Comments to the Board

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January 23, 2014 Board Meeting

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November 26, 2013

To: Ken Woods, Senior Advisor, Covered California

From: Beth Capell, Health Access
Betsy Imholz, Consumers Union
Ellen Wu, California Pan-Ethnic Health Network
Elizabeth Landsberg, Western Center on Law & Poverty

Re: 2015 Benefit Design

1. Network Adequacy for CDI Products

Under current regulations, DMHC applies three standards for network adequacy:

- Geographic access;
- Access to appropriately qualified specialists at in-network cost-sharing; and
- Timely access.

CDI has specific regulations regarding geographic access, but not the other two standards.

Covered California needs to level the playing field for all QHPs participating. An issuer with CDI products should be required to comply, by contract, with all three of the DMHC standards. We believe this is facilitated because all QHP contractors for 9.5 plans offer DMHC products and thus are familiar with the DMHC standards. We note that this may not be the case for stand-alone dental plans.

2. Deductibles

There is now ample literature demonstrating that consumers find deductibles confusing. Even the phrase “deductible applies” may befuddle consumers. While this is common terminology in the insurance industry and eases the calculation of actuarial value for actuaries, consumers are usually mystified by deductibles. In addition to the specific asks below, we urge Covered California to re-examine the presentation of benefits to footnote or otherwise clarify the term itself and its implications.

We recognize that it is difficult to construct catastrophic, bronze and silver plans without applying a deductible. We very much appreciated the demonstration of this fact by the benefit designs shown at the Nov 15 plan management meeting that eliminated deductibles.

We seek the following:

First, deductibles should apply to the same benefits for the HMO and PPO product in the same metal tier. For example, under the 2014 offerings, the silver PPO applies the deductible to imaging, but the silver HMO does not. The silver HMO applies the deductible to professional services for pregnancy and hospital stays, but the silver PPO does not. This is very confusing and makes it difficult for consumers to compare products.

Second, to the extent feasible, deductibles should be consistent in application for silver and bronze. Evidence to date on enrollment suggests that most consumers are selecting either bronze or silver plans. The presentation of the benefit design comparisons on-line groups bronze/silver and gold/platinum. It is really confusing that the deductible applies to most physician visits for bronze, but not for silver. So how much does it cost to go to the doctor? Does it cost $70 for a specialist visit but only after spending $5,000 or is it $65? A consumer would think a product that cost $70 for a specialist was fairly comparable to a product where it costs $65 to see a specialist, but they would be sadly wrong. Color coding is of limited usefulness if consumers do not understand the role of the deductible.

The product that creates the biggest confusion is the bronze product where deductibles apply to almost all benefits. In contrast, for the silver plan, the deductible generally applies to facility services and there is a separate lower deductible for brand name drugs. We recognize that there are trade-offs to achieve the necessary actuarial value. But significantly higher co-pays for office visits for the bronze plan would more accurately reflect the actual cost-sharing impact on the consumer and would communicate that more clearly. A consumer choosing between a bronze product with $100 or $125 co-pay for a specialist visit would readily understand that such a product was twice as expensive to use as a silver plan with $65 co-pay for a specialist visit.

3. Co-Insurance

Co-insurance multiplies confusion for consumers. There is literally no way to calculate the cost exposure because there is literally no way to determine what the 20% is based on; 20% of what? This fact prevents careful comparison of products. It leaves consumers facing unknowable cost exposure.

The out of pocket maximum mitigates the cost exposure created by co-insurance. Imagine telling a single consumer living on $35,000-$40,000 a year that going to the hospital or having a baby will cost that consumer two months' income. That is what $6,350 is for a single consumer at 300%FPL-400%FPL. It is two months' gross income.

Co-insurance combined with co-pays is particularly confusing. Is a silver PPO with 20% co-insurance for imaging cheaper than a silver HMO with $250 co-pay for imaging? Is a

bronze plan with 30% co-insurance a better deal than a silver plan with $250 co-pays for the same services? How would anyone ever know? And that assumes that consumers understand the first point, that they cannot know 20% of what. What about a consumer who thinks 20 is less than 250, so it must be better? Add to that the confusion caused by deductibles being applied differently and how could even the most conscientious consumer ever sort out what creates greater cost exposure?

We reiterate our request that you model plans without co-insurance, but keeping a deductible, in order for the Plan Management Advisory Committee to have a robust conversation about that benefit design. We appreciate your presentation of designs without co-insurance or deductible at the last meeting, but know that conflating those two features increased the premiums considerably. We understand that eliminating co-insurance, but keeping a deductible, would moderate premiums and likely be more understandable to consumers.

4. Reduced Cost Sharing Products

A single individual eligible for a reduced cost sharing product makes between about $1,000 a month and $2,500 a month.

Co-insurance is particularly problematic at this income level. The out of pocket maximum of $2,250 for someone below 200%FPL is literally one to two months' gross income. For someone 200%-250%FPL, the out of pocket maximum of $5,200 is two months' gross income. The reduced cost sharing benefit designs with co-insurance have the effect that the cost for a pregnancy or a hospital stay for even one day is literally one to two months' gross income. A specialty drug for someone with MS, HIV/AIDS or cancer could also result in the consumer hitting their out of pocket maximum just for that drug. Outpatient surgery is also subject to co-insurance.

Asking consumers to spend one to two months' income for an overnight stay in the hospital, a pregnancy or a medically necessary specialty drug will result in homelessness and financial ruin for low-income consumers. Consumers below 250%FPL have few assets and often little in savings. The reason for the cost-sharing reductions is to protect such low-income consumers from financial ruin.

We do not offer specific suggestions because of the complexity of the interactions in the current standard benefit designs. We very much appreciate the low co-pays for these consumers for the most frequently used benefits. Replacing co-insurance with co-pays is our preference. While $200 co-pay for a hospital stay or $500 for pregnancy seems like a lot of money, it is less than blowing through thousands of dollars for a single night in the hospital. And, again, the certainty of the co-pay as compared to the co-insurance is very important to consumers.

5. Alternative Benefit Designs

We understand that QHP contractors submitted alternative benefit designs. We note that all QHP contractors are offering alternative benefit designs outside the Exchange. We suggest that as a first step, the Exchange ask that QHP contractors provide the non-standard benefit designs for review by the Plan Management Committee.

Our view of what consumers regard as more consumer friendly is quite different from what insurers regard as consumer friendly. Marketing products with cute names and confusing benefit designs (see above) is not consumer friendly. Buying health insurance is one step above a root canal for most consumers and often more confusing than buying an automobile.

We applaud the decision of the Exchange not to offer alternative benefit designs for 2014. We suggest for 2015 that any alternative benefit designs be subject to review and discussion in the plan management committee prior to review and adoption by the Exchange board. We urge Covered California to work with the Plan Management Advisory Committee to develop criteria for evaluating alternative benefit design so that all proposals are evaluated with the same goals and standards. Consumer protections should be embedded throughout the criteria. (For example, see Consumers Union consumer protection criteria for value-based benefit designs previously submitted to the Exchange http://consumersunion.org/wp-content/uploads/2013/01/Consumer_Critera_1_13.pdf). We also suggest that the Exchange review the actual experience of consumers shopping through the various avenues (on-line, CEEs, agents, PBEs) before adopting alternative benefit designs.

6. Family choice for subsidized coverage (aka “Member Level Benefits”)

Because the CalHEERS system was not designed to provide families eligible for subsidized coverage the option to enroll individual family members in different health plan policies, as required by the ACA, a manual work around is required so that families between 100 and 400% FPL who are eligible for advance tax credits and cost-sharing reductions can accomplish that. We understand that there are a variety of other CalHEERS changes that are vitally important, including first and foremost, the SAWS-CalHEERS interface by January 1, 2014 (in addition to implementing electronic verification of residency for Medi-Cal and online plan choice for Medi-Cal). Without “bumping” these priorities, it is also very important that a Covered California manual work around be put in place to ensure that individual family members are not denied their right to “guaranteed availability” and their access to advanced premium tax credits.

Recently we learned that an electronic CalHEERS work around is being used when family members choose to enroll in different QHPs, rather than a manual one. The work around appears to allow families to apply the advanced premium tax credit to only one health plan, requiring the remaining eligible family members who choose to enroll in

different QHPs to pay the full premiums and wait for the tax credit until April of 2015. Such an electronic work around prevents all family members with incomes between 100-400% from exercising their right to health insurance and advance tax credits, which we believe violates the federal statute and regulations.

The CalHEERS work around also does not provide the customer service experience required for the design problem. Families with more than two individuals in them will, in the majority of instances, prefer to enroll the entire family in one QHP policy to access the reduced deductible and out-of-pocket maximums. The current CalHEERS work around does not ensure that families are made aware of the financial benefits of choosing a family policy, nor does it provide them the ability to compare the options to find the best fit for their families.

We recognize that resources may be strained by a manual work around, but believe it is necessary to deal with the original CalHEERS programming problem. A manual work around should be designed so that when families are determined eligible and they go to the CalHEERS screens to pick their plans – a family who chooses different QHPs for different family members will be stopped from proceeding and be told that they can choose different plans, but that the next steps must be done over the telephone (i.e. manually for Exchange staff). They can choose between getting a call from customer service or providing them a direct telephone number where dedicated customer service staff can talk them through the choices of one family policy or individual policies or a combination thereof.

As currently designed, Medi-Cal eligible individuals cannot currently enroll in a health plan through CalHEERS and must proceed to pick plans outside of the CalHEERS system. For the small minority of families who may wish to consider separate policies for family members, this manual option should exist for 2014 Covered California enrollment as well.

For 2015 plan selection, CalHEERS should be fixed to ensure that families can choose different QHPs, regardless of whether they are eligible for advanced tax credits or not. Families with incomes below 400% FPL should not be prevented from applying the advanced tax credit to more than one QHP. Moreover, CalHEERS must be designed so that families are provided clear choices, including the ability to compare the financial and coverage implications between choosing one QHP with a family deductible and a family out-of-pocket maximum and having separate health plans with higher deductibles and maximums if there are more than two people in the family.

CPEHN
California Pan-Ethnic Health Network

Consumers Union
Nonprofit Publisher of Consumer Reports

HEALTH ACCESS

WESTERN CENTER ON LAW & POVERTY

January 17, 2014

Diana Dooley, Chair, Covered California Board
Peter Lee, Executive Director
Ken Wood, Senior Advisor

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

Re: 2015 Plan Year Benefit Design

Our organizations commend Covered California for choosing to exercise its authority to standardize benefit designs for the 2014 plan year. Standardizing benefit designs allows consumers to select plans based on premium, actuarial value tier, network and quality rating rather than being confused by dozens of choices that may appear comparable but in practice conceal significant differences in consumer cost sharing. Apples to apples comparisons ease consumer selection of a plan, lessen the need for assistance in selecting an appropriate product, and increase the salience of quality ratings of insurers. Because California law requires carriers to offer standardized products in the market outside the Exchange, this decision of Covered California has facilitated consumer comparison of products inside and outside the Exchange as well.

However, the 2014 plan year was the first time ever that standardized products had been offered. The open enrollment period was the first time consumers, and those who assist them, had practical experience with these specific product designs. We recognize that there is a desire to minimize benefit design changes for the 2015 plan year, given the magnitude of the changes in the insurance market faced by carriers for the 2014 plan year and thereafter. From a consumer perspective, modest adjustments to the 2014 benefit design for the 2015 plan year would significantly advance the goal of facilitating consumer comparison and choice while minimizing confusion.

1. Deductibles

There is now ample literature demonstrating that consumers find deductibles confusing. Even the phrase "the deductible applies" is confusing to consumers. A consumer may

wonder whether having a deductible apply is a good thing or a bad thing or even simply what it means. We attach an article in which a consumer complains specifically about the products offered by Covered California, titled "Deductible or Medical Deductible". Several of us have attempted to explain the difference to actual consumers attempting to purchase Covered California products and we have found ourselves challenged to do so. If expert consumer advocates cannot explain the difference, how can the average consumer comprehend it?

While deductible is common terminology in the insurance industry and eases the calculation of actuarial value for actuaries, consumers are usually mystified by deductibles. In addition to the specific asks below, we urge Covered California to re-examine the presentation of benefits to footnote or otherwise clarify the term itself and its implications.

We recognize that it is difficult to construct catastrophic, bronze and silver plans without applying a deductible. We very much appreciated the demonstration of this fact by the benefit designs shown at the November 15 Plan Management Committee meeting that eliminated deductibles. Our overall suggestion is that deductibles apply to facility services but not to professional services.

We seek the following:

First, deductibles should apply to the same benefits for the HMO and PPO product in the same metal tier. For example, under the 2014 offerings, the silver PPO applies the deductible to imaging, but the silver HMO does not. The silver HMO applies the deductible to professional services for pregnancy and hospital stays, but the silver PPO does not. This is very confusing and makes it difficult for consumers to compare products.

Second, to the extent feasible, deductibles should be consistent in application for both silver and bronze products. Evidence to date on enrollment suggests that most consumers are selecting either bronze or silver plans. The presentation of the benefit design comparisons on-line groups bronze/silver and gold/platinum. It is really confusing that the deductible applies to most physician visits for bronze, but not for silver. So how much does it cost to go to the doctor? Does it cost $70 for a specialist visit but only after spending $5,000 on the deductible or is it $65? A consumer would think a product that cost $70 for a specialist was fairly comparable to a product where it costs $65 to see a specialist, but they would be sadly wrong. Color coding is of limited usefulness if consumers do not understand the role of the deductible.

The product that creates the biggest confusion is the bronze product where deductibles apply to almost all benefits. In contrast, for the silver plan the deductible generally applies to facility services and there is a separate lower deductible for brand name drugs. We recognize that there are trade-offs to achieve the necessary actuarial value. But significantly higher co-pays for office visits for the bronze plan would more accurately reflect the actual cost-sharing impact on the consumer and would

communicate that more clearly. A consumer choosing between a bronze product with $100 or $125 co-pay (and no deductible) for a specialist visit would readily understand that such a product was twice as expensive to use as a silver plan with $65 co-pay for a specialist visit.

2. Co-Insurance

Co-insurance multiplies confusion for consumers. There is literally no way to calculate the cost exposure because the consumer has no means of determining what the 20% is based on; 20% of what? This fact prevents careful comparison of products. It leaves consumers facing unknowable cost exposure.

The out of pocket maximum mitigates the cost exposure created by co-insurance. Imagine telling a single consumer living on $35,000-$40,000 a year that going to the hospital or having a baby will cost that consumer two months' income. That is what $6,350 is for a single consumer at 300%FPL-400%FPL. It is two months' gross income.

Co-insurance compared with co-pays is particularly confusing. Is a silver PPO with 20% co-insurance for imaging cheaper than a silver HMO with $250 co-pay for imaging? Is a bronze plan with 30% co-insurance a better deal than a silver plan with $250 co-pays for the same services? How would anyone ever know? And that assumes that consumers understand the first point, that they can know 20% of what. What about a consumer who thinks 20 is less than 250, so it must be better? Add to that the confusion caused by deductibles being applied differently and how could even the most conscientious consumer ever sort out what creates greater cost exposure?

We reiterate our request that you *model plans without co-insurance, but keeping a deductible*, in order for the Plan Management Advisory Committee to have a robust conversation about that benefit design. We appreciate the presentation made to the Plan Management Committee of designs without co-insurance or deductible at an Committee meeting last fall, but know that combining those two features increased the premiums considerably. We understand that eliminating co-insurance, but keeping a deductible, would moderate premiums and likely be more understandable to consumers. If time permitted for Covered California to conduct consumer testing on consumer understanding of products containing co-insurance, we are sure that testing would confirm what the testing by Consumers Union and our experience has shown: that while all health insurance terminology is confusing to consumers, co-insurance wins the prize as the least understandable.

3. Reduced Cost Sharing Products

A single individual eligible for a reduced cost sharing product makes between about $1,000 a month and $2,500 a month.

Co-insurance is particularly problematic at this income level. The out of pocket maximum of $2,250 for someone below 200%FPL is literally one to two months' gross

income. For someone 200%-250%FPL, the out of pocket maximum of $5,200 is two months' gross income. The reduced cost sharing benefit designs with co-insurance have the effect that the cost for a pregnancy or a hospital stay for even one day is equal to one to two months' gross income. A specialty drug for someone with MS, HIV/AIDS or cancer could also result in the consumer hitting their out of pocket maximum just for that drug. Outpatient surgery is also subject to co-insurance.

Asking consumers to spend one to two months' income for an overnight stay in the hospital, a pregnancy or a medically necessary specialty drug will result in homelessness and financial ruin for low-income consumers. Consumers below 250%FPL have few assets and often little in savings. The reason for the cost-sharing reductions is to protect such low-income consumers from financial ruin.

We respect the complexity of the interactions in the current standard benefit designs which make this issue difficult to address. We very much appreciate the low co-pays for these consumers for the most frequently used benefits. Replacing co-insurance with co-pays is our preference. While $200 co-pay for a hospital stay or $500 for pregnancy seems like a lot of money, it is less than blowing through thousands of dollars for a single night in the hospital. And, again, the certainty of the co-pay as compared to the co-insurance is very important to consumers.

In modeling benefit designs for consumers with reduced cost sharing, we ask that the goal be that no consumer is expected to spend more than a month's gross income for a hospital stay, a specialty drug or labor and delivery at the most. We recognize that the out of pocket maximums may need to be higher than this but the copay or co-insurance should not exceed this threshold. Consumers at these income levels are most likely to live paycheck to paycheck and to have limited assets.

4. Network Adequacy for CDI Products

Under current regulations, DMHC applies three standards for network adequacy:

- Geographic access;
- Access to appropriate care at in-network cost-sharing; and
- Timely access.

These standards are applied to all health care service plan products regulated by the Department of Managed Health Care, including PPO products as well as HMO products.

These standards, particularly timely access to appropriate care at in-network cost-sharing, are essential so that consumers do not face financial ruin in order to obtain necessary care. Consumers should be able to count on the annual out of pocket limit to protect them from financial ruin by protecting them from out of pocket costs in excess of $6,350 for an individual.

CDI has specific regulations regarding geographic access, but not the other two standards. We recognize that the Department of Insurance is considering additional

regulations in this area. Until these are finally approved by the Office of Administrative Law, consumers cannot be certain that products regulated by the Department of Insurance meet the same standards as those regulated by the Department of Managed Health Care.

Covered California needs to level the playing field for all QHPs participating. An issuer with CDI products should be required to comply, by contract, with all three of the DMHC standards. We believe this is facilitated because all QHP contractors for 9.5 plans offer DMHC products and thus are familiar with the DMHC standards.

5. Pediatric Dental Benefits: Benefit Design

Recent changes to California law require that for the 2015 plan year, the annual out of pocket limit include all essential health benefits, including pediatric dental.

