CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD
November 21, 2013
East End Complex Auditorium
1500 Capitol Ave.
Sacramento, CA 95814

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

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

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

Board members absent:
none

Agenda Item II: Closed Session

Chairwoman Dooley called the meeting back to order at 11:50 a.m. A conflict disclosure was performed; there were no conflicts from the Board members that needed to be disclosed.

Agenda Item III: Approval of Board Meeting Minutes

After asking if there were any changes to be made, Chairwoman Dooley asked for a motion to approve the minutes from the meeting held October 24, 2013.

Presentation: October 24, 2013, Minutes

Discussion: none

Public Comments: none

Motion/Action: Board Member Fearer moved to approve the October 24, 2013, minutes. Board Member Belshé seconded the motion.

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

Prior to moving to the Executive Director's Report, Chairwoman Dooley addressed the federal announcement made one week prior which allowed state-based exchanges to make their own decisions regarding whether to allow health plans to renew grandfathered plans. Since the Board received this notice within the ten-day period required for putting items on the agenda, there are three legal options for acting on it. Because it is a contract matter, one option would be for the

Board to discuss it in closed session and act on it. A second option would be to publicly discuss the matter and then give authority to Peter Lee, Executive Director, to decide whether to change the contracts. A third option would be to discuss it in public and have the Board take public action. The Board chose the third option. Since it is an urgent matter, it can legally be added to the agenda in fewer than ten days before the meeting with a two-thirds vote from the Board.

Motion: Kathy Keeshen, General Counsel, made a motion to enable the Board to act on the issue of whether or not to allow plans to reenroll members in plans that are not compliant with the Affordable Care Act, since it's an imperative issue that arose after the agenda was posted. Board Member Ross seconded the motion.

Discussion: none

Public comment: none

Action: Board Member Kennedy was absent during the vote. The rest of the Board unanimously approved the motion.

Agenda Item IV: Executive Director's Report

Presentation: Executive Director's Report

Discussion: Announcement of Closed Session Actions
In closed session, the Board approved several contract actions:

- Authorized staff to enter into agreements to pay counties for enrollment into Covered California plans
- Amended the interagency agreement with the California Department of Social Services for SHOP appeals
- Amended the contract with Weber Shandwick for ongoing marketing services, additional marketing collateral development, and marketing campaign research services
- Approved a Covered California quarterly contracting update which will be posted on the website's solicitations page.

Mr. Lee announced that David Maxwell-Jolly, Chief Deputy Executive Director, is retiring at the end of the year. He was the first Chief Deputy of Covered California, and his leadership has led to the success of the website. The Board members expressed their appreciation of Mr. Maxwell-Jolly's service. Mr. Maxwell-Jolly accepted a commemorative plaque and commented that his many years of experience with state infrastructure and policy served him well as a team member in the planning and launch of Covered California.

Discussion: Executive Director's Update
Mr. Lee presented slides on enrollment trends and demographics. As of November 19, there have been 360,000 individuals determined eligible for coverage in either Medi-Cal or Covered California.

He moved on to present slides related to the National Voter Registration Act (NVRA) and voter registration availability on Covered California's website. Diane Stanton, Deputy Director of External Affairs, will serve as Covered California's interim voter registration coordinator. An email address is being established to reach the coordinator at voter.reg@covered.ca.gov.

Discussion:
Board Member Ross thanked Mr. Lee for the good news on enrollment figures. He appreciated the staff's commitment to quality improvement. He acknowledged that, while the voter registration element may be competing with the many other priorities, it is important, and he was thrilled to hear that Covered California has an interim director.

Public Comments:
Beth Capell, Policy Advocate, Health Access California, is thrilled at enrollment numbers regarding those who are subsidy eligible, those who are not subsidy eligible, and Medi-Cal eligible. They will all benefit from the Affordable Care Act. They hope to see a vast increase in the number of Spanish-speaking enrollees. It is the goal of Health Access California to get Spanish-speaking residents enrolled.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network, expressed excitement about the enrollment numbers and reiterated Ms. Capell's comments. She has heard that significant numbers of LIHP and Cal Fresh individuals may also soon be enrolled. They are pleased that more marketing has been added in other languages. They are disappointed in the current low numbers of non-English speakers, but hopeful regarding future numbers with the increased marketing efforts. They look forward to seeing the final application, and they're working with their community partners to verify the accuracy of translations.

