Comments to the Board

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NATIONAL ASSOCIATION
OF VISION CARE PLANS

September 12, 2013

Peter Lee, Executive Director
California Health Benefit Exchange
Health Plan Advisory Group
560 J. Street, Suite 290
Sacramento, California 95814

Dear Executive Director Lee:

Thank you for the opportunity to speak with the Health Plan Advisory Group. As an organization representing the managed vision care industry, we support any structure that provides access to consumers to quality vision care and ensures a competitive and level playing field for all participating vision care plans. As an organization we support both options presented in the Adult Supplemental Vision Care Proposal presented on September 11th. After the presentation, there were several questions and comments from Committee members that I would like to address.

1. As stated, NAVCP is supportive of both proposed options, however, we are concerned with the consumer experience if they are directed to OPA and they are simply provided a list of state licensed vision care plans, which may or may not be willing to participate. Also, our understanding is that the consumer would also be directed to the homepage of the vision care plan with no direction on how to locate information about the available individual plans or how they may enroll.
2. There appeared to be concerns by the Committee that only NAVCP members could participate if NAVCP provided the landing page. NAVCP's intent is for all vision care plans that are licensed and regulated by the state of California, be listed regardless of NAVCP membership status nor would any preference be given to NAVCP members. All would be presented equally.
3. There was also concern regarding NACVP developing criteria and administrating the criteria. NAVCP proposes that the criteria be clear-cut and should not be subjective or left up to interpretation. We recommend that the criteria should be:
    a. The Plan is licensed to provide vision coverage in the state of California. Managed vision care plans must meet certain criteria to be licensed in the state which could address some of the Committees concerns.
    b. The Plan is interested in providing adult vision coverage to CC Exchange participants. Not all plans may be willing or interested in participating.
    c. The plan must establish a page for CC Exchange participants to be directed to for plan information and registration.
    d. After the purchase of the vision policy, the CC Exchange participant is then linked back to the CC Exchange.
    e. Any other criteria that CC deems necessary.

4. There was also discussion as to a federal requirement that the landing page should be from a state agency. According to the CMS FAQs dated March 29, 2013, the state exchange dollars cannot be expended for product pages for adult vision. Since the proposal is not asking for CC to host the product page, it does not violate the terms outlined in the FAQs.

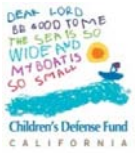
Millions of Californians have managed vision care benefits and many have realized improvements to their overall health as a result. Managed vision care is heavily regulated in the state of California; therefore, providing access to CC Exchange participants ensures consumers have a coordinated, transparent opportunity that already incorporates predefined standards and criteria.

The vision industry, in conjunction with CC leadership, has a unique opportunity to ensure immediate access to this important wellness benefit. Together, we can provide a simple and timely solution that allows for additional enhancements as we journey through the CC consumer experience in 2014 and beyond.

Thank you again for your time and consideration. I am available any time to address questions or to participate in any additional discussions. I can be reached at 404-634-8911 or jroberts@navcp.org .

Best Regards,

Julian Roberts
NAVCP Executive Director



September 6, 2013

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

RE: Family Policies

Dear Ms. Lam and Ms. Tori:

We write today to oppose the policy position articulated in proposed eligibility and enrollment regulation section 6512, requiring all members of families eligible for premium tax credits and cost-sharing reductions to purchase family policies. The proposed policy is not in the best interest of consumers and does not comport with the spirit and letter of the Affordable Care Act (ACA).

Family policies are likely to be the right choice for most family members enrolling in Covered California because of the cost-sharing benefits and the ease of making a single premium payment. Some family members, however, for reasons of continuity of care or otherwise, may prefer to purchase an individual policy distinct from one that other family members have purchased. We do not believe Covered California should prevent family members from purchasing individual policies, if that is their preferred choice.

Furthermore, we are troubled by the fact that the proposed language creates disparate treatment toward low- and moderate-income families. That is, the draft regulation imposes the limitation to family policies *only* on families receiving premium assistance or cost-sharing reductions. Families with higher income, families with members in different programs (i.e., children in Medi-Cal and parents in Covered California), as well as those on Medi-Cal, will be afforded the full right to choose as granted under the ACA. While we recognize that the regulation carves out some limited exceptions, they are extremely narrow. We do not believe income and family status should prohibit an individual from being able to select the right QHP for his or her health needs.

We understand that this proposed policy may have arisen due to a CalHEERS system design issue, but technical hurdles should not drive Covered California's important policy positions. If the IT system cannot process enrollment in individual policies for subsidy-eligible families, those applications should be processed by hand until the IT system can be adjusted to process electronic enrollment as required under the ACA.

The ACA affords every individual the right to enroll in the QHP of their choosing and requires issuers to accept for coverage any individual who applies. For the reasons cited above, and as required by the ACA, we urge Covered California to permit family members from all income levels to choose individual policies if they deem such products in their best interest. Please contact Julie Silas (415) 431-6747 or jsilas@consumer.org with any questions or concerns. Thank you for your consideration.

Sincerely,

Kristin Jacobson, Alliance of California Autism Organizations & Autism Deserves Equal Coverage
Doreena Wong, Asian Americans Advancing Justice | Los Angeles
Richard Konda, Asian Law Alliance
Karen Fessel, Autism Health Insurance Project
Lorri Unumb, Autism Speaks
Suzie Shupe, California Coverage and Health Initiative
Ronald Coleman, California Immigrants Policy Center

Cary Sanders, California Pan-Ethnic Health Network
Carmela Casellano-Garcia, California Primary Care Association
Mike Odeh, Children Now
Jamila Edwards, Children's Defense Fund – California
Kevin Aslanian, Coalition of California Welfare Rights Organizations
Gary Passmore, Congress of California Seniors
Julie Silas, Consumers Union
Silvia Yee, Disability Rights, Education, and Defense Fund
Daniel Brzovic, Disability Rights Center
Paula Pearlman, Disability Rights Legal Center
Kathleen Berry, Families For Early Autism Treatment
Carla Saporta, Greenlining Institute
Anthony Wright, Health Access
Lynn Kersey, Maternal and Child Health Access
Kimberly Lewis, National Health Law Program
Katie Murphy, Neighborhood Legal Services – Los Angeles
John Gressman, San Francisco Community Clinic Consortium
Wendy Lazarus, The Children's Partnership
Pete Manzo, United Ways of California
Elizabeth Landsberg, Western Center on Law and Poverty
Linda Leu, Young Invincibles

cc: David Panush
Peter Lee

FIRST 5 SONOMA COUNTY

August 20, 2013

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

RE: Pediatric Dental Coverage

Dear Mr. Lee:
On behalf of the First 5 Sonoma County Commission, I strongly urge Covered California to embed coverage for pediatric dental services in all of the health insurance products offered in the State's exchange before 2015. Embedded coverage offers a better, more affordable, more accessible coverage than stand alone plans. The increased costs of stand-alone plans and their non eligibility for federal subsidies make it likely that families will not maintain the coverage for children. In Sonoma County the lack of accessible care has led to an epidemic of tooth decay.

According to the California Health Interview Survey, 27.8 percent of Sonoma County children lack dental insurance, compared to 19.6 percent statewide; 39.3 percent of Sonoma County's uninsured patients having never seen a dentist, compared to only 8 percent of insured patients. The survey also indicates that 87.9 percent of uninsured children miss two or more days of school due to dental problems. Notably, in Sonoma County 46 percent of kindergarteners have a history of tooth decay and 16 percent have untreated decay.

Good dental health is essential to overall health. Poor dental health can threaten the health and healthy development of young children. A growing body of research indicates that poor dental health is directly linked to a number of major health conditions including cancer, diabetes, heart disease and stroke.

Poor dental health is preventable. Critical to ensuring prevention and dental health is access to dental insurance coverage for children. Because of this, we believe it is essential for health insurance products offered via Covered California include strong coverage for pediatric dental health and to offer it as soon as possible.

Sincerely,

Loren Soukup
Chair, First 5 Sonoma County Commission

490 Mendocino Avenue, Suite 203 · Santa Rosa, CA 95401 · (707) 565-6680 · Fax (707) 565-6619

COUNTY OF SONOMA

BOARD OF SUPERVISORS

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SANTA ROSA, CALIFORNIA 95403

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August 5, 2013

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

RE: Pediatric Dental Coverage

Dear Mr. Lee:

On behalf of the Sonoma County Board of Supervisors, I strongly urge Covered California to embed coverage for pediatric dental services in all of the health insurance products offered in the State's exchange. Embedded coverage offers a better, more affordable, more accessible coverage than stand alone plans.

Good dental health is essential to overall health. Poor dental health can threaten the health and healthy development of young children and compromise the health and wellbeing of adults. It can have devastating effects on the social functioning, self-esteem, productivity and overall quality of life of young and old alike. A growing body of research indicates that poor dental health is directly linked to a number of major health conditions including cancer, diabetes, heart disease and stroke.

Dental decay is the most prevalent chronic disease of childhood – five times more common than asthma; as many as 7% of children in California miss school due to a dental problem. In a recent assessment, 52% of Sonoma County third-graders had a history of decay, and low-income kindergarteners and third-graders have more than twice the level of untreated decay as more affluent children.

As troubling as these data are, poor dental health is preventable. Critical to ensuring prevention and dental health is access to dental insurance coverage for youth and adults. Because of this, we believe it is essential for health insurance products offered via Covered California include strong coverage for pediatric dental health.

Sincerely,

DAVID RABBITT,
Chair and Second District Supervisor
Sonoma County Board of Supervisors

CC: Board of Supervisors
Paul Yoder, Peterson Consulting, Inc.

Consumers Union®

POLICY & ACTION FROM CONSUMER REPORTS

September 16, 2013

Ms. Claire Veeninga
Covered California
560 J St., Ste. 200
Sacramento, CA 95814

Re: Plan-Based Enrollers Draft Regulation—**Electronic submission**

Dear Ms. Veeninga:

Consumers Union (CU) submits the following comments regarding the latest version of the draft regulation for plan-based enrollers (PBEs). We see progress in this set of proposed regulations, appreciate your adoption of several of our prior comments, and note below a few quick fixes that we believe are in order before filing.

We are continuing to investigate the significance of the August 2013 federal regulations distinguishing "issuer application assistors," such as customer service representatives, from licensed agents and brokers who are subject to the March 2012 regulations. We believe these distinct regulations may warrant separate processes for captive agents and for other PBEs.

- We do not see any definition of "Affordability Programs" here or in **§ 6410** (in the proposed Eligibility and Enrollment regulation) and reiterate our suggestion for one as follows:

  "Affordability Programs" refers to any and all programs eligibility for which the single, streamlined application, including through CalHEERS, is the vehicle. This includes Medi-Cal and Advance Premium Tax Credits and Cost-Sharing Subsidies for Covered California's Qualified Health Plans.

- Training requirements on the eligibility for APTCs, as you have in **§6706(b)(4)** is crucial, but so is training on the implications of reconciliation requirements and deciding whether to take the tax credit in advance, fully or partially. Below is the suggested revision we made previously:

  (b)(4) Eligibility requirements for, and options about when to take, the APTC and taking it partially or fully in advance….and the impacts of APTC on reconciliation and the cost of premiums.

- Training on how to work effectively with the enumerated groups is also key, and we see you took our suggestion to explicit that part of training is also to avoid discrimination. We also urged adding "income" to the list of on-discrimination categories in **§6706(b)(12)**:

  (b)(12) Working effectively with, and not discriminating against, individuals of various income levels, racial and ethnic backgrounds,…

- To comport with the new federal regulation, §156.1230, **§6710(a)(7)** of the Exchange regulations needs to require PBEs to provide on their websites a *direct web link to the Exchange*, in addition to explaining how to access the Exchange website, as currently written.

