Comments to the Board

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August 22nd, 2013 Board Meeting

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AB1761 – Analysis and Insight

Exact Match Domains and the Covered CA Exchange

It is possible to drive enrollment without being deceptive

This analysis was prepared by Bridgeport Benefits. Bridgeport is a California Health Insurance Brokerage with over 25 years of history doing business in California and Nationwide. Bridgeport strives to be a resource to all of our clients, partners and governing bodies to further our mutual interests in the best, most ethical and practical ways possible. In this regard, we would like to share our opinions and analysis on a very specific topic that will relate to the roll out and process of marketing efforts to drive eligible individuals to enroll on the Covered CA Exchange.

The issue that we will be focusing on is solely: The use of exact match domains with "covered ca" or any similar text or amalgamations thereof.

As we know:

AB 1761 Prohibits an individual or entity from holding himself, herself, or itself out as representing, constituting, or otherwise providing services on behalf of the Exchange unless that individual or entity has a valid agreement with the Exchange to engage in those activities.

Makes any person who engages in any unfair method of competition or any unfair or deceptive act or practice liable to the state for a civil penalty to be fixed by the Insurance Commissioner.

Prohibits plans, solicitors, solicitor firms, or representatives from using or permitting the use of any advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive.

Health Access California states that almost from the moment that the Exchange was created, there have been misleading websites put up by agents and
brokers that appear to be the official website of the Exchange.

Please Note: Bridgeport Benefits has not yet engaged marketing for enrollment on the exchange that is customer facing. This analysis and any related inquiries are in anticipation of the discussion and subsequent branding guidelines that are eminently expected from the committee on marketing and branding that has been established by Covered California. Bridgeport holds itself and its representatives to the highest standards of ethics, compliance, and professional conduct as it relates to these matters. Although we seek aggressive partnership with the CA State Exchange, we do so in accordance with the guidelines set forth by Federal, State and local authorities. We will not take the popular posture, "ask for forgiveness rather than permission." We are, however, in current development of a dedicated marketing effort to enroll individuals on the exchange which includes staff recruitment, collateral creation, SEO web development, etc… We certainly appreciate any courtesies, resources, support and decisions that are in favor of our desire to market aggressively.

Position: We believe that we (and others) can effectively drive traffic to channels of exchange enrollment via an exact match domain, WITHOUT misleading or deceiving consumers. Exact match domain names such as www.coveredcaexchange.org (just an example, not a live site) will receive better indexing and placement on search results by Google because of their perceived relevance to the search topic by Google's algorithm. The Digital Marketing Glossary defines an exact match domain: *An exact match domain or EMD is a domain name that matches precisely a targeted search engine query to obtain high rank in SERPs (search engine results pages) for this query. Exact match domains are intensively used in SEO (search engine optimization) because search engines give high importance to domain names as an indication of a website topic. Thus, for many (niche) queries, a relatively large proportion of first page results are occupied by EMD.*

Argument #1: In almost every case that an entity was forced to stop using an exact match domain that was similar or the same as another companies mark, there was an element of bad faith where the violator was attempting to steal business, internet traffic or subscribers from the known mark. Here is the most recent and drastic example as it relates to Facebook http://techcrunch.com/2013/05/01/u-s-court-rules-for-facebook-in-its-case-against-typosquatters-on-105-domains-2-8m-in-damages/. You may read this and assert that this further fuels the assertion that using "coveredca" in a domain name is a violation of AB1761, but I would ask you to consider this: Certified Agents and Brokers are not trying to steal clients from the exchange; they are rather trying to direct eligible individuals to enroll on the exchange.

Whether the application is taken via paper app, connected web portal or over the phone, the people are enrolled with the state in either event. The responsibility then becomes to CLEARLY identify the relationship of that agent or broker to Covered California as will be stated in the forthcoming brand guidelines. In other words, as long as the logos, messaging and text clearly state that we are a certified agent, and not the exchange itself (and I would argue that a prominent link with graphic directing people to the state website should they wish to do their research there) then there really is no deception at all. The domain as a vehicle to get them there will actually be a HELP to Covered California and its mission.

Argument #2: It's all about page one. As referenced in the following article, http://searchenginewatch.com/article/2276184/No.-1-Position-in-Google-Gets-33-of-Search-Traffic-Study, roughly 92% of all Google traffic clicks on page one (5% click on page two). There are 10 search results that appear on page one, 20 if you include page two (this does not include pay per click advertising). Covered California, I assume, is going to focus their efforts on one main website, maybe 2. I doubt that Covered California is looking to manage 10-20 websites. There absolutely WILL be websites with "coveredca" or some other related text (i.e. "coveredcalifornia", "californiahealthexchange") that appear on page one and two search results. These sites will obviously be of concern to Covered California and the state government as a whole. The companies with the most to gain will be running these prominent sites. The bigger budgets and most marketing savvy will gain the positioning. Those that will have the most to gain will be certified agents. Why not let them enjoy the results of an ethical and effective marketing campaign, while locking out other parties that will undoubtedly be looking to deceive, steal identities, misdirect, etc. This brings me to my next point…

Argument #3: The truth is that this is really an area that will be unable to be policed by the state. There will be agents, brokers, insurance carriers, internet marketers, scam artists, and many, many others (some out of state and out of the country) that will be creating websites surrounding this topic. Some will be legitimate, some will be informational, some will be illegal and everything in between. The state is going to have its hands full with JUST trying to get people enrolled on the exchange. The man power that it will take to police the entire internet for this issue is not even a realistic topic for conversation, no less actual target. The better place to police for violations will be Pages 1 and 2 of search results (The reality is that even this is a burden because which search terms are we talking about (Covered California? Affordable Insurance?) and what day of the week? (search results are changing day to day, minute to minute, hour to hour). There is NO BETTER way to lock the scam artists and unauthorized companies out of the prominent search positions than by giving certified agents and brokers the ability to use these exact match domains with VERY STRICT branding guidelines. These people will have the biggest budgets, the most skin in the game and the most to lose by violating the guidelines. It will take very little to convince them that compliance is the only option. This will also allow for a more realistic target of those companies that need to be ceased and desisted, investigated, prosecuted etc.

Argument #4: Consumer Protection. By giving certified agents a license to use exact match domain names and monitoring their content, consumers are more likely to be driven to a state affiliated site that leads them to the actual exchange. When certified agents and brokers are locked out from participation in this element of SEO you actually are inviting those acting with bad faith to have better search engine positioning. In other words, you leave a gaping hole in the internet landscape that will undoubtedly be filled by those with negative intent.

Summary: Bridgeport Benefits is looking for authorization to use a domain name with the Covered California name in it to help drive eligible individuals to enroll on the exchange. We look to do so with Covered California's approval and only in that circumstance. We believe that other entities that are certified on the exchange should be able to use this strategy as well. We believe that the benefits of this strategy will greatly assist Covered California in providing individuals with affordable health care by creating better indexing for their certified partners. Additionally we believe that by allowing certified agents and brokers to use this method, you actually protect, to a degree, the search positions from those that are looking to leverage those terms with negative intentions. In no circumstances are we asking or do we believe that this should be done in conjunction with misleading text, graphics, or any other messaging that would make the consumer have the misconception that they have landed on the Covered California website itself or any other state entity. We firmly believe in and will strictly follow the Covered California Brand Guidelines.

Thank you for your time and consideration in this matter. Please feel free to contact me for further questions or concerns.

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August 1, 2013

Peter Lee
Executive Director
Covered California
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VIA ELECTRONIC MAIL: Peter.Lee@covered.ca.gov

Re: Draft Bridge Demonstration Plan

Dear Mr. Lee:

The California Association of Health Plans ("CAHP") represents 40 public and private health care service plans that collectively provide coverage to over 21 million Californians. We appreciate the opportunity to provide feedback on the Draft Bridge Plan Demonstration Proposal dated July 22, 2013.

Many of our member plans are also members of the Local health Plans of California (LHPC) and CAHP supports the comments submitted to Covered California by LHPC. CAHP agrees with LHPC that it is important to clarify the bridge plan pricing and request that the proposal be updated to reflect the language from the enabling legislation SBX1 3, which permits Bridge plans to have premiums that match the lowest cost silver plan in that rating region. CAHP also supports efforts that would minimize any delay in eligibility for parents or caretaker relatives and requests clarification on any impact a delay in implementation would have on the transitional Medi-Cal population as outlined in the LHPC comment letter.

In addition to the clarifications requested by LHPC, CAHP's member plans request that the proposal be updated to clearly state that participation in the Bridge plan is optional for Medi-Cal plans. We believe this is clear in SBX1 3 and would appreciate a confirmation in this proposal that Covered California intends to make participation in the Bridge optional.

CAHP would also appreciate if clarification could be added to the proposal that would specify that eligibility for enrollment in a Bridge plan is limited to individuals who have recently lost Medi-Cal managed care coverage, and it is not available to anyone who was previously enrolled in Medi-Cal. It is clear from the language in SBX1 3 that the Bridge program was created to ensure continuity of care and reduce gaps in coverage. As it is currently written there does not appear to be any time limit in this proposal and we do not believe that is the intent of the program nor that it is prudent to leave it open ended. We therefore suggest that Covered California work with stakeholders to define a reasonable timeframe in which a consumer would be eligible to enroll in a Bridge plan after losing Medi-Cal coverage.

Lastly, CAHP believes that requirements related to the Bridge program are most appropriately handled in the contract between Covered California and the Bridge Plan, and not through changes to Medi-Cal contracts. While Section 14005.70 of the Welfare and Institutions code was added as a result of SBX1 3 to require that the Department of Health Care Services (DHCS) include specific requirements related to the Bridge program in its contracts it also gives DHCS the authority in section 14005.70 (b) to delegate the implementation of this section to Covered California. Since not every Medi-Cal plan will necessarily become a bridge plan and there has been a concerted effort over the past few years to standardize Medi-Cal contracts we respectfully suggest that Covered California work with DHCS to have these responsibilities delegated and included in contracts between Bridge plans and Covered California. We believe that since these are distinct programs it is important to contain all Bridge related requirements in the Covered California contract.

We appreciate your review of the items outlined in this letter and are available at your convenience to discuss.

Sincerely,

Athena Chapman
Director of Regulatory Affairs

cc: David Panush, Director of External Affairs, Covered California

California Association of
Public Hospitals and Health Systems

July 2, 2013

The Honorable Jerry Brown
Governor, State of California
State Capitol, Governor's Office
Sacramento, CA 95814

Subject: SBX1 3 (Hernandez) – REQUEST FOR SIGNATURE

Dear Governor Brown:

On behalf of the members of the California Association of Public Hospitals and Health Systems (CAPH) and the millions of patients they serve, I am writing to express our support for SBX1 3, which would establish a Bridge Plan in Covered California.

California's 21 public hospital systems are the core of the state's health care safety net, delivering care to all who need it, regardless of ability to pay or insurance status. As safety net providers who care deeply about the need to maximize enrollment under health reform, the Bridge plan provides an important opportunity to ensure that many low income individuals and families transitioning from Medi-Cal to Covered California will be able to afford coverage. The Bridge targets populations most at risk of being unable to afford health insurance in Covered California, extremely low-income individuals who are transitioning from Medi-Cal where they likely had no premiums and minimal out-of pocket costs. Although they will be eligible for significant federal subsidies, they are barely scrapping by with current expenses, and have minimal room available in their monthly budget for health care premiums. Developing a more affordable option for these low-income families will make a big difference between whether or not they enroll.

In addition to addressing affordability, the Bridge can also help ensure that these patients can continue to see their existing health care providers, preserving continuity of care. For example, many Medi-Cal enrollees are receiving regular primary care services in medical homes with traditional safety net providers, usually county or community clinics. The Bridge can help ensure continuity of care for these patients and a seamless transition.

We would also note that even after full implementation of health care reform, and under a best case scenario, an estimated 3-4 million individuals will remain uninsured in California. Structures like the Bridge plan can help core safety net providers like public hospital systems continue to serve the remaining uninsured, by contributing to a diverse payor mix with Covered California enrollees.

For these reasons, we urge your signature of SBX1 3. If you have any questions, please contact Terri Thomas, our Sacramento representative, at 916-325-1010. Thank you for your consideration.

Sincerely,

Erica Murray
Senior Vice President

cc: The Honorable Senator Ed Hernandez
Lark Park, Office of the Governor
Diana Dooley, Secretary, Health & Human Services Agency
Peter Lee, Executive Director, Covered California
Terri Thomas, Thomas Advocacy

Health Plan of San Joaquin

July 30, 2013

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

Dear Mr Lee;

Thank you for the opportunity to comment on Covered California's draft "Bridge Plan Demonstration Project. A Strategy to Promote Continuity of Care & Affordability" dated July 22, 2013

Health Plan of San Joaquin (HPSJ) is a Local Initiative health plan serving members and the community since 1996 HPSJ is the leading Medi-Cal managed care provider in San Joaquin and Stanislaus counties, with over 190,000 members HPSJ is a supportive member of Local Health Plans of California (LHPC) that represents 14 California Local Initiatives and County Organized Health Systems.

Health Plan of San Joaquin would like to recognize Covered California's efforts in developing a Bridge Plan and diligently working toward gaining legislative and federal approval on a plan that promotes care continuity at an affordable price As a vested stakeholder in providing healthcare coverage to our community, HPSJ is supportive of the legislation enabling the creation of a Bridge Plan in California.

We are aligned and support the comments submitted by the Chair, Maya Altman in LHPC's Bridge Plan Proposal response As stated in their letter, we, too, request additional clarity regarding

- **Bridge Plan pricing:** Please clarify whether Covered California expects Bridge plans to offer a rate that is lower than the lowest price silver plan for a given region.
- **Delayed eligibility for Parents or Caretaker relatives of enrolled Medi-Cal child** Please provide clarification on the operational issues that would cause a delay until 2015 for this eligible population.
- **Transitional Medi-Cal:** Please provide clarification on whether transitional Medi-Cal coverage would continue if Bridge implementation is delayed beyond April 1, 2014

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In addition, HPSJ would like to provide comments on the following:

Implementation Issues – Eligibility:
With the delay in implementation for all Bridge eligible participants, is it the intent to have those individuals enroll in an Exchange plan until a Bridge Plan is available? HPSJ feels this would have a significant impact on the continuity of care aspects as they would more than likely not be covered by the same Medi-Cal issuer with the same provider network.

Medi-Cal Plan participation in Bridge Plan
While HPSJ does not believe it is the intent of the legislation nor Covered California to require all Medi-Cal plans to participate as a Bridge Plan, there are sections of the document that we feel may be interpreted in that way. We suggest that this be clarified in the final version.

Demonstration Project
In reviewing and comparing the original board brief and legislation, we do not recall language regarding the Bridge Plan to be considered a CMS Demonstration Project. Can you please provide clarification on the impact of this change?

Thank you in advance for accepting our comments on the draft proposal and addressing our concerns We look forward to working collaboratively with Covered California's staff to implement California's Bridge plan I can be reached by email at dhurst@hpsj.com or phone (209) 461-2241

Regards,

David Hurst, Vice President
Marketing and Public Affairs

Hellan Roth Dowden (received via e-mail)
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Comments on Exchange Draft for Bridge Plan Demonstration Project

Demonstration Project. Casts the bridge as a 3 year demonstration project and suggests the if the state wants to continue the program, it could then apply for a 5 year innovation waiver as allowed under the ACA. SBx 3X sunsets authorization for the bill 5 years after federal approval of the program and does not specifically provide for a shorter demonstration period.

Perhaps the Exchange is relying on another provision in SBX 3X that requires the bridge program to be compliant with federal approvals—and anticipates that the federal approval will be for a shorter period?

- **Do these time periods require reconciliation?**

Eligible Participants. The eligibility is consistent with that in SB 3X -- those with incomes under 250% of FPL who are:

- Newly enrolled in the Exchange and previously enrolled in Medi-Cal managed care;
- Exchange enrollees with a family member in Medi-Cal managed care;
- A parent or caretaker of a Medi-Cal enrolled child.

Initially, the target population would be limited to those in bullet 1. The Exchange will seek federal approval to also include the populations in the next two bullets. SBx 3X allows the Exchange to delay covering those in the bullet 3 populations until 1/1/2015.

Bridge Implementation Timeframes: It is not clear when the program would actually be implemented. The paper indicates that once approval for the demonstration is obtained, an "implementation effort will be required to modify the enrollment system to support these new enrollment options, to review and certify Medi-Cal manage care plans to participate, and to negotiate rates." Covered California will develop an implementation timeline in consultation with the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) development team, Covered California staff, and stakeholders. (Pg. 5) But, as the paper goes on to say (pg. 9) "The Bridge proposal requires additional functions to be designed and developed within the CalHEERS. Once the program has been approved, Covered California will initiate development activities and determine the implementation schedule that balances the significant operational needs of the system. "

- **Is it important to get a clearer since of the implementation time frames?**

Rates for Bridge Plans. SBx 3X requires that bridge plan rates be "equal to or less than the lowest rate otherwise available for silver tier coverage". The Exchange proposal appears to envision two different rate approaches. The first, described on pg. 5 of the proposal, is consistent with SBx 3xX. The second, described on pg. 6, presumes that the bridge rate will be lower or equal to "the price differential between the lowest and second lowest premiums otherwise available in the silver tier" (pg. 6 of the proposal).

- **Are these, in fact, two different approaches? If so, the Exchange should clarify whether rates will be the lowest or at a price differential between the two lowest.**

Federal Pre-requisite. One of the pre-requisites the federal government has established for bridge programs is that bridge plan eligibles must not be disadvantaged in terms of buying power for their advance payments of premium tax credits. But, the California approach does seem to disadvantage the eligibles' ability to buy regular Exchange coverage. This is because subsidies for the eligible population would be less than those for other (higher income) Exchange enrollees.

Note that this would be true for anyone **eligible** for a bridge product—whether or not they want one. Any person fitting into one of the 3 eligibility categories for the bridge could chose a regular Exchange plan, but would pay more for it because their subsidy would be linked to the bridge plan product. UC Berkeley estimates the size of this population at between 670,000-840,000 in year one.

The rationale for California's approach is that the "trade off" of higher priced regular Exchange coverage for Medi-Cal managed care coverage is worth it to those with incomes at or below 250% because it allows a person moving into Exchange coverage from MC to remain in their same MCMC plan and that "mixed" families (with Exchange and MC members in the same household) can be in the same (MCMC) plan.

- **This is not a surprising element of the proposal. It was discussed during the legislative process and is consistent with stakeholder expectations. But it does seem to conflict with the federal guidance. Presumably the Exchange staff has discussed this dilemma with the federal government and believes the Exchange proposal will be approved**.

Guaranteed Issue. Health care reform requires insurers to sell all of their products to any interested purchaser. Medi-Cal managed care plans, generally, do not feel that this is possible for them. SBx 3X specifically exempts them from having to offer all the various coverage levels to purchasers. Instead, they only must offer the gold and silver levels. The MCMC plans also do not want to have to sell coverage to the entire Exchange population. If the issuer demonstrates that the provider network serving both Medi-Cal Managed Care enrollees and Bridge enrollees is only sufficient to adequately handle the bridge population, then the Bridge could be

closed to non-Bridge eligible individuals. To implement this provision, the paper indicates that:

> Legislation be enacted requiring DHCS to ensure there its contracts with MCMC plans contain a legally binding contractual obligation in place requiring a Medi-Cal Managed Care plan that offers a Bridge plan product to enroll Bridge plan eligible individuals; and
>
> The federal government authorizes the Department of Managed Health Care to ascertain whether a plan is at capacity by looking at the capacity of the Bridge plan product rather than the capacity of the plan as a whole.

Evaluation. The Proposal indicates that the Exchange will conduct an evaluation of the Bridge plan to assess " the policy tradeoffs" for consumers inherent in the design of the Bridge plan. This design reduces an eligible individual's federal tax credit and purchasing power for those who prefer to purchase a non-Bridge plan in exchange for (conceptually) more affordable monthly premiums offered by Medi-Cal managed care plans.

