 · Fax (213) 368-0774
101 East Weaver Street, Suite G-7 · Carrboro, NC 27510 · (919) 968-6308 · Fax (919) 968-8855
www.healthlaw.org

interest or values that may conflict with providing comprehensive information.

Comments on Preamble

Certified Application Counselors (78 Fed. Reg. 20585)

CMS requested comment as to whether all or some of the standards should be applicable to certified application counselors. We believe the answer should be yes. Individuals seeking assistance applying for insurance or understanding eligibility requirements may not understand the differences between navigators, non-navigator assistance personnel and certified application counselor. Consumers may select an assister based on geography, language, accessibility or other reasons. Thus the type of assistance and information provided should not depend on a consumer's understanding of the different roles. Rather, a consumer should receive the same assistance regardless of the type of assister providing the information. Otherwise, one consumer may receive less assistance or have to seek assistance from a second assister if the standards and requirements differ. While we recognize that the previous role of certified application counselors (CACs) may have been limited in scope to Medicaid and CHIP enrollment, if CMS' final rule governing CACs allows their use by Exchanges or in an assister role, the requirements for training, knowledge, and assistance provided should align with those of navigators and non-navigator assistance personnel as described in this rule.

We also suggest that HHS amend § 155.225 to ensure that states do not preclude the ability of certified application counselors to perform the full scope of their duties. We are concerned that states have sought to limit their activities through state legislation. We thus suggest adding the language from § 155.210(c)(1)(iii) into § 155.225.

Standards for Non-Navigator Assistance Personnel

We also suggest that HHS create a new regulatory provision to specify standards for non-navigator assistance personnel. As noted in the preamble at 78 Fed. Reg. 20583, state-based exchanges may delay implementation of a navigator program and instead provide assistance solely through a non-navigator assistance program using exchange establishment funds in the first year of exchange operation. For states that take advantage of this flexibility, the non-navigator program will effectively serve as the navigator program in the first year and it is therefore imperative that it provide the same scope of services and that state requirements to not prevent full functioning of the program.

Further, this is important to ensure that states do not preclude the ability of non-navigator assistance personnel to perform the full scope of their duties. Some states have already sought to limit assisters' activities through state legislation. We thus suggest adding a new regulatory section addressing non-navigator assistance personnel that includes, among other standards, the language from § 155.210(c)(1)(iii).

Conflict of Interest Standards (78 Fed. Reg. 20586-7)

CMS requested comment on whether conflict-of-interest standards should apply to both navigator and non-navigator assistance personnel or not. We support the conflict of interest standards and do not see any reason why different assisters should be subject to different conflict-of-interest standards. As stated above, consumers likely will be unaware of the differences between types of assisters and should receive the same unbiased information regardless of the type of assister accessed. If different conflict-of-interest standards exist, one consumer may receive different information than another, solely based on whether the consumer went to a navigator versus non-navigator assistance personnel. The system must operate seamlessly for the consumer so that the consumer selects an assister based on factors the consumer will understand and know (geography or language services provided) rather than unknown.

Written Conflict of Interest Plan (78 Fed. Reg. 20587)

NHeLP fully supports the proposed requirement that assisters have a written plan to remain free of conflicts of interest. As the preamble recognizes, many entities may have a changing workforce. It is essential that the workforce not have any conflicts of interest, regardless of when someone begins working for an entity. It is insufficient to have conflict of interest requirements met upon initiation of an assister contract but not continue throughout. Otherwise, an entity could hire individuals without conflict to satisfy contract requirements but then hire others during the contract period who have conflicts. CMS must require entities to maintain and document each staff person's ongoing commitment to avoiding conflicts of interest. Thus the entity should have a written plan with policies and procedures to ensure the conflict of interest protections are in place for all employees and contractors, regardless of hire date, and throughout the life of the assister contract.

We suggest that each entity have a formal agreement regarding conflict-of-interest that details the specific conflict of interest provisions and the staff person's understanding and agreement. HHS could create a template to assist in this process. Each staff person should sign the document, with the entity also signing it and keeping a copy in the staff person's record. This agreement should be updated and signed each year to ensure continued lack of conflicts. We also suggest the entity have a written plan on notifying the entity if a new conflict arises and how to resolve potential conflicts, including having an independent review to ascertain if a conflict does actually or potentially exist so that appropriate actions should be taken. Further, prior to hiring assister staff and likely as part of the application process, the entity should conduct a conflicts check to ensure that any individual with a conflict is not hired.

Training Regarding Culturally and Linguistically Appropriate Services and Accessibility for People with Disabilities (78 Fed. Reg. 20590)

We strongly support the requirements for training regarding culturally and linguistically appropriate (CLAS) services and accessibility for people with disabilities. All assisters are subject to compliance with federal civil rights laws including ACA § 1557, Title VI of the Civil Rights Act of 1964, § 504 of the Rehabilitation Act, and the Americans with Disabilities Act. Further, HHS's final Exchange eligibility and enrollment regulations, at § 155.120, specifically require states and Exchanges – and thus the assisters connected with the Exchanges – to comply with applicable nondiscrimination statutes and not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.[1] This training is essential to ensure that assisters do not discriminate in the provision of their services.

As HHS recognized with its release of the 2013 Enhanced CLAS Standards, numerous ethical and practical reasons exist to provide culturally and linguistically appropriate services in health and health care, including:

- responding to current and projected demographic changes;
- eliminating long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds;
- improving the quality of services and primary care outcomes; and
- meeting legislative and regulatory mandates.[2]

For all these reasons, the training on CLAS and accessibility for people with disabilities is critical to ensure assisters understand how to identify language or accessibility needs, work with these populations (including how to access and use language services, TTD/TTY, and augmentative and alternative communication (AAC) assistance), and ensure nondiscrimination. Unfortunately, despite the longstanding existence of civil rights requirements, significant examples continue to arise of discrimination. Without specific training (and enforcement), this would likely continue since many assisters may not have direct experience or expertise in working with these populations.

We also specifically suggest that CMS include ACA § 1557 in the references to "certain civil rights laws" throughout the document. For example, there is a list under "3. Providing Culturally and Linguistically Appropriate Services" at 78 Fed. Reg. 20590 (middle column). In this list, we suggest adding § 1557 but deleting reference to § 504 since the section is about providing culturally and linguistically appropriate services. In "4. Standards Ensuring Access by Persons with Disabilities" at 78 Fed. Reg. 20591, we also suggest adding in reference to § 1557 and the Americans with Disabilities Act and deleting reference to Title VI.

---

[1] 77 Fed. Reg. 18310, 18447 (March 27, 2012) (see 42 C.F.R. § 155.120).

[2] Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (April 2013) at 8, available at https://www.thinkculturalhealth.hhs.gov/.

In addition to these two sections, however, we suggest adding a new section that includes specific reference to nondiscrimination requirements based on race, ethnicity, gender, age, sexual orientation, and gender identity. These are covered by § 1557 and HHS should specify them in addition to CLAS Standards and accessibility for individuals with disabilities.

Referrals

To comply with the ACA and civil rights requirements, each navigator must provide communication services for limited English proficient (LEP) individuals and individuals with disabilities. Yet the preamble states that an assister may refer an individual to other resources when the assister is unable to provide full enrollment services for a particular person. 78 Fed. Reg. 20589. We ask that HHS clarify that this referral option does ***not*** negate the requirement of assisters to provide communication assistance. The provision of culturally and linguistically appropriate care is a specific statutory requirement and longstanding civil rights laws prohibit discrimination on the basis of language or disability. If HHS permits an assister to refer LEP consumers or consumers with disabilities because of language or disability needs, it would undermine Congressional intent. It also would likely be discriminatory since only these individuals would have to go to an alternate location to receive assistance. Providing communication services can be done easily and effectively, as HHS noted in the preamble:

> We anticipate that most Navigators and non-Navigator assistance personnel would use readily available telephonic interpretation services and other effective low-cost services in order to meet the requirement to provide language access to the consumers they serve, so that it will not be costly or onerous. 78 Fed. Reg. at 20590.

If HHS permits referral to other assisters, we strongly urge HHS to clarify that referrals may not be done solely due to communication needs. As one solution to help assisters effectively provide communication assistance, an exchange could negotiate a group rate or contract for language services and auxiliary aids and services and provide access to all assisters. As an example, Kansas' Medicaid agency contracted with an over-the-phone interpreting company and then provided the telephone number and an access code to all Kansas primary care case management providers. The providers benefitted by having access to competent interpreters and by not having to research and negotiate independently for language services while the Medicaid agency was able to negotiate lower rates for bulk purchasing, saving the state money.[3]

Availability of Assister Training

---

[3] National Health Law Program, Medicaid and SCHIP Reimbursement Models for Language Services (2009 update), *available at* http://www.healthlaw.org/index.php?option=com_content&view=article&id=240%3Alanguage-access-publications&catid=45&Itemid=196.

We urge CMS to allow access to the training program for navigators and non-navigator personnel by those trusted resources who may not formally serve as assisters but who will work with consumers by providing education or problem-solving. For example, many legal services organizations or Protection & Advocacy entities may not undertake formal assister roles but will likely receive referrals from assisters for problem solving. Or legal services organizations may engage in a formal but limited support role with navigators or exchanges, such as current CAP grantees. Thus, they should have access to the training, even if they do not complete the certification examinations. As another example, some community based organizations may not apply to become assisters but still will provide outreach and assistance to consumers they serve and would benefit from access to the training. This particularly includes organizations serving particular segments of the population, such as certain language groups or immigrants. We thus encourage CMS to ensure access to the navigator training programs to all who may be interested while limiting certification only to those who are officially designated as assisters.

While we recognize there may be concerns about providing the training to any interested party, we believe HHS could establish a mechanism for trusted entities/partners to access the training. HHS could limit the access to certain modules that do not address navigator administrative activities. We believe at least three alternatives exist for accomplishing this:

- allow an entity to sign an agreement that its staff will view the trainings but will not seek certification or hold themselves out as certified;
- provide access to training materials and powerpoints but not access to the web-based training itself; or
- authorize a "train-the-trainer" program whereby certified assisters or others can utilize training materials for outreach/education to interested parties.

Any agreement an entity receiving access to training signs should include enforcement provisions for noncompliance and a requirement that the entity may not charge consumers for providing assistance arising from information provided in the training.

We further urge HHS to establish a public "registry" of certified assisters. Such a registry can help prevent fraud by ensuring public access to a list of those who are appropriately trained and certified as assisters.

Comments on the Proposed Rules

§ 155.210

NHeLP supports the regulation's pre-emption of any state law that imposes any licensing, certification or training standards upon assisters that *prevents* implementation of the provisions in Title I of the Affordable Care Act. For example, states may not require that assisters be certified brokers, insurance agents, or licensed producers. If

assister programs are to be effective in helping to enroll people in coverage, it is very important that states do not implement legislation that has the potential to impede the delivery of the full scope of assister duties.

We suggest HHS clarify, however, in what circumstances a state may require additional training beyond the "up to 30 hours" mentioned in the preamble. In some situations, it may be beneficial for a state to require additional training, such as state-based information or details on eligibility for a state-replacement program available to immigrants. In other situations, however, additional training may serve to thwart the underlying goals of the assister program by adding onerous requirements that are unattainable or would delay operation of assisters beyond the launch of open enrollment. We suggest HHS provide parameters to states that further explain in what situations additional training, licensing or certification is allowable.

§ 155.215(a)

We strongly support HHS' prohibition on health insurers or subsidiaries serving as assisters, and the prohibition of assisters from lobbying on behalf of the insurance industry. We further support the prohibition on stop loss insurers or those who receive compensation from stop loss insurers from being assisters.

We also support the provision requiring assisters to submit written notice attesting to the conflict of interest standards, and promising to remain conflict-free throughout the time they serve as assisters.

We recognize that certain conflicts of interest may not bar assisters from serving, but we support the disclosure of these to the exchange. These include selling other types of insurance business (such as life or disability insurance), employment with an insurance company in the last five years, and any anticipated contractual relationship with health insurers. The regulations maintain a balance between ensuring integrity and impartiality of assisters while not imposing regulations so stringent that they become prohibitive.

NHeLP thanks HHS for maintaining strong and stringent conflict of interest standards and for demonstrating a commitment to the delivery of unbiased assister services.

§ 155.215(b)

§ 155.215(b)

With regard to the requirements in (b)(1)(i) (ii) and (iii), we suggest that HHS evaluate whether assisters may be able to begin assisting consumers prior to obtaining certification. Given that FFE/state partnership assister grants will not be awarded until August, the timeframe for ensuring assisters obtain training and certification is very short. For the initial open enrollment period, we suggest HHS determine whether assisters could begin limited consumer assistance prior to receiving certification, perhaps upon completion of a significant amount of the training. Or HHS could consider,

for this initial open enrollment period, that individuals who pass all examinations but whose formal certification is not yet approved may be able to begin assisting consumers.

In (b)(1)(iv), we suggest HHS provide more information on the type and length of continuing education and recertification. Assisters must understand how much time may be involved and may need to begin continuing education soon after receiving certification, particularly if certification is valid for only one year. We suggest HHS provide information on the amount of continuing education required, topics that must be covered, what types of training will count (e.g. will only HHS-approved curricula be permitted?), and the costs for ongoing training. This information will be important for assister entities for planning and budgetary purposes, particularly if they will allow assisters to complete continuing education as part of employment and/or pay for it.

§ 155.215(b)(2)

We support the delineation of specific training module content standards and suggest certain additions, as follows.

In (ii) and (v), we want to ensure that consumers found ineligible receive information about other programs or providers that may offer coverage. This should include information about Medicare, state/local-funded programs, community health centers and free clinics, charity care, and other available assistance. Assisters should receive training on alternate programs and providers, particularly since some families (e.g. mixed status families) may have both eligible and non-eligible family members.

Also in (ii), we recommend that the training include information about minimum essential coverage and how that may impact eligibility. For example, a pregnant woman who is receiving pregnancy-related services through Medicaid should also be eligible to receive services through the exchange and receive a tax credit since pregnancy-related coverage, as proposed in the Department of Treasury regulations, is not minimum essential coverage. Similarly, an individual receiving family planning coverage through Medicaid would also be eligible for an APTC as would some children only receiving limited Medicaid services. Thus assisters must understand these limited coverage categories and inform consumers they can still apply and be eligible for broader coverage through the exchange.

In (iv), we suggest adding requirements about training regarding cost-sharing. Assisters must understand how cost-sharing assistance may be affected by the consumer's choice of a plan, particularly a non-silver plan. Currently, the subsection mentions the impact of premium tax credits on the cost of premiums but it is critical that individuals understand that if they are eligible for cost-sharing assistance that it only applies if they select a "silver" level plan. Further, since cost-sharing differs among the tiers of plans, consumers must understand that selecting a plan based solely on premiums may have other financial implications. Consumers must understand the interaction between

premium assistance and cost-sharing assistance to make an informed decision about plan selection.

We strongly support the requirements in (viii) and (ix) regarding providing culturally and linguistically appropriate care and accessibility for individuals with disabilities.

In (xii) we suggest including specific training on working with immigrants and mixed-status families, how to determine eligible immigration status, and what questions can be asked of non-immigrants. The complexity of immigrant's eligibility for benefits directly impacts access to insurance for both an individual and his/her household so assisters must understand these rules to provide accurate information and support. Further, assisters must understand what types of information may, and more importantly may not, be asked of non-applicants. Otherwise, assisters may inadvertently discourage applications of eligible family members.

In (xv), we suggest including information on applicable administrative rules, processes and systems related to Medicaid and CHIP. This should also include information about redetermination and where to seek assistance during that process.

We also strongly encourage additional training modules content so that assisters fully understand the legal requirements for nondiscrimination and providing culturally and linguistically appropriate care. These modules should include the following information:

- civil rights and nondiscrimination requirements including ACA § 1557, Title VI of the Civil Rights Act, § 504 of the Rehabilitation Act, Americans with Disabilities Act, Age Discrimination Act, and Title XI; and
- where to refer individuals who have issues or problems that navigators cannot address, such as consumers who are denied eligibility and wish to file a complaint.

Finally, we urge HHS to involved consumer advocates in the development and review of the training modules. Many consumer advocates have extensive experience in developing and administering training programs, particularly with regards to working with underserved populations, and can provide needed expertise to ensure the efficacy of the training.

§ 155.215(c)

We strongly encourage HHS to define what is included in providing culturally and linguistically appropriate services (CLAS). For many, the common understanding may be limited to race, ethnicity and language. Yet CLAS should have broader reach, including knowledge about additional issues including age, disabilities, sexual orientation and gender identity. All assisters must understand all of the cultural groups in their service area. As recognized by the Enhanced CLAS (Culturally and Linguistically Appropriate Services) Standards recently released by the Office of Minority Health, "culture" includes more than race, ethnicity and language but also religious, spiritual,

biological, geographical and sociological characteristics. OMH's "Blueprint" for advancing and sustaining CLAS defines culture to incorporate other factors such as age, gender identity, physical ability or limitations, sex, sexual orientation and socioeconomic status.[4] Thus, the regulatory text should include a broadr definition of culture or a cross-reference to the new CLAS Standards.

We would suggest HHS consider dividing (c) into two subparts – one focusing broadly on cultural issues and one specific to language issues. Subsections (1), (2), (5) and (6) would apply more broadly than language and also include people with disabilities. Subsections (3) & (4) are more tailored to language access. It may also be helpful to include the disability standards as a subpart of this same section to demonstrate that disability is a part of CLAS as well.

§ 155.215(c)(1)

We suggest that HHS specifically add disability, gender, sexual orientation and gender identity into the list of knowledge required by assisters. As mentioned above, these groups are among the ones recognized by the Office of Minority Health as part of one's culture and thus it is important that assisters understand their potential impact on eligibility and enrollment decisions.

§ 155.215(c)(2)

We support (c)(2) to ensure that assisters have the information needed to appropriately plan to meet the needs of their clients. While some of this data may be gathered from external sources, we also suggest that CMS require assisters to collect some demographic data itself (e.g. race, ethnicity, language, gender, and disability-status). This could be accomplished by collecting the data itself or having access to data submitted on an application. We also suggest assisters record information about their use of interpreters (both foreign language and sign language), augmentative and assistive communication devices and TTD/TTY. Collecting this data will help the entity monitor needs and ensure that it can meet the ongoing needs of the communities it serves as well as document that it is providing culturally and linguistically appropriate services, a specific requirement not only of federal civil rights laws but also specifically required by the statutory text authorizing navigators. The statutory text states that an entity serving as a navigator must "provide information ***in a manner that is culturally and linguistically appropriate to the needs of the population being served***. . ." (emphasis added).[5] Further, we believe part of HHS' monitoring of assisters must include compliance with these laws so that it will be important for assisters to have this data.

---

[4] Office of Minority Health, *National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*, at 28-29, *available at* https://www.thinkculturalhealth.hhs.gov/Content/clas.asp.

[5] 42 U.S.C. § 18031 (ACA § 1311(i)(3)(E)).

§ 155.215(c)(3)

Regarding (c)(3) we have a number of suggestions to ensure that the intent of the provision is clear.

First, we are concerned that the regulation requires provision of oral interpretation and written translation "where necessary for effective communication." These services should be provided when requested by a consumer and the navigator should not have discretion to determine if the services are "necessary." The current language could leave "when necessary" open to the assister's determination and thus HHS should clarify it to ensure that limited English proficient (LEP) consumers are not denied services because an assister erroneously believes assistance is not necessary. We recommend changing this language to "when requested by the consumer to ensure effective communication."