- **§6710(a)(12)** provides that "[i]f the consumer is determined to be *eligible* for Medi-Cal, the PBE shall either transfer the consumer to the county of residence for enrollment in Medi-Cal or transmit all eligibility information to DHCS …." But CalHEERS (whether accessed by plans or the Exchange itself) will not "determine" Medi-Cal eligibility. Whether through the "quick sort" or more thorough assessment during the first open enrollment period, the final determination rests with the counties. This could be fixed simply by changing "determined eligible" to "determined likely eligible."

  We had also urged clarifying that the manner of transfers to the counties for those likely eligible for Medi-Cal. We believe it should be parallel to that of the Exchange, which we understand will be via warm-handoff" to the county consortia.

- We are pleased to see PBEs have a role, per **§6710(a)(14),** in advising those ineligible for subsidies of the availability of other products, but do not see why they should simply advise such consumers of other products *outside* the Exchange and do so solely via captive agents. We urge that they be required to advise such consumers of other products, both inside and outside the Exchange, and not simply those products outside the Exchange offered by that carrier.

- We appreciate your taking our suggestions for some additional prohibited activities, i.e. the claims firewall, now in §6710(j)(1)(M), and bar on retention of income and immigration information in (Q). We believe the exception in sub-section in **§6710(j)(1)(N)**, allowing health status information for the purpose of "Connecting the consumer to the issuer's appropriate QHP" is problematic and urge you delete it. See Health and Safety Code §1357.503 (h) (2).

Thank you for your consideration of these comments.

Sincerely,

Betsy Imholz
Special Projects Director/CU

cc: Leesa Tori
Kathleen Keeshen
Peter Lee

Consumers Union
POLICY & ACTION FROM CONSUMER REPORTS

CPEHN
California Pan-Ethnic Health Network

September 6, 2013
Ms. Claire Veeninga
Covered California
560 J St., Ste. 200
Sacramento, CA 95814

Re: Plan-Based Enrollers Draft Regulation

Dear Ms. Veeninga:

Consumers Union (CU), CPEHN, and Health Access submit the following comments regarding the draft regulation for plan-based enrollers (PBEs). We see progress in this set of draft regulations and, in particular, note with favor and urge you to retain the following:

- Allowing Medi-Cal Managed Care Plans (MMCPs) to provide enrollment assistance. Given their familiarity with and access to traditional Medi-Cal-eligible populations, they can be especially effective in reaching them as well as "Bridge Plan" populations and others newly eligible for affordability programs.
- Prohibiting PBEs from employing marketing techniques that result in adverse selection in §6710(j)(9). This concern was a major theme in our prior sets of comments and we appreciate your hearing that and attempting to curb that practice.
- Banning "cold calls" to non-member target populations. Recent CU surveys have found that, in this atmosphere of public confusion, the public is as or more skeptical than ever about private health plans and about new scams on the horizon. Calls from issuers, out of the blue, offering affordability programs will aggravate that skepticism. The main message to consumers should be to go to Covered CA for the full array of products to find the best one for that individual.

Since our last letter on PBEs, dated August 9, your draft regulations have been circulated and the relevant final federal regulations have been issued. Below, this letter reiterates some points we made previously but do not see reflected in the draft, and touches on some additional points raised by the federal regulations.

The **new federal Program Integrity regulations (**dated August 23, 2013 and excerpted as an addendum hereto) place some requirements that will require adjustment to the draft. The new federal regulations:

1. Label PBEs "Issuer application assistors," a name you may or may not want to adopt.

2. Place specific requirements on issuers' web sites as follows, requiring an adjustment to your draft §6710(a)(9) and (b)(3):

" (ii) The QHP issuer's Web site provides applicants the ability to view QHPs offered by the issuer with the data elements listed in §155.205(b)(1)(i) through (viii) of this subchapter.

(iii) The QHP issuer's Web site clearly distinguishes between QHPs for which the consumer is eligible and other non-QHPs that the issuer may offer, and indicate that advance payments of the premium tax credit and cost sharing reductions apply only to QHPs offered through the Exchange.

(v) The QHP issuer's Web site allows applicants to select and attest to an advance Payment of the premium tax credit amount, if applicable, in accordance with §155.310(d)(2) of this subchapter."

3. Require QHPs to inform applicants of availability of other QHP products through the Exchange (as does your draft). The federal regulations add to your draft requirements in §6710(a)(9), however, by also requiring three specific things as shown below: display of the Exchange web site link and an HHS-approved universal disclaimer on the issuer's web site, and by requiring issuer application assistors to describe for consumers how to access the Exchange web site:

   "(iv) The QHP issuer informs all applicants of the availability of other QHP products offered through the Exchange through an HHS-approved universal disclaimer and displays the Web link to and describes how to access the Exchange Web site."

4. The relevant federal regulations distinguish "issuer application assistors," such as customer service representatives, from licensed agents and brokers. Agents and brokers are explicitly excluded as "issuer application assistors" under the August 23, 2013 final regulation (see 45 CFR §155.20 definition of "Issuer application assistors," excerpted in Addendum hereto). However, they must comply with standards in the March 27, 2012 federal regulation (Fed. Reg Vol. 77, No. 59, p. 18449) §155.220(c), which appears to require agents to go through the Exchange web site, rather than the issuer web site, to assist in applying for affordability programs. If our reading of the federal regulation is correct, "captive agents" (by your definition licensed by the Dept. of Insurance) would need to be distinguished in this Covered CA regulation as well, and potentially subject to a different process.

We are pleased to see more **references to Medi-Cal** in the draft regulations and an acknowledgement that some individuals currently enrolled in QHPs (an estimated 200,000 enrollees), as well as those newly contacting QHPs, may well be Medi-Cal-eligible. Sections §6710(a)(11) and (b)(5) each provide that "[i]f the consumer is determined to be eligible for Medi-Cal, the PBE may provide information regarding available Medi-Cal managed health care plan selection options to applicants and shall complete the *referral* of the consumer to the county of residence for enrollment in Medi-Cal…." This does not align with the transfer protocol for Covered CA or state law. CalHEERS (whether accessed by plans or the Exchange itself) will not "determine" Medi-Cal eligibility. Whether through the "quick sort" or more thorough assessment during the first open enrollment period, the final determination

rests with the counties. This could partially be fixed by changing "determined eligible" to "determined likely eligible."

The many applicants who will come through the Exchange Service Center and be found "likely eligible" for Medi-Cal are to be shifted to the county consortia via "warm hand-off." A parallel process should be established for PBEs—whether consumers are connected to county consortia through the Exchange or directly via warm hand-off by PBEs to county consortia. The draft regulation simply states that applicants will be referred to the county of residence—this could mean simply being given a phone number or address. This is not just a wordsmithing issue, but also one of substance and clear process.

PBEs will need to inform **applicants, including current enrollees, found ineligible for Medi-Cal or subsidies** of their appeal rights. They should also be told that they may still apply for Covered California products. In either case, a warm hand-off should be made to Covered California to exercise that right. This could be an addition to 6710(a) and (b) as follows:

> Advise all consumers found ineligible for Affordability Programs of their appeal rights, including the time limits and methods for filing appeals, and the right to apply for unsubsidized products through Covered CA, and if on the telephone ensure that they are connected with a Covered California employee for exercising their appeal rights, if desired.

We have listed the remaining comments in the order they appear in the draft regulation:

§6700-Definitions

We urge adding a definition of "Affordability Programs." The term comes up in several places in this draft regulation (eg under §§6700(d), 6702(b)(3), 6702(c)(2), 6710(a)(3)). In each place, it implies that it means Medi-Cal. We note this same implication where the term is used in the Model Agents' Contract. But actually, in the context of applying through the single, streamlined application, it means Medi-Cal or Exchange products with subsidies (APTC and/or cost-sharing subsidies). The definition we suggest below comports with how the term is used throughout various federal regulations, and seems to be your intended meaning. We suggest the following definition:

> (New a) "Affordability Programs" refers to any and all programs eligibility for which the single, streamlined application, including through CalHEERS, is the vehicle. This includes Medi-Cal and Advance Premium Tax Credits and Cost-Sharing Subsidies for Covered California's Qualified Health Plans.

§6710(a)(10) Roles-Functions

A tweak to this section on APTC would also allow applicants to take the credit in advance or not, which may be helpful to consumers with fluctuating income, to avoid reconciliation problems.

(a)(10) Allow applicants to select and attest to an APTC amount, if applicable, in accordance with 45 C.F.R. 155.310(d)(2), and to decide whether and how much of it to take in advance.

§6710(j)-Roles—Prohibited Activities

To this list we urge adding a prohibition on seeking or accessing any health status or claims information (the "firewall issue" we have raised previously) and on retaining in plan databases income and immigration status information obtained through the application for Affordability Programs. The Final Federal Rules make clear that both these prohibitions are intended. (Note: There seems to be a numbering problem on the version we have, with (j)(9) appearing on p. 15. We believe re-numbering/re-lettering is needed.) Suggested language is under-lined below:

All Certified Plan-Based Enrollment Entities and their Contractors and Employees that are Certified Plan-Based Enrollers may not:

(P) Have access to any information related to a health-status-related factor, including any information in the possession of the plan about health status, medical condition, claims experience, receipt of medical care, medical history, genetic information, disability or any other health status related factor. [See Health and Safety Code §1357.503 (h) (1). This suggestion, and the following one, modify sub-section "M" in your draft.]

(Q) Acquire or, request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment. [See Health and Safety Code Section §1357.503 (h) (2)]

(R) Retain any information related to income, citizenship or immigration status.

§6706(b)(4)

Training requirements on the tax implications and impact of APTCs and cost-sharing subsidies are crucial, as are the implications of reconciliation requirements and deciding whether to take the tax credit in advance, fully or partially. Below is a suggested revision:

(b)(4) Eligibility requirements for, and options about when to take, the APTC and taking it partially or fully in advance….and the impacts of APTC on reconciliation and the cost of premiums.

§6706(b)(12)

Training on how to work effectively with the enumerated groups is key. We also suggest adding "income" to the list, and making explicit training to avoid discrimination:

(b)(12) Working effectively with, and not discriminating against, individuals of various income levels, racial and ethnic backgrounds,…

Thank you for your consideration of these joint comments. If you have any questions or concerns, please do not hesitate to call.

Sincerely,

Betsy Imholz
Special Projects Director/CU

Ellen Wu
Executive Director/CPEHN

cc: Leesa Tori
Kathleen Keeshen
Peter Lee

ADDENDUM

Final Federal Rule, August 23, 2013 (relevant excerpts)

§ 155.20 Definitions.

* * * * *

Issuer application assister means an employee, contractor, or agent of a QHP issuer who is not licensed as an agent, broker, or producer under State law and who assists individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange or for insurance affordability programs.

Subpart M – Qualified Health Plan Issuer Responsibilities

§ 156.1230 Direct enrollment with the QHP issuer in a manner considered to be through the Exchange.

(a) A QHP issuer that is directly contacted by a potential applicant may, at the Exchange's option, enroll such applicant in a QHP in a manner that is considered through the Exchange. In order for the enrollment to be made directly with the issuer in a manner that is considered to be through the Exchange, the QHP issuer needs to comply with at least the following requirements:

(1) QHP issuer general requirements.

(i) The QHP issuer follows the enrollment process for qualified individuals consistent with § 156.265.

(ii) The QHP issuer's Web site provides applicants the ability to view QHPs offered by the issuer with the data elements listed in § 155.205(b)(1)(i) through (viii) of this subchapter.

(iii) The QHP issuer's Web site clearly distinguishes between QHPs for which the consumer is eligible and other non-QHPs that the issuer may offer, and indicate that advance payments of the premium tax credit and cost sharing reductions apply only to QHPs offered through the Exchange.