Covered California chose an annual out of pocket limit for pediatric dental of $1,000 and for some products, a deductible of $50 or $60. Our organizations suggest that careful consideration be given to substantial redesign of the pediatric dental benefit.

Our comments about deductibles and coinsurance apply just as strongly to pediatric dental as to any other Essential Health Benefit. How many consumers would think that 50% coinsurance is less than a copay of $365 for major services? Is 20% coinsurance half the cost of a $40 copay for the same benefit tier? Does it cost less to use a product with no deductible? For pediatric dental, we request that serious consideration be given to the elimination of deductibles, which seem to apply only to DPPO products. We also question whether coinsurance should be used. We suggest the Board consider whether DPPO products could be converted to copays.

The annual out of pocket limit of $1,000 needs to be revisited. California law requires for the 2015 plan year that there be a single out of pocket limit for all essential health benefits. Given that context, the amount of an out of pocket limit for pediatric dental should be lower. We also note that the federal exchange and other states have chosen lower out of pocket limits for pediatric dental. We recognize that a lower out of pocket limit impacts premiums but the big impact on premiums comes from embedding rather than allowing (some) families to purchase pediatric dental coverage separately. Further, reducing the out of pocket limit for other essential health benefits from $6,350 to $5,350 has an impact on premiums for most essential health benefits. We would ask that serious consideration be given to an annual out of pocket limit for pediatric dental of $300 or $400. It would be helpful to see modeling how different cost sharing impacts on premiums, not just for pediatric dental but for all essential health benefits.

6. Alternative Benefit Designs

We understand that QHP contractors submitted alternative, nonstandard benefit designs for the 2014 plan year. We note that all QHP contractors are offering alternative benefit designs outside the Exchange. It is our position that standardized benefit

designs are a key factor in Covered California's high enrollment, a feature that is unique or nearly so among Exchanges nationwide, and by far the most consumer-friendly model of offerings. That is why we have recommended the further simplification and standardization above. We urge that for the 2015 plan year Covered California not permit non-standard benefit designs to be offered to its enrollees.

If Covered California intends to consider any alternative benefit designs for the 2015 play year, we urge working with the Plan Management committee to develop criteria for evaluating alternative benefit designs. Consumer protections should be embedded throughout the criteria. (For example, see the consumer protection criteria for value-based benefit designs previously submitted to the Exchange by Consumers Union: http://consumersunion.org/wp-content/uploads/2013/01/Consumer_Critera_1_13.pdf) We also suggest that the Exchange ask that QHP contractors to provide the non-standard benefit designs that are being offered in the market outside the Exchange for review by staff and the Plan Management Committee. We also suggest that the Exchange review the actual experience of consumers shopping through various avenues (on-line, Certified Enrollment Entities, agents, Plan-Based Enrollers) before adopting any alternative benefit designs. Interviewing your own call center employees might be revealing as well.

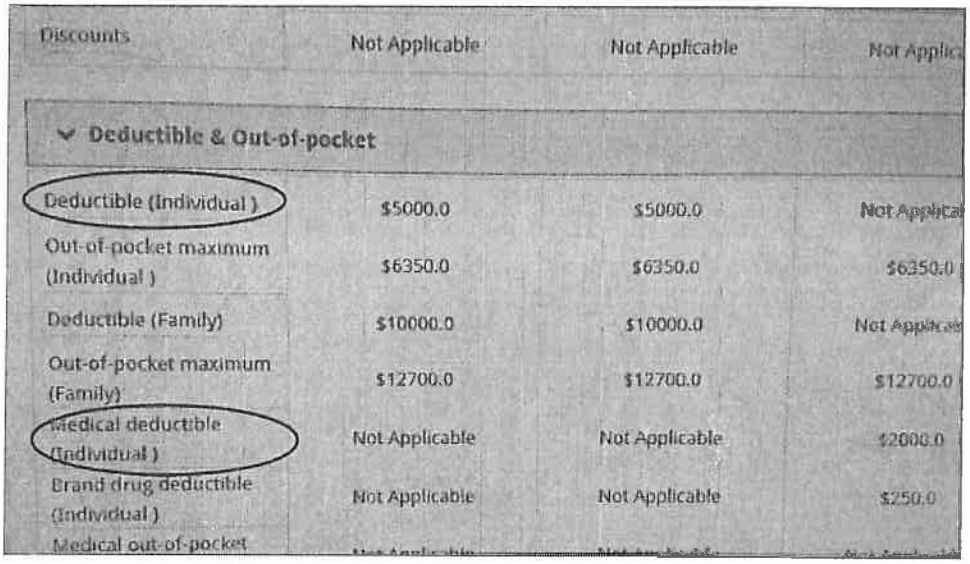
7. Summary

We commend Covered California for standardizing benefit designs. We recommend further simplification and standardization of these designs. We recommend particular consideration of the benefit designs for the products with reduced cost sharing to assure that no consumer is expected to spend two months gross income for a night in the hospital or a necessary prescription. We look forward to discussion of the benefit design for pediatric dental within the constraints of state law as well as in the context of the benefit design for the entire package of Essential Health Benefits. We oppose alternative benefit designs.

Sincerely,

Ellen Wu, California Pan-Ethnic Health Network
Betsy Imholz, Consumers Union
Anthony Wright, Beth Capell, Health Access
Elizabeth Landsberg, Western Center on Law and Poverty

What's the Difference Between a Deductible and a 'Medical' Deductible?



Discounts	Not Applicable	Not Applicable	Not Applic
▼ Deductible & Out-of-pocket			
Deductible (Individual)	$5000.0	$5000.0	Not Applica
Out-of-pocket maximum (Individual)	$6350.0	$6350.0	$6350.0
Deductible (Family)	$10000.0	$10000.0	Not Applica
Out-of-pocket maximum (Family)	$12700.0	$12700.0	$12700.0
Medical deductible (Individual)	Not Applicable	Not Applicable	$2000.0
Brand drug deductible (Individual)	Not Applicable	Not Applicable	$250.0
Medical out-of-pocket			

Different deductibles and medical deductibles for one Covered California applicant. (Lisa Aliferis/KQED)

Sunday afternoon was flying by when I received an email from Jon Brooks, a colleague who is currently shopping for health insurance for himself and his family on Covered California.

"Do you have any idea," he wrote, "what the difference is between a 'deductible' and a 'medical deductible'? Plan I'm looking at has 'deductible' of $0 and 'medical deductible' of $4,000 for family."

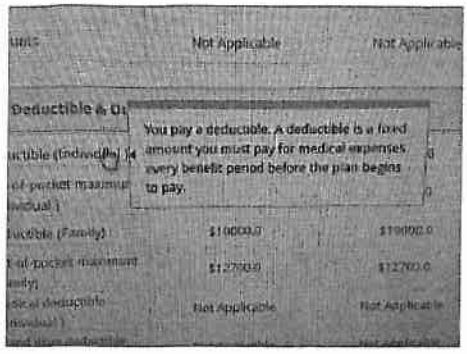
Huh?

Then today, a freelance reporter, also working on her application, asked me the same thing. As you can see in the screenshot above, she was comparing three plans. For two of the plans, the deductible was $5,000, but for the third plan, the deductible was "not applicable." Further down, the medical deductible for two plans was "not applicable" but for the third plan was $2,000.

We were both confused.

At first James Scullary, a spokesman at Covered California, was confused, too. But he called me back with the answer. It turns out that some insurance plans split their deductible. Some insurance plans have a "combined" deductible.

A medical deductible refers to "most medical services," but does not include prescription drugs. In the shot above, you can see that the plan in the third column has a $2,000 medical deductible and a $250 "brand drug" deductible. The plan has



Definition of 'deductible' as captured from the Covered California website. (Lisa Aliferis/KQED)

"not applicable" under plain old "deductible" because the plan does not have a plain old deductible. It has a medical deductible combined with a drug deductible for (I'm doing the math here) a total deductible of $2,250.

One of the promises of the ACA is that consumers will be able to make an "**apples-to-apples**" comparison. But Scullary agreed this deductible-vs-medical-deductible was confusing. "It's not apples-to-apples," he said, adding that it's an issue that has been raised internally and that Covered California is "looking to simplify, so we don't have the confusion."

I pointed out that a reasonable person might equate "not applicable" with "zero." Scullary agreed that "not applicable" was "not as clear as it could be."

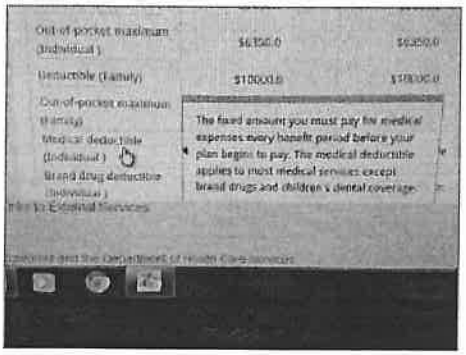
One thing that could simplify the confusion is better definitions. If you mouse over the terms, a dialogue box pops up with the definition. Check out the photo of the 'medical deductible' definition. It's similar to, yet different from, the definition for "deductible" above.

Note that **children's dental benefits are not included** under Covered California health plans, because consumers must buy a separate policy for children's dental. The fact that the words appear here in this definition suggests that children's dental benefits are somehow covered.

I called Brooks to fill him in. He said he had been confused and he wanted an answer "because it was going to factor into my decision as to which plan I picked."

But he somehow knew that equating "not applicable" with "zero" was too good to be true, when he was also seeing "$4,000" elsewhere.

"I used the logic that whatever is worse for me is probably true," he said.



Definition of 'medical deductible' from the Covered California website. (Lisa Aliferis/KQED)

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Occupational Therapy Association of California

December 2, 2013

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

Dear Mr. Lee:

I am writing on behalf of the Occupational Therapy Association of California (OTAC) to ask that you add some crucial information for consumers to the Covered California website related to enrollee benefits, specifically regarding the cost-sharing for rehabilitative and habilitative services.

OTAC is a not-for-profit professional association that represents more than 14,000 occupational therapy practitioners throughout California, as well as the tens of thousands of consumers they serve. Occupational therapy practitioners work with people of all ages experiencing medical conditions or disabilities to develop, improve, or restore functional daily living skills, such as caring for oneself, managing a home, achieving independence in the community, driving, or returning to work.

OTAC is very pleased that California is such a strong supporter of the Affordable Care Act (ACA) and applauds Covered California for its initiative and pro-active efforts to provide all Californians with affordable health care. We were very supportive of the inclusion of rehabilitative and habilitative services as part of the ACA's list of essential health benefits, and also the California State Legislature's efforts to clearly define the scope of habilitative services.

We are concerned, however, that the current Covered California website does not provide adequate information about the cost-sharing for rehabilitative and habilitative services. As a result, consumers, particularly those with special needs (e.g., parents of children with disabilities), are not able to easily make informed choices about which plan is best for their situations. We appreciate that Covered California includes charts with standard and enhanced benefit descriptions (https://www.coveredca.com/shopandcompare/#benefits), both as a standalone page and during the "shop and compare" process. However, essential health benefits clearly described in the emergency rule (2013-0322-02E) that standardized the benefits (e.g., rehabilitative and habilitative services and mental/behavioral health services) are conspicuously absent from Covered California's benefit descriptions. **How is the parent of a child with special needs supposed to make an educated**

choice between a bronze plan where habilitative services are subject to the deductible, and a silver plan where habilitative services are exempt from the deductible, when information that describes that fact is not shown during the shopping experience? If this information was available, some parents may choose to pay the higher premium for the silver plan that includes lower cost-sharing, knowing that their children are going to need significant therapy.

OTAC respectfully asks that you re-evaluate the current information contained on Covered California's website and include information at least as extensive as that included in the emergency rule during "shop and compare," so that consumers and have the necessary information to make informed decisions about the coverage option best for their unique circumstances. In particular, because habilitative services are in many cases new health benefits for enrollees, we believe it is important that Covered California provide this information.

Let us know if we can provide you with any further information or assistance in looking into our request. We look forward to hearing from you soon.

Sincerely,

Patricia S. Nagaishi

Patricia S. Nagaishi, PhD,OTR/L
OTAC President

Cc: David Panush, Director, External Affairs, Covered California
Diana Dooley, Director, California Health and Human Services Agency

CPEHN
California Pan-Ethnic Health Network

December 9, 2013

Sarah Soto-Taylor, Deputy Director, Stakeholder Engagement
Covered California
560 J St., Suite 290
Sacramento, CA 95814
Submitted electronically to outreach@covered.ca.gov

Re: Enrollment Assistance Program Regulations

Dear Ms. Soto-Taylor:

On behalf of the California Pan-Ethnic Health Network (CPEHN), we thank you for the opportunity to comment on the **Enrollment Assistance Program Regulations.**

CPEHN applauds Covered California's commitment to ensuring culturally and linguistically appropriate enrollment assistance to California's diverse communities. This is especially important as at least 66% (roughly 1.8 million) of adults eligible to receive tax credits to purchase health coverage in Covered California will be people of color, and 40% (roughly 1.06 million) will speak English less than very well.[1] We also applaud the steps Covered California is taking through these updated draft regulations to simplify the application process for Certified Enrollment Entities (CEEs). These proposed updates will go a long way in encouraging more community based organizations to apply to become CEEs. However we are concerned by the proposal to strike the requirement that entities provide detailed information on the race, ethnicity and languages of the individuals they serve and urge you to reinstate those provisions with some proposed changes.

Section 6654 – In-Person Assistance Program Application.

Subdivision (b)(17): We appreciate the requirement that applicants identify whether they serve families of mixed immigration status. This is important, as the majority of immigrants in California live in mixed status households in which certain family

[1] Gans D, Kinane CM, Watson G, Roby DH, Graham-Squire D, Needleman J, Jacobs K, Kominski GF, Dexter D, and Wu E. Achieving Equity by Building a Bridge from Eligible to Enrolled. Los Angeles, CA: UCLA Center for Health Policy Research and California Pan-Ethnic Health Network, 2012.

members may be eligible for coverage in Covered California or Medi-Cal while others may not. It will be important for Covered California to partner with entities that serve this population in order to understand and respond to the specific needs of these families.

Subdivision (b)(18): We appreciate the requirement that applicants identify whether the entity provides services to persons with disabilities. This is important in order to ensure Covered California is adequately meeting the Section 1557 non-discrimination provisions under the ACA.

Subdivision (19)(A-D): We are disappointed by Covered California's decision to strike the requirement that CEE applicants provide information on the percentage of individuals served in each language and ethnicity. We urge Covered California to reinstate this requirement in the regulations for county-based organizations. For statewide organizations that work in multiple counties where county-based estimates may be too burdensome, we would propose instead, that Covered California require CEEs to provide statewide estimates of the percentage of individuals served by race, ethnicity and primary language.

Subdivision (21) (M-P): We urge Covered California to require applicants to not only list the languages and ethnicities they serve but to provide a percentage of the population they serve or at a minimum an estimated number of each population served by spoken and written language, race and ethnicity. Specifically we suggest the following changes:

(M) Percentage and/or number of total individuals served in each spoken language~~s~~;
(N) Percentage and/or number of total individuals served in each written language~~s~~;
(O) An indication of whether the entity or individual offers services in sign language and a percentage and/or number of the total individuals served in that language;
(P) Percentage and/or number of the total individuals served in each race and ethnicity;

Section 6664 – Roles & Responsibilities

In subdivision (a), (1) we applaud the additional requirement that "Individuals and entities registered under the Navigator Program must also conduct public education activities to raise awareness about the Exchange." We urge Covered California to further expand the role of Navigators to include activities related to utilization and retention.

Thank you for your consideration of our comments.

Sincerely,

Caroline B. Sanders, MPP
Director Policy Analysis/CPEHN

AMI BERA, M.D.
7TH DISTRICT, CALIFORNIA

COMMITTEE ON FOREIGN AFFAIRS
SUBCOMMITTEES:
ASIA AND THE PACIFIC
AFRICA, GLOBAL HEALTH, AND HUMAN RIGHTS

COMMITTEE ON SCIENCE, SPACE, AND TECHNOLOGY
SUBCOMMITTEES:
RESEARCH
SPACE

Congress of the United States
House of Representatives

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December 3, 2013

Diana Dooley
Secretary, California Health and Human Services
1600 9th Street, Room 450
Sacramento, CA 95814

Mr. Peter V. Lee
Executive Director, California Health Benefit Exchange
560 J Street, Suite 270
Sacramento, CA 95814

Dear Secretary Dooley and Mr. Lee,

Covered California's recent enrollment numbers demonstrate the potential for successful health care implementation with a state that is committed to making the Affordable Care Act work for its residents. I applaud you for your hard work and continuous improvement. While Covered California has not experienced the same challenges that the federal exchange website has, widespread reports of technical glitches impact consumer confidence and enrollment patterns across state lines. In response to the technical challenges of federal health insurance marketplaces, I am requesting details from Covered California about enrollment reports to health insurers.

The backend reporting mechanism that notifies insurance companies of individual enrollment, known as the 834 transmission, is critical to the success of the Affordable Care Act. If the information in the data file is not accurate, individuals and their families may not actually have the insurance coverage they are expecting.

With news that the enrollment records for a significant number of Americans enrolling in coverage through healthcare.gov contain errors, I respectfully request information about the 834 transmission process through Covered California. What errors, if any, have been present in the data transmission process to insurers? If errors have been identified, how has Covered California addressed the problem and confirmed consumer enrollment?

I want to ensure that consumers know with certainty that the health care plans they have enrolled in will be there for them January 1. I appreciate your prompt attention prior to the December 23 enrollment deadline and thank you for your hard work to make access to health care possible for thousands of Californians.

Sincerely,

AMI BERA, M.D.
Member of Congress

CPEHN
California Pan-Ethnic Health Network

HEALTH ACCESS

SEIU California
Stronger Together

ConsumersUnion
POLICY & ACTION FROM CONSUMER REPORTS

WESTERN CENTER ON LAW & POVERTY

November 19, 2013

Diana Dooley, Chair and Members of the Board
Covered California
560 J Street
Sacramento, CA 95814

Dear Secretary Dooley and Members of the Board:

Our organizations strongly support the Medi-Cal changes, including the expansion of eligibility, as well as the creation of a California exchange which are central elements of the implementation of the Affordable Care Act in California. We appreciate the many challenges faced in fully implementing this transformation of health care in our state.

A cornerstone of ACA implementation is the expansion of Medi-Cal to childless adults and the simplification of eligibility rules including the reliance on Modified Adjusted Gross Income (MAGI) eligibility standards. Because the MAGI Medi-Cal business rules are programmed into CalHEERS, county eligibility workers, along with enrollment assisters and individuals under 138% FPL will rely on the proper functioning of the CalHEERS/SAWS Interface, to perform their enrollment and eligibility work as seamlessly as possible.