Second, we have serious concerns about allowing the use of a consumer's family or friends if requested by the consumer if other interpreter services are offered and declined. The application process is complex and requires accurate information to ensure correct eligibility determinations. For limited English proficient individuals, competent language services must be provided to comply with federal civil rights laws (ACA § 1557 and Title VI of the Civil Rights Act of 1964) as well as the ACA provision authorizing navigators. Interpreting requires specialized skills and abilities that must be learned; being bilingual is insufficient.[6] Guidance from the federal Department of Health and Human Services Office for Civil Rights recognizes he drawbacks of using family members and friends and encourages the use of trained interpreters whenever possible.[7] Further, OMH's Enhanced CLAS Standard also reiterate that "the use of untrained individuals and/or minors as interpreters should be avoided."[8]

Significant problems can arise from the use of family members, friends and particularly children, rather than trained professionals, as interpreters. Adult family members or friends who act as interpreters often do not interpret accurately. Untrained interpreters are prone to omissions, additions, substitutions, and volunteered answers. For example, family members and friends often do not understand the need to interpret everything the patient says, and may summarize information instead. They may also inject their own opinions and observations, or impose their own values and judgments as they interpret. Family members and friends who act as interpreters may themselves have limited English language abilities and may be unfamiliar with the complex terminology involved

---

[6] *See* National Health Law Program, *What's in a Word: A Guide to Understanding Interpreting and Translation in Health Care*, available at http://www.healthlaw.org/index.php?option=com_content&view=article&id=240%3Alanguage-access-publications&catid=45&Itemid=196.

[7] Office for Civil Rights, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* 68 Fed. Reg 47311 (August 8, 2003), *available at* www.lep.gov.

[8] *Id.* at note 3, Standard 7.

in enrollment and eligibility. All of these factors could directly affect an eligibility determination, rendering an individual ineligible for APTCs or Medicaid.

While many problems can result from using adult family members and friends as interpreters, additional problems arise when the interpreter is a minor. Children who interpret for their LEP parents act as "language brokers" and informally mediate, rather than merely interpret or translate information. Children who act as language brokers often influence the content of the messages they interpret, which in turn affects their parents' decisions. Other concerns with using children as interpreters include:

- requiring children to take on additional burdens, such as decision-making responsibilities;
- creating friction and a role reversal within the family structure, which can even lead to child abuse;
- violating beneficiary confidentiality, which can lead to inadequate services or mistakes in the provision of services; and
- causing children to miss school.

Further exemplifying the problems of using children as interpreters, a study of 150 Vietnamese-American and Mexican-American women who are or had been welfare recipients in California found that more than half (53.3%) used their children to interpret for them.[9] Most used their children for communicating with schools and government agencies and filling out forms. More than half of the women who used their children as interpreters identified problems with this practice. The top four problems were:

- the child interpreted incorrectly;
- the child left out information;
- the information was too technical for the child; and
- the child was unable to properly interpret due to limited language skills.

Several of the Mexican-American women reported that their children sometimes answered questions without first checking with them.

Many individuals may choose to have a family member or friend interpret because they do not understand that an interpreter must be provided free-of-charge or think that asking for an interpreter may delay the application process. Thus the offer of interpreting must ensure understanding by the consumer of his rights.

Individuals who choose to have their family members or friends serve as advocates during the eligibility process should be encouraged to do so. But to avoid mistakes and ensure compliance with federal law, assisters should always utilize competent

[9] The Access Project, *Language Services Action Kit*, at 45, *available at* http://www.accessproject.org/new/pages/pubLanguage.php, *citing* Equal Right Advocates, "From War on Poverty to War on Welfare: The Impact of Welfare Reform on the Lives of Immigrant Women" (April 1999).

interpreters. If a consumer insists on using a family member or friend, the assister should have a competent interpreter available to monitor the interaction and intervene if a family member or friend initially begins interpreting and makes errors. The regulation should also specifically prohibit the use of children as interpreters.

We would suggest that HHS implement an effective and cost-efficient way to provide access to interpreting services for navigators. Assister grants should include funding specifically for language services. HHS could also enter into contracts with language services providers and allow assisters access. As stated above, Kansas' Medicaid agency contracted with an over-the-phone interpreting company and then provided the telephone number and an access code to all Kansas primary care case management providers.[10]

§ 155.215(c)(4)

We strongly support the requirement that assisters provide oral and written notice to consumers of their right to receive language assistance services and how to obtain them. We suggest the provision specifically mention that this notice must be provided in the consumer's language as an English notice would be insufficient.

§ 155.215(5) & (6)

We strongly support these provisions. They will ensure compliance with statutory and civil rights requirements. We suggest HHS provide additional specifications or guidance to ensure assisters understanding and compliance.

§ 155.215(d)

As we suggested above, HHS should consider reordering § 155.215 to add in a definition of CLAS and incorporate both (c) and (d) under that subsection. While we recognize that a broad understanding of "culturally and linguistically appropriate services" would include disability issues, it is unfortunate that many entities may understand this term to be more limited in scope to racial, ethnic and language diversity. Thus as we suggested earlier, HHS should adopt and include a broad definition of "culturally and linguistically appropriate services" as defined by the Office of Minority Health in the recently released Enhanced CLAS Standards or specifically include additional provisions clarifying the applicability of (c)(5) & (6) to the subsection on Standards ensuring access by persons with disabilities.

In addition to our specific comments below, we also suggest that HHS adapt subsections 155.215(c)(5) and (6) and add them to (d). Just as it is important that assisters receive ongoing education and training in culturally and linguistically appropriate service delivery and recruiting, supporting and promoting a staff

---

[10] NHeLP, supra note 3.

representative of the demographics served, it is also important that assisters receive ongoing training in providing services to people with disabilities and recruit staff that includes people with disabilities.

§ 155.215(d)(1)

We fully support requirements that educational materials, websites and other tools utilized for consumer assistance are accessible to people with disabilities. We suggest including a specific requirement that websites comply with § 508 of the Rehabilitation Act.

§ 155.215(d)(2)

We are concerned that the regulation requires provision of auxiliary aids and services "where necessary for effective communication." These services should be provided when requested by a consumer and the navigator should not have discretion to determine if the services are "necessary." The current language could leave "when necessary" open to the assister's determination and thus HHS should clarify it. We recommend changing this language to "when requested by the consumer to ensure effective communication."

We further suggest HHS provide navigators with information about commonly needed auxiliary aids and services, how to access/purchase them, how to use them, and how to identify those who may need them. Many navigators may not have direct experience working with auxiliary aids and services and will need this information and training to effectively assist people with disabilities.

As stated above, we have significant concerns with allowing family members or friends to serve as interpreters. The application process is complex and requires accurate information to ensure correct eligibility determinations. For individuals with disabilities, competent interpreter services must be provided to comply with federal civil rights laws (ACA § 1557, § 504 of the Rehabilitation Act and the Americans with Disabilities Act) as well as the ACA provision authorizing navigators.

For the same reasons discussed above with regard to foreign language interpreters, we believe HHS should not permit the use of family members or friends to interpret or only permit them when a competent interpreter is also present. HHS could negotiate access to sign language interpreters – in-person or via video-link – to assist navigators in meeting this requirement.

§ 155.215(d)(3)

We recommend including a specific reference to the Americans with Disabilities Act and the Department of Justice's (DOJ) updated standards to ensure physical accessibility for individuals with disabilities.[11]

§ 155.215(d)(4)

The proposed regulation only permits assistance from a ***legally*** authorized representative. We urge HHS to delete "legally". Many individuals with disabilities will have an authorized representative who was not legally determined. Indeed, the draft single streamlined application permits an individual to select an authorized representative to assist with the application. This same individual (or another authorized by the applicant) should be able to assist an individual with a disability in making informed decisions without having to obtain judicial consent. Otherwise, it would render the ability to designate an authorized representative on the application moot since the individual with a disability would have to also obtain a legally authorized representative if seeking information from an assister.

§ 155.215(d)(5)

We appreciate the recognition that assisters must know about long-term services and supports programs. However, we are concerned that the wording of this section may result in an assister "referring" an individual to another entity for assistance, rather than providing the individual with assistance and "informing" the consumer about other potential services/programs. Thus we suggest rewording this section as follows: "Acquire sufficient knowledge to understand the range of supports provided in long term services programs that are funded by Medicaid and make appropriate referrals to the Medicaid office and local, state and federal long term services and supports programs."

Additional Comments

We also suggest HHS add a new (7) that assisters acquire sufficient knowledge of the physical and programmatic accessibility of the QHPs or know how to access plan information about accessibility to assist consumers in making an informed selection of a QHP.

§ 155.215(e)

We strongly support the monitoring requirement. We suggest that HHS provide details to assisters as to the types of information and data that assisters must provide and include these requirements in grantee contracts. As we have mentioned above, we suggest that assisters collect demographic data from the consumers served for monitoring purposes to document compliance with federal civil rights laws as well as the

---

[11] *See* Department of Justice, *2010 Standards for Accessible Design*, http://www.ada.gov/regs2010/2010ADAStandards/2010ADAstandards.htm.

statutory provision requiring navigators to provide culturally and linguistically appropriate care.

Conclusion

The Affordable Care Act has already made impressive strides in improving the health of women, low-income individuals, underserved populations and individuals with disabilities. We look forward to continuing to work with the Department to ensure the navigators, non-navigator assistance personnel and certified application counselors work effectively with all individuals and we thank you for this chance to provide input on these important provisions.

Please do not hesitate to contact Mara Youdelman, Managing Attorney at (202) 289-7661 or Youdelman@healthlaw.org if you have any questions.

Sincerely,

Emily Spitzer
Executive Director

www.sfccc.org
1550 Bryant St, Ste 450 | San Francisco, CA 94103 | P: 415.355.2222 | F: 415.865.9960

May 14, 2013

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

RE: Assister Regulations

To Whom It May Concern,

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 our existing uninsured patients and the larger community about the benefits of enrolling in the Exchange and Medicaid, and to assist them to enroll.

SFCCC, as a member of the California Primary Care Association, supports CPCA's comments and their request to correct the draft regulations for the Assistors Program to keep them consistent with the *Statewide Assisters Program Design Options and Recommendations,* which were adopted by Covered California's Board on June 19, 2012 after extensive review and input.

Comments

§ 6574. In-Person Assistance Program
SFCCC respectfully points out a significant error included within §6574 of the draft Assister Regulations. This section contains a list of the types of organizations which are ineligible for compensation by the Exchange for functions performed as Assister Enrollment Entities. Subsection (a)(5) includes "providers, including, but no limited to, Hospitals, Clinics, and County Health Departments that provide health care services" as entities ineligible for compensation.

By including "clinics" carte blanche in the list of entities ineligible for compensation, §6574 directly contradicts the clear intent of the Covered California Board of Directors as stated within the *Statewide Assisters Program Design Options and Recommendations,* which specifically lists "community clinics" as entities eligible to serve as enrollment assisters and be compensated by the Exchange.

SFCCC recognizes that there is a distinct difference between "community clinics" and "clinics" as listed in §6574. However, the regulation as currently written does not reflect this differentiation nor allow for the participation and compensation of "community clinics" per the clear intent of the Covered California Board.

SFCCC believes it is necessary and imperative to revise this proposed regulation to reflect the Board-adopted *Statewide Assisters Program Design Options and Recommendations.* SFCCC recommends that the regulation be revised to include both a definition of "community clinic" within §6570, and a clarification that entities classified as "community clinics" are specifically eligible for compensation for functions performed as Assister Enrollment Entities.

§6570 should be revised to include:

<u>Community Clinics:</u> Community clinics or health centers licensed as either a "community clinic or "free clinic", by the state of California under Health and Safety Code section 1204(a) and (2), or is a community clinic or free clinic exempt from licensure under Section 1206(c).

§6574(a) should be revised to include:

5) Providers, including, but not limited to, Hospitals, Clinics not designated as "community clinics", and County Health Departments that provide health care services. Community clinics are eligible for compensation by the Exchange for functions performed as Assister Enrollment Entities."

§ 6576. Navigator Program

Section 6576 includes a drafting error similar to that included in §6574 by including "clinics" within the list of the types of organizations which are ineligible to apply for the Navigator Program. Again, the regulation must clearly differentiate "community clinics" as entities which are eligible to apply in order to reflect the clear intent of the Covered California Board.

The *Statewide Assisters Program Design Options and Recommendations* clearly states that "The Exchange is still defining which classification of organizations will be eligible to serve as Navigator enrollment entities. However, at a minimum, non-profit organizations, community clinics, County Social Service offices employing Eligibility Workers, and labor unions will be eligible to serve as Navigator enrollment entities for purposes of Exchange enrollment."

SFCCC requests that §6576 of the proposed Assisters Regulations be revised to reflect the clear intent of the Board. The revision should include:

§ 6576. Navigator Program

(a) The following types of organizations are ineligible to apply for the Navigator Program:

5) Providers, including, but not limited to, Hospitals, Clinics not designated as "community clinics", and County Health Departments that provide health care services. Community clinics are eligible to apply for the Navigator program."

Thank you for the opportunity to comment on these draft regulations for Covered California's Assistor Program. If you have any questions about our comments or would like additional information, please contact Merrill Buice at (415) 355-2234 or mbuice@sfccc.org.

Sincerely,

John Gressman
President & CEO

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

Subject: Comments regarding draft regulations for Assisters Program

The San Luis Obispo County Public Health Department appreciates the opportunity to comment on the proposed Article 8. Assisters Program regulations, and specifically Section 6574.(a), item 5, which includes "County Health Departments that provide health care services" among the types of organizations ineligible for compensation by the Exchange for any functions performed as an Assister Enrollment Entity.

We are requesting clarification on the definition of "health care services." In addition, we recommend exclusion of county health departments that provide "public health" services as opposed to primary, secondary or tertiary care.

The San Luis Obispo County Public Health Department does not provide primary care services. Our clinical services are limited to preventive health services, such as family planning, immunization, and STD control. There is no incentive for our Department to direct enrollment towards any particular health plan, and thus there is no conflict of interest. Our services are paid for through government funding, Medi-Cal reimbursement, or directly from the patient, and we do not receive reimbursement from private insurance plans.

Please feel free to contact me at any time with any questions or comments.

Thank you,

Jennifer Shay
Administrative Services Officer
San Luis Obispo County Public Health Department
Office Phone: 805-781-4773
Mobile Phone: 805-748-6963

20 May 2013

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

Re: Draft Assisters regulations (Title 10, Chapter 12, §§ 6570, et seq.)

Dear Mr. Lee:

On behalf of the Independent Insurance Agents and Brokers of California, the California Association of Health Underwriters, and the National Association of Insurance and Financial Advisors-California, I am writing to urge the professional staff of Covered California to recommend, and its Board of Directors to adopt, certain amendments to the above-referenced proposed regulations.

First, in proposed Section 6572(a)(1), agents and brokers are defined by reference to a regulation previously promulgated by Covered California (Title 10, Chapter 12, §6410, California Code of Regulations).

We have two objections to this provision: 1) the cited reference does not, in fact, appear to contain any definition of agents or brokers; 2) the reference to "brokers" is inapposite, inasmuch as the California Insurance Code permits only agents (holding a "life license" and authorized to transact either "accident and health insurance," or "life and accident and health insurance") to transact health insurance. See California Insurance Code Section 1622. Insurance brokers, pursuant to California Insurance Code Section 1623, are expressly prohibited from transacting "life, disability or health insurance."

We recommend that you delete any and all references to "brokers" (which we find not only in proposed § 6572(a), but also in proposed § 6580), and that you define "agent" by reference to provisions in the California Insurance Code, such as Sections 32, 1622, and/or 1626.

Second, proposed Sections 6574(a)(3) and 6576(a)(3) prohibit "associations that include members of, or lobbying on behalf of, the insurance industry" from eligibility for compensation for functions performed as "Assister Enrollment Entities," and participation in the Navigator Program, respectively.

It is not clear to us what entities are covered by these prohibitions, why the prohibitions are necessary, or what the legal authority is for their promulgation.

We are aware that underlying federal and state law prohibits assisters and navigators from receiving compensation, directly or indirectly, from health plans. However, it is not our reading of those laws that they extend to trade or other associations solely because their membership might include one or more persons who work in the insurance industry—at least to the extent such associations are not acting, themselves, as health insurance agents.

We note that the term "association" is not defined in the proposed regulation. Does that mean that any chamber of commerce, fraternal or non-profit organization, or church that includes an insurance agent or insurance company employee within its membership is barred by these regulations?

Likewise, the phrase "lobbying on behalf of the insurance industry" is not defined. Does that mean that if Health Access or Consumers Union offers testimony in support of a bill that is also supported by one or more elements of an incredibly large and diverse insurance industry, then they are "lobbying on behalf of the insurance industry," and must be precluded from participation in the Navigator program or eligibility for assister compensation?

Regardless of how the term “lobbying” is defined, it remains an activity protected by the First Amendment. We fail to see why this outside activity should be linked in any way to eligibility for participation or compensation, per se, in the Exchange, or why such bans should, or Constitutionally may, be imposed on only some “associations.” Why should similar prohibitions not also be placed on labor unions, doctors’ groups, plaintiffs’ attorneys, or any of the scores of other special interests who routinely attempt to influence the professional staff and Board of Directors of Covered California, and the legislature, on Exchange issues?

We respectfully urge you to delete proposed subsections (a)(3) of both § 6574 and 6576, or at the very least to better define the parameters thereof to ensure their legality.

On behalf of IIABCal, CAHU, and NAIFA-California, I thank you for the opportunity to submit these comments. My colleagues and I would be delighted to answer any questions or provide any additional information you might have in regard to these concerns.

Very truly yours,

Stephen L. Young

Stephen L. Young
Senior Vice President & General Counsel
IIABCal

May 17, 2013

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

Re: Comments on Draft Assisters Regulations

Dear Exchange Board Members and Staff:

On behalf of the Transgender Law Center, an organization advocating on behalf of lesbian, gay, bisexual and transgender (LGBT) Californians, we write to comment on the draft Assisters Regulations that were released on May 7, 2013.

Under Section 6576 (c), related to the Navigator Program, the regulations list as a criterion for Navigator applications "access to target markets including, but not limited to, factors such as geography, ethnicity, language, employment sector, income, age, and limited English proficiency." We urge that the factors of sexual orientation and gender identity also be included for the purposes of the target market list.

Demographic data indicates that California has one of the most distinct and sizeable LGBT populations in the nation. Moreover, research such as a 2011 report from the Institute of Medicine also shows that the LGBT population is disproportionately uninsured and underinsured and experiences significant health disparities as a result. Covered California therefore must be able to appropriately serve the LGBT population as part of the Affordable Care Act's broad goal of reaching individuals and populations who have been historically disenfranchised by the health care system.

The Assistor and Navigator Programs will be important vehicles to strengthening consumer assistance for the LGBT community, and thus we again urge that the regulations include sexual orientation and gender identity as factors in the target market provisions.

Thank you for your consideration. Should you have any questions or concerns, please contact Alice Kessler, Legislative Advocate, at akessler@lawpolicy.com or (916) 341-0808.

Sincerely,

Masen Davis
Executive Director
Transgender Law Center

May 14, 2013

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

Re: Stakeholder Input: Assisters Program

Dear Mr. Lee:

United Ways of California appreciates the opportunity to comment on the current proposed Assisters program. We appreciate all the hard work the staff at Covered California has put in over the past several months to design a program that works for Californians. Your ongoing commitment to stakeholder involvement is also greatly appreciated.

Key Issue #1: Compensation.

UWCA agrees with the proposed compensation amounts and timelines for paying assisters.

Key Issue #2: Background checks.

UWCA agrees with the proposed background check protocols and the proposed protocol for appeals. We are pleased to see that Covered California is agreeing to pay for the costs of background checks and fingerprinting of assisters during 2014 and will reevaluate it thereafter. These costs can become substantial for smaller non-profits and we want to ensure a diverse pool of assisters.

Key Issue #3: Training.

