CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD
October 24, 2013
Secretary of State Office Auditorium
1500 11th Street
Sacramento, CA 95814

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

Chairwoman Dooley called the meeting to order at 10:00 a.m.

Board Members present during roll call:
Diana S. Dooley, Chair
Susan Kennedy
Kimberly Belshé
Paul Fearer
Robert Ross, MD

Board Members absent:
None

Agenda Item II: Closed Session

Chairwoman Dooley reconvened the meeting at 12:08 p.m. A conflict disclosure was performed; there were no conflicts from the Board Members that needed to be disclosed.

Agenda Item III: Approval of Board Meeting Minutes

After asking if there were any changes to be made, Chairwoman Dooley asked for a motion to approve the minutes from the meeting held September 19, 2013.

Presentation: September 19, 2013, Minutes

Discussion: none

Public Comments: none

Motion/Action: Board Member Kennedy moved to approve the September 19, 2013, minutes. Board Member Fearer seconded the motion.

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

Agenda Item IV: Executive Director's Report

Peter Lee, Executive Director, noted that since public comments following the Executive Director's Report have expanded significantly, the agenda will be rearranged slightly to accommodate comments focused on shorter segments.

Presentation: Executive Director's Report

Discussion: Announcement of Closed Session Actions
The Board approved an amendment to the Accenture contract and approved engaging in interagency agreements with the California Department of Social Services for the administration of the appeals process, the Department of Managed Health Care, and the California Department of Insurance. The Board delegated to the staff the ability to finalize a lease arrangement for the future location of Covered California's headquarters.

Discussion: Legislative Update
David Panush, Director, External Affairs, presented a legislative update. He commended the legislative staff who worked hard to get this done, along with the agency and governor's office. The bills that have been discussed over the last several months are now law. Some sharing of information from the high-risk pool is required. Stop-loss insurance coverage has been addressed and that will help the SHOP. The transparency bill conforms current exchange policies to state law. One bill clarified that the index rate for small groups can be adjusted and limited the out-of-pocket max for essential health benefits which will affect the future discussion on dental benefits. Covered California will have access to information from the former Healthy Families program which will become part of the Medi-Cal program for kids in order to reach out to their families. It also allows for the transition of some staff from the Managed Risk Medical Insurance Board (MRMIB) to Covered California. There is a co-pay cap for cancer treatment which takes effect in 2015. School lunch recipients will receive a notice about Covered California and other subsidized options.

Board Member Fearer clarified that the stop-loss bill affects non-SHOP self-insured plans. It affects the SHOP by making it relatively more attractive.

Mr. Panush explained that there had been concern that creating incentives for healthier small businesses to self-insure would affect the overall risk pool. The attachment point at an appropriate level reduces that risk.

Board Member Fearer asked about Ms. Capell's mention of a bill affecting essential health benefits.

Mr. Panush said that one aspect of SB 639 relates to the out-of-pocket cap for the package containing the essential health benefits.

Discussion: Federal Rules Update
Mr. Panush presented a federal rules update, including key issues, and mentioned the effects of the federal shutdown.

Mr. Lee said it's helpful that people can now sign up through the entire six-month open enrollment period without penalty.

Mr. Lee explained the resolution which would allow staff to make comments on the regulations relating to the federal exemption form. It currently is not very consumer friendly and could be simpler.

Motion/Action: Board Member Ross moved to accept the resolution for allowing staff to make comments to the federal government. Board Member Fearer seconded the motion.

Mr. Panush commented that the line between what can be done administratively and what can be done statutorily is sometimes blurred. It would be preferable to do what can be done administratively given the timeline.

Public Comments:
Beth Capell, Policy Advocate, Health Access California, agreed that it's desirable to have the most consumer friendly process for the exemptions. If the federal government doesn't see fit to make the changes that California wants, the process should be revisited to make sure it is done in the most consumer friendly way. She hopes Covered California would confer with their California delegation. With respect to the list of potential federal rule changes, almost all of those can be done through administrative action. It's an excellent beginning list.

Jim Mullen, Manager of Public and Government Affairs, Delta Dental California, commented on the federal clarification request which would allow for embedded dental plans to the exclusion of 9.5 plans. That means that a .5 standalone plan like theirs would be excluded. They believe that would go contrary to the Affordable Care Act. If approved, they hope that this request would allow the Board to know what the guardrails are when beginning to study the Wakely Report. They also hope that the federal response to the request to HHS is a resounding no and would be surprised if it were otherwise. They would like to see Covered California's Board join them and Senators Boxer and Feinstein in asking Treasury Secretary Liu to allow the advanced premium tax credit to flow to dental benefits. They were surprised by the original issue. The pediatric oral benefit is essential, so the rule that suggests it would not flow through does not make sense. Please add that to the list, even if it must be as an addition.

Betsy Imholz, Director of Special Projects, Consumers Union, supports the resolution but would like to see pediatric dental included in the out-of-pocket expenditures.

Brianna Hintze, Attorney, Guardian Dental, noted that they are a SHOP dental plan partner and a large dental carrier in the state. As Covered California considers whether it should eliminate standalone dental, it is important to note that the individual and SHOP markets are fundamentally different marketplaces and should not be treated the same. Purchasing behaviors are different, income levels are different, and the enrollees are diverse. Subsidies are one of the biggest impediments to standalone dental plans in the individual market, but that is not a barrier in the SHOP program. There has been a major focus on the importance of affordability, but consumer choice is also very important. The other point for the Board to consider is that the elimination of standalone would affect

continuity of care and cause marketplace disruption and consolidate market power with a few carriers.

On phone: John Valencia, Attorney, VSP, appreciated the inclusion of the final slide in the presentation by Mr. Panush. They also appreciated the efforts of staff, stakeholders and agencies in trying to find a way for Covered California to offer supplemental vision coverage opportunities. They were not able to come up with a sister state agency that could push the envelope on existing statutory limitations, so they will pursue that in the next legislative session.

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

Agenda Item V: Covered California Program Reports

Presentation: Covered California Program Reports

Discussion: Launch Update

Mr. Lee reported on Covered California's launch day on October 1. Board members attended events throughout the state. During the first three weeks of open enrollment, over two million unique individuals visited the CoveredCA.com website and over 156,000 callers contacted the Service Center. Further details will be released on November 14. He shared personal stories about the toll that lack of insurance has taken on various individuals. Things have not been perfect during the initial launch weeks, but the most critical aspects have been successful. Affordable plans will make health care coverage possible for millions of Californians.