Kathleen Hamilton, Director of Sacramento Governmental Affairs, The Children's Partnership, says it's heartening to be a Californian and part of the guiding light for the rest of the county. She hopes that a data category capturing enrollment numbers for children can be added to the metrics report. Data was only given for those over 18. They are most interested in seeing the pediatric dental enrollment.

Carla Saporta, Health Policy Director, Greenlining Institute, was happy to hear about increased enrollment. She seconded Ms. Sanders' comments about optimism for increased enrollment of non-English-speaking populations. She thanked the Board for the update on where they are with NVRA and they look forward to working with Diane Stanton on getting to full compliance.

Kim Alexander, President and Founder, California Voter Foundation, commented that her organization, along with 42 other organizations, signed on to the November 14th letter asking Covered California to fulfill its voter registration requirements. They were also part of the phone call yesterday and are happy to be moving forward. They appreciated having a formal report in the public record of the progress being made. She spoke about

the advantage of placing a link on the home page and, while that requirement is not part of the NVRA, it is part of the recently passed bill, SB 4444. They are happy to see it was added to the Covered California website.

Linda Leu, California Research and Policy Director, Young Invincibles, is excited that young adults are enrolling at a proportionate rate, but they want to be better than average. They echo the comments of their colleagues and look forward to making sure outreach and education are reflective of the diversity of the young adult population. They hope to see greater enrollment from the limited English-speaking populations.

Julianne Broyles, Legislative Advocate, California Association of Health Underwriters, agents have been pleased to be part of the progress made to date. As registration metrics are collected and reported, it would be interesting to see them broken out by the source of the application. Their agents are putting in thousands of applications daily and would like to see that information since it would help with resource allotment. Their association has started a public relations campaign to get the word out about Covered California.

Kate Birch, Network Director, California LGBT Health & Human Services Network, stated that the LGBT people don't have the access they need to select a plan. They have not accessed the evidence of coverage for plans and don't know about transition coverage or fertility coverage. That should be made available. The demographic information is helpful to see and they'd like to see LGBT numbers included.

Darcel Lee, Executive Director, California Black Health Network, reported that they are grantees and have been very engaged in the enrollment process. They recently coordinated the mayor of Sacramento's enrollment day and noted that it needed more support. It was successful but was smaller than it could have been. They are concerned about the need for more outreach and marketing support and would like Covered California to stress the outreach to the African-American community and language communities. Doctors, nurses, and various agencies are all asking for more marketing and outreach support.

Meg Sheldon, Information Technology Associate, County Welfare Directors Association, reported that counties are proud to be part of this effort in enrolling people in Medi-Cal.

Tia Orr, Senior Government Advocate, Service Employees International Union, shared that both their state and county workers have been very excited about this rollout which was somewhat difficult, as rollouts on this scale tend to be. They are also excited about the enrollment numbers.

On phone: Louis Segal, a consumer in Santa Barbara, stated that he had a non-grandfathered individual plan with Blue Shield. In 2012, he changed plans because the premium had gone up, and he was told by Blue Shield that his new plan was grandfathered. He has now been told that it is not grandfathered, although Blue Shield assured him that it was when he made the change. His plan is now canceled and his new premium is going to almost double. His previous plan had no caps, all the benefits he

wanted, and now his out of pocket maximum has gone up. None of his doctors are in the network now.

On phone: Silvia Yee, Disability Rights Education and Defense Fund, thanked the Board and staff for the useful data information. She reiterated that they would like to see a breakout of people enrolled who have indicated that they have a disability and she wondered whether they are encountering barriers during enrollment. Someone with a disability contacted her and reported on having a great experience, but she also heard from someone with a vision impairment who called in, had a long wait, left his number, and did not get a call back. He would like an application in Braille or in a format that will work for him.

On phone: Cammy Louvy wondered what Covered California will do to increase young adult enrollment going forward.

Mr. Lee noted that they have significantly stepped up their outreach efforts in African-American and limited-English proficient communities. He has enjoyed seeing some of the new outreach and marketing materials that have been released. They are a growing organization and their data and analysis will grow as new elements are added. Data metrics on children are available and can be downloaded. Covered California and Department of Health Care Services (DHCS) will be coordinating data to merge qualified health plan (QHP) enrollment with Medi-Cal enrollment.