UWCA appreciates the design of the training program and feels the proposal is thoughtful and appropriate for the assisters and navigators. We especially appreciate the options for in person or web-based training. As travel is expensive and time consuming, we feel confident that excellent training courses can be administered online. We also agree that a train the trainer program is not realistic at this point in the development of the assisters program. In a year or two when there are experts in the system and the training protocol has been tested thoroughly a train the trainer program should be considered.

One recommendation given at the Covered California Board meeting was to include in the training Market Abuse issues arising from fraudulent practices from non-exchange certified persons and entities. We have already heard concerns about this in our local communities and recommend that assisters are trained in how to report such abuses when they are made aware of them and to alert consumers of the risks.

In addition to the initial training, assisters will need on-going support to address difficult issues, whether through the Consumer Assistance Program or provided by an on-going training mechanism. This could take the form of Frequently Asked Questions for assisters or a live person to help with whatever issue arises. In this way, the exchange would also gather topics that should be added to the training curriculum.

Key Issue #4: Agent-Assister collaboration.

UWCA agrees that Assisters must be independent from any agent/broker relationship. This would include the prohibition of co-locating assisters in agents' offices or other in-kind contributions by agents to assisters or assister entities. This would be particularly important in rural areas where entities that employ assisters could accepts offers of assistance for out-stationed staff. Clarity of these rules is crucial.

Key Issue #5: Medi-Cal Enrollment Assistance.

Finally, we would like to acknowledge our strong support and thanks for The California Endowment's investment of funds for Medi-Cal enrollment. We are advocating for the state to accept this contribution and draw down the federal match. We think it only makes sense to have one well-managed program that can enroll into both the exchange plans and into Medi-Cal and serve California families well. With the knowledge of The California Endowment's investment and hopefully investment by other entities, we encourage the exchange to work with the state to manage and oversee a unified assisters program.

Again, we thank you for the opportunity to comment on the developing assisters program and look forward to continuing our work with you.

Best regards,

Judith L Darnell

Judy Darnell, Director of Public Policy
United Ways of California

cc: Members of the California Health Benefit Exchange Board

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

Subject: Covered California Issue of Agent and Enrollment Entity Relationship Requirements

Dear Covered California –

As a 7 year member of the California Children's Health Initiatives and an advocate for health insurance for everyone – Yolo County Community Health Initiative is very concerned about the policy recommendation for Agent and Enrollment Entity Relationship Requirements. We know you are seeking input on including the agent payment prohibition as a condition of agent appointments with Covered California issuers. The CHIs in Yolo, Napa, and Sonoma have agents on staff to offer private coverage to residents who are ineligible for subsidized coverage or have gaps in their employer sponsored coverage, such as dental insurance. As the suggested policy stands as it will create barriers for us to serve the most vulnerable residents of Yolo County, making it even more difficult to get insurance to those who need it most.

We would also like to suggest the following changes to the language;

1. Prohibit grantees and Assisters from accepting payment or other valuable consideration from for-profit agents for referrals and/or enrollment services; and
2. Prohibit for-profit agents trained and certified by Covered California from providing payment or other valuable consideration to grantees, Assisters and other community-based groups for referrals and/or enrollment services as a condition of program participation.

Thank you for your consideration. If you would like to talk to me directly, I can be reached at 530-979-6555.

Sincerely,

Katie Villegas

May 6, 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 Covered California

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

Thank you for the opportunity to review and comment on Covered California's staff policy recommendations on eligibility and enrollment. We offer comments below based on key decisions that your staff is recommending, as reported through Ms. Lam's PowerPoint (PPT) presentation at the April

23, 2013 Board meeting.[1] We also reiterate some of the comments we first presented to you all April 3, 2013 that were not addressed by Covered California in its presentation. On behalf of the undersigned, we submit these group comments:

Policy Matrix:

We appreciate the following changes to the policy matrix:

- Replacing the word "immediately" with the words "within minutes," to make clear that this is as close to real-time as humanly possible (Slide 5 and page 1 of Policy Matrix);
- No longer disenrolling someone from the program and providing them a termination letter and their appeal rights when they fail to provide a response within the additional 30 day reasonable opportunity period, but rather opting to determine the person's eligibility based on information received from electronic data sources (page 2 of Policy Matrix);
- Recognizing that there should be a threshold above which consumers will be required to report income changes. We look forward to hearing the staff recommendation of what that threshold should be at the May Board meeting. We urge you to consider that when Covered California makes an initial eligibility determination and the applicant is informed of the coverage (e.g. Medi-Cal or the exchange) or amount of advance premium tax credits (APTCs), the notice also include detailed information about what change of income would result in the applicant being found eligible for a different program or APTC level , and thus may require the applicant to report the change to Covered California. Without this specific information, Covered California is leaving it to individuals to try to figure out what to report and it would be far easier to inform them through the IT system (and potentially minimize consumers reporting changes in income that will not affect eligibility (Slide 7 and page 4 of the Policy Matrix)); and
- Allowing an online signature to delegate authority to an authorized representative and communicating to consumers that they can change or remove an authorized representative (Slide 8 and page 5 of the Policy Matrix);

Our continuing concerns with the policy matrix are as follows:

Timing of application processing (Slide 4 and page 1 of Policy Matrix): We continue to assert that it should not require 10 calendar days to process paper applications. Once they are received at Covered California or at a county, they will be scanned into the system and then be equivalent to an online application, at that point requiring processing "within minutes." It should not require 10 calendar days to scan paper applications into the system. We suggest a time frame of 3 calendar days to scan and process a paper application.

Incomplete applications (Slide 5 and page 1 of Policy Matrix): The section identifying the time to process incomplete applications has deleted any reference to incomplete ***online*** applications. We see no additional provision that specifies how incomplete online applications will be processed and the timeline to do so. Does this mean that individuals will not be able to submit an online application that is incomplete? We have successfully advocated at the federal level to allow for incomplete applications with subsequent follow-up from call center staff or an Assister (the recently released short form paper application that will likely require additional follow-up). There should be clear but minimal required information that individuals can complete online to move forward and submit an application, with any necessary follow-up afterwards through the California Service Center or county.

[1] Although there are regulations dated April 23, 2013, these appear to be the same proposed regulations that we commented on in our April 3, 2013 letter to you. If there is a newer version of the regulations that reflects the policy recommendations identified at the April 23rd Board meeting, we have not seen those to provide detailed comments.

Appeals process (Slide 9 and page 5 of the Policy Matrix): We continue to assert that 90 days is the appropriate standard for Covered California to complete the appeals process, as is currently the standard in the proposed federal regulations.

Eligibility and Enrollment Proposed Regulations:

Our continuing concerns with the proposed regulations are as follows:

Paying premiums before coverage is effectuated (Slide 11): We understand that Covered California and QHPs need to be sure that an enrollee will pay premiums. Our concern is that, as drafted, the proposed regulation could be interpreted to establish an effective **date of *enrollment*** based on the date premiums are received by the QHP, resulting in the potential for the payment to be made after a federally-mandated open enrollment period.

For example, if an individual applies for coverage in the Exchange on March 28, 2014, during the open enrollment period, he will not be notified that he is eligible and can enroll in coverage in real-time, that same day.[2] If after doing some research and talking with his other family members, the next day (March 29th), he goes back online and picks his QHP. He immediately writes a check and mails it to his selected QHP, and if the check does not arrive and get processed in the issuer's system until April 5, 2014, five days after the open enrollment period is closed, he would be outside of the open enrollment period, as the regulations are currently drafted. The language in the regulations must be changed to ensure that the enrollment date is effectuated at the time a person selects a QHP through the Exchange (allowing coverage to be effective once the payment has been received by the QHP by a specified due date).

> §6500(b) For purposes of this section, the effective enrollment date ~~enrollment~~ shall be the date the enrollee selects a QHP through the Exchange. Coverage will not be effective unless ~~deemed complete when the applicant's coverage is effectuated, which shall occur when~~ the QHP issuer receives the applicant's initial premium payment in full and by the due date.
>
> §6500 (c)(1) Notify the applicant of her or his initial premium payment methodology options, if applicable, and of the requirement that the applicant's initial premium payment shall be received in full and by the due date by the QHP issuer in order for the applicant's coverage to be ~~effectuated~~ effective, as specified in paragraph (b) of this section.

Issuers assisting with eligibility (Slide 12): We have grave concerns with the proposed regulations that would allow an insurer to ***assist*** with an application for an eligibility determination, thereby giving insurers private information about income and health status that should be kept out of the hands of insurers until after people are enrolled. At no place in the federal rules is the QHP issuer 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])

The Board has identified the important partnership with QHP issuers to engage in ***enrollment activities***. As drafted, however, the proposed regulations allow QHP issuers to reach into the eligibility process,

[2] Because he enrolled during the second half of the month, his coverage will not be effective until May 1, 2014. (42 C.F.R. §155.410(c) and California proposed rules §6502(c)(3)).

something the federal regulations explicitly do not allow. We disagree with staff's interpretation of the federal regulations. Federal rules do not allow QHP issuers to "assist consumers [to] apply for coverage." We would urge that Covered California use the exact same language in its regulations as are used in the federal rules as follows:

§6500 (g) If an applicant initiates enrollment directly with a QHP issuer for enrollment through the Exchange, the QHP issuer shall either:
(1) Direct the individual to file an application with the Exchange, or
(2) ~~Assist the applicant, upon the applicant's request, to apply for and receive an eligibility determination for coverage through the Exchange through the Exchange Internet Web site.~~ Ensure the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site.

Collection of SSNs for non-applicants (Slide 13):

We appreciate the commitment from Covered California to limit the use of SSNs and communicate that limitation clearly and concisely to applicants. The regulation should explicitly state that the tax filer's SSN is only for income verification. The specific use of a non-applicant's SSN should be made clear since it is otherwise not permitted to be requested or provided. The regulation should be edited as follows:

§6474(c)(5) An application filer shall provide the SSN of a tax filer who is not an applicant for the sole purpose of income verification only if an applicant attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be used to verify household income and family size,~~.~~ in accordance with 42 C.F.R. §155.310.

Electronic Verification of Immigration Status (Slide 14):

Most lawfully present immigrants have an Alien Registration Number (A#) that was issued by Department of Homeland Security and which should allow their status to be electronically verified for purposes of the Exchange. However, there are lawfully present immigrants who may not have an Alien Registration Number but have other documentation that verifies their lawful status. We recommend that the Exchange make clear to applicants who are lawfully present that they do not have to initially submit paper documentation of their immigration status if they are able to provide their A# on the application (similar to the way citizens are primarily asked for their SSN to verify citizenship). And like citizens, they can be notified they may be asked for additional documentation if there is a problem with their electronic verification. We also recommend the Exchange provide the opportunity for an applicant to initially provide paper documentation of his or her status in the event they do not have an A#. We do not agree that the Exchange should be requiring paper documentation from every applicant who attests to being lawfully present, which is how 6478(c)(2) could be interpreted, as written.

In addition, whether the applicant initially provides an A# or paper documentation to verify his/her immigration status, the Exchange must not delay processing the application waiting for a response from DHS. Under existing federal and state law (*Ruiz v. Kizer*), an applicant is required to only attest to lawful status for an eligibility determination. Once an applicant provides an A# or paper documentation, she or he has in fact attested to their status and the application process must continue.

Finally, we recommend that the request for documentation of immigration status, just as for citizenship status, be allowed only after all attempts to verify electronically have failed and the exception process is invoked. There are multiple levels of verification that can be done by USCIS through the SAVE database and if the initial verification is not successful, the Exchange should request DHS to conduct secondary or

manual verification with the information already provided. If additional information is needed to complete the verification by DHS, the Exchange may request additional documentation from the applicant as part of the exception process and the applicant has a reasonable opportunity period to comply as well as demonstrate a good faith effort.

> §6478(c)(2) For an applicant who attests to lawful presence or citizenship status, the Exchange shall request an Alien Registration Number or SSN and other identifying information needed by SSA or DHS to electronically verify status. The Exchange shall transmit necessary information to HHS to electronically verify the applicant's status in accordance with 42 C.F.R. §255.320. For an applicant who attests to lawful presence but who does not have an SSN or Alien Registration Number, the applicant may provide the Exchange with paper documentation of immigration status. For an applicant who ~~documentation that can be verified through the DHS and who~~ attests to lawful presence, or who attests to citizenship and for whom the Exchange cannot electronically verify his/her status or substantiate a claim of citizenship through DHS or the SSA, the Exchange shall request additional information from the applicant~~'s~~ ~~documentation and other identifying information to HHS, which will submit necessary information to the DHS for verification of an applicant.~~ and follow the exception process procedures required under federal law.

Readability Standards (Slide 15): We appreciate staff's recognition that whenever feasible, a 9th grade reading level should not be the standard for readability for Covered California materials and that the standard for the reading level will be lowered to 6th grade for most materials. What concerns us, however, is that the staff is recommending preserving the 9th grade reading level standard for more complex issues, which is exactly why this regulation is needed. It is precisely these complex issues (e.g. APTC's and exemption from the individual mandate) that should be made clear for applicants because of the serious repercussions if an applicant does not understand them. We strongly urge the Board to set as its goal a 6th grade reading level for ***all*** materials used with consumers, regardless of their complexity, as is done in the Medi-Cal program. Materials for Assisters might be at a higher grade level.

Moreover, there are formatting guidelines/principles for people who have limited literacy skills and certain tests (e.g., the SAM [Suitability Assessment of Materials]) that will help identify if formatting has been appropriately designed for audiences with low literacy skills. The proposed regulation should be changed as follows:

> § 6452(b): "Information shall be provided to applicants and enrollees in plain language, as defined in Section 6410 of Article 2 of this chapter, and all written correspondence shall also:
> (1) Be formatted in such a way that uses commonly accepted practices of plain language design and can be understood at the ~~ninth-grade~~ sixth-grade level."

Single Streamlined Application:

We appreciate the following changes to the single streamlined application data elements:

- We support the explicit recognition that "domestic partner" will be provided as an option on the application under "type of relationship" and "marital status" (Slide 20); and
- We appreciate that questions on written and spoken language will be guided by questions identified in the former Healthy Families Program application and that the state will consider asking more detailed questions about the level of the consumer's Limited-English Proficiency. We look forward to reviewing drafts of that language at your earliest convenience (Slide 23).

Pre-populated data (Slide 19): We understand that there are limits to the design of CalHEERS and availability of accurate income and household information at this time, which prevent the ability to pre-populate data upon initial application. While we can accept this for 2014, we are concerned because of information we have obtained about the State's Verification Plan for Medi-Cal that there are no plans to provide an electronic query for CalHEERS to obtain data in SAWS, which would continue to prevent CalHEERS from having access to pre-populated data for applicants that the State already has in its system. Covered California should commit to not only pre-populate data stored in CalHEERS, but enable the SAWS-CalHEERS interface to be fully bilateral as quickly as is practical, given the design choices made to date, which would provide the capability to pre-populate applications from data stored in both CalHEERS and SAWS.

Same-Sex Married Couples and Registered Domestic Partners (Slide 21):

We appreciate Covered California trying to resolve this issue within the parameters of what is allowed under federal law. We are interested in hearing the final outcome and having a chance to review it

Privacy Policy Statements (Slide 22): We understand that Covered California is developing its privacy statement, but has not yet done so. We look forward to reviewing drafts of privacy policy statements as early as possible, to provide robust feedback on this very important issue.

Other program referrals (Slide 24): As stated above (comments to Slide 19), we recognize that under the tight time constraints, CalHEERS will not be able to electronically interface with CalWORKs and other human services data and in the meantime will provide links to other human services programs on the website. However, we must reiterate our serious concern that DHCS has very limited plans to interface SAWS with CalHEERS. We urge Covered California to work with DHCS to ensure that the important capability to interface with the state human services programs is realized, not only for determining eligibility for health coverage programs, but to support low-income applicants' access to vital human services programs.

Sexual Orientation and Gender (Slide 25): We would like to see the initial application for health insurance programs include questions about sexual orientation and gender identity, not just the two options of "male" and "female." While we appreciate Covered California's efforts to collect this data on the application in 2015 (and to survey applicants until then), we think there is no reason why this information cannot be collected on the 2014 application. Gender identity is an important data component for an eligibility determination. If someone has changed their gender, that could create a barrier to their application. For example, there have been cases where someone was previously on Medi-Cal as one gender and when they reapplied later with the other gender, the system rejected their application as being inconsistent. This must be rectified to properly process applications.

As currently proposed (Slide 16), a revised version of the draft regulations will not be circulated for public comment, but rather a webinar will be held for stakeholders early this month and a final set of regulations presented to the Board at the May 23rd meeting. We also note that the current version of the proposed regulations, dated April 23, 2013, is the same as the draft dated March 21, 2013 and does not reflect any edits or modifications. While the April 23rd Covered California presentation presented five key policy decisions, our organizations provided a detailed chart of many additional concerns we had with the regulations as drafted. Without a new or revised version of the regulations, we cannot comment on any changes that may have been made to the proposed regulations. Moreover, there are still several important sections of the regulations which are "reserved" and we have still seen anything

on these areas, including notices and appeals. We strongly urge Covered California to provide us with a revised version of the regulations and an opportunity to comment on them before they are presented to the Board as final for adoption. We also hope that the revised draft of the proposed regulations reflects the changes staff outlined in the presentation at the April 23rd Board meeting and addresses our other concerns.

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

Sincerely,

Kris Calvin, American Academy of Pediatrics, California District IX
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
Mike Odeh, Children Now
Kevin Aslanian, 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
Anthony Wright, Health Access
Lynn Kersey, Maternal and Child Health Access
Kimberly 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 & Poverty

April 29, 2013

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

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

Re: Covered California Eligibility and Enrollment Process

Dear Ms. Lam and Mr. Finocchio:

The Children's Partnership (TCP) and Social Interest Solutions (SIS) are committed to ensuring that families encounter a simple, efficient, highly usable enrollment experience when they apply for coverage later this year. In that spirit, we are writing to voice concerns about the currently proposed eligibility and enrollment process and to provide recommendations to address these concerns.

SIS and TCP have both worked steadily at the state and federal levels to ensure that the Covered California user experience will be a good one, starting on day one. We were encouraged the state included the Enroll UX 2014 standard in the RFP for the CalHEERS vendor. However, since that step was taken, there has been very little engagement on usability issues. The documents we have seen signal creation of a system that does not include functionality to support consumers in the way the federal model and Enroll UX 2014 do, both of which were extensively informed by usability testing during the design process and both of which strongly recommended further user testing once the systems have been built.

Specifically, our concerns are as follows:

- Although Covered California has released the proposed single streamlined application data elements and has provided a handful of static screen shots of the online application, we have not had the opportunity to review a dynamic, interactive prototype (such as the ones prototyped by CMS and Enroll UX). We also haven't seen a detailed design specification that would allow us to understand what the consumer will experience when applying for these important coverage programs and how they will access various help resources, which we assume will be built into the system.

- It is our understanding that at this juncture there are no plans to test the application with consumers prior to launch. We recognize the enormous pressure you are under to design, develop and deploy an online application on time, but believe that consumer testing is

critical, and that launching a poorly executed online application on day one will do significant damage to the reputation of the program and deter future participation.

- We are concerned about the proposed electronic data verification plan. At the April 23rd Covered California Board Meeting, CalHEERS staff acknowledged there will be different electronic data verification processes for Medi-Cal and the other Insurance Affordability Programs. Further, we understand that CalHEERS will not access data from SAWS to support the verification process, which could avoid the need for collection of data that is already known to the state. Given this, we remain worried about how a mixed-case family will be able to experience a uniform and consistent enrollment process.

- Further, we understand that California does not plan to follow the federal model of mid-application verification and pre-population of data. It would be helpful to understand the rationale behind this, as past experience in other health coverage enrollment systems and other environments indicates this could be of tremendous assistance to individuals and families. Further, it would help ensure that applications are completed and submitted.