There have been some challenges with the IT system. The provider directory was not ready as soon as they had hoped, but now it is up and improving every day. Staff will be holding focus groups with a variety of user types. The search function to find nearby assistance has had some issues and should be fixed soon. The Spanish site is up and undergoing improvement. The learning management systems have been too slow for community groups and agents and corrections have been made. Training capacity has also been dramatically increased.

Another area of challenge relates to collateral and printed materials. Although materials in a dozen different languages were available and distributed, some of them were not quite culturally in tune. The single streamlined paper application in languages other than English is still awaiting federal approval. Covered California is offering language-appropriate assistance in lieu of the printed application for now.

The staff wants to constantly improve, listen and learn. This has been just the first few weeks of a six-month open-enrollment period that is the beginning of the next hundred years of health care in America. Covered California is building a new system that is about getting health care right and being responsive to all Californians.

Board Member Ross commented that he heard from Mr. Lee an appropriate balance of optimism and candor. He wondered if there might be any way to increase the speed of registering and certifying assisters.

Mr. Lee responded that Covered California has significantly increased the speed. Technical bottlenecks have been cleared and training efforts have been increased. They appreciate the levels of partnership in the area of certified enrollment counselors. The health plans have been reaching out to their new enrollees. A large amount of training is scheduled for this month.

Discussion: Small Business Health Options (SHOP) Report
Anne Gezi, SHOP Manager, reported on the Small Business Health Options (SHOP).

Board Member Fearer said an insurance broker/agent contacted him and said that he and several colleagues took the training, passed the exam, became certified, and paid their fees but now cannot get into the system on the individual side.

Ms. Gezi acknowledged there had been some login problems and other system issues with both agents and individuals, especially during the first week.

Mr. Lee asked anyone who had these types of problems to notify Covered California.

Discussion: Marketing and Outreach Report
Mr. Lee noted that outreach is happening on both large and small scales. Several mayors have made plans to hold outreach events, and Covered California has sent letters to 500 other mayors encouraging them to step up and join the efforts. Staff hopes to stimulate grassroots efforts.

Sarah Soto-Taylor, Deputy Director of Community Relations, presented the marketing and outreach report. Covered California is encouraging many organizations, such as places of worship, to partner with outreach efforts. They want enrollment entities to understand where they are in the process and discussed the upcoming webinar that will solicit stakeholder feedback. She shared a draft of the Welcome to Answers series being developed to help consumers going through the enrollment process.

Mr. Lee voiced excitement about the Welcome to Answers series. Moving into 2014, thousands of people will be able to reach these accessible materials. Community stakeholders are reviewing drafts and staff will make timely revisions. The information must get out there quickly; many people are waiting on the front lines.

Board Member Ross had heard that it should take two to three days to receive fingerprint reports. He wondered if that was indeed the case.

Ms. Soto-Taylor reported there has been a longer turnaround time from the Department of Justice, typically a week or week and a half, and then additional time is required to pair up that information with individuals' declarations of conflict.

Mr. Lee noted they are sending applicants into fingerprinting without knowing if they will successfully complete their training. They would rather risk performing extra background checks than make applicants wait to get their results before they can start training.

Board Member Belshé said they participated in the All-In Campaign which focuses on child care providers and educational institutions that are engaging families, as well as the early-learning workforce which often doesn't have access to coverage. She asked what is involved in becoming part of the community outreach network, not in terms of funding, but in terms of access to materials and benefits.

Ms. Soto-Taylor responded that there is a simple interest form for organizations to fill out describing their demographics, what they'd like to participate in, and their capacity. Covered California receives those and reviews them, making sure the organization would be an appropriate partner. Then staff sends out a Memorandum of Understanding (MOU) about Covered California's rules and expectations. Community partners can download sets of materials and engage in a streamlined process for receiving materials.

In preparation for the presentation on marketing, Mr. Lee noted that health plans are also doing marketing in Covered California's name. It's a new day in affordable care and the marketing reflects a change in culture.

Colleen Stevens, Marketing Lead, provided a presentation on marketing and advertising, including NORC's Consumer Market Baseline/Segmentation Study and the results. She concluded that no group should be ignored because all groups include people that are receptive to or committed to getting insurance. She also discussed the Kaiser Family Foundation study on the uninsured.

The marketing team is working with partners on local campaigns to find people who should be signing up for Covered California. She presented ways that different groups will be reached and showed advertisements targeted to various languages or groups.

The biggest barrier to signing up is money. There will always be a group of people between Medi-Cal and the subsidies and money will continue to be a major barrier for them.

Mr. Lee expressed that these reports and data have informed everything. Affordability is critical. Consumers have demonstrated receptivity or commitment to buy after hearing statements such as, "Given your income, X is what you would qualify for."

Board Member Ross said staff arranged for him to go on stage during a hip-hop concert with a huge, young audience, and he was well-received. That kind of presence is good public relations.

Board Member Belshé asked about the fact that respondents to the NORC report prioritized things differently.

Mr. Lee explained that the NORC report says in the full text that affordability matters most, but the elements listed on the presentation slide are elements of the Affordable Care Act that people find attractive.

Ms. Stevens reported that they clearly found that giving people specific information about subsidies enhanced their interest. It was also a lower-rated aspect of the Affordable Care Act that they are required to buy insurance.

Discussion: Eligibility and Enrollment Operations Report

i. Service Center Report

Carene Carolan, Deputy Director, gave a service center update and reported good progress on goals and metrics. Service center staff is being armed with the knowledge to help callers. They are also working to reinforce staff training on the Quick Sort process with the Consortia.

Board Member Belshé asked if the Quick Sort process has proven effective thus far in terms of sending people to the right place.

Ms. Carolan responded that the metrics presented reflect making sure staff employs the process immediately. Covered California is gathering feedback from the counties to determine whether people are being sent to the right place.

ii. Consumer Website Report

Karen Ruiz, Project Director, and Keith Ketcher, President, Accenture, spoke about the launch of the website. They were happy to see they could successfully provide the ability for consumers to connect for enrollment. The large number of users attempting to log into the system upon launch challenged the system. Ms. Ruiz reported on specific issues and the work being done to correct them.