Board Member Ross said it was a great report. He thanked the grantees for doing such good work and hoped someone on staff will follow up with Ms. Darcel Lee.

Agenda Item V: Center for Consumer Information and Insurance Oversight Transition Policy

Mr. Lee invited Leesa Tori to give background on the issue of California's response to the recent presidential announcement made one week prior. There is an urgent need for the Board to take action on this item.

Presentation: California Center for Information and Insurance Oversight Transition Policy

During her presentation, Ms. Tori announced a hotline phone number, 855-857-0445, to connect to a new unit of specially-trained service center representatives who can address premium affordability transition issues. She discussed the three options before the Board: staying on course with the current process, allowing for a delay of three months, or allowing for a delay of one year.

Isaac Menashe, Policy Analyst, External Affairs, joined Ms. Tori to present estimations of who will be adversely affected.

Mr. Lee pointed out that of those impacted, some will see very slight increases and some will see significantly larger increases. Those who are not eligible for subsidies due to earning more than 400 percent of the federal poverty level are likely to experience the greatest adverse financial impact, especially among older families. This is important to address.

Ms. Tori explained that there are two reasons why increases may occur. Consumers who have very "thin" plans with minimal benefits packages that are not allowed under the Affordable Care Act will be required to buy better coverage. The federal law created a set of ten benefits that must be covered. Also, in the past, those with preexisting conditions could be denied coverage or have coverage canceled. Now everyone will be in the risk pool. Thus those who are healthy may see their premium costs rise. It is sometimes difficult to determine the specific benefits and exclusions of a particular plan. Some plans had very low lifetime maximums that might not cover even one catastrophic event.

Chairwoman Dooley thanked Ms. Tori for her explanation of such a dense topic. The Department of Managed Healthcare (DMHC) and the California Department of Insurance (CDI) were invited to give their input.

Board Member Ross thanked Ms. Tori for her thorough and clear presentation on a rapid-turnaround regarding this complicated issue.

Chairwoman Dooley introduced Shelley Rouillard who will become the new director at DMHC, effective November 25. Ms. Rouillard noted that DMHC has been pleased to partner with Covered California during the review process. She explained that the plans that have noncompliant products have already submitted intent to withdraw them by the end of the year. She also gave credit to Ms. Tori for outlining all the options, and agreed that there are no easy answers here. DMHC's main concern is to protect consumers and ensure market stability. There will be disruptions for some people, and that will be challenging. It will work with the plans to make whatever option the Board chooses work. This is not going to be an easy process.

Janice Rocco, Deputy Commissioner of Health Policy and Reform, CDI, pointed out that there is no legal impediment to any of the three options presented. However, option 1 is less viable because over 200,000 policyholders with non-grandfathered products from two insurance carriers recently received notices that their plans were being extended into 2014. Since that has already happened, CDI asked that the extensions be permitted for everyone else. When the law was still in the legislative process, they debated the issue and finally determined that as long as a policy is renewed in 2013, it could be extended into 2014. Addressing the sixty-day issue, she noted that health insurers must give sixty days' notice to change rates or coverage, but they are not necessarily required to submit notifications if they choose to allow enrollment. There's a ninety-day notice of cancellation requirement, but there is no requirement for allowing continuation of coverage. CDI supports option 3. Insurers have not told CDI what they intend to do; they are waiting for the Board to act first. Because there are no legal impediments, Covered California's contract is the impediment. She advised that the Board not let health plans

hide behind that contract and blame Covered California when their policyholders ask them to continue coverage. CDI evaluated the risk pool situation. The presentation that was shown on PowerPoint expressed concern about increased rates in 2015, but CDI's chief actuary disputes that supposition and believes an extension will not cause rates to increase in 2015. The risk adjustment program in the Affordable Care Act will mitigate any of the concerns that have been raised in that regard as well.

Board Member Fearer asked, under options 2 and 3, what would actually happen to people whose policies were not in alignment with the Affordable Care Act. How will they be informed of an opportunity for extension? When do they have to decide if they are accepting an extension? Could they still be subject to premium increases?

Ms. Tori said state law requires that consumers be notified of their extensions by December 31. The health plans would send a mailing out with details about the opportunity and give a respond-by date. If notices were sent out by December 1, consumers could have a couple weeks to respond, and then carriers would have to move quickly to provide January coverage.