- Finally, the delay in the CalHEERS/SAWS interface raises many concerns about what mixed-case families will experience in the short-term, and questions about how cases - and data - will be transferred between systems. For example, what will the online consumer completing an application from home experience if she has a family member eligible for Medi-Cal and there is no interface to get the data to SAWS? This issue has not been adequately clarified and deserves a public airing.

To that end, we respectfully offer the following recommendations:

- Release the dynamic online single streamlined application as soon as possible, and provide ample opportunity for both written feedback and discussion. We understand that the system is a work in progress, but we would like to understand what progress has been made and what direction the design is taking.

- Ensure a mechanism for pre-launch consumer testing. California itself has helped demonstrate the need for robust pre-launch user testing, having learned the value of such work through the Health-e-App experience. Even one week of focused consumer testing prior to launch would provide invaluable information about clarity of questions and areas of potential confusion. Additionally, CalHEERS must be equipped to make any modifications suggested by user testing. The state must do its utmost to follow industry best practices and complete adequate pre-launch testing. There is absolutely no substitute for this step of the process.

- Implement a consistent set of electronic data verification standards for both Medi-Cal and the other Insurance Affordability Programs. Adopt the process modeled by the federal single streamlined application, which will pull income, citizenship and other data from federal and state systems and present it to the applicant for verification or modification. This could be handled in a manner similar to what the State is proposing for redetermination, whereby data previously provided will be pre-populated and presented to the applicant for verification.

- Deploy whatever resources necessary to have the CalHEERS/SAWS interface functioning and ready to go-live on October 1, 2013. This is critical to ensuring that families experience a cohesive and comprehensive eligibility determination and screening process at the outset. Short of that goal, provide a detailed description of how the absence of an interface will impact the consumer experience.

We would welcome the opportunity to discuss these issues and our recommendations further, and provide feedback on your proposed plans.

Sincerely,

Lucy Streett	Kathleen Hamilton
Senior Policy Manager	Director, Sacramento Governmental Affairs
Social Interest Solutions	The Children's Partnership

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

ALLIANCE FOR
Boys and Men of Color

Invest in the Health and Success
of California's Future

April 22, 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 a partner and supporter of the Alliance for Boys and Men of Color, I 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,
Dr. Barry Krisberg

Director of Research and Policy, and Lecturer in Residence
Chief Justice Earl Warren Institute on Law and Social Policy
University of California, Berkeley School of Law
2850 Telegraph Avenue, Suite 500
Berkeley, CA 94705-7220
Tel: 510-642-8589
Fax: 510-643-7095
Email Address: bkrisberg@law.berkeley.edu

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

April 22, 2013

Via: info@hbex.ca.gov

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

Dear Mr. Lee:

On behalf of the Health Justice Network (HJN), a statewide collaborative of over 30 community-based organizations, health care providers, and small business associations working in the Asian American, Native Hawaiian and Pacific Islander (AANHPI) communities that is working on health care reform implementation in California, the Asian Pacific American Legal Center (APALC) is writing to express our deep concern that Covered California (CC) is not adequately addressing the issues facing our communities. APALC, a member of the Asian American Center for Advancing Justice, is dedicated to providing the growing AANHPI communities with multilingual and culturally sensitive legal services, education, leadership development, and public policy and advocacy support. As the coordinator of HJN, APALC's Health Access Project seeks to address the health care needs of the AANHPI 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.

As you may know, AANHPIs are the fastest-growing racial groups in California and are extraordinarily diverse with dozens of different cultures and languages. [1] While Asian Americans and NHPI in California are disproportionately impacted by disease, many lack health insurance. In a recent demographic report, among the findings are the following: 1) approximately 14% of Asian Americans and 15% of NHPI in California do not have health insurance, a rate higher than Whites (10%); 2) among Asian American groups, more Korean (27%), Thai (22%), and Cambodian Americans (21%) lack health insurance; 3) one-quarter of Tongan Americans live without health insurance, the highest of the NHPI groups; 4) in 2010, Asian American women were less likely than all other racial groups to have visited a doctor for a

[1] According to the U.S. Census Bureau, California's Asian American population grew 34% between 2000 and 2010, while its NHPI population grew 29%. In comparison, the state's Latino population grew 28%, while its White population decreased 5% over the same decade. Asian American Center for Advancing Justice, *A Community of Contrasts: Asian Americans, Native Hawaiians and Pacific Islanders in California* at 3, 8-10 (2103), *available at:* http://apalc.org/media-center/publications/community-contrasts-asian-americans-native-hawaiians-and-pacific-islande-0.

routine medical checkup in the past year (73%); 5) Asian American women were less likely than any other racial group to have a Pap test in the past three years; 6) approximately 12% of Asian Americans and 10% of NHPI did not see a doctor because of cost, rates higher than Whites; 7) Cambodian, Guamanian or Chamorro, Laotian, Native Hawaiian, and Samoan Americans have higher percentages of late or no prenatal care and preterm births than the state total; and 8) statewide, Asian Americans are the only racial group for whom cancer is the leading cause of death; for other groups, heart disease is the leading cause of death.[2]

Many are also limited-English proficient (LEP) and continue to face language barriers.[3] By CC's own estimates, almost 600,000, or over 14% of its total eligible population, will be uninsured AANHPIs. As a significant portion of the state and the most culturally and linguistically diverse populations in the state, there will be many challenges faced by our communities, which suffers from many health disparities and will be hard to reach.

As you know, APALC and HJN have actively engaged with CC for the last couple of years and have attended most of its meetings either in person or through the webcast. We have tried to consistently provide public input and submitted written comments on the myriad of issues presented at the CC board meetings and webinars.

Because CC has expressed its commitment to ensure cultural and linguistic access to the diverse population in the state, we would like to provide some feedback about its most recent oversight at the March 21st board meeting. We are not sure of the reasons for the absence of any discussion of the health care needs of AANHPI communities on the Health Equity and Health Disparities Panel at the meeting but we were disappointed at the lack of representation of the AANHPI communities on the panel. Similar to the lack of members working in the AANHPI communities on the three CC Advisory work groups, we are wondering if CC understands the cultural and linguistic challenges facing our communities. We believe that the one or two minute public comment periods allocated after certain agenda items at the CC board meeting, the one-way system of written comments, and the lack of time provided to review materials and respond may not have allowed enough time to provide meaningful input about the health challenges facing the AANHPI communities..

We would like to offer our assistance to inform CC about the health care needs of the AANHPI communities and to share our knowledge regarding effective education efforts to reach out to our complex communities. Therefore, we would appreciate an opportunity to meet with CC staff, preferably in Los Angeles, where more HJN members could participate and our regional partners could participate by telephone. At a minimum, we urge CC to incorporate the health disparities experienced by the AANHPI communities into any health equity and health disparity report that it releases to the public and uses to develop its plans to improve the health outcomes of vulnerable populations in California.

---

[2] *Id*. at 4-5, 24-25.

[3] *Id*. at 4-5. There are nearly 3.6 million Californians who speak an Asian or Pacific Island language. Statewide, the top five Asian languages spoken at home are Chinese, Tagalog, Vietnamese, Korean, and Japanese; Samoan is the most commonly spoken Pacific Island language. Approximately 72% of Asian Americans and 39% of NHPI in California speak a language other than English at home. In 2010, almost 1.7 million Asian Americans in California were limited English proficient (LEP), an 11% increase since 2000. Over one-third of Asian Americans statewide are LEP, a rate second only to Latinos; over one out of every ten NHPI is LEP. Many Asian Americans live in linguistically isolated households in which everyone over the age of 14 is LEP. Over 23% of Asian American households in the state are linguistically isolated, a rate similar to Latinos (24%). Korean American households have the highest rate of linguistic isolation (40%); Vietnamese (37%), Burmese (36%), Mongolian (33%), Taiwanese (33%), and Nepalese American (31%) households also have high rates of linguistic isolation. *Id.* at 16-17.

We also would appreciate responses concerning the following ongoing issues:

1) **CalHEERs Web Portal in Multiple Languages**
At the January 17th CC Board meeting, many HJN members requested that the web portal/ website, including the online application, be translated into the other 11 Medi-Cal threshold languages in addition to Spanish and English. We explained that close to 40% of the newly enrolled in CC who will be eligible for subsidies are likely to be LEP and require language assistance services, including both oral and interpreter services and written or translation services. As you are also aware, LEP individuals are projected to enroll at lower rates than their English-speaking counterparts and as many as 110,000 LEP persons, who will be eligible for subsidies in CC, may not enroll due to language barriers without proactive outreach.[4]

We appreciated that Dr. Ross asked you, as CC's Executive Director, to explore the feasibility of having the web portal/website translated into the other Medi-Cal threshold languages and you responded that you would report back to the Board about the issue. However, since time is quickly passing by and we have not heard about any progress on this issue, we are asking for an update and any decisions you have made or are contemplating. While we appreciate that CC will have the Service Centers with language capacity, we also look forward to further details about ensuring cultural and linguistic access, such as its commitment to hire bilingual staff rather than rely on contracted telephone interpreter services. Regardless of the interpreter services provided by the Service Centers, we believe that it is essential that linguistic access be provided on the website to ensure the success of maximizing the enrollment of AANHPIs in CC.

2) **CC's Marketing, Outreach and Education Plan**
We would also like to discuss ways to improve CC's final Marketing, Outreach and Education Plan as adopted by CC staff to the AANHPI communities and again offer our assistance in ensuring effective outreach is conducted under the plan. Because the AANHPI population is comprised of such diverse communities, our HJN members have the cultural and linguistic ability to reach many of these hard-to-reach and LEP populations. We urge CC to meet with HJN members, who have the trusted relationships and knowledge to reach our communities and to assist CC in its marketing, outreach and education efforts for the AANHPI population in state.

3) **CC's Assisters Program**
Many of our HJN members will likely assist enrollment of their clients for CC, either as certified assisters or navigators. However, we anticipate there may be enrollment barriers faced by our communities, including issues that may prevent smaller community-based organizations from participating in the Assisters program and raised issues such as the longer time it may take to enroll LEP applicants and mixed status families, the low reimbursement rate for successful enrollments, and the stringent legal requirements for certified assisters. We would like to further discuss how these challenges will be addressed and possible recommendations.

---

[4] California Pan-Ethnic Health Network, UCLA Center for Health Policy Research, & UC Berkeley Center for Labor Research and Education, *Achieving Equity by Building a Bridge From Eligible to Enrolled* at 2 (Feb. 2012). The report further noted that though these enrollees are predominantly Spanish-speaking, a significant number speak other languages, with roughly 31,000 speaking Chinese, 13,000 Vietnamese, and 9,000 Korean. *Id.*

We appreciate the opportunity to share these concerns and look forward to hearing from you to schedule a meeting to discuss how we can develop a more proactive and collaborative working relationship in order to ensure our common goal of maximizing the enrollment of AANHPIs in Covered California.

Sincerely,

Doreena Wong

Doreena Wong, Esq.
Health Access Project Director
on behalf of the undersigned organizations

Asian Pacific American Legal Center
APAIT Health Center
Asian Law Alliance
Asian Pacific Islander California Action Network (APIsCAN)
Asian Pacific Policy and Planning Council (AP3CON)
Asian Resources Inc
Guam Communications Network
Korean American Family Service Center
Korean Churches for Community Development
Korean Community Center of the East Bay
Korean Resource Center
Little Tokyo Service Center
National Asian Pacific American Families Against Substance Abuse
Operation Samahan-SDAPI Community Health Network
South Asian Network
Southeast Asian Resource Action Center (SEARAC)

May 20, 2013

Peter Lee
Executive Director
Covered California
560 J St., Suite 290
Sacramento, CA 95814
Submitted electronically to info@hbex.ca.gov

Re: CPEHN comments regarding Covered California's Brief: *Addressing Health Equity and Health Disparities*

Dear Peter:

On behalf of the California Pan-Ethnic Health Network (CPEHN), thank you for the opportunity to participate in the Health Benefit Exchange's March 21st stakeholder panel on addressing health equity in the Exchange and to provide comments on your brief, *Addressing Health Equity and Health Disparities*.

As you are already aware, over 2.7 million adult Californians will be eligible to receive federal tax credits to purchase affordable health coverage in Covered California. Of these eligible adults, 66% (about 1.8 million) will be people of color and 40% (about 1.09 million) will speak English less than very well. In addition, of those who are limited English proficient, over 720,000 will speak Spanish; over 128,000 Chinese; 50,000 Vietnamese; 27,600 Tagalog; and 18,700 Korean.

Given the diversity of Exchange enrollees, it is critical that the specific needs of communities of color are met. CPEHN applauds the Exchange for working to achieve health equity and "walking the talk" by incorporating efforts to eliminate health disparities in all functional areas of the organization. In particular, we would like to acknowledge Covered California's commitment to:

- Translate materials into the 13 Medi-Cal managed care threshold languages;
- Hire Customer Service representatives who speak the 13 Medi-Cal managed care threshold languages;
- Culturally adapt and build CalHEERS into Spanish;
- Require Qualified Health Plans to work with you to identify strategies that will address health disparities including completing the eValue8 Racial, Cultural, and Language Competency module and describing how they collect and use demographic data to identify and develop targeted interventions;
- Promote community health and wellness by requiring Qualified Health Plans to annually report on their initiatives and projects that better community health;

BOARD OF DIRECTORS
Jacquie Anderson
Director, State Health Advocacy Program
Community Catalyst
James Allen Crouch, MPH
Executive Director
California Rural
Indian Health Board
Jennifer Hernández, MPP
Founder and Partner
Cultivo Consulting
Miya Iwataki
Los Angeles Chapter
Asian and Pacific Islanders California
Action Network
Kathy Ko Chin, MS
President and Chief Executive Officer
Asian & Pacific Islander American
Health Forum
B. Darcel Lee
Executive Director
California Black Health Network
Donzella Lee, MPH, CHES
David J. Lent
Executive Director
Toiyabe Indian Health Project, Inc.
Tana Lepule
Executive Director
Empowering Pacific Islander Communities
Alma Martinez
Radio Bilingue
Xavier Morales, PhD
Executive Director
Latino Coalition for a
Healthy California
Poki Stewart Namkung, MD, MPH
Dong Suh, MPP
Associate Director
Asian Health Services
Pete White
Founder/Executive Director
Los Angeles Community Action Network
Kevin Williams, JD, MPH
Associate Director
Berkeley Youth Alternatives
Ellen Wu, MPH
Executive Director

We also have additional recommendations for actions Covered California can take to achieve your mission of eliminating health disparities:

Marketing and Outreach

- **Field test marketing materials:** Field testing materials with the intended audience is an important step to ensure the message is effective and culturally appropriate. We would recommend engaging in this process for some of your key marketing materials.
- **Review marketing materials:** A significant share of the public (42%) lacks enough information to understand how the ACA will affect their own family members and this number is even higher among the uninsured (56%) and low-income households (58%) according to a Kaiser Family Foundation poll. A Covered California review of marketing materials (even a small sample) will help to ensure insurance carriers and Assisters are not misrepresenting the products and requirements of the ACA to vulnerable populations.
- **Develop an Assister program that is representative of California's diverse population and truly capable of helping consumers "navigate" through the system:** For many consumers this may be the first time they are purchasing health insurance. It will be important for the Exchange to ensure that the Assister program reflects the diversity of the state and that Navigators are trained, not only in how to enroll consumers but in how to best assist them – after they are enrolled – in getting the care they need.
- **Collect granular enrollment data by race, ethnicity and primary language:** The Exchange must ensure that granular data on race, ethnicity, and primary language is collected at enrollment, on the paper forms and online application. This type of data will be absolutely critical in ensuring that the Exchange is maximizing enrollment among communities of color.
- **Continue to use data to "micro-target" marketing efforts:** The Exchange should continue to invest in data analysis, focus groups, and other types of research, including member surveys, in order to further refine the focus of its marketing efforts.

Eligibility and Enrollment

- **Use technology appropriately:** CPEHN's report, *Equity in the Digital Age: How Health Information Technology Can Reduce Disparities*, discusses how Health Information Technology (HIT) can be used to help with enrollment but must be done with the needs of special populations in mind. For example, while communities of color may have limited access to the internet, they are more likely to use mobile applications making cell phones an important strategy to employ to maximize enrollment in the Exchange.
- **Ensure a streamlined enrollment process, particularly through CalHEERs:** The CalHEERs system must be developed in such a way that it is welcoming and open to everyone – regardless of what program a person is eligible for. The system must provide real-time eligibility determinations so consumers can access coverage quickly and easily. Additionally, the system must take into account the needs of mixed-status families and those who may be ineligible for coverage through the ACA, but in need of emergency Medi-Cal by providing links to these coverage options.
- **Develop an online system that is accessible to all:** The CalHEERs system must be developed using plain language which is generally defined as between a 4th and 6th grade level. Taglines should be provided in at least 15 different languages with information on how people can get help in their language. Additionally, the website should make

alternative formats available for persons with disabilities such as those with visual or hearing impairments.

- **Establish dedicated 800 numbers for non-English languages:** Once a limited English speaker takes the initiative of making a call to the Exchange, it will be important for them to know that they will be able to immediately and easily speak to someone in their language. Dedicated 800 numbers for different non-English languages will go a long way to providing a "first class" customer service experience for these consumers, and building their trust of the Exchange.
- **Ensure access to Customer Service representatives who speak the 13 Medi-Cal managed care threshold languages:** We understand that Covered California will be hiring Customer Service representatives who speak the 13 Medi-Cal managed care threshold languages to answer calls and help process enrollment applications. Callers in those 13 languages should be allowed to have their application processed by a knowledgeable, bilingual staff person, before the services of a language line are utilized, regardless of whether they are being served by a state or county call center.

Plan Management

- **Ensure access to quality care:** Covered California must work to ensure there is an adequate and diverse network of providers and timely access to care for everyone, particularly those with mental health and substance use treatment needs. As part of this guarantee, the Exchange should include in its Provider Directory, the language(s) spoken by providers as well as office staff and such preferences should be included as part of any consumer choice architecture designed by the Exchange.
- **Institute quality improvement measures:** We know that racial and ethnic differences in utilization, treatment, and outcome are prevalent and pervasive. We appreciate that in your first year of operations, you will be collecting information from the Qualified Health Plans (QHPs) on how they may be addressing health disparities. However, for future years, we urge you to require the QHPs to analyze their quality data by demographic characteristics and implement quality improvement plans to address identified disparities.
- **Use translated CAHPS surveys:** The diversity of Exchange enrollees require the use of the translated Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys in order to get an accurate picture of their experiences. The CAHPS survey is available in Spanish, Chinese, Korean, and Vietnamese, and has been used by the Healthy Families program.

Once again, we thank you for the opportunity to share our thoughts with you on strategies for addressing health equity in Covered California and look forward to our continued partnership with you to ensure attainment of the highest level of health for all Californians.

Sincerely,

Ellen Wu
Executive Director

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

Subject: Input on Broker Commission Process

As I looked at the Cal HEERS proposed website for individual enrolling in the exchange, I do not see the ability for a broker to assist individuals to enroll in the exchange and to set up compensation for that assistance. In the webinar the concept of broker commission was deferred till after January 2014 for development.

In an enrollment meeting where certain individuals will find the group health plan unaffordable (greater than 9.5% of household income), I would like to be able to direct them to your website, walk them through the enrollment process and receive compensation for that assistance. There should be a place for a broker who delivers assistance to be identified and compensated in that process.

I believe that it is critical for Covered California to partner with the broker community and harness the thousands of insurance professionals who are already meeting with individual and firms across the state. To deliberately make it difficult for brokers to be compensated will cause that community to withdraw their needed support.

Thank you for all the hard work you are doing.

Dave Schmitt
Vice President
Business Development
Wells Fargo Insurance Services
Phone 916-589-8112
Cell 916-642-3187

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

Subject: Comments from my attendance at the Riverside Town Hall Meeting Last Week

To whom it may concern:

As a Certified Financial Planner/ Life and Health Insurance Professional of 25 years, I wanted to follow up with the Board as it relates to my comments and general impressions of the Town Hall Meeting Last Thursday.