Mr. Ketcher discussed upcoming releases. Release 2.5, planned for November 15, will focus on financial management and SHOP enrollment. Release 3.0, planned for January 1, will focus on integration with the SAWS system used by counties.

Board Member Fearer asked if the login problems discussed in their report are already resolved or if they are being resolved but have resulted in a current backlog.

The initial backlog, Ms. Ruiz said, has been resolved. But there are new agents, service center representatives, certified enrollment counselors and county eligibility workers being trained every day, so it's a continuous process. The training has become far more efficient. Mr. Ketcher clarified that it was the

people supporting the enrollment process who encountered those challenges, not consumers.

Board Member Fearer voiced that the press has covered the provider directory more than anything, and that issue is not a core technical function.

Mr. Lee feels that it is. Staff had hoped to have the provider directory ready upon launch. It was not essential because 99 percent of consumers typically call their plans to find out if their doctors participate. Today the function is live and working and consumers can look up their doctors. The next level will be hospitals. Searching for hospital names is more complicated since hospitals are often identified in different ways by plans and consumers.

Board Member Fearer said he would love to meet the goal. But his experience in working with employer plans is that the quality of provider directories varies widely from plan to plan. Some are very accurate and some are out of date, some are easier to navigate and some are harder, and they collect different information.

Mr. Lee agreed that it is hard to do this right. They are making sure the combined provider directory is searchable, but the underlying data is only as good as what they receive from the plans. However, it's an important tool for a subset of consumers. Keeping their current doctor is critical for 25 percent, and the other 75 percent look for cost or delivery system.

Board Member Ross said getting the provider directory right will be a process. Is there a single point of contact that providers can use to call in to get their information correct?

Mr. Lee said they will post that point of contact next to the directory.

Board Member Ross wondered what the impact on the consumer will be of these anticipated release points.

Ms. Ruiz explained that the biggest impact is that they must take the system down, usually in the evenings of the weekends, for the releases. When the system is down, people cannot enroll. They do an extensive regression test for each release, so the consumer should not encounter new issues. When release 2.0 was launched, the system was down for ten days. For 2.5, it will probably be down for two days. Release 3.0 at the end of the year will be another big update, so it might take more than two days. It would cost far more money to have multiple systems running simultaneously.

Board Member Ross thought it would be important to time outreach and enrollment events so they don't run up against the down periods.

Mr. Lee said they are determining if it would be better to be closed a few days before the first of January, or after. There will be a number of days when people won't be able to enroll and he doesn't like that.

Board Member Fearer wondered if the closures will be announced well in advance. He recommended that pessimistic estimates be given about how long it will take.

Mr. Lee said that system closures are announced to plan partners and the sales force, but not to the media or press.

Board Member Fearer disagreed with this approach, suggesting that consumers would likely prefer knowing when the system would be down for upgrades. If it is just down without an announcement, reporters will attack it. If Covered California knows in advance when the system will be unavailable, it would be good to have a soft announcement.

Discussion: Financial Report

John Hiber, Chief Financial Officer, presented the financial report. He acknowledged that the expenditure report through August 31 reflects increasing personnel costs as more staff is being hired. It will take several months into the fiscal year before they can see more meaningful trends.

Board Member Ross inquired about the variance, asking for clarification.

Mr. Lee said it is not available money on a balance sheet. This is purely a timing issue; those are CalHEERS billed costs, so none of those federal funds ever go to the balance sheet.

Mr. Lee noted that there will be far fewer changes this year than in the prior year when everything was gearing up. They did a lot of good work with stakeholders, though they have little data yet on what will and will not work. They will continue to work on some important issues such as the pediatric dental benefit. Medi-Cal plans have particular challenges, and they will consider new Medi-Cal plans for 2015. They will also be open to adjusting the benefit designs and the contracts.

Discussion: Covered California Health Plan Report

Andrea Rosen, Attorney, presented a health plan report, including a proposed recertification/decertification/certification timeline. Upcoming opportunities for stakeholder input include the discussion on pediatric dental policy scheduled for the November 21 Board meeting and the discussion on Standard Plan Benefit Designs planned for the December 19 Board meeting.

Board Member Fearer said he understood that Covered California is re-contracting with the existing plans unless they don't meet the requirements, and it has also said it is open to new Medi-Cal plans. Are there any kinds of new bidders that would be considered?

Ms. Rosen said that plans were advised last August that if they wanted to be in the 2015 exchange market, they really should bid for 2014. That message was effective and got robust participation. They wanted to make exceptions for new entrants and new Medi-Cal plans since the Medi-Cal plans were so overwhelmed by the expansion. There are some other plans the board may want to consider that are not Medi-Cal managed care plans; they are county health plans. Covered California will look at possibly expanding their acceptance policy slightly.

Board Member Fearer said there was a lot of discussion about the benefit design, plan choices, etc. He wondered if there were there any other major policy issues deferred until this round besides pediatric dental.

Ms. Rosen replied affirmatively that the Board was to consider whether Covered California would permit qualified health plans to bid nonstandard alternate benefit designs in the individual market.

Board Member Belshé noted that the presentation showed that plan compliance tracking was on a to-do list. There are a lot of standards, so what is the process by which staff will evaluate prioritization?

Ms. Rosen said their exhaustive document lays out every reporting requirement. Qualified health plans and stakeholder advisory groups are working together to determine which among those are most important.

Board Member Belshé requested an update next month, adding that setting these priorities is an important step for Covered California as an active purchaser.

Mr. Lee said that Covered California is not just focused on compliance tracking, but on how they will promote better care delivery.

Ms. Rosen noted that another important area of concern is reporting on at-risk enrollees and the management of their conditions.

Public Comments:
Beth Capell, Policy Advocate, Health Access California, voiced that they are pleased to see the timeline for contract recertification for QHPs because there are few Board meetings left before decisions must be made. Conforming to SB 639 will necessitate changes in benefit design and make the benefit design more consumer friendly than the current ones. Deductibles still worry them. They also were intrigued by the NORC report. They note that many service center calls have been in English, and much of the eligible population is non-English speakers. This means marketing needs to be retargeted. They were delighted to see the Asian-language ad.