(iv) The QHP issuer informs all applicants of the availability of other QHP products offered through the Exchange through an HHS-approved universal disclaimer and displays the Web link to and describes how to access the Exchange Web site.

(v) The QHP issuer's Web site allows applicants to select and attest to an advance Payment of the premium tax credit amount, if applicable, in accordance with § 155.310(d)(2) of this subchapter.

(2) QHP issuer application assister eligibility application assistance requirements. If permitted by the Exchange pursuant to § 155.415 of this subchapter, and to the extent permitted by State law, a QHP issuer may permit its issuer application assisters, as defined at § 155.20, to assist individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange and for insurance affordability programs, Provided that such issuer ensures that each of its application assisters at least-

(i) Receives training on QHP options and insurance affordability programs, eligibility, and benefits rules and regulations;

(ii) Complies with the Exchange's privacy and security standards adopted consistent with § 155.260 of this subchapter; and

(iii) Complies with applicable State law related to the sale, solicitation, and negotiation of health insurance products, including applicable State law related to agent, broker, and producer licensure; confidentiality; and conflicts of interest.

PREMIER ACCESS
Dental and Vision

ACCESS DENTAL

September 5, 2013

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

RE: Plan Based Enrollers, Proposed Amendments to California Code of Regulations, Article 9, Sections 6700 et seq.

Dear Mr. Lee:

Thank you for the opportunity to comment on Covered California's draft regulations which would define which entities may serve as a Certified Plan Based Enroller (PBE). (Add Article 9, Plan Based Enrollers, Section 6700 et seq. to Chapter 12, California Code of Regulations).

Premier Access Dental Insurance Company is a California based, standalone dental plan, headquartered in Sacramento with over 350 employees and 650,000 enrollees. Our plan has a long history of participating in state-funded coverage programs, namely the Healthy Families and Medi-Cal programs. We are pleased to have been selected by Covered California as one of the standalone dental plans that will be offered through the Exchange when open enrollment begins in October.

We are very committed to the success of Covered California and in our discussions around how to support the Exchange's efforts to expand enrollment, we had assumed that Premier Access Dental Plan would have the opportunity to serve as a plan based enroller. However, as we read the language in the proposed regulations, it appears that a dental plan would not be eligible to serve as a certified plan based enroller as the definition included in the proposed 6702 (a) only recognizes Qualified Health Plans, Medi-Cal Managed Care Plans, or representatives or agents that are employed or contracted by a certified plan based enrollment entity. **We request that these regulations be revised to allow a qualified dental plan to be recognized as one of the entities that may serve as a certified plan-based enrollment entity.**

Premier Access Dental Insurance Company has a long and successful record of assisting consumers in enrollment functions in the Healthy Families Program. In fact, when MRMIB allowed health and dental plans participating in the Healthy Families Program to engage consumers and assist them in the process of enrollment, most observers assumed that it would be the health plans that would place the largest resources in enrolling individuals in the program. However, in the past several years, until the enrollment

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process in the Healthy Families Program stopped due to its scheduled transition to Medi-Cal, the largest enrollment entities in the Healthy Families Program were associated with dental providers or plans. Our plan affiliated entity held the top position as an enrollment entity for several years running and our enrollment activities resulted in tens of thousands of children enrolling into Healthy Families Program and obtaining health, dental and vision coverage.

We believe the mission of Covered California to expand coverage to as many Californians as possible would be best served if all entities that are partnering with the Exchange are allowed to dedicate resources to reach out to consumers and employer groups to inform them of the benefits available. Premier Access has no objection to complying with the additional proposed standards and requirements expected of certified plan based enrollment entities.

We hope that Covered California will act to amend the proposed regulations to allow dental plans to apply to serve as certified plan based enrollment entities.

Please do not hesitate to contact me at (916) 563-6010 or reza@premierlife.com with any questions about our request.

Sincerely,

Reza Abbaszadeh, D.D.S.,
Chief Executive Officer

cc: Secretary Diana Dooley, Chair, Covered California
Board Members, Covered California
David Pannush, Director, Government Relations, Covered California
Kristy Wiese, Capitol Advocacy

Health Care LA, IPA

September 6, 2013

Mr. Aldo De La Torre
Vice President, Provider Engagement & Contracting
Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, California 91367

Dear Mr. De La Torre,

I am writing on behalf of the Board of Directors of Health Care LA, IPA to express its concerns, discontent and dismay at Anthem's exclusionary approach to contracting for its Covered California HMO Product. HCLA, the largest not-for-profit safety net IPA in California, has been a strong partner to Anthem over the last twenty years and is now caring for almost 40,000 of Anthem's Medi-Cal patients.

Despite the fact that HCLA has been in negotiation with the Government Programs division for a Covered California HMO contract, the IPA recently was informed by Anthem that it had entered into an exclusive contract with AltaMed Health Services (AltaMed) for Anthem's Covered California HMO product in Los Angeles and Orange Counties. It is our understanding that under the provisions of the contract Anthem is prohibited from contracting with any providers within 10 miles of an AltaMed site. As such, if HCLA had a proposed contract to consider which it does not, it would exclude from the Anthem Covered California HMO product 22 of the current 34 HCLA member agencies, representing 69 of its 99 sites or 63% of its primary care providers.

As a long standing partner of Anthem, HCLA strongly objects to this exclusionary approach to the Covered California HMO contracting. HCLA is sorely disappointed at not being given the opportunity for ALL of its member agencies to participate in the Covered California HMO product. Most of our members are FQHC's or community clinics with a long history of serving uninsured patients who will be eligible for Covered California.

Ultimately, it is our mutual patients that will be negatively impacted. Without seamless access to this Anthem product, members will be precluded from moving smoothly between products as a result of shifts in financial eligibility. Patients will be required to change their health plan should they wish to remain with their primary care health center as their financial status changes.

Given the impact that this may have on our IPA member organizations and our existing patients we respectfully request that you explain the exclusivity arrangement with AltaMed, and Anthem's justification for excluding member agencies of HCLA IPA from this product line. To this end, you are invited to attend the next HCLA, IPA Board of Director's meeting scheduled for 8:30 am on Thursday, September 19, 2013 at California Hospital, Los Angeles Center for Women's Health, 1513 South Grand Avenue, Ste. 400, Los Angeles, CA 90015. It is critical that the Board

understand these matters so that we can accurately inform our membership. Please verify your availability to attend to Kimberly Carey, MedPoint Management, at (818) 702-0100, ext. 224.

We urge Anthem to reconsider this exclusive arrangement and negotiate in good faith with all of HCLA's providers for Anthem's Covered California HMO product.

Sincerely,

Kimberly Wyard
President
Health Care LA, IPA

cc: Kimberly Belshé, Covered California Board of Directors
Jeffrey Bujer, Treasurer, Health Care LA, IPA & CEO, Saban Community Clinic
Carmela Castellano-Garcia, President & CEO, California Primary Care Association
Diana S. Dooley, Chair, Covered California Board of Directors
Paul Fearer, Covered California Board of Directors
Barbara Hines, Secretary, Health Care LA, IPA & CEO, QueensCare Family Clinics
William Hobson, Vice President, Health Care LA, IPA & CEO, Watts Healthcare Corp.
Susan Kennedy, Covered California Board of Directors
Peter V. Lee, Executive Director, Covered California
Louise McCarthy, President & CEO, Community Clinic Association of Los Angeles County
Steve Melody, Regional Vice President, Medicaid, California State Business, Anthem
Paul Pakuckas, Regional VP, Provider Engagement & Contracting for Gov't. Products, Anthem
Robert Ross, M.D., Covered California Board of Directors

Health Care LA, IPA

September 6, 2013

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

Dear Mr. Lee,

On behalf of HCLA and its member health centers, I have been asked to notify Covered California and other interested parties of the IPA's serious concern with and objection to the practice of exclusive contracting in the safety net arena. Exclusivity blocks participation of FQHC's in the marketplace and undermines the safety net in counties throughout the State. Further, it makes it difficult for patients to move smoothly between products when financial eligibility demands transitions from Medi-Cal to the California Bridge plan and ultimately the Covered California HMO product. Patients will be put in a position of having to change their health plan in order to remain with their primary care provider.

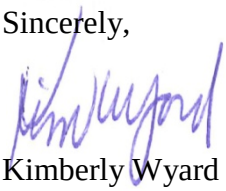
Established in 1991, Health Care LA, IPA (HCLA) is a California Non-Profit mutual benefit organization predominately comprised of Federally Qualified Health Centers (FQHCs) and community clinics. HCLA's mission is to provide essential community based providers in Los Angeles County with a managed, integrated healthcare delivery system to serve their communities in an organized, efficient, compassionate and financially responsible manner. It is composed of 34 clinics and community health centers (CCHCs) with 99 sites that are an essential segment of the safety net across Los Angeles County. HCLA's CCHC members provide health care to the most underserved within the county including 30,000 Seniors and Persons with Disabilities. The IPA provides a vehicle for these CCHC's to contract with health plans to serve Medi-Cal and government insured patients as well as commercial HMO and Medicare Advantage/Dual Eligible enrollees. HCLA's enrollment, which is 64% Latino, is composed of 200,000 patients that are predominately in Medi-Cal. This is a critical revenue source for CCHC's, which enables them to also serve the uninsured and under insured patient populations. HCLA will be an integral participant for the new ACA products including Covered California, the Medi-Cal expansion and ultimately Cal Medi Connect.

HCLA,recently learned that Anthem Blue Cross (Anthem) entered into an exclusive contract with AltaMed Health Services (AltaMed) for its Covered California HMO product in Los Angeles and Orange Counties. Under the provisions of the exclusivity, Anthem has agreed to exclude any provider within 10 miles of an AltaMed site from its Covered California HMO product. As such, 22 of the 34 HCLA member agencies, representing 69 sites, will not be able to offer the Anthem

Covered California HMO Product to their patients. HCLA has been a strong partner to Anthem over the last twenty years and is now caring for almost 40,000 of Anthem's Medi-Cal patients.

We urge the Covered California Board to promulgate rules that promote inclusivity to ensure patient access to all safety net providers.

Sincerely,



Kimberly Wyard
President
Health Care LA, IPA

cc: Kimberly Belshé, Covered California Board of Directors
Jeffrey Bujer, Treasurer, Health Care LA, IPA & CEO, Saban Community Clinic
Carmela Castellano-Garcia, President & CEO, California Primary Care Association
Diana S. Dooley, Chair, Covered California Board of Directors
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William Hobson, Vice President, Health Care LA, IPA & CEO, Watts Healthcare Corp.
Susan Kennedy, Covered California Board of Directors
Louise McCarthy, MPP, President & CEO, Community Clinic Assoc. of Los Angeles County
Robert Ross, M.D., Covered California Board of Directors

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT

Alex Briscoe, Director
Muntu Davis, MD, MPH, Director and County Health Officer

Office of the Director

1000 Broadway, Ste. 5000
Oakland, California 94607

(510) 267-8010
(510) 268-2140

September 17, 2013

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

RE: Premium Payment Policy of the California Health Benefit Exchange

Dear Covered California Board Members:

On behalf of the Alameda County Public Health Department (ACPHD), I am writing to urge Covered California to develop uniform policies for and consumer protection standards for premium payment methods that allow maximum flexibility for people to pay their health plan premiums. This will be particularly important for people without a bank account or that use alternative financial services.

As you may know, there are over one million Californians that do not have a bank account. They are known by the Federal Deposit Insurance Corporation (FDIC) and other policy makers as "unbanked." In addition to the "unbanked," there are another 2.3 million Californians that are "under-banked"—they have a bank account but still use alternative financial services such as check cashers and money transmitters.

Many of these unbanked and under-banked Californians will need and can pay for health coverage. They will be among the many people who will be comparing health insurance plans and choosing the one that works best for their health needs and budget through the new marketplace created by Covered California.