Overall, I think Peter Lee and the panel did a fairly good job for their first one. However, I have some concerns. And, it they're not addressed, I am concerned that the roll-out of Covered CA will be problematic. Below are my concerns:

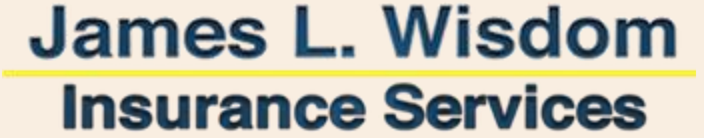
1. As you know, this law was very controversial. I don't think the panelists conveyed that they fully appreciate that fact. About half of America is behind this law. The other half is not. But, it's the law of the land. So, a little more sensitivity to this fact would be welcome. To think that everybody is really excited to get started with the new Health Care Law is delusional.
2. A number of panelists (I think Kim Belshe said it the most) was that preventive care is "free." Either she doesn't understand health care, or she's purposely perpetrating a falsehood. If you don't believe me, ask all the doctors that used to treat routine preventive care if it was "free." What she means it's "No Charge" to the insured. That's a big difference from "free." And, this concept of the new Health Care law offering any "free" health care feeds into this narrative that any part of it is truly "free." There is a cost for everything.
3. Kim Belshe also said they were offering deductibles that "were not a deterrent to care." I think she means high deductibles are a deterrent to care. But, one of the things that's proved to contain costs over the years is employee cost-sharing. And, because there are several plans with no copays (i.e. not a deterrent to care, per Ms. Belshe), that tells me that the health care utilization will be much higher than anticipated (because it's perceived to be "free" by the insured). As for an expanded explanation of "free" health care, please refer to #2 above.
4. I was somewhat offended that Dr. Bob Ross said he was "heartened" by the turnout at the first Town Hall Meeting. Does he really think that all of us were there because we are strong supporters of this law? I was there because I am concerned (as are my clients) about how the cost of their health insurance (both groups and individuals) will substantially increase in 2014.
5. Peter Lee pointed out all the subsidies and tax credits that individuals and companies could benefit from. However, very little to no attention was paid to the taxed and penalties that will be imposed on individuals, companies, medical device firms, insurance companies, etc. to pay for this law. The bottom line is that when you add 30 Million to the insurance rolls, there will be a significant cost to be paid by somebody. And, even if you account for efficiencies, health insurance costs for health care (on a per unit basis and in the aggregate) are bound to increase. I know some of you may not agree, but that's the reality that we as insurance brokers are living in.
6. I was disappointed that you controlled the Q&A by having people submit questions. What you seemed to be saying is "we better get the Q&A under control by passing out cards or we may lose control of this Town Hall Meeting." I tried to attend a Town Hall Meeting in Santa Barbara in the summer of 2009 and it was a total charade.
7. I believe that if Peter Lee and the other Board Members don't speak candidly and straightforwardly about this law, you may lose half of your audience. I'm not saying it will be easy. But, in order for everybody to get behind this very controversial law, I hope the board will consider my viewpoint. If there is a penalty, let people know about it. If there is a tax to be paid, be honest about it.
8. Peter Lee said that Congress must abide by the Health Care Exchanges like everybody else. However, this is not entirely true (it's still being negotiated). Please read today's WSJ on this very subject. Congress has reportedly been trying to exempt themselves since this law passed. Peter was either being less than truthful or he truly didn't know. In either case, it doesn't reflect favorably on him.

9. Finally, I thought Peter lost control of the meeting to some extent when his view of the employer penalty didn't agree with the questioner's view (most likely a health insurance agent/broker). The only way to deal with these penalties is to also build them into your presentation. If you just present all the positive aspects of this law and ignore the negatives, you will be misinforming the public. And, by misinforming the public, you are setting yourself up for failure when they find out the truth.

I just wanted to pass along these thoughts because Peter Lee said he welcomed our feedback. Whether or not we in the insurance agent/broker community supported this law or not, I believe that we are committed to helping our clients understand it and help them determine the most effective plan for them going forward.

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

Sincerely,



Email Jim | work: **805-497-9264**
fax: **805-435-3636** | cell: **818-469-6640**
Read Jim's Healthcare Reform Blog

***<u>General</u>* Comment Received via E-mail**

Subject: Reconsider age limit for Catastrophic Coverage

Please route this message to the Executive Director and the Board.

In looking at the estimate for an individual plan for myself, age 56 with an income of $60,000, I'm looking at a premium that exceeds 8 percent of my income by quite a bit. Presumably I won't have to pay a penalty since I would qualify for the "unaffordability" exemption; however, this leaves me with no insurance options at all. This is not in the spirit of "affordable" healthcare. I see no reason to limit your catastrophic coverage option to those under 30. Some insurance is better than none. I currently have a catastrophic plan and its unclear if I will be able to keep this or lose it under the new system. It would be absurd to install a new system that forces millions of middle class wage earners out of insurance coverage.

Ken Alan

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

Subject: Errors and Omissions Insurance

Here is a comment. As a Insurance professional. I would highly recommend that you require any person or entity, who is going to be involved in any capacity to carry Errors and Omissions Insurance. Not requiring that opens the state and this program up to an unnecessary exposure for lawsuits. It would be extremely irresponsible and a waste of an exurbanite amount of taxpayers' money in my opinion not to do so.

Thank you,

Stephen Benveniste- Branch Owner

CA Lic # 0C35471
1355 Westwood Blvd # 209
Los Angeles, CA 90024
Phone: 310-473-2680
Fax: 310-473-2678
Email: sbenveniste@twfg.com

May 8, 2013 Via Email: Natalia.Chavez@covered.ca.gov

Peter Lee, Executive Director
The Covered California

Subject: Plan-based Enrollment Marketing Guidelines

Dear Mr. Lee:

As a member of the Covered California Plan Management and Delivery System Reform Advisory Group, I appreciate this opportunity to provide feedback on the first draft of the Plan-Based Enrollment Marketing Guidelines.

I strongly support Covered California's policy to allow health plans to assist individuals to apply for Covered California. My understanding of the intent of this policy is to create a mechanism for health plans to help (1) individuals who choose to switch from an existing individual commercial product into a Covered California product, (2) uninsured individuals, and (3) individuals who will be transitioned from a government program into a Covered California product because of a change in their financial status.

The first draft of the Plan-Based Enrollment Marketing Guidelines is presented as a completely separate component from the overall Covered California marketing guidance. In addition, it is mainly for marketing practices that health plans use to reach out to their currently enrolled members to switch them to a Covered California product. I understand the reason why Covered California wants to transition the enrollees in the individual commercial coverage into the Covered California products. However, this approach narrowly defines only a subset of the Covered California's eligible populations. It falls short of addressing the needs to enroll hundreds of thousands of uninsured individuals into Covered California.

I highly recommend that Covered California reevaluates this first draft to allow health plans to assist all populations identified above. I also suggest that Covered California develops a broader, overall Covered California marketing guidance with general marketing guidelines and with specific marketing provisions for different enrollment/outreach practices, such as Assisters, Health Navigator, brokers/agents, plan-based enrollment, etc. This will allow all Covered California-certified enrollment/outreach entities to follow the same overall program guidelines as well as specific requirements that are relevant to their enrollment/outreach practices.

Please contact me at (909) 890-2010 or email at gilbert-b@iehp.org if you have any questions.

Sincerely,

Bradley P. Gilbert, M.D., M.P.P.
IEHP Chief Executive Officer

P.O. Box 19026, San Bernardino, CA 92423-9026
Tel (909) 890-2000 Fax (909) 890-2003 For TTY Users (909) 890-0731
Visit our website at: www.iehp.org

May 22, 2013

Via E-Mail: info@hbex.ca.gov

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

RE: National Voter Registration Act Implementation

Dear Mr. Lee:

On behalf the undersigned organizations and the Asian Pacific American Legal Center, member of the Asian American Center for Advancing Justice, we would like to express our strong support for the Secretary of State's designation of the California Health Benefit Exchange as a voter registration agency under the National Voter Registration Act (NVRA). We believe that Covered California will emerge as a national leader in NVRA implementation and will become a model for other states on effective and timely compliance with the NVRA's requirements. ***While we understand the pressure Covered California is under to implement many moving pieces in such a short timeline, we urge you to consider making voter registration opportunities available from the launch of Covered California's services.***

Lack of voter registration is one of the most significant voting barriers that Asian American, Native Hawaiian and Pacific Islander citizens face. In California, only 59 percent of Asian Americans who are eligible to vote are registered to vote. Over 1.2 million Asian Americans are eligible but unregistered to vote. This opportunity would be huge for AANHPIs throughout California.

We know the Board understands the importance of civic participation to overall personal and community health. We also know the challenges the Board faces as it prepares for its October 1st launch. However, incorporation of voter registration services into the Exchange's application processes from the onset is an attainable and worthy goal.

First, and unlike other services the Exchange is attempting to offer, voter registration services simply require the addition of the voter preference form and a voter registration card or, in most cases, a link to California's online voter registration system.

Second, incorporating voter registration into the online, phone, mail and in-person applications now – before the applications and attendant processes and trainings are finalized – will ensure that NVRA compliance is uniform and effective from the beginning. In addition, it will save time and money later since the addition of voter registration services to existing processes would be burdensome and likely inconsistent given how decentralized and dispersed the navigators and assisters will be.

Finally, the NVRA designation and the requirement that the Exchange offer voter registration from the onset ensures that every eligible Californian who accesses the Exchange – an anticipated one million consumers in the first year alone – will be given the opportunity to register to vote. This is critical in a state that ranks 45th in the nation in voter registration because one in four eligible Californians are not registered to vote.

Our hope is that the Board will embrace this opportunity to serve consumers rather than see it as an additional burden. Thank you for all you are doing to make California a healthier state.

Sincerely,

Doreena Wong

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

Asian and Pacific Islanders California Action Network (APIsCAN)
Asian Law Alliance
Asian Resources Inc
Chinatown Service Center
Families in Good Health
Guam Communication Network
Korean Churches for Community Development
Korean Community Center of the East Bay
Latin American Community Center
Operation Samahan SDAPI Community Health Network
Orange County Asian and Pacific Islander Community Alliance
South Asian Network

May 22, 2013

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

RE: National Voter Registration Act Implementation

Dear Mr. Lee:

We want to share our excitement over the Secretary of State's designation of the California Health Benefit Exchange as a voter registration agency under the National Voter Registration Act (NVRA). By incorporating voter registration services into all of its application processes, Covered California will lead the nation by offering those services to millions of consumers from the outset. We encourage the Exchange to make this opportunity available to all Californians from the onset.

We know the Board understands the importance of civic participation to overall personal and community health. We also know the challenges the Board faces as it prepares for its October 1st launch. However, incorporation of voter registration services into the Exchange's application processes from the onset is an attainable and worthy goal.

First, and unlike other services the Exchange is attempting to offer, voter registration services simply require the addition of the voter preference form and a voter registration card or, in most cases, a link to California's online voter registration system.

Second, incorporating voter registration into the online, phone, mail and in-person applications now – before the applications and attendant processes and trainings are finalized – will ensure that NVRA compliance is uniform and effective from the beginning. In addition, it will save time and money later since the addition of voter registration services to existing processes would be burdensome and likely inconsistent given how decentralized and dispersed the navigators and assisters will be.

Finally, the NVRA designation and the requirement that the Exchange offer voter registration from the onset ensures that every eligible Californian who accesses the Exchange – an anticipated one million consumers in the first year alone – will be given the opportunity to register to vote. This is critical in a state that ranks 45th in the nation in voter registration because one in four eligible Californians are not registered to vote.

We applaud Secretary Bowen and the Exchange for their work to bring access to online voter registration. California Forward believes that the best government performance occurs when Californians are actively involved in holding their elected accountable. Thank you for all that you are doing to get Californians registered and improve our great state.

Sincerely,

James P. Mayer
Executive Director

Communications Workers of America
AFL-CIO, CLC

501 Third Street, N.W.
Washington, D.C. 20001-2797
202/434-1110 Fax: 202/434-1139

Larry Cohen
President

May 22, 2013

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

Dear Mr. Lee:

Re: National Voter Registration Act Implementation

The Secretary of State's designation of the California Health Benefit Exchange as a voter registration agency under the National Voter Registration Act (NVRA) was historic. California will be a national leader in NVRA implementation. The Exchange must do everything possible to make voter registration opportunities available from the launch of the Exchange's services.

We understand the challenges the Board faces as it prepares for its October 1st launch. However, incorporation of voter registration services into the Exchange's application processes from the onset is an attainable and worthy goal. Voter registration services will require the addition of the voter preference form and a voter registration card or a link to California's online voter registration system. Incorporating voter registration into the online, phone, mail and in-person applications now — before the applications and attendant processes and trainings are finalized — will ensure that NVRA compliance is uniform and effective from the beginning. If not implemented now, the addition of voter registration services will be more costly and burdensome.

The NVRA designation and the requirement that the Exchange offer voter registration from the beginning will ensure that every eligible Californian who accesses the Exchange will be given the opportunity to register to vote. This is critical in a state that ranks 45th in the nation in voter registration because one in four eligible Californians are not registered to vote.

Sincerely,

Larry Cohen
President

UNION CWA LABEL 101

County of Santa Cruz

COUNTY CLERK / ELECTIONS

701 OCEAN STREET, ROOM 210, SANTA CRUZ, CA 95060-4076
831-454-2060 (Elections) 831-454-2470 (County Clerk) TOLL-FREE: 866-282-5900
FAX: 831 454-2445 TDD: 831-454-2123
E-MAIL: gail.pellerin@co.santa-cruz.ca.us
Web Sites: www.votescount.com and www.sccoclerk.com

GAIL L. PELLERIN, COUNTY CLERK

May 22, 2013

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

RE: National Voter Registration Act Implementation

Dear Mr. Lee:

I am writing to express my support for Secretary of State Debra Bowen's decision to designated California Health Benefit Exchange as a voter registration agency under the National Voter Registration Act (NVRA). I also want to tell you how proud I am that the Exchange is willing to take on this new task and that I and my staff are here to assist any way we can to ensure that voter registration opportunities are available from October 1 launch of the new services.

I am confident that the Exchange will be a national leader on NVRA implementation and will set the national bar for effective and timely compliance with the NVRA's requirements. Other agencies we have worked with on implementation of NVRA were overwhelmed at first, but quickly found that voter registration services were easier to implement than they thought.

In most cases, agencies offer either a voter preference form, a voter registration card, or a link to California's online voter registration system.

The Exchange is in a unique opportunity because you are launching a new program with new services. You will be able to incorporate voter registration into the online, phone, mail and in-person applications now to ensure that NVRA compliance is uniform and effective from the beginning.

Moreover, thanks to the addition of the Exchange to the NVRA designated agencies, more than one million Californians who will utilize your services will have access to voter registration. This is critical in a state that ranks 45th in the nation in voter registration because one in four eligible Californians are not registered to vote.

Thank you and the Exchange Board for joining us in this effort to make sure every Californian has access to voter registration. Again, if there is anything I can do to help in providing this vital service to our citizens, please let me know.

Sincerely,

Gail L. Pellerin

Gail L. Pellerin
Santa Cruz County Clerk

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

May 20, 2013

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

National Voter Registration Act Agency Designation

Dear Mr. Lee:

In light of the California Health Benefit Exchanges recent designation as a voter registration agency under the National Voter Registration Act (NVRA) Section 7,[1] The Greenlining Institute would like to offer its comments to the board and staff to assist with effective implementation of voter registration services at the Exchange.

We commend Secretary of State Debra Bowen for properly recognizing Covered California as a public assistance agency, and for creating an opportunity for the millions of newly eligible Californians who will be purchasing health insurance through the Exchange, to also register to vote.

Voting correlates with certain health benefits. For example, voting has been linked to personal efficacy, a feeling of empowerment that positively affects mental health. Communities that vote are also better represented in government and receive more attention as a result, reaping benefits such as greater social capital, less crime, more connectivity, better services, and better health.

As a voter registration agency, the Exchange will now have the opportunity to provide voter registration services each time a person applies for services or assistance, requests renewal, or requests a change of address.

Voter registration services include: Providing a voter preference form that asks the applicant if they would like to register to vote; explaining that voter registration is available and not a condition of receiving benefits; assisting applicants that request help with completing a voter registration card; and sending completed voter registration cards to the appropriate elections official.

---

[1] Secretary of State letter and official designation found here: http://www.sos.ca.gov/elections/nvra/laws-standards/pdf/chbe.pdf

In addition to what the NVRA requires, in 2012, California passed Senate Bill 35,[2] which codified best practices for NVRA implementation and requires California voter registration agencies to: 1) notify election officials of each site in the county, in this case, Assister Entities, 2) designate state and local NVRA coordinators, 3) provide an annual training for every person who provides voter registration services, 4) offer forms in top threshold languages for limited English proficient individuals, and 5) integrate an online voter preference form and online voter registration form if the agency offers online services.

We do recognize the challenges facing Covered California to ensure there is compliance with both the NVRA and SB 35 at the onset, both online and offline. It is critical that effective voter registration policies and practices are implemented at the onset so that a maximum number of eligible Californians can take advantage of this opportunity.

We offer the following recommendations as you begin to think about implementation:

- **Embrace this opportunity as an additional way to improve health outcomes through voting, and prioritize the implementation of voter registration services the same as any other services provided by the Exchange.** Do not put off implementation of voter registration services. Not only will it be most cost-effective to implement this program from the beginning, it is also the best way to ensure a maximum number of newly eligible enrollees will have access to voter registration opportunities. By viewing this as an additional opportunity to serve consumers, rather than a burden, you will improve the Exchange's ability to stay in compliance as the attitude taken by the Exchange Board and its staff will have a trickle down affect to navigators and assisters who will ultimately assist consumers. If assisters and navigators don't think voter registration services are important to you, they may not think it is all that important for them to provide this service.

- **Integrate online voter registration services into the web portal where a consumer may engage in enrollment, renewal or change of service, or change of address transactions.** It is not sufficient to simply integrate voter registration during one of these transactions or on a main page; it must be integrated for each type of transaction to comply with the law. This is true of telephone or paper-based transactions too..

- **Do provide voter registration services in all applicable languages.** Voter preference forms and voter registration forms (paper-based, phone, or online) should be available in the top threshold languages as outlined in Senate Bill 35. In California, depending on the county where operating, this could include at least: Chinese, Hindi, Japanese, Khmer, Korean, Spanish, Tagalog, Thai, and Vietnamese. However, since Covered California will be providing other material in the top 13

[2] Senate Bill 35 can be found here:
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB35&search_keywords=

threshold languages, we would encourage you to do the same for voter registration materials. Although currently the Secretary of State has not provided an online voter registration system that is translated beyond Spanish, the Exchange should push the Secretary to make the online voter registration system language accessible so that it may comply with the entirety of the law. This is in line with the Exchange's priority to provide culturally and linguistically competent and appropriate service.

- **Integrate voter registration and NVRA compliance training for assisters and navigators from the onset, especially as it relates to offline transactions.** Online NVRA implementation is important but does not, in isolation, fulfill the Exchange's obligations as a voter registration agency. Assisters and navigators must be able to assist consumers who will be enrolling both online and offline. The most efficient way to train them will be to integrate NVRA and SB 35 compliance curriculum into their initial training. It could be costly to re-train assisters and navigators who are brought on during this early stage if they are not properly informed and trained on their obligations from the beginning. It could also make the Exchange non-compliant if assisters and navigators are not following NVRA regulations.

We are here to help. The Greenlining Institute, in partnership with the ACLU of San Diego, can assist staff by providing training materials and technical assistance throughout implementation. Our organizations are already working together on NVRA and SB 35 implementation at traditional public assistance agencies and can share our experience. We look forward to the effective implementation of voter registration services at the Exchange and offer our help wherever we can.