John Arensmeyer, Founder and Chief Executive Officer, Small Business Majority, expressed that the agent recertification process is very important to small businesses.

They are traveling around the state doing events and have seen much pent-up desire among small business owners for SHOP access. Making the SHOP a high priority portion of upcoming releases is appreciated and they welcome the opportunity to participate in the feedback process. If Covered California does not get something up by mid-November, it will be hard to get significant numbers to sign up for January 1. Small Business Majority and their business partners are available as resources at all times, not just during advisory meetings. Covered California will likely experience media issues related to potentially low SHOP enrollment numbers, and they want to work with Covered California on that. For self-employed Californians and small business owners that don't yet plan to sign up, Covered California should look at business organizations as an effective channel to get the word out.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network, reported that polls show women of limited English proficiency are the least knowledgeable but most enthusiastic about signing up once they understand Covered California. She wondered if the ads would be tested. They noticed the small volume of Spanish and Asian language calls and assume once marketing is launched, those numbers will increase. They would like an update on bilingual certified enrollment and were glad to hear Covered California has been working through the glitches. She was unable to figure out how to register for the navigator webinar October 28. She echoed Board Member Fearer's comments on announcing the website upgrades and suggested that consumers will understand the need for down time during upgrades.

Julie Silas, Senior Policy Analyst, Consumers Union, said it helped people to be able to browse while enrollment was not yet possible. They have received great feedback about customer service and the provider directory and are hearing more and more great stories about the exchange. They hope they can help work to make the public materials and the Welcome to Answers more accessible, noting that there are two different audiences, the advocates and the consumers. They look forward to further collaboration on public reports of enrollment data.

Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law and Poverty, voiced that she called the call center and had a great experience. They are concerned about making sure the right people get to Medi-Cal. They are also concerned about notices going out to people which have not been very transparent. The notices do not comply with Covered California's own mission and accessibility regulations and there are considerable problems with them.

Brett Johnson, Associate Director, California Medical Association, noted they appreciate all the work that has gone into the provider directory. Covered California is close to getting a good product out there. There are inaccuracies and they are concerned about patients not knowing that there could be inaccuracies. Covered California should stress that consumers should contact their providers. A surprising number of physicians are unclear if they are in exchange products. Until they can get it accurate, the provider directory should not be up. They are glad that there will be a single place to report inaccuracies. One of their members is listed as participating in Anthem products, and he

is not contracted with any of them, and he is listed as speaking Spanish, though he does not and only some of his office staff does.

Emily Lamb, Senior Director of Health Care, Silicon Valley Leadership Group, echoed the comments of Mr. Arensmeyer, expressing excitement about the SHOP release and pointing out that the business community is standing ready to help. They have made a lot of comments on the SHOP advisory board. They will not participate in SHOP this year because they were offered a very good early renewal package of 2.3%. Lots of nonprofits and startups have taken early renewal rates since the SHOP wasn't up yet. A lot of their small businesses in Silicon Valley have tech and customer service expertise and have offered to test the website before it goes up. Web-based brokers should be included in the sales force. They work closely with elected officials, and they would love to promote the SHOP. A coalition of the fourteen largest chambers of commerce will talk about the exchange and SHOP at their next meeting and, along with elected officials, they can help boost membership in the SHOP.

Chairwoman Dooley hopes the low renewal rate is a sign that progress in reform is being made.

On phone: Tina Hussein, LA Area Chamber of Commerce, [inaudible].
Due to the poor quality of the phone connection, Chairwoman Dooley requested the caller send in written comments.

Beth Malinowski, Associate Director of Policy, California Primary Care Association, noted that their partners are eager to get started. They commend Covered California for being responsive and making great progress. Staff has been great working with their membership. but their members still feel the process is taking too long, and they are frustrated with the onerous delays. This issue is bigger than their health centers. Thousands of enrollment counselors are working through the process, but only 400 are currently certified, meaning only 10 percent can provide communities with support. Please prioritize improving the certified enrollment counselor process, and work out tech flaws with learning management systems to ensure communities can be enrolled through the great work of the assisters. They want to ensure the provider directory, including lists of facilities, is up as soon as possible.

Raúl Macías, Voting Rights Advocate, ACLU, pointed out that Covered California is required to offer voter registration to all consumers. Staff did not meet its initial goal. They are sympathetic to the different goals and deliverables, and they have seen things that have fallen off the list. They are confident that the exchange will reach full compliance, but would like a formal update and timeline for compliance. They provided the Board with a toolkit in May with practical steps and also sent a letter. They are available to assist staff.

Carla Saporta, Health Policy Director, Greenlining Institute, echoed Ms. Sanders' comments. They were excited to see the launch on the API marketing and targeting and hope to see how that will help enrollment. They would like to see desegregated data for

enrollment. They thanked the staff for its work on updating the employer/employee application and appreciated that a lot of their suggested changes were implemented. She urged adding a tagline about in-language help which may be required. Some employers and employees don't speak English as a first language. They are excited to see the live launch of SHOP in mid-November, and they understand the difficulties in making it happen sooner. They appreciated the acknowledgement of the website problems and how Covered California is fixing them. She concurred with Mr. Macias, and expressed disappointment that the voter registration was not at the end of the application, only on the landing page for the application. They encouraged staff to actually designate a coordinator for the voter registration process, believing that a specifically engaged community is a healthy community.

Cathy Senderling-McDonald, Deputy Executive Director, County Welfare Directors Association of California, said the counties are open and staffed and taking phone calls through warm handoffs, as well as from elsewhere. They interact daily with Covered California, CalHEERS, and DHCS staff. They appreciate the improvements to the training and have been able to use materials to update some of their scripts so that the transition point from staff to staff goes as smoothly as possible. They look forward to ensuring that the data being sent over matches up with their records about data received. Their eligibility workers are putting CalHEERS through its paces and are working together to resolve issues. They are mindful of the enhancements that are going on, noting that the SAWS and CalHEERS interface is critical.

On phone: Silvia Yee, Senior Attorney, Disability Rights Education and Defense Fund, received comments about television ads that are not close-captioned. This is important because people who are deaf are often not on Medi-Cal. Deaf individuals can face barriers to getting adequate education and can have lower-income jobs that don't carry insurance. It's important for them to know about Covered California and the exchange options, so the ads must be close-captioned.