California should be proud that it has enjoyed a relatively successful launch of Open Enrollment. A functioning CalHEERS/SAWS interface is essential to assuring that consumers who are eligible for Medi-Cal, including children up to 250%FPL with parents on the Exchange, are able to enroll easily and smoothly into the Medi-Cal program.

Initially, Covered California had planned to have SAWS and CalHEERS fully integrated for the beginning of pre-enrollment in October 2013, but Covered California determined fairly early on in the planning process that it would not be able to complete the SAWS interface until January 1, 2014. Although this was a disappointment for county eligibility workers, it has since been the expectation that the January 1st deadline would be a priority given the importance of the SAWS interface for MAGI Medi-Cal eligibility determinations.

At the October Covered California board meeting, it was reported that the CalHEERS Release 3.0, which will include the SAWS Integration "and other significant enhancements for Medi-Cal and related programs" is scheduled and on track for January 1, 2014. We write to underscore the importance of the SAWS Interface and ensuring that in the final month and a half before implementation, that we do not lose sight of the January 1st date for MAGI Medi-Cal population who will depend on this infrastructure working properly to ensure that everyone applying for coverage under the ACA benefits from a first class user experience.

A smooth interface between the SAWS/CalHEERS systems is crucial to the MAGI Medi-Cal population and to workers administering Medi-Cal. Given the decision to include the MAGI Medi-Cal rules engine in CalHEERS and maintain case management in SAWS, the system of record for Medi-Cal, the Board must now weigh the importance of ensuring a smooth enrollment process for Medi-Cal beneficiaries in addition to that of Covered California's enrollees. Covered California and counties have spent the last year and a half working diligently to develop a SAWS/CalHEERS interface that supports Medi-Cal beneficiaries and eligibility workers and we urge you to fulfill your commitment to have the interface completed by January 1, 2014 in order to avoid negative effects on service to Covered California's customers. It is for these reasons that we write to urge the Board to ensure that the CalHEERS Release 3.0 is fully executed in time for January 1, 2014 and includes the SAWS Interface.

Respectfully,

Anthony Wright
Health Access

Elizabeth Landsberg
Western Center on Law & Poverty

Ellen Wu
California Pan-Ethnic Health Network

Tia Orr
SEIU CA

Betsy Imholz
Consumers Union

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

Subject: CoveredCA Service Issues

I would like to inform you that to reach CoveredCa by phone, e-mail or live chat has been so frustrating, depressing, impossible and very much time wasting. You may never be able to reach customer service by dialing 1-800-300-1506. Same recording and phone becomes silent or try later. I myself have called 94 times in last 30 days but no live customer service agent available. Every time recorded message went on and no luck. On the web site it says that call customer service for more info and no agent available on phone. To know the application status, in recording they provide two different phone#s 1-800-752-6631 and 1-800-675-2607 but looks all are same with same recording and info.

If you try to contact them through web email from web site, no body reach you back by e-mail or call.

If you try to connect live chat online, you remain in queue for 25 minutes and then you see no live chat agent available at this time. I tried at least 15 times on different time and same thing.

It is really very piteous and irritating situation that you cannot contact anybody. What kind of administration going on ?Are you joking, disrespecting or humiliating the citizens like this ? Is this a way to serve the people? Are you in government to sooth us or to punish us ?

You try yourself and you will realize our problems, difficulties and anxiety for not being able to contact them.

This is very good healthcare program and beneficial to millions like me. I myself have advised more than 50 people to apply for it. I congratulate US government for these scheme but your system has failed many people to get benefit out of it.

What else to say but remain helpless in such situation and wait that one day somebody speaks to you on phone and resolve your issue. Until than keep trying and waste your valuable time for nothing.

I have login issue to my CoveredCa account, and it suggests to call customer service to fix it. Perhaps the day will come when I will be lucky to have somebody to fix my problem.

Thanks,
Bill Bhagvat
billbhagvat@yahoo.com

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

Subject: Delayed Transition

I am writing to get my comments and opinion to the Board, especially Ms. Kennedy regarding the article in the Bee on Friday, November 22.

Contrary to Ms. Kennedy's statement that "delaying the transition is not going to solve a single problem" , delaying the transition will give me more time to figure out how I am going to pay $200.00 more each month for health insurance. I have a good policy now with a high deductible, but one I can manage.

I do not earn over $100,000 per year and have my health insurance paid for by tax dollars (you are welcome, by the way). So if you want to send me the additional $200.00 I am going to have to pay because of your decision not to delay the transition, I will gladly receive it.

Oh, and don't tell me to enroll in Covered Calif (a backwards name by the way) because I do not qualify for a subsidy AND none of my doctors are going to accept it. So either way I am getting worse health insurance than I had before. I don't need to pay $200.00 more each month to have a $235.00 mammogram every other year. I don't need children's dental and I don't need a higher deductible.

You are totally out of touch with the people who are buying individual policies.
I am not an extravagant person. I still watch free TV. I just do not want to pay almost $500.00 per month for health insurance that I may need.

Sincerely,
Marjorie Bookout
Central Valley
marjoriebookout@yahoo.com

November 21, 2013

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

RE: ID Proofing Policy for on-line applications via Covered California

Dear Ms. Dooley and Mr. Lee:

We are writing to express concerns about the potential barriers to enrollment created by the enhanced ID proofing requirement. Due to the federal government's new requirements for ID proofing that was released in June 2013 through guidance (and not in regulations), Covered California must now revise its existing ID proofing policy to comply with the new federal rules. Yet we are concerned that the enhanced ID proofing is too restrictive for California's state-based exchange and will harm a number of vulnerable populations in California based on our state's demographics. Given the existing technology challenges to enrollment faced by consumers in the federally facilitated and state-based exchanges, this enhanced ID proofing policy could lead to unintended consequences and keep millions of Californians (as well as Americans) from being able to apply for coverage via the streamlined application in the comfort of their own home. If so, this could further erode support for the Affordable Care Act (ACA), including from those who could most benefit from the ACA.

While we understand Board action is required today to comply with federal instructions, we support the Board approving this policy on a temporary, 90-day basis at this time. First, we believe federal guidance for ID proofing allows state-based exchanges, such as Covered California, additional flexibility and are working with staff to ensure California takes advantage of this flexibility to the fullest extent possible. We appreciate your staff's ongoing efforts to try to mitigate the harm of this policy on Californians. In addition, as advocates who represent low-income and other vulnerable consumers, the National Health Law Program and the Western Center on Law and Poverty will also raise these concerns directly with the federal government in the next several months and request certain changes to this policy.

<u>Background</u>
Based on CMS' "Guidance Regarding Identity Proofing for the Marketplace, Medicaid, CHIP, and the Disclosure of Certain Data Obtained through the Data Services Hub"(dated June 11, 2013)(hereinafter referred to as "CMS Guidance") and Covered California's October 2013 board brief and draft regulation, all applicants and application filers –who file an online and telephone application without enrollment assistance - will be required to have their identity verified before they can even start and complete an application and receive an eligibility determination. An individual ideally will be able to

have his/her identity electronically verified in real-time, but if not, he/she will have to take additional steps and provide further documentation to prove his/her identity, just to be able to start an application. This new enhanced ID proofing is required by the federal agencies for privacy safeguards so that an applicant's application information can be verified in real time against the information in the federal data services hub (FDSH).

Based on available guidance, for both the federally facilitated and state-based marketplaces, the first step in the ID proofing process is referred to as Remote Identity Proofing Process (RIDP) and entails an applicant's ID be electronically verified via a credit reporting agency (either Experian or Equifax Working Solutions). If an applicant's ID cannot be electronically verified in this first step, the applicant/application filer will be referred to the Experian Help Desk for telephone assistance to complete an electronic verification. CMS has distributed the enclosed FAQ which provides details of this second step with the Experian Help Desk. If an applicant/application filer still cannot have his/her ID verified in this second step, he or she must complete a manual verification of identity by providing a copy of an acceptable ID document to the marketplace or Medicaid agency by mail, electronic upload, fax or in-person. Per the FAQ, the Experian Help Desk will not be able to assist consumers with this manual verification process or help accept documents from consumers.

Consumer Concerns

We are concerned that the enhanced ID proofing is unnecessary. We agree and support that consumers' personal data should be safeguarded and not easily accessible and thus some type of ID proofing is needed when applying on-line. However, Covered California has already been operating with ID proofing. Furthermore, the benefit of this enhanced ID proofing is unclear. First, the CMS Guidance states that income information from the Internal Revenue Service (IRS) will not be accessible to the applicant even with the changes to the ID proofing because the level of ID proofing still does not meet IRS data sharing requirements. Second, there are concerns on how accurate this real time verification against the credit reporting agencies' database will actually be. Finally, the request for SSN for ID proofing is problematic. Per the CMS guidance, a Social Security Number (SSN) is NOT to verify identity through this process, but it is unclear how an individual could verify his/her identity electronically without an SSN. However, requiring an SSN from an application filer, who is likely a non-applicant, in order to verify his/her ID would violate existing federal prohibitions of requiring an SSN of a non-applicant.

Yet we are most concerned that the enhanced ID proofing policy will create a new enrollment barrier for low-income and vulnerable Californians. The new stricter ID proofing policy assumes that the majority of on-line applicants will be able to easily verify their identity through this real-time system. This ID proofing policy applies to all applicants and application filers; however, the policy will disproportionately create barriers for lower income Californians and likely those in most need of coverage.

Verification of identify through the credit reporting agency requires an individual to have a well-documented financial history sufficient to be able to establish a credit history. This would require individuals to have open lines of credit in terms of loans, credit cards, mortgages, and banking history. However, certain populations of Californians do not have access nor use these financial services and thus will not be able to prove their identity electronically at the first or second steps of the process under the current policy. In effect, these individuals have no alternative but to prove their identity through the

manual process of providing Covered California or Medi-Cal a copy of certain acceptable identification. These individuals also may not have acceptable identity documents for the same reasons their identity cannot be verified electronically.

Many vulnerable populations may not be able to provide proof of identify via a credit report or a limited set of acceptable identity documents for a variety of reasons. For example, 38% of low income households in the U.S are "unbanked" or "underbanked" – those who do not have bank accounts or credit cards or have little in the way of the proper financial documentation to have a credit history to verify against.[1] This includes communities of color, self-employed, part-time workers, freelancers, contractors, younger individuals (including former foster youth), immigrants, and homeless individuals.[2]

In addition, seniors, younger individuals, and minorities are most likely to not have the proper identity documents. For example, when the Medicaid citizenship documentation requirements were implemented in 2006, it was estimated that 1-2 million Americans would not have the appropriate documents to prove citizenship and identity.[3] In Wisconsin, the identity documentation requirements proved more of a barrier than citizenship documentation for Medicaid enrollees under the new federal rule.[4] Furthermore, transgender individuals and individuals recently released from incarceration may not have current identity documents and may have challenges obtaining current identity documents.

We understand the need to ensure the person applying for coverage is who they say they are, yet the current electronic ID proofing policy may be too strict given other policies and protections.
First, the CMS guidance states that an individual's personal and sensitive data from the federal data services hub will not be able to be seen by the applicant, even to someone who has proved his/her identity under the enhanced ID proofing. This information may only be accessible to the marketplace or Medicaid/CHIP agencies in order to conduct its eligibility determination for Medicaid, CHIP or APTCs. Second, this policy targets and creates challenges only for consumers who attempt to apply on their own on-line or by phone. For instance, those who apply via a paper application, a signature is sufficient to prove identity. Consumers who seek assistance from navigators or enrollment assistors can have the assistors verify their identity without going through the electronic verification of ID. Thus, it is counter-

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[1] "2011 FDIC National Survey Of Unbanked And Underbanked Households," FDIC, September 2012, http://www.fincapdev.com/wp-content/uploads/2012_unbankedreport.pdf "Fair Premium Payment Policies and Practices in Covered California," Consumers Union, June 2013, available at:http://consumersunion.org/wp-content/uploads/2013/07/fair_premium_practices_CA_2013.pdf; See also, "Stringent Income Verification Requirements for Obamacare Could Easily Undermine ACA Rollout," available at: http://www.dailykos.com/story/2013/10/14/1247282/-Stringent-Income-Verification-Requirements-for-Obamacare-Could-Easily-Undermine-ACA-Rollout# (stating up to 40 million individuals in the U.S. workforce are unbanked.)

[2] "Latino Access To Latino Financial Access And Inclusion In California," National Council of La Raza, June 2013, http://www.nclr.org/images/uploads/publications/CA_Latino_Financial_Access_ReportWeb.pdf; "A Portrait of Older Underbanked and Unbanked Consumers: Findings from a National Survey," AARP, available at: http://assets.aarp.org/rgcenter/ppi/econ-sec/underbank-economic-full-092110.pdf

[3] See e.g., "Revised Medicaid Documentation Requirement Jeopardizes Coverage For 1 To 2 Million Citizens," Leighton Ku, Center on Budget for Policies and Priorities, July 2006, available at: http://www.cbpp.org/files/7-13-06health2.pdf

[4] See "New Medicaid Citizenship Documentation Requirement is Taking a Toll: States Report Enrollment Is Down and Administrative Costs Are Up," Donna Cohen Ross, Center on Budget for Policies and Priorities, March 2007, available at: http://www.cbpp.org/cms/?fa=view&id=1090. See e.g., "The Dramatic Effects of Federal Documentation Requirements on Participation of Citizens in Wisconsin's Health Care Programs, Wisconsin Council of Children and Families, January 2007, available at: http://www.wccf.org/pdf/DRA_effectWI_013107.pdf

intuitive to think that consumers may be advised that applying via a paper application is easier than applying on-line under the enhanced ID proofing.

Recommendations

Below are suggestions for immediate ways that California can mitigate the harm of enhanced ID proofing policy. We have shared these suggestions with Covered California staff and appreciate their consideration of our recommendations, some of which they have already taken into account.

1) We recommend clear notice be provided to on-line and telephone applicants that ID proofing is required, what it entails, and that electronic verification of ID will not affect one's credit report.

2) We recommend the list of acceptable documentation to prove identity for those who cannot be electronically verified (described in the draft regulations at (e)(2)(ii)) be expanded to the fullest extent possible. The CMS guidance indicates that a "Marketplace, state Medicaid agency, or state CHIP agency may accept additional documents, provided that these documents are described in the Marketplace/agency's security artifacts."

   We suggest that Covered California adopt the list of identity documents allowed under existing Medi-Cal citizenship documentation rules. See California Department of Health Care Services' (DHCS) All County Welfare Directors' Letter 08-29, pages 6-7 and DHCS Enclosure 2, pages 8-9. See also Title 42 Code of Federal Regulations Section 274a.2(b)(1)(v)(B)(1). In addition, California's voter ID regulation includes additional acceptable ID documents that we recommend be included among Covered California's acceptable identity documents. See Title 2 California Code of Regulations Section § 20107 (2006)

3) We recommend Covered California and Medi-Cal explicitly add the ability for an applicant to email a copy of his/her identity documents in addition to regular mail, fax, in-person, or electronic upload to CoveredCA.com. We also recommend that additional alternatives to bringing ID in person be created. We appreciate that applicants are able to mail, fax, or upload a copy of acceptable ID; however, we are concerned that the additional burden of showing ID in person simply to start an online application will likely lead to individuals not following up due to simple inconvenience. Best practices from the private sector and lessons learned by California when the Medicaid citizenship documentation requirement was implemented in 2006 may be helpful in developing alternatives to in-person verification.

4) We recommend that an on-line applicant be able to start his/her application even if his/her ID cannot be electronically verified and that he/she has an opportunity to "save" the application on-line and be able to return to this application after verification of identity. We recommend that the application date be preserved for on-line and telephone applicants who attempt to start the application process, but are unable to complete the application due to the enhanced ID proofing policy.

5) We recommend that applicants be given and notified that they have a reasonable opportunity period to provide proof of identity through an alternative process if they are unable to verify ID electronically.

6) We recommend on-line or telephone applicants be provided clear notice from the onset about the ID proofing requirements and be instructed that there are alternative ways to apply if they do not want to have their identity verified electronically.

7) We recommend clear instructions be provided to on-line or telephone applicants who fail the first step of the ID proofing process on the alternative methods of providing proof of identity – the Experian Help Desk, in person, mail, or electronic upload. We also recommend that an applicant who fails the first step of ID proofing also be instructed that he/she can choose to forgo the Experian Help Desk verification and go directly to other manual verification options. Finally, we recommend that an applicant who fails ID verification on-line be offered an option to complete a paper application.

8) We recommend Covered California, Medi-Cal, and CalHEERS develop metrics and reporting mechanisms to track successful and unsuccessful attempts to verify ID under the enhanced ID proofing. We also recommend that the time between the first attempt to start an application and submission of the application for an eligibility determination post ID verification be tracked to document the application delays caused by the enhanced ID proofing. We also recommend tracking of the number of applicants who do not have the required ID documents to manually verify their identity.

9) We recommend Covered California and Medi-Cal periodicallyevaluate and update the list of acceptable identity documents that can be used to manually verify identity.

Thank you for considering our recommendations and we look forward to working with your staff to ensure low-income and vulnerable Californians can apply for affordable health care without significant hurdles despite this enhanced ID proofing policy. If you have any questions, feel free to contact Sonal Ambegaokar at ambegaokar@healhtlaw.org.

Sincerely,

Sonal Ambegaokar and Byron Gross, National Health Law Program
Elizabeth Landsberg and Jen Flory, Western Center on Law and Poverty

cc: Board Member Kimberly Belshé
Board Member Paul Fearer
Board Member Susan Kennedy
Board Member Dr. Robert Ross

CALIFORNIA LATINO LEGISLATIVE CAUCUS

December 17, 2013

Board of Directors
Covered California/CA Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814

Dear Board of Directors:

We appreciate the enormous amount of work that Covered California has done to make the long awaited dream of coverage a reality for millions of Californians. As the first state in the nation to establish an exchange, California has led the way in embracing the Affordable Care Act. Indeed, we in the Legislature have instituted significant insurance market reforms, established California's essential health benefit levels, and moved to aggressively expand Medicaid to our neediest population. The Latino community in particular has readily embraced health reform. A USC Dornsife/Los Angeles Times poll published last month showed that nearly two-thirds of Latinos in the state backed the law, compared with 50% approval among registered voters overall.

However, as members of the California Latino Legislative Caucus we are deeply concerned by reports indicating that the number of Latino enrollees in Covered California is lagging, particularly among Spanish speakers. Given that Latinos make up nearly forty percent of California's population and more than fifty percent of the subsidy eligible population, it is impossible for Covered California to achieve its goals without drastically improving participation within our state's Latino population. Five percent of overall enrollment is not acceptable.

In light of these figures, we request that Covered California publically share its plans to improve outreach and enrollment efforts to this community before the open enrollment period ends on March 31, 2014. Additionally, we urge you to allot significant time at the January 23rd Covered California Board meeting to discuss this plan in detail during an open forum so that members of the Legislature, the public at large and other interested parties have a clear understanding of the steps that will be taken to rectify this problem.