Board Member Fearer inquired as to why a carrier would extend its policies if it can't increase the premium. When would the consumers know what the prices would be for these extended plans? It would be hard for consumers to choose without knowing what the price would be.

Ms. Tori noted that if there were an opportunity to adjust the rates, it would probably be more palatable for carriers. The prices can't change yet. It's unclear how they would come up with new prices.

Mr. Lee expressed there has been a lot of discussion about this as a contract, but it is important to note that it is a mutually agreed-upon contract. A lot of thought about what makes sense for consumers went into building it. California has said it wants to have a level playing field so that plans treat consumers the same and consumers have consistent choices and options across the plans. If the Board were to choose the March 31 extension option, it would be troubling to have some plans agree to the extension and some not. If the Board selects option 2 or 3, it would be telling the plans to do what's best for themselves which does not align well with Covered California's desire to work for the interest of consumers in the marketplace. It would be necessary to work with all eleven health plans to come to a unanimous agreement regarding a March 31 extension.

Chairwoman Dooley pointed out the Board can't compel the plans to extend or not, so she asked Mr. Lee if choosing options 2 or 3 would be conditioned upon all plans agreeing to the extension.

Mr. Lee had not laid out the details yet, but his recommendation would be something to that effect. Covered California has negotiated consistent contract terms. If the contract was potentially changed, it would be reasonable to seek to make it work across all health plans. The Board and staff have done a lot of work to structure a marketplace that is

about and for consumers. He also pointed out that options 2 and 3 would be extensions to current plan products, and the plans all set premium prices under the assumption that their current products would be ending as of December 31, 2013. So they had not determined a new premium for their old products.

Board Member Fearer did not want to ask consumers to decide whether or not to continue their old plans without knowing the new prices.

Chairwoman Dooley asked about plans that are month-to-month with expirations coming up at different times. If Covered California extended for three months or twelve months, would these plans have to come up with a three-month or twelve-month policy to match those expiration dates instead of allowing the usual monthly renewal?

Mr. Lee said yes.

Ms. Rocco explained that the policy would have to be renewed by December 31 of this year for whatever length would be allowed (three months or twelve months). For the two carriers that were recently required by regulators to provide short-term extensions, notices were sent out to policyholders, and it took less than a week to work with the carriers on the content. The notices inform consumers as to what their options are and provide more information about Covered California. The initial notices did not include information about subsidies, and there was steering toward off-exchange products that are not subsidy eligible. Option 1 will not allow for consistency in the marketplace since two carriers have already sent out these short-term extension notices. In terms of the rates, the state law that locks rates in for twelve months applies to the new Affordable-Care-Act-compliant policies. It does not apply to the policies that could be renewed this year and extended into next year. The state law about rates requires plans to submit a rate filing to the regulator at least sixty days in advance, so there could be rate increases on those policies if they were extended through December, but it would go through the regular process.

Board Member Fearer asked if people in noncompliant plans will know by December 15 what their premium cost for 2014 will be.

Ms. Rocco answered that these consumers might not know what their future prices will be. Their rates could rise in the course of the year.

Chairwoman Dooley asked how many people are choosing to keep their old policies within the two plans that were required to provide extensions.

Ms. Rocco did not know at this time. The notices went out during the previous two weeks. In December, policyholders will have to make a decision. CDI is hearing complaints that there is not enough time to decide, and they are also hearing complaints from those who are not allowed to keep their policies.

Board Member Belshé asked about the rate implications. Covered California negotiated rates with qualified health plans for 2014, but nobody anticipated this transitional policy. She asked what the implications would be for the rates Covered California has negotiated under option 3.

Mr. Lee replied that all the plans bid on the rates for 2014 with the assumption that everyone would be in the risk pool. If a substantial number of people who had gone through underwriting weren't included in the risk pool, it is possible that health plans would have additional losses. The hope is that reinsurance and risk corridors would moderate that. Nationally, there has been a push to make federal changes regarding reinsurance and risk corridors to moderate what could be additional losses for health plans. It changes the actuarial mix.

Board Member Belshé thought the risk adjustment and risk corridors were meant to apply to people in the reformed marketplace, so if different populations remain in a different market with different rules, then the risk adjustments would not apply.

Mr. Lee agreed that if a health plan had individuals in a non-Affordable-Care-Act-compliant product, the plan would not benefit from the readjustment or reinsurance mechanisms. They are solely for the new pool.