The paper indicates that the evaluation would assess across the following domains: Total enrollment; Reduced churn between Medi-Cal and Exchange plans; Greater continuity of care; Affordability; and Quality Measurement.

The paper also states that "additional information about consumer preferences, behavior, and plan selection options would be needed to gauge the extent to which Bridge eligible consumers might be disadvantaged by having reduced purchasing power".

- **Knowing how consumers felt about the bridge experience, and whether they approve of the "policy trade-off' inherent in its design is a critical—the most critical—evaluation point. The draft document should specifically add an evaluation requirement for a statistically valid consumer survey answering the following questions:**

  - Were consumers content with the trade off?
  - Did they feel they had adequate provider access in the MCMC plan?
  - Were they satisfied with the coverage they received in Medi-Cal managed care?
  - Do they have suggestions for revising or improving the approach?

LOCAL HEALTH PLANS of California

Promoting Health Care For All

July 29, 2013

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

Dear Mr. Lee:

Thank you for the opportunity to comment on Covered California's draft "Bridge Plan Demonstration Project: A Strategy to Promote Continuity of Care & Affordability" dated July 22, 2013. The Local Health Plans of California (LHPC) represents 14 California Local Initiatives and County Organized Health Systems. Our members are a vital part of California's health care safety net and were immensely supportive of the legislation enabling the creation of a Bridge plan in California.

We applaud Covered California's efforts to gain federal approval for the Bridge plan as quickly as possible. We request additional clarity regarding three significant issues in the draft proposal:

- Bridge Plan pricing
- Delayed eligibility
- Transitional Medi-Cal

Bridge Plan Pricing. Please clarify whether Covered California expects Bridge plans to offer a rate that is lower than the lowest priced silver plan for a given region. SB X1 3 provides that Bridge plans can match the lowest cost silver plan in a rating region. Page 5 and page 6 of the draft proposal assume that the Bridge plan rates would be priced under the lowest cost silver and outline the subsequent reduction of the federal tax credit as a result.

Delayed Eligibility. The draft proposal indicates that Covered California may delay Bridge enrollment until January 1, 2015 for a parent or caretaker relative of a child enrolled in Medi-Cal. We understand that eligibility verification and updates to the CalHEERS system may require a delayed start. However, we also believe it is critical for the enrollment period for this eligible population to be as close to the start of Bridge enrollment for those who lose Medi-Cal. This would

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minimize confusion for individuals and families. LHPC would like clarification on the operational issues that would cause a delay until 2015 for this eligible population.

Transitional Medi-Cal. The draft proposal states that four months of transitional Medi-Cal coverage would be available to individuals who lose Medi-Cal coverage on or after January 1, 2014 but before Bridge enrollment begins. LHPC would like clarification on whether transitional Medi-Cal coverage would continue if Bridge implementation is delayed beyond April 1, 2014.

Thank you in advance for accepting our comments on the draft proposal and addressing our concerns. We look forward to working collaboratively with Covered California's staff to implement California's Bridge plan. I can be reached at maya.altman@hpsm.org or phone 650-616-2145.

Regards,

Maya Altman
Chair

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July 29, 2013

TO: California Health Benefits Exchange Board
FROM: Lynn Kersey, MA, MPH, CLE, Executive Director
RE: Draft Bridge Plan Demonstration Project
CC: Department of Health Care Services

Maternal and Child Health Access (MCHA) appreciates this opportunity to comment on the Draft Bridge Plan Demonstration Project.

Located in downtown Los Angeles, MCHA operates many health, nutrition and social service programs, all working with low income individuals and families to ensure access to quality health and social services. For nearly two decades, we have been assisting low-income people enroll and use health care programs and have been a member of the state's Medi-Cal Managed Care Advisory Group since its beginning in the late 1990s.

Many of our clients would be affected by the Bridge Plan Demonstration Project. We greatly appreciate the effort to find an affordable approach to Exchange enrollment that could also help with continuity of care for individuals and families with income at or below 250% of poverty. However, we have a series of concerns about the proposed Demonstration Project for all affected individuals. The following comments focus on pregnant women in particular. We look forward to continuing to work toward a coordinated resolution of these issues between the Exchange Board and the Department of Health Care Services (DHCS) with leadership from the California Health and Human Services Agency. Our concerns and suggestions follow.

- **High consumer costs under the Bridge Demonstration:** The cost of Bridge premiums are still likely to be out of reach for many individuals with income at or below 250% of poverty, including pregnant women. Medi-Cal provides coverage to pregnant women with income up to 200% of poverty at no cost. The CHIP-funded Access for Infants and Mothers program, AIM, covers pregnant women with income over 200% up to 300% at very low cost-- i.e., premiums of no more than 1.5% of income with no point-of-service copayments or similar charges. The Bridge Demonstration premium charges alone far exceed the cost to pregnant women of Medi-Cal or AIM.

- **Network inadequacy**: There have been numerous reports that the approach to controlling the cost for most Exchange plan premiums has been to narrow networks. To offer premiums lower than those for their other Exchange products, Bridge plans will likely narrow the networks even further. Bridge networks may also differ from those of the insurer's Medi-Cal products. Wait times for primary care providers and access to specialists will be problems under the Bridge if the networks are not truly robust and designed to

promptly meet patients' needs. Pregnant women in Los Angeles County already experience serious access problems to perinatal specialists for high risk pregnancies under Medi-Cal managed care; leading perinatal specialty centers will accept Medi-Cal only in fee-for-service, and the plans too often fail to make appropriate arrangements for women to access specialty care out of network. Examples are provided in MCHA testimony of April 22, 2013, attached.

- **Concerns about Medi-Cal managed care plans**: Under the proposal, Bridge services would be delivered by Medi-Cal managed care plans. As noted, MCHA has been actively participating in DHCS' advisory group on Medi-Cal managed care for many years. We have shared with DHCS, the plans, and others, the following major concerns in Medi-Cal managed care:

    - Network inadequacy, especially re: perinatal specialists for high risk pregnancies;
    - Poor care management by plans, leading to breaks in continuity of care, especially for high risk pregnancies; and
    - Lax oversight by DHCS and DMHC.

  For a detailed explanation, please see the attached copy of MCHA's April 22, 2013 testimony.

- **Preserve continuity of care by not prematurely changing a pregnant or postpartum woman's eligibility to the Bridge or other Exchange plan:** Women enrolled in Medi-Cal are entitled to "continuous eligibility" (CE) during pregnancy and until the end of the month in which the 60th day following the end of the pregnancy occurs. CE under AIM is a bit shorter, ending on the 60th day postpartum. **It is imperative that all parts of the eligibility re-evaluation process, including CalHEERS, be designed to identify women entitled to CE under either Medi-Cal or AIM when income increases or other changes result in a re-evaluation of eligibility.** Meeting this challenge will be particularly important in the following contexts:

    - Not all women who are pregnant at the time of applying for coverage and who are found eligible for Medi-Cal will be assigned a Medi-Cal "Aid Code" that indicates the pregnancy. In addition, many women become pregnant only after enrolling in Medi-Cal under non-pregnancy Aid Codes. Providing women with clear information during the re-evaluation process about the importance of reporting a pregnancy will be critical ; and

    - There is a question about what policy DHCS will adopt for women who become pregnant after enrolling in Medi-Cal's 138% adult expansion program and who are pregnant at the time of an eligibility re-evaluation. MCHA urges that CE be granted

for these women as well, to ensure both affordability as well as continuity of care under Medi-Cal until the end of the postpartum period.[1]

- **<u>Provide women with clear, comprehensive information about their coverage options during pregnancy and postpartum</u>:** Whether a woman is applying or having her eligibility re-evaluated, online or otherwise, she must be given a clear, complete picture about her choices for coverage during pregnancy and postpartum, with **information about the differences in costs, enrollment periods, scope of coverage,[2] health care delivery system, and provider networks under each option, for easy comparisons**:

    - Free Medi-Cal outside the Exchange to 200% of poverty:
    - Low cost AIM to 300%;
    - Bridge demonstration if over 200%, up to 250%; and
    - Other Exchange plans if 100% to 400%.

  Consumer advocates should be given an opportunity to review and comment on such proposed messaging both for the on-line as well as the "paper" enrollment and re-evaluation process before final adoption. To date, we have not had such an opportunity, thought the time for final CalHEERS programming and paper application/instructions printing is fast approaching.

For the Bridge to succeed, it is critical that each of these problem areas be adequately addressed. Certain features of the proposed Bridge, however, raise the concern that these problems could instead actually become worse. According to the draft document, the Bridge networks may be different than the Medi-Cal managed care networks and narrower than the networks of other Exchange plans. In addition, the demonstration would be evaluated apparently based on the DHCS Medi-Cal managed care data set (see p. 10), which are lacking even as to the Medi-Cal population. MCHA remains committed to working with the state to resolve these pressing issues. Please do not hesitate to contact me at lynnk@mchaccess.org if you have any questions.

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[1] See pp. 2-3 of attached July 25, 2013 letter to DHCS.

[2] The Bridge plans would be QHPs, not Medi-Cal plans, and many of Medi-Cal's essential services for pregnant women would not be included in the Bridge scope of benefits. Examples here include, but are not limited to, psychosocial services through Medi-Cal's Comprehensive Perinatal Services Program (CPSP), non-medical non-emergency transportation, and dental care for pregnant women. DHCS' Premium Assistance proposal for pregnant women does not adequately address this issue (see attached letter of July 25, 2013, pp. 4-6).

Maternal and Child Health Access

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Budget Subcommittee No. 1 on Health and Human Services
Monday, April 22, 2013
Lynn Kersey, Executive Director, Maternal and Child Health Access

Good afternoon. Thank you for inviting me to speak about network adequacy and related issues in Medi-Cal managed care.

Maternal and Child Health Access (MCHA), located in downtown Los Angeles, operates many health, nutrition and social service programs, all working with low income individuals and families to ensure access to quality health and social services. We began in 1990 when women in LA County were giving birth in the halls of County General hospital, where at one time 1 in every 25 babies in the country were born, and when it took six weeks to six months to get a first prenatal appointment at county clinics. We have worked assisting low-income people with enrollment and eligibility for Medi-Cal for two decades and have been a member of the state's Medi-Cal Managed Care Advisory Committee since its beginning in the late 1990s.

Our concerns with managed care are:

- Network inadequacy. For example, there are few high risk OB providers contracted with Medi-Cal plans. Major birthing and high risk maternity hospitals and major cancer centers do take Medi-Cal but they do not contract with plans. In meetings about high risk pregnancy, state representatives have indicated that they have no way to measure adequacy, except by lack of access when people complain.

- Interruption of existing care and existing relationships with providers. Too many low income people are yanked from their relationships with their specialty centers and high risk providers. Even when the continuity of care process works, it is a one-year continuation at best. Some health plans are granting one day or one week, long enough to get medication or a scheduled test only. MCHA made the suggestion that the average amount of time for continuity of care waivers be listed on the program's dashboard of statistics, but it has not been added.

- Delays in making referrals to specialists and lack of care coordination, so that our staff become our clients' de facto care coordinators. The layers of approval and authorization are exacerbated by the power and authority the plans give to the provider organizations, the Independent Provider Association, or IPAs. We have experienced many situations in which the health plans defer to the IPAs on care decisions and coordination and approval decisions.

- Inaccurate managed care status information from the state, , so that women with written notices confirming they are in regular, or Fee for Service (FFS), Medi-Cal show up in the state's computer as still enrolled in a managed care plan instead when they go to a doctor or clinic.

- Inappropriate default assignments to plans and providers, for example, pregnant women defaulted to providers who don't see pregnant women, and a breast cancer patient who was defaulted to a provider who doesn't take Medi-Cal at all.

The options for pregnant women, whether disabled or not, have narrowed considerably since the enrollment of Seniors and People with Disabilities. The Department of Health Care Services Medi-Cal Managed Care Division (MMCD) has determined that prior criteria for avoiding sudden and inappropriate managed care enrollment can be superseded, and often by state staff with no expertise in the specialty areas for which they are determining a course of treatment. The Department had promised careful handholding and support for disabled patients transitioning to managed care and it did not fulfill its promise. Earlier this year and last month, for example, the Department had to send thousands of notices to Seniors and People with Disabilities to tell them that they actually had more time before they had to make a choice of plans. In addition, enrollment has had to betemporarily halted in one area of disability, that of the Genetically Handicapped Persons Program (GHPP), while surveys of issues and concerns are conducted. GHPP promotes high quality, coordinated medical care through case management services for adults with Hemophilia, Cystic Fibrosis, Sickle Cell Disease, Phenylketonuria, Huntington's disease and many others. The transition to managed care has blocked many patients in that program from their lifesaving special treatment centers.

- On Friday, we received a call from a young woman, seven months pregnant, who is diabetic taking insulin 4 x/day, hypertensive on blood pressure medications and asthmatic on medication. She panted as she spoke to us. She was seeing a low-risk provider who transferred her to a high-risk provider but was then defaulted into Medi-Cal managed care, blocking access to the high-risk fee-for-service provider. The high-risk provider had successfully executed a Medical Exemption to disenroll her, but continued to see her without compensation because she was in the plan even though the Exemption should have prevented the default from occurring. She received a notice dated March 27 saying she was disenrolled, but no effective date was listed. She made an appointment for April with the appropriate provider but when she showed up they found that she was still in the managed care plan, despite the notice. Desperate, she went back to the low-risk doctor who could see her on the plan for a visit in April. Once a patient is seen in-plan, MMCD delays the disenrollment until the following month. MCHA was able to get her disenrolled from the plan immediately, but most clients calling on their own would not have the same success.

She needs the perinatal endocrinologist for rigorous control of her blood sugar using a measurement scale that is different from the scale a regular endocrinologist would use and to assess the impact of her high blood sugar levels on the condition of the fetus. We should not be making it more difficult for women to have their care managed appropriately in Fee for Services Medi-Cal.

- Last week a father called us about his wife, six weeks pregnant, who has lived with Hepatitis B from childhood. The father informed us that for their first pregnancy, they had searched high and low and reviewed over 20 doctors to find one who was familiar with the disease and could monitor the pregnancy and delivery. People with chronic Hep B are at a very high lifetime risk of developing severe complications including cirrhosis and hepatocellular carcinoma. Babies born to women with Hep B must be given immune globulin and vaccine at birth.

For their first pregnancy, the couple found an MD they really trusted and who helped them deliver a healthy baby girl. However, the mom has now been in a Medi-Cal managed care plan for more than 90 days, the limit for MMCD to grant a request for disenrollment from managed care.

Furthermore, the family would have to at least be seen for this current pregnancy to establish continuity of care. Although we have tried to reassure the father that the plan most likely can find a specialist, he is insistent that only this doctor will do. This man and his wife are so stressed, they are calling us daily to ask about progress in allowing her to see her first doctor. Numerous studies have documented the effects of stressful events on birth outcomes.

It is with good reason that the couple wants to be seen by someone familiar with the disease: the Hepatitis B Foundation states that all obstetrical care providers need to refer their Hep B positive patients to a specialist or other provider with experience in managing the hepatitis B virus (HBV). Just a regular OB will not do. According to the Institute of Medicine's report on HBV infection in pregnancy, about 40% of obstetrical care providers in one study did not refer their Hep B positive patients to a specialist, either prior to or after delivery. We have approached the plan and the fee-for-service provider to see if they will consider a one-time contract, but the birthing hospitals are also an issue, because many hospitals in Los Angeles that do take Medi-Cal do not contract with managed care plans. The state does not address such contracting and network adequacy issues.

- In the last two months we have worked with two pregnant women who were defaulted into care provider Gay and Lesbian Service Center at six months of pregnancy, on the basis of their geography only and despite the fact that this center does not provide prenatal care. The providers the women had seen since the beginning of their pregnancies did not take managed care plans and had filed medical exemptions to continue seeing these patients. One woman was high-risk and her medical exemption was denied until we intervened. The other woman was not high-risk, but said she had tried to navigate the managed care system and had been unsuccessful. She happened to fall while awaiting her exemption. Per our notes:

> The client "said she was out yesterday and she fell in the street on her stomach. She didn't know what to do so she called the Health Plan. She was told by a rep she could go to any Urgent Care Center or to go to her PCP because they are obligated to see her. The client said she went to a few Urgent Care places but was told they could not see her because of her health plan. She also went to her assigned PCP, Gay and Lesbian Center and was told there they could not see her because she does not have HIV".

We are concerned about plans misinforming patients that any urgent care center will see them—urgent care is not emergency care, and without a plan contract, an urgent care center will turn the patient away if she does not pay out of pocket. We are also concerned about computer assignments that would bring not one but two such patients to our attention in a short period of time and about all the other inappropriate default assignments.

To my knowledge, the MMCD fails in most cases to ensure that FFS Medi-Cal providers are brought into managed care before patients are transitioned. <u>What we see is that the transitions interrupt existing relationships and patterns of care</u>. Medi-Cal has made great strides improving birth outcomes for the 50% of pregnancies covered by Medi-Cal in California, but these improvements are undermined by the process of switching to managed care, especially late in pregnancy.

Medi-Cal is not one program, as you may be aware. For example, women who become eligible for Medi-Cal because of pregnancy are enrolled in the limited scope 200% Program but are then moved into full scope Medi-Cal in their third trimester if otherwise eligible. This is due to arcane state law that treats the woman as having "linkage" to full-scope through a dependent child only starting in the third trimester. Once the women are determined full scope, the state computers enroll them in managed care. Women get one of the famous enrollment packets during the third trimester. This is the worst possible time to switch providers. Some FFS providers may have managed care contracts and can accommodate the woman's change to managed care. But not all providers do and, in addition, just because that main OB or Family Practice Physician contracts with a plan, it doesn't mean that the birthing hospital, the specialists, or other parts of the woman's care contract with a plan, or contract with the same plan. The existing FFS networks are not replicated in managed care. Many hospitals do not have managed care contracts in Los Angeles County. This is important because women start care in FFS and build doctor, specialist and hospital relationships much earlier than the third trimester. The state's own studies have shown that FFS has a better record for initial trimester in which prenatal care starts.

The state does not have to enroll these women in managed care in order to give them more comprehensive care in their third trimester. MCHA has asked the state to postpone the managed care enrollment for these women until postpartum, after their obstetrical care is completed. The state has declined.

One health plan has tracked that one-third of their deliveries were to women who had enrolled during the three prior months, and 11% enrolled the same month they delivered. MCHA believes the state should be tracking this information for ALL deliveries and connect these late enrollments to birth outcomes.

It does matter that existing FFS provider arrangements are not replicated in managed care contracts. In one situation involving a fetus with a lung (and maybe heart) defect, the fetus was already being monitored with fetal heart rate tracing and ultrasound twice a week at a hospital. This hospital had planned to order an MRI to fully evaluate the extent of the baby's birth defect to decide whether the patient should deliver there or another high-risk FFS-only facility, where the baby could have access to intensive neonatal resuscitation and immediate neonatal surgery to correct the birth defect. However, the patient's Medi-Cal was changed late in pregnancy to a Medi-Cal plan. This disrupted the patient's care late in pregnancy, and the managed care-contracted hospital would have been burdened with the care of this very high risk fetus whom they have no previous knowledge of, and who may have required immediate neonatal surgery to ensure its survival (something that that hospital did not offer). Luckily for the patient, the physicians at her original FFS hospital understood the gravity of the situation, and decided to continue to see her despite the fact that she did not have FFS Medi-Cal. It took about three weeks to switch her back to FFS Medi-Cal. We accomplished this switch right before the baby's birth. During this time, the original hospital physicians instructed the patient to present to Labor & Deliver for emergent care each time (minimum of twice per week), knowing that the business office/ billing desk would otherwise refuse this patient access.

Because the population that we serve are often VERY low income, and have difficulty accessing regular medical care, a significant higher proportion of these patients are in poor health coming into care, and have significant medical complications that a general community OB/GYN physician may

not be comfortable managing. Some examples include seizure disorder, poorly controlled diabetes and hypertension, heart disease, and chronic renal failure due to poor control of hypertension or diabetes. Controlling blood sugar to a normal range is very important during the first trimester when the baby's organs are forming. High blood sugar during this critical period can cause birth defects. Patients with Type I (juvenile diabetes) may have blood sugar with extreme highs and lows, making the control of blood sugar during pregnancy difficult and challenging for general OB-GYNs. Frequently these patients cannot be appropriately managed until they are able to see the specialists who have the ability and the resources to provide the care they need.