Because they have limited access to traditional payment methods, such as credit and debit cards, any restrictions on the methods of premium payment accepted by insurers can cause significant barrier to getting and maintaining health coverage for eligible individuals. They should not be restricted by the financial instruments available to them.

We support Covered California's efforts to provide health insurance to all Californians and will continue to work towards achieving health equity by addressing their root causes of poor health, which includes the economic, social and physical environment and policies that foster disparate health outcomes. Part of our vision is that all residents, regardless of race or place of residence, can build the economic security necessary to lead a long and healthy life.

Ensuring inclusive payment policies will both help us achieve our vision and facilitate eligible individuals' entry into the new health insurance marketplace.

As California moves to implement its marketplace for health insurance, we hope that the great benefits of expanded access to healthcare will not be undermined by barriers for low-income and financially underserved people. Thank you for your consideration.

Sincerely,

Muntu Davis, MD, MPH
Health Officer and Public Health Department Director
Alameda County

CALIFORNIA REINVESTMENT COALITION

September 12, 2013

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

Dear Covered California Board Members,

Please accept these comments from the California Reinvestment Coalition in response to the discussion on Premium Payment Policy at the California Health Benefit Exchange Board Meeting on August 22, 2013. The California Reinvestment Coalition is a non-profit coalition of over 300 organizations from across all of California. We advocate for financial services practices and policies that respond to the needs of low income households, communities of color and other economically and politically marginalized communities in California.

We gratefully welcome the recent federal adoption of requirements that "for all payments in the individual market, [insurers must] accept paper checks, cashier's checks, money orders, EFT, and all general-purpose pre-paid debit cards as methods of payment and present all payment method options equally for a consumer to select their preferred payment method." 45 CFR §156.1240. We believe that Covered California can only be successful if health plans offer and accept all forms of payment for premiums equally, including those listed above. We are heartened to learn that currently, all participating Covered California insurers accept payment methods beyond checks and credit cards, including money orders, debit and pre-paid cards, and that some Covered California Health Plans are planning to include other payment options including the ability for enrollees to make payments with cash or EFT/ACH transactions.

As you know, there are over one million Californians that do not have a bank account; they are known by the Federal Deposit Insurance Corporation and other policy makers as "unbanked." In addition to the "unbanked", there are another 2.3 million Californians that are "under-banked"—they own a bank account that does not meet their needs for basic financial services. These unbanked and under-banked households must have access to health insurance that must not be restricted by the financial instruments available to them.

We applaud your sensitivity to the fact that the choice of payment methods will affect selection of plans, as noted in the in the Board Background Brief written for the Board meeting on August 22, 2103. We therefore urge you to take steps to ensure that neither insurers nor enrollers steer families to particular payment tools. Specifically, we are concerned that tax preparers that are certified enrollment entities per 10 CCR §652 be prevented from exploiting the mandate and opportunity to enroll for health coverage to sell expensive financial products.

474 Valencia Street, Suite 230 San Francisco, CA 94103 tel 415.864.3980 fax 415.864.3981 www.calreinvest.org

Unfortunately, there are companies that have proven themselves predators of low income people who need financial services and have limited choices. Jackson Hewitt, H&R Block and Liberty Tax are perfect examples of such predatory companies. Although Jackson Hewitt has recently acted as a champion of unbanked households' need for health coverage, they and their brethren have proven themselves over many years to be unconscionably exploitative of low income families' needs. We believe that Covered California should prohibit these companies and all other enrollers from selling financial instruments to pay for premiums to those they enroll.

Low income, unbanked households are vulnerable to exploitation.

Households without bank accounts rely on a variety of financial services to conduct transactions, such as paying cash at in-person payment centers or using non-bank financial instruments, such as money orders and pre-paid cards. These instruments generally cost much more per transaction and can add up to a significant portion of a low income family's budget.

For example, a mother who takes home $2,000 a month can easily pay 6% of her income, or about $60 monthly using a combination of money orders, in-person payments and a pre-paid card to conduct basic transactions. To cash a paycheck and pay rent, two utility bills, a mobile phone bill, and car insurance at a Western Union payment center, she would pay: 2% of the check being cashed, $1.50 for a money order for rent, $1.50 each for in-person payments for the utility and mobile phone bills, $12 for an in-person payment for car insurance, and about $6 to load a pre-paid card she can use to withdraw money at an ATM once that month.

The lack of a bank account renders households powerless against financial service providers that can charge whatever the market will bear. Unfortunately, many companies use this vulnerability to gouge the very households that can least afford it.

Jackson Hewitt and other tax preparers have consistently exploited this vulnerability.

Like payday lenders, pawn shops and loan sharks, Jackson Hewitt, H&R Block, Liberty Tax Services, and others have targeted these households for many years by exploiting their need for financial services and charging unconscionable prices. For example, until the IRS took action in 2012, Jackson Hewitt and their ilk routinely sold expensive tax refund loans to cash-strapped households. The scheme took advantage of households' eligibility for tax refunds through the Earned Income Tax Credit and similar programs that are intended -- like the Affordable Care Act- to provide critically needed help to families. Jackson Hewitt and company would provide a loan for the amount of the refund minus a hefty fee. That loan would be repaid in less than three weeks when the IRS processed the tax refund. In 2012, the last year that Jackson Hewitt made these loans, the price for three week tax refund loan of $1,500 was $61.22, translating into an APR of 149%.

Since these loans were effectively banned by the IRS and bank regulators, Jackson Hewitt and other tax preparers have taken to selling refund anticipation checks, also at a heavy cost. Again, the tax preparer uses the refund recipient's lack of funds and a bank account against her to make a profit. Jackson Hewitt does this by opening a temporary bank account into which the IRS direct deposits the customer's refund

check. After the refund is deposited, the bank issues the consumer a check or pre-paid card and closes the temporary account, often at a fee. This scheme allows the tax preparer to pay itself through the tax refund for charges such as tax preparation fees and other spurious "add-on" fees, like application fees and document processing. Jackson Hewitt charges $29.95 to $49.95 for these services. The unbanked customer then has the choice of accepting the remaining refund via either a check – which they can cash for a fee – or on a Jackson Hewitt Pre-paid Visa Card, which carries a monthly fee of $5.95 and a $2.50 fee for ATM cash withdrawals.

Covered California should prohibit Jackson Hewitt and all enrollers from selling financial services to those they enroll.

Covered California has adopted rules prohibiting conflicts of interest and that prevents enrollers from, among other things, accepting premium payments from the consumer or inducing or accepting any type of remuneration direct or indirect from the consumer. 10 CCR §664(e)(3)(h)(5) and (8). We strongly urge you to apply these rules to enrollers that would sell payment instruments, such as pre-paid cards, used to pay premiums. Given their track record of exploiting the needs of their customers, Jackson Hewitt, H&R Block, Liberty Tax Services and other for-profit tax preparers acting as enrollers should not be allowed to exploit the aim of Covered California and the needs of unbanked consumers to sell expensive financial services.

To be clear, although we are troubled that pre-paid cards are, to date, wholly unregulated and lacking in price standards such that it is virtually impossible for a consumer to compare costs between cards, we believe that insurers should accept them as premium payment platforms. However, we strongly oppose *enrollers* selling pre-paid cards to the people they enroll in health plans.

Just as you wisely predict that the choice of payment method will skew enrollment in health plans, we predict that, unless precluded from doing so, for-profit entities selling financial services will skew customer adoption of a payment method that may not be the most affordable for them. The undue selection for these products, above others that may be more affordable to the consumer but not being presented to them as they are enrolling, will drain household resources, undoing the good work that Covered California has done to lower costs and make health coverage more accessible to all Californians.

Jackson Hewitt and others sell pre-paid cards to generate unlimited revenue.

Though pre-paid cards often look like bank-issued debit cards, they work differently, cost much more for customers to use and generate more fee revenue to issuers. Unlike money in bank accounts and spent through debit cards, money loaded on a pre-paid card are not insured by the FDIC for the consumer. Pre-paid cards also do not have the same protections against fraud- if a customer loses her card she may still be liable for purchases made with it even if she reported the loss immediately.

The pre-paid card industry is exploding in size because, while banks can charge merchants a fee of up to a certain amount to process purchases paid for via credit and debit cards, there is no such limitation on fees to process payments via pre-paid cards. Because of this fee loophole, pre-paid card sellers stand to

profit not only from the fees charged customers, which vary wildly, but also every time the cards are used to pay for purchases. This is why Jackson Hewitt and others are pushing so strongly not only to have insurers accept payments by pre-paid card, but to allow recurring automatic payments for premiums as well.

Pre-paid cards generally are also unregulated and unstandardized, making them virtually impossible to compare by cost conscious consumers. Some cards appear less expensive at first, for example, by not charging a monthly fee, but ultimately can cost more depending on how they are used, how often they are used and what uses trigger fees. Others will not have use fees but will charge a high monthly fee and ATM fees. By comparison, other cards charge a flat fee and no other fees beyond those charged by ATMs not in the cards network.

The Jackson Hewitt Smart Card costs $5.95 every month, a $2.50 fee each time it is used at an 'in-network' ATMs, plus ATM fees charged by the owner of the ATM if it is not in-network. The H&R Block Emerald Pre-paid MasterCard does not charge a monthly fee, but charges a load fee of up to $4.95, also charges $2.50 for all ATM use, in addition to charges imposed by the owner of the ATM if it is different than the one used by the card issuer, and also charges a $1 balance inquiry fee, $1 when the card is declined for purchases and $2.50 monthly for inactivity if the card has not been used for three months. The Liberty Tax Card, issued by NetSpend, can cost from zero to $9.95 a month depending on which plan you choose, $1 for purchases made with a signature and $2 for purchases made with a PIN under the no monthly service fee plan, $1 for declined purchases and ATM withdrawals, $0.50 for balance inquiries not made online, $2.50 for ATM use not including other fees imposed by ATM owners, and several other fees not charged by the previous two companies.

As you can see, customers using pre-paid cards from Jackson Hewitt and similar companies face a large number of fees, and CRC is concerned that these companies view the Affordable Care Act and Covered California as yet another opportunity to make more money from those who can least afford it.

Enrollers should have the consumers, and Covered California's best interest in mind, not their desire to generate fee revenue from products sold to customers.

CRC advocates for more access to financial services that are affordable and help people save money rather than exploit their lack of options. We very much appreciate all the work that Covered California has done and continues to do to provide health insurance to all Californians, including making sure that lack of financial services does not impede the ability to obtain coverage.

We urge you to protect that good work by prohibiting enrollers from selling financial services to the households they enroll. We believe that no additional regulation is needed but merely enforcement of the rules prohibiting enrollers from accepting premiums and inducing remuneration.

Jackson Hewitt and others should not both enroll a person, and then sell her a pre-paid card on which she will load money meant for premiums, thereby causing her to generate fees every time she pays a premium using that card. Enrollers should not be allowed to use the trust the state has granted them to

serve Covered California customers for private gain, nor should a motivation to make profits compete with the primary goal of providing the best health coverage plan to the consumer.

Sincerely,

Andrea Luquetta, Esq.
Policy Advocate

cc: Sara Soto-Taylor, Manager
Eligibility, Enrollment and Marketing

September 5, 2013

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

Re: QHP Model Contract – Compliance with CAQH CORE Eligibility and Claim Status Operating Rules

Dear Peter:

First, congratulations on the excellent progress Covered California has been making. You and your team deserve enormous credit for achieving an impressive array of early accomplishments in launching Covered California -- high on that list is the vibrant competition among QHPs that has driven premiums to levels far lower than most had predicted. CAPG remains highly supportive of your work and is optimistic that Covered California can be both a great success and a highly effective driver of the improvement of healthcare in California.