Ms. Tori added that if the Board opted for the twelve-month extension period, consumers will be in the exact same position in a year from now, and if plans did not have an opportunity to increase rates for 2014, those future increases could be larger.

Chairwoman Dooley asked, if the Board chose option 3 with the twelve-month extension and plans then realized they couldn't afford their old products and increased their rates, would consumers be stuck in their more expensive policies for the rest of that year if they had missed Covered California's open enrollment period?

Ms. Tori responded that allowing a special enrollment period for these individuals would introduce a lot of risk for the plans. The carriers would be understandably nervous if consumers were allowed special enrollment periods for anyone wanting out of their plans simply due to premium cost.

Kathy Keeshen, General Counsel, confirmed that there are specific qualifying events that allow for special enrollment in Covered California outside of normal open enrollment periods, but choosing to stop coverage due to cost is not one of them. People who did not go through a specific qualifying event would be stuck if a plan raised rates. An increase in premium would not be a qualifying event to trigger a special enrollment period.

Public Comments:
Charles Bacchi, Executive Vice President, California Association of Health Plans, was sympathetic to consumers who are seeing premium increases. They have been consistently trying to inform people that under the ACA, some people will pay more and some will pay less. These changes are coming, whether it's now or in a year. In

California, we have a market that is transforming. People can actually choose whether or not to buy coverage through the Exchange. They urge Covered California to stay the course and continue this transition; extending the transition for a year would be disruptive to the market and would prevent consumers from accessing their subsidies. It's important to understand the legal and operational and timing issues. Plans are going to have to scramble if there is a renewal process. People have only a couple of weeks to review, make a decision, and pay, and then the plans have to process the payment and issue the policy during the holiday season. Mistakes will be made, but plans would need a legal safe harbor to protect from class action lawsuits. Let's not move backward. On rate changes, the law requires plans to give a sixty-day notice. However, a rate change may be considered an amendment to the policy. It's not clear if plans could change rates. Thus, the premiums charged would be based on the cost of care from eighteen months ago. They do not believe it is designed to take care of this problem.

Micah Weinberg, Senior Policy Advisor, Bay Area Council, observed that it feels like we're talking about the prenuptial after the wedding. It's too late for this conversation. We're not talking about the president's proposal, allowing people to renew their policies in 2014. That doesn't work under state law. This conversation today is about whether we take the plans inside of Covered California and put them on the same playing field as those outside. As a consumer in the marketplace outside of the Exchange, you can currently buy an outside plan that is not ACA-compliant. Those risk corridors, designed to take some funds from plans making money and give to plans incurring losses, may not add up. If more plans end up losing money than making money, there will be no funds in the risk corridor to pay for those plans that lose money. It's too late in the day to be thinking through the implications of making this change at this hour.

Sonya Vasquez, Policy Director, Community Health Councils, would love to give a concrete answer, but it's difficult. She urged the Board, once a decision is made, to develop clear messaging and materials for immediate distribution to grantees, outreach workers, and local legislative offices. They have already been receiving these types of questions.

Betsy Imholz, Director of Special Projects, Consumers Union, appreciated the open forum in the tradition of transparency. There's an understandable atmosphere of both fear and confusion. The advocates worry about damaging the risk pool assumptions that were put in place, and they also worry about asking consumers to make decisions when they may not know the price. There is no happy path. The key will be the messaging, consumer information, and clear wording. The notices being sent out from plans do not do enough to direct people to Covered California subsidies, and it's really hard for consumers to know what they actually have in their current plan. It's very confusing time for consumers. It seems that option 1 is the most workable of the three options.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), appreciated the hard decision facing the Board. Communities of color and LEP are disproportionately uninsured or under-insured. The floor that Covered California has set will ensure that millions get the comprehensive, affordable coverage they need.

She feels sympathy for the caller who must now pay more for worse coverage, but we must continue to support the majority's needs. Changing the conditions of the market would result in mass confusion. That would be exacerbated in limited-English-proficient (LEP) communities already struggling to understand changes. The enormous task that is at hand right now is educating LEP consumers about all these major changes. She does not believe that options 2 or 3 would be viable.