Specialists with adequate resources, knowledge, and experience to take care of these unusually high risk pregnant patients are typically at academic centers and large County Hospitals. The current disenrollment process is very difficult and cumbersome. It often takes 3-4 weeks for a clinic or private provider even under the best circumstances. The 3-4 week delay in appropriate care can lead to serious adverse medical outcomes, including birth defects and compromised maternal and child health.

Some of the women convert to managed care in third trimester, as explained above, some right after Presumptive Eligibility (PE). Either way, continuity of care has been established and there are implications for care and outcomes. If the woman is low-risk, one has to worry whether the patient will get the packet timely and make the right choice for the health plan that will enable the patient to stay with her provider. If she is high-risk, the clinic staff have to be concerned about trying to maintain continuity with the appropriate providers and hospital.

Patients may be scheduled for surgery, such as C-sections, and have to be refused because their insurance changes. This happened to a client the day before her procedure because of her managed care enrollment and she had to have the c-section at another hospital she had not been prepped to go to, that had not anticipated seeing her.

Another issue is that of obtaining an amniocentesis. It is best done between 16 and 19 weeks of pregnancy, yet if the woman's Medi-Cal has converted to managed care by then, it can take three to four weeks for community providers to disenroll her and the window of opportunity is lost.

Another important issue is Vaginal Birth After Caesarian (VBAC) which women have a right to request and are evaluated for to see if they are a good candidate. ONLY certain hospitals are adequately set up to see these patients because they have a residency program which means they'll have an OB and anesthesiologist on call all the time, 24/7. Other hospitals will not. A prior c-section can rupture during birth, causing the mom to hemorrhage, cutting off the flow of blood to the baby and potentially causing brain damage. These hospitals do have an OB and an anesthesiologist <u>on staff</u>; however, the OB and anesthesiologist are <u>not</u> mandated to be at the hospital 24/7. The nursing staff calls the OB, and the OB will then come to the hospital for delivery. The time frame for crash C-Section to save the baby from permanent brain damage is 10-15 minutes, which means that the baby may already be brain damaged by the time the OB even sets foot in the hospital.

The need to disenroll a woman from managed care in order to get her to the right hospital has caused women to lose the opportunity to have a VBAC, costing the state much more money and more importantly, causing heartbreak in a woman who believed she could attempt a vaginal birth and then is told she can't at 35-36 weeks not because of medical issues, but because of her Medi-

Cal. Clinic and private provider staff try to be preemptive but women still may not get the packets and/or may not get into the right circumstance for continuity of care and risk-appropriate care.

Breast and Cervical Cancer

The state's Breast and Cervical Cancer Treatment Program sets women up with outstanding full-scope care, not just cancer care, in the best treatment centers, only to yank them from those centers if their income falls, for example, and they become eligible for other Medi-Cal. One such example involves a woman I'll call Wanda. She was diagnosed with stage four breast cancer and has been getting treatment at the City Of Hope since April 2011. She has had kidney disease since Jan 2012 and currently sees a nephrologist, and had a single mastectomy in September of 2012. She sees a doctor at least twice a week for her complex conditions. Wanda is currently getting the following complex treatment:

Hormone Therapy-1x a day (a pill in the evening)
Chemo Therapy-1x a week
Occupational Therapy- 2x a week
Hormone Blocker-injection-Once every 4 weeks
Has not had reconstructive surgery yet and will start radiation within the next month.

Wanda was taken off the BCCTP program as of December when she went to DPSS to apply for Medi-Cal and other aid for her children. She asked the worker not to include her in the Medi-Cal application because she was currently signed on with the BCCTP program and she was in the middle of treatment. However, the adult applying for cash aid and food stamps, which Wanda desperately needed given her inability to work, cannot be excluded from the case and even thought Wanda had full scope Medi-Cal through the BCCTP program, Wanda received a different full-scope Medi-Cal that put her in managed care.

The state would reject the request for an exemption from managed care, because City of Hope (COH) accepts some managed care plans. However, continuing at COH while in the plan does not maintain treatment regimens, because if the client is a current patient at COH, the Managed Care unit at COH contacts the plan and works out an agreement with them. The client would only be able to see the specialist at COH and would have to get lab work, MRI's, chemo, radiation, etc. within the Managed Care Plan. Rather than care coordinated as it already is, the client must go to multiple community sites and see providers who may or may not be familiar with the patient's disease and the patient's case. According to a National Institutes of Health-funded study, where you are treated has significant impact on cancer survival[1].

- Early this month we were contacted by a breast cancer client I'll call Martha. She is in Medi-Cal managed care and had been trying unsuccessfully since November, 2012, to have a biopsy of her right breast. She went to her PCP's office when she started having right breast pain and she felt a few lumps. Per the client, her PCP submitted an authorization for her to have an ultrasound and a mammogram. For whatever reason, it did not happen as quickly as it should have. In February

[1] "**Cancer survival depends on where you are treated, says new study"**

http://www.stonehearthnewsletters.com/cancer-survival-depends-on-where-you-are-treated-says-new-study/cancer-2/ Posted on March 1, 2013 by Stone Hearth News; accessed April 19, 2013

2013, the client was given an authorization to an imaging center to have an ultrasound and mammogram. Martha went in on Feb. 6th and was told she only had an approved authorization just for the ultrasounds and not for the mammogram. The technician told her they could not do the ultrasound because the ultrasound and mammogram have to be done together. The tech advised Martha to go back to her PCP and have them submit the authorization. Martha went back to PCP and explained what happened. Another authorization was submitted and approved for the mammogram. Martha made an appt for February 15 and had both her ultrasound and mammogram that day. Then her PCP referred her to a surgeon so she could have a biopsy of the breast. When she called the surgeon to make an appointment, she was told that the surgeon is not accepting new Medi-Cal patients at this time. Martha went back to her PCP who submitted another authorization and Martha was sent to another surgeon. Martha went to her appointment March 19, 2013. This doctor did an evaluation and told Martha that he would have his office staff submit an authorization so she can have a biopsy of her right breast. Then she was told by the surgeon's office that as of this month her IPA was changed from X to Z IPA, and the surgeon is not contracted with Z. Apparently Martha's PCP changed IPAs and took her patients with her, but Martha never got any notice of this nor had the opportunity to decide whether she wanted to stay with her existing IPA, even without her PCP, because she was now connected to a surgeon she liked.

The surgeon told Martha that because she has a new IPA, she will need to restart the process with a new surgeon. Maria is angry, frustrated, scared and just wants to have her biopsy ASAP since she has waited since Nov. 2012. Martha said that she started with 2 lumps and now she feels multiple. Martha also said she feels a burning sensation, discomfort and even pain if she tries to touch her breast. Martha also brought the concern that she's starting to feel the same sensation in her other breast. MCHA told Martha we would work on her case and call her with an answer by this week.

With MCHA's intervention, Martha has now gotten the biopsy and should receive her results today. She is grateful for finally having been able to get her biopsy, but scared and worried about the results and worried that the delay and stress may have had an impact on her results.

A recent study found that most women with ovarian cancer, which kills 15,000 women a year in the US, receive inadequate care and miss out on treatments that could add a year or more to their lives.[2] Cancer specialists around the country say the main reason for the poor care is that most women are treated by doctors and hospitals that see few cases of the disease and lack expertise in the complex surgery and chemotherapy that can prolong life.

In this study, only 37 percent received treatment that adhered to guidelines set by the National Comprehensive Cancer Network, an alliance of 21 major cancer centers with expert panels that analyze research and recommend treatments. This confirms a troubling pattern that other studies have also documented. The guidelines for ovarian cancer specify surgical procedures and chemotherapy, depending on the stage of the disease.

- Sometimes MCHA just has to move the care along within managed care plans. "Anita" was referred to our agency by a state agency in mid-February. She was diagnosed January 2013 with

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[2] New York Times, March 11, 2013, "Widespread Flaws Found in Ovarian Cancer Treatment" http://www.nytimes.com/2013/03/12/health/ovarian-cancer-study-finds-widespread-flaws-in-treatment.html?ref=todayspaper&_r=0 Accessed April 19, 2013

throat cancer and also has kidney failure. She is disabled. Anita's daughter is frustrated with her mom's Medi-Cal Managed Care Plan because she was told that her mother could not see a specialist until late March. Both Anita and her daughter wanted her to start treatment ASAP. MCHA spoke with the health plan and the representative said he would assign the case to one of his case navigators and mark it as urgent. MCHA also asked if she could be assigned a case manager for her treatment and for support. The plan said they would look for a nephrologist and oncologist ASAP. Anita had her first nephrology appointment 2/27/2013 and her 2nd appointment 3/4/2013 to see the oncologist and will be followed by a case manager.

- MCHA recently received a call from a young mom about her son. She had been trying to access dental care and wasn't getting anywhere and was frustrated and reaching out for help. Her three year old son was born with a heart condition and is under the care of a cardiologist, thus a high-risk patient. The mother does not remember when or how her child was switched to dental managed care, but the child was placed in a plan. She tried to seek care through the plan by making an appointment for her son. First she was assigned to a provider who was far away, then she was assigned to a provider nearby, but the plan would not approve her request for a pediatric dentist. She finally lost patience. paid for an office visit out of pocket; however the estimate for actual work was over $1,000 and she could not afford to pay for it. Her son has three cavities and will need to be fully sedated (IV sedation) for the work to be done. She wrote to us on the internet:

> "After our conversation yesterday and hearing more in detail about the family you helped I began to wonder if Medi-Cal will look close at the fact that I have not gone through the first step of actually seeing the primary office he's assigned to and trying to get that authorization for a specialist? I'm very frustrated that the first step is taking so long so that's why I called to get your help since like I told you yesterday, I'm afraid on sitting on this for 3-4 months and at the end not getting an approval. His cardiologist, as am I, is very worried that these cavities will get infected and the infection go to his heart. I'm really worried and just wanted to explain why I have not been so patient in waiting for this office to give me an appointment which may be normal but I don't feel I have that time with him. I'm even looking to see if Medi-Cal has any plan that will help me with some of the bills as long as I can get him help faster. Anything at this point."

In summary:

- MCHA believes that the state is not at all ready for additional groups of seniors and people with disabilities, including children, to be transitioned into managed care for a number of reasons. Adequate care has not been taken with prior populations to ensure their providers have agreed to accept managed care and to ensure optimal health. This is important for reasons of continuity and for the sheer numbers of providers that are needed in Medi-Cal.

- The state should place a moratorium on managed care enrollment of seniors and people with disabilities until and unless it can be proven that adequate networks exist in managed care. Medi-Cal managed care was set up as a pilot and never adequately evaluated to prove cost savings or better care. Indeed, HEDIS studies show the opposite in many measures.

- Quality of care should be paramount. Managed care plans should be adhering to professional standards and guidelines, such as those for ovarian and other cancers and high risk pregnancies. DHCS is making many efforts in this direction, but the projects and protocols should be completed and evaluated *prior* to major changes in service delivery.

What are MCHA's recommendations to improve quality of care and health outcomes for people on Medi-Cal?

- Make improvements in network adequacy for high risk pregnancies, comprehensive measurement for network adequacy, and compliance enforcement;

- Permit all women who start Medi-Cal in fee-for-service to remain in fee-for-service until the end of the post-partum period and end switching from fee-for-service to managed care in the third-trimester. This is necessary for "continuity of care".

- Allow a simple and easy process for women to be released from managed care when pregnant whenever the woman wishes to remain with a current prenatal care provider, lab, specialist, hospital or birthing center or cannot get the services she needs in a timely manner through her plan;

- Permit all women undergoing a course of treatment through BCCTP to remain in fee-for-service until their BCCTP eligibility ends;

- Improve the state's continuity of care process for all other Medi-Cal beneficiaries who must currently use it when seeking to stay with a fee-for-service provider;

- Ensure that default assignments are appropriate (e.g., so that pregnant women are not assigned to clinics that do not provide prenatal care; so that people without HIV are not assigned to HIV clinics; breast cancer patients in a course of treatment are not assigned to networks in which their current providers do not participate; geographic access; etc.);

- Ensure that notices are sent to managed care enrollees when any of their providers leaves their IPA, so that pregnant women can make informed decisions about whether to stay with the IPA (e.g., because they value its specialists) or change (e.g., to preserve a relationship with a PCP). This is supposed to be routine but it does not always happen;

- Improve monitoring and enforcement of plan wait times standards;

- Provide timely, accurate descriptions of a woman's fee-for-service vs. managed care status in the state computer systems on which providers rely for such information;

- Put more resources into marketing and enrollment fraud. Too many families with children in "voluntary" dental managed care in Los Angeles, for example, don't know how theire children got enrolled or signed enrollment forms because they were told something else.

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July 25, 2013

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Mall, Sixth Floor
Sacramento, CA 95814

Re: Coverage for pregnant women under health care reform

Dear Director Douglas:

We understand that the Department continues to assess how low-income pregnant women would be covered under health care reform. As you know, MCHA and others have been advocating for no-cost, comprehensive coverage for women who are eligible for Medi-Cal only under the 200% Pregnancy program (please see attached group memo). As a result of Medi-Cal's narrow interpretation of "pregnancy-related" services, pregnant women are too often denied no-cost coverage for serious medical conditions, such as broken hands, heart disease, brain tumors, and medically necessary services, such as physical therapy for women with bone disease or who were injured during the delivery of their babies. We look forward to continuing to work with the state to ensure comprehensive, affordable coverage for *all* pregnant women, including those eligible for Medi-Cal.

Provide Comprehensive Coverage Under the 200% Program: Coverage under the federal poverty level programs for pregnant women is meant to be comprehensive. This month, the Centers for Medicare and Medicaid Services (CMS) reiterated, for the second time since the Affordable Care Act (ACA) was passed, that:

> [a]s described in the March 2012 final eligibility rule, 'Pregnancy related services' is *presumed* to include all services otherwise covered under the state plan unless the state has justified classification as not pregnancy-related in its state plan (italics added).

75 Fed. Reg. 42160, 42281 (July 15, 2013). We hope that the Department will soon confirm that the 200% Program will provide comprehensive coverage for pregnant women. We also propose a stakeholder process for adopting the necessary administrative procedures to ensure simple, easy, timely implementation. The cost of adding benefits here can reasonably be expected to be extremely low. Women use the 200% Program mainly for maternity services, which are already covered; in addition, under health reform, many of the women will be covered for comprehensive services under other Medi-Cal categories (discussed below). But for women ineligible for other no-cost Medi-Cal coverage and who will not be able to participate in the Exchange (e.g., due to closed enrollment, immigration status) or who may not be able to afford to pay for premiums and cost-sharing even after federal Exchange subsidies are applied, comprehensive coverage under the 200% Program is both necessary and their right.

Include Pregnant Women with Income At or Below 100% of Poverty in the 1931(b) Program Without Regard to Trimester: Very low-income women belong in the 1931(b) full-scope program in the first and second trimesters. The current policy of excluding these women from 1931(b) until the third trimester results in women being switched from their fee-for-service provider networks to mandatory managed care, breaking continuity of care at the worst possible time during the pregnancy. Covering women under 1931(b) from the beginning eliminates the serious problem of third trimester switching. As you know, the Legislature recently ended the "deprivation" requirement for the 1931(b) program. Thus, third trimester "deprivation" is no longer required. Pregnancy per se, in any trimester, creates the necessary "linkage" to the 1931(b) eligibility group.[1] We urge the Department to conform its policies as soon as possible to the new state law and begin enrolling otherwise eligible low-income pregnant women in 1931(b) without regard to trimester.

Women Who Become Pregnant *After* Enrolling in the 138% Adult Expansion: We realize that enhanced federal match for Medi-Cal's 138% adult expansion program is not available for pregnant applicants, although CMS has indicated that states are not expected to track the pregnancy status of 138% program enrollees. However, there is a question as to eligibility for women who become pregnant after enrolling in the 138% program and who are *still pregnant at the time of the next eligibility review.* Such women should have the option to remain in the 138% program if otherwise eligible, at regular state match if necessary, instead of going to the 200% program. Without the option to remain in the 138% program, provider

[1] Under 42 U.S.C. § 1396a(a)(10)(A)(i)(III), states must cover "qualified pregnant women." As defined in 42 U.S.C. 1396d(n)(1)(A), these include "a pregnant woman who would be eligible for aid to families with dependent children. . .if her child had been born and was living with her in the month such aid would be paid. . ."

Under at 42 U.S.C. § 1396u-1(b)(1)(A)(ii)—enacted as part of the 1996 federal welfare reform-- a state's AFDC non-financial eligibility requirements in effect on July 16, 1996 apply to Medicaid in what is often referred to as the Section 1931(b) program. Under subdivision (d) of § 1396u-1, any AFDC waiver eligibility provisions in effect in the state on July 16, 1996 "may (but need not) continue to be applied, at the option of the State" to Section 1931(b) Medicaid eligibility. California's former AFDC program limited the eligibility of pregnant women with no other "dependent/deprived" children in the home to women in the third trimester, and the state opted to continue that rule in Medi-Cal.

In one of the Special Session bills recently enacted, "deprivation" has been dropped from Medi-Cal's 1931(b) program: "When determining eligibility under [1931(b)], . . . deprivation shall not be a requirement for eligibility." Section 4 of AB X1-1, repealing and re-enacting Welf. & Inst. C. § 14005.30(b)(2). The state has thus exercised the option, as provided in 42 U.S.C. § 1396u-1(d), not to continue applying the former AFDC third trimester "dependent/deprived" child rule in Medi-Cal. Accordingly, having a "dependent/deprived" child (i.e., fetus in the third trimester or born) is no longer an eligibility requirement for § 1931(b) Medi-Cal. Thus, pregnancy per se now gives the woman "linkage" to 1931(b), and, under 42 U.S.C. § 1396a(a)(10(A)(i)(III) and § 1396d(n), pregnant women in the first and second (as well as the third) trimester are "qualified pregnant women" who the state is required to cover under § 1931(b) Medi-Cal.

relationships could be disrupted and the women could lose continuity of care late in pregnancy.

We underscore that remaining in the 138% program should only be an option and that women must have the choice of leaving the 138% program for the 200% program at any time during pregnancy. For a woman whose pregnancy has begun only shortly after enrolling in the 138% program or shortly before her eligibility review, continuity of care may be less of a concern than access to a perinatal provider not in the Medi-Cal managed care network.

Protections for Women with Income to 200% Eligible Both for Medi-Cal and Subsidized Exchange Coverage: We understand that the Department plans to extend no-cost comprehensive coverage to women with income to 200% of poverty *only if* they enroll in the Exchange. Our many concerns with the Department's approach are summarized below.

Pregnant applicants: As noted, comprehensive coverage should be available to women under Medi-Cal's 200% Program. Pregnant applicants should not be encouraged to automatically enroll into the Exchange to access comprehensive care. There are many pregnancy-related services available under the 200% Program that the private Exchange plans are ill equipped to provide and will not provide. Pregnant applicants should be clearly informed of their choices; it is for the woman to decide whether her needs will be better served in Medi-Cal's 200% Program with access to fee-for-service prenatal care providers, including Comprehensive Perinatal Services Program (CPSP) providers, perinatal specialists, and more (see below). There must be an "opt in" to the Exchange for these women, not an "opt out".

Exchange enrollees: Women who become pregnant *after* enrolling in the Exchange must have the choice of disenrolling from the Exchange and using Medi-Cal's 200% program alone instead. A woman who becomes pregnant shortly after enrolling in the Exchange may not have established a relationship with a prenatal care provider, and she may prefer to be seen by the out-of-network OB who delivered her other children and at the hospital she knows but that doesn't contract with her Exchange plan. Some perinatal specialty care centers in Los Angeles County that do take Medi-Cal in fee-for-service do not have contracts with the Exchange. There are many other reasons why a woman may need or prefer to leave the Exchange and use Medi-Cal alone instead during pregnancy.