Michelle Cabrera, Director of Research, SEIU, noted that they represent workers at the state call centers and county eligibility offices. They would expect glitches with a rollout this large, and their workers have experienced those, but they have been able to draw on their experience as eligibility workers to adjust as needed, doing things like working extra hours and using paper applications. The customers may not realize the extra mile they are going, so she wanted to let the Board know that, while it may be frustrating for the person signing up, the county workers are being really flexible. She has heard a lot of enthusiasm for getting this done right. Version 3.0 must be done on time.

Sonal Ambegaokar, Senior Attorney, National Health Law Program, addressed the timing of when the website goes down, noting that weekends and evenings are more efficient times for many low-income consumers to call. If the website goes down during those times, Covered California might lose low-income consumers. They would like to find out more about the segment of Medi-Cal eligible individuals who didn't know they were eligible. They worry there are still immigration status barriers, especially for mixed-status families. They thanked the SHOP staff for their work on the application, adding that they

would like to see more notice of appeal rights on the application and an FAQ for employees. She echoed Ms. Landsberg's comments about due process. There are some basic accessibility problems as well.

Doreena Wong, Project Director, Health Access Project, Asian Americans Advancing Justice, voiced that their community appreciated being included in the launch and the public events and it helped get the word out. She supported the comments from Ms. Saporta, Ms. Sanders, Ms. Capell, and Ms. Ambegaokar. Many of their Health Justice Network partners are part of the community outreach network, and they have not been trained as certified educators since priority has been given to contracted partners. They would like them to participate in the online webinar so that they can more effectively get the word out. If they could be allowed to do the trainings themselves, after a train-the-trainers course, that would speed up the training and get counselors out there to start work. Right now, enrollment counselors must do in-person assistance; if they could assist people on the phone, it would help maximize the capacity.

Tameka Butler, California Director, Young Invincibles, voiced appreciation for the staff and asked for more time for giving feedback. She expressed uncertainty about the Welcome to Answers format. It was described as great for consumers and people on the front lines—and then accompanied by a list of names of different categories of users who are all different audiences. It is text intensive, which may help advocates, but young consumers won't read it. They hope the commercial is part of a series of commercials because young people are diverse. Young adults will sign up later in the year, so it would be helpful to provide notice of when the site will shut down so procrastinators know what to work around.

Mr. Lee explained that Welcome to Answers is more a tool for agents and enrollment counselors, and less for consumers. It is not intended to be everything.

Kim Alexander, President and Founder, California Voter Foundation, aligned herself with the comments of the ACLU and the Greenlining Institute. They are eager to see a timeline for implementation and are eager to work with a designated coordinator They would like the agency add a register to vote link on the coveredca.com home page so that everyone who visits the site will see it. A new law has been passed, effective January 1, requiring every website maintained by the state to add a link to the Secretary of State's voter registration site and they hope that can be added soon. Ms. Alexander suggested acquiring the domain of coveredca.gov since some people will be going to the wrong site and will expect to find the application there. Setting up a redirect is easy and should prevent mischief. She also proposed setting up routine penetration testing to ensure that those opposed to health care reform are not attacking the site.

On phone: Regina Wilson, Executive Director, California Black Media, agreed with some of the other comments. She would like to see a timeline covering the ethnic breakout of those who have applied and completed applications.

Gilbert Ojeda, Director, California Program on Access to Care, UC Berkeley, was in Washington, DC for a recent nationwide assembly convened by the Health Ministry of Mexico and the embassy. They discovered that the word on the streets was what's happening in California. They briefed the staffers from the California delegation. The young Latinos, those under 25, are the most highly interconnected group in terms of social media. Also, the University of California's Survey Research Center has done some of the best survey research in the last 40 years. As mentioned at the last Board meeting, radio advertising is essential. More outreach will be necessary.

Hugo Morales, Executive Director, Radio Bilingüe, asked that geography be added to the list of elements that should be reported on. He appreciated the opening of the Fresno call center. He asked that Covered California seriously consider Mr. Johnson's comments about the doctor incorrectly listed as Spanish-speaking because a doctor visit is a completely different experience if interpretation is involved. He appreciated the study about the customer experience, but would like to see it highlight the experience of the non-English-speaking community. Blue Shield's study shows a dismal level of engagement with non-English speakers.

Bill Barcelona, Senior Vice President for Government Affairs, California Association of Physician Groups, pointed out that the Knox-Keene Act mandates the publication of written provider directories, and all but one of the plans are Knox-Keene Act plans. Their information should be easy to scan and make available as soon as possible.

Kathleen Hamilton, Director of Sacramento Governmental Affairs, The Children's Partnership and Children's Health Coverage Coalition, said thanks and congratulations.

Board Member Ross asked for a voter registration coordinator update next month.

Agenda Item VI: Covered California Policy and Action Items

Presentation: Covered California Policy and Action Items

Discussion: Quality Rating System

Jeff Rideout, MD, Senior Medical Advisor, began the presentation by acknowledging the hard work and professionalism on both sides of this important issue over the past year. If Covered California should decide to move forward with a quality ratings system at the present time, there would be only nine out of twelve issuers with data available and only four have networks that actually meet the 80 percent threshold (deemed identical by DMHC). Some have smaller networks, a point of contention, some have different networks, and some have networks in some parts of the state but not others. The scores that would be used would be those that have already been produced.

Mr. Lee said Covered California makes evidence-based decisions and must make some decisions on the edge. It must be very deliberate about this. They constructed fifty-two measures of quality, addressing patient experience along with clinical information. This has been a very tough decision and his background is in this arena. They recommend

waiting to post quality ratings, citing the rationale that Covered California has to be about getting people covered. If 70 percent of the plans have no quality rating information, that could be misinterpreted as being poor quality and it might dissuade people from enrolling. There has been very good quality work done by the three plans who are broadly in the commercial market and have good scores available.

Chairwoman Dooley supported the staff's original recommendation. This is a very difficult and thorny issue for everyone. It goes to the basic core principles and mission of Covered California. Good value means good quality for a good price, and they've always seen it as being very closely linked. There is a fairness issue involved. It doesn't seem possible at this time to do what the Board really wants to do. If it accepts the staff's current recommendation, staff can continue to see if there is something less than the full package that could be posted for 2015. She would like to consider what could feasibly be done.