Doreena Wong, Project Director, Asian Americans Advancing Justice, supported the comments made by Ms. Imholz and Ms. Sanders. Option 1 seems to be the lesser of the evils. There is already a lot of confusion out there. Whatever option is chosen, health educators and enrollment counselors really need to understand what they are supposed to say. Having specialized service reps at the service centers is really key. Being able to refer counselors to these specialized reps would help clarify issues for the consumers. If the Board would like to take a little time to explore these big questions that have come up, her organization would be willing to participate and provide feedback.

Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law and Poverty and Health Consumer Alliance, thanked staff for looking into the issues about extending enrollment dates. They are also confused about all the notices going out. People need to clearly know that subsidies are only available through the Exchange. They applaud the creation of the new Options Hotline. It will be helpful for people to have access to that specialized line.

David Chase, California Outreach Director, Small Business Majority, explained that his organization is looking at this issue from the perspective of the 2.5 million self-employed Californians. They believe the best choice is to protect the integrity of the risk pool of the individual exchange. Option 1 is the best way to achieve that. It's unfortunate that carriers haven't been clear in their communications. If other stakeholders or plans or the Exchange can come up with a new option, they would be willing to take a look at it, but for now, stay the course with option 1.

Darcel Lee, Executive Director, California Black Health Network, commented that this is a mess and echoed what Ms. Sanders said. They will be very challenged in explaining this to constituents; many are already confused. The messaging must be extremely clear and extremely straight. There may be an opportunity for the Board, the plans, and the regulators to take this offline so they can come back and explain the exact strategy, but include some outreach educators in that decision-making process. Right now, they are supporting option 1.

Beth Capell, Policy Advocate, Health Access California, observed that in some ways this discussion is the wrong conversation. The right conversation is how to ensure that all Californians have access to quality affordable care. The ACA means access to affordable good benefits that are better than what people have. All of those things are accomplished through the exchange, Medi-Cal, and market reform. They have begun looking for ways to provide targeted transition relief to the 1% of people who are above 400% FPL and already have fairly decent benefits but are facing, in some cases, significant rate

increases. By every estimate, that's less than 1% of Californians. They appreciate the options that staff has presented to the Board and think there is merit in giving consumers some time to consider their options. She noted that there were product cancellations in the insurance market long before the ACA and it has always been a common practice in order to move new products.

Chairwoman Dooley inquired about actions that other states have taken in the recent days since President Obama's announcement that extensions would be allowed.

Mr. Lee responded that about a dozen states have taken action. About eight states have said they would stay the course, and four or five have said they would permit the plans to decide. So far, the states that have declared they will continue unchanged are virtually all states with state-based exchanges that are functioning well. Massachusetts did permit a three-month extension. But those states operating in the federal marketplace are allowing the plans to decide.

Chairwoman Dooley wondered if there is any way to know if there has been an uptick in sales of plans that are noncompliant.

Ms. Tori explained that while there is no way to know those figures, the huge amount of enrollment in Covered California shows that people are taking advantage of the Affordable Care Act.

On phone: Carolina Coleman, Research Manager, Insure the Uninsured Project, advocated for option 1. Option 3 is not even remotely possible, and option 2 is less than desirable for the reasons already laid out. The implications are extremely challenging, given the time frame limitations. Consumers should not be subjected to potential rate increases while being locked out of open enrollment.

Mr. Lee clarified that staff and Covered California are not considering staying the course. No matter which option is chosen, staff has identified four very distinct and important actions that should be taken, and he wanted to add a fifth action as follows:

1. Extend the enrollment period to December 23rd and payment period to January 5th.
2. Create a dedicated help unit trained to help consumers understand their options.
3. Continue the path of producing a cobranded mailing to ensure consumers know about subsidies.
4. Collect and report data on individuals who have converted.
5. Give education and support to those who are talking to consumers and provide tools for certified enrollment counselors, legislative offices, and agents.

This set of additional actions is consumer-centered and focused on continuing the work of changing health care in America. Several commenters had noted that insurance is confusing. Covered California needs to support consumers in understanding their options. This is a tough issue. People won't always get happy answers about their premiums, but they will get clear support and information. Covered California will make the best of

less-than-great options. Staff can focus in upcoming months on creating a system that will work for all Californians.

Motion: Board Member Belshé moved to approve option 1 (no change to current contracts with plans) along with the five suggested enhancements. Board Member Ross seconded the motion.

Mr. Lee noted that two plans will have short periods with noncompliant products in early 2014, but this route would maintain what was developed and agreed to under the contract.