For women in the Exchange who do wish to maintain existing provider relationships after becoming pregnant, there should also be the choice of retaining Exchange coverage and seamlessly receiving all of Medi-Cal as supplemental benefits, including cost-sharing, due process, and other necessary protections, from the Exchange plan with one card. This is the approach that MCHA and others have been urging the Department to consider as an alternative to "wrapping" Medi-Cal benefits around Exchange coverage with a separate Medi-Cal card should the Department go forward with its plans to adopt Premium Assistance. Whether the one or the two card option is adopted, all of the following must occur:

- Premiums: Premiums must be billed to the state, not the pregnant woman who chooses to remain in the Exchange during pregnancy. We are encouraged by what we understand is the Department's agreement with this point. The devil will, however, be in the details.

- Copayments and similar out-of-pocket charges: The pregnant woman must never be charged a copayment, deductible, coinsurance or similar charges by an Exchange plan provider for any medical service or other benefit during her pregnancy. We are also encouraged by the Department's apparent agreement with this point as well—but the details for a "smart" Exchange card to implement are equally important here.

- Blocked access to overlapping coverage categories: Under premium assistance, the women are still Medi-Cal beneficiaries, and DHCS must furnish them with "all benefits for which the individual is covered under the State plan that are not available through the individual [Exchange] health plan." 42 C.F.R. § 435.1015(a)(2)(75 Fed. Reg. 41260, 42304 (July 15, 2013). If a woman must present a separate Medi-Cal card for Medi-Cal services that the Exchange plan does not cover, or covers in lesser amount or duration, then access to the woman's Medi-Cal benefits could be blocked by the Department's current policies on "other health coverage" (OHC) for beneficiaries with private insurance. While we are very encouraged by what we understand to be the Department's intention to extend to women the same scope of Medi-Cal benefits as will be provided to adults in the 138% expansion program, we are very concerned that the women will not be able to actually access the additional Medi-Cal benefits. While this will not be an issue for dental, fortunately, since the Exchange does not provide dental coverage for adults, it will be a major problem for every other general category of coverage under the Department's current OHC rules, as there is some degree of overlap in the general categories of benefits that Medi-Cal and the Exchange provide.[2]

    - Options: The supplemental benefits/one card approach generally eliminates this problem. With the wraparound/two card approach, however, changes in OHC policy, similar to those adopted for foster children enrolled in both Medi-Cal and private coverage, would be necessary to ensure access to all of Medi-Cal's benefits for pregnant women. We urge the Department to take all of the steps necessary to

[2] Here are just a few of many possible examples:

Under Medi-Cal, a woman can receive a hospital-grade electric breast pump and extensive lactation consultation when necessary to assist with difficulty in breastfeeding. The Department's current OHC policies, however, could be a barrier to accessing these services through Medi-Cal for women who are also enrolled in the Exchange with a separate card because the Exchange covers the general category of maternity services but may not cover the kind of breast pump the woman needs and may impose more restrictive limits on the amount or duration of lactation consultation than Medi-Cal does.

The ACA now requires Medi-Cal to cover the services of nurse midwives and birth attendants at freestanding birth centers (*see,* H.R. 3590, § 2301), but it is not yet clear whether the Exchange plans will do the same. Since maternity is a general category of service covered by the Exchange plans, the Department's current OHC policies could block access through Medi-Cal to these nurse midwife/birth attendant services.

A woman entitled to weekly individual mental health therapy visits under Medi-Cal to treat postpartum depression may not be able to access those benefits under the Department's OHC rules if the Exchange plan approves her for mental health services only in a group setting or less frequently than weekly.

ensure that low-income pregnant women enrolled in the Exchange can actually access all of Medi-Cal's covered services and benefits promptly.

- Special concerns re: access to Medi-Cal CPSP: CPSP includes critically important psychosocial services based on a comprehensive assessment of a woman's needs. Integrating CPSP services into prenatal care contributes to improved birth outcomes for low-income women, whose health care and social needs are generally the greatest and most complex.[3] Medi-Cal CPSP providers also provide the woman's labor, delivery and postpartum care services or make the necessary arrangements. While private Exchange plans will cover maternity services generally, they are not required and will not provide the CPSP level of assessment, still less the whole range of CPSP services. Only Medi-Cal CPSP providers will be able to effectively integrate CPSP with the woman's prenatal care; in addition, for continuity of care, in most cases a woman's CPSP/prenatal care provider should also be delivering her at the hospital or birthing center as well. Yet we understand that many Medi-Cal CPSP, prenatal, and labor and delivery providers will not be part of the Exchange networks, even if, as is under discussion, all Exchange enrollees will have out of network access to Federally Qualified Health Centers (FQHCs) as an Exchange benefit. **California's maternal mortality rate was a disturbing 49% higher in 2006-2008 than in 1999-2001. African-American women in California are four times more likely to die from pregnancy-related causes according to DHCS' most recent data**.[4] We simply cannot afford, in any sense of the term, to adopt policies that would undermine CPSP and its impact on improved birth outcomes.

    - Options: To ensure effective, integrated access to CPSP, prenatal care, and labor and delivery services for all eligible women, the Department's OHC policies should be modified to accommodate women whose Medi-Cal prenatal CPSP providers do not contract with their Exchange plans, so that women can receive CPSP with their prenatal care and labor and delivery services. The Department's existing OHC post-services recovery mechanisms could be adapted for use in the context of maternity care for these women. The Department could also coordinate with the Exchange to adjust plan rates based on post-utilization data, similar to the approach currently used with Medi-Cal managed care plans for beneficiaries who also have private coverage. A different approach could involve the Department working with the Exchange to require a sufficient number of Medi-Cal CPSP providers in the Exchange networks for prenatal, labor and delivery services. We remain committed to continuing to work with the Department to resolve these crucial access issues.

- Special concerns re: access to family planning and other reproductive health services: A woman with Medi-Cal today has the legal right to access the providers of her choice for family planning as well as abortion services. This is essential to address the clear need for

[3] *See, e.g.*, Johnson, *Addressing Women's Health Needs and Improving Birth Outcomes: Results from a Peer-to-Peer State Medicaid Learning Project*, Commonwealth Fund, pub. 1620, Vol. 21 (August 2012), pp. 1-2.

[4] *The California Pregnancy-Associated Mortality Review: Report from 2002-2003 Maternal Death Reviews*, California Department of Public Health (April 2011).

prompt access to these services and also to protect the woman's safety, privacy, and confidentiality by not having a private plan's explanation of benefits sent to her home.

  - Options: With the supplemental benefits/one card approach, women must continue to be able to access the family planning and abortion providers, by going out of the Exchange plan network when necessary to protect confidentiality and/or prompt access to services. With the wraparound/two card approach, the Department would need to adjust its OHC policies, so that women who need to use family planning or abortion services confidentially through Medi-Cal would not have access blocked when their Medi-Cal files indicate they also have Exchange coverage.

- Due process rights: Women should not have to give up their right to notice and hearing, with benefits pending the final outcome of a fair hearing, as the price for participating in both the Exchange and Medi-Cal during pregnancy to access comprehensive coverage. The best way to address this key right is to adopt the advocates' approach for notice and hearing in *all* CalHEERS programs, including Covered California.

I hope you will not hesitate to let me know if you have any questions or comments. We know that the clock is ticking on a Regular Session bill to address these issues, and we look forward to continuing to work with the Department, the Exchange Board, the California Health and Human Services Agency, and the Legislature.

Sincerely,

Lynn Kersey, MA, MPH, CLE

Encl.

cc: Peter Lee, Executive Director, California Health Benefits Exchange Board
Diana S. Dooley, Secretary, CA HHS
Jennifer Ryan, Centers for Medicare and Medicaid Services
Senate President pro Tempore, Daryl Steinberg
Assembly Speaker, John Perez

July 29, 2013

David Panush
Director, Government Relations
Covered California

Re: Comments on Draft Bridge Plan Demonstration Project

Dear Mr. Panush:

On behalf of the National Health Law Program and the Western Center on Law & Poverty, thank you for giving us the opportunity to submit comments on the Draft of the "Bridge Plan Demonstration Project: A Strategy to Promote Continuity of Care & Affordability." We appreciate that you have sent out the draft for public comment prior to submission to CMS.

As advocates for lower-income enrollees in Covered California who will need these bridge plans, we share Covered California's concerns about affordability and continuity of care for this population. While we have been very supportive of the bridge plan option that has been proposed to meet these concerns, we continue to believe that adoption of a Basic Health Plan in California would better meet these concerns and serve to guarantee affordability, in particular, for all lower income enrollees, not just those transitioning off Medi-Cal or with family members enrolled in Medi-Cal. To the extent that there is discussion about delaying implementation of any aspects of the Bridge Plan until 2015, we believe that efforts would better go towards supporting, developing and implementing a Basic Health Plan in 2015. We hope that Covered California will support the Basic Health Plan when the issue comes before the Legislature again. In addition, we urge Covered California to protect and promote continuity of coverage and care for pregnant women in Bridge Plans and the Basic Health Plan, if enacted.

Our specific comments on the draft are as follows:

Timing of Implementation. While we understand the enormous amount of work that Covered California is doing to begin accepting applications for enrollment on October 1, 2013, we believe that efforts

should be made to implement the Bridge Plan as soon as possible. While the current draft is vague about when implementation could actually occur, we understand that staff has indicated that there will be delays beyond the April 1, 2014 start date that was previously announced. We are very concerned about such potential delay, and we do not believe that it is authorized by SBx1 3, which only permits a delay for one limited category of potential enrollees in the Bridge Plan. *See* Welf. & Inst. Code § 14005.70(a)(2)(C).

Staff had previously indicated that the provision of Transitional Medical Assistance (TMA) would cover the gap for those persons losing Medi-Cal until the Bridge Plans could become operational. However, TMA does not cover all persons losing Medi-Cal eligibility, so it is not a panacea. Further, if implementation is delayed beyond the previous April 1, 2014 start date, even those receiving TMA will be at risk of losing affordable coverage and the ability to maintain access to their existing providers. ***Thus, we urge that you maintain a definitive start date of April 1, 2014, that you set forth the goal of meeting that start date in the memo, and that you seek CMS approval on an expedited basis to ensure that you can meet this goal.***

"Substantially Similar Provider Network." As we have commented previously, in order to meet the stated goal of continuity of care, it is critical that the Bridge Plans have the same provider networks as the Medi-Cal Plans from which Medi-Cal enrollees will be transitioning. The proposal uses the language from SBx1 3 that issuers must demonstrate that their Bridge plans have "a substantially similar provider network as the Medi-Cal Managed Care plans offered by the health plan issuer." While we realize that it may be impossible for such networks to be identical, they should be as close as possible. This is particularly important in regard to primary care providers. We believe that the term "substantially similar" is too vague and that a definition of this term, as precise as possible, should be added to the draft. **We suggest the following language to explicate what "substantially similar" means:**

> ***Substantially similar means that the issuer demonstrates network overlap of at least 90% between the Medi-Cal plan and the Bridge plan in the areas of Primary Care, Specialty Care, Pharmacy, and Ancillary Service providers.***

Premium Levels. We have concerns about how the draft addresses the premium levels that are expected of the Bridge Plans. Bridge Plans will not be affordable for persons between 138% and 250% FPL unless the premium levels are set sufficiently below the second lowest Silver Level plan to maximize the impact of the tax credit. In the Board Recommendation Brief regarding Bridge Plans, it was suggested that premiums should be set at least 5% to 15% below what would become the second lowest silver plan option in order to achieve affordability. ***The current draft does not specifically set forth where rates should be set and should be revised to do so, with plans encouraged to achieve the "15% below" level in order to achieve real affordability.***

Further, the discussion of premium levels on page 6 is confusing. It states: "The Medi-Cal Managed Care plans in Los Angeles would have the opportunity to offer a Bridge plan with a monthly premium that could be lower, or equal to, the **price differential** between the lowest and second lowest plan currently expected to be offered in this area." We don't understand this,

because in the example given the second lowest silver plan has a premium of $252 per month and the lowest has a premium of $222 per month, so the "price differential" would be $30, seemingly not where the Bridge Plan premium would be set. This discussion should be clearer and should set clear goals for how Bridge Plan premiums will be set, and how Covered California will ensure that the premiums are affordable for low income people.

Clarification of Enrollment Periods. In the paragraph at the bottom of page 7 of the Draft, there is a discussion of enrollment periods which is not clear. The third sentence states that MAGI household members and parents/caretaker relatives could enroll "during the special enrollment period;" it is not clear what this term is referring to. This should be clarified. ***These related persons should be permitted to enroll in a Bridge Plan whenever during 2014 such plans become operable. If this is after open enrollment is over, then the Exchange should allow for a special enrollment period to give such persons an opportunity to get affordable coverage as soon as possible.*** Federal regulations allow for special enrollment periods in "exceptional circumstances as the Exchange may provide." 45 C.F.R. § 155.420(d)(9). Covered California should create a special enrollment period for the time period Bridge Plans become operational.

We are encouraged that Covered California is moving forward to implement Bridge Plans that promote affordability and continuity of care. Please do not hesitate to contact Byron Gross at gross@healthlaw.org or (310) 204-6010 if you have any questions or need any further information. Thank you considering our comments.

Sincerely,

Byron J. Gross
Of Counsel,
National Health Law Program

Kim Lewis
Managing Attorney,
National Health Law Program

Shirley Sanematsu
Senior Health Attorney,
Western Center on Law & Poverty

Elizabeth Landsberg
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Cc: Peter Lee, Covered California
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August 2, 2013

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

Dear Mr. Lee,

On behalf of the more than 700,000 members of SEIU California, thank you for the opportunity to comment on Covered California's draft "Bridge Plan Demonstration Project: A Strategy to Promote Continuity of Care & Affordability" dated July 22, 2013.

As the state's largest healthcare union, representing public and private healthcare workers in all settings, SEIU has a huge stake in the successful implementation of the Affordable Care Act. We were strong supporters of the legislation to create the Bridge plan to provide increased continuity of care, and in many cases, increase the affordable coverage options available to low-income Californians through Covered California.

We commend Covered California for your efforts to provide Californians with a broad range of affordable health insurance options, including your work to receive swift federal approval for the Bridge plan.

SEIU has worked closely with other stakeholders, Covered California, and Senator Hernandez, the legislation's author, to maximize the affordability of the Bridge concept to the extent permitted by federal law. Given the 2014 rates for Qualified Health Plans (QHPs), some regions of the state may not benefit from a Bridge plan offering as currently structured. In other regions, the Bridge plan may provide consumers a greater level of affordability while preserving the continuity of care for beneficiaries moving between Medi-Cal and Covered California. The Bridge plan may further benefit consumers by allowing families to maintain coverage under a single plan. We encourage you to continue to work with the federal government and the plans to improve affordability and to maximize the availability of Bridge plans across the state and to the broadest population of low-income Californians possible.

In keeping with the intent of the Legislature in creating the Bridge plan, SEIU urges Covered California to maximize continuity of care for the low-income population eligible for the Bridge plan and to accelerate availability of low-cost Bridge coverage options for eligible Californians. The draft proposal states that individuals who lose Medi-Cal commencing January 1, 2014 would be eligible for four months of transitional Medi-Cal coverage. If Covered California delays Bridge enrollment past April 1, 2014, we would request that transitional Medi-Cal coverage be extended to provide low-income Californians with seamless coverage.

In addition, we understand Covered California has the option to delay Bridge enrollment until January 1, 2015 for a parent or caretaker relative of a child enrolled in Medi-Cal. SEIU would urge Covered California to align enrollment periods for all individuals eligible for the Bridge plan to reduce confusion and maximize continuity of care. This is vitally important to the success of the Bridge plan option and will also impact the evaluation findings.

Finally, SEIU is strongly in support of a robust evaluation process for the Bridge plan and, as an interested stakeholder, hopes to provide input on evaluation development. As the proposal states, information about consumer preferences, behavior, and plan selection options is a vital part of the evaluation process. This must include information on consumer satisfaction with provider access and other aspects of Bridge coverage.

Thank you for your time and consideration of our comments on the draft proposal. We look forward to continuing to work with Covered California on this important program.

Sincerely,

Michelle Doty Cabrera
Director of Research

CCLHO
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Roberta Lawson
RDH, MPH
Executive Administrator

August 5, 2013

Diana S. Dooley, Board Chair
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: Diagnosis and Treatment of Tuberculosis and Covered California

Dear Secretary Dooley:

On January 18, 2013, the California Conference of Local Health Officers (CCLHO) sent a letter to you with a strong recommendation that services for the diagnosis and treatment of tuberculosis (TB) infection and disease should be included in the preventive care services for Californians participating in a Covered California health plan. We have attached the original January 18, 2013 letter for your review.

We respectfully request written verification of the services for the diagnosis and treatment of TB disease and TB infection that will be included in the Covered California health plans. The services in question include:

- Diagnostics including tuberculin skin tests and interferon gamma release assays, blood work, radiological imaging, and microbiological testing
- Medical visits in the outpatient, emergency, and inpatient settings during evaluation and treatment for TB
- Drugs to treat TB, drug resistant TB, and to treat the adverse effects that can be caused by anti-TB treatment

Our direct inquiries with selected health plans and review of the TB services covered in the health plans that will be participating in Covered California have not been able to confirm coverage for TB services without cost sharing. TB is a crucial public safety concern in California where over 20% of the nation's TB cases occur annually, and access to TB diagnosis and treatment is essential to prevent a costly resurgence of TB.

Currently the TB Medi-Cal Program provides coverage without cost for TB diagnosis and treatment services. We urge Covered California to avoid a disparity in access to TB services between the TB Medi-Cal Program and Covered California health plans.

TB is an equal opportunity disease because it is spread through the air. Early and effective diagnosis and treatment saves lives. In the last year, the American Medical Association, National Tuberculosis Controllers Association, Advisory Council for the Elimination of Tuberculosis, and the American Thoracic Association have endorsed the provision of services to diagnose and treat TB without cost sharing.

As you know, CCLHO was established in statute in 1947 to advise the California Department of Health Services (now California Department of Public Health), other departments, boards, commissions, and officials of federal, state and local

agencies, the Legislature and other organizations on all matters affecting health. CCLHO membership consists of all legally appointed physician health officers in California's 61 city and county jurisdictions.

For more information about TB in California, please contact Mike Carson, President of the California Tuberculosis Controllers Association at mcarson@ctca.org.

Sincerely,

Muntu Davis, MD, MPH
President-Elect, California Conference of Local Health Officers

cc: Peter Lee, Executive Director, Covered California
Ron Chapman, MD, MPH, Director, California Department of Public Health

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Roberta Lawson
RDH, MPH
Executive Administrator

January 18, 2013

Diana S. Dooley, Board Chair
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Dear Secretary Dooley:

The California Conference of Local Health Officers (CCLHO) urges Covered California to recognize the diagnosis and treatment of tuberculosis (TB) as an essential health benefit for all Californians.

CCLHO was established in statute in 1947 to advise the California Department of Health Services (now California Department of Public Health), other departments, boards, commissions, and officials of federal, state and local agencies, the Legislature and other organizations on all matters affecting health. CCLHO membership consists of all legally appointed physician health officers in California's 61 city and county jurisdictions.

TB in the United States remains a public safety concern, especially in California, which reports more than 20% of the TB cases in the country every year. When a person with active TB disease coughs infectious droplets into the air, anyone in continuous close contact breathing that air can become infected with TB. Even though TB is treatable, every other day a Californian dies with TB, and every week a young child is reported with TB disease in California. Prompt diagnosis, isolation, and treatment of TB is necessary to stop transmission in our California communities.

Because there is no effective vaccine to prevent TB, the only way to stop the spread of TB is to find and treat people with TB. Many people with normal immune systems are able to keep TB infection under control in a state that is not contagious. However, development of a medical condition like diabetes, HIV, cancer, immunosuppressive medical therapy or simply the aging process can cause TB infection to progress to active TB disease. Individuals with TB infection and risk factors for progression represent the reservoir of future active cases. Preventive treatment is the only way to effectively eliminate TB infection in this vulnerable population.