We are sure you agree that enrollment of the eligible Latino population is key to the success of the Affordable Care Act in California. Please be assured, we stand ready to assist Covered California as needed to help achieve its goals. We all want to see health reform succeed.

A member of our caucus or designated staff person will be in attendance at the January 23rd board meeting to speak briefly regarding our concerns and to participate in the discussion about how we utilize the next three months to, as your mission appropriately states, make sure California's diverse population has fair and equal access to quality health care.

1020 N Street, Room 511 • Sacramento, CA 95814 • Phone (916) 651-1535 • Fax (916) 651-4933

Thank you for your consideration of this letter. If you have any questions or need any additional information, please feel free to contact Willie Guerrero, the Latino Caucus' Principal Consultant, at (916) 651-1535 or willie.guerrero@sen.ca.gov.

Sincerely,

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

LUIS ALEJO
Assembly Member, 30th District
Vice Chair, CA Latino Legislative Caucus

NORMA TORRES
Senator, 32nd District

ED HERNANDEZ, O.D.
Senator, 24th District

Nora Campos
Signature

Nora Campos 27
Print Name District

Signature

Susan Eggman 13
Print Name District

Signature

Jimmy Gomez 51
Print Name District

Raul Bocanegra
Signature

RAUL BOCANEGRA 39
Print Name District

Kevin de León
Signature

Kevin de León 22
Print Name District

Signature

CRISTINA GARCIA 58
Print Name District

Signature

ASM. LORENA GONZALEZ
Print Name District 80

Signature

Sen. Ben Hueso, 40
Print Name District

Signature

Roger Hernández, 48
Print Name District

Signature

Ronald Calderon 30th
Print Name District

Signature

FREDDIE RODRIGUEZ, 52
Print Name District

Signature

Print Name District

Congress of the United States
Washington, DC 20515

January 10, 2014

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

Dear Mr. Lee:

We write today because we have serious concerns about the low number of Hispanic Californians signing up for health insurance through Covered California. Hispanic residents account for two-thirds of California's uninsured population and almost one-third of the state's overall population. Their enrollment is vital to the success of our health insurance exchange. However, a recent report by Kaiser Health News stated that of the 159,000 Californians enrolled in Covered California, less than five percent are Hispanic.

These numbers are alarming and we request you conduct a full review of Covered California's Hispanic outreach efforts. While we applaud the recent announcements regarding new Spanish-language advertising efforts and enrollment forms, there is more that can and must be done to increase enrollment, including resolving the shortage of bilingual enrollment counselors in key areas of the state and continuing to catch and fix translation problems on the website.

We urge you to ensure that efforts to enroll Hispanics remain a priority in California. We remain committed to carrying out the true intent of the Affordable Care Act and ensuring equal opportunity enrollment for all of our California communities is fundamental to that effort. We look forward to developing solutions to expand the enrollment of Covered California and are willing to help in any way possible.

Sincerely,

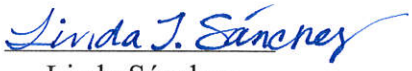
Loretta Sanchez
Member of Congress

Zoe Lofgren
Member of Congress

Lois Capps
Member of Congress

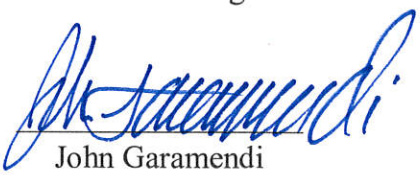
Mike Thompson
Member of Congress

Mike Honda
Member of Congress



Linda Sánchez
Member of Congress

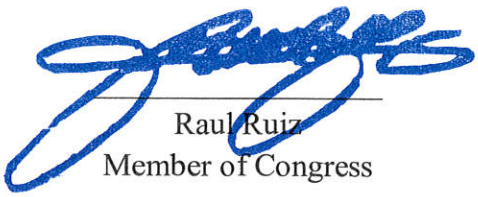
Adam Schiff
Member of Congress



John Garamendi
Member of Congress

Janice Hahn
Member of Congress

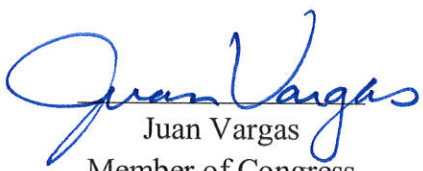
Mark Takano
Member of Congress



Raul Ruiz
Member of Congress

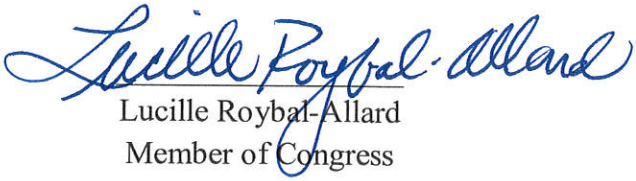
Tony Cardenas
Member of Congress

Jared Huffman
Member of Congress



Juan Vargas
Member of Congress

Alan Lowenthal
Member of Congress



Lucille Roybal-Allard
Member of Congress

CADP

CALIFORNIA ASSOCIATION OF DENTAL PLANS
One Capitol Mall, Suite 320, Sacramento, CA 95814
v: 916.446.3122; f: 916.444.7462; www.caldentalplans.org

January 17, 2014

TO: Covered California Board Members

FR: Jackie Miller, Executive Director, CADP
Pam Loomis, Policy Advisor for CADP
Mary Antoine, Legal Counsel for CADP

CC: Peter Lee, Executive Director, Covered California
Covered California staff: Casey Morrigan, Leesa Tori, Kate Ross, Peter Von Hermann, Taylor Priestley

RE: Jan. 23 Board Meeting & Staff Recommendation for Pediatric Dental Coverage in 2015

Thank you for your time and thoughtful consideration of CADP's concerns with the staff recommendation (10.0 with duplicative 0.5 offerings and an allowance for 9.5 bids) and CADP's alternative proposal (10.0, 9.5., 0.5 and bundled offerings).

Many of our members participated in the Dental Ad Hoc Advisory Group meeting on January 15th. For the first time since the discussion on pediatric dental started in earnest in August 2013, Covered California staff acknowledged that federal law requires the Exchange to allow a 9.5 plan.

However, we were astounded when staff made it very clear that while their recommendation is to allow the submission of 9.5 plans to meet the letter of the law, it is their stated intention to actively encourage all health plan participants in the Exchange to only submit 10.0 plans with dental fully embedded.

We feel compelled to draw your attention to how such an approach essentially frustrates the objectives and purposes of the Affordable Care Act, which was explicitly amended by Congress to ensure competition among, and consumer access to, standalone dental plans. Adoption of such an approach with its implicit work around of the federal law undercuts the credibility of Covered California. **We request that staff not be allowed to in essence actively discourage the inclusion of 9.5 plans**, but rather abide by the spirit of the ACA and consumer choice, and welcome 9.5 plans that choose to participate.

While the CADP alternative may require some additional effort for Covered California to implement, it is an honest, straight forward solution to the board's stated policy objectives of ensuring the cost of pediatric dental is always included in the APTC, and towards ensuring all children in Covered California will receive all ten essential health benefits, including pediatric oral services. It achieves this while avoiding disruption for thousands of consumers in 2015 who will lose their dental plan, will have to move to a new medical plan, and may lose their dentists under the staff proposal. Furthermore, it affords all stakeholders the benefits of a competitive market; and provides Covered California more flexibility for adapting to evolving federal regulations and market changes.

CADP

CALIFORNIA ASSOCIATION OF DENTAL PLANS

The vast majority of states offer a full suite of both standalone and embedded dental options, and their experience so far demonstrates that consumers are capable of evaluating and selecting benefits that address their particular needs without significant operational challenges. Please refer to our previous communications with you (dated Nov. 20, 2013 and Jan. 11, 2014) for the full explanation of our position.

For purposes of the January 23rd Board Meeting, CADP would like to underscore stand-alone dental plans' (SADPs) keen interest in providing affordable, quality dental coverage through Covered California. While the staff recommendation, if adopted, will be a disappointing result after such a heavy commitment to and investment in Covered California by CADP member plans in 2014, we can at least support the staff's expressed intent to do the following:

- Limit the staff recommendation to the Individual market, recognizing that the SHOP does not have the same APTC issues and presents a very different marketplace.

- Consider all options for SADP participation in the SHOP.

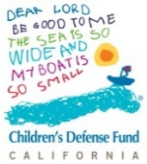
- Create a supplemental family dental product for both the Individual and SHOP markets.

CADP's member plans therefore ask that the Board postpone a decision on the staff recommendation until the staff's full intentions regarding the future of SADPs in the SHOP and supplemental dental are memorialized in writing and submitted for approval by the Board, along with targeted deadlines that will provide structure and accountability for resolving these issues. We believe the motion before the Board should reflect the following:

> ~~**Consistent with the Board's directive,**~~ Covered California recommends: ***for the Individual market only*** that the Exchange offer an embedded pediatric dental benefit side by side with a standalone benefit in plan year 2015, understanding that the Exchange must certify an otherwise qualified health plan without a pediatric dental benefit ("9.5") if offered by an issuer in this context***; for the SHOP market that the Exchange allow embedded, 9.5 and standalone pediatric dental options in plan year 2015; and for both the Individual and SHOP markets that the Exchange, offer a supplemental dental benefit no later than plan year 2016.***

We cannot stand by while Covered California changes course in the Individual market without assurances that the Board is committed to providing all options in the SHOP and expediting the availability of supplemental coverage in both markets.

Thank you for your consideration. Please do not hesitate to contact us to discuss the contents of this memo further.



January 17, 2014
Updated

Diana Dooley, Chair
Kim Belshe, Member
Paul Fearer, Member
Susan Kennedy, Member
Dr. Robert Ross, Member

Peter Lee, Executive Director
California Health Benefits Exchange Board

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

Re: Pediatric Dental Benefit Staff Recommendation

Dear Mr. Lee and Board Members,

Our organizations urge the adoption of the staff recommendation to offer pediatric dental in embedded plans to assure that all enrollees are able to purchase Qualified Health Plans (QHPs) that include all ten of the essential health benefits, including pediatric dental benefits. The staff recommendation accomplishes the goal of the Board resolution from the August 8, 2013 meeting (adopted by acceptance of the minutes of that meeting at the September meeting), and addresses consumer needs in the strongest possible way by affording 10.0 embedded as well as .5 stand-alone pediatric dental policies.

Our organizations support the staff recommendation for the following reasons:

- **Affordability**: Inclusion of pediatric dental benefits in an embedded plan allows consumers to apply the advance premium tax credit to all ten essential benefits, not a subset of those benefits. Embedded pediatric dental maximizes the affordability of coverage. As stated in the staff recommendation, under the current 2014 policy that allows only stand-alone pediatric dental benefits, consumers are "foregoing an estimated **$8.6 million to $21.2 million tax credit dollars** per year in California." For low-income and moderate-income families, every federal subsidy dollar helps.

- **Access:** Embedded plans ensure that all children eligible and entitled to receive coverage for pediatric dental benefits receive them without taking any additional action and without costing them additional financial resources. The experience to date suggests that not all families will purchase pediatric dental coverage when it is offered on a standalone basis: embedding assures that every child has dental coverage.

- **Consumer protections**: Many of the key consumer protections in California law apply to full service plans but not to specialized plans. These include guaranteed issue, community rating, rate review and medical loss ratio. Stand-alone dental plans thus lack the consumer protections that are afforded embedded plans. While Covered California imposed these protections via contract with the stand-alone plans, we believe consumers should be afforded the legal protections provided under state and federal law, not solely contract provisions.

- **Comprehensive benefits**: Under both state and federal law, pediatric dental is an essential benefit, not a supplemental or incidental benefit. Comprehensive benefits include benefits that many of us will never use: some of us will never need maternity

coverage, others among us will never need prostate cancer screening. Children need neither, yet all of the plans cover both.

- **Spreading the risk, increasing the tax credits**: Embedding pediatric dental benefits embodies a fundamental precept of the Affordable Care Act, spreading the cost for dental coverage for children across the full enrollee population, just as the costs are spread for pediatric vision and all other essential health benefits. The result is a lower price for the dental benefit than it is in a stand-alone product. Moreover, while embedding pediatric dental increases the overall cost very slightly of each QHP, individuals eligible for subsidies will benefit from the increased tax credits, even those enrollees eligible for subsidies who do not have children.

- **Market distortions**: California has a long, dysfunctional history in which different rules in different parts of the market have resulted in market shifts. Allowing consumers in the Exchange to purchase a partial benefit package that does not include pediatric dental benefits while requiring consumers in the outside market to buy all ten essential health benefits will have predictable, unfortunate market consequences.

- **Continuity of care rules should apply either by statute or contract provision**: Existing California law, Health and Safety Code Section 1373.96 and Insurance Code Section 10133.56, provide consumers with serious conditions or in the midst of treatment the opportunity to complete care or transition to other providers when a provider is terminated or not participating. Both provisions apply to specialized plans, including dental plans. Further legal research is needed to determine whether these sections apply to the Exchange products in the individual exchange but the Exchange could apply these provisions by including them in the 2015 plan year contract, as has been done for other consumer protections. The QHP carriers are familiar with these statutory requirements which have been in place for a decade.

Given these impacts, we believe that it is in the best interests of consumers to offer pediatric dental embedded in a comprehensive QHP product. The .5 stand-alone product offering ensures the continuity of care that is important to consumers. Through the Affordable Care Act, Congress made an important policy decision to include pediatric dental as a comprehensive medical benefit, not as a separate benefit. We understand that the market has long separated out dental from medical benefits, but believe that Congress was very clear that under the ACA, it was no longer business as usual.

We urge moving forward with the staff recommendation without delay, as much work still must be done to incorporate pediatric dental benefits into the 2015 standard benefit package. We encourage the Exchange to adopt a policy that maximizes the offering of embedded pediatric dental plans to ensure that all ten essential health benefits are included in QHPs offered both inside and outside the Exchange.

We look forward to the opportunity to discuss next steps with you all. If you have any questions or concerns, please contact Julie Silas or Betsy Imholz at Consumers Union (415) 431-6747.

Sincerely,

Doreena Wong, Asian Americans Advancing Justice, Los Angeles
Richard Konda, Asian Law Alliance
Karen Fessel, Autism Health Insurance Project
Suzie Shupe, California Coverage and Health Initiatives
Ellen Wu and Cary Sanders, California Pan-Ethnic Health Network
Seth South, California Primary Care Association
Serena Clayton, California School-Based Health Alliance
Michele Stillwell-Parvensky, Childrens Defense Fund, California
Kelly Hardy, Children Now
Kevin Aslanian, Coalition of California Welfare Rights Organizations, Inc.
Sonya Vasquez, Community Health Councils, Inc.
Julie Silas and Betsy Imholz, Consumers Union
Silvia Yee, Disability Rights, Education and Defense Fund
Carla Saporta, The Greenlining Institute
Anthony Wright, Health Access
Rebecca DeLaRosa, Latino Coalition for a Healthy California
Lynn Kersey, Maternal and Child Health Access
Michelle Lillienfield and Kim Lewis, National Health Law Program
John Gressman, San Francisco Community Clinic
Kathleen Hamilton, The Children's Partnership
Judy Darnell, United Ways of California
Elizabeth Landsberg, Western Center on Law and Poverty
Sandra Hamameh, Women's Empowerment

DAVE JONES
Insurance Commissioner

By electronic transmission

January 22, 2014

Diana Dooley, Chair and Board Members
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Re: Pediatric Dental Coverage

Dear Chairperson Dooley and Board Members:

I am writing in advance of the January 23, 2014 Board meeting of the California Health Benefit Exchange to urge the Board to adopt the Covered California staff recommendation pertaining to pediatric dental coverage [Agenda action item VI(A)]. Consistent with the staff recommendation, the Board should encourage health insurers and HMOs to offer plans with embedded pediatric dental coverage for the 2015 plan year in addition to the standalone dental plans you may offer. Pediatric dental coverage is one of the ten Essential Health Benefits (EHBs) and people buying through Covered California should be able to buy health insurance that includes this critical benefit, and have access to the tax credit when doing so.

As my previous letters to Covered California and the Department's public testimony before your Board addressed in detail last year, there are sound economic and public policy reasons for embedded pediatric dental coverage to be available to those whose purchase their health insurance through Covered California.

By embedding pediatric dental coverage in the health insurance product and including it in the premium for that product, you maximize the number of children who are enrolled in coverage that includes this critical EHB. As with all the other EHBs, by embedding the pediatric dental coverage in the health insurance policy, you spread the cost of this benefit across all those who purchase health insurance coverage. At the same time, the embedded pediatric dental coverage

300 Capitol Mall, Suite 1700
Sacramento, California 95814
Phone (916) 492-3500 • Facsimile (916) 445-5280

is also eligible for the premium tax credit, which makes this coverage more affordable, particularly for those families buying coverage for more than one child.

All of the information the Department has about the cost of embedded pediatric dental coverage indicates that the premium for embedded coverage is less expensive than for stand-alone dental coverage. In some cases the premium for stand-alone coverage is 400% of what embedded dental would cost. This is consistent with the conclusion of the November 13, 2013 report prepared for the Board by Wakely Consulting Group, which, notes that embedding spreads the cost of dental benefits for children across the full covered population, resulting in a lower price for the dental benefit.

As required by state law, the health insurers regulated by the Department of Insurance that offer products outside Covered California have embedded pediatric dental coverage in their 2014 plans that cover EHBs. These products are subject to all the state and federal consumer protections in the Affordable Care Act, which differs from how stand-alone products are treated under the law. In adopting the Covered CA staff recommendation to include policies with embedded pediatric dental coverage in 2015, you will also ensure that the health insurance offerings inside and outside Covered CA for 2015 are more standardized in their coverage for all ten EHBs. Additionally, by including embedded pediatric dental coverage, you will subject that benefit to important consumer protections in the law.

Coverage of pediatric dental care meets an important health care need. Inclusion of embedded pediatric dental coverage in plans sold through Covered California will result in more children having this coverage in 2015 and these children will have access to the dental care they need for their overall health and well-being.

Thank you for your attention to this important issue. The Department will be present at the January 23rd Board meeting to participate in the discussion of these issues before any decisions are made. Please feel free to contact me or Janice Rocco, Deputy Commissioner at (916) 492-3500 to discuss these or any other issues.