Board Member Ross agreed that this is a thorny issue. He appreciated the work and commitment from staff and stakeholders. Covered California is trying to fix an already complicated system. Ms. Capell's reminder of how we got here resonated with him. Nearly everyone was paying more every year for health insurance. People got sick and went bankrupt or were dropped from health plans. They weren't buying standardized coverage. We're going from a system that was maddening and unfair and discriminatory to one that is not perfect but is far better than before. There are some tradeoffs and we're learning what those are. It is important to be as candid, clear, transparent and communicative as possible about what those tradeoffs are. Most stakeholders advised to keep calm and carry on and that is the path he would like to take.

Chairwoman Dooley said she had come to the Board meeting thinking she would like to offer a little extra time to help those who are being adversely affected. She thought Covered California could help by extending that transition period for three months to add the consumer hotline and to help consumers land as well as possible given the reality of the federal law. The federal law helps a lot of people, but some people are adversely affected so Covered California has an obligation to smooth the edges. She has been persuaded by the staff analysis and the testimony and will support the motion, but she would like to produce as much information as possible on what the real effects and consequences will be. This is very hard on some people who have done the right thing, who bought their own insurance and who have been afraid of not having good coverage but couldn't afford more. It will get better over time, but the short-term dislocation is troubling. She appreciated the staff's five-point plan to help mitigate it. It is her hope that the federal government will look for ways to smooth the edges, too. Nobody really understood all of the implications of this and Covered California should stand ready with its federal partners to help those adversely affected. Bringing this to a public discussion today was an attempt to keep faith with Covered California's policies and values.

Board Member Ross thanked her for her words.

Board Member Kennedy said they knew it would be complicated, and no one supported all of the elements of the federal law. This transition is difficult, and some people will get hurt while many others will benefit. There's no way to make it work without this transition. Delaying the transition will not solve any problems and could cause more confusion and difficulty. If she thought delaying it would solve problems, she would vote that way, but she thinks it would make a bad situation worse. The best Covered

California can do is try everything in its power to help those facing complicated situations to see if there are options available that haven't been seen yet. Option 1 feels like the only choice.

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

Mr. Lee said California has been lauded for doing a good job, and this is another example of why. The Board and public are ready to engage in a public discussion of hard issues. This is a product of good governance and good government. There are no easy choices. California is making the tough choices to make health care work. He thanked the Board, staff, health plans, advocates, and regulators.

Agenda Item VI: Covered California Policy and Action Items

Presentation: Covered California Policy and Action Items

Discussion: Identity Proofing Policy and Regulations
David Maxwell-Jolly presented draft regulations in conformance with recent federal guidance on identity proofing designed to ensure that those filling out applications are who they purport to be. This is a joint process being developed with the Department of Health Care Services.

Motion: Board Member Belshé moved to accept the staff recommendation for identify proofing regulations. Board Member Fearer seconded the motion.

Board Member Fearer asked if the presented option uses the same process that Medicare and Social Security use. He finds their system unusual and difficult. Covered California should find out if consumers find this process difficult.

Mr. Maxwell-Jolly explained that staff has been consulting with Kentucky, a state that relies on this federal service. Kentucky has the highest per capita enrollment, so it is comforting to know that the system can work well. Staff is concerned about not imposing a barrier, and getting feedback would be important, but he is optimistic about the process.

Public Comments:
Bill Wehrle, Vice President of Health Insurance Exchanges, Kaiser Permanente, wondered if we could leave some flexibility in this language. He listened in yesterday to their own call centers and plan-based enrollers (PBEs). The first part of the call, establishing identity, takes a long time and is confusing. If they could put in a little flexibility and try something more streamlined, it would be worth exploring.

(Name unclear), National Health Law Program, stated that, as consumer advocates, they are concerned that this policy could create enrollment barriers for certain populations like younger individuals, former foster care, those with no credit history, Latinos, and immigrants. They understand that the Board has to take action, but they hope to work on improving it for those who cannot be verified electronically. They would suggest that

those who successfully pass the ID system be allowed to use that identity proofing to meet the residency requirement for the application.

Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law and Poverty, and Health Consumer Alliance, agreed with the previous commenter. She corrected Mr. Wehrle by saying that identity proofing is not happening yet, so he had only been observing the security questions process. They are concerned about those low-income people who do not have a credit history with Experian, but they appreciate the changes for those who need an alternate path for identity proofing. They plan to help push the feds for additional flexibility because no one wants to see barriers to online enrollment.