One of the criticisms of Covered California that I know you have heard repeatedly, however, is that it appears to be an engine for fragmented care and a barrier to the advance of coordinated care. If true - and there is substantial evidence to indicate it is -- this is a most unfortunate unintended consequence. I think we all had hoped that the Exchange would drive increased levels of coordinated and accountable care in California, the kind of organized systems that can moderate cost trend as they promote higher quality.

Proof of the Exchange's unfortunate bias in favor of fragmentation lies in the products being offered by the QHPs in the individual market. The plans publicized in the Plan Booklet published on May 22, 2013 reveal a disappointing preponderance of PPO plans. Aside from Kaiser Permanente HMO products, there are no HMO products offered in the

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majority of the bidding regions, including some metropolitan areas where commercial HMO products are typically found. The SHOP offers just one non-Kaiser HMO product in each of 16 regions through Blue Shield. We noted that both Sacramento and San Francisco are the only metropolitan areas in which two non-Kaiser health plans also offer HMO products.

We believe the leading reason for the PPO bias in the exchange is the inability of QHPs to administer deductible products. The laudable efforts your team made to create a co-pay only product suggests to us that you are familiar with the problem. The relatively high cost sharing features of the plans offered on the exchange compel the inclusion of a deductible across most of the metal tiers.

The unfortunate reality, however, is that the QHPs do not have the infrastructure or systems to administer a deductible – they cannot, on a real time basis, track the amount of cash a patient has paid out-of-pocket to satisfy deductible and other out of pocket requirements. More specifically, the QHPs cannot track deductible payments across shared risk, delegated model arrangements – they cannot integrate information as to how much a patient may have paid out of pocket to a physician (who is paid by a delegated group usually) and to a hospital (who is often paid directly by the QHP.).

Consequently, health plans that have historically relied on the California "delegated model" provider network system have elected to contract directly with individual physicians in a fragmented delivery model. We have not seen this kind of infrastructure used for HMO since the days of Lifeguard Health Plan (which closed due to insolvency in 2003). These plans will have to bypass the IHA pay-for-performance quality measurement system, since it is structured through delegated model physician groups. Instead of leveraging off the existing quality measurement chassis that currently tracks the performance relative to 15 million Californians, these health plans will have to spend time and money reinventing the wheel.

This QHP shortcoming is a major disservice to patients, and is a leading barrier to the advance of coordinated care in California. We believe it can be remedied by including in the model QHP contract provisions requiring QHPs to track out of pocket payments electronically and digitally. As an active purchaser whose mission includes improving the healthcare system, it would appear incumbent for the Exchange to require QHPs to build and deploy the kind of modernized systems necessary to move California away from wasteful fragmentation toward system supported coordinated care.

As you may already be aware, there is a Federal mandate in place for health plans to provide this information as part of their responsibilities under HIPAA. In December 2011, HHS adopted the Phase I & Phase II CAQH CORE Eligibility and Claim Status Operating Rules to fulfill the ACA Section 1104 Federal mandate for operating rules to further standardize use of electronic transactions. The requirement for health plans to follow these rules, as HIPAA standards, was effective January 1, 2013 (see 45 CFR 162.1203). The regulation was published in the Federal Register/ Vol. 76, No. 131 / Friday, July 8, 2011.

The operating rules require that all health plans provide, on a real time basis, detailed information on the deductible and co-insurance status of their beneficiaries. This information is to be included in their electronic eligibility response to providers.

Specifically, these rules require that health plans must electronically provide the patient financial responsibility for base and remaining deductible, co-insurance and co-payment for up to 51 specific service types upon request of a provider. It must also provide base and remaining deductible amounts for the health plan as a whole in response to any provider eligibility inquiry. The specific requirements of the Phase I and Phase II Core Rules can be found at the CAQH web site, http://caqh.org/CORE_overview.php.

We understand that the systems necessary to track deductibles and integrate financial data on a real time basis are available, and think that a requirement to deploy them would be appropriate. We hope you agree and modify the model QHP accordingly.

Thank you for your consideration.

Sincerely,

DONALD H. CRANE
President & CEO
California Association of Physician Groups

cc: Jeff Rideout, MD

Consumers Union
POLICY & ACTION FROM CONSUMER REPORTS

CPEHN
California Pan-Ethnic Health Network

HEALTH ACCESS

Via Electronic submission

September 4, 2013

Peter V. Lee
Executive Director
Covered California
560 J Street, Suite 200
Sacramento, CA 95814

Dear Mr. Lee:

We write on behalf of our respective consumer groups which have advocated consistently at Covered California, since its creation, in support of public display of quality ratings for health plans. This information is essential in order to foster healthy competition among plans for quality and customer service improvements and to afford consumers the information they need to make purchasing decisions based on plan value—both cost and quality.

We know that Covered California shares our goal of posting plan quality ratings and has been hampered by start-up issues and that it is considering providing the public with quality data by January 2014. We write to urge that the data be made available, as described below, as soon as possible, but by January at the latest.

We urge you to:

- Require the Qualified Health Plans (QHPs) to submit their analysis of provider network overlap by a date certain, e.g., October 1, 2013, along with back-up data and a statement as to whether they believe the plan meets a standard 80% overlap between current networks and the QHP product network. Self-attestation by plans, with simple verification by Covered CA, would save scarce staff resources and should not be disputable by plans.
- Allow the posting of the QRS ranking on the web display for those plans meeting the 80% test, starting as soon as possible during the first open enrollment period.
- Label the plans that do not meet the 80% test appropriately, with a statement such as: “New product for which data is not yet available.”
- Also consider posting this year the Consumer Assessment of Health Plans Survey (CAHPS) data, or portions thereof that relate to plan performance and thus are not contingent on network composition.

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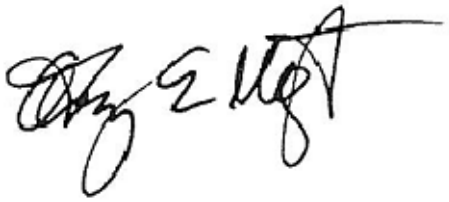
We recognize that there likely are related issues to be decided, such as the weight given in the “smart sort” for the web tool’s plan chooser, for plans that do not meet the 80% standard. We urge Covered CA to make those decisions pragmatically, with an eye toward encouraging plans to step forward expeditiously to provide publicly available data on clinical and customer service measures. Only with such public information will Covered CA be able to reach its worthy goals to transform the health care marketplace.

We look forward to working with Covered CA, as always, in improving these measures in the coming years.

Very truly yours,

Elizabeth M. Imholz, Special Projects Director, CU

Ellen Wu, Executive Director, CPEHN



Anthony Wright, Executive Director, Health Access

cc: Jeffrey Rideout, MD

華人保健計劃 Chinese Community Health Plan CCHP

445 Grant Avenue, Suite 700 San Francisco, CA 94108 |Tel (415) 955-8800 | Fax (415) 955-8818

To: Covered CA Board

September 18, 2013

We fully share Covered California's commitment to make accurate and understandable cost and quality information available to consumers. As such, we understand Covered California's desire to display Qualified Health Plan (QHP) quality ratings as soon as possible. However, we object to the most recent health plan quality ratings proposal outlined at the most recent board meeting and strongly encourage you to reinstate the methodology that was presented as Covered California policy on August 2nd. We are writing this letter because we want to make sure that the board has heard our collective position on this issue in the detail we describe below.

Per the August 2nd memorandum to the Board on this issue, staff shared that "after thoughtful and deliberate discussion" with the plans, consumer groups, and state agencies, Covered California concluded that it "would not be in the best interest of consumers" to have a Quality Rating System (QRS) for 2013 that is based on historic plan quality performance. Instead, Covered California would work with its plan partners to explore how to collect plan-specific data with the first enrollees in 2014 and then develop an Exchange-specific QRS ahead of the federal requirements that provides "highly reliable quality information for consumers." The rationale for this decision is solid and was well articulated in the August 2nd memorandum:

- The best available information for the vast majority of plans participating in the Exchange reflects products/networks that often differ significantly from the products/networks that will be offered on the Exchange
- The information that would be available would reflect the quality of services from 2011
- For some plans, there would be no information available at all
- The performance reflected in such ratings would largely be for health plan members that may be very different from the populations likely to participate in the Exchange

Nothing about this rationale has changed and there have been no subsequent discussions that have included all of the health plan partners. Yet despite this fact, Covered California now indicates that it intends, as soon as possible, to move forward with a QRS approach that will display quality ratings but only for some QHPs while other QHPs would have no rating but instead be designated with yet-to-be-determined language indicating that their quality is not yet rated.

We are very concerned about this new proposed approach to quality ratings. The methodology used in deriving the new quality ratings for QHPs is not transparent, and there has been extremely limited stakeholder input in the development of the actual quality measures in the proposed QRS. In addition, the policy direction as to how and when these ratings would be displayed to consumers has shifted repeatedly during the past several weeks, which itself has caused much confusion. We believe that the proposed approach will result in consumers receiving unreliable and misleading information and that some plans will be labeled in such a way as to inaccurately represent the quality of care that they will be providing. The reasons for our objection are outlined below.

Ratings Will Confuse – Not Help -- Consumers

With the considerable changes under health reform, consumers who are faced with one plan that has a quality star rating and another plan that is noted as "not yet rated" would understandably be confused. And under the proposed approach, the consumer will be expected to know what a "highly similar" network is; what a plan's "best fit" existing line of business network is; and how that all translates into a plan receiving a quality rating or not.

In addition, a "not yet rated" designation creates a negative impression of uncertainty and incompleteness when, in fact, QHPs have labored for over a year to build new affordable, quality networks for Covered California in time for open enrollment 2013. All these networks have been fully reviewed by state regulators and been determined to meet all state network adequacy standards. They should not be labeled to consumers as somehow incomplete.

Ratings Not Reflective Of The Population Being Served

The performance reflected in any short term quality ratings would largely be for health plan members that may be very different from the populations likely to participate in the Exchange (e.g. reflecting many low-income and previously uninsured individuals). Thus, it is not clear what benefit these ratings would have for consumers purchasing on the Exchange.

Ratings Are Based On Old Data

The proposed QRS ratings will be based on 2011 data which do not provide consumers with any up-to-date information that they can use to assess the quality of care they will get from Exchange products in 2014.

No Information Is Available For Some Plans

As noted in the August 2nd memorandum to the Board, several QHPs do not have comparable commercial HEDIS and CAHPS data available. It is unfair to label these plans as somehow incomplete because they have not served commercial populations in the past.

Basis For Proposed Quality Measure Remains Questionable

The proposed QRS methodology measures all plans irrespective of plan type (HMO, PPO, or Medi-Cal) against a single national PPO benchmark. This is not how plan quality is measured or displayed on the Office of Patient Advocate report card or any other state report card today and is not required under the Affordable Care Act. On all existing report cards, HMOs and PPOs are displayed and assessed on different parameters as an acknowledgement that HEDIS and CAHPS results for PPOs and HMOs differ materially, due in large part to the nature of the products themselves. In addition, Medi-Cal plans are generally rated and displayed separately from commercial plans. Rating all products against a single benchmark is misleading and inaccurately represents the actual quality provided by the plan. Instead HMOs should be rated against HMO benchmarks, PPOs against a PPO benchmark and Medi-Cal plans against a Medicaid benchmark.

We are fully aligned with Covered California's commitment to help consumers as soon as possible choose among their health plan options using accurate and reliable cost and quality data. The best approach to achieve that goal is to pursue the August 2nd policy, and we urge the Board to do so. As part of that approach we are committed to work with Covered California to devise a way to rapidly collect plan-specific performance information with the first enrollees in 2014, allowing an Exchange-specific QRS to be created ahead of the Federal requirements that provides consumers with accurate and reliable quality information.