Diagnosis and treatment of TB must be accessible to all Californians as an essential health benefit and preventive care service with no cost sharing for the patient. This would encourage providers to include a TB risk assessment in their routine practice and execute targeted diagnosis and treatment of TB when identified at no additional cost to the patient. Making these services more accessible in all health care settings is critical for reducing the impact of TB in California, since some people with TB infection do not have symptoms. Removing cost sharing for TB diagnosis and treatment minimizes costly delays in detecting TB cases and improves opportunities to offer preventive treatment.

CCLHO recommends that the following services should be considered important preventative services as part of the routine diagnosis and treatment for TB disease and TB infection:

- Diagnostics, including tuberculosis skin tests and Quantiferon, blood work, radiological imaging, and microbiological testing
- Medical visits in the outpatient, emergency, and inpatient settings during evaluation and treatment for TB
- Drugs to treat TB, drug resistant TB, and the adverse effects that can be caused by anti-TB treatment.

Patients should not be required to share costs such as copays and deductibles for appropriate medical evaluation and treatment of TB.

Recognizing that the diagnosis and treatment of TB is an essential health benefit for Californians is central for continued TB control and to advance TB elimination in California. Making the diagnosis and treatment of TB as accessible as possible will aid California communities that are disproportionately affected by TB, and will lead to a healthier and more equitable California.

For more information about TB in California, please contact Julie Higashi, President of the California Tuberculosis Controller's Association at Julie.Higashi@ctca.org.

Sincerely,

Wilma J. Wooten, M.D.

Wilma J. Wooten, MD, MPH
President, California Conference of Local Health Officers

cc: √Peter Lee, Executive Director, Covered California
Ron Chapman, MD, MPH, Director, California Department of Public Health

July 15, 2013

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

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

Re: Advocate Comments on California's Draft Paper Application

Dear Ms. Lam and Mr. Finnochio,

Thank you for the important opportunity to comment on California's draft paper application for insurance affordability programs. As requested, below please find our comments in two sections – one with larger policy issues we are particularly concerned about and one with our suggestions page-by-page.

I. Policy Concerns

Medi-Cal and AIM Application

As discussed, we are concerned that the draft application is not clearly an application for Medi-Cal and AIM. "Covered California" was a name chosen by the California Health Benefits Exchange for its population and while we support the close coordination between Covered California and Medi-Cal on outreach and education as well as the joint application and CalHEERS, we had not understood, nor to our knowledge has there been any public stakeholder process about using the Covered California brand and logo to the exclusion of Medi-Cal and AIM. Nor are we aware of any market testing of the branding of Covered California to Medi-Cal enrollees or likely eligible Medi-Cal expansion populations. While we are open to the conversation about eventually having Covered California be used as an umbrella brand for all the insurance affordability programs, we definitely do not think the initial application is the time or place to do that. Many people know and like the Medi-Cal

program and the name should be prominently displayed on the front page - as it is on the joint MC/HFP application – for 2013 and 2014 at least. We are open to a conversation about whether, over time, it would make sense to move to an "umbrella brand."

Identifying and enrolling "deemed eligible" infants

An infant under the age of one whose mother had either Medi-Cal or AIM coverage for the delivery is "deemed eligible" for Medi-Cal without having to complete the application process until the first birthday. Both the paper and on-line application forms must ask whether the mother of an infant had either Medi-Cal or AIM for the delivery and, if so, request her Medi-Cal or AIM number or SSN (all optional). If the mother's information is provided and a match is found, the infant must be enrolled in Medi-Cal.

Information about offers of employer coverage and the Employer Coverage Form

Information about offers of employer coverage is relevant only for the premium tax credit and employer penalties, not for Medi-Cal eligibility. The draft application does not clearly make the distinction. Having to take the "Employer Coverage Form" (Appendix C) to the employer and collect all of that information could be a major barrier to completing the application and enrollment process. It is therefore very important to be clear that: (1) such information is required only of applicants who may actually be eligible for employer coverage, as the federal forms do make clear (both short and long); and (2) applicants who are likely eligible for Medi-Cal do not need to collect or provide information about employer coverage, *whether it is offered or not.*

We therefore strongly recommend that the changes we set out further below be included on Appendices/Attachments B and C (along with other suggestions for those sections). We also request that anyone assisting with or processing applications be informed that consumers likely income eligible for Medi-Cal need not submit this information.

Verification

It has come to our attention that there will not be any electronic data source connected to CalHEERS to verify state residency for Medi-Cal by October 1, 2013 and likely not even by January 1, 2014. For applicants who use the paper application who are income-eligible for Medi-Cal, before the applicant is contacted to request residency information, the county should first conduct an *ex parte* review to see if they have access to information confirming the applicant's residency in California - in SAWS, MEDS and any other data source to which they have access. Federal guidance is clear that electronic sources must be checked before an applicant is required to give paper documents.

Citizenship and Immigration Status Issues

As discussed, we have several recommendations regarding what questions should be asked and how as well as what reassuring language should be included to maximize the comfort of the many immigrant Californians who are eligible for coverage. Our specific recommendations are below but we wanted to include this topic in our priority areas to highlight the importance of making an application which immigrant communities will trust as much as possible.

Projected Income

The newly signed Medi-Cal special session bills ensure that an applicant can qualify for Medi-Cal based on their projected annual income - not just their current monthly income multiplied for the year. We have several comments about how income information is collected to ensure greater clarity but want to highlight that the income questions must also allow for projected income for those persons who have reasonably predictable annual income.

Disability Access

Federal and state disability rights laws (which explicitly adopt Title II of the ADA as floor in state law) requires entities that receive federal/state funding or financial assistance to "furnish appropriate auxiliary aids and services where necessary to afford qualified individuals with disabilities, including applicants, participants, companions, and members of the public, an equal opportunity to participate in, and enjoy the benefits of, a service, program, or activity of a public entity." Section 504 of the Rehabilitation Act indicates that Braille, taped material, and interpreters are non-exhaustive examples of the kinds of auxiliary aids that people with impaired sensory, manual or speaking skills may require to have an equal opportunity to benefit from a service. Disability access will typically encompass five distinct components: **notice** to the public of the right to reasonable accommodations, auxiliary aids and policy modifications; policies and procedures to **solicit and record the accommodation requests** of potential or current participants with a disability; policies and procedures to **assess and consistently meet accommodation requests**; consumer **assistance, compliant and appeal** procedures if accommodation needs are not met; and **monitoring** and incorporation of feedback from people with disabilities.

The paper application implicates all of these components, and in particular requires a question concerning the effective communication needs of people with various disabilities who need the application itself, as well as all subsequent individualized notices and information, in an alternative format such as Braille, large font print, CD, or American Sign Language, or who alternatively may request an accommodation in the

form of live consumer assistance. Covered California and DHCS must develop the functional capacity to ensure that an applicant will reliably receive communications in his or her needed alternative format.

Non-MAGI Medi-Cal Determinations

We are concered that in the section regarding additional information, you included "full Medi-Cal determination" as an option. A consumer should not have to request a non-MAGI Medi-Cal determination; we understand this is what was meant by "full" determination. We understand that in every application, where an applicant is 65 or older or has indicated they have a disability, that application will be sent to the county for a non-MAGI determination. We have suggested language below regarding how to communicate this to consumers.

II. Specific Formatting & Wording Comments

Overarching Comments:

We like the overall look and feel of the application, its spacing and use of pictures.

We like including the "Need help" bar at the bottom of each page to best ensure consumers can figure out how to get help when they need it.

While we like the clean and simple look of the form, we urge you to consider including numbers for each line of the application so people getting assistance over the phone will be able to use the numbering as a reference.

As discussed, we feel it is very important that the application include branding for Medi-Cal and AIM as well a Covered California. The application should include the Medi-Cal and AIM logos and references to Covered California should also reference Medi-Cal and AIM where applicable.

When you print the application on a regular printer, the highlights denoting separate sections get lost, which makes the application harder to follow. We urge that the coloroing of the application work on a gray scale as well as in color.

Many people do not understand the term "appendix" as used in the application. Accordingly, we agree with the Center recommendation to use the term "attachment."

The page numbering is confusing. We urge that you have one number system all the way through.

References to skip to other sections are hard to follow, especially since only underlined words are used as a cue, and particularly when printed in gray scale.

It is confusing to gather information from every person and only gather information on pages such as A6 if the person is applying. That should be in the title – top of page A6 "Person 2 (Fill-out if person 2 is applying for insurance. If not applying, skip to page A7)"

Cover Page:

As discussed, the application shoud have the Medi-Cal and AIM logos and references to Covered California should also references Medi-Cal and AIM where applicable.

We appreciate the reference to translated application forms being available and the use of the 11 languages but there are no tag lines in the languages that explain how to get translated application forms. There are two options to correct this: 1) Translate the line, "You can get this application in (language) by calling xx," in each of the 11 languages, or 2) include dedicated 800 numbers with the list of languages. Please note that if there are not different, dedicated 800 numbers for each language available (option 2), it would be more appropriate to use option 1 as many LEP enrollees will be hesitant to call a general 800. They will assume that they will not be able to speak to someone in their language.

Information should be added to this page about appropriate alternative formats – information about large print or Braille. We suggest the following: "You can get this application in alternative formats including, but not limited to, Braille, large font print, CD, American Sign Language."

At the top instead of "Find out if you can get help with costs" change to "Find out if you can get free or low-cost insurance."

The FPL for family of four on this application is different from the federal application – federal is $94,000, whereas the state application says $92k (2012). The federal application is using 2013 numbers, state is using 2012 numbers. We urge that the most recent number - $94,000 – be used.

Under the "Use this application" section, bullet #2 should be changed from "Assistance paying your health insurance bill" to "Assistance paying for your health insurance." Since the APTCs are used to pay a portion of the premium, it has the wrong connotation when referencing a "bill."

Move language about not needing to have filed a tax return to page 2. Most people will not assume they need to have filed a tax return.

We appreciate that the application includes the help contact information at the bottom of the first page. We suggest formatting that information in the "Need Help" tag line used on other pages. Add Saturday hours and a Spanish number if there is one.

Add a sentence on the cover page or Things to Know page indicating people can apply on behalf of other members of their family using this application.

If there is room on the cover page, it would be helpful to add the following sentence, "If you are an American Indian or Alaska Native who is getting services from an Indian Health Services' funded tribal health program or urban Indian health program, you should still apply for health insurance." Many AI/AN don't realize that the services are not insurance and that they should still get coverage.

Things to Know Page

What you may need to apply – should have a sentence about getting help at no cost in one of the arrows.

First bullet should be rewritten as follows: "Proof of citizenship or immigration status required only for applicants." Also delete "document numbers" from this bullet because it is not a common reference like SSN and most people will not immediately know what that is. Furthermore, document ID or numbers from an applicant is **not** an eligibility requirement like an SSN so it is not appropriate to request it in an application. Also, as currently worded, this bullet appears to only apply to immigrants (and not citizens) and does not make clear this information is required only of applicants. It is critical the first pages of the application make it clear not everyone will be required to provide SSN or immigration status and that you can apply on behalf of others without providing this information.

It is unnecessary to include birth dates in this list. People generally know their own and their families' birth dates.

We urge the following addition: "We keep your information private and secure, as required by law."

For the When You're Done section add: "If you don't have all the information we ask for, sign and send it anyway. We can call you to help you finish your application."

"We'll tell you… days of ~~receiving~~ getting the application. If you don't hear from us, please call us at 800##"

For the Get help with this application section: in person: "For a list of places offering assistance at no cost to you, near where you live, visit …"

This section should also include a reference to the county social services office for help in person. Counties are checking on what number or website to include for this.

"If you have a disability or other ~~special~~ need,…"

For the Need help tagline – Need instructions in Spanish (See Federal tagline) and inclusion of Saturday hours.

Need to add something on first 2 pages about families with immigrants being able to apply as included in the federal application: "Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen."

Step 1:

We support the inclusion of the language questions in Step 1 and the specific wording of the questions as we requested.

In addition to the language questions add "What alternative format, such as Braille, large print font, electronic disc, or American Sign Language, do you need when we communicate with you?"

After asking about how people want communications, e.g. phone, email, etc, add "(you may pick more than one.)" We want consumers to be able to get more than one method of communication. And, delete the text option if neither Covered California or counties have the functionality to text applicants.

The Step 1 person should be better cross-referenced to the Step 2 "tell us about yourself". It is included at the bottom of page A1, 'Complete Step 2 for each person in your family. Start with yourself! " but is not prominent enough.

Step 2:

Step 2: page A1

"Your spouse~~, if you are married~~"

"Your children under 21 who live with you"

Why only your partner who lives with you if they have children? Federal application says "Your unmarried partner who needs health coverage." Add "unmarried" here. The counties will also need to know about this for non-MAGI determinations.

We urge you to include a list of who you don't have to include on the application as the federal application does.

"Anyone on your federal tax return (if you file one), even if they don't live with you."

Need new sentence in the list that says "Anyone else under 21 who you take care of and lives with you." See federal application language.

We urge you to include reassuring immigration status qualifying, similar to the federal application: "We'll keep all your information private as required by law. We'll use personal information only to check if you are eligible for health coverage. You do not need to provide the immigration status or SSN for those in your family who are not applying for health coverage."

The application must somewhere ask, for child applicants under age one year, whether the mother had either Medi-Cal or AIM coverage for the delivery. Such infants are "deemed eligilble" to Medi-Cal without an application, so, once such an infant has been identified, the infant should be automatically enrolled into Medi-Cal without the family having to answer any other question. We recommend adopting simple questions similar to those used on the CHDP Gateway form to identify "deemed eligible" infants, i.e., "For applicants under age one year, did the mother have Medi-Cal or AIM for the delivery? If yes, what is her Medi-Cal number or AIM number (or, optional, her SSN)?"

Add a reassuring sentence here to explain that one can apply for only some members of the family and only those who are applying will need to provide a SSN or immigration status. Rephrase as follows: "You must include these people on this application" to something like, "Your family members should include:"

Step 2: page A2

Why ask for status of relationship on the top of the page when you ask for how you filed taxes with similar questions?

Add a question about sexual orientation (in development by HHS Data Council and the National Center for Health Statistics).

Add a question about whether the applicant is transgender:
Do you consider yourself to be transgender?
[ ] Yes

[ ] No
[ ] Don't know/not sure

In the section asking for SSN (optional), include a Star Symbol to reference the star below that to explain the use of SSN.

Eliminate the section/box asking why the applicant doesn't have an SSN. This is too early in the application process to be asking for an SSN and will have a chilling effect especially when the starred language says you don't have to provide an SSN if not applying. Sends mixed messages like if you do not have an SSN, you have to have a good reason before you can proceed with this application even though you are not the one applying. Move the box to under the federal income tax information on A2.

When you do ask the question we have the following suggested changes:"If you do not have an SSN, ~~what is the reason,~~ do you have:"

For the star explanation of SSN:

- "If someone on this application does not have an SSN and wants help getting one, call…"
- We support the Center recommendation on changing SSN language to avoid the double negative.

Change the wording on the tax questions to simpler terms, e.g.say, "who in the family filed a tax return?" rather than "primary tax filer"?

Step 2: page A3

If not applying for health insurance, go to page A3. (no need to collect race data for non-applicants.)

"If you have other insurance ~~or~~, such as insurance through a job, check here"

Regarding SSN / Immigration Status questions:

1. Reword SSN question on A3 as follows: ***Social Security Number (SSN) (Optional if not seeking coverage):]*** We also recommend adding language here to indicate you can get help if you don't have an SSN, which is required under federal Medicaid rules.
2. For immigration status, the Spanish-speaking focus group participants understood "satisfactory status" and while there was consideration of using "documented status" we urge keeping "satisfactory status."
3. Eliminate yes/no question about naturalized citizen. It's discriminatory, violates Equal Protection, and will lead to confusion and maybe even a chilling

effect. This question in **not required by law** and there is a requirement to ask only for information that is **strictly necessary** which this would violate since they already answered yes/no to are you a citizen?

4. Eliminate requests for document type and ID from eligible immigrants because this is not the best data for the state to verify immigration status. In addition, these are data fields that are not "strictly necessary" for eligibility and thus are in violation of ACA Section 1411(g) and Cal. Welf. & Inst Code § 15926.
5. Replace document type/ID with request for "Alien Registration Number (A#)(if available)"
6. Delete the "have you lived in the US since 1996" question. Date of entry in the US is not necessarily the same answer as "have you lived in the US since 1996?" Asking this question of every applicant violates the requirement that you ask only information that is strictly necessary as this question should only be asked if an applicant is income-eligible for Medi-Cal as it is not relevant for Covered California eligible applicants. Even among Medi-Cal eligible applicants, this question only applies to "qualified" legal immigrants – not every immigrant with satisfactory status, so again the application would be asking other legal immigrants unnecessary questions. We believe date of entry for purposes of determining whether an applicant is eligible for federal Medicaid such that the state can draw down federal dollars should be done administratively on the back end using information that USCIS has in their records (via a SAVE inquiry).

Regarding the disability / health status questions our preference would be the ACS 6 questions which we have previously recommended. If the state will only use two questions we recommend replacing the current questions with the following:

1. "Do you have serious difficulty hearing, seeing even when wearing glasses, walking, climbing stairs, concentrating, remembering, making decisions, or figuring out when they are personally safe?

2. Do you have a physical, mental, emotional or developmental condition that makes it difficult to do daily activities such as dressing and bathing, or run errands alone such as shopping or visiting a doctor's office?"

~~Did~~ Do you have ~~medical expense~~ bills for medical expenses in the last 3 months?

For the military question, the federal application asks it of the person or spouse or parent. "Are you or your spouse or parent a veteran or an active-duty member of the U.S. military?"

Foster care question should be simplified to what is on the federal application: "Were you in foster care at age 18 or older?"

Race or ethnicity – change "~~You do not have to answer this~~" to "Optional"
It should also include the following statement to encourage response:
"Please tell us about yourself. This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health program you are eligible for."

Race/Ethnicity

List of Hispanic, Latino, or Spanish subpopulations should include relevant ACS ethnic categories for California – Mexican, Salvadoran, Guatemalen, Puerto Rican

The option, "Other Hispanic" needs to include a fill in the blank line.

The question, "What is your ethnicity" should be "What is your race?"

Recommend deleting "Other Asian" and "Other Pacific Islander," and just keep the "Other" fill in the blank section at the end. People checking "Other Asian" or "Other Pacific Islander" without being able to specify what their race is, is not helpful data to collect.

Move the are you Hispanic question to after what is your ethnicity. It seems as though Hispanics are being pulled out separately for a reason that may have a chilling effect on immigrants applying.

Step 2: page A4

"How often do you get paid?"

Reference to "other income" is hard to find – make more bold and include in CAPS and then the section with other income should match – very hard to see in black and white printed application.

Switch order of income questions – ask first how often you get paid, then subsequently ask how much you get paid before taxes – otherwise, hard to know what is expected to fill-out the amount. Once they check weekly, more likely to report the weekly amount.

Do you have other income? – "Appendix D on page 8 lists examples of other income you need to know about."

Chart with "Where does this income come from? (See Attachment D for a list of examples)" Need to repeat, as people often skip the header explanation or don't remember when they get to the filling-out part.

The application asks what was total income this year, but how can someone know their income for a year that hasn't ended? Also, as discussed above, the income questions need to be able to get to projected income. This is required for Medi-Cal under the special session bills recently signed into law and is also appropriate for APTC. If someone knows their income is going up, they may want to take a lower APTC level. There should be a question which says, "If your income changes for future months, and you know what your total income for the year will be, fill in your total income here?" Should indicate if it is before or after taxes.

"Type of Deduction (see Appendix D)" - **NOTE**, there is nothing on deductions in Appendix D – this is missing totally from the application and must be added.

Alimony paid – important to distinguish from alimony received – confusing otherwise.

"Do you have other income" implies non-work income such as interest. But the additional questions look as though one only can provide work income which is confusing.

Where does someone indicate other types of non-work income income? Make the reference to Appendix D more prominent so people know what kinds of other income people may need to declare or not declare under MAGI rules as folks may not review the list on the appendix first. Recommend adding additional types of income that are not needed under MAGI to the existing list in the question.