Sincerely,

DAVE JONES
Insurance Commissioner

MetLife®

5 Park Plaza, Suite 1900
Irvine, CA 92614
Direct Tel: 908.253.1445
Fax: 949.425.4586
Email: ahirschberg@metlife.com

November 21, 2013

Sent Via Email: Peter.Lee@covered.ca.gov and info@hbex.ca.gov
Peter Lee
Executive Director
Covered California
560 J Street, Suite 920
Sacramento, CA 95814

Re: Covered California Options to Offer Pediatric Dental Coverage in 2015

Dear Mr. Lee:

I am writing on behalf of Metropolitan Life Insurance Company ("MetLife") and SafeGuard Health Plans, Inc. ("SafeGuard") to provide comments on the most recent draft of the Wakeley Consulting Group report, "Options for Covered California to Offer Pediatric Dental Coverage in 2015," as prepared on November 13, 2013 (the "Wakeley Report").

MetLife and SafeGuard signed an agreement to participate as a Stand Alone Dental Plan ("SADP") in the SHOP Exchange in 2014 and have placed significant time and resources into partnering with Covered California in anticipation of a long term relationship. With the release of the Wakeley Report, we understand that Covered California is under an expedited timeframe for a pediatric dental resolution to allow time for operational implementation. However, the Board should take time to consider the practical and financial implications of their decision and the alternate structural option for pediatric dental as advocated by the California Association of Dental Plans ("CADP") before coming to a decision to move forward with the Wakeley Report recommendation of an embedded 10.0 Qualified Health Plan ("QHP") and 0.5 SADP.

We request that you and the Board consider the arguments below with respect to the applicability of the Wakeley Report recommendation to the SHOP Market and in support of the CADP alternate structural position in the individual market.

Applicability to SHOP Market

Our understanding from verbal responses by Covered California is that the Wakeley Report will apply only to the individual market and will consider pediatric dental in the SHOP market after finalizing its decision for the individual market. However, it is increasingly unclear whether Covered California will have the time to analyze the Report's applicability to the SHOP market or just adapt the same approach in its simplest form. Before coming to a decision, the Board should fully consider and understand the small group market is a very different marketplace.

Covered California has worked intensely on the standardization of benefits and uniformity of offerings in order to simplify the consumer shopping experience. MetLife and SafeGuard's concern is that Covered California may, in the interest of standardization and uniformity with

respect to the pediatric dental options, apply the individual market decision to SHOP without consideration of the separate markets. The most important objectives of the Wakeley Report upon which its recommendation is based are (1) to apply the Advance Premium Tax Credit ("APTC") to the cost of the dental benefit, and (2) to ensure that eligible children are enrolled in it. Jon Kingsdale from the Wakeley Consulting Group confirmed that the considerations in the Wakeley Report were limited only to the individual market, and intended only to apply to the individual market. As evidenced by the first criteria, the APTC is strictly a benefit that is available to the individual market only and seems to be the criteria that carries the most weight for Covered California and consumer advocates. Additionally, while a uniform pediatric dental decision may be easier from an administration standpoint, the application of the same policy to the SHOP market does not better serve California's small group employers or place the necessary importance on consumer choice and disruption of the small group marketplace.

In the existing small group market, the employer purchasing experience is typically separate for both medical and SADP plans and the purchasing considerations are generally made apart from one another. The current offering of the 9.5 medical plans and SADP mirrors the existing market, and satisfies the federal requirement that the Exchange must allow a 9.5 QHP when a SADP pediatric dental Essential Health Benefit ("EHB") product is offered.

Additionally, we understand the complications that Covered California faces with the development of the shopping platform, CalHEERS, and MetLife argues that there is little need to reinvent the wheel with regard to the SHOP market and focus its efforts on programming CalHEERS for the individual market to accept all offerings as advanced by CADP.

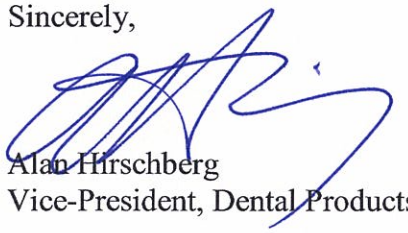
Support of CADP Alternate Options in the Individual Market

MetLife and SafeGuard additionally support the alternate structural options for pediatric dental coverage in Covered California in the individual market to allow all policy types. In support of Covered California's drive towards consumer choice and a price competitive marketplace, MetLife and SafeGuard are heavily weighing the entry into the individual market in 2015, but will strongly consider the cost/benefit implications if Covered CA decides to adopt the Wakeley Report recommendation. CADP's option provides a legal alternative to the Wakeley Report recommendation that expands consumer choice, promotes competition, and avoids disruption in the 2014 Covered CA individual market.

MetLife and SafeGuard would appreciate the opportunity to provide feedback regarding the small group dental market to you and your staff. We have been in the business of group dental insurance for over 50 years and look forward to having constructive discussions as you begin to consider SADP and the SHOP market.

Thank you for your consideration of our comments. If you have any additional questions, please contact me at (908) 253-1445 or ahirschberg@metlife.com.

Sincerely,



Alan Hirschberg
Vice-President, Dental Products

December 6, 2013

Mr. Peter Lee, Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814
Sent via Email: info@hbex.ca.gov

RE: **Dental Policy Recommendation for Covered California in 2015**

Dear Mr. Lee;

The National Association of Dental Plans (NADP) appreciates the opportunity to provide comments on the structure and offer of pediatric dental benefits on the Covered California Marketplace. This issue is critical for California residents to have choice and access to quality, affordable oral health care.

BACKGROUND

The U.S. Congress was very clear on the importance and role of oral health and dental benefits within the Patient Protection and Affordable Care Act (ACA). Pediatric dental is identified as one of the 10 essential health benefits[1] *and* that stand-alone dental plans have the ability to offer policies on newly established Marketplaces[2].

A critical component of the Marketplaces is Advance Premium Tax Credits (APTC), which provide Americans who qualify, with subsidies to assist in covering health and dental premiums. Within current IRS calculations, the dental portion of tax subsidies is not always included in the overall equation for enrollees, which means many Californians may not receive the full amount of tax credits available. (NADP's Issue Brief on this issue is attached.)

Covered California has also been discussing whether pediatric dental should be a required purchase by enrollees. A required purchase of pediatric dental for children has been required in Kentucky, Nevada, and Washington[3].

[1] ACA Section 1302(b)(1)(J).
[2] ACA Section 1311(d)(2)(B)(ii) "each Exchange within a State shall allow an issuer of a plan that provides only limited scope dental benefits… to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits..."

RECOMMENDATION

How to develop a legal, vibrant and competitive medical and dental marketplace within Covered California, while ensuring Californians receive all the tax credits to which they are entitled, has been debated over the last few months. The California Association of Dental Plans (CADP), which NADP works with, has a solution:

- Allow all policy types, including a medical policy with embedded pediatric dental (10), medical policies without pediatric dental (9.5), and separate dental policies (.5) to offer coverage on Covered California to meet ACA's legal requirements. This arrangement is also how 47 other state Marketplaces are allowing dental benefits to be offered[4]. To ensure the full APTC is applied, Covered California can utilize its status as an active purchaser to work with carriers to guarantee the 2nd lowest silver plan is a 10 policy.

  Further, if Covered California should require the purchase of pediatric dental for children, this is a simple technical correction within the CalHEERS website and NADP would encourage Covered California to work with Kentucky, Nevada and Washington Exchanges to learn more about how their systems are complying with a similar state requirement, as HHS Exchange grants encouraged the sharing of this type of information among states.

The procedure of confirming the 2nd lowest silver policy is a medical policy with embedded pediatric dental must be transparent to carriers when applying to be on the Marketplace. It will become part of the negotiation process Covered California currently utilizes to negotiate rates with carriers. As outlined, the recommendation from the industry ensures that Covered California aligns with the ACA and ensures enrollees competitive choices which parallel the typical employer market.

WAKELY REPORT

In November, Covered California released a report it commissioned from the Wakely Consulting Group on the inclusion of pediatric dental within the new Marketplace. The report offers recommendations based on actuarial data, pricing and background information but did not include legal review or guidance.

Covered California has recommended to its Board and subcommittees one of the options outlined in the Wakely Report in which the Marketplace would only offer medical policies with embedded pediatric dental (10) and separate stand-alone dental policies (.5). This would mean that policies offered by stand-alone dental plans would be duplicative of what is offered by the medical carrier and that medical plans do not have the option of offering a 9.5 plan. When a board member asked the legal question as where the 9.5 requirement comes into play, the response was to request a waiver from HHS and push those plans to the side (or hide them.) This recommendation goes entirely against what is stated clearly in the ACA and is an inappropriate attempt to bypass legal requirements.

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[3] CT is not able to offer separate dental policies in 2014 and therefore, their medical policies must embed pediatric dental which by default makes it a required purchase by their enrollees.

[4] WA and CA are states in which there are 9.5 and .5 plans offered, while CT received a waiver to not offer .5 plans for only 2014 due to technical issues.

In addition, a 10 and .5 policy recommendation requires a change and disruption to 2014 policy holders and severely limits enrollee choice. Understandably, enrollees will choose their medical policy first and thus by default will have to use the dental benefit that is included in that policy. They will not have the option to shop for a dental plan which includes their dentist or has the best selection of benefits for them. To further suggest the purchase of an additional .5 policy in order to keep their dentist is burdensome, costly and not in the best interests of the consumer.

The U.S. Senate, including Senator Boxer and Senator Feinstein, oral health stakeholders, NADP, and others continue to advocate for the clarification of tax credits to the IRS (letters attached.) While we have heard there are no policy objections, it has not become a priority of the IRS to resolve to date. NADP encourages Covered California and all interested stakeholders to contact the IRS and join in this effort.

We are greatly appreciative for Covered California's attention to the oral health of young Californian's, and reaching out to stakeholders to better understand the complex issues surrounding dental benefits within the ACA. When Covered California met with CADP and their members they requested alternatives, and we hope that you will carefully consider our proposed recommendation.

Thank you for your attention to our letter, and if you have any questions related to this letter or how dental is being incorporated in other states, please feel free to contact me directly at 972.458.6998x111 or khathaway@nadp.org.

Sincerely,

Kris Hathaway

Kris Hathaway
Director of Government Relations
National Association of Dental Plans

DENTAL &TAX CREDITS WITHIN THE ACA

BACKGROUND: The ACA requires tax credits, also known as premium assistance, to be available for lower income individuals purchasing health coverage on individual Exchanges. The assistance can be used to pay premiums for a consumer's health benefits --both medical and pediatric dental.

The ACA specifically provides for pediatric dental coverage to be offered separately from medical coverage in Exchanges to parallel today's insurance market. Under the ACA and IRS rules, premium assistance that a consumer receives is the lesser of:

1) the premium they will pay for the coverage purchased through an Exchange, or
2) the excess of the state's benchmark plan's (2nd lowest silver) premium over the maximum percentage of the consumer's household income to be paid in premium[1].

The ACA included a special rule to include the premium for pediatric dental in the calculation of premium assistance. IRS rules on Health Insurance Premium Tax Credits apply this special rule only to option 1 of the calculation of premium assistance outlined above. In other words, if a consumer purchases a medical policy without dental and a separate dental policy AND the combined premiums are less than the calculated premium assistance based on the benchmark plan, then pediatric dental is specifically included in the tax credit.

Most tax credits are expected to be calculated based on the 2nd option above, i.e. the 2nd lowest cost silver plan. In most Exchanges, the 2nd lowest cost silver plan will be a medical policy without dental. IRS plans to use only the medical premium for premium assistance calculations under option 2 above. Therefore, in states where the 2nd lowest medical plan does not include pediatric dental, no consumer will receive premium assistance for their pediatric dental benefits. In other states where the 2nd lowest silver plan includes pediatric dental, all consumers will receive premium assistance for dental, whether they purchase health benefits with pediatric dental or not.

Because the Federally-facilitated Marketplace and many state-based Exchanges have determined that stand-alone pediatric dental is a required *offer* not a required *purchase*, without premium assistance consumers may not purchase critical pediatric dental coverage for their children as Congress intended.

RECOMMENDATION: IRS should calculate tax credits based on all 10 essential benefits—whether contained in 2 policies or one for consumers in all states to be treated equally with regard to premium assistance. Further the IRS should segregate a portion of the tax credit to be utilized only when pediatric dental is purchased, as intended by Congress. In each state, the IRS should note:

1. The total subsidy is available for a medical policy covering all 10 essential benefits;
2. A portion[2] of the subsidy is reserved for the purchase of pediatric dental under a stand-alone dental plan in addition to a medical policy without a pediatric dental benefit.

VALUE: By improving the affordability of pediatric dental benefits, more families are likely to enroll and seek critical preventive pediatric dental care.

[1] 26 CFR 1.36B-3(f)(3); pg. 30391

[2] Dental benefits average about 1/12th of the annual premium of a medical policy. So if a medical policy costs $12,000 annually, the corresponding dental policy for a family would be about $1000. Since only the child portion of a family dental policy is being supported by tax credits, an allocation of 5%-6% of the tax credit for the purchase of pediatric dental coverage would be reasonable.

United States Senate
WASHINGTON, DC 20510

September 24, 2013

The Honorable Jack Lew, Secretary
U.S. Department of Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Dear Secretary Lew,

We thank you for your critical work implementing the Affordable Care Act, including the premium tax credits that will help families across the country choose a health insurance plan that fits their budget through the new insurance marketplaces. As you continue working to implement the premium tax credits going forward, we urge you to clarify that the value of the credit takes into account pediatric dental benefits, even in states in which those benefits are offered through stand-alone plans.

One of the primary goals of the Affordable Care Act is to ensure that every family is able to afford the care they need, especially for children. This includes pediatric dental benefits. It is critical that the premium tax credits that will help families afford comprehensive health insurance account for the cost of pediatric dental benefits in all cases. Without premium credits that can assist with the purchase of stand-alone dental plans, some families may be forced to forgo pediatric dental coverage.

Congress intended for these premium tax credits to be based on plans that take into account all 10 essential benefits (EHB), including pediatric dental benefits whether purchased as an "embedded" part of a medical plan or in a separate, "stand alone" dental policy. Section 1401 of the ACA reflects this intent with the addition of 36B (b)(3)(E) to the Internal Revenue Code that requires pediatric dental premiums for stand-alone dental plans to be treated as part of the qualified health plan premium for calculating the premium tax credit.

The final rule on the Health Insurance Premium Tax Credit provides in part for the calculation of the premium tax credits in the new health insurance marketplaces with reference to the cost of a "benchmark" plan defined in the statute as the second-lowest cost 70% actuarial value silver plan. As noted, the statute, and to an extent, the rule also requires that premiums paid for pediatric dental benefits from stand-alone dental plans be treated as premium for that plan where an individual enrolls in both a qualified health plan and a stand-alone dental plan.

In many states, however, the benchmark plan used to calculate these credits will not provide coverage for pediatric dental benefits even though they are an EHB. In those states, pediatric dental benefits will be offered by a stand-alone dental plan, but consumers would receive a lower credit that would not account for the costs of purchasing a stand-alone pediatric dental plan, thereby decreasing their affordability for families.

It is important to make clear that the premium tax credit includes pediatric dental in all methods of calculating the assistance to ensure that individuals and families have the same basic affordable coverage options available in every state. We urge you to use your rulemaking authority going forward to clarify that the premium tax credit is calculated with reference to plans that reflect the full range of essential health benefits including pediatric dental benefits provided through a stand-alone plan where an individual enrolls in both a qualified health plan and a stand-alone dental plan.

This can be accomplished by calculating the credits in a manner that takes into account the pediatric portion of the premium for the second-lowest cost 70% actuarial value stand-alone dental plan in states in which the benchmark silver plan does not include pediatric dental benefits. It would also need to be made clear that the full credit amount that includes the cost of the stand-alone pediatric dental benefit should only be available when pediatric dental benefits are purchased, whether as a stand-alone plan, or an embedded benefit.

We thank you again for your efforts implementing the premium tax credits in the Affordable Care Act, and look forward to working with you to ensure that they are applied consistent with the statute to all essential health benefits including pediatric dental benefits and are distributed on an equitable basis to families across all the states.

Sincerely,

Mark F. Brnovich

Kirsten E. Gillibrand

Mark R. Warner

Jeffrey A. Merkley

September 26, 2013

The Honorable Jack Lew, Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Dear Secretary Lew:

In May, our four organizations, and others working to improve oral health care for children, wrote to you regarding the affordability of coverage for dental benefits under the Affordable Care Act. Our letter urged Treasury to apply the premium tax credit provisions of the ACA so that all pediatric dental benefits receive premium assistance just as other essential health benefits do.

We are writing today to again urge you to either 1) change your internal interpretation of the final rule on "Health Insurance Premium Tax Credit" to provide premium assistance for dental benefits regardless of how they are offered or 2) to reopen these rules to consider our input on both the policy issues relating to premium assistance for pediatric dental benefits and the legal path to revise your interpretation of policy in this area.

Our organizations and other parties with an interest in pediatric dental issues were not aware of how the Treasury Department envisioned that the section 36B credit would be calculated until after the publication of final regulations on May 23, 2012. In the preamble to the proposed regulations, the Treasury Department stated that premiums for pediatric dental coverage would be added to the premium for the benchmark plan in computing the credit. Despite this statement, in meetings with your department, we have learned that IRS plans to make premium tax credits available to support the purchase of stand-alone pediatric dental plans only in those very limited circumstances when the actual premiums for purchased coverage are lower than the premium assistance amount based on the benchmark plan in a state.

Our organizations expect that most taxpayers' premium tax credits will be calculated with reference to the cost of a "benchmark" plan—often defined as the second-lowest cost silver

plan that would cover the taxpayer's family. Based on the preamble statement and the ACA's special rule for pediatric dental coverage, we expected that benchmark would include a pediatric dental premium in the calculation whether it was included in the medical benchmark or purchased as a separate product. We anticipate that a substantial number of states will not have pediatric dental coverage in the medical benchmark, so this issue is critical to fairly provide for premium assistance for the coverage that is being purchased by consumers in those states. For example, Covered California will have no medical plans offered with pediatric dental included in 2014. New Mexico also anticipates that no medical plans will embed on their Marketplace and recently Nevada announced that no medical plan embedded dental coverage on its Exchange. As more states announce coverage and rates, others will join this list and your decision will impact millions.

As we stated in our previous letter, the Affordable Care Act allows the costs for stand-alone dental coverage to be included in the cost of benchmark coverage. Internal Revenue Code section 36B, paragraph (b)(3)(E), provides that "For purposes of determining the amount of any monthly premium," a premium paid for a separately offered EHB dental benefit should be considered a premium payable for a qualified health plan. The law's reference to "any" monthly premium must be interpreted to apply to the benchmark plan premium that determines a taxpayer's premium credit amount. Without such a reading, some families would be required to pay more than their applicable percentage of income to purchase coverage for all the EHBs—this is not what Congress intended.