Respectfully,

Brenda Yee, RN, MSN
Chief Executive Officer
Chinese Community Health Plan

September 18, 2013

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

Dear Board Members:

We fully share Covered California's commitment to make accurate and understandable cost and quality information available to consumers. As such, we understand Covered California's desire to display Qualified Health Plan (QHP) quality ratings as soon as possible. However, we object to the most recent health plan quality ratings proposal outlined at the most recent board meeting and strongly encourage you to reinstate the methodology that was presented as Covered California policy on August 2nd. We are writing this letter because we want to make sure that the board has heard our collective position on this issue in the detail we describe below.

Per the August 2nd memorandum to the Board on this issue, staff shared that "after thoughtful and deliberate discussion" with the plans, consumer groups, and state agencies, Covered California concluded that it "would not be in the best interest of consumers" to have a Quality Rating System (QRS) for 2013 that is based on historic plan quality performance. Instead, Covered California would work with its plan partners to explore how to collect plan-specific data with the first enrollees in 2014 and then develop an Exchange-specific QRS ahead of the federal requirements that provides "highly reliable quality information for consumers." The rationale for this decision is solid and was well articulated in the August 2nd memorandum:

- The best available information for the vast majority of plans participating in the Exchange reflects products/networks that often differ significantly from the products/networks that will be offered on the Exchange
- The information that would be available would reflect the quality of services from 2011
- For some plans, there would be no information available at all
- The performance reflected in such ratings would largely be for health plan members that may be very different from the populations likely to participate in the Exchange

Nothing about this rationale has changed and there have been no subsequent discussions that have included all of the health plan partners. Yet despite this fact, Covered California now indicates that it intends, as soon as possible, to move forward with a QRS approach that will display quality ratings but only for some QHPs while other QHPs would have no rating but instead be designated with yet-to-be-determined language indicating that their quality is not yet rated.

We are very concerned about this new proposed approach to quality ratings. The methodology used in deriving the new quality ratings for QHPs is not transparent, and there has been extremely limited stakeholder input in the development of the actual quality measures in the proposed QRS. In addition, the policy direction as to how and when these ratings would be displayed to consumers has shifted repeatedly during the past several weeks, which itself has caused much confusion. We believe that the proposed approach will result in consumers receiving unreliable and misleading information and that some plans will be labeled in such a way as to inaccurately represent the quality of care that they will be providing. The reasons for our objection are outlined below.

Ratings Will Confuse – Not Help – Consumers

With the considerable changes under health reform, consumers who are faced with one plan that has a quality star rating and another plan that is noted as "not yet rated" would understandably be confused. And under the proposed approach, the consumer will be expected to know what a "highly similar" network is; what a plan's "best fit" existing line of business network is; and how that all translates into a plan receiving a quality rating or not.

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against HMO benchmarks, PPOs against a PPO benchmark and Medi-Cal plans against a Medicaid benchmark.

We are fully aligned with Covered California's commitment to help consumers as soon as possible choose among their health plan options using accurate and reliable cost and quality data. The best approach to achieve that goal is to pursue the August 2nd policy, and we urge the Board to do so. As part of that approach we are committed to work with Covered California to devise a way to rapidly collect plan-specific performance information with the first enrollees in 2014, allowing an Exchange-specific QRS to be created ahead of the Federal requirements that provides consumers with accurate and reliable quality information.

Respectfully,

Jennifer A Moore
Vice President, ACA Transition Planning
Western Region Health Plan, Health Net

Lily Boris, MD
Chief Medical Officer
Alameda Alliance for Health

Michael Belman, MD, MPH
Reg. Vice President
Medical Director, Clinical Programs
Anthem Blue Cross

Richard Chambers
President
Molina Healthcare of California

Neil A. Solomon, MD, FACP
VP of Quality and Care System Transformation
Blue Shield of California

cc: Peter Lee, Executive Director
Covered California

September 18, 2013

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

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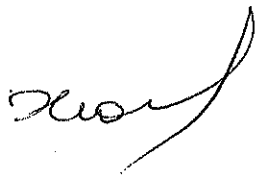


Dolly Goel, MD
Medical Director
Valley Health Plan

CPEHN
California Pan-Ethnic Health Network

September 16, 2013

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

Re: Demographic data collection on the paper application and CalHEERs

Dear Peter:

I am writing to express my grave disappointment in the decision not to collect granular race and ethnicity data through CalHEERS and the new streamlined paper application for health coverage.

Given the diversity of California – with almost 60% of the population from communities of color – and the persistent disparities communities of color experience, Covered California is undermining a critical opportunity to achieve its mission "to increase the number of insured Californians, improve health care quality, lower costs, and ***reduce health disparities***…"

As you know, of the 2.7 million Californians eligible for advanced premium tax credits in Covered California, an estimated 66%, or 1.8 million, will be from communities of color. The first step in being able to identify and reduce health disparities is the accurate collection of racial and ethnic data of those enrolling in health coverage.

AB 1296 Stakeholder Process

CPEHN has been a strong advocate for the collection of granular race and ethnicity data since before the development of the new streamlined application with the introduction and passage of AB 1296 (Bonilla) in the 2011-12 legislative session. The legislation required the Department of Health Care Services (DHCS) and Covered California to give stakeholders the opportunity to provide meaningful input into the planning and development of the new streamlined application.

As early as May 3, 2012, CPEHN, along with other statewide advocates including the Disability Rights & Education Defense Fund (DREDF) and Equality California, provided specific recommendations about the importance of and best practices for the collection of more granular data on race and ethnicity, disability status, sexual orientation, and gender identity. CPEHN gave presentations, participated in numerous meetings, and provided written feedback to DHCS and Covered California on the following dates:

- ***May 3, 2012:*** CPEHN provided recommendations (see attached document dated May 3), and also helped secure Ignatius Bau, a national expert on health disparities and a committee member for the Institute of Medicine's report on "Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement," to speak about the importance of more granular data collection.
- ***March 8, 2013:*** CPEHN responded to a draft document released by DHCS and Covered California outlining the data elements under consideration in the single, streamlined application (see attached letter dated March 19).
- ***July 15, 2013:*** CPEHN drafted and signed onto a letter with DREDF, Equality California, and other statewide advocates, after reviewing a draft of the paper application, reiterating our request for more granular data collection on race and ethnicity, disability status, sexual orientation, and gender identity.
- ***August 16, 2013:*** CPEHN again drafted and signed onto a letter with other statewide advocates outlining our recommendations, after reviewing revisions to the draft paper application.

Additionally, on July 30th, we emailed Covered California staff, Isaac Menashe, outlining federal guidance which clearly states that agencies are encouraged and "permitted to collect as much additional detail as desired, provided that the additional detail could be aggregated back to the minimum standard."

California's application should reflect the unique demographics of our state

We were told over a year ago, before the state had begun to develop the single application or the CalHEERs system that our recommendations would be taken under consideration. That is why we were surprised to learn on July 30, 2013 that Covered California and DHCS have decided to simply mirror the federal application with regards to the collection of demographic data on the new single streamlined application without consideration of the unique demographics of our state.

As advocates we understand that not all of our recommendations will be adopted. However, to blindly copy how the federal application collects data on race and ethnicity is inappropriate.

Not only is California the most diverse state in the country, the racial and ethnic make-up of California is very different from other states and the nation. For example, the Latino subcategories that the federal (and now California) application uses are Mexican, Puerto Rican, and Cuban. However, in California, Guatemalans and Salvadorans are almost two times and three times more prevalent, respectively, than Puerto Ricans, and Salvadorans are six times more prevalent than Cubans. It would be more appropriate for California's application to list subpopulations that are predominant in the state.

In addition, while we are pleased that subpopulations of Pacific Islanders are included on the application – Native Hawaiian, Chamorro, and Samoan – Taiwanese, Hmong, Cambodian, and Laotian are almost double in numbers. And because there is just a checkbox for "Other Asian," these populations, also considered Medi-Cal Managed Care threshold populations, will not be accounted for. Similarly, the Other options categories (Other Asian, Other Pacific Islander, Other Hispanic, and Other) should be a fill-in-the blank, rather than a catch all. Again, without an opportunity for populations that are not listed on the application to write in their specific race, they will be unaccounted for.

Lack of granular data in the CalHEERs system
The development of an online, automated enrollment system, CalHEERS, provided the state with an opportunity to easily standardize and collect accurate demographic data through drop-down menus. CPEHN, along with other statewide advocates, met with and provided written feedback to DHCS and Covered California with recommendations on how the state could take advantage of this unique opportunity. In fact, representatives of the CalHEERs development team attended the AB 1296 stakeholder meetings on May 3, 2012 and March 8, 2013. At that time, CPEHN, DREDF, and Equality California recommended that CalHEERs programming allow for Covered California to electronically collect detailed and accurate granular data through drop-down menus that could be aggregated back to the minimum federal data categories. We also sent letters to Covered California providing further clarification on our request.

Despite these early and frequent conversations, we recently learned that drop-down menus have not been programmed into the CalHEERs system and consumers who fill out the "other" categories will not be able to fill in their specific race and ethnicity. This is not acceptable.

As the most diverse state in the country, California has led the effort to ensure that communities of color have equal access to quality care. The passage of the Affordable Care Act has provided a historic opportunity for the state to improve and standardize its data collection systems and more accurately capture the demographics of our state, as is encouraged by federal guidance. We urge you to invest the appropriate time and resources to ensure Covered California has the data it needs to achieve its mission of eliminating health disparities in California.

Sincerely,

Ellen Wu, MPH
Executive Director

March 18, 2013

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

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

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

Dear Ms. Lam and Mr. Finocchio:

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

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

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

General comments

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

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

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

Approach to the Application

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

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

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

Treatment of immigrants and immigration status issues

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

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

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

Collection of optional demographic information

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

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

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

Income Information

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

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

We also recommend asking about how frequently the income is received, i.e., weekly, bi-weekly, monthly or annually and whether an applicant is a seasonal or temporary worker and, if so, how their income comes in throughout the year. This will be necessary to do the calculation of annual income for

APTC/CSR purposes. Further, applicants should be able to indicate whether the amount of income in the month of application is unusually high in comparison to what is expected in coming months and whether or not the applicant is a seasonal worker, in order to establish a projected income to determine Medi-Cal eligibility when the applicant has fluctuating income.

Traditional Medi-Cal groups

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

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

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

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

Other health care information

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

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

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

Sincerely,

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

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

MATERNAL AND CHILD HEALTH ACCESS

WESTERN CENTER ON LAW & POVERTY

September 6, 2013

Janette Casillas
Executive Director
Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 94814

David Maxwell-Jolly
Chief Deputy Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 9814

Re: AIM and ACA implementation

Dear Ms. Casillas and Mr. Maxwell-Jolly,

Thank you for meeting on September 4, 2013 with me on behalf of Maternal and Child Health Access (MCHA) and Elizabeth Landsberg of the Western Center on Law and Poverty (WCLP).

As explained at the meeting, we were extremely disappointed to hear that: (1) CalHEERS, the enrollment system for the Covered California portal, has not been programmed to identify much less enroll pregnant women with income from 200% to 300% of poverty into the Access for Infants and Mothers (AIM) program, which is funded by the Children's Health Insurance Program (CHIP); and (2) the single streamlined paper application to be used by Covered California has not been designed to include AIM.

AIM limits premiums to 1.5% of income, which is far less than the cost to consumers at these income levels of post-subsidy Exchange premiums. Further, AIM charges no co-payments at all, for any service, whereas the Exchange plans will have significant out-of-pocket cost-sharing, even for individuals with income at or below 250% of poverty who qualify for cost-sharing reductions.

As discussed at the meeting, we look forward to working with you to ensure that all of the following is done:

- **By September 20, 2013:** All necessary measures are taken to ensure that no pregnant woman with income from 200% to 300% of poverty who is eligible for AIM will instead be enrolled in an Exchange plan with no coverage until January 1, 2014 and at higher cost to the woman.