Board Member Kennedy feels strongly about including as much quality data as the exchange has access to and doing it now. She understands the argument about misinterpretation and fairness, but Covered California has to err on the side of being fair to consumers. Consumers could also misinterpret the data if only prices are included and no quality information. Covered California has spent a lot of time and energy creating an apples-to-apples comparison of products so that consumers could choose based on a competition of price and quality. To withhold any information takes away a large data point. She has a right to know if she is going to choose between a plan with an existing network with data available and a plan with an untested network. The absence of quality data is in itself a data point and should encourage plans to provide updated data as soon as possible. Covered California is not scoring; it can present the data and trust that consumers are intelligent enough to use the data appropriately.

Board Member Ross said the decision is more a point of when ratings will be shared. There are reasonable honest differences of opinion and he changes his mind about the issue often. He wondered about the possibility of a compromise proposal.

Mr. Rideout said the quality rating system is comprised of two parts. One is called HEDIS, a clinical survey, and the other is called CAPS, a member survey process that addresses some different issues. About seventeen of the fifty quality measures come from the CAPS member survey. Both include some historic data. Some measures would be more specific to certain plans. It would be based on past years, not past networks.

Board Member Ross said that's less than ideal, but doable.

Dr. Rideout responded that Colorado used just one measure of those seventeen or eighteen measures that might be available.

Mr. Lee said that while it is doable, they thought it might be better to have no ratings rather than ratings for only three plans out of the twelve. He added that maybe it would be good to have other data for most of the plans. Quality means grading the plans.

Consumers see a lack of data as an "incomplete." Plans with no ratings feel this will be perceived as low quality.

Board Member Kennedy expressed that consumer perceptions will be impacted by how the data is presented. Consumers can understand that a new plan will have no data.

Mr. Lee said this is a consumer test question. If using CAPS, staff would need to do some work to learn more. Performance measurement and scoring and reporting are complex. There's validity to CAPS; it is a piece of quality and performance. Patient experience is a core domain of quality and so is clinical performance. Staff maintains its current recommendation.

Board Member Fearer said he's also struggling, and he finds many of the arguments compelling. The Board should not pick a path that puts at risk any other important aspect of implementing exchange activities. There are downsides to any path and there are ways to mitigate those downsides. The phrasing is important, and Covered California can find ways to reduce the risk. Not having quality ratings also carries risks, and the exchange should do everything it can to point people to existing quality information if they want to seek it out. He leans toward providing data of some sort. The core values are critical, and quality is central to those values. Two years is not that long to wait. Board Member Kennedy's comments resonated with him: if there is some good data on some plans, how can we not give it out? If Covered California does not provide quality data on a particular plan, it will need to communicate affirmatively that the plan is new. If the Board does not want to present CAPS and HEDIS data for a plan because the network is less than 80 percent, then the message why it won't have data is because it's different. It would be important to advertise to the consumers that this may not be the network they think it is. Consumers should be sure to confirm that their doctors and hospitals are covered in that plan. Even if Covered California decides to provide no data, Mr. Fearer is concerned people won't understand what that really means.

Board Member Belshé also struggles with this. Board Member Fearer's comments about the core values resonate with all of them. The Board is proud of its commitment to creating a good marketplace. It's important to consider what kind of information consumers need and what kind of competition Covered California wants to promote in the long term and also right now. In considering what information consumers need, price is not enough to drive competition. What information is available that could be provided now? There seem to be some viable alternatives. They are not perfect, but issues associated with historical data don't seem like good reasons for withholding information.

Chairwoman Dooley sees this quality rating system as critically important, but that's not the only place Covered California is affecting quality. The plan recruitment process was robust, and it only chose plans that met certain quality experience and commitment in order to even be here to be on this next level of quality review. Covered California pressed hard on affordability since this is the Affordable Care Act. The first value is affordability and it's also the first priority. They bargained hard for the plans to come in with affordable products, and that means some products are new. She wants to keep a

level playing field. She is interested in finding out if something imperfect can be offered in the interim.

Board Member Belshé echoed that. She wants to get to reliable and meaningful and helpful data in terms of current plan-specific CAPS results. It wouldn't be perfect, but it would be consistent. She wondered if that might potentially be a place to go as an initial marker since it deals with equity issues.

Mr. Lee said he loves wrestling with issues like this. They have been working on a lot of issues very quickly. A lot of enrollment will be happening soon. He worries about adding work, but that often must be done. Staff needs to get better information to bring back to the Board about issues such as how the best possible language will affect perceptions. Using both the HEDIS and CAPS historical ratings would only include three plans (with maybe one plan in a market and the others with nothing). Using CAPS alone would include around three-quarters of the plans. Staff could come back at the next Board meeting with additional data and options. For any option, January 1 would be the very earliest that something could be added. However, it is a relatively simple thing on the design side to add a table with stars.

Chairwoman Dooley would like to give the plan partners a request that they answer the question about the CAPS measures.

Mr. Lee pointed out that all IT issues are incremental and he does not want to sacrifice any other aspect.

David Maxwell-Jolly said that focusing on this would come at the expense of something else. There are things of value that they have already queued up for January. Those are high priority needs that have pushed other elements off the table. If the Board does not decide until next month, it takes a month of preparation off the table and it would be hard to get something designed by January. Until they know what the design is, they won't know how long it will take to implement. If it was in a very simple format, it is likely something could be put up in January.

Dr. Rideout emphasized that if they do come back with something for the Board to vote on next month, they must decide that the issue is settled. They've got much bigger things to deal with on the quality front, and they don't want to challenge the relationships they have built. He then suggested another option: if only historic CAPS data for quality ratings is used, they could tee that up for open enrollment in 2014. This would provide some data a full year faster.

Chairwoman Dooley clarified that this option would be for CAPS only in 2014 and the more robust information in 2015.

Dr. Rideout concurred. The way it is set up now, it's all or nothing until 2016. He mentioned that Covered California could also request voluntary reporting.