Oral health is critical to children's overall wellbeing. Congress recognized as much when it included oral care for children as one of the essential health benefits specified in the ACA. Congress also intended that the purchase of the entire essential health benefits package be supported with premium tax credits. In a 2011 Senate colloquy, three Senators who were key to the inclusion of pediatric dental benefits as an essential health benefit and the ability of stand-alone dental plans to provide that coverage clarified that the law intends that "children receiving coverage through an Exchange would have the same level of benefits and consumer protections, including all cost sharing and affordability protections, with respect to oral care. This holds true whether they received pediatric oral care coverage from a stand-alone dental plan or from a qualified health plan."[i]

Adding the cost of the pediatric dental coverage in a separate dental policy would raise the premium assistance amount for many families, allowing them to afford dental care for their children. Given the HHS determination that pediatric dental coverage is a required offer rather than a required purchase inside Exchanges, this premium assistance is even more critical to families obtaining needed coverage. It can, in fact, act as an incentive to purchase coverage.

Without premium credits for separate dental policies, many families will be tempted to forego dental coverage for their children. This would be an enormous missed opportunity to provide oral health services to vulnerable children who need them and circumvent Congressional intent that pediatric dental benefits be included in the essential benefits that Exchange enrollees will receive.

Treasury has an important role to play in supporting children's health by assuring that premium credits are applied as intended by the Affordable Care Act. Our organizations offer the attached legal memo providing support to interpret the ACA to provide premium assistance for pediatric dental for all consumers. We are happy to meet further with your staff to provide additional insight on this issue. Thank you for your consideration.

Sincerely,

Kathleen O'Loughlin
Executive Director
American Dental Association

Patrice Pascual, MA
Executive Director
Children's Dental Health Project

Steven R. Olson
President & CEO
Delta Dental Plans Association

Evelyn F. Ireland, CAE
Executive Director
National Association of Dental Plans

Cc: Mark J. Mazur, Assistant Secretary for Tax Policy, U.S. Department of the Treasury

Jason Levitis, Senior Advisor to the Assistant Secretary, Office of Tax Policy, U.S. Department of the Treasury

Lisa M. Zarlenga, Tax Legislative Counsel, Office of Tax Policy, U.S. Department of the Treasury

Cameron Arterton, Associate Tax Legislative Counsel, Office of Tax Policy, U.S. Department of the Treasury

William J. Wilkins, Chief Counsel, Internal Revenue Service

Erik H. Corwin, Deputy Chief Counsel (Technical), Internal Revenue Service

W. Thomas ("Tom") Reeder, Health Care Counsel, Office of Chief Counsel, Internal Revenue Service

[i] Senator Stabenow (MI). "Affordable Care Act." Congressional Record 157: 144 (September 26, 2011).

MEMORANDUM

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TO National Association of Dental Plans

FROM Kurt L.P. Lawson **TELEPHONE** +1 202 637 5660

DATE September 5, 2013

SUBJECT Inclusion of Cost of Pediatric Dental Coverage in Benchmark Plan under Section 36B

Issue

You asked whether the Treasury Department has the authority to adopt a rule analogous to section 1.36B-3(f)(3) of the Treasury Regulations (the "family coverage rule") in situations where one or more silver-level plans offered through an Exchange do not include the pediatric dental coverage element of the essential health benefits package that qualified health plans must provide under section 1302 of the Affordable Care Act (the "ACA").

The family coverage rule provides that if one or more silver-level plans for family coverage offered through an Exchange do not cover all members of a taxpayer's family under one policy, the premium for the "applicable benchmark plan" under section 36B(b)[1] may be the premium for a single "qualified health plan" that covers all members of the taxpayer's family or the premiums for more than one "qualified health plan," whichever is the second lowest cost silver option.

The analogous rule would provide that, if at least one silver-level plan offered through an Exchange does not include pediatric dental coverage, the premium for the "applicable benchmark plan" under section 36B(b) may be either the premium for a single "qualified health plan" that includes pediatric dental coverage, or the premium for a "qualified health plan" that does not include pediatric dental coverage plus the premium for pediatric dental coverage under a plan described in section 1311(d)(2)(B)(ii) of the ACA (a "stand-alone dental plan") offered on the same Exchange, whichever is the second lowest cost silver option.

As explained below, the Treasury Department has the authority to adopt a rule analogous to the family coverage rule in situations where one or more silver-level plans offered through an Exchange do not include pediatric dental coverage.

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[1] Unless otherwise indicated, all references to sections are references to sections of the Internal Revenue Code of 1986 (the "Code").

Analysis

1. Authority Based on General Rule in Section 36B(b)(2)

Section 36B(b)(2) defines the "premium assistance" amount for a month as the lesser of (i) the premiums for the month for the "qualified health plans" actually purchased on the Exchange[2] for the taxpayer and the taxpayer's spouse and dependents, or (ii) the excess of (a) the "adjusted monthly premium" for the month for the "applicable second lowest cost silver plan" with respect to the taxpayer, i.e., the "applicable benchmark plan," over (b) a sliding-scale percentage of the taxpayer's household income for the month.

Section 36B(b)(3)(B) defines the "applicable second lowest cost silver plan" as the "second lowest cost silver plan" in the taxpayer's rating area that is offered on the Exchange and that (i) "provides . . . self-only coverage" in the case of a taxpayer who either has no spouse or dependents or purchases self-only coverage, or (ii) "provides . . . family coverage" in the case of any other taxpayer.

In adopting the family coverage rule, the Treasury Department properly interpreted the definition of "second lowest cost silver plan" in the statute to include more than one plan in situations where some qualified health plans offered through an Exchange might exclude certain tax dependents (for example, a niece). It explained that this was consistent with the fact that "[s]ection 36B determines family size by reference to individuals for whom the taxpayer claims a personal exemption."[3] Without this interpretation, the "coverage" that the statute requires the second lowest cost silver plan to "provide" would not match the family members that section 36B is intended to benefit, and whose incomes are taken in to account in determining the maximum amount of the credit; and taxpayers would not be encouraged, and in some cases would not even be able, to purchase coverage for the family members they are required to cover under section 5000A of the ACA.

The Treasury Department could do the same thing in situations where some qualified health plans offered through an Exchange do not include pediatric dental coverage. All that would be required would be for it to interpret the term "silver plan" in section 36B(b)(3)(B) to include multiple policies if a single policy might not suffice to carry out the purposes of that section, as it already did under the family coverage rule.

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[2] The statute adds that the Exchange is one "established by the State under [section] 1311 of the [ACA]." Section 1.36B-1(k) of the Treasury Regulations interprets this, by cross-reference to section 155.20 of the Department of Health and Human Services regulations (the "HHS Regulations"), to include a Federally-facilitated Exchange established pursuant to section 1321 of the ACA. According to testimony by Deputy Assistant Secretary for Tax Policy Emily S. McMahon on July 31, 2013, "Treasury and IRS believe that" this interpretation of the statutory language "is appropriate to its context and consistent with the purpose and structure of the statute as a whole, pursuant to longstanding and well-established principles of statutory construction."

[3] *See* 76 Fed. Reg. 50931, 50937 (Aug. 17, 2011).

A "plan" in this context means a qualified health plan.[4] That is not an obstacle to this interpretation because the HHS Regulations already treat a stand-alone dental plan offered on an Exchange as "a type of qualified health plan" as defined in section 1301 of the ACA, and require it to meet all of the qualified health plan certification requirements except those that cannot be met because it covers only dental benefits.[5] Such a plan also must be a silver plan. That, too, is not an obstacle because, while stand-alone dental plans offered on an Exchange are not required to provide specific metal levels of coverage in the same way as major-medical plans are, they are subject to a very closely analogous rule.[6] The Treasury Department could, for example, treat a stand-alone dental plan that provides a "low" level of coverage under that rule as equivalent to a silver-level plan. Section 36B(b)(2) also refers to a "plan" in the singular. However, that should not be an obstacle because the term "plan" easily encompasses coverage provided under more than one policy or contract of insurance.[7]

The Treasury Department could, further, limit the scope of this rule to situations where an individual either enrolls in a "qualified health plan" that provides pediatric dental coverage or enrolls in both a "qualified health plan" and a stand-alone dental plan that provides pediatric dental coverage. That would help align the premium assistance amount with the cost of the coverage that's actually being purchased, similar to the rules in section 36B(b)(3)(B)(ii)(I)(bb) (taxpayer with family who purchases self-only coverage) and (b)(3)(E) (individual who enrolls in both qualified health plan and stand-alone dental plan), and affirmatively encourage taxpayers to purchase pediatric dental coverage for their children.

Without this interpretation:

- The "coverage" that section 36B(b)(3)(B)(ii) requires the second lowest cost silver plan to "provide" would not match the package of essential health benefits that the ACA requires issuers to make available on an Exchange, which the drafters of the ACA considered so essential that they extended the requirement to insurance policies offered in the individual and small group market outside of an Exchange;

- Taxpayers would not be encouraged, and in some cases would not even be able, to purchase pediatric dental coverage for their children; and

---

[4] *See* ACA § 1302(d)(4) ("In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.").

[5] *See* 45 C.F.R. § 155.1065(a)(3) and 77 Fed. Reg. 18310, 18315 (March 27, 2012); *cf.* 26 C.F.R. § 1.36B-1(c) ("The term qualified health plan has the same meaning as in section 1301(a) of the Affordable Care Act.").

[6] *See* 45 C.F.R. § 156.150(b)(2).

[7] *See* ACA § 1301(a)(1) ("The term 'qualified health plan' means a health plan [that satisfies certain specified requirements].") and (b)(1)(A) ("The term 'health plan' means health insurance coverage and a group health plan."); Public Health Service Act § 2791(b)(1) ("health insurance coverage" means "benefits consisting of medical care . . . under *any* hospital or medical service policy or certificate" (emphasis added)); *Ali v. Federal Bureau of Prisons*, 552 U.S. 214, 218-19 (2008) ("any" has an expansive meaning, that is, "one or some indiscriminately of whatever kind" (citations omitted)); *Teles AG v. Kappos*, 846 F. Supp.2d 102, 112 (D.D.C. 2012) ("any" is generally used in the sense of "all" or "every" and its meaning is "most comprehensive" (citations omitted)); *cf.* 26 C.F.R. § 54.9801-4(c)(2) (rule for plans that provide creditable coverage through one or more policies or contracts of insurance).

- The regulations on advance payments of the credit under section 1412 of the ACA, which require an allocation of the credit between plans purchased on an Exchange that do not include pediatric dental coverage and stand-alone dental plans that do,[8] would makes little sense where the premium assistance amount could easily disregard the cost of purchasing pediatric dental coverage on that Exchange.

2. Authority Based on the Special Rule for Pediatric Dental Coverage in Section 36B(b)(3)(E)

Section 36B(b)(3)(E) provides that "[f]or purposes of determining the amount of any monthly premium," if an individual enrolls in both a qualified health plan and a stand-alone dental plan, the portion of the premium for the stand-alone dental plan that is allocable to the pediatric dental coverage element of the essential health benefits package "shall be treated as a premium payable for a qualified health plan."

We understand that the Treasury Department and Internal Revenue Service currently interpret this special rule to apply only to the first prong of the rule for determining the premium assistance amount, in section 36B(b)(2)(A), and not to the section prong in section 36B(b)(2)(B).[9]

This limited interpretation is not necessarily required by the statutory language. The Treasury Department could interpret the special rule more broadly to create a rule analogous to the family coverage rule. Section 36B(b)(3)(E) states that the special rule applies "[f]or purposes of determining the amount of *any* monthly premium" (emphasis added). The Treasury Department could interpret this to refer to the monthly premium for the applicable second lowest cost silver plan (*i.e.*, the benchmark plan) referenced in section 36B(b)(2)(B). The premium must be for a "qualified health plan," but, as noted above, the HHS Regulations already treat a stand-alone dental plan offered on an Exchange as "a type of qualified health plan" and require it to meet most of the qualified health plan certification requirements. If the Treasury Department considered it appropriate, it also could limit the scope of this rule to situations where the stand-alone dental plan in which the individual enrolls provides a "high" level of coverage or is otherwise analogous to a silver-level plan.

We understand that the Treasury Department and Internal Revenue Service might be concerned that the separate references to "the monthly premium or the adjusted monthly premium" in the same sentence in section 36B(b)(3)(D) suggest that the phrase "monthly premium" in section 36B(b)(3)(E) refers only to "the monthly premium" in section 36B(b)(2)(A) and not to "the adjusted monthly premium" in section 36B(b)(2)(B). However, such an interpretation is not required: an "adjusted monthly premium" clearly is *a* "monthly premium," and the reference in section 36B(b)(3)(E) is to "*any* monthly premium" (emphasis added) not "*the* monthly premium" (emphasis added) as in section 36B(b)(3)(D). As the Supreme Court has explained, when interpreting a statute "any" has an expansive meaning, that is, "one or some indiscriminately of whatever kind."[10]

[8] *See* 45 C.F.R. § 155.340(e) and (f).

[9] *See also* 26 C.F.R. § 1.36B-3(k)(3).

[10] *See Ali*, *supra* note 7.

This interpretation appears to have been contemplated by the Treasury Department when it developed the proposed regulations: The preamble to the proposed regulations states that, when the special rule for pediatric dental coverage in section 36B(b)(3)(E) is triggered, "the portion of the premium for the separate pediatric dental coverage is added to the premium for the *benchmark plan* in computing the credit" (emphasis added).[11]

The only difference between this interpretation of the special rule in section 36B(b)(3)(E) and the interpretation of the general rules in section 36B(b) described above is that the premiums that are taken into account are based on the plan actually purchased by the individual rather than a benchmark plan in the individual's rating area.

3. Need to Re-Open Comment Period

The National Association of Dental Plans ("NADP") and other parties with an interest in pediatric dental issues were not made aware of how the Treasury Department envisioned that the section 36B credit would be calculated until after the publication of final regulations on May 23, 2012. As noted above, the preamble to the proposed regulations stated that premiums for pediatric dental coverage would be added to the premium for the *benchmark plan* in computing the credit.[12] Moreover, it was not clear until after the end of the comment period that individuals would even be *allowed* to purchase coverage on an Exchange that did not include the pediatric dental coverage element of the essential health benefits package.[13] Thus, NADP and others were not put on notice of the significance of the interpretive issue discussed above in time to comment effectively on it.

The Administrative Procedure Act demands that when an agency engages in rulemaking, it publish a notice that includes "either the terms or substance of the proposed rule or a description of the subjects and issues involved."[14] The notice must be sufficiently detailed for interested parties to "know what to comment on."[15] Under the circumstances it therefore is appropriate for the Treasury Department to accept and consider new comments on this issue.

Conclusion

Section 36B(g) gives the Treasury Department broad authority to "prescribe such regulations as may be necessary to carry out the provisions of this section." It is within the scope of that authority to adopt a rule analogous to the family coverage rule in situations where one or more silver-level plans offered through an Exchange do not include the pediatric dental coverage, based either on the general rules in section 36B(b) or the special rule in section 36B(b)(3)(E).

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[11] *See* 76 Fed. Reg. 50931, 50937 (Aug. 17, 2011).

[12] The proposed regulations also stated that the exact portion of the premium for a stand-alone dental plan that was properly allocable to pediatric dental benefits would be determined under yet-to-be-issued guidance provided by HHS. *See* Proposed 26 C.F.R. § 1.36B-3(k)(2).

[13] *See* 78 Fed. Reg. 12833, 12853 (Feb. 25, 2013) (stating that "nothing in this rule requires the purchase of the full set of EHB if the purchase is made through an Exchange. Thus, in an Exchange, someone (with a child or without) can purchase a QHP that does not cover the pediatric dental EHB without purchasing a stand-alone dental plan.").

[14] *See* 5 U.S.C. § 553(b)(3).

[15] *See Owner-Operator Indep. Drivers Assoc. v. Fed. Motor Carrier Safety Admin.*, 494 F.3d 188, 209 (D.C. Cir. 1997); *see also CSX Transp., Inc. v. Surface Transp. Bd.*, 584 F.3d 1076, 1081 (D.C. Cir. 2009).

Although the period for commenting on the proposed regulations under section 36B that were published in 2011 is now closed, because the proposed regulations did not provide adequate notice that the final regulations might not include the cost of pediatric dental coverage in the cost of the applicable benchmark plan under all circumstances it is appropriate for the Treasury Department to re-open the comment period with respect to this issue.

Kurt L.P. Lawson
Partner
kurt.lawson@hoganlovells.com

The Children's Partnership

PRESIDENTS
Wendy Lazarus & Laurie Lippin

December 19, 2013

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

Re: Enrollment Data for Pediatric Dental Coverage

Dear Mr. Lee and Members of the Board:

We are pleased to join others who have expressed kudos for the successful and promising launch of Covered California. It is heartening that California can lead the way nationally, and help build the public's confidence that the ACA will, indeed, bring affordable health coverage for families who need it.

We are also pleased to have reviewed the first month enrollment data, as reported in the Executive Director's report at the November Board meeting. In the weeks ahead, we may share with you several specific suggestions for additional data related to children's access to coverage and care that should be collected and reported as Covered California moves forward. In our view, by collecting meaningful data, both quantitative and qualitative, California will have the best opportunity to identify areas where improvements can be made, and take steps to achieve maximum enrollment, as well as a smooth process for families.

At this time, however, we are writing to request that your next enrollment report include the number of children under age 18 who applied for and are enrolled in pediatric dental coverage. Anecdotal reports suggest that accessing pediatric dental coverage has been challenging for families, so we believe it is critical to monitor on a consistent basis the actual number of pediatric dental enrollments. We had the opportunity recently to view the enrollment application and the "screen shots" providing links to pediatric dental coverage, and found them to be deficient. Because all children need dental care, we will be looking to see that a comparable number of individuals under age 18 enrolled in 9.5 plans (16,000 in October) are enrolled in pediatric dental coverage.

Thank you for your consideration. We look forward to working with you to make sure that the promise of the ACA with regard to dental coverage becomes a reality for California's children.

Yours Sincerely,

Wendy Lazarus

Wendy Lazarus
Founder & Co-President

cc: Casey Morrigan, Covered California
Katie Ravel, Covered California

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DIANNE FEINSTEIN
CALIFORNIA

SELECT COMMITTEE ON INTELLIGENCE - CHAIRMAN
COMMITTEE ON APPROPRIATIONS
COMMITTEE ON THE JUDICIARY
COMMITTEE ON RULES AND ADMINISTRATION

United States Senate
WASHINGTON, DC 20510-0504
http://feinstein.senate.gov

January 16, 2014

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

Dear Peter,

I received your reply in response to my letter to Governor Brown regarding premium increases for individuals who received cancellation notices and are now facing a significant premium increase. Thank you for your response and the work you are doing to gather additional information about this population.

I would appreciate additional suggestions on what options you believe could assist the approximately 200,000 individuals who are seeing a substantial increase in their premiums, especially those who are between 50 and 64 years old and do not qualify for a federal subsidy. As you gather additional data, I would also like to know the age and household income breakdown of the 200,000 population and how large the premium increases are compared to what they were previously paying.