    - This will require changing the IT for Covered California's online portal so that no AIM-eligible woman is instead directed to, much less enrolled in, an Exchange plan and asked for premium payments.

    - It will also require conforming changes to Covered California's call center scripts for the new, single streamlined application and to the training for county workers and enrollment counselors.

- At a minimum, until December 31, 2013, AIM-eligible women applying online, calling the call center or submitting a streamlined paper application must be informed that they are entitled to comprehensive low-cost coverage from an AIM health plan and what to do to apply and enroll right away. No pregnant woman should have to wait up to three months for care.

You indicated you would review options and share with us in about two weeks, for our feedback and review, the exact measures you believe can be implemented by October 1 to address these critical issues. We request that you share this information with us no later than September 17.

- **By December 15, 2013:** The Covered California portal must have the capacity to actually enroll AIM-eligible women into the AIM program, whether a woman applies online, by phone, or using the paper application.

We are mystified as to how California is in the position of having to make these essential changes at this stage in the implementation process. The Affordable Care Act (ACA), which requires all states to include CHIP programs in their single, streamlined applications and to make real time on-line eligibility enrollment available for CHIP-funded programs, was enacted in March of 2010. AB 1296, the state law which specifically requires the inclusion of CHIP programs in CalHEERS and the streamlined application, was enacted in September of 2011.

MCHA, WCLP and others have been asking, consistently and repeatedly since 2010, in writing and at numerous meetings with state policymakers and/or staff, about the inclusion of AIM in CalHEERS as well as the paper version of the single streamlined application.

Never once until August 29, 2013 has anyone from the state indicated that AIM would not be included. Never once until September 4, 2013 did anyone from the state indicate that MRMIB needed policy guidance from the federal regulator, the Centers for Medicare and Medicaid Services (CMS), before AIM could be included-- the reason now proffered by MRMIB for the delay. To the contrary, Covered California's own January 18, 2012 solicitation for vendors explicitly included the AIM program. *See* HBEX4 Solicitation page 1-2 at www.healthexchange.ca.gov/Documents/Solicitation%20HBEX4%20-%20CalHEERS%20Dev%20and%20Ops%20Services%201-18-12.pdf

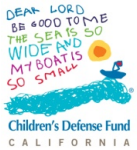
MCHA will be sending the MRMIB Board separate correspondence about various troublesome aspects of the AIM program that MCHA has brought to MRMIB's attention but for which no improvement has been made. In the meantime, however, whether or not CMS is recommending changes to AIM's current rules is no excuse for designing much less implementing an enrollment system that would disadvantage AIM-eligible pregnant women by putting them into an Exchange plan instead of AIM, either "conditionally" starting October 1 or actually starting January 1.

Sincerely,

Lucy Quacinella, for Maternal and Child Health Access
Elizabeth Landsberg, Western Center on Law & Poverty

cc: Katie Johnson, California Health & Human Services Agency
Toby Douglas, California Department of Health Care Services
Cynthia Mann, Centers for Medicare and Medicaid Services

CH1LDREN NOW



September 10, 2013

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

Re: Updated Draft SHOP Regulations (rev. 9/3/13)

Dear Mr. Lee:

We appreciate this opportunity to provide comments on proposed SHOP regulations addressing application, eligibility and enrollment. Our comments are based on the revised proposal (9/3/13) made available September 4, 2013.

We have a particular interest in the manner in which SHOP's eligible employees' dependents are provided with information and access to health coverage. Accordingly, our focus here will, for the most part, be on child dependents, regardless of whether a SHOP employer offers dependent coverage.

First, we fully support recent amendments to the proposed regulations that delete requirements for employees and dependents to provide Social Security Numbers. As we have previously noted, that information is not required by the ACA or any subsequent federal guidance, and adequate record management can be accomplished with use of other identifying numbers.

Section 6520 a) 10) A. needs additional clarification. The proposed language requires employers to provide SHOP with information regarding "the employer's health premium contribution amount for employees and their dependents." With regard to dependents, we suggest this be modified to require such information "if dependent coverage is offered."

Additionally, in the following sub-paragraph 10) B. we are concerned by the implication that only stand-alone pediatric dental coverage will be offered in SHOP. While we appreciate that may be the case for 2014, given the Board's clearly expressed directive to explore embedded pediatric plans for 2015, we do

not believe this express requirement to disclose a tier level for a stand-alone pediatric dental plan, without allowing for other options, is appropriate in the regulations. We suggest the language be modified along the lines of: "If dependent coverage is offered, the employer's offer of health insurance coverage must include the employer's selection of pediatric dental coverage, whether embedded, bundled or stand-alone. If a stand-alone pediatric dental plan is offered, the selected tier level (high or low) must be provided."

We support provisions that permit employer attestations related to employee eligibility (Section 6520 b. 6).

Section 6520, b. 8) presents concerns. This provision appears to allow for the possibility that plans could ultimately produce plan documents that limit coverage in some manner inconsistent with information previously provided for plan comparison purposes. SHOP plans should be held accountable for coverage representations made to SHOP and shared with SHOP employers and employees. Perhaps this section should clarify that it only pertains to inconsistencies in summaries or comparisons made outside of SHOP (e.g. private market or Individual Exchange).

We believe Section 6520, d) can be improved upon. We wonder if it is appropriate to require (rather than request) email and telephone information from any SHOP employee. It is entirely possible that SHOP employees won't have email accounts or telephones. We recommend that Section 6520, d) be revised to distinguish between required information that an employee MUST submit, and additional information that a qualified employee may be asked to submit. There is no requirement that qualified SHOP employees have email accounts or telephone numbers, so requiring them to submit that information is excessive, and could be an enrollment deterrent.

While we are pleased to see the requirement to provide a SSN for dependents removed from the proposed regulation, much of the additional information required also seems unnecessary, especially for child dependents. For example, information regarding marital status should not be required for children. Also, for children only the responsible adult's contact information should be requested. Phone numbers and email addresses should not be requested for children; in fact, because young people often have mobile phones and email accounts, we would not want SHOP to be contacting them directly regarding health coverage – follow-up communications should be directed to the parent, or other responsible adult.

The language pertaining to disclosure of information regarding dental plans is problematic. First, SHOP employees not purchasing coverage for children should not select a stand-alone pediatric dental plan, if one is offered, and it should be clear to SHOP employees that those plans only provide coverage for children 18 and younger. Our understanding is that at this time adult dental plans will not be offered by SHOP. If that is the case, requiring employees to provide dental plan information is unnecessary and could be confusing and a deterrent to employees. Additionally the language in Section 6520, d) 5) suggests that dental plans are separate from health plans, and while that may be the case at this time regarding pediatric dental plans, the potential to ultimately offer 10.0 embedded plans should be

retained. It seems premature and unnecessary to adopt such limited regulatory language regarding dental plan selection. We suggest that the regulation only address the SHOP's duty to provide clear, complete information about any available dental benefits. Further, regarding both medical and dental plans, why should an employee have to disclose their physician or dentist provider names or locations? Also, providers do not only practice at "clinics" – it is unclear why an employee would have to provide a "clinic" name. Those requirements are intrusive and should be deleted.

While we are pleased to see dependent coverage addressed in part in these proposed regulations, they do not adequately address issues related to SHOP employee dependents who may be eligible for, or already recipients of, non-SHOP coverage. So while it is important to note, as the proposed regulations do in Section 6522 e) that "the dependents of qualified employees, if offered health insurance coverage by the qualified employer are eligible to purchase a QHP through the SHOP," it should also be noted that such dependents are not required to purchase that coverage, and in fact may be eligible for other public (and lower cost) programs such as Medi-Cal. Employees' dependents should also be provided with information regarding possible eligibility for coverage and financial assistance in the Individual Exchange. We recognize that the affordability standard potentially presents a significant obstacle for dependents of employees, but those restrictions do not apply to individuals, including dependent children, who are Medicaid eligible. **We continue to recommend that when SHOP employees provide information regarding their dependents they be given an express opportunity to indicate they have dependents seeking coverage and to request information about all options.** It is not our intent to impose any obligation on SHOP employers to provide such information; rather, a request for additional information should be linked and transmitted to Covered California's CalHEERS system, so that Covered California can respond to the employee request. Handling the follow-up in this way not only protects employers from additional workload, but protects the employees' privacy as well.

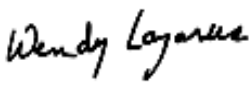
Thank you for the opportunity to provide comments on the proposed regulations, and for your attention to the needs of SHOP employee dependents.

Sincerely,

Ted Lempert
President
Children Now

Peter Manzo
President & CEO
United Ways of California

Suzie Shupe
Executive Director
California Coverage & Health Initiatives



Wendy Lazarus
Founder and Co-President
The Children's Partnership

Jamila Iris Edwards
Northern California Director
Children's Defense Fund-California

Having Our Say!

Communities of Color's Stake in Health Care Reform

September 16, 2013

Oscar Hidalgo, Director of Communications
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Re: Covered California Translated Fact Sheets and Spanish Language Web Portal

Dear Mr. Hidalgo:

Having Our Say (HOS), a statewide coalition comprised of over 30 organizations working to ensure that health policies address the needs of California's communities of color, appreciates that Covered California is committed to providing translated fact sheets in all 13 of the Medi-Cal managed care threshold languages. These fact sheets will be an important resource for our members as they promote accessibility, particularly for community members who are Limited English Proficient (LEP).

Ensuring that materials are translated accurately and are culturally appropriate is a multi-step process:

1. The use of different translators is important to ensure accuracy, completeness, and reliability of the translated document. One translator makes the original translation, and another edits the document. Often there will be terminology or phrasing for which the two translators may need to reach consensus.
2. A professional review of the translated document can help catch errors during the initial translation. The document should be reviewed by a health professional or expert who is proficient in both English and the translated language, and familiar with the content area and intended audience.
3. For key documents, field testing of the translated document with the intended audience is helpful to ensure that the document is conveying the intended message and is culturally appropriate.

As we near open enrollment on October 1st, our communities will have more and more questions about the Affordable Care Act and health coverage in Covered California. For this reason, we recently asked HOS coalition members to review Covered California Fact Sheets (English and translated) and provide feedback on both their content and translation.

After downloading materials from the Covered California website (www.coveredca.com) HOS members carefully reviewed all available facts sheets from July 2013 to August 2013 in the following languages: English, Spanish, Chinese, Korean, Hmong, Vietnamese, and Lao.

Review of the fact sheets, and web portal, highlighted the lack of available information about the translation process used by Covered California. For example, it is not clear who we could contact about issues with translated materials, nor do we know the organizations Covered California is contracting with to provide translations for each language. Additionally, because the materials are not officially dated (month and year) we found it difficult to know what version of the fact sheet(s) we should review.

Although the general content of the fact sheets was found to be useful by HOS members, they encountered a variety of issues during their reviews. The following are some of the highlights of their feedback:

- *Syntax mistakes across many languages*: Our members highlighted consistent syntax mistakes in the translated fact sheets. In both the Korean and Chinese language fact sheets our members indicated numerous words that were translated phonetically instead of using more familiar words. Examples include the Chinese translation of "California." Instead of using the more familiar translation "加州," the fact sheets translate the word into 6 Chinese characters. This is a less commonly used translation and could cause some confusion. In the Korean language fact sheets Covered California is referred to as a "Marketplace." The word "Marketplace" is translated phonetically, instead of using an existing Korean term, which could result in a misunderstanding.

  Sentences were frequently translated word-for-word, from English to other languages, which contributed to awkward sentence structure and some confusion. For example, in the Covered California Fact Sheet "Getting California Covered," the second sentence of the paragraph states, "Covered California was created to develop an organized marketplace…" However, the Chinese translation reads, "Covered California is a[n] organized new market." The meaning is slightly deviated and the sentence does not flow properly.