Step 2: page A5

For all other persons than the person applying, need preferred written and spoken language questions as well as new alternative format question from page A1.

Add sexual orientation and transgender questions – see comment above.

Change alternatives to SSN number question as stated above.

SSN request – should add language that repeats offer to help get SSN from page A2.

All the questions for persons 2, 3, and 4 should have "same as for Person 1" or skip options for some issues - like best contact to reach, and federal income tax information. Parents should not have to include adolescent phone numbers and the income tax info will be confusing.

Step 2: page A6

What is the relevance of the question for someone 18 years old, "does he or she have a parent living outside the home?"?

Race and ethnicity – repeat of comments to page A1

Step 3:

Authorized Representative

"You can give a trusted friend, ~~or~~ partner, or family member, permission to …"

Add phone number and e-mail contact of authorized representative and their preferred mode of communication.

Federal application asks for organization affiliation of authorized representative and should ask if they have a Covered CA ID #.

Revised Privacy Statement (Revised July 11)

We are concerned about the revised privacy statement It is too long, has unnecessary information and may well scare some consumers away. The wording should be rewritten for the 6th grade reading level standard and all of it reviewed to eliminate unnecessary components. For example, why do you need to include the Govt Code section citations? Few consumers know what "Department of Health Care Services (DHCS)" is (and you have the long name spelled out twice). Substitute with "Medi-Cal program."

The sentence, "The consequence of not supplying the mandatory information requested is denial of the application," is quite harsh and does not correlate with the beginning message of, "... if you don't have all of the information we ask, sign it and send it anyway."

"This means we will share your information with other agencies and the plans you want to enroll in." There should be a specific list of other agencies that information will be shared with – see federal application (page 7). Also, plans should not be getting all of this information – should delete that or narrow it – they will only be getting information that is limited to enrollment – need to be clear about this.

In the second last paragraph, after the sentence "You have the right to access and inspect your personal information in records maintained by federal and state agencies, with some limited exceptions," please add "You also have the right to an alternative format or auxillary aid such as Braille, large font, or interpreters that will enable you to effectively review your personal information."

Rights and Responsibilities (Revised July 11)

We are very concerned about the addition of the 4th bullet requiring application for other benefits to be eligible for Medi-Cal. Neither of the two federal forms requires such a declaration and we know of no state or federal statute that authorizes DHCS to make applying for such income or benefits a condition of Medi-Cal eligibility. We therefore strongly urge that you delete this from the declarations.

We appreciate that the revised version is more consistent in including Medi-Cal as well as Covered California. Medi-Cal should be added to the 6th and 8th bullets after Covered California

In the 2nd last bullet in the left column of the first page, after "If I think Covered California has discriminated against me," please add: "including the failure to provide reasonable accommodations or policy modifications as required under state and federal law".

In the 2nd bullet on the 2nd page under Your right to appeal, there should be a TTY number here (and operators must be trained in receiving TTY and video relay calls as well).

5th bullet – "~~I know that~~ I must tell, Covered California or my county ~~welfare~~ social service office

8th bullet – "~~I know that~~ If Medi-Cal pays…"

Your rights and responsibilities (A15)

Your right to appeal

1st bullet – "…mistake, I can appeal ~~its~~ the decision. . ."

2nd, 3rd and 4th bullets – strike "~~I know that~~" throughout.

3rd bullet: use "family member" instead of "relative"

What is meant by "I understand that any changes in my eligibility or eligibility of any member(s) in my household may affect the eligibility of other members of the household"? This is scary, especially since one's immigration status should **not** affect someone else in the household's qualifications.

Renewal of insurance

Suggested rewrite of first sentence: "I understand if I qualify for free or low cost health insurance this year, Covered California and Medi-Cal need to check if I still qualify next year."

The second paragraph is confusing. We suggest the following rewrite: "Covered California or Medi-Cal will send me a renewal notice each year. I should report new income information if my income has changed. If my income does not change, I will get the same help with free or low-cost health insurance."

Federal application language is preferable about giving consent for verification: "To make it easier to determine my eligibility for help paying of health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time."

Declaration and signature

Remove "~~I know that~~" in bullets 2 and 3.

We have several concerns with the revised penalty of perjury statement sent to us July 11. It is not written for the appropriate grade level readability. For example, why was "I understand that if I do not tell the truth" changed to "I acknowledge that if I am not truthful . . . "? This is too complicated for many consumers to clearly understand. Similarly, the use of "foregoing" is not understandable to the average applicant. This language must be significantly simplified.

Application assistance section

We understand this section was inserted as placeholder and will be completely revised to reflect Covered California and Medi-Cal – not HFP. We would like to be able to review the revised section.

Step 4:

Mailed applications should go to Covered California

A few more questions

How do they know about open enrollment – why not just ask if they have had any recent changes in their life and give the list of options?

Need more Information

It is confusing to have "Full Medi-Cal determination in this list." This is a Medi-Cal application which, along with a supplental form, can be used for a non-MAGI Medi-Cal determination. We suggest the following language:

"This application works for Medi-Cal for people whose income is counted using the new gross income test. Others, including people 65 years of age or older and those applying as a person with a disability have to give other information about their income and assets (like savings accounts)."

AIM should not be included here. This application is for AIM, as well as Medi-Cal and Covered California.

Need to add county health care here and also tell about county heath care options in the notice of action for applicants denied all full-scope insurance affordability programs as required by Cal Welf & Inst Code 15926.

Appendix A: For American Indians or Alaska Natives

Include language from the federal application form, "Complete this Attachment if you or a family member are American Indian or Alaska Native. Make sure to submit it with your application."

"American Indians and Alaska Natives can get services from Indian Health Services' funded tribal health programs or Indian health programs. They can also get no or low-cost insurance. If you are an American Indian or Alaska Native, you may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible."

Appendix B (p. 5): "Tell us about your family's health insurance"

Should check boxes be added for "TRICARE (don't check if you have Driect Care of Line of Duty)" and "Peace Corps" (see short federal application, p. 3)? These are mentioned at p. 6 in the continuation of Appendix B.

What type? Add "(check all that apply)" as people may have multiple types of coverage.

List of types should be revised to say:

[ ] employer offered insurance (please also see next page)
[ ] other private insurance _____
[ ] other _____

The column asking "Does this health plan meet the minimum standard value?" should be dropped, as applicants will not know what that means, and the employer needs to provide that information (see Appendix C).

The on-line application should be conformed.

Appendix B (continued on p. 6):

Appendix B, p. 6 starts with: "Employer health insurance. Answer these questions for everyone who *needs help paying* for health inusrance. We need to know ahout any health insurance you *could* get through an employer. You can use Appendix C, Employwer Coverage Form on page 7 to help you complete this section." Applicants are then asked: "Is anyone on this application *offered* health insurance by an employer?" (all italics added). If yes, a series of questions must be answered; if no, the applicant is directed to go back to the application, but this instruction could easily be missed. We strongly recommend adding the following:

· "You **DON'T** need to answer these questions or use Appendix C, the Employer Coverage Form, unless someone in the household is eligible for health coverage from a job." (see Appendix A of long federal form); and

· Add: "You **DON'T** need to answer these questions or use Appendix C, the Employer Coverage Form, for anyone who is eligible for Medi-Cal. The income limits for Medi-Cal by family size are: [INSERT CHART]"

Appendix C (p. 6): "Employer Coverage Form"

Again, we strongly recommend clarifying:

· Skip this form if no one in the household is eligible for health coverage from a job.
· Skip this form for anyone who is eligible for Medi-Cal (see income chart on Appendix B, p. 6).

For applicants who do need to use the Employer Coverage Form reassuring language is needed that if your employer does not complete this form, there are other ways to provide proof of income. Should also indicate this form is only needed for those who are **applying** for benefits (to determine minimum essential coverage). Non-applicants should not be required to provide information about their existing coverage since that can be asked by the IRS for individual mandate purposes.

Asks for name and SSN without recognizing that applicant may not have an SSN.

"Use this form to get the information ~~you need~~ required from the employer who offers health coverage."

Note for employer – "we need to know about health insurance that ~~your~~ this employee might be able to get from you."

Don't understand, "What's the name of the lowest cost, self-only health plan..."
Appendix D:

Immigration Status issues:

- Reword "if your papers say any of these things," "Papers" is **not** appropriate. Instead, ask if you have one of the listed immigration statuses, you are **considered eligible for health care coverage**.
- Delete "you may apply for health insurance." This is not accurate. Immigrants who are NOT on this list, can still apply for health insurance and may be eligible for limited-scope coverage. For example, PRUCOLs or undocumented.
- Need to add at the bottom of the list a sentence indicating that if your immigration status is not listed above, you may still be eligible for health care coverage and should still apply.

Totally missing a list of types of deductions, as promised in Step 2 A4 and A7, etc..

Examples of income – "Use this list to see what kinds of other income ~~are asked~~ we need to know about in Step 2:"

"Are you self-employed?" is not the same as "did you file a Schedule C?" Immigrants may be self-employed but have not filed taxes so the instructions in Appendix D for "Self-Employment" is confusing. Also reference to Step 2 here does not make sense. The Appendix directions for this section should instead say "Use this list to answer the question about tax deductions on page A4."

Appendix E: "Choose your health plan"

Please clarify that: (1) this form is only for choosing Covered California plans; and (2) for Medi-Cal, enrollees will be covered back to the date of application once found eligible but will choose their health plans at another time.

For Covered California, how does the applicant get a list of the health plans available to them (and the code)?

Frequently Asked Questions

Insert as second question: What is Medi-Cal?

Third question should be What is AIM?

It would be helpful to include a FAQ about the unique eligibility rules for American Indians and Alaska Natives. If they qualify, there is no cost to them in Medi-Cal, and if they are below 300% FPL in Covered California, they do not have any share of cost (but do have to pay premiums). They are also able to enroll in Covered California throughout the year.

Another helpful FAQ would be to outline the distinction between receiving health care services from an Indian Health Services' funded tribal health program or urban Indian health program and insurance.

#2 – "~~Everyone~~ can apply for health insurance through Covered California." We want to be careful with this language – literally everyone can apply, but some won't be eligible, so it is misleading.

#3 add county social services office as place where people can apply

#4 shoud make it clear that some people can get free coverage

#5 – People who would have to pay more than 8 percent of their income…" Shouldn't that be 9.5%??

#6 – This question and answer are not correct. People on Medi-Cal cannot get Covered California.

#7 dates wrong. ACA was not enacted in 2013 - or 2012. 2010

Is this question only related to someone who has insurance in the individual market? It doesn't make sense if they are insured through their employer.

#8 Covered California will open "later this year." If the state is worried that CalHEERS will not be ready October 1, could say October 2013, but "later this year" is too confusing.

Third paragraph about the metal plans is confusing. The paragraph below it is much simpler and seems to say the same thing.

#10 why will it take 30 days for an answer? Page 2 states that it will take 10-15 days.

#11 same as above regarding 30 days.

Family size and income

#1 No. Not everyone on the application has to be a US citizen or national. Answer is wrong. Should be: "No. They can also be an immigrant .with . ."

#3 – the answer is not responsive to the actual question asked.. Change the question or the answer.

#4 typo in answer. delete "you're" in 3rd sentence

#6 The website listed to get more information about tax credits is too long to be helpful.

Other questions

#2 should have an additional reassuring component at the end of the answer: "The questions concerning any impairments conditions that affect your daily activities are intended to make sure you and your family get the most benefits possible and will not affect whether you can get coverage or how much you will have to pay for health insurance."

#3 should be entitled something like "What help can I get getting health coverage before January 1, 2014?"

2nd bullet under #3 is confusing. People can to use this application for Medi-Cal in 2013.

Thank you for your consideration of our comments,

Elizabeth A. Landsberg, Western Center on Law and Poverty
Ellen Wu, California Pan Ethnic Health Network
Julie Silas, Consumers Union
Silvia Yee, Disability Rights Education & Defense Fund
Lynn Kersey, Maternal and Child Health Access
Kim Lewis, National Health Law Program
Sonal Ambegaokar, National Immigration Law Center

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

California Legislature

ASSEMBLY REPUBLICAN CAUCUS

June 4, 2013

Board Members and Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Dear Board Members Belshe, Dooley, Fearer, Kennedy and Ross and Executive Director Lee:

We write to urge the leadership of the California Health Benefits Exchange (also known as *Covered California)* to put the public safety protection of health plan applicants first by implementing a zero tolerance policy in the hiring of Exchange employees and the certification of Individual Assisters with criminal records. Individuals, who have demonstrated poor character in the past, as exhibited by their conviction of one or more crimes, should not have access to the confidential, personal and financial information of health plan applicants.

As *Covered California* begins operations in October 2013, thousands of inadequately trained Exchange employees and Individual Assisters will, in the effort to facilitate the enrollment of potentially five and a half million persons in qualified health plans through the Exchange over the next several years, have access to the health plan applicants' confidential, personal and financial information. There is considerable danger that low- and middle-income health plan applicants will become victims of financial crimes and identity theft because Exchange employees and Individual Assisters will not have to undergo the well-developed screening, fiduciary and ethical training and examination process that is currently required of health insurance agents and brokers in California. It was wrong and bad public policy that the federal Affordable Care Act mandated second-class treatment for uninsured people seeking health care coverage. But *Covered California* does have sufficient discretion under federal and state law to protect health plan applicants against potential financial crimes and identity theft.

As you know, on May 21, 2013, the Exchange adopted regulations to provide guidance related to those that could be hired as Exchange employees or be certified as Individual Assisters if they have a criminal record. The regulations provide that when considering the criminal background information received, the Exchange shall take into consideration the nature of the job held or sought, the age, nature and gravity of the offense and any evidence of rehabilitation including evidence provided by the individual, including but not limited to participation in treatment programs.

(916) 319-3900 1020 N Street, Suite 400 - Sacramento, CA 95814 FAX (916) 319-3902

Unfortunately, these regulations fall short compared to what is required of insurance agents and brokers. Training and education is not incorporated as a part of the certification process of Assisters, there is no requirement that applicants disclose all criminal convictions and administrative actions on the Assister application, and no provided process to investigate complaints against Assisters. It is imperative that the same administrative and criminal remedies that currently apply to agents and brokers for wrongdoing are also applied to Assisters.

In other words, the success or failure in protecting low- and middle income health plan applicants from financial crimes and identity theft will be solely determined by whether the leadership of *Covered California* puts the public safety interests of health plan applicants first or puts the remunerative interests of Exchange employees and Individual Assisters first. If the Exchange decides that they will deny most or all people with criminal records from becoming Exchange employees that facilitate health plan enrollment, have access to information technology systems, or Individual Assisters there will be fewer financial crimes and identity theft crimes committed against health plan applicants. If, on the other hand, the Exchange chooses a more liberal approach and allows people with criminal records to be hired as Exchange employees, have access to information technology systems or become certified as Individual Assisters, then more financial crime and identity theft crime will be committed against health plan applicants. This important responsibility falls upon you.

We strongly urge the leadership of *Covered California* to implement the May 21, 2013 regulations and add further consumer protections in such a way that clearly puts the public safety interests of health plan applicants first by implementing a zero tolerance policy in the hiring of Exchange employees or the certification of Individual Assisters with criminal records. The closer the Exchange implements the well-developed process that the Department of Insurance uses for screening applicants for agent and brokers licenses, the better.

Sincerely,

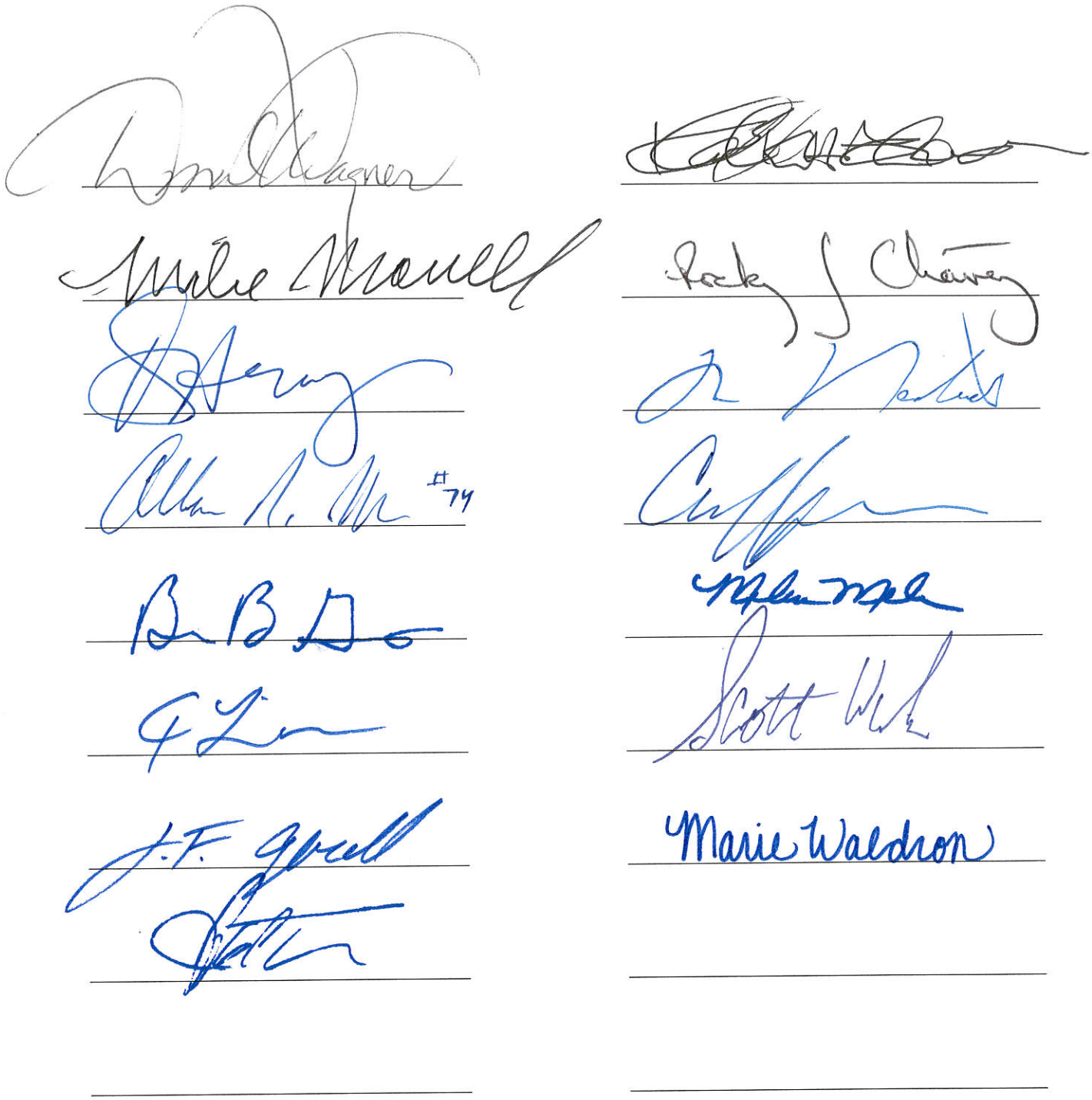
Connie Conway

Brian Jones AD71

Brian Dahle AD1

Frank Bigelow AD-5

Kristin Olsen AD12



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ASSEMBLYMEMBER CONNIE CONWAY
TWENTY-SIXTH DISTRICT
CALIFORNIA LEGISLATURE
CAPITOL OFFICE
P.O. BOX 942849
SACRAMENTO CA 94249-0026

for

Board Members and
Executive Director

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

July 22, 2013

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

Re: Proposed regulations governing eligibility and enrollment for Covered California – Reserved provisions in June 20, 2013 version

Dear Ms. Lam,

Thank you for the discussion regarding the reserved sections of the proposed regulations related to eligibility and enrollment issues. Please find below our written comments on the regulations.

Section 6454 – Exemption from Individual Mandate

Subdivision (f)(1) should clarify that only one of (A) – (D) need be met to establish lack of affordability. Accordingly, we recommend that you add "*because they meet one of the following*" to the end of (f)(1).