Sincerely,

Michelle Romero
Claiming Our Democracy Director

Carla Saporta
Health Policy Director

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

Greenlining Coalition:
Allen Temple Baptist Church
American GI Forum
AnewAmerica
Asian Business Assn
Asian Inc
Black Business Assn.
Brightline Defense Project
California Black Chamber
California Hispanic Chambers
California Journal for FilAm
California Rural Legal Assistance
Chicana/Latina Foundation
Chicano Federation, San Diego
Community Child Care Council
Community Resource Project
Council of Asian American Business Assn.
El Concilio of San Mateo County
Ella Baker Center
FAME Renaissance
Greater Phoenix Area Urban League
Hispanic American Growers Assn.
Hmong American Political Assn.
KHEIR Center
La Maestra Family Clinic
Mexican American Grocers Assn.
Mexican American Political Assn.
Mission Language & Vocational School
Mission Housing Development Corporation
National Federation of Filipino American Assn.
Oakland Citizens Committee for Urban Renewal
Our Weekly
Precinct Reporter Group
Sacramento Observer
San Francisco African American Chamber
San Francisco Housing Development
Search to Involve Pilipino-Americans
Southeast Asian Community Center
TELACU
Ward Economic Development
West Angeles Community Development

Board of Directors:
Rosario Anaya
Robert Apodaca
Jessie Buendia
George Dean
Alfred Fraijo, Jr.
Yusef Freeman
David Glover
Ortensia Lopez
Darlene Mar
Olga Talamante
Tunua Thrash
Executive Director: Orson Aguilar
General Counsel: Samuel S. Kang
Program Directors:
Daniel Byrd
Stephanie Chen
Virginia Hill
Janine Macbeth
Braelan Murray
Claudia Paredes
Michelle Romero
Carla Saporta
Vien Truong
Preeti Vissa

May 22, 2013

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

Dear Mr. Lee,

Rock the Vote was very excited to learn about the California Health Benefit Exchange's designation as a voter registration agency under the National Voter Registration Act (NVRA) by the Secretary of State last week. This will truly establish the Exchange as a national leader in NVRA implementation and set the national bar for both timely and effective compliance with the various NVRA-related requirements. We recognize that the next four months will be very busy, as you gear up for the launch of the Exchange's services, but urge you and your team to do everything possible to ensure the voter registration opportunities are available by October.

Rock the Vote is a national, nonpartisan advocacy organization with a mission to engage and build political power for young people in our country. We do this by engaging them in the electoral process, urging politicians to pay attention to issues that matter to young voters, and protecting their fundamental right to vote. Using music, popular culture, new technologies, and grassroots organizing for more than 20 years, Rock the Vote has registered more than 5 million young people, including a record-shattering 2.25 million registration downloads in the historic 2008 election.

We know that the Board understands the importance of civic participation to overall personal and community health. We share this value. We also know that the challenges in these coming months may be overwhelming. Please know that you have the full support of Rock the Vote and we are happy to be a reference or even sounding point as you take this on. The incorporation of voter registration services in the Exchange's application process is an ambitious, but fully attainable goal – and certainly worthy.

There are many reasons. Here are a few:

1) Voter registration, unlike the other services that the Exchange will offer, simply requires the addition of the voter preference form and a voter registration card or, in most cases, a link to the online voter registration system.

2) By incorporating voter registration into the online, phone, mail, and in-person applications now will ensure that the NVRA compliance is uniform and effective – throughout the various applications, attendant processes and trainings.

1001 Connecticut Ave. NW • Suite 640 • Washington, DC 20036 • Phone 202.719.9910 • Web www.rockthevote.com

3) This will also save time and money, since doing this work later would be more burdensome and likely inconsistent given how decentralized and dispersed the navigators and assistors will be.

4) The NVRA designation and the requirement that the Exchange offer voter registration from the onset ensures that every eligible Californian who will access the Exchange – an anticipated <u>one million consumers</u> in the first year alone – will have an opportunity to register to vote. We would not be Rock the Vote if we did not note that the importance of this work – since California currently ranks 45th in the nation in voter registration. Only one in four eligible Californians are not registered to vote.

We have two decades of experience with voter registration, and take great pride in the innovative technologies we have pioneered to make voter registration more accessible to the communities that we work with. We are happy to share best practices and other guidance as you take on this work.

We do hope that you can appreciate the significant role you will play and fully embrace this opportunity to provide voter registration to consumers. Please consider this line of communication open. And thank you again for all you are doing to make California healthy, and your leadership

Sincerely,

Heather Smith
President, Rock the Vote

1001 Connecticut Ave. NW • Suite 640 • Washington, DC 20036 • Phone 202.719.9910 • Web www.rockthevote.com

UAW Local 4123

1228 "N" St., Ste. 34, Sacramento, CA 95814 • Phone (916) 498-8452 • Fax (916) 498-8337 • union@uaw4123.org

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

RE: National Voter Registration Act Implementation

Dear Mr. Lee:

UAW Local 4123, representing over 6,000 Teaching Assistants, Graduate Assistants, and Tutors at the California State Universities, we want to share our excitement over the Secretary of State's designation of the California Health Benefit Exchange as a voter registration agency under the National Voter Registration Act (NVRA). We are confident the Exchange will emerge as a national leader in NVRA implementation and will set the national bar for effective and timely compliance with the NVRA's requirements. ***We urge the Exchange to do everything possible to make voter registration opportunities available from the launch of the Exchange's services.***

We know the Board understands the importance of civic participation to overall personal and community health. We also know the challenges the Board faces as it prepares for its October 1st launch. However, incorporation of voter registration services into the Exchange's application processes from the onset is an attainable and worthy goal.

First, and unlike other services the Exchange is attempting to offer, voter registration services simply require the addition of the voter preference form and a voter registration card or, in most cases, a link to California's online voter registration system.

Second, incorporating voter registration into the online, phone, mail and in-person applications now – before the applications and attendant processes and trainings are finalized – will ensure that NVRA compliance is uniform and effective from the beginning. In addition, it will save time and money later since the addition of voter registration services to existing processes would be burdensome and likely inconsistent given how decentralized and dispersed the navigators and assisters will be.

Finally, the NVRA designation and the requirement that the Exchange offer voter registration from the onset ensures that every eligible Californian who accesses the Exchange – an anticipated one million consumers in the first year alone – will be given the opportunity to register to vote. This is critical in a state that ranks 45th in the nation in voter registration because one in four eligible Californians are not registered to vote.

Our hope is that the Board will embrace this opportunity to serve consumers rather than see it as an additional burden. Thank you for all you are doing to make California a healthier state.

Sincerely,

Rich Anderson
President, UAW Local 4123

LOCAL 5810
2070 Allston Way, Suite 102
Berkeley, CA 94704

p: 510-845-5726 f: 510-845-5863
uaw5810@uaw5810.org
www.uaw5810.org

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

RE: National Voter Registration Act Implementation

Dear Mr. Lee:

On behalf of UAW Local 5810, the union for over 6,000 postdoctoral researchers at the University of California, we applaud the Secretary of State's designation of the California Health Benefit Exchange as a voter registration agency under the National Voter Registration Act (NVRA). This is an important step toward increasing voting access and California can serve as a model for other states in terms of effective and timely compliance with the NVRA's requirements. **We urge the Exchange to do everything possible to make voter registration opportunities available from the launch of the Exchange's services.**

Many studies have shown the importance of civic participation to overall personal and community health, and while incorporating voter registration services into the Exchange's launch on October 1 is a challenge, we think it is an attainable and worthy goal. Despite the limited time, integration from the start should be straightforward and will be most effective for NVRA compliance and maximizing access to voter registration.

First, voter registration services simply require the addition of the voter preference form and a voter registration card or, in most cases, a link to California's online voter registration system.

Second, incorporating voter registration into the online, phone, mail and in-person applications now – before the applications and attendant processes and trainings are finalized – will ensure that NVRA compliance is uniform and effective from the beginning. In addition, it will save time and money later since the addition of voter registration services to existing processes would be burdensome and likely inconsistent given how decentralized and dispersed the navigators and assisters will be.

Finally, the NVRA designation and the requirement that the Exchange offer voter registration from the onset ensures that every eligible Californian who accesses the Exchange – an anticipated one million consumers in the first year alone – will be given

the opportunity to register to vote. This is critical since one in four eligible Californians are not registered to vote, resulting in California ranking 45th in the nation in voter registration. Our union includes a significant number of newly naturalized citizens and we also move frequently due to the nature of the job market, both of which make facilitating voter registration an important issue to our members.

Our hope is that the Board will embrace this opportunity to serve consumers and contribute to a fostering democratic participation in our state. Thank you for all you do to make California a healthier place to live.

Sincerely,

Neal Sweeney, Ph.D.
President, UAW Local 5810

BOARD OF DIRECTORS

Genoveva Islas-Hooker, MPH
Board Chair
Regional Program Director, Central California Regional Obesity Prevention Program

George Flores, MD, MPH
Board Vice-Chair
Program Manager
The California Endowment

Carmela Castellano-Garcia, Esq.,
Board Treasurer
President and CEO, California Primary Care Association

Robert Garcia, Esq.
Founding Director and Counsel
The City Project

Howard A. Kahn
Chief Executive Officer
L.A. Care Health Plan

Carmen Rita Nevárez, MD, MPH
Vice President of External Relations & Preventive Medicine Advisor
Public Health Institute

Gilbert Ojeda
Director, California Program on Access to Care
UC Berkeley, School of Public Health

Michael A. Rodriguez, MD, MPH
Professor & Vice Chair of Research, UCLA, Department of Family Medicine

Brenda Solórzano, Esq.
Chief Program Director & Director
Health Care and Coverage
Blue Shield of California Foundation

Adela de la Torre, PhD
Interim Vice Chancellor, Student Affairs, UC Davis

Xóchitl Castañeda
Director, Health Initiative of Americas School of Public Health, UC Berkeley

STAFF

Xavier Morales, Ph.D.
Executive Director

Diana Garza
Office Manager

Chad M. Silva, JD
Policy Director

+Affiliation for Identification Only
LCHC is a project of the Tides Center, a nonprofit public charity exempt from federal income tax under sections 501(c)(3) and 509(a)(1) of the Internal Revenue Code.

May 1, 2013

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

RE: Comments to Covered California: Outreach and Education Grant Program

Director Lee:

The Latino Coalition for a Healthy California is pleased to provide comments regarding Covered California's Outreach and Education Grant Program. As a trusted voice for Latino health for over 20 years, we have assisted decision-makers throughout California to develop policies, services and the social, economic, and environmental conditions that improve the health of Latinos. Considering the preponderance of Latinos among the millions of residents newly eligible to enroll in Covered California, and in the spirit of our common interests to improve the health of all Californians, we offer some recommendations for strengthening the Outreach and Education program.

Discussion

In reviewing the RFP, the priority to reach Latinos is quite apparent. However, it is also our observation that the wording of the RFP—specifically that of the review criteria—seemed to favor large urban organizations, which -de-emphasizes the reality that many rural counties have the highest percentages of Latinos as a function of total county population.

Specifically, The First Cycle RFP's Guiding Principles state that Covered California will "target resources based on the greatest opportunity to reach the highest number of uninsured and subsidy eligible individuals." Covered California's effort to primarily focus on volume versus reaching essential specific populations is a concern. Marketing through large volume media that focus primarily on larger urban areas in the outreach and enrollment process may shortchange the ability to target smaller harder-to-reach populations and rural areas.

Moreover, the First Cycle RFP is written in such way that it may have discouraged small non-profits that do not have the ability to engage in cost reimbursement contracts. Many of these smaller non-profit organizations are the very ones that have been successful in conducting the outreach and enrollment of hard-to-reach Latino populations – such as limited English proficient, homebound, migratory agricultural industry workers, and mixed legal status families.

As the Outreach and Education Grant Program is unfolding, including a robust Second Cycle, we remain concerned about the following:

- The complexity and often conflicting nature of application documentation including supplemental documents, such as the Question and Answers;
- The need for assurances that funding would be available to successful awardees on a timely basis through an advance funding and/or expedited reimbursements;
- The need for a technical assistance process in Second Cycle to help smaller, non-profit community agencies to navigate the RFP process; and

Latino Coalition for a Healthy California
1225 Eighth Street, Suite 550
Sacramento, CA 95814
Telephone: (916) 448-3234 * Fax: (916) 448-3248
Web Site: www.lchc.org

- An outreach and enrollment process that is clearly linked to the new media campaign infrastructure can be leveraged to play a significant role in improving health literacy and improving health system navigation.

Recommendations

In light of these observations, we make the following specific recommendations.

- Through its final First Cycle decisions and its Second Cycle approach, Covered California supplement its large volume approach with a targeted approach aimed at rural and more difficult to reach Latino populations.

- The review process for First Cycle specifically seeks outreach and education contractors that demonstrate capacity to reach these populations through personal or direct organizational contact.

- **Substantial funding should be set aside for a Second Cycle RFP to fill gaps in First Cycle Outreach and Education.** These funds should target geographic areas that were overlooked and populations that may have been missed.

- Second Cycle funding for outreach and education prioritize support for smaller non-profit organizations, particularly ones that demonstrate capacity to make personal contact with remote and other difficult to reach populations

- Funding should be dedicated to utilize the Outreach and Education workforce and infrastructure to also provide education to improve health literacy and improve appropriate health system navigation.

Thank you for the opportunity to provide these comments. We recognize the complexity of implementing Covered California, and express our wish to partner with you to assure that the largest possible target population is enrolled and educated in a manner that is equitable and sustainable over the long term.

Sincerely,

Xavier Morales
Executive Director

c.c.: Latino Coalition Board members
Senator Ricardo Lara, Chair of Latino Legislative Caucus

Via Email

May 10, 2013

Juli Baker
Chief Technology Officer
Covered California

Len Finocchio
Associate Director
California Department of Health Care Services

Dear Ms. Baker and Mr. Finocchio:

Consumers Union writes with some questions and recommendations concerning the webinar presentation on May 1, 2013 regarding "Customer Service Center Quick Sort Transfers to Counties/Consortia: Service Standards and Contingencies."

1. Regarding **performance standards (**Slide 11), the proposed Quick Sort Service Level suggests that even for those cases considered to meet the 80%/30 second standard, the wait would actually be considerably longer for consumers. First, consumers calling the Exchange Service Center may be subject to a 30 second period until the call is answered at the Exchange. Then, after the Quick Sort they will also potentially be subject to a 30 second wait to get to the Consortium. As we read the slides, another 30 second wait could be imposed if the Consortium wants/needs to transfer them to a particular county. If so, consumers will face a 30+30+30 second timeframe. Are we correct about these timeframes? If so, we urge you instead limit the wait times (before contingency plans kick in) to one minute total—30 seconds at the Exchange level and 30 seconds for the warm hand-off.

2. Slide 5 suggests that Consortia will route calls "automatically, invisibly, and instantaneously to participating county customer service centers for a warm hand-off." Another bullet states that the calls will go to "the county of residence, if agent is available, or another available agent in that network." Will some county customer service **centers NOT be participating**? Is it true that not all counties have customer service centers with phone capability? If so, does that mean some callers will be routed elsewhere, defeating the stated goal of getting to the county of residence?

3. Is the transferring system a "**first available agent system**" so wait times are limited and transfers smooth?

4. For those calls that do not meet the service level standard of 30 seconds, we urge choosing as the **contingency plan** that the Covered California Service Center handles the call. See Slide 14 options. Transferring to a different Consortium does not meet the stated purpose of the Quick Sort of having such calls handled by the County of residence, and

West Coast Office
1535 Mission Street • San Francisco, CA 94103-2512
(415) 461-6747• (415) 431-0906 (fax)
www.consumersunion.org

from the consumer perspective every transfer—especially after a significant wait—is an opportunity to be dropped, feel ill-served, or just become frustrated and give up. If, as we understand it, the county SAWS systems can access the full application in CALHEERS at a later point, even a Medi-Cal-eligible person's case would be easily and promptly transferred to the appropriate County for case management.

5. As to **monitoring and measuring service level performance** (Slide 11):
   - We continue to advocate for measurement on the individual consumer experience, rather than aggregate level consumer experience. We suggest that while contract/MOU penalties and corrective actions might appropriately be based on the aggregate approach, including termination of agreements and structural shifts in call handling, the individual experience is what counts for consumers.
   - In answer to the question on Slide 12, during any cure period the contingency plan should be handling of calls by the Service Center so as not to subject consumers to performance problems and to preserve Covered California's reputation.
   - As to the right measurement period, monitoring needs to be frequent enough to catch problems before they are beyond repair, but not so frequent as to over-tax Exchange Service center staff. Weekly periods may strike the right balance.

6. As set forth on Slide 8, the Quick Sort would require 8 questions, including county of residence. That is expanded from the 4-5 previously discussed, and means more **duplicative questions** will need to be asked. And because none of this information will be stored in CALHEERS, it means **duplicative work** for intake workers at the Service Center and the counties, right?

7. Which entity or entities will be collecting the service level measurements and tracking to 80%/30 second data? Consortia or Covered California? And will it be publicly available?

8. Slide 5 helpfully notes that callers will be routed according to language choice, as well as county of residence. We suggest that, vis a vis Slide 6, language capability is one of the issues that should be inventoried and planned for by counties as it will directly impact routing. Assuming that not all counties have capacity for 13 threshold languages, we recommend that where the relevant language capacity does not exist in the county of residence the contingency be a translation telephone line at the Exchange Service Center.

Thank you for this opportunity to comment. We look forward to working with DHCS and Covered California to ensure a first-class consumer experience that builds public trust in both agencies and the ACA.

Sincerely,

Betsy Imholz
Special Projects Director

Supplemental Benefit Comment and Supporting Materials Received via E-mail

Subject: VSP - Letter - Proposal to Covered California for Supplemental Vision Coverage Benefits and Supporting Materials

THIS E-MAIL IS AN INTRODUCTION TO THE ATTACHED DOCUMENTS

Board of Directors
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

To the Members of the Board of Covered California:

On behalf of VSP Global, I'm pleased to submit the attached "turn-key" proposal and supporting materials that would provide for the offering of supplemental vision benefits beginning as soon as open enrollment in October 2013, with implementation as of January 2013.

The Covered California Board meeting presentation of April 23, 2013, charted a collaborative course for work by Covered California with stakeholder partners, such as our client, VSP Global, to assess other federally-permissible options for offering stand-alone and/or supplemental vision benefits beginning as soon as possible. However, the presentation contemplated a, perhaps, unnecessarily lengthy deferred implementation goal.

VSP Global maintains that, with no impact and no cost to Covered California, a solution that is in full compliance with federal guidance can, and should, begin consonant with the October 1, 2013, opening of enrollment in Covered California plan offerings, with a January 1, 2014 effective date for non-EHB/Supplemental vision coverage. We would respectfully urge the Covered California Board to make a decision to allow VSP and stand-alone vision plans to provide Supplemental Vision coverage in this manner.

In short, with little more than a "link" to the sources for Supplemental Vision coverage, Californians utilizing the Exchange will enjoy the fullest options available to secure coverage.

We look forward to proceeding with Covered California on next steps in this matter.