- *In Asian languages, the use of appropriate characters is important*: Reviews for the Korean and Chinese translated fact sheets stated potential issues with the formality of the language used. The Korean language fact sheets use a more "formal/honorific" version of the language, one that is frequently used in media and official letters. Recommendations included using a more informal version of the language to make readers more comfortable. In the Chinese fact sheets, "simplified Chinese character[s]" were used instead of "traditional Chinese characters." Our reviewer noted that while most consumers who read Chinese might understand both, in order to maximize comprehension and readability it would be best to offer, at a minimum, the traditional Chinese characters. Lastly, the font used for the Lao language materials was cited as "difficult to read." Our reviewers suggested using a more standard font

type, Saysettha OT font, which is the one used by Lao web and print media.

- *Translated documents and web portal use out-dated terms*: Our reviewers voiced concern about the use of terms they considered "archaic." For example out-dated words can be found in the Spanish language materials. Our members discouraged the use of "asequible" as a translation for "affordable" in both the Spanish language fact sheets and web portal, citing it as archaic and infrequently used. Also, the term "internet" is translated to "línea." This term is not frequently used and feedback suggests that Spanish speakers are actually more familiar with the term "internet."

- *Some jargon has not been accurately translated*: Although the Exchange has engaged in some multi-lingual focus group testing, it does not appear that replacement words have been vetted for each language group for terms like "Exchange" or "Marketplace," which may cause confusion for our members. In the "Hoja informativa de Covered California" the material describes tax credit subsidies using the same jargon only in Spanish: "créditos tributarios" and "subsidios" which were highlighted by our reviewer as infrequently used Spanish words. Our reviewer asked for the inclusion of a brief definition of the terms in order to promote comprehension. It is extremely important that each fact sheet use terminology that correctly conveys the intended meaning of these technical terms.

- *Language assistance resources and links to websites are not consistently identified*: Our reviewers highlighted issues with the lack of language assistance resources acknowledged in the English language fact sheets. Although the presence of fact sheets in various languages may suggest that language assistance is available, the English language fact sheets should still make reference to their availability. It is very important that these resources are identified because an English-speaking or -reading family member might see these fact sheets and want to refer a LEP family member to a site where they can access materials in other languages.

  Additionally, reference to important websites or other online resources in the fact sheets is inconsistent. While one fact sheet clearly tells readers, "to find out if you qualify for these unique benefits and for more information on health benefit exchanges, visit CoveredCA.com," other fact sheets only include the Covered California website in conjunction with the logo at the end of the document. This inconsistency could lead to the under utilization of Covered California's web portal and online resources due to the lack of promotion within the documents.

- *Covered California's Spanish language web portal is incomplete*: When visiting the Spanish language web portal HOS members reported numerous "404 Error" messages, missing content, and poor translation. Our members are curious as to when the Spanish language web portal will be running at full capacity. We understand CalHEERs is still under development. However, it would be helpful to provide Covered California website visitors with information and updates on when they will be able to access various sections of the Spanish language web portal still under development or review.

Recommendations:
After reviewing the feedback from our members, the Having Our Say coalition makes the following recommendations to ensure that materials are culturally and linguistically appropriate for California's diverse communities:

- ***Guarantee the use of quality control processes in the translation of Covered California materials:*** We urge Covered California to use quality-control translation processes for all official Covered California materials and the web portal. This is a multi-step process involving several reviewers as outlined above that will help to ensure quality translated materials, while also highlighting Covered California's continued commitment to providing health care access to LEP communities. In order to determine whether those protocols are in place, it would be helpful to know more about the current translation process being used.

  Additionally, we believe that the "field testing" of translated documents should involve partnerships with community and grassroots organizations to ensure diversity and cultural competence. These organizations can serve as a valuable bridge for immigrants and LEP populations navigating through the complex U.S. health care system.

  When contracting with translation companies, every effort should be made to use local translators, preferably within California, who fully understand the complexities of our health care system and are poised to communicate about it in culturally and linguistically appropriate ways. This is especially important as large translation companies often contract with translators that reside outside the United States which often results in complications that can include: discrepancies in terminology, inaccurate translations that do not adequately capture the original meaning, and culturally inappropriate language that can sound nonsensical to the local target audience. The health care system in this country is a completely foreign concept in other countries, and many of our terms and concepts cannot be easily translated by those not familiar with it.

- ***Provide translated versions of the Glossary of Terms for Affordable Care Act and Covered California terminology:*** We appreciate the Glossary of Terms on Covered California's website (www.coveredca.com/glossary.html) and assume it will also be made available on Covered California's Spanish language web portal. We urge Covered California to translate the Glossary of Terms into other threshold languages and make it available to translators and consumers. A glossary would ensure that the vocabulary used in future Covered California materials is consistent with terms previously used, promotes reading comprehension, and reduces the use of jargon and other confusing terminology.

  Examples of helpful glossaries include those found on both the IRS website at www.irs.gov/pub/irs-pdf/p850.pdf, and Healthcare.gov's website in English at www.healthcare.gov/glossary/ and in Spanish at www.cuidadodesalud.gov/es/glossary/.

- ***Utilize focus group findings:*** We recommend increased adherence to focus group recommendations, especially as they pertain to translated materials. We found that a number of helpful recommendations included in the May 2013 NORC Report, "Effective Communication about Important Insurance Concepts: Results of Key Word Research," were not integrated into the final Covered California materials. For example, in the Spanish language fact sheets and web portal, the term "mercado" is used to connote "marketplace" despite focus group feedback suggesting the use of alternative terms to convey "consumer choice and convenience." In the future we would encourage more consistency in the inclusion of focus group findings.

- ***Conduct focus groups in other threshold languages:*** We urge Covered California to invest in focus groups in all of the Covered California threshold languages. Per our review, it is crucial that focus groups be consulted in order to ensure key concepts are conveyed in culturally and linguistically appropriate ways. Focus groups would help inform the translations of the web portal and future fact sheets, ensuring that they are linguistically and culturally appropriate.

- ***Establish a point of contact for all translated materials:*** We strongly advise the appointment of a Covered California staff member with expertise in the development and provision of culturally and linguistically appropriate materials to serve as a point of contact between Covered California and consumer groups. Ideally, the staff person would possess the authority to facilitate the timely resolution of language access and translation issues as they arise. Our communities are incredible resources and can provide great insight and assistance in the development and translation of Covered California materials. We believe that developing a process in which our communities can easily participate which includes appointing a staff member to serve as an accessible point of contact, would prove valuable to Covered California.

Having Our Say offers these comments in recognition of the continuous commitment on behalf of Covered California staff and its contractors to provide materials in other languages. We look forward to working collaboratively with you and staff and believe that with careful consideration of our recommendations Covered California can produce quality translated materials that are both clear and helpful for consumers.

Sincerely,

ACCESS Women's Health Justice
ACT for Women and Girls
Alliance for a Better Community
American Cancer Society Cancer Action Network
Asian Americans Advancing Justice - Los Angeles
Black Women for Wellness
California Latinas for Reproductive Justice
California Rural Legal Assistance Foundation
Cal-Islanders Humanitarian Association
El Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) – Fresno

El Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) – Greenfield & King City
El Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) – Los Angeles
Central Valley Partnership
Chinese Progressive Association
Coalition for Humane Immigrant Rights of Los Angeles
Earth Mama Healing
El Quinto Sol De America
Fresno Interdenominational Refugee Ministries
Guam Communications Network
Korean Community Center of the East Bay
Korean Resource Center
Latino Coalition for a Healthy California
Libreria del Pueblo
Low-Income Families' Empowerment through Education
Madera Coalition for Community Justice
Mid-City Community Advocacy Network
Pacific Islander Cancer Survivors Network
Services, Immigrant Rights, and Education Network
South Asian Network
Special Service for Groups/Tongan Community Service Center
SSG/PALS for Health
Street Level Health Project
The Council of Mexican Federations
Visión y Compromiso
Young Invincibles

Cc: Katie Ravel, Director of Program Policy
Yolanda Richardson, Deputy Chief Operations Officer
Caroline Sanders, Director of Policy Analysis & Having Our Say Coalition

California Voter Foundation

September 5, 2013

Via Email and U.S. Mail

Chairwoman Diana S. Dooley
Board Member Kimberly Belshé
Board Member Paul Fearer
Board Member Susan Kennedy
Board Member Robert Ross, M.D.
Covered California
California Health Benefit Exchange
560 J Street, Suite 270
Sacramento, CA 95814

RE: Implementing Voter Registration through the California Health Benefit Exchange

Dear Chairwoman Dooley and Board Members:

I'm writing on behalf of the California Voter Foundation, a non-partisan, nonprofit organization working to improve the voting process to better serve the interests of voters, online at www.calvoter.org.

The California Voter Foundation supports and applauds your implementation of the National Voter Registration Act (NVRA), a federal law enacted in 1993 to ensure the public has access to voter registration. As I mentioned when I addressed the board at your August 22nd, 2013 hearing, we recognize that you have a lot on your plate and are on a tight timeline to meet important deadlines and milestones. Fortunately California is one of only 13 states offering online voter registration, which will make it much easier to fulfill this goal than it would be with a paper-only registration process.

The number of eligible, nonregistered voters in California currently is about 5.8 million, and the number of Californians without health care is estimated to be 5.3 million. It is likely there is quite a bit of overlap between these two groups as they share similar ethnic, age and income demographics.

Implementing voter registration with the Affordable Care Act presents a wonderful opportunity to expand the number of California's registered voters. Our registration rate is 45th in the nation[i], much lower than other states, due in part to delays in modernizing our voter registration database and also poor NVRA implementation by California agencies since its adoption, as recently reported by the Bureau of State Audits.[ii]

There is an opportunity with the next generation of online voter registration to pre-populate online applications so relevant information already provided by the applicant is carried forward on the registration form.

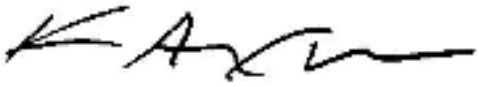
We understand the agency is pursuing a phased-in approach to NVRA implementation, and moving toward incorporating a link to the online registration form housed at the Secretary of State's web site. We hope you succeed in achieving this goal by the October 1st launch and would appreciate it if an update to the agency's voter registration implementation plans and timeline, including training of certified enrollment counselors could be given at the commission's September meeting.

We hope that planning for a form pre-population process will be part of the agency's overall planning process and are happy to support that effort and to work with you and your staff to move toward a state-of-the-art agency application process that facilitates voter registration.

Implementing voter registration through the health benefit exchange will not only improve California's registration rates; it can also have a positive impact on Californians' health. Health advocates are increasingly realizing that how we live, work and play in our communities and whether we are engaged and participate in community activities such as voting and elections can negatively and positively impact personal health. Registration is the first step to healthy civic engagement and community involvement.

Please feel free to contact me at 916-441-2494 or via email at kimalex@calvoter.org.

Sincerely,



Kim Alexander
President

cc: Peter Lee, Executive Director

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[i] See "Voting and Registration in the 2012 Election – Detailed Tables", published by The U.S. Census Bureau, Table 4a, "Reported Voting and Registration, for States: November 2012" at http://www.census.gov/hhes/www/socdemo/voting/publications/p20/2012/tables.html.

[ii] The Bureau of State Audits' August 2013 report on the Office of the Secretary of State is online at http://www.bsa.ca.gov/pdfs/reports/2012-112.pdf; analysis; recommendations regarding the National Voter Registration Act appear on pages 31-37. Specific recommendations include the Secretary of State working with the Department of Motor Vehicles to streamline its voter registration process and to designate additional state and local entities as NVRA agencies in order to maximize voter registration.