Subdivision (f)(1)(A): Though we understand the language is from the federal regulations, it is confusing. We recommend that this be stated more clearly.

Subdivision (h)(3)(B): The statement that the Exchange will "provide the tools to file an application" is unclear. We recommend rephrasing this to say the Exchange will "*provide assistance and instruction to file an application.*"

Section 6470 – Application

We urge that you add a new subdivison (b) specifying that the Exchange shall use the application to determine potential eligibility for non-MAGI Medi-Cal.

In subdivision (e), we suggest that you change "facsimile" to "*other commonly available electronic means*" as is used in Cal. Welf & Inst. Code 1596 (b) and also, we believe, in federal regulations.

We urge you to add a new subsection indicating that the Exchange will accept incomplete applications and advise the applicant of the missing information rather than denying eligibility based on missing information. We were pleased to see that California's paper

application advises applicants that if they cannot answer a question, they should submit the application anyway.

Section 6488 – Verification Process

We urge you to delete this section as it governs Medi-Cal eligibility procedures. While we realize MAGI Medi-Cal rules are being built into the CalHEERS rules engine, those rules are still governed by DHCS as the Medicaid agency and Covered California should not promulgate regulations to deal with Medi-Cal. The special session Medi-Cal legislation lays out Medi-Cal's rules and standards regarding verification, including the "reasonable compatibility" standard (see ABx1 1 Sec. 15 codifying WIC §14013.3) and we think DHCS should issue Medi-Cal regulations to spell out any requirements that need to be laid out with greater specificity.

Section 6490 – Verification Process Employer sponsored plans

Now that the employer mandate is postponed until 2015, we are concerned that plans as outlined in this section may not come to fruition. This section should address any contingency plans that must be used until then, consistent with the most recent federal regulations which allow the Exchanges to rely on self-attestation by the applicant as to whether they have access to employer sponsored coverage without having to verify that coverage is not available or affordable.

Section 6508 – Authorized Representative

We have concerns about allowing an organization to be an authorized representative and urge that this be changed so that only an individual can be an authorized representative. While many authorized representatives work for organizations, it is important to designate a particular person. This is consistent with the recent Medi-Cal special session bills that require an individual authorized representative be named. To adopt this policy we suggest that you delete "or organization" from subdivision (a) and delete subdivision (h) in its entirety.

Section 6510 – Right to Appeal

No comments.

Article 7 – Appeals Process

Section 6602 General Eligibility Appeals Requirements

In subsection (a)(1) we suggest that you change "eligibility determination" to "*action or inaction related to an eligibility or enrollment determination.*" Applicants and enrollees have the right to appeal failure to act, as well as actions with which they disagree. We suggest that you add "*or enrollment*" after "eligibility" in (a)(1) and elsewhere to make it

clear that consumers can appeal enrollment decisions, such as those related to open enrollment and special enrollment periods. We also advocate that you explicitly include eligibility for a bridge plan as an appealable issue.

We urge you to explicitly designate the Department of Social Services as the appeals entity in the definition section and in 6602(b), rather than a generic "appeals entity." We understand that Covered California will only be using DSS for individual Exchange appeals, not SHOP. The language "by the Exchange" should be eliminated and "*by DSS*" inserted in its place. Your draft Subsection (b) mirrors the federal rules but does not seem to comport with decisions the Exchange has made. We look forward to seeing the redraft of this provision.

Subsection (e) indicates that in the case of an appeal of an adverse Medi-Cal or CHIP determination made by the Exchange, the appeals entity will transfer the case file to DHCS. This prompted a discussion regarding how DSS will determine if a particular appeal is contesting the Medi-Cal or Exchange determination given that every MAGI determination is both an Exchange and Medi-Cal determination. We think it will be difficult to determine whether something is a Medi-Cal or Exchange appeals and think the federal regulations are clear that appeals are for both. Therefore, language should be added that clarify that information should be transmitted to both the Exchange and DHCS in all cases, and eliminate "as applicable" from the subsection.

Section 6604 Notice of Appeals Procedures

Because the Exchange is not the only entity that will be processing applications (counties will be as well), we suggest the following change to subsection (a). "The Exchange *and any other entities making eligibility determinations* shall provide a notice . . ."

Subsection (b) outlining what must be included in the notices attempts to accomplish two different things: (1) provide applicants with a general description of the appeals process at the time they apply, and (2) provide people with a specific notice (in Medi-Cal called a "notice of action") that informs them of the decision re eligibility and the basis for the decision. Because there is nothing in the proposed regulations (either here or in other provisions where notice is addressed, e.g. Section 6476(g)) to describe what information should be included in the specific notice of the Exchange's decision, this section must be amended to include information on the specific basis for eligibility/ineligibility for any of the programs for which an applicant has been determined eligible or ineligible for, or potentially eligible/ineligible for. This is also critical if these notices will serve as a Medi-Cal eligibility determination because the notices of an adverse action must contain all of the information and elements required to be included in Medi-Cal notices of action (*Goldberg v. Kelly*, and 42 CFR §431.210). Therefore, a new subsection (c) must be added as follows:

(c) Notices provided to an applicant pursuant to subsection (a)(2) must include all of the following additional information,:

(1) Information about each insurance affordability program for which an individual or multiple family members of a household have been determined to be eligible or ineligible and the effective date of eligibility and enrollment.

(2) Information regarding the specific bases of eligibility or ineligibility for non-Modified Adjusted Gross Income (MAGI) Medi-Cal and the benefits and services afforded to individuals eligible on those bases, sufficient to enable the individual to make an informed choice as to whether to appeal the eligibility determination or the date of enrollment. Any notice of ineligibility or other adverse determination must contain all of the information provided for in Medicaid notices of action, pursuant to 42 CFR §431.210.

We also understand that for an individual or family determined eligible or ineligible for the same insurance affordability program, they will receive one notice telling them about both MAGI Medi-Cal and Exchange. We would like to confirm that is still true. However, for mixed coverage families, we are very disturbed to learn that California plans to send two separate notices – one to those determined eligible/ineligible for Medi-Cal but not the Exchange (sent by the county) and one to those determined eligible/ineligible for the Exchange but not Medi-Cal (sent by the Exchange). This is a bad policy decision, which will result in consumer confusion. We do not understand why it is necessary to send a family two notices when they can apply together and get one determination online. We fail to see how this is a "systems issue," given that the notices will all be generated in CalHEERS and for use by whichever entity is sending them out. We urge both Covered California and DHCS to revisit this policy in the best interest of California consumers.

Section 6606 Appeal Requests

We urge that (a)(1)(C) be clarified to ensure that consumers can apply in person by deleting everything after "in person as follows, "In person~~, if the Exchange or the appeals entity, as applicable, is capable of receiving in-person appeals requests~~." We also suggest that you add *"(E) other commonly available electronic means*" to allow consumers to file an appeal by fax and related future technologies.

In (a)(2) "may" should be changed to "***shall***" so that enrollees are assured of help with appeals if needed as such: "(2) ~~May~~ ***Shall*** assist the applicant or enrollee in filing ~~making~~ the appeal, if requested."

In (d)(1) we urge that you add to the elements to be included in the acknowledgement of the appeal request *"(C) an explanation of the informal resolution process*."

In (e)(1) we urge you to add language informing the applicant/enrollee of the right to address the problems with the defective in the "invalid" appeal by including the following language at the end of the sentence before ", and" to read as follows: "*and that the applicant or enrollee can cure the defect and resubmit the appeal again as long as it meets the timeliness requirement*; and

Section 6612 Informal Resolution

We agree that appellants should have the opportunity to informally resolve their case before it proceeds to fair hearing and think additional detail is needed here. We urge the Exchange to adopt the informal resolution currently used by DSS for Medi-Cal and other programs, and, as discussed, suggest that you reference the Manual of Policies and Procedures 22-073. Participation in the informal resolution process must not impair the appellant's right to a hearing where the appellant remains dissatisfied with the outcome. Therefore we support (d) preserving the right to a hearing if the informal resolution is not successful.

The regulation should ensure that the informal review process timeline runs concurrently with the hearing timeline unless there is a conditional withdrawal of the hearing by the appellant to "stop the clock." This is critical to ensure that the informal process does not indefinitely delay (or infringe upon) the appellant's due process right to a hearing or to cause an appellant to drop or not pursue the hearing altogether. Further, the right to proceed to a hearing should not be impaired with the appellant having to make a new hearing request if dissatisfied with the informal review should they elect it. This option should also not delay the appellant's right to a hearing decision.

We are concerned with (f), which states that if the appeal does not go to hearing, the informal resolution decision shall be final and binding. There is no "informal resolution decision" per se. Rather, only if the appellant and the agency agree to a conditional withdrawal should the appeal be withdrawn. We urge (f) be replaced with the following:

> *The appellant or the authorized representative may withdraw the hearing request voluntarily or may agree to a conditional withdrawal that shall list the agreed-upon conditions that the appellant and the Exchange or county shall meet.*

A new subsection (g) should be added to indicate that the timeframe for holding the hearing shall not be delayed as a result of the informal resolution process, to read as follows::

> *(g) The 90-day deadline for holding a hearing shall not be tolled or delayed as a result of the informal resolution process, unless a resolution is reached and agreed to in writing by the parties.*

A new subsection (h) should be added as follows:

> *(h) The formal resolution shall be considered final unless the conditional withdrawal is revoked and a hearing is reinstated by the applicant or enrollee.*

The state should specify who will be conducting the informal resolution process for which cases. We are concerned that, based on our conversation, the state plans to have both a county and Exchange representative each involved in the informal resolution

process. While this arrangement seems to rightly take into account that almost every appeal is effectively both an Exchange and a Medi-Cal appeal, we are concerned that it will be burdensome for a consumer to have to participate in informal resolution discussions with two entities – not to mention the inefficiency of this. This seems particularly unnecessary given that there is one rules engine upon which all MAGI determinations will be based. As with the notices, we urge that Covered California, DHCS and the counties find a commonsense way to split the cases so that there is one entity doing the informal resolution in the best interest of consumers. Similarly, we hope there will only be one position statement and entity participating in the hearing in the name of coordination and efficiency.

As we discussed, we would like to have a meeting in early August to talk further about the informal resolution process.

Section 6614 Hearing Requirements

In (c), the appellant should have the choice of format of the hearing, including in person, telephone or videoconferencing, all of which DSS already offers and should be spelled out here. The appellant should also be consulted when choosing a date for the hearing.

In (d)(1), the provision that the appellant shall have the opportunity to review the appeal record "at a reasonable time" before the hearing is too vague. This should be provided at least two days prior to the hearing.

Section 6616 Expedited Appeals

While we are supportive of the Subsection overall, the proposed regulation (paragraph (b)(2)) that requires the notice of the denial of the request for an expedited appeal should include information regarding the reason for the denial, the fact that the appeal will be heard on the standard appeal timeline, and any options appellant may have if she disagrees with the decision (e.g. potentially an informal review process). Therefore, (b)(2) should be amended as follows:

> Make reasonable efforts to inform the appellant through electronic or oral notification of the denial and, if notified orally, follow up with the appellant by written notice within 2 days of the denial**,** *including information in the notice stating the reason for the denial, the fact that the appeal will be heard on the standard appeal timeline, and any options the appellant may have if he or she disagrees with the decision.*

Section 6618 Appeal Decisions

In subsection (b), we generally support the requirement that notice of the decision be provided in writing within 90 days of the date an appeal request is received. That said, it is critical that the language "as administratively feasible" be removed as it eliminates all of the gain that the deadline provides, essentially creating a major loophole allowing the

standard to be ignored if the Appeals entity doesn't find it feasible. This is particularly a concern if the exchange appeal entity hears the Medicaid appeal, as this could create a serious problem in getting a timely Medicaid hearing decision. It should also be made clear that the Exchange appeal decision timeline does not in any way alter any legal time frames that apply to issuing a Medicaid decision.

In (c)(1)(A), language should be added to broaden the types of decisions that can be made, consistent with DSS' authority to hear issues other than eligibility alone, We recommend amending it as follows:

> *(A)* Retroactive to the date the incorrect eligibility determination was made *or other adverse action was taken;*

Thank you for your consideration of our comments.

Sincerely,

Julie Silas and Betsy Imholz, Consumers Union
Kim Lewis and Byron Gross, National Health Law Program
Elizabeth Landsberg, Western Center on Law & Poverty
Ellen Wu and Cary Sanders, California Pan-Ethnic Health Network

cc: Peter Lee
David Panush
Toby Douglas
Rene Mollow
Darryl Lewis

July 10, 2013

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

Re: Exclusion of Family Planning Providers from 15% ECP Threshold

Dear Mr. Lee:

We are writing to urge Covered California to reconsider excluding family planning health centers from the list of eligible Essential Community Providers (ECPs) that can count toward the 15 percent ECP threshold.

As the leading organizations providing and promoting quality family planning services to and for millions of Californians, we believe that not including family planning health centers in the ECP designation will not only negatively impact access to health care for Covered California consumers across the state, but is contrary to the provisions in the Patient Protection and Affordable Care Act (ACA).

The ACA explicitly included family planning health centers in the ECP definition and intended for these safety-net providers to have robust participation in the insurance marketplaces. Federal guidance has continually affirmed Congress's intent in this area and the most recent regulations regarding ECPs released in March of this year made clear that there should be at least one ECP in each county representing six provider categories. Family planning health centers were one of the six provider categories listed.

Barring family planning health centers from the 15 percent ECP threshold in practice will make the ECP designation insignificant for many family planning health centers as there will be no incentive for Qualified Health Plans (QHPs) to contract with them. Carving out family planning health centers also creates unnecessary restrictions that will lead to a fragmented health system and could create difficulties for QHPs to meet the 15 percent threshold, particularly in areas with provider shortages and in regions that lack a sufficient number of federally qualified health centers and look-alikes. In addition, excluding family planning health centers could make it difficult to achieve the Covered California goal of consumers having a well woman visit within one year.

Family planning health centers are a key part of California's health care delivery system and are important access points for Californians in need of vital health care – particularly women. Six in ten women consider their family planning provider their only or usual source of health care. Family planning health centers that receive federal Title X family planning funding in California – like Planned Parenthood – provide a broad range of services.

These include well woman visits, breast and pelvic exams, breast and cervical cancer screenings, sexually transmitted disease (STD) prevention, detection, treatment and education, counseling and referral and pregnancy diagnosis and counseling.

Since the passage of the ACA, California has been a national leader in implementation. States and leaders across the country are looking to our state and Covered California as a model for best practices. To stay true to the intent of ACA authors and expand access to vital health care across the state, we urge Covered California to reconsider excluding family planning health centers from the 15 percent ECP threshold during the first year of Covered California operations.

We remain committed partners in the long-term success of Covered California and would like to request a meeting with you and other appropriate staff to discuss these issues in greater detail. Your team can contact Kathy Mossburg at Kathy@kmossburg.com to schedule an in-person meeting at your earliest convenience.

Sincerely,

Julie Rabinovitz, President and CEO
California Family Health Council

Kathy Kneer, President and CEO
Planned Parenthood Affiliates of California

Cc: Ms. Andrea Rosen
Mr. David Panush
Secretary Diana Dooley
Ms. Kim Belshé
Mr. Paul Fearer
Ms. Susan Kennedy
Dr. Robert Ross

July 25, 2013

Concerned Los Angeles Community Essential Providers

Honorable Diana Dooley
Secretary of the California Health and Human Services Agency
Chair, California Health Benefits Exchange
1600 Ninth Street, Room 640
Sacramento, CA 95814

Dear Secretary:

We, a group of independent Concerned Los Angeles Community Essential Providers, are writing to challenge the exclusion of many qualified traditional health care providers in the Los Angeles area, including many African-American and Latino physicians, from the Covered California health plan networks. This exclusion will eliminate many patients' rights to continue working with their existing physician and separate many of the most vulnerable patients—the elderly, disabled, poor, and immigrant—from the health support system on which they have depended for years.

The federal mandate under the Affordable Care Act (ACA) requires health exchanges to include "essential community providers," which are defined as providers who serve predominately low income, medically underserved individuals. To meet this mandate, the Exchange Board initially proposed a broad expansion of this definition to include all providers with a patient mix of at least 30% Medi-Cal patients. However, in response to lobbying from the California Primary Care Association (CPCA) and others, the Exchange Board abandoned its initial proposal for Medi-Cal providers and adopted the current definition—which eliminated over 35% of eligible physicians that would have been eligible under the original definition.

Going forward with the current program hurts patients in key ways. First, it disrupts the existing network of providers that currently serve low-income patients, and forces patients to seek care at over-crowded clinics. These clinics are already experiencing unacceptable appointment time frame wait times for the most vulnerable patients who require the services of a specialist.[1] Limiting the participation of key traditional providers will only aggravate this problem.

Additionally, many clinics may not be financially stable enough to handle the expected demand. State budget shortfalls, proposed cuts to Medi-Cal rates, and the unavailability of

[1] A report by Dr. Alexander Lee reveals chronic noncompliance with state mandates for appointment time frames—with the average waiting period for a visit to a specialist totaling 220 days.

capital loans due to the credit crisis has resulted in the closure of at least 12 California clinics since 2009.[2]

Secondly, limiting networks under Covered California deprives patients of their right to choose accessible care and disrupts the continuity of care between patients and their current physicians. Patients want to continue care with their traditional providers, and cite the desire to maintain this relationship as a chief concern when choosing an insurance plan. If that patient's doctor is not included as a network provider in a Covered California health plan, the relationship between the patient and their current doctor is severely limited (or possibly even terminated). Severing the current doctor-patient relationship also impairs the medical home of the patient, which is especially problematic for patients with complex medical conditions.

As you know, in the State of California, there is an extreme shortfall of physicians serving our most vulnerable communities. This physician workforce shortfall is expected to be aggravated by the pending retirement of 33% of current physicians, who are all over the age of 60. What strikes us as non-sensical is that, rather than address this alarming shortfall, Covered California's only steps have been to eliminate even more physicians from serving patients. The motivation and wisdom of decreasing patient access to physicians in these communities is unclear.

A recent survey of minority physicians who primarily serve the African-American and Latino community indicated that more than 60% are currently eliminated from participating in the Covered California direct contracting process. Many of these same physicians have approached these individual health plans to request contracts, but have been informed that no other invitations would be extended.

At a time when there are extreme issues regarding access to care, especially in Latino and African American communities, why have the Governor and the Exchange Board allowed Covered California to severely restrict a patient's access to a qualified physician?

We request that in order to ensure adequate patient care for our most vulnerable communities, as well as preserve current doctor-patient relationships, Covered California direct the health plans to accept all "essential community providers" that request direct contracts (including providers with approved applications for the Hi-Tech Medi-Cal EHR Incentive Program). Additionally, we request that you also direct the health plans to analyze the report card data at their disposal to identify and invite additional "essential community providers" that have not yet requested to be included as network providers. With your assistance, Covered California can provide patients with the access to healthcare that they deserve.

[2] "Maintaining Clinic Financial Stability: Navigating Change, Leveraging Opportunities" report

Thank you for your immediate attention to this matter. We stand ready to meet with you to resolve this major healthcare crisis.