I am concerned because, as you know, this is a population of older, middle class individuals who are likely to need access to the health care system. It is important that they have access to quality, affordable healthcare plans so they don't drop out of the insurance market and are able to receive care when needed.

Your hard work and leadership running Covered California is greatly appreciated. Thank you for your attention to this important issue.

Sincerely,

Dianne Feinstein
United States Senator

CC: Secretary Diana Dooley
DF:mt

Thank you very much!

COVERED CALIFORNIA

January 14, 2014

The Honorable Dianne Feinstein
United States Senate
331 Hart Senate Office Building
Washington, DC 20510

Dear Senator Feinstein,

Governor Brown has asked me to respond to your recent letter regarding premium increases some constituents are facing as health care policies transition to Affordable Care Act compliant coverage in 2014.

Covered California appreciates the importance of this issue, and we are very mindful of the difficulties that some consumers may face as the individual and small group marketplaces align with the new requirements of state and federal law, which include minimum essential health benefits and guaranteed issue.

At its November 2013 meeting, the Covered California Board adopted several recommendations to both assure that consumers had the best information possible and to collect information to better understand the nature and scope of how Californians are impacted by these changes. (A summary of these actions is attached.)

In considering why some consumers may be experiencing premium rate increases, there are two primary factors that have significant impact. First, is the individual getting substantially more comprehensive coverage because of the Affordable Care Act's requirements? And, second, was the individual in a highly advantageous risk pool as a consequence of their health plan's rigorous medical underwriting? In either case, the premium impact to the consumer is magnified for those who are between 50 and 64 years of age, and are just above the 400% federal poverty level (FPL) and therefore are not eligible for federal premium assistance.

We have estimated that of the nearly two million individuals covered in the individual and family plan market, perhaps 200,000 Californians may be seeing price increases as a result of the change that exceed the increases they would have seen absent the market reform. Unfortunately, these are rough estimates; below we outline the steps we are taking to gather better information on these consumers.

We know that affordability impacts are heightened for older consumers due to age rating factors that allow older consumers to be charged more than younger consumers under the same policy. Older consumers are benefitting from the Affordable Care Act's new age rating bands, which establish a maximum 3 to 1 ratio for premiums (for example, a 64 year old can only be charged three times what a 21 year old is charged). Yet, it is still a fact that the premiums for some older Californians have risen above the 8% of their income that defines the cut-off for the "hardship exemption" under the Affordable Care Act.

Because of older consumers' higher total premiums, the financial impact of the 400% Federal Poverty Level (FPL) "cliff" for premium assistance can have dramatic impacts for older consumers. In cases where a consumer is just over the income cut-off, and thereby ineligible for premium assistance, they will find that their coverage options will cost more than the 9.5% "fair share" of their income that would be required if they were just under the 400% FPL cut-off. Under the Affordable Care Act, these individuals would likely be eligible for the affordability exemption and (1) eligible to purchase a minimum coverage plan (also known as the "catastrophic plan") and (2) not be subject to the personal responsibility tax penalties. The federal government has clarified that the affordability exemption will be available to *all* consumers who had non-grandfathered plans in 2013.

Covered California is gathering data to assess the scope and nature of the financial impacts on California consumers who received cancellations. Our efforts include:

- On-going market research with survey questions to help us better understand the consumer experience for those who received cancellation notices. Specifically, we will be asking whether consumers received a cancellation, whether they are pursuing new coverage through Covered California, and if so, how their new coverage compares in cost and value to their old coverage. The survey data will also supplement what we are learning from our Coverage Options Hotline.

- Working with our health plan partners to gauge the number of their former consumers who may have shifted coverage to another plan or dropped coverage entirely.

- Gathering data on consumers who apply for a minimum coverage plan through Covered California under a hardship exemption.

By collecting and analyzing more data about the experience of these consumers, Covered California hopes to provide federal and state policy makers with a more

accurate understanding of the impact on both individuals and the marketplace. This information will help guide future policy decisions.

Please let me know if we can be of further assistance.

Sincerely,

Peter V. Lee
Executive Director

cc: Diana S. Dooley, Chair, Covered California Board

Attachment:

Action by the Covered California Board Relating to Plan Transition/Cancellation Issue

At its November 21, 2013 meeting, the Covered California Board considered several options in response to the new federal policy. After extensive testimony and discussion, the Board unanimously decided to retain an existing provision of our contract with our qualified health plan partners that requires them to align all policies by January 1, 2014.

However, the Board also recognized the need to provide additional assistance to consumers who need to transition into new coverage options that are compliant with federal and state law. To help provide greater assistance and support for consumers, the Board adopted the following measures:

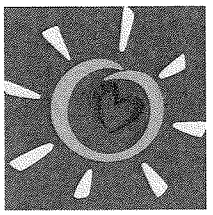
- Created a California Coverage Options Hotline – a specially trained unit of our service center which opened on November 25, 2013 – to help consumers find the best deal possible as they assess their options for converting into compliant health plans. The special phone number for this unit is (855) 857-0445. These options include the ability to change insurance carrier or explore alternate benefit designs that may provide better value.

- Partnered with health plans to provide more than 1.1 million additional notices to consumers in policies that were being cancelled. All of the individuals who have had or will have their plans terminated had received at least 3 notices already from their health plan. In addition, Covered California in partnership with Blue Shield of California, Anthem Blue Cross, and Kaiser Permanente, sent joint letters at the end of 2013 to their respective enrollees describing their coverage options.

- Provide a special extension for enrollment for January 1, 2014: consumers can enroll by December 23, 2013 and pay by January 6, 2014 for coverage effective January 1, 2014 [this deadline was subsequently extended to January 15, 2014]. We believe these extensions were important as there had been confusion and we did not want the holiday season to result in individuals losing the opportunity to have coverage that started on January 1, 2014.

- Collect data on transitioning consumers that will be publicly reported. Covered California is concerned that there will be individuals with household incomes above 400% of the Federal Poverty Level (FPL) who are not subsidy eligible and

whose premium cost may be unaffordable. By providing additional information about these individuals to federal and state policy makers, we hope to help inform future policy decisions.



November 20, 2013

Howard A. Kahn
Chief Executive Officer

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

Via Electronic Mail: Peter.Lee@covered.ca.gov

Dear Mr. Lee:

This is to reiterate L.A. Care's concerns, conveyed in our letter of October 15, 2013 (enclosed), that Covered California not adopt a Quality Rating System (QRS) sooner than 2015 Open Enrollment.

The most recent QRS proposal to develop ratings based on existing CAHPS scores has the same problem of the prior QRS approach, namely factors, populations, and provider networks that do not accurately represent those Qualified Health Plans (QHPs) participating in Covered California. This is particularly true for L.A. Care as our CAHPS scores include the networks of subcontracted Medi-Cal plans which are not part of our QHP, and comprise two-thirds of Medi-Cal members. Additionally, our QHP network includes major traditionally commercial provider groups and hospitals that have not been part of our Medi-Cal provider network.

Moreover, it is important to note that CAHPS is a member-level survey which is not only subject to the error inherent in all surveys, but also subject to misinterpretation if survey results are not clearly aligned against the actual provider network being evaluated. For L.A. Care, we estimate that less than 40% of the CAHPS responses are reflective of our QHP network.

I urge you to not adopt a QRS sooner than the 2015 Open Enrollment period as mismatched information provides an incomplete, and likely incorrect, picture to consumers, and creates an uneven playing field among QHPs. We strongly support Covered California moving to a QRS based on actual Covered California experience, but do not believe that consumers are well served with knowingly inaccurate information.

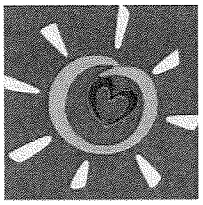
If you have any questions, please contact me at (213) 694-1250 ext. 4102.

Sincerely,

Howard A. Kahn

Encl.

cc: Covered California Board Members



L.A. Care
HEALTH PLAN

October 15, 2013

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

Via Electronic Mail: Peter.Lee@coverec.ca.gov

Howard A. Kahn
Chief Executive Officer

Dear Mr. Lee:

On behalf of L.A. Care, a Qualified Health Plan (QHP) participating in Covered California, I am writing to voice my concerns regarding Covered California's most recent health plan quality rating system proposal. I am surprised and disappointed that Covered California is considering reversing its earlier plan to display a quality rating system beginning with open enrollment 2015 and instead is considering to display a quality rating system as early as January 2014. L.A. Care does not agree with Covered California's confusing and contradictory stance and further objects to displaying a quality rating system sooner than open enrollment 2015.

L.A. Care fully endorses the use of a quality rating system that assists consumers in making informed decisions when choosing a health plan. As you know, the ACA requires the use of health plan quality ratings beginning in Year 3. This requirement ensures that there will be two years of exchange-specific historical data available that result in uniform measurement amongst the health plans. With two full years of data, the quality ratings would represent the actual Exchange provider network and population, thereby providing meaningful information to the consumer. With that being said, L.A. Care has and will continue to work with Covered California and other stakeholders to explore ways to quickly collect exchange-specific data to be used in open enrollment 2015 – which still results in California implementing a quality rating system a full year earlier than the ACA requirement.

It is surprising that Covered California would consider such a controversial change when there has been no new evidence or rationale to support the change, and since the proposal represents a complete departure from previous representations from Covered California. In fact, an August 2, 2013 memo from Covered California specifically declared holding off implementing quality rating scores as the most appropriate course of action after meeting with numerous stakeholders and determining it was not in the best interests of consumers to institute a quality rating system for 2014. The memo cited several reasons for Covered California's conclusion including the potential differences in the current ratings based on populations, product lines, and networks, which all or some of the elements could result in different quality ratings in the Exchange. Covered California concluded in its August 2 memo, "*Taken together, these factors raise substantial concerns that the historic performance of plans may not represent or complete enough to allow for direct comparisons among plans.*"

Based on recent discussions with Covered California staff, it is my understanding that if quality ratings are posted in January 2014, L.A. Care and most other plans would be classified as "*Not Yet*

Rated". Regardless of how "*Not Yet Rated*" may be defined, it will have a negative undertone and would unfairly mischaracterize L.A. Care. For instance, if a consumer is comparing one health plan that has a star rating against a plan that is noted as "*Not Yet Rated*" it is expected the consumer would be apprehensive and consider the non-rated health plan to be less credible/inferior, even though the non-rated health plan may be better for the enrollee's specific needs. In such a scenario, all parties experience detriment by the inadequate quality rating system.

I am at a loss in understanding what significant event transpired that resulted in Covered California's complete departure from its prior pronouncement to work with stakeholders to develop a quality rating system that could be implemented in Year 2 – still one full year ahead of the ACA requirement. I am further surprised that Covered California would act without an ability to clearly state how consumers will benefit from this information. It will be providing an incomplete picture to consumers, as well creating an uneven playing field among the health plans in the exchange.

L.A. Care worked tirelessly throughout 2012 in order to meet all statutory and regulatory requirements standards and is pleased to be chosen as a QHP in Covered California. L.A. Care is fully committed to providing transparent and accurate information to California's consumers and believes the best approach to achieving these goals is through the policies outlined in Covered California's August 2, 2013 memo.

If you have any questions, please contact me at (213) 694-1250 ext. 4102.

Sincerely,

Howard A. Kahn

cc: Covered California Board Members

LEAGUE OF WOMEN VOTERS® OF CALIFORNIA

December 23, 2013

Peter V. Lee, Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814
Sent by email and hand-delivered

Re: Covered California's NVRA voter registration obligation

Dear Mr. Lee:

The League of Women Voters of California appreciates and commends your efforts to bring health care coverage to more Californians. Affordable and accessible health care is an issue to which the League at all levels—national, state, and local—has long been committed. We supported the passage of the Affordable Care Act and are working to educate our communities about it and advocate for its successful implementation.

The League also has a long-standing commitment to making voter registration and re-registration more accessible for Californians. In 1993, the League of Women Voters was the lead advocacy organization to push for enactment of the National Voter Registration Act (NVRA). Today, state and local Leagues of Women Voters around the country continue to advocate for the enforcement of the NVRA, which has effectively helped millions of American citizens to register to vote. We write today to share our serious concerns about Covered California's failure to comply with its obligations under the NVRA.

For a number of months, various partner organizations have kept us informed about this issue. On November 14, the League signed a letter with 42 other organizations urging Covered California to comply with the NVRA. We were thus disappointed to hear about Covered California's December 16 NVRA implementation update, in which interim NVRA Coordinator Diane Stanton shared the following:

- There is no timeline to bring the online application into compliance with the NVRA, nor a plan to provide an alternative means of voter registration opportunities to every online applicant.
- There is no plan and no timeline to bring paper applications into compliance with the NVRA.
- There is no plan and no timeline to bring call centers into compliance with the NVRA.
- There is no plan and no timeline to train certified enrollment counselors to provide voter registration services.

We also understand that, when asked how Covered California plans to ensure that the hundreds of thousands of Californians who have already applied for coverage since October 1, 2013 will be provided an opportunity to register to vote, Ms. Stanton did not offer any substantive plans.

We urge Covered California to explore a range of options for coming into compliance in the near future. For example, while it may be that Covered California faces technological

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www.easyvoter.org

difficulties that currently prevent it from incorporating the voter registration question and link to online voter registration into its online system in a way that ensures that *every applicant* is offered the opportunity to register to vote, there are other alternatives available that would still guarantee that every applicant is offered the opportunity to register to vote. For example, Covered California could mail a voter registration card to everyone who has applied for coverage and, in the future, for renewals or changes of address. Moreover, software and online challenges in no way prevent Covered California from simply including a voter preference form and a voter registration card in every paper application packet, just as states like Nevada have done.

Covered California has a particularly important and unique opportunity to reach unregistered voters because California's uninsured population is demographically very similar to the unregistered population. The surge in voter registration that Covered California's full compliance with the NVRA would bring would allow an organization like the League to focus on engaging and educating these newly registered voters, instead of needing to focus on identifying and registering them. We understand you have many pressing responsibilities, but most other state-based exchanges have found a way to incorporate voter registration into their applications while also enrolling people in health care. Covered California must likewise find a way to do both.

Nearly half of Covered California's open enrollment period has already passed and we cannot afford to miss any more opportunities to register Californians. We were impressed by the comprehensive toolkit for implementation that you received over seven months ago from the ACLU of California that clearly outlines the various steps you can take to simply and effectively offer voter registration services to each and every applicant. We understand the ACLU and the Secretary of State's office have also suggested and explored alternative and interim solutions to any obstacles you may be facing in reaching full NVRA compliance, in addition to providing you with sample training modules and materials for certified enrollment counselors.

We urge you to use the tools and other readily available resources at your disposal to fully comply with the NVRA in time for the second half of open enrollment, beginning January 1, 2014. The League is available to work with you with this effort and welcomes the opportunity to help you reach this goal.

Sincerely,

Jennifer A. Waggoner
President

cc: The Honorable Edmund G. Brown, Jr., Governor of California
The Honorable Debra Bowen, California Secretary of State
California Health Benefit Exchange Board:
Diana S. Dooley, Chair
Kimberly Belshé
Paul Fearer
Susan Kennedy
Robert Ross, MD
Covered California Interim NVRA Coordinator Diane Stanton

December 20, 2013

NOTICE OF BOARD ACTION

SUBJECT: Web-Based Technology: Expanded Use - SUPPORT

The California Association of Health (CAHU) Board of Directors unanimously voted to endorse expanded use of Web-Based Entity Technology by the state Exchange at the December 17, 2013 Board meeting:

> The Board of Directors of CAHU applauds Covered California's efforts to engage licensed insurance agents in expanding enrollment. We believe that agents can make a even greater contribution by supporting the subsidy qualifications and enrollment of their Individual Market clients and prospects through web-based technology. The current process requires too many steps and can result in missed enrollment opportunities.
>
> The CMS Web-Based Entity approach that was developed for the federal Exchange allows certified agents to seamlessly walk their Individual Market clients through the subsidy qualification, shop and compare, and enrollment processes under the rigorous MARS-E privacy and security standards.
>
> CAHU strongly supports a WBE approach for Covered California. This approach should be inclusive, allowing all certified independent, community-based agents who utilize WBE-certified technology to participate, so that Covered California can fully achieve its goal of providing a website that links individuals to their health coverage options as efficiently and effectively as possible.

CALIFORNIA LATINO LEGISLATIVE CAUCUS

October 25, 2013

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

Dear Mr. Lee:

We are writing to urge you to allow "web-based brokers," which meet the conditions of relevant federal regulations, to partner immediately with Covered California in order to maximize the number of enrollees coming into the California Exchange. Failure to utilize all available tools at our disposal, including web-based brokers, may undermine our collective goal of enrolling as many eligible individuals as possible under the Affordable Care Act (ACA).

As you know, under the ACA, consumers who earn more than 400% of the federal poverty level (i.e. do not qualify for premium tax credits or cost sharing assistance) and wish to purchase health insurance coverage meeting the requirements of the ACA's mandate have the option of purchasing coverage through a variety of avenues. Unfortunately, unless Covered CA takes action to work with web brokers, consumers who are subsidy eligible will not have the same options to enroll in qualified health plans made available under the ACA.

In essence this imposes a dual class system – one for the subsidy eligible population, and the other for those not eligible for the federal subsidies. We believe this dual system not only unnecessarily limits options for lower income Californians, but also ignores an important resource available to help the exchange enroll more uninsured Californians, including 1.2 million eligible Latinos. In fact, the federal government encourages web-based brokers to actively participate in the 36 federal health care exchanges. As such, we see no legitimate reason why Covered California should delay in partnering with any reputable web-based brokers, particularly those based in California.

Thank you for your consideration of this letter. We look forward to hearing back from you as soon as possible.

Sincerely,

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

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

LUIS ALEJO
Assembly Member, 30th District
Chair, CLLC Budget & Policy Committee

cc: Governor Edmund G. Brown Jr.

1020 N Street, Room 511 · Sacramento, CA 95814 · Phone (916) 651-1535 · Fax (916) 651-4933

December 18, 2013

Mr. Peter Lee
560 J St., Suite 290
Sacramento, CA 95814

Dear Mr. Lee:

Consumers Union, Health Access, California Pan-Ethnic Health Network and Western Center on Law and Poverty write regarding a policy decision we understand is on your agenda: whether to incorporate web-based entities as enrollers. We urge you to defer allowing them to directly enroll consumers in Covered California during the first two plan years.

Covered California has done important work to provide consumers with a single streamlined process to apply and enroll in coverage that is easily understood and consumer protective. You opted to adopt strong consumer protections embodied in a standard benefit design. California was one of the first Marketplace websites to allow for anonymous browsing. And we may be one of a few that allows consumers to filter their plan selection options through a number of different lenses. And an army of assisters certified by Covered California is now helping consumers apply and enroll.