Mr. Lee pointed out this is not the only quality agenda. Attachment 7 has as whole range of quality issues, such as what is being done for people with chronic illnesses. Dr. Rideout will be spending a lot of his time on this in the next few weeks, and many other issues will be less attended to. There are other aspects of quality. It's not just a star; it's in holding all plans accountable for everyone they enroll and getting them to that primary care provider.

Board Member Belshé asked about the statement that three-quarters of the plans would have historic CAPS data.

Mr. Lee replied that this is public data. It's unclear if the plans will like it.

Dr. Rideout said one or two plans may not have the data.

Mr. Lee said some plans are Medi-Cal plans, and there is still the argument that populations matter as well. Are CAPS scores on a Medi-Cal population the same as CAPS scores on a commercial population? These are important things to consider.

Dr. Rideout commented that the biggest issue with CAPS is the language barriers.

Public Comments:
Betsy Imholz, Director of Special Projects, Consumers Union, said this is familiar, painful, and important territory. Because of the groundbreaking work done in standardizing benefits, people can go in and make apples-to-apples comparisons, and yet price will pop out as the key differentiator. Getting quality information out is a big way to spur quality improvement as well as inform people how to shop. This will improve quality partly because it will create a competitive incentive for plans to improve on customer service. Consumers Union has carefully weighed arguments on both sides and has come to the conclusion that not having information is a bigger risk than having imperfect information. Some quality measures need to be up and ready to go as soon as possible, such as the Office of the Patient Advocate (OPA) ratings or use of the CAPS data. Rhode Island and Colorado decided to do just that. It's not perfect or based on identical networks—but it never is because of time lags and variations between networks. Covered California should move forward on something this year. Other states have dealt with the issue of a rating in progress or no current data. She believes in consumer testing, but does not want to see that delay the process. The full title of the law is the Patient Protection and Affordable Care Act. Affordability is the key, and so is safety and quality. She hopes to find a middle path. It will keep improving over time.

Linda Leu, California Research and Policy Director, Young Invincibles, thanked Covered California for all of its work wrestling with this. Young adults believe that two years is forever. Please do something sooner. They are looking to the exchange to provide them with the information they need and are looking to it as the trusted source of information for these plans. Otherwise they will find it by searching around on the unreliable internet. Consumers are already used to seeing rated products and unrated products, such as when shopping on Amazon. It's not a foreign concept to them.

Jennifer Kent, Executive Director, Local Health Plans of California, expressed that she worked on authorizing language for the exchange, so she is aware of the discussion about wanting plans to compete on a level playing field. She hears the need to have that quality data included, but she thinks there should be no data until there is a level playing field. Medi-Cal managed care plans should not be rated on the same level as plans with commercial populations. If the Board wants consumers to make decisions based on price, value, and quality, this is not going to be a fair comparison and would cause issues relating to market advantage in the first year. This would mean only a one-year delay, not a permanent lack. It makes sense to have quality scores based on plan experience within exchange populations.

John Fox, Consumer Advocate, California Public Interest Research Group, encouraged the Board not to let the perfect become the enemy of the possible. Consumers need all the information that is available. As a member of the demographic being sought out, when he enrolled, he only had price to inform his decision among eighteen options. Consumers need some form of quality to inform their choices. People his age look at ratings when they are just shopping for sandwiches. They are used to unrated products and can understand that these are new products; the message just needs to be phrased carefully. They object to the staff recommendation. Consumers need information sooner, preferably the CAPS option, which would provide consumer rating data for ten of the plans. He recognizes that it's not ideal, but it's a stopgap solution for the next year. If that's not possible, anything is better than nothing.

Mr. Lee clarified that there are two options for presenting data in the near term. One option is to present robust clinical and consumer information on the three plans meeting the 80 percent network similarity threshold. The second near-term option would provide just the CAPS information which would result in consumer rating data for ten plans. The long-term option would be to wait two years for robust historic exchange data.

Tom McCaffrey, Vice President of California State Partnerships, Blue Shield of California, questioned the premise that some have talked about thus far with quality. If Covered California doesn't display quality ratings in some fashion, there is the assumption that it's not committed to the core value of quality. The whole selection process for qualified health plans is equally important in terms of Covered California's commitment to quality. They think it would be best to go with the staff recommendation. If it's about providing consumers with comprehensive accurate information in the 2014 exchange experience, then it can only be on exchange-specific measures. The least helpful consumer experience would be to provide CAPS and HEDIS on only three plans.

Jeff Shelton, Vice President of Government Relations, Regulatory Affairs, and Compliance, Health Net, supports the staff proposal. To him, 2016 doesn't feel that far away, and 2015 definitely doesn't. He strongly disagreed with the premise that something is better than nothing, especially if it confuses potential enrollees. One of the challenges will be onboarding and making sure people are properly enrolled, billed and signed up with a physician—if that doesn't happen, they will have a bad experience. Many low-

income people will be shocked when they learn they have high deductibles. That will affect their experiences. Health Net typically offers HMO products at a comparable gold and platinum level, but many people will buy those bronze and silver plans. It's important to help them understand what that means, and it is equally important to realize that the understanding won't come from historical information.

Allison Barnett, Government Relations Director, Anthem Blue Cross, echoed the plan comments. They share a commitment to making sure consumers have the best possible quality they can, but they ask for a delay and support the staff recommendation to ensure consumers have current and consistent information. She would need more information to be able to answer if the CAPS or the CAPS/HEDIS option would be better.

Bill Barcelona, Senior Vice President for Government Affairs, California Association of Physician Groups, supported Kaiser Permanente's and Western Health Advantage's letter for the simple reason that it doesn't prioritize cost over quality; it holds them as co-equal. There was a similar dilemma several years ago at DMHC over whether they should publish financial solvency information on RBOs. They decided to go ahead and publish as much information as possible, even if imperfect. More than half of the groups fell below average. It raised the standards of those groups very quickly. They don't share the concern that publishing data on four plans and not all twelve would be detrimental. He suggested that Covered California could hold focus groups and test wording with customers, maybe this weekend, and see how they react. Oregon's website publishes all data, including provider lists, and it looks like a good consumer experience.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network, supports the option of publishing the CAPS data in 2014. It doesn't include the clinical measures, and they are committed to having those discussions, but it's the only consumer satisfaction measure. Covered California should consider looking up data in other languages, but not at the expense of using the CAPS survey data that is available today in English. As Board Member Kennedy said, in a new world of mandating that people buy insurance, some people are coming to the website because they have to follow the mandate. As the NORC report showed, quality is the number two concern. Covered California should move forward with providing the data and evaluate how to provide more comprehensive quality data in the future.

Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law and Poverty, supported the comments made by Board Member Kennedy and Ms. Imholz. As an organization representing low-income consumers, they have focused more on affordability, but quality is also important. They have been acting under the assumption that quality data would be available. They hope to see CAPS data for 2014 and more comprehensive measures for 2015.

Garry Maisel, President and Chief Executive Officer, Western Health Advantage, noted that there has been a lot of conversation about price, and price has been talked about as a lure to get enrollment into Covered California. But quality has to be the issue that closes the deal. Covered California and the federal exchange will fail if they are not ultimately

about quality. Covered California should be excited that it includes the three highest quality plans in the state based on independent sources such as Consumer Reports and NCQA data. The OPA gave high ratings to them as well. The network really doesn't matter because the plan sets its quality agenda and reaches down to be sure immunization rates are met. The plan sets the command and control structure. They want to see the full quality rating information, though they agree that something is better than nothing.

Beth Capell, Health Access California, noted that they also instigated the letter because they were troubled by the notion that consumers would wait two or more years for quality data. With respect to clinical data, some measures require two years of experience. Some plans won't even have two years of experience by the end of 2015. They are concerned there will be continuing delays and pushes to delay quality reporting. The efforts to delay are being made by those whose grades aren't as good. They support the option of having CAPS data and have supported OPA stars, and they are unsympathetic to the notion that the populations are that different. These are the parents of the Healthy Families children who are now in Medi-Cal. They are mindful of their health plan colleagues' concerns but are not sympathetic. According to California law, the plans have an obligation to ensure you can get the care you need, so those measures that speak to the responsibility of the plan seem to override the concerns about the differences in the networks. It shouldn't matter that the network is different. People should still be able to get the care they need. They are strongly supportive of using those measures that are available as quickly as possible.

Jerry Fleming, Senior Vice President of Health Reform Implementation and Policy, Kaiser Permanente, said quality can become an abstraction. Quality ratings are really talking about the issue of whether people with diabetes can get the medicine they need and not go blind or lose their feet. Those issues make the difference between a population managed to a high level of HEDIS scores and ones who are not. This is about people's lives. Kaiser has improved and even saved lives with their care. Every plan really has to build in a lot of capabilities in order to get these high scores. Regarding the argument that historical ratings of HEDIS scores would not be valid because the network is slightly different, he expressed that the difference between a two star and a four star rating is all about how the systems and approaches have been used. They prefer the CAPs data affecting ten plans over something where only two or three plans get data because they want to create a competitive world.

Chairwoman Dooley asked how dissimilar it would be if Covered California took all 51 HEDIS and CAPS measures for the plans and applied them to all the products in the exchange. Would that be fair?

Mr. Lee did not know, but said probably not. A lot of quality is about the system, and a lot is about the providers. Is the similarity line 65 percent or is it 80 percent? Providers are themselves systems. LA Care has added health care partners, and how that affects the scoring becomes complex. He suggested that, after hearing comments, staff withdraws its recommendation. He is not ready to completely recommend the CAPS option. Staff should do all due diligence to see how CAPS could work and come back to the Board

with a recommendation. There are many issues to consider, including fairness and IT. As stated earlier by Mr. Maxwell-Jolly, planning for contingencies that the Board does not adopt will take staff off other important tasks that must be done. Covered California does want to do something concrete with the quality ratings as soon as it can. The CAPS option is the better one at the plan level.

Chairwoman Dooley asked the Board for comments and a recommendation.

Board Member Ross said he would be happy to make Mr. Lee's suggestion a motion.

Mr. Lee said the work the staff did on displaying quality ratings systems was sound work. The OPA ratings are HEDIS and CAPS ratings. To carry those ratings over to the Covered California site is to say that networks aren't important. The CAPS score is less sensitive on the network side and thus there's a lot of strength in that. To go with the HEDIS data, and potentially have five plans in Los Angeles with no data and only one with data, concerns him. The CAPS solution gets around that.

Chairwoman Dooley would like to give clear direction to the staff. There are many concerns that still need to be addressed. She is worried about the SAWS interface from an IT standpoint, and she is not comfortable suggesting a contingency. She wanted to direct the staff to do something specific. If we can get the best CAPS data for the most plans that will be up in January, then she would hate to ask staff to do something on a contingency basis and then have the Board decide in November whether or not to use it.

Board Member Belshé wondered if they should direct staff to implement a quality ratings system using plan-specific CAPS performance information. The anticipated presentation of this material would pertain to open enrollment for 2013–2014.

Board Member Fearer said the key amendment of that is "but not at the underlying risk of the exchange or implementing necessary aspects." They would like to see something as soon as possible, obviously, but not at the expense of something else that must get completed.

Board Member Kennedy liked what Mr. Lee said. But rather than being too specific, she would prefer to give the staff more flexibility and not be restrictive by saying it has to use CAPS. If there's a better way to do that, then staff can come back with it.

Board Member Belshé said the question is one of timing. This is when consumers are weighing their decisions.

Mr. Lee suggested direction from the Board that requests performance information that is as robust as possible, on as many plans as possible, as soon as possible, for open enrollment now. Specifying how to implement that makes him nervous. He doesn't think it will be HEDIS data; he believes that the CAPS option will work best. Mr. Lee said it was likely that the staff recommendation would land on a national benchmark. It could be presented to the Board next month and then amended later.

Mr. Lee asked that people comment on the other materials at the next meeting because of time constraints.

Discussion: Federal Establishment Support and Blueprint Application
John Hiber, Chief Financial Officer, presented on the federal establishment support and blueprint application. Covered California received conditional certification based on its blueprint submission.

The resolution would authorize a subcommittee of the Board to finalize and submit the application for supplemental Level II funding and complete the federal blueprint approval process. This is time sensitive.

Motion/Action: Board Member Ross moved to approve the resolution. Board Member Kennedy seconded the motion.

Public Comments:
none

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

Agenda Item VII: Adjournment
The meeting was adjourned at 5:00 p.m.