Sincerely,

Richard Baker, M.D.
Concerned Physician

Phillip E. Hill, M.D.
Concerned Physician

Toni Johnson-Chavis, M.D., M.P.H.,
Concerned Physician

Lorna McFarland, M.D.
Concerned Physician

Lemmon McMillan, M.D.
Concerned Physician

Nathaniel Neal, M.D.
Concerned Physician

Paul Wallace, M.D.
Concerned Physician

cc:

Hon. Jerry Brown, Governor State of California	Hon. Maxine Waters United States Congress
Hon. Holly Mitchell, Chair California Legislative Black Caucus	Members, Los Angeles Delegation California Legislative Black Caucus
Hon. Mark Ridley-Thomas Los Angeles County Board of Supervisors	Rahn K. Bailey, MD, President National Medical Association
Paul Phinney, MD, President California Medical Association	Marshall Morgan, MD, President Los Angeles County Medical Association
Members, Covered California Board of Directors	George Ma, MD, President Chinese American Medical Association
Khadijah Lang, MD, President Charles Drew Medical Society	Young-jik Lee, MD, President Korean American Medical Association
Nicole Alexander, MD, President Association of Black Women Physicians	Jose Villagomez, MD, Director California Latino Medical Association
José Alberto Arévalo, MD, Chair, Latino Physicians of California	Vladimir Zeester, DPM, President Los Angeles County Podiatric Society
Vicken Sepilian, MD, President Armenian American Medical Society	Gabriel Halperin, DPM, President Latino Diabetes Association
Alex Gershman, MD, President American-Russian Medical Association	Nina Nolcox, President California Association for Adult Day Services
Karen Wrubel, DPM, President California Podiatric Medical Association	Hernan Vera, President Public Counsel
Robert Romasco, President AARP	Patricia Ryan, Executive Director California Mental Health Directors Assoc
Tom Saenz, President MALDEF	Catherine Blakemore, Executive Director Disability Rights California
Tepper Paul, Executive Director Western Center of Law and Poverty	Kimberly Lewis, Managing Attorney National Health Law Program

Mr. Peter Lee, Executive Director California Health Benefits Exchange	Sandra Risdon, Program Manager Center for Health Care Rights
Neal Dudovitz, Executive Director Neighborhood Legal Services	Members, Miller Lawrence Medical & Dental Society
Amber Cutler, Staff Attorney National Senior Citizens Law Center	Sylvia Carlisle, MD, Medical Director Anthem Blue Cross California
Nancy Gomez, Program Director Health Access	Keith Emmons, MD, Medical Director United HealthCare
Paulette Brown-Hinds, PhD, President California Black Media	David Pryor, MD, Medical Director NBC Universal

August 6, 2013

Ms. Thien Lam
Mr. Daryl Lewis
Ms. Leesa Tori
Covered California
560 J St., Ste. 200
Sacramento, CA 95814

Dear Ms. Lam, Mr. Lewis and Ms. Tori:

We understand that you expect to bring to the Board of Covered California at the August 22nd meeting, a policy decision that would require that all family members purchase a family policy in the Exchange, rather than allowing each individual family member to choose whether it is in her or his best interest to purchase an individual policy. Attached is a short paper arguing against a policy requiring the same family plan for all family members. It is meant to inform your thinking and our future dialogue with you before the Board meeting.

While we believe it likely that most families will enroll in QHP family policies and benefit from them, there will be some families for which it is not the preferred option. Further, we do not believe Covered California has the authority to prevent family members from purchasing individual policies, if that is their preferred choice. We understand that the Federally-facilitated Exchange and several states will be offering both individual and family policies that consumers will be able to choose from. We think Covered California is required to do the same.

We would appreciate meeting with you at your earliest convenience, in advance of the Board meeting on August 22, to discuss this matter. Please contact Julie Silas (415) 431-6747 or jsilas@consumer.org. Thank you for your consideration.

Sincerely,

Ellen Wu
CPEHN

Betsy Imholz & Julie Silas
Consumers Union

Anthony Wright
Health Access

Kim Lewis & Byron Gross,
National Health Law Program

Elizabeth Landsberg
Western Center on Law and Poverty

cc: David Panush

Covered California has emphasized consumer choice as a fundamental principle at the heart of the Affordable Care Act (ACA). The federal law clearly provides consumers the autonomy to decide for themselves which products are in their best interests, guided by simple and clear information provided by Exchanges. For example, the ACA ensures as a matter of consumer choice the ability to select a Qualified Health Plan (QHP) and tier level; the decision whether to opt in or out of insurance affordability programs; the option to take premium tax credits in advance or defer taking them until tax filing, and the ability for family members to choose individual policies or a family policy.

It is our understanding that Covered California is contemplating requiring anyone in a family who is enrolling in the Exchange to be on the same family policy. Family policies are likely to be the right choice for most family members enrolling in Covered California because of the cost-sharing and the ease of making one premium payment. Some family members, for reasons of care continuity or otherwise, may prefer to purchase an individual policy distinct from one that other family members have purchased. The ACA is clear that this is a required option.

ACA Does Not Permit Exchanges to Limit Consumer Choice

Under the ACA, every individual has the freedom to enroll in a QHP of his or her choosing; the law states that "a qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible."[1] Issuers must accept any individual that applies for coverage, regardless of whether that individual is married or not.[2] Issuers may not decline to offer coverage to any individual based on her or his family status.[3] Furthermore, in the specific section on "empowering consumer choice," the statute articulates that a qualified individual may enroll in any QHP.[4]

The ACA also requires individual choice regarding enrollment in insurance affordability programs. Individuals can opt to have an Exchange conduct an eligibility determination for insurance affordability programs, and to accept or decline an eligibility determination for such programs.[5]

[1] 42 U.S.C.§18032(a)(1).
[2] See statutory provision on guaranteed issue, 42 U.S.C. § 300gg-1.excepting those individuals ineligible because of immigration or incarceration status.
[3] See statutory provision on guaranteed availability, 42 U.S.C. § 300gg-41.
[4] 42 U.S.C.§18032(d)(3)(C). The exception is the limitation on purchasing catastrophic plans.
[5] 45 C.F.R. § 155.310 (b). However, if an individual chooses to request an eligibility determination for affordability programs, he or she may not do so for fewer than all of them.

For the tax credit affordability program specifically, Exchanges must allow consumers the option to take all, part, or none of the premium tax credit.[6] It is the enrollee's choice regarding what portion of the premium tax credit s/he would like to take in advance; individuals may choose to defer taking the tax credit until tax return filing.

The ACA consistently defines enrollment as it relates to individuals.[7] In establishing premium payment rates, even though family size is considered, QHPs are required to apportion the premium "per individual."[8] States with community rating that operate with a family tiering policy must have a method in place for determining "per-person" premium rates.[9]

The federal regulations specifically account for the possibility that household members will be enrolled in multiple QHPs.[10] In the Preamble to the Benefit and Payment Parameter rules, regarding calculation of premium tax credits, CMS stresses that Exchanges must give families the ability to weigh the costs and benefits of enrolling in individual or family policies:

> HHS will encourage Exchanges to provide appropriate guidance to consumers on the relative costs and benefits of enrolling in one family policy versus multiple individual policies so that families can best take advantage of cost-sharing reductions.[11]

The Preamble further identifies an example of a family made up of one child and two parents who enroll in two different QHPs, one for the child and one parent and a second for the other parent.[12] The example recognizes the importance of QHP choice and the rules ensure that many choices are possible.[13] No federal statute or regulation provides the Exchange authority to take away the ability for consumers to evaluate the pros and cons of enrolling in a family policy or individual policies.

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[6] 45 C.F.R. § 155.310 (d)(2)(i).
[7] 42 U.S.C. § 18031(d)(2)(A).
[8] 45 C.F.R. § 147.102 (c)(1).
[9] 45 C.F.R. § 147.102 (c)(2).
[10] 45 C.F.R. § 155.340 (e).
[11] 78 F.R. 47. page 15475
[12] Exchange Responsibilities With Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions, 78 F.R. 47, page 15476 (March 11, 2013).
[13] CMS references stakeholder comments that consumers should not be dissuaded from appropriate coverage or encouraged to select one family policy when it may not be in the best interest of the family. CMS responded by recognizing the importance of a transparent shopping experience, stating that it therefore will allow Exchanges flexibility in making the allocation of the tax credit visible throughout the selection process. Notice of Benefit and Payment Parameters for 2014, 78 FR 47, page 15476 (March 11, 2013).

It is notable that CCIIO has indicated that the Federally Facilitated Exchange (FFE) will allow members of the same household to purchase individual or family policies. Other state-based Exchanges, as well, will permit consumers to choose between individual policies and a family policy.[14]

Advantages of ACA Family Policies

Purchasing family policies from Covered California will be a preferable option for most households, rather than purchasing separate individual policies, for several financial and convenience reasons:

- *Family policies reduce consumer cost-sharing due to a cap of twice that of an individual policy*.[15] For 2014, that means that the out-of-pocket maximum would be $12,700 in a family policy, contrasted to $6,350 for each individual policy. Three family members in 3 individual policies would thus have a total out-of-pocket maximum of three times $6,350, or $19,050.

- *Family policies can reduce premiums for large families.* For families with four or more children, under a family policy Exchanges can only include the parents and the three eldest children in calculating the premium for family coverage.[16] The remaining children will be covered under the family policy at no additional premium charge. If that same family were to purchase individual policies for each member, premiums would be charged for every single child, not just the three eldest children.

- *Family policies will require only one premium payment for the entire family.* Families wishing to ease the burden of writing multiple checks, paying different issuers, or being charged multiple fees for money orders or pre-paid card transactions, will be able to make one single premium payment to one issuer for the entire family.

- *Family policies allow access to the same network.* Families under one single policy will share the same physician network and have access to the same hospitals.

[14] It is our understanding that state-based Exchanges in Colorado, Maryland, Massachusetts, Nevada, Oregon, and Vermont, provide consumer choice of individual or family policies.
[15] 45 C.F.R. § 156.130 (b)(2)(ii).
[16] 45 C.F.R. § 147.102 (c)(1).

Family Policies May Not Always Address the Needs of Individual Family Members

Family policies require that all individuals in a family enroll in the same QHP, which means all members must choose the same metal tier, with the same provider network. For some families, this may result in significant barriers to care, including in continuity of providers.

For example, a younger family member's pediatrician may not be in the same provider network as her mother's primary care physician. In order to enroll in a family policy, one of the family members will have to discontinue her longstanding relationship with her provider. The family needs the full choice provided by the ACA to ensure that the mother has the option to enroll her child in a different plan so she can remain with her pediatrician. This continuity of care will take on special significance for those with chronic conditions who thus have complex medical histories over a long period of time.

For families with only two adults, each adult will be required to enroll in the same QHP with the same provider network, restricting their choice of caregivers, a policy that will not apply to couples who are not married.

The ACA Requires Covered California to Offer Consumers the Choice of Individual Policies or a Family Policy

We do not find legal authority in the ACA to limit choice of QHPs based on family status. While we understand the confusion that having too much choice can generate, Covered California does not have the authority to require all family members to purchase only family coverage. While many families will want to buy a family policy, as it is in their best interest for the cost-saving reasons cited above, some families may not benefit from purchasing a family policy based on their individual circumstances. [17]

Family status should not prohibit an individual from being able to select the right QHP for his or her health needs. For the reasons cited above, and as required by the ACA, Covered California must permit family members to choose individual policies if the families deem such products in their best interest.

[17] Exchanges will want to include pop-up boxes, flags, or other clear notices on the website when families are at the point of choosing coverage, to alert consumers that while choice is open, they may get a better financial benefit from choosing a family plan for all family members. In addition, a tool should be provided on-line to enable families to compare and contrast the financial and other implications of purchasing a family policy versus one or more family members purchasing individual policies.

"The Clinic makes me feel good about myself in a way I never thought health care could"

—Women's Community Clinic Client

womens community clinic

July 16, 2013

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

Re: Family Planning Providers Excluded from 15% ECP Threshold

Dear Mr Lee:
I am writing on behalf of the Women's Community Clinic and the thousands of women we serve in the San Francisco Bay Area to urge Covered California to reconsider the exclusion of family planning providers from the list of eligible Essential Community Providers (ECPs) that can count toward the 15% ECP threshold.

Since 1999, the Women's Community Clinic has provided quality, comprehensive family planning services in the Bay Area. We believe that not including family planning health centers like ours in the ECP designation will not only negatively impact access to health care for Covered California consumers, but is also contrary to the provisions in the Patient Protection and Affordable Care Act (ACA).

The ACA was explicit in the inclusion of family planning health centers in the ECP definition and intended for these safety-net providers to have robust participation in the insurance marketplaces. Federal guidance has continually affirmed Congress's intent in this area and the most recent regulations regarding ECPs released in March of this year made clear that there should be at least one ECP in each county representing six provider categories. Family planning health centers were one of the six provider categories listed.

Barring family planning health centers from the 15% ECP threshold in practice will make the ECP designation insignificant for many family planning health centers as there will be no incentive for Qualified Health Plans (QHPs) to contract with them. Carving out family planning health centers also creates unnecessary restrictions that will lead to a fragmented health system and could create difficulties for QHPs to meet the 15% threshold, particularly in areas with provider shortages and in regions that lack a sufficient number of federally qualified health centers and look-alikes. In addition, excluding family planning health centers could make it difficult to achieve the Covered California goal of consumers having a well woman visit within one year.

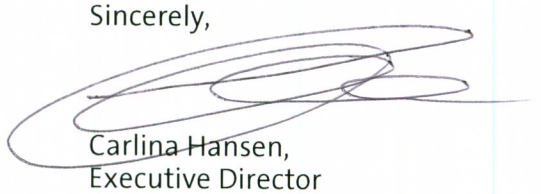
Family planning health centers are a vital part of California health care delivery system and are important access points for Californians in need of vital health care – particularly women. Six in ten women consider their family planning provider their only or usual source of health care. Family planning health centers that receive federal Title X family planning funding in California – like the Women's Community Clinic – provide a broad range of services.

1833 Fillmore St.
3rd Floor
San Francisco
California 94115
415 379 7800 tel
415 379 7804 fax
womenscommunityclinic.org

These services include well woman visits; breast and pelvic exams; breast and cervical cancer screenings; sexually transmitted infection prevention, detection, treatments and education, counseling, and referral and pregnancy diagnosis and counseling.

Since the passage of the ACA, California has been a national leader in implementation. States and leaders across the country are looking to our state and Covered California as a model for best practices. To stay true to the intent of the ACA authors and expand access to vital health care across the state, I urge Covered California to reconsider excluding family planning health centers from the 15% ECP threshold during the first year of Covered California operations.

Sincerely,



Carlina Hansen,
Executive Director

August 20, 2013

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

Comments on the Regulations on Background Checks for Plan-Based Enrollers

Dear Mr. Lee:

The Greenlining Institute (Greenlining) and the National Employment Law Project (NELP) are writing regarding the proposed regulations on background checks for Plan-Based Enrollers posted on the Plan Management webpage on August 19, 2013 and which will be voted on the Board meeting on August 22, 2012.

We write to raise a concern with the proposed criminal records disclosure form required to be presented unnecessarily early during the application process. The form requires the applicant to list any and all convictions, including misdemeanors no matter the age of the offense and administrative actions taken against the individual.

First, the Equal Employment Opportunity Commission (EEOC) states, in its criminal records enforcement guidance, that employers should only ask about records that they consider to be disqualifying, not all criminal records no matter the age or seriousness of the offense.[1] As such, the scope of the questions on the disclosure form are overly broad. Nor does the proposed language discussing the disclosure form indicate that the applicant may have an opportunity to provide proof of rehabilitation or mitigating circumstances for the offenses.

Second, and more importantly, the detail required here is unnecessary and a waste of limited resources given that Covered California is actually conducting both a state and FBI background check later in the certification process. The combination of these comprehensive checks should suffice in obtaining information about an applicant's criminal history, other than additional explanations of rehabilitation and mitigating circumstances by the applicant.

We are aware that some employers prefer to have the information collected on an application to verify an individual's trustworthiness against the information they receive on the background check. However, Covered California is not hiring the

[1] *See generally* Equal Employment Opportunity Commission (EEOC) in its *Enforcement Guidance on the Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964,* 42 U.S.C. 2000(e) *et seq*. (April 25, 2012).

workers and the agencies will have all the information they need to determine if the worker is a safety or security risk. In our experience, these questions confuse most workers through no fault of their own.. There are much more effective ways to evaluate an individual's trustworthiness, assuming that is the underlying rationale for the proposed disclosure form.

Finally, the level of detail required in the form may also have an undesirable chilling effect on qualified workers who may just be too intimidated by the process to apply even if they have an old or minor record. That, in turn, limits the pool of qualified applicants, especially of people of color from low-income communities. Based on our experience, many security sensitive licensing programs do not require disclosure forms of the sort proposed here, including the program regulating port worker background checks required by the U.S. Transportation Security Administration.

Eliminating the criminal history disclosure form is also consistent with a grow trend in California and across the U.S. of removing the question about criminal history information from the application stage of the hiring process. For example, in 2010, the California Personnel Department issued a policy stating that for state employment, individuals do not have to indicate on the application if they have a criminal record unless the state hiring agency specifically decides otherwise. Ten states and over 50 cities around the country have adopted similar "ban the box" hiring policies to reduce unnecessary barriers to employment of people with criminal records.

For the reasons described above, we urge Covered California to eliminate the proposed criminal history disclosure form requirement, which helps ensure that Covered California maintains a fair screening and certification process that also promotes consumer safety and privacy. We look forward to hearing your response and discussing this further with you. Please contact us with any questions.

Sincerely,

Carla Saporta
Health Policy Director
Greenlining Institute

Maurice Emsellem
Policy-Co Director
National Employment Law Project

Noemi Gallardo
Legal Fellow
Greenlining Institute

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

NATIONAL ASSOCIATION
OF VISION CARE PLANS

August 19, 2013

Peter Lee
Executive Director
California Health Benefit Exchange (Covered California)
560 J. Street, Suite 290
Sacramento, California 95814

Dear Mr. Lee:

The National Association of Vision Care Plans (NAVCP) has reviewed the Covered California (CC) revised Vision Proposal dated 8/12/13, and I'm pleased to inform you that NAVCP is able and willing to meet its terms. ***Specifically, NAVCP will host a website linked to the CC website for the purpose of educating CC customers on the availability of quality vision insurance options available for individual purchase.*** As the largest national vision care industry organization including several California-based member organizations and other members covering eye care for millions of Californians, NAVCP is in an unparalleled positioned to serve California consumers in this capacity. We are fully prepared to launch the site for an October 1, 2013 rollout while meeting CC's site specifications including:

- Vision-exclusive marketplace (no access to Health, Dental, etc.) which details plan information and houses purchase functionality
- Listed Carriers will be vetted by NAVCP to ensure standards are met including:
  - Licensed by the State of California to sell approved vision insurance to individuals in the State of California
  - Carrier must generate a minimum annual premium revenue and/or a minimum net asset threshold, to ensure all carriers are well established with a proven model for providing vision insurance
  - Have an established web presence
  - Specialty health geographic access in California
  - Have multi-lingual capabilities, as required
  - Other requirements as desired/ determined by CC

We look forward to partnering with CC in this endeavor to deliver seamless, quality eye care to Californians. Should you have any questions or wish to discuss in further detail, please don't hesitate to contact me at 404/634-8911 or e-mail at jroberts@navcp.com.

Best Regards,

Julian Roberts
NAVCP Executive Director

CALIFORNIA LATINO LEGISLATIVE CAUCUS

June 3, 2013

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

RE: National Voter Registration Act Implementation via the CA Health Benefit Exchange

Dear Mr. Lee:

We were encouraged by the Secretary of State's designation on May 15, 2013 of the California Health Benefit Exchange as a covered agency under the National Voter Registration Act (NVRA). The designation of the Exchange as a point of access to voter registration for millions of eligible Californians is important to helping to strengthen California's future. While we commend your Board's leadership in embracing this responsibility and service to our communities, we are troubled to learn that the Exchange may not fulfill it in a timely manner. With the deepest of appreciation for the tremendous work the Board has and is doing to ensure Californians have access to affordable care, we strongly urge you to implement voter registration assistance as a service available starting October 1, 2013.

The National Voter Registration Act has been critical to expanding access to the right to vote for many historically underserved communities and populations. It would be a great disservice to Californians if the Health Benefit Exchange did not support this tradition of an inclusive democracy.

We acknowledge the challenges the Board faces to ensure a timely and successful implementation of voter registration services by its October 1st launch. However, delaying implementation will mean that potentially hundreds of thousands of Californians will not have the opportunity to register to vote at the time of applying for services through the exchange.

We look forward to working with you to make sure our state can serve as a model of what is possible for the rest of the country.

Sincerely,

RICARDO LARA
Senator, 33rd District
Chair, CA Latino Legislative Caucus

V. MANUEL PEREZ
Assembly Member, 56th District
Vice Chair, CA Latino Legislative Caucus

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