Respectfully submitted,

John R. Valencia
Partner
Wilke, Fleury, Hoffelt, Gould & Birney, LLP
400 Capitol Mall, 22nd Floor
Sacramento, CA 95814
O: (916) 441-2430
Fx: (916) 442-6664
jvalencia@wilkefleury.com
www.wilkefleury.com

WILKE, FLEURY, HOFFELT, GOULD & BIRNEY, LLP

TWENTY-SECOND FLOOR
400 CAPITOL MALL
SACRAMENTO, CALIFORNIA 95814

WWW.WILKEFLEURY.COM

TELEPHONE (916) 441-2430

FACSIMILE (916) 442-6664

SCOTT L. GASSAWAY
ERNEST JAMES KRTIL
ROBERT R. MIRKIN
MATTHEW W. POWELL
STEPHEN K. MARMADUKE
DAVID A. FRENZNICK
JOHN R. VALENCIA
KELLI M. KENNADAY
MICHAEL G. POLIS
DANIEL L. EGAN
DANIEL L. BAXTER
RONALD R. LAMB
MEGAN A. LEWIS
TREVOR L. STAPLETON
CURTIS S. LEAVITT
MICHAEL J. DAPONDE

RICHARD H. HOFFELT (RET.)
WILLIAM A. GOULD, JR.
PHILLIP R. BIRNEY
ROBERT F. TYLER, JR.
GENE E. PENDERGAST, JR.
THOMAS G. REDMON
KELLY A. RYAN

ANTHONY R. EATON
STEVEN J. WILLIAMSON
LATIKA SHARMA
SAMSON R. ELSBERND
STACY M. HUNTER
BIANCA S. WATTS
TROY R. SZABO

May 15, 2013

JVALENCIA@WILKEFLEURY.COM

VIA E-MAIL David.Panush@covered.ca.gov

Mr. David Panush
Director of External Affairs
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Re: VSP Global "Turn-Key" Proposal for Supplemental Vision Coverage
Covered California – Action Item V.C Supplemental Benefits, May 23, 2013

Dear David:

At its April 23, 2013, meeting, the Covered California Board received your report on federal agency guidance concluding that ancillary insurance products, which are not qualified health plans (QHPs), may be offered by separate state programs that share resources and infrastructure with a State-based Exchange, such as Covered California, provided certain conditions are met. These include:

1. The Exchange neither provides services nor makes non-QHPs available in a manner that is prohibited or inconsistent with the Affordable Care Act.

2. The agency or program facilitating the coverage must be legally and publicly distinct from the Exchange.

3. Federal funds must not be used to support these "non-Exchange activities" and Exchange user fees and assessments may not be used to support these non-Exchange activities.

4. To the extent that an Exchange resource is used for non-Exchange purposes, the cost of using the resource must be paid by the other, non-Exchange state program.

The Board meeting presentation charted a collaborative course for work by Covered California with stakeholder partners, such as our client, VSP Global, to assess other federally-permissible options for offering stand-alone and/or supplemental vision benefits beginning as soon as possible, but contemplated an unnecessarily lengthy deferred implementation goal.

VSP Global maintains that, with no impact and no cost to Covered California, a solution that is in full compliance with federal guidance can, and should, begin consonant with the October 1, 2013, opening of enrollment in Covered California plan offerings, with a January 1, 2014 effective date for non-EHB/Supplemental vision coverage. We would respectfully urge the Covered California Board to make a decision to allow VSP and stand-alone vision plans to provide Supplemental Vision coverage in this manner.

In short, with little more than a “link” to the sources for Supplemental Vision coverage, Californians utilizing the Exchange will enjoy the fullest options available to secure coverage.

In this collaborative vein, we submit the attached proposal, and supporting materials, for proceeding with Supplemental Vision services and benefits at the earliest opportunity.

1. Non-EHB Vision CA – A Proposal to provide compliant non-EHB/Supplemental Vision services and benefits at no cost to Covered California.

2. Exchange Website CA – Screen shots from the proposed VSP Individual Plan offering website to be co-branded with Covered California.

3. “Why Everyone Needs Vision Care” - A Sample broker or navigator communication piece describing the importance and cost savings of quality vision care. With appropriate co-branding, this would be specifically tailored for Covered California.

4. Distribution Channels Flier – An additional sample broker or navigator communication piece motivating communications on the non-EHB/Supplemental offering of vision care for Individuals. Again, with appropriate co-branding, this would be specifically tailored for Covered California.

We note, with optimism for similar achievement in California, that the State of Colorado Exchange (Connect for Health Colorado) is in the final stages of obtaining exchange board approval for this approach. Similarly, the Nevada Exchange (Nevada Health Link) is presently considering a similar proposal as that submitted herein for Covered California.

Our immediate goal in preparing this information in this fashion was to make it as short and to the point as possible.

As such pointed brevity may leave a few open questions, VSP Global is committed convening the appropriate team to meet and confer with Covered California staff or answer your questions in any format, prior to the May 23, 2013, Covered California Board meeting.

Please do not hesitate to call on me at (916) 441-2430, or by e-mail at jvalencia@wilkefleury.com.

Respectfully submitted,

JOHN R. VALENCIA

JRV:mab
Attachments (4)
cc: Board of Directors, Covered California
via info@hbex.ca.gov

952707.1

Why Everyone Needs Vision Care

Vision is more critical to a benefits package than you might think. In fact, **84%** of employees state this benefit is important to them. Employees who are enrolled in this benefit are nearly **twice as likely to be satisfied** with their benefits program.

A Benefit Your Employees Need

75%	120 million	$51 billion
U.S. adult population that wears some form of vision correction[1]	People in the U.S. are affected with eye-health problems[2]	Economic cost of eye and vision disorders in the U.S.[3]

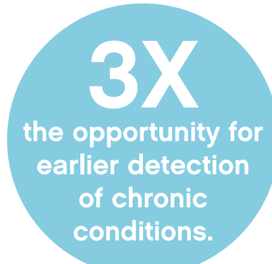
Smarter Vision Care doubles as preventive healthcare.

A comprehensive WellVision Exam® promotes good vision and supports overall health and wellness. VSP Providers are often the first to detect signs of serious and costly chronic conditions before other healthcare providers[4]:

Diabetes:	Hypertension:	High Cholesterol:
20%	30%	65%
of the time	of the time	of the time

1:5 Americans get annual physical exams.

3:5 members get annual eye exams.



Increase productivity. Lower healthcare costs.

Earlier detection of chronic conditions leads to higher productivity, retention, and lowers healthcare costs. For every employee who sought care after early detection during a VSP eye exam, our clients saved the following over two years:

Diabetes:	Hypertension:	High Cholesterol:
$2,787	$2,997	$1,145

It all adds up to $4.5 billion in savings.

Considering the potential implications for health, safety, and productivity, you can't afford not to offer vision.

Contact your VSP representative to see how a small investment in Smarter Vision Care pays big benefits.

[1]VisionWatch, a study conducted by the Vision Council, 12ME December, 2011
[2]National Eye Institute
[3]Prevent Blindness America, 2007
[4]Human Capital Management Services, Inc. (HCMS) study on behalf of VSP, 2010

®2012 Vision Service Plan. All rights reserved.
VSP is a registered trademark and Smarter Vision Care is a trademark of Vision Service Plan

JOB#9285CL 6/12

Offer Affordable Individual and Family Vision Insurance through VSP® Vision Care

VSP Vision care

Deliver the best service and value to your customers by offering individual and family vision insurance from VSP. As the only national not-for-profit vision care company, VSP reinvests in the things your customers value most—the best care at the lowest out-of-pocket costs. Putting members first has made VSP consumers' #1 choice in vision care.[1]

VSP delivers what consumers want.

Low Out-of-pocket Costs

- Wholesale pricing guarantee on a wide selection of frames
- Cost controls on frames and lens options
- Fully covered polycarbonate lenses for children
- Exclusive rebates for new and replacement contact lenses

Network Access and Locations

- Largest national network of private-practice doctors
- Early morning, evening, and weekend appointments
- Access to national retail chains

Quality Customer Service

- Industry leader in member satisfaction[2]
- World class customer service call center[3]
- Rated highest on easy-to-use benefits[4]

When you sell VSP, you win.

- Commissions paid on every enrollment
- Robust and hassle-free administration
- Delivers the best value and service to your clients

Everyone Needs Vision Insurance

80% of the U.S. adult population wears some form of vision correction.[5]

120 million people in the U.S. have eye-health problems.[6]

Vision care is the most requested ancillary benefit other than dental.[7]

Don't wait. Start selling VSP individual insurance today.

Contact your VSP sales representative to get started: 800.852.7600.

1. Ipsos National Vision Plan Member Research, 2012. **2.** Ipsos, 2012. **3.** Service Quality Management, Inc. 2012. **4.** Ipsos, 2012. **5.** VisionWatch, a study conducted by the Vision Council, Dec 12ME 2011. **6.** VisionWatch, 2011. **7.** VisionWatch, 2011.

©2013 Vision Service Plan. All rights reserved.
VSP is a registered trademark of Vision Service Plan.

Non-EHB/Supplemental Vision Proposal
For Covered California

Background:
Covered California (CC) Exchange staff held a conference call with VSP on April 16, 2013 to discuss the *CMS/FAQ on the reuse of Exchanges for Ancillary products* issued on March 29th, 2013. Exchange personnel indicated the terms of this FAQ inhibit the ability of Covered California to allow VSP and Stand-Alone Vision Plans (SAVP) to provide coverage associated with the Exchanges, any time before July 1, 2014 or later. Exchange personnel indicated an interest in reviewing a VSP proposal to provide non-Essential Health Benefit (EHB) vision services and benefits in compliance with the *CMS/FAQ*.

Proposal:
VSP and SAVP seek approval of the Covered California Board of Directors to authorize the simple provision of a utility to link Exchange participants directly with VSP/SAVP as part of the same Covered California enrollment experience. Upon the successful conclusion of non-EHB/Supplemental vision enrollment, the participant will be linked back to the Covered California website.

The non-EHB/Supplemental offering of said vision services and benefits will be at no cost to Covered California and with little or no administrative impact. VSP and SAVP understand that Covered California participants that select non-EHB/Supplemental coverage will not receive federal subsidies and will enter into a private transaction for individual vision coverage with the vision carrier.

We specifically ask the Covered California Board of Directors at the upcoming May 23rd, 2013 meeting to make the decision to allow VSP/SAVP to provide these services in this way. Due to the lack of impact or cost to Covered California as requested in the April 16th conference call and since the recommended solution will be in compliance with the *CMS/FAQ*, VSP respectfully requests the inception of this offering be reconsidered for the 10/1/13 beginning of enrollment, for a January 1, 2014 effective date for non-EHB/Supplemental vision coverage.

Demo Navigation:
The attached contains an expansion of the proposed VSP landing page to accomplish the non-EHB/Supplemental enrollment in just a few clicks or over the phone.

<u>Administrative Responsibilities:</u>

Covered California:

- ✓ Provides web and telephone links to VSP/SAVP landing page (personalized for Covered California)

VSP/SAVP:

- ✓ Provides user with plan information
- ✓ Provides easy online enrollment
- ✓ Collects subscriber information
- ✓ Processes subscriber payment (in annual or monthly payments)
- ✓ Fulfills new subscriber welcome kit/ID card (electronically)
- ✓ Provides Covered California (CC) with monthly report of link activity (clicks/conversions/etc.)
- ✓ Pays commissions to CC (monthly)
- ✓ Provides CC with monthly report of new members enrolled
- ✓ Provides optional monthly member communication (EnVision e-newsletter)
- ✓ Provides Customer Service for ongoing questions or claims issues
- ✓ Sends renewal notices to subscribers
- ✓ Processes renewal credit card payment automatically

<u>About VSP and vision benefits</u>:

VSP is the nation's largest provider of eyecare coverage, headquartered in California for nearly 60 years. The California footprint for VSP includes significant support for the 'typical employer' requirement in the Affordable Care Act (ACA):

- Currently 93% of vision coverage in California is provided through stand-alone vision plans, like VSP.
- A tax-paying not-for-profit vision insurance company that is the leading provider of preventive vision services in the country.
- Preventive vision benefits provided on a bundled basis – through healthplans, have half the utilization as when delivered by Stand-Alone vision plans.
- Support for small business owners by working through more than 5,000 private-practice California eye doctors in more than 6,400 locations statewide.
- Approximately 14 million, or 1 in 3, California covered members – this is a larger membership than Anthem Blue Cross, Kaiser and Blue Shield medical combined.
- Coverage to more than 11,100 California employers, 8,475 of which are small businesses with less than 100 employees. 7,175 of these small businesses have less than 50 employees.
- Jobs provided to more than 2,100 people in this state.
- An average of $5.4 million in tax payments a year.

AS/kf
5/13/13

Covered California logo here

Return to Covered California

01 INDIVIDUAL PLANS | 02 SELECT A PLAN | 03 GET RATES | 04 ENROLL

AFFORDABLE PLANS FOR INDIVIDUALS & FAMILIES IN CALIFORNIA

YOU DON'T HAVE TO WORK FOR A LARGE COMPANY TO GET THE BEST VISION INSURANCE COVERAGE.

PURCHASE YOUR VSP VISION PLAN FOR AS LITTLE AS 41 CENTS A DAY*

*Based on annual rates. Rates and fees vary by state.

PURCHASE A PLAN DIRECTLY FROM VSP

HOW WILL MY VISION PLAN BENEFIT ME?

SEE YOUR SAVINGS

WHY IS MY VISION HEALTH SO IMPORTANT?

TAKE A LOOK

WHAT MAKES VSP THE BEST CHOICE?

GET THE SCOOP

For questions not covered on the website, please call 800.785.0699.

©2012 Vision Service Plan. All rights reserved.

Choose a VSP Worldwide Site

01 INDIVIDUAL PLANS 02 SELECT A PLAN 03 GET RATES 04 ENROLL

HOW WILL MY VISION PLAN BENEFIT ME?

Vision insurance gives you access to the services and products you need to care for your eyes. Of course you could choose to pay for these entirely out-of-pocket, but with a VSP insurance plan you'll realize substantial savings while receiving the personalized care you deserve.

TYPICAL SAVINGS ON AN INDIVIDUAL PLAN:

	WITHOUT VSP	WITH VSP
EYE EXAM	$144	$15
FRAME	$120	$25
SINGLE VISION LENSES	$86	
ANTI-REFLECTIVE COATING	$107	$69
TRANSITIONS® LENSES	$99	$70
POLYCARBONATE LENSES	$53	$31
MEMBER ANNUAL PREMIUM		$182
TOTAL OUT-OF-POCKET	**$609**	**$392**

Comparison based on national averages for comprehensive eye exams and most commonly purchased brands. This chart represents a typical savings for VSP members.

No vision insurance through an employer? No worries. In just minutes you could enroll in an individual or family plan through VSP that can save you hundreds of dollars. Select a Plan

WHY ENROLL

SEE VSP TV AD

01 INDIVIDUAL PLANS 02 SELECT A PLAN 03 GET RATES 04 ENROLL

WHY IS VISION HEALTH SO IMPORTANT?

Your eyes not only affect how you see, but how you feel. Caring for your vision can lead to a better quality of life. Your eyesight impacts your performance at work, school, and home. When your vision health is at its best, you perform better in all aspects of your life. Not to mention, eye strain leads to headaches, fatigue, and other discomforts that keep you from feeling your best.

A WINDOW TO THE REST OF YOUR BODY

Did you know that a number of health conditions can be detected early by your eye doctor? An eye exam can detect conditions like diabetes, years before you show signs of the disease, allowing you to better manage health issues before they become a problem.

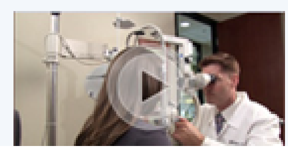
In addition to diabetes, annual eye exams can identify eye and general health conditions, such as:

- Macular degeneration
- Glaucoma
- Diabetes
- High blood pressure
- High cholesterol
- Multiple sclerosis
- Risk of stroke
- Risk of heart disease

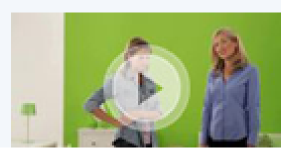
YOU'RE IN CHARGE.

The eye is controlled by muscles, just like many other parts of the body. So just like the rest of your body, your eye health is impacted by your lifestyle, including eating habits, regular exercise, and routine physical exams. Getting an annual eye exam is a very important part of maintaining your overall health!

WELLVISION EXAM DETECTS EARLY ISSUES



PREVENT UV DAMAGE TO EYES



THE DANGERS OF DIGITAL DEVICES ON EYES

THE CONNECTION BETWEEN 3D AND VISION PROBLEMS

01 INDIVIDUAL PLANS | 02 SELECT A PLAN | 03 GET RATES | 04 ENROLL

WHAT MAKES VSP THE BEST CHOICE?

For years VSP has maintained member satisfaction ratings above 95%. That means that nearly all of our 58 million members love what we do for them. As a not-for-profit vision care company, we put our **members first** and are dedicated to helping them maintain excellent eye health.

Getting you high-quality vision care is so important to us that if you're not fully satisfied, we want to hear from you so we can make it right.

100% SATISFACTION GUARANTEED

THE BEST ACCESS

You want a doctor that's conveniently located to you. With more than 28,000 doctors VSP boasts the most extensive doctor network of any vision company. These eye care professionals partner with VSP to deliver the best patient experience and to ensure personalized care. Find a Doctor

DOCTORS RATE VSP THE #1 VISION INSURANCE PROVIDER

THE BEST CHOICES

Once you're a member of VSP, you'll be thrilled by the large selection of eyewear available to you. From classic styles to trendy frames, you'll find hundreds of options to choose from. Our frames include dozens of top brand names, so you can find one that fits your personality.

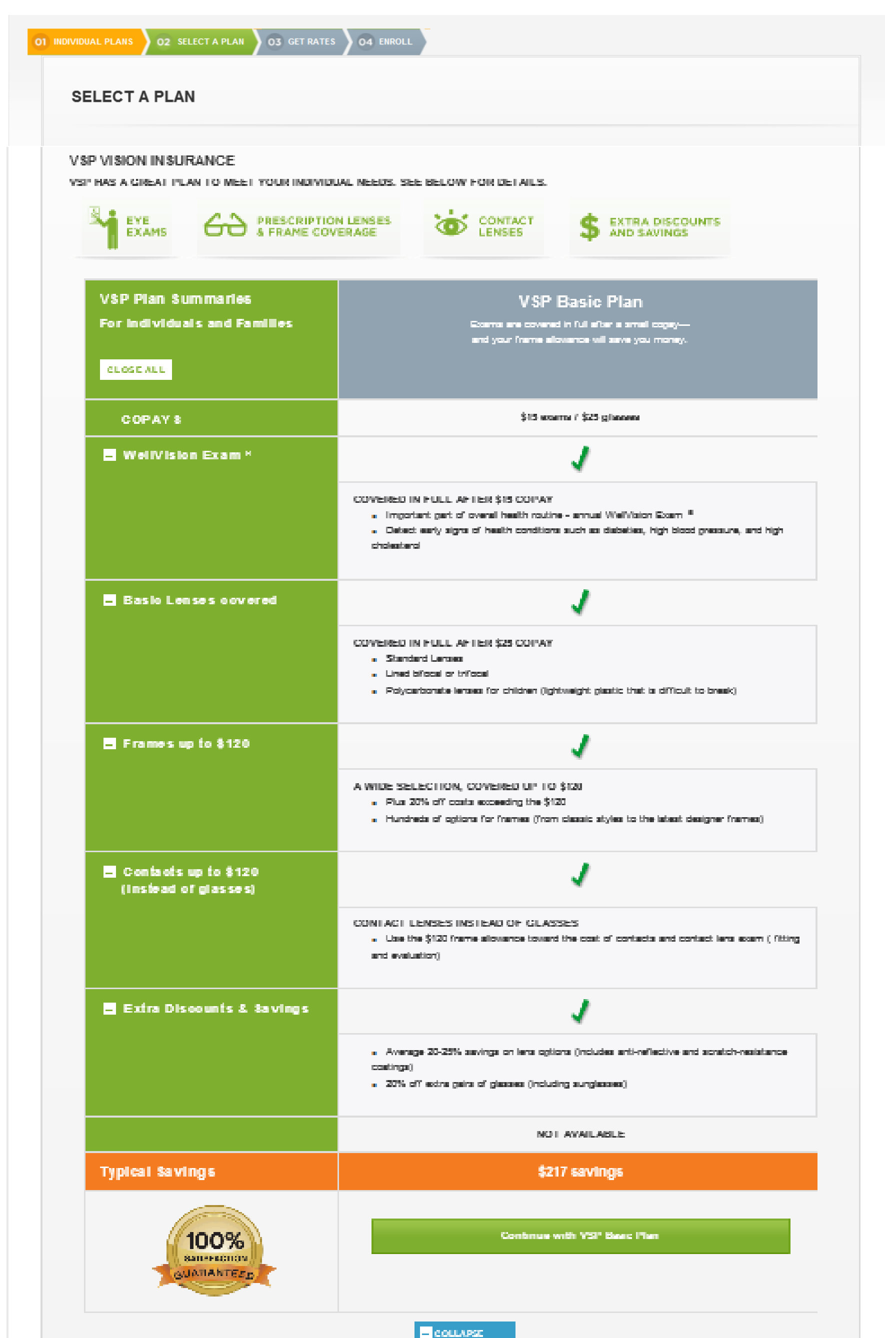
SIMPLICITY

We make it easy for you to obtain and use VSP insurance. Our easy online process will have you enrolled within minutes. And using your benefits is as simple as showing up at your doctor's office. Enroll

A NOT-FOR-PROFIT THAT CARES

VSP got its start with a group of optometrists who shared a dream to provide high-quality, cost-effective eye care benefits. Together, they formed the first prepaid, not-for-profit vision benefit. To this day VSP continues to care about our members—it's ingrained in our nature.