"Web-based entities" (WBEs) refers to producers that offer health insurance options through a publicly-facing web portal.[1] Often these are large corporate entities operating in several states. We understand WBEs are urging Covered CA to allow subsidy-eligible individuals to enroll into Qualified Health Plans (QHPs) through their websites. For the reasons set forth below, we urge you not to establish the WBE eligibility and enrollment avenue for direct enrollment for 2014 and 2015.

I. There are currently too many competing priorities to carefully analyze and establish the proper policy and protocols for WBEs

There are a number of other, important unresolved issues before Covered California currently, and their resolution—which affects CalHEERS and substantive policy development—is critical. Maximizing enrollment during the initial open enrollment period ending March 31, 2014, achieving the CalHEERS-SAWS interface, finalizing and posting the Quality Rating System, electronic verification of residency for Medi-Cal applicants, and resolution of the electronic option to select different QHPs and still provide access to the advanced premium tax credit for all family members must be top priorities from our perspective. Each technical fix requires staff time and close attention to achieve a smooth and high quality consumer experience.

For future years, if Covered California chooses to allow WBEs to handle applications and access CalHEERS—a decision we would have questions about (see below)-- we urge you to address the important considerations set forth below. We recommend that you bring any proposal to allow WBEs first to the Plan Management Advisory Committee for vetting, and then also to full public conversation and Board action.

[1] The Federal regulations refer to "web-based brokers." Covered California has referred to "web-based entities" in presentations on this topic. We use your nomenclature web-based entities, throughout, except in describing the Federal regulations.

II. Consumers have already been duped by fake websites pretending to be Covered CA, and another web entry point will compound confusion

Over the past few months, consumers have been confronted with deceptive websites, designed to confuse. We know that many Californians still believe that they have to apply through www.healthcare.gov. Attorney General Harris has sent cease and desist letters to several "copycat sites", designed to steer consumers to their business, rather than to Covered California. And more recently, the website of the California Republican party has puzzled consumers even more so.

Consumers are already confused about this transition and are just starting to register name recognition with Covered CA - allowing WBEs at this state of the game will only further confuse consumers. The potential problems will only be exacerbated for Limited English-Proficient consumers.

III. When time permits Covered California dealing carefully with WBEs, you will need to improve upon the Federal regulations in order to ensure complete, unbiased information for consumers.

After Consumers Union submitted our paper on WBEs to you in September 2012, CMS promulgated final regulations on the topic (codified at 45 CFR §155.220(c)(3)). These regulations lay out minimum parameters and requirements for web-based brokers, but leave leeway for states to set higher standards. We urge California to do so through a thoughtful process via regulatory guidance, when priorities permit.

The final federal regulations require an individual applying through a web-based broker to receive an eligibility determination through Covered CA in order to access advance premium tax credits and cost-sharing reductions. Federal rules also indicate that a web-based broker must:

- Meet standards for disclosure and display of QHP information;
- Provide consumers the ability to view all QHPs offered through the Exchange;
- Not provide financial incentives, such as rebates and giveaways;
- Display all QHP data provided by the Exchange;
- Maintain audit trails and records in an electronic format for a minimum of ten years; and
- Provide consumers with the ability to withdraw from the process and use the Exchange Web site at any time.

45 CFR §155.220(c)(3)

A large loophole in the federal regulations allows web-based brokers to display different information than is displayed on our Exchange website. That is, they are not required to display *all* information required under 45 CFR §155.205(b)(1)[2]. Such information includes, for every QHP:

[2] If all information required by the Exchange is not displayed on a WBE's site for a QHP, Federal regulations require the website to "prominently display a standardized disclaimer provided by HHS stating that information required under §155.205(b)(1) for the QHP is available on the Exchange Web site, and provide a Web link to the Exchange Web site." 45 CFR §155.220(c)(3)(i). We do not believe a disclaimer and link are sufficient to overcome the disadvantages to consumers of incomplete displays.

(a) premium and cost-sharing information; (b) summary of benefits and coverage; (c) metal level (bronze, silver, gold, or platinum); (d) enrollee satisfaction survey results; (e) quality ratings; (f) medical loss ratio, (g) transparency of coverage measures reported to the Exchange during certification; and (h) provider directory. The original Federal regulation had required full disclosure of this information, but this requirement was subsequently eliminated.

We understand that the rationale for this revision is that the data provided by each issuer in the Federal Exchange requires customized calculations at the time of display (to take into consideration different benefit design, tobacco rating factors, etc.). Since the data used to make those calculations is proprietary to each individual issuer, the Federal Exchange was limited in sharing this information with the WBEs through contractual restrictions between the Federal Exchange and the individual issuers. Through conversations with staff at CCIIO, we understand that some issuers did not have contractual relationships with the WBEs and thus were reluctant or not readily able to share proprietary information directly with them.

Covered California, however, is in a far different situation. With a standard benefit design, no alternative benefit designs currently, and no ability to institute additional rating factors, Covered California's QHP rates and benefit packages do not vary based on issuers' proprietary information, but vary solely on the ACA-allowable rating factors California has adopted: age, family size and geographic region. So, at a minimum, Covered California can and should require WBEs to display precisely the same QHP information that is available on your web site. .

If the same information from Covered CA is not displayed on the WBE site, it is likely that WBE displays will list complete information for only *some* plans (such as those with whom the WBE has contracted to receive a commission) and incomplete information for other products, creating a very different and inherently biased shopping experience for consumers.[3]

Recommendation: Require all WBEs to meet and display the content requirements of Covered California's existing website elements.

IV. Covered California should require WBEs to abide by California's display template and ranking algorithm.

How content is displayed is critical to achieving the optimal consumer experience. The fact that some issuers have direct financial relationships with WBEs may affect the manner in which WBEs present QHP information. WBEs have their own proprietary algorithms, that are likely to be different from that of Covered CA, and that would result in different display and ordering of information during the browsing and selection process. If Covered CA allows the WBEs to display QHP information differently from the way it is displayed on your web site, it will skew presentation of information and impact consumer choice.

The order of display and other "choice architecture" issues are critical to consumer decision making. Without the requirement to display the information in the same manner as the Marketplace, issuers that have favorable arrangements with WBEs might, for example, appear higher on the list of displayed plans, inflating their value during the search process. Research shows that consumers confronted with multiple choices will favor what appears earliest on the

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3 See Consumers Union, *Recommended Consumer Protections for Web-based Agents and Brokers Offering Exchange Coverage*, September 2012.

first screen/page. Thus, issuers with those favored relationships will receive an advantage in the choice displays available via WBEs.

Such a display might look like this:

Health Plan Name	**Metal Level**	**Premium Quote**	**Deductible**	**Office Visit Co-pay**	**Summary of Benefits and Coverage**
Plan C	Bronze	$231	$5,000	$60	Link
Plan D	Bronze	$240	$5,000	$60	Link
Plan E	Bronze	$262	$5,000	$60	Link
Plan A	Bronze	**N/A** see coveredca.com	**N/A** see coveredca.com	**N/A** see coveredca.com	Link
Plan B	Bronze	**N/A** see coveredca.com	**N/A** see coveredca.com	**N/A** see coveredca.com	Link

Consumer preference for selection from among the first screen of search results, and from the top down without clicking through to other potentially more optimal options, is well documented.[4]

We believe that WBEs may theoretically add value only when consumers can see all the QHP options, displayed together and in the same order as the default sort on the Covered California web site, ideally with complete data for each plan. This and all subsequent recommendations should be applied equally to web content in English and any other languages for which a WBE provides content. WBE displays that do not treat all QHPs equally have no place selling Covered California products. Such displays are not consistent with the improved, unbiased shopping experience that the ACA is supposed to be delivering for consumers.

> **Recommendation:** Require all WBEs to meet the display requirements and to use the ranking algorithm of Covered California.

An alternative approach that would address consumers' needs, though less preferable, is to require WBEs to use an I-frame to display the QHP options available to the consumer.

An I-frame embeds another HTML page into the current page. In this case, the WBE "frame" would surround and display the actual Covered California website content (exactly as it is displayed at Covered California), including premium rates. An I-frame would alleviate the

[4] See, e.g., report by Consumers Union and Kleimann Communications, *Choice Architecture: Design Decisions that Affect Consumers' Health Plan Choices*, July 2012, http://consumersunion.org/research/report-choice-architecture-design-decisions-that-affect-consumers-health-plan-choices/.

concerns about establishing arrangements to share proprietary information and intermediate ranking factors. Each page has its own history and content. Depending on how it is used, the I-frame approach can be consumer-friendly. However, if not designed appropriately, I-frames can be used to inappropriately steer consumers, for example by:

- Embedding other links in the frame, with design elements that seek to have consumers click on the embedded HTML, redirecting them to new content, rather than remaining on the official page.
- Directing customers to the telephone instead of the website. Once on the telephone, inappropriate steering to favored plans is simpler and less easily auditable.

  Recommendation: If Covered California permits I-frames, state regulations should be promulgated that establish consumer protections to ensure that steering tactics are not permissible, including:

  - Requiring the **prominent display** of a link that allows the consumer to click through to the Exchange website directly, without the I-frame.
  - Prohibiting advertisements and embedding other links in the I-frame that would allow re-directing consumers to new content.
  - Prohibiting direction of consumers to telephone contact with the WBE, which would allow for directing consumers to carriers that have favored commission arrangements with the WBE.

  Recommendation : With or without I-frame technology, state regulations should be promulgated that require WBEs to prominently display a web link to the Covered CA web site.

Specifically, we recommend that:

- A link to www.CoveredCA.com should always be prominently displayed on any WBE site (regardless of how much QHP data the WBE displays);
- The state regulations require a link to Covered CA be embedded directly where any missing information would be located (see sample table above), along with a disclaimer noting the missing information should not be read to imply less value in these products.

Recommendation: If Covered California cannot resolve the technical issues that would ensure that WBEs display all data for all QHPs (per the earlier federal rule) the same as on the Covered California web site, we urge you not to use WBEs to sell these products.

V. Monitoring compliance

It is difficult at this stage to anticipate how WBEs will use any latitude provided by the Federal regulations and by Covered California. If WBEs are permitted, we recommend that Covered CA embark on a dedicated monitoring effort, including requirement of a publicly available report published mid-year the first year of selling Covered CA products and each year thereafter. This report should include results from the QHP displays used by WBEs in CA. Covered California should collect data that shows how people shop on the WBEs' sites, what order they click through to each product, and which carriers and products they pick. Covered CA should track

patterns to detect steering (whether explicit or more subtle, eg due to display functions), flag differences (if any) between choices made on the Covered CA site and WBE sites, and make that information publicly available Well understood principles of choice architecture should be applied so that inappropriate steering can be identified. An example of inappropriate steering would be to list all plans, but on the first page of results only, list those plans that pay the WBE commissions and to require several clicks to see the other plans.[5]

VI. Ensuring disclaimers on WBE sites

We strongly urge requiring WBE web sites to prominently display language notifying consumers of certain facts about the WBE site, e.g. that it receives commissions from some, but not all plans and from Covered CA, and how that affects ranking or displays. The HHS-required disclaimer, content of which we have not yet seen, may fulfill some of this requirement. We also suggest specific reference to a route for reporting noncompliance, i.e. dedicated email and telephone number to report WBEs that appear to violate the basic principles of displaying complete and unbiased information about QHP health plans.

VII. Prohibiting WBE arrangements with other agents and brokers

Federal regulations appear to allow WBEs to enter into arrangements with *other agents and brokers* under which those agents and brokers would be able to enroll qualified individuals in the Federally-facilitated Marketplace through the WBE's web site. Consumers Union had argued against this Federal regulatory provision and opposes these sorts of arrangements for Covered California.

We are concerned that these "other" agents and brokers may not have entered into an agreement with the Exchange, either as a WBE or as an independent broker registered with the Exchange. Brokers may flock to such WBE sites, particularly if WBE sites are allowed to display premium rate information for only a partial list of QHPs. If those QHPs are the high commission plans, then these "other" brokers would have an incentive to limit their clients' view to just those plans.

> **Recommendation :** We recommend prohibiting the use of WBE websites by other agents and brokers. To do otherwise would provide a means of circumventing the Federal and state rules surrounding brokers vis-a-vis Exchange plans and subsidies.

VIII. Requiring, at a minimum, the same nondiscrimination requirements as the Exchange, including access for Limited .English-Proficient consumers and persons with disabilities.

Covered California has a Spanish language web site and telephone assistance in any language. WBEs should be held to the same standard, thus making available their websites and customer service in English and Spanish and telephone assistance in any language, including American Sign Language. At a minimum, the list of Covered California's dedicated 800 telephone numbers for each of the threshold languages should be prominently displayed on the WBE site along with links to translated applications in those languages. Additionally, applications

[5] See Consumers Union, *Recommended Consumer Protections for Web-based Agents and Brokers Offering Exchange Coverage*, September 2012.

should be provided in alternative formats including Braille and large print font for those with visual impairments.

IX. Prohibiting WBEs from collecting and storing any personal consumer data and using it for marketing other products.

Web-based entities must abide by Federal and state privacy and security protections that apply to Covered California. Thus, they must be prohibited from collecting and storing any personal consumer data – and most importantly, from using that data for purposes other than eligibility and enrollment in Covered California health plans, CHIP or Medi-Cal. For example, a WBE might use an internet cookie to collect information on a potential enrollee. While this facilitates enrollment for a customer who starts an application, pauses and then returns to complete it, there is a risk that this tracking could be used by the WBE or a contracting issuer or broker with multiple business lines to market other goods or services to potential enrollees. As a vendor of an Exchange product, this must be explicitly prohibited to comport with Federal law.

> **Recommendation:** In regulations and contract provisions, prohibit WBEs from collecting and storing personal consumer data via "cookies" or other tracking tools. Also, bar WBEs from storing or using information gathered from consumers in the application process for marketing products.

Conclusion

Covered CA is off to an exemplary start, having launched without the major glitches of the Federally–facilitated exchange. An army of outreach partners, including service center and county employees, community-based navigators, hospitals, agents, and plans is enrolling people across the state. Thus, WBEs may not be needed in California to meet our enrollment goals. Moreover, important substantive and technical work remains to be done for 2014 and 2015.

WBE commissions from Covered California—as well as payments from issuers—add to health insurance system costs, ultimately passed along to consumers. These extra costs are unnecessary with all the other outlets and leads at Covered California's disposal. With consumers being asked to bear more and more of the cost of health insurance through higher deductibles and out-of-pockets costs, we urge Covered California not to add to that with another layer of sales commissions.

California has consistently enacted legislation and regulations that improve on the ACA. Unlike the majority of states, California requires a standard benefit design. We have imposed consumer protections on stand-alone dental plans via contract. We have exercised the option to require agents to provide impartial information about all QHPs offered on the Exchange, not just those with which they have financial arrangements. We have prohibited steering based on compensation or payment schedules. Our agents are required to assist Medi-Cal applicants as they enroll in coverage for Medi-Cal and/or CHIP.

The public is just now becoming familiar with what Covered California is. We are in a strong position. Introducing another entity through which to apply and enroll, when your own system is functioning well, would most likely add to the existing public confusion. With all these factors in mind, and recognizing the goal of building trust and sound, informed consumer decision on plan

choice, we urge you to defer a decision about whether or not to allow web-based entities until after the first two plan years.

Sincerely,

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SUBCOMMITTEE ON GAS & ELECTRIC INFRASTRUCTURE SAFETY
CHAIR

October 29, 2013

Diana Dooley, Chair
Peter Lee, Executive Director
Covered California Board
560 J St., Ste. 200
Sacramento, CA 95814

Dear Chair Dooley and Executive Director Lee:

We are writing to urge you to allow "web-based brokers", meeting the conditions of the relevant federal regulations, the opportunity to immediately partner with Covered California in order to maximize the number of enrollees into the California Exchange. Not utilizing and bringing to bear the long time private sector experience that many, including California-based tech companies have in this space is a missed opportunity.

Like you, we believe that it is of paramount importance that California enroll as many eligible individuals as possible into California's exchange to ensure the Affordable Care Act (ACA) is a success. However, we are deeply concerned that unless California utilizes all tools at its disposal, including web-based brokers, as authorized under federal law, enrollment numbers will not be as robust as they can be.

Under the Affordable Care Act, consumers who earn more than 400% of the federal poverty level (i.e. do not qualify for premium tax credits or cost sharing assistance) and wish to purchase health insurance coverage meeting the requirements of the ACA's mandate have the option of purchasing coverage through a variety of avenues including a state exchange, through the insurance issuer directly, from an agent or broker, or through an online marketplace or "web-based broker."

Unfortunately, unless Covered CA takes action to work with web brokers, consumers who are subsidy eligible will not have the same options to enroll in qualified health plans made available under the ACA. Their only option will be to buy insurance through Covered California or be directed to a Covered California plan via a health care navigator – in essence imposing a dual class system – one for the subsidy eligible population, and the other for those not eligible for the federal subsidies. We believe this dual system not only unnecessarily limits options for lower income Californians, but also fails to utilize an important tool to help the exchange enroll more uninsured Californians.

Recently, the Centers for Medicare and Medicaid Services (CMS) signed an agreement, including strict consumer protections, with California based eHealth, the largest source of individual insurance coverage in the country, and several other online health insurance marketplaces or "web brokers" which allow them to help enroll tax subsidy eligible individuals in the 36 states where the federal government will be operating a federally facilitated marketplace (FFM). CMS signed this agreement along with several other online companies

because it concluded that having private sector expertise, experience, and ability to reach uninsured people on the internet would help the federal government achieve its enrollment goals under the ACA, including those who qualify for premium tax credits.

In light of the federal government's policy of encouraging "web-based brokers" to actively participate in the 36 federal health care exchanges, we believe there are no technical nor capacity issues that prevent Covered California from partnering with other web-based brokers, particularly those based in California that employ thousands of people and are poised to employ many more in the future as a "public-private partnership" with the goal of enrolling all eligible consumers into California's exchange.

Finally, while we understand that Covered California is taking a close look at partnering with "web-based brokers," it has come to our attention through recent press reports that such consideration will not occur until 2015 at the earliest. With the looming March 2014 deadline for enrollment fast approaching, we urge you to reconsider this decision and work to partner with private "web-based brokers" immediately so that all California consumers can take advantage of the different avenues to purchasing affordable health care coverage. As leaders from the Silicon Valley, we believe that our tech companies have unmatched expertise in this space and should have the opportunity to share their knowledge and cutting edge technology with Covered California.

Thank you for your consideration of this request.

Sincerely,

Jerry Hill
Senator, 13th District

Kevin Mullin
Assemblymember, 22nd District

Richard S. Gordon
Assemblymember, 24th District

Paul Fong
Assemblymember, 28th District

Nora Campos
Assemblymember, 27th District