VSP GLOBAL™ OUTREACH


01 INDIVIDUAL PLANS
02 SELECT A PLAN
03 GET RATES
04 ENROLL
SELECT A PLAN
VSP VISION INSURANCE
VSP HAS A GREAT PLAN TO MEET YOUR INDIVIDUAL NEEDS. SEE BELOW FOR DETAILS.
EYE EXAMS
PRESCRIPTION LENSES & FRAME COVERAGE
CONTACT LENSES
EXTRA DISCOUNTS AND SAVINGS
VSP Plan Summaries
For Individuals and Families
CLOSE ALL
VSP Basic Plan
Exams are covered in full after a small copay—
and your frame allowance will save you money.
COPAYS
$15 exams / $25 glasses
WellVision Exam ®
COVERED IN FULL AFTER $15 COPAY
Important part of overall health routine - annual WellVision Exam ®
Detect early signs of health conditions such as diabetes, high blood pressure, and high cholesterol
Basic Lenses covered
COVERED IN FULL AFTER $25 COPAY
Standard Lenses
Lined bifocal or trifocal
Polycarbonate lenses for children (lightweight plastic that is difficult to break)
Frames up to $120
A WIDE SELECTION, COVERED UP TO $120
Plus 20% off costs exceeding the $120
Hundreds of options for frames (from classic styles to the latest designer frames)
Contacts up to $120 (instead of glasses)
CONTACT LENSES INSTEAD OF GLASSES
Use the $120 frame allowance toward the cost of contacts and contact lens exam (fitting and evaluation)
Extra Discounts & Savings
Average 20-25% savings on lens options (includes anti-reflective and scratch-resistance coatings)
20% off extra pairs of glasses (including sunglasses)
NOT AVAILABLE
Typical Savings
$217 savings
100% SATISFACTION GUARANTEED
Continue with VSP Basic Plan
COLLAPSE

01 INDIVIDUAL PLANS | 02 SELECT A PLAN | 03 GET RATES | 04 ENROLL

GET RATES

STEP 3: CHOOSE YOUR COVERAGE

- One-person Plan: **$178.95 Annual**
- Two-person Plan: **$338.95 Annual**
- Family Plan: **$464.95 Annual**
- One-person Plan: **$14.92 Monthly**
- Two-person Plan: **$28.25 Monthly**
- Family Plan: **$38.75 Monthly**

Click the plan you'd like to select.

Check box if you're giving this plan to someone else as a gift. Since this is a gift, please make sure that on the previous page you **entered the zip code of the person receiving the gift** because plan details change by region.

CONTINUE

If you've selected the monthly payment option for the annual benefit term, you have agreed to pay the required annual premium in 12 payments.

VSP Choice Plan for Individuals® is offered through Vision Service Plan Insurance Company.

Out of network (OON) coverage is available. Your benefits are reduced. Please call VSP before seeing an OON provider.

The following form is secure. If you have any concerns about On-Line Transactions, click here to learn more about how we protect your information.

VSP Basic Plan (Family Plan) Annual	$514.95
One-time Enrollment Fee	$ 10.00
Total Cost	$524.95

Continue to Step 2

FORM CODE CICONLINEAPP

All contents Copyright **Care**ington International Corporation

Terms and Conditions

Application
Products Included: Vision

BILLING OPTIONS → 2 MEMBER INFORMATION → 3 PAYMENT INFORMATION → 4 REVIEW ORDER → 5 CONFIRM ORDER

Step 2: Member Information

*Required Fields

*First Name
*Last Name
*Mailing Address
*City
*State ARIZONA
*Zip Code
*Home Phone
Mobile Phone
*Date of Birth MM DD YYYY
*Gender -Select Gender-
*Have you recently seen a TV commercial for VSP? -Select-

Is your billing address the same as your mailing address? ◉ Yes ○ No

A valid e-mail address is required to communicate with you.

*E-mail Address
*Confirm E-mail Address

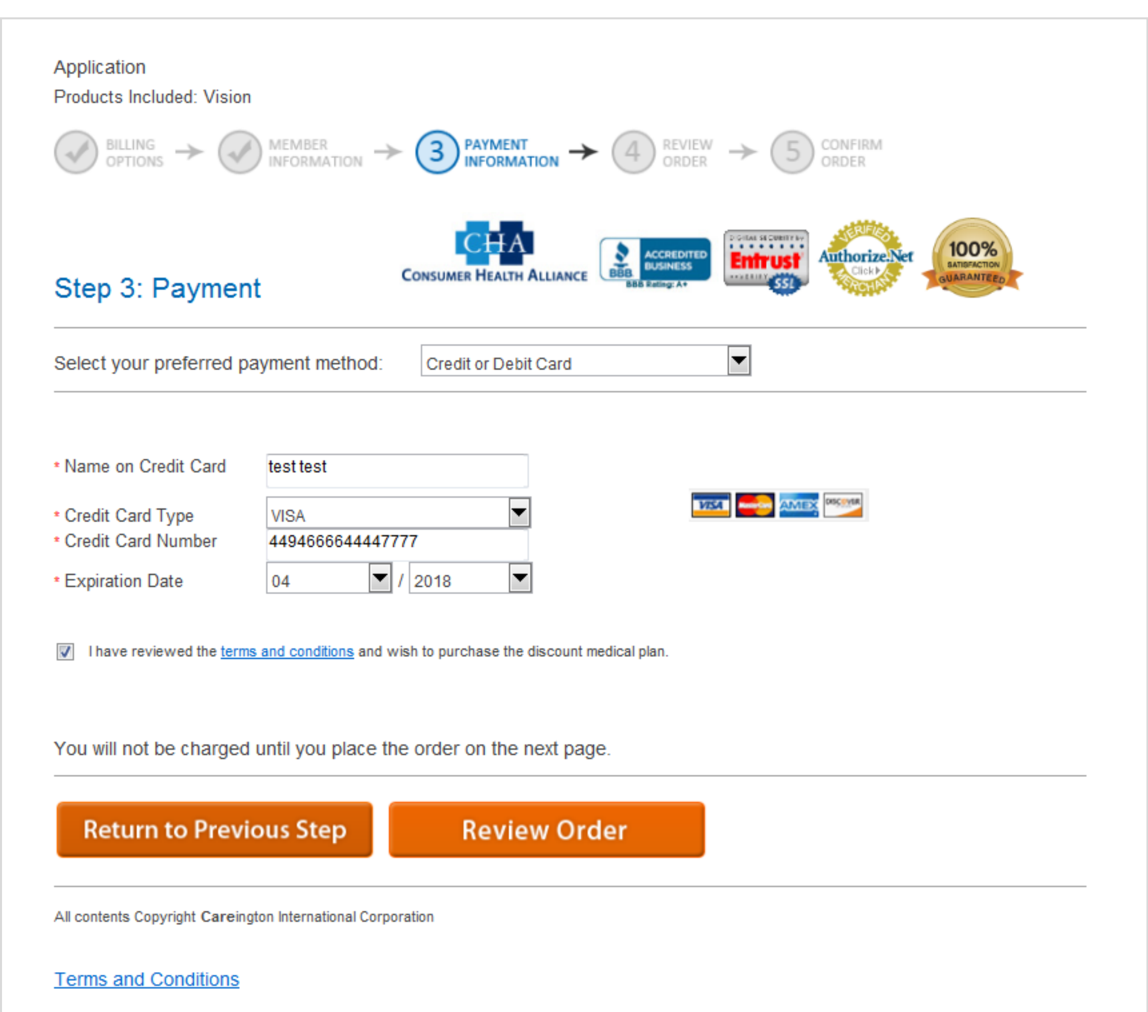
☑ I am interested in receiving future offers for other products or services from **Care**ington.

I understand that my e-mail information is not shared with other companies for any purpose.

Return to Previous Step | Continue to Step 3

All contents Copyright **Care**ington International Corporation

Terms and Conditions


Application
Products Included: Vision
BILLING OPTIONS
MEMBER INFORMATION
3 PAYMENT INFORMATION
4 REVIEW ORDER
5 CONFIRM ORDER
Step 3: Payment
CHA
CONSUMER HEALTH ALLIANCE
ACCREDITED BUSINESS
Entrust
SSL
Authorize.Net
100%
GUARANTEED
Select your preferred payment method:
Credit or Debit Card
* Name on Credit Card
test test
* Credit Card Type
VISA
* Credit Card Number
4494666644447777
* Expiration Date
04
/
2018
I have reviewed the terms and conditions and wish to purchase the discount medical plan.
You will not be charged until you place the order on the next page.
Return to Previous Step
Review Order
All contents Copyright Careington International Corporation
Terms and Conditions

Application

Products Included: Vision

CONFIRM
ORDER

Step 4: Review Order

Billing Option:	Member Plus Family
Total Price:	$532.95 will be charged for your first year, $532.95 will be charged annually thereafter
Billing Address:	Same as Shipping Address Edit
Shipping Address:	TEST TEST AZ 80214 Edit

Note : You will receive an email to download your membership guide in 1-2 business days.

Return to Previous Step   Place Your Order

All contents Copyright **Care**ington International Corporation

Terms and Conditions

01 INDIVIDUAL PLANS | 02 SELECT A PLAN | 03 GET RATES | 04 ENROLL

PURCHASE INDIVIDUAL AND FAMILY PLANS

Enrolling is fast, easy and secure. After completing the application, you'll receive an e-mail confirming your enrollment. You may begin using the program the first day of the next month if you enroll before or on the 20th of the current month. If you enroll on the 21st of the month or later, your enrollment becomes effective the following month.

APPLICATION

Transaction Approved

Thank you for your order Judith Malm.

To check on the status of your application, please call us toll-free at 800.785.0699.

An e-mail has been sent to you with the details of your purchase. Please keep a copy of this e-mail for your records.

Please click this survey link to provide feedback to help us improve our website.

Return to Covered California

FORM CODE CICONLINEAPP

All contents Copyright **Care**ington International

This is not health insurance.

Terms and Conditions

Simple, Easy Administration with VSP

Covered California:

- ✓ Provides links to VSP IP landing page (personalized for CC)

VSP:

- ✓ Provides user with plan information
- ✓ Provides easy online enrollment
- ✓ Collects subscriber information
- ✓ Processes subscriber payment (in annual or monthly payments)
- ✓ Fulfills new subscriber welcome kit/ID card (electronically)
- ✓ Provides CC with monthly report of link activity (clicks/conversions/etc.)
- ✓ Pays commissions to CC (monthly)
- ✓ Provides CC with monthly report of new members enrolled
- ✓ Provides optional monthly member communication (EnVision e-newsletter)
- ✓ Provides Customer Service for ongoing questions or claims issues
- ✓ Sends renewal notices to subscribers
- ✓ Processes renewal credit card payment automatically

California Optometric Association
2415 K Street Sacramento, California 95816
916.441.3990 800.877.5738 Fax 916.448.1423 www.coavision.org

May 1, 2013

Diana Dooley, Chair
Dr. Robert Ross, Board Member
Paul Fearer, Board Member
Kimberly Belshe, Board Member
Susan Kennedy, Board Member
Peter Lee, Executive Director
California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814

RE: Support for Stand-Alone Vision Plans in the Exchange

Dear Board Members and Mr. Lee:

On behalf of the California Optometric Association (COA), I write to express COA's continued support for the inclusion of stand-alone vision plans in Covered California. COA appreciates Covered California's decision and effort to include the offering of stand-alone vision plans as a supplemental benefit, but we also understand that there are technical and legal barriers for their inclusion at this time. We will continue to work with Covered California to assess options for how best to ensure patients have the option to choose a stand-alone vision plan in the near future. Please feel free to contact me should you have questions.

Sincerely,

Fred Dubick, OD, MBA, FAAO
COA President

May 8, 2013

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

Re: Comments on April 22 Draft of the Qualified Health Plan Model Contract

Dear Exchange Board Members and Staff:

On behalf of the Transgender Law Center, an organization advocating on behalf of lesbian, gay, bisexual and transgender (LGBT) Californians, we write to ask that the April 22 draft of the Qualified Health Plan Model Contract be revised so that it provides clear guidance on data collection, utilizes definitions of family consistent with California law, and makes clear the need for compliance with non-discrimination statutes. Our specific concerns are as follows:

<u>Definition of Family Member</u>

The definition "family member "under Article 13 of the model contract - "an individual who is within an Enrollee's or Employee's family, as defined in 26 USC 36B" – is appropriate only for limited purposes of Exchange and Qualified Health Plan administration. We seek the following change to the model contract to conform to existing state law:

> **13.34 Family Member** – An individual who is ~~within~~ an Enrollee's or Employee's ~~family~~ <u>dependent</u>, as defined in ~~26 USC 36B~~ <u>Health and Safety Code Section 1357.500(b), Health and Safety Code Section 1399.845(b) and Insurance Code Section 10753(e).</u>

While we recognize that under federal law, same-sex partners are treated differently with respect to the advanced premium tax credit and cost sharing reductions, use of this federal definition for the purposes of describing coverage eligibility ignores California's clear mandates to treat registered domestic partners and same-sex spouses equally to opposite-sex spouses in all aspects of state government, including the individual Exchange and the Small Business Health Options Program. Please see the following statutes:

- Family Code § 297.5(g) ("No public agency in this state may discriminate against any person or couple on the ground that the person is a registered domestic partner rather than a spouse or that the couple are registered domestic partners rather than spouses");

- Family Code § 308(c) ("…two persons of the same sex who contracted a marriage on or after November 5, 2008, that would be valid by the laws of the jurisdiction in which the marriage was contracted shall have the same rights, protections, and benefits, and shall be subject to the same responsibilities, obligations, and duties under law, whether they derive from the California Constitution, the United States Constitution, statutes, administrative regulations, court rules, government policies, common law, or any other provisions or sources of law, as are granted to and imposed upon spouses with the sole exception of the designation of "marriage");

- Health & Safety Code § 1374.58(a) ("…A plan shall not offer or provide coverage for a registered domestic partner that is not equal to the coverage provided to the spouse of an employee or subscriber"); and

- Insurance Code § 381.5(a) ("Every policy issued, amended, delivered, or renewed in this state shall provide coverage for the registered domestic partner of an insured or policyholder that is equal to, and subject to the same terms and conditions as, the coverage provided to a spouse of an insured or policyholder").

Should you have any questions or concerns, please contact Alice Kessler, Legislative Advocate, at akessler@lawpolicy.com or (916) 341-0808.

Sincerely,

Masen Davis
Executive Director
Transgender Law Center

May 3, 2013

Andrea Rosen
Interim Health Plan Management Director
Covered California™
560 J Street, Suite 290
Sacramento, CA 95814

Sent via email to infor@hbex.ca.gov

Re: Board Recommendation Brief on the Offer of Adult-only Dental Plans

Dear Andrea:

Thank you for the opportunity to provide comments on the board recommendation brief (BRB) on vision and dental benefits.

In 2012, the Covered California™ Board adopted policies on stand-alone pediatric EHBs, which the Affordable Care Act (ACA) permits to be offered through separate plans (or issuers), and supplemental benefits, such as adult dental or vision. The current policy was intended to allow:

- Bids from stand-alone plans offering EHB pediatric dental and visions benefits in both the individual Exchange and Small Business Health Options Program (SHOP).
- The sale of supplemental dental and vision benefits in both the individual Exchange and SHOP, provided through either stand-alone plans or through embedded comprehensive QHPs.

As noted in the BRB discussed at the April board meeting, Covered California staff's current interpretation of the March 29, 2013 CMS guidance is that supplemental adult dental benefits can be offered through Exchanges in stand-alone plans as long as coverage includes at least EHB-required pediatric dental benefits. As a result, the conclusion is that adult-only dental plans cannot be sold through Covered California.

United Concordia interprets the CMS guidance on March 29 to mean ancillary benefits other than stand-alone dental plans (SADPs) which are according to HHS "a type of Qualified Health Plan" (§155.1065(a)(3) of the Exchange final rule). Our interpretation is based on the federal rules on the offer of child-only policies and CMS' dental-specific template for certification of plans and benefits.

Stand-alone dental plans/issuers are required, according to the Exchange Final Rule (pp. 282-283) to provide a child-only plan to enrollees who are age 19 and 20. This benefit is not the pediatric EHB (as "pediatric" is defined as to age 19). Instead, these enrollees would be offered the "adult" benefit that is provided to non-pediatric aged individuals. If an employee aged 20 (without children) has an employer who is providing coverage via the SHOP, this employee would need an "adult-only" stand-alone dental policy.

HHS must have contemplated this scenario because the Dental-specific Plans & Benefit Template v1.32 that was released on May 1 includes the Plan Attribute "child-only offering" which has values for adult & child offering, adult only offering and child-only offering. (See attached screenshots.) This indicates HHS' intent that the March 29, 2013 Q&A on ancillary products does not apply to stand-alone dental plans (i.e., "ancillary products" does not include SADPs of any kind). In the response to question 1, CMS says that an Exchange may only offer QHPs, including SADPs. It does not say "child-only" SADPs or SADPs that include the EHB. It goes further to say ancillary products "which are not QHPs, may be offered by separate state programs." Again, the Exchange Final Rule also includes SADPs as a type of QHP.

It is also important to note that while the Essential Health Benefits, Actuarial Value and Accreditation final rule and preamble use the terms "plan" and "issuer" as though they are synonyms, they are not. The CMS FAQ on March 29 makes the same mistake. The term "stand-alone dental plan" in this context refers to the issuer or entity not a policy type. Use of "plan" to refer to the issuer, insurer or carrier is commonplace (e.g., National Association of Dental Plans, America's Health Insurance Plans, and California Association of Dental Plans).

United Concordia supports appropriate standardization both inside and outside the Exchange in order to avoid adverse selection consequences. Prohibiting the offer of adult-only dental benefits on Covered California will create incentives for adults to purchase both health and dental off Exchange. For this reason and those articulated above, we recommend that Covered California keep the 2012 Board approved policy on supplemental dental and vision intact.

Thank you again for the opportunity to discuss these important issues with you. Should you have any questions or comments, please feel free to contact me at 717-260-6983 or kurtis.shook@ucci.com.

Sincerely,

Kurtis S. Shook
Director, Health Care Reform Exchanges
United Concordia Dental

Enclosure (Screenshots of CMS Dental Template)

Screenshot of Plan Attribute field on CMS Dental Template (v1.32)

Note: CMS permits an "Adult-Only" plan/policy