Cary Sanders, Director of Policy Analysis, CPEHN, agreed with Ms. Landsberg. They would like to see data on how this might impact those communities not connected with Experian. They also hope this process potentially serves to verify residency and other important information.

Betsy Imholz, Director of Special Projects, Consumers Union, agreed with Ms. Sanders and Ms. Landsberg, regarding monitoring for people who have no credit history or who may have a security freeze on their bank accounts. She supported the idea about using identity proofing as a means of expediting the residency verification requirements.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, agreed that the federal system is clunky and difficult to work with. They believe there may be flexibility in federal law to use verbal attestation, although they realize there is disagreement about that. They also understand that the emergency regulation process moves quickly and they look forward to working together on permanent regulations.

Mr. Maxwell-Jolly thought it was a good suggestion to leverage this information with the residency verification process.

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

Discussion: SHOP Appeals Regulations
Mr. Lee noted that the Small Business Health Options Program (SHOP) is a very important element for California. They look forward to opening the doors for enrollment on November 25. Right now, small businesses can shop online and with brokers. Having an appeals process in place for SHOP will require fast action.

Anne Gezi presented slides on the proposed emergency regulations for SHOP appeals. They are working on a separate complaint process.

Motion: Board Member Fearer moved to accept the proposed emergency regulations regarding appeals in the SHOP. Board Member Ross seconded the motion.

Public Comments:

Carla Saporta, Health Policy Director, Greenlining Institute, appreciated seeing their comments considered and utilized in development of the emergency regulations. They would have liked to see the complaint process mentioned in the regulations but they understand staff is working on that.

(Name unclear), National Health Law Program, echoed Ms. Saporta's compliments about stakeholder participation in the regulations development process. She noted that the emergency regulations currently mirror much of the federal law, but that's inadequate in terms of protecting employees' rights of appeals. They plan to work with federal partners and look forward to participating again when the emergency regulations come up for renewal.

Cary Sanders, Director of Policy Analysis, CPEHN, echoed Ms. Saporta's comments. They would have liked to see written language about how non-eligibility complaints will be treated in SHOP. They look forward to continuing the discussion.

Beth Capell, Policy Advocate, Health Access California, noted that Covered California will need a complaint process in both the individual and SHOP markets. She commended staff for including notices of employees' appeal rights.

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

Discussion: Re-adoption of Fingerprinting and Criminal Background Check Emergency Regulations
Katie Ravel asked for the first ninety-day extension with no changes. These emergency regulations were first approved by the Board in June 2013.

Motion: Board Member Belshé moved extending the emergency regulations with no changes. Board Member Ross seconded the motion.

Public Comments:
Carla Saporta, Health Policy Director, Greenlining Institute, reminded the Board that these regulations have already gone through a robust stakeholder process and they support them.

Mr. Lee said that the ability to affirm that the thousands of certified enrollment counselors have undergone these background checks is critical in gaining consumers' trust.

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

Discussion: Covered California Incompatible Activities Policy
Gabriel Ravel, Assistant General Counsel, presented the incompatible activities statement, a requirement for all state agencies under Government Code Section 19990.

Motion: Board Member Ross moved to approve the staff recommendation. Board Member Kennedy seconded the motion.

Public Comments:
Beth Capell, Policy Advocate, Health Access California, said it is nice that this is a state agency where this is a routine item.

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

Discussion: Quality Rating System
Jeff Rideout, M.D., Senior Medical Advisor, presented the revised staff recommendation for a quality ratings systems. At the October Board meeting, staff was directed to go back and draft a proposal based on using CAHPS ratings. The staff recommendation is to go with the 10-measure CAHPS scores which would include quality ratings for all plans in 17 of the 19 California regions.

Motion: Board Member Fearer moved to approve the revised staff recommendation. Board Member Belshé seconded the motion.

Mr. Lee appreciated the good work. The motion does not state the date; the intent is to have this up by January 1. The Medi-Cal integration takes first priority, however, but the intent is to have this displayed as quickly as possible.

Chairwoman Dooley agreed that this is a priority, but the SAWS interface is number one and must come ahead of everything else.

Board Member Belshé appreciated the staff for listening to the Board at the last meeting and for its forthright engagement and work. The overarching values and priorities came into play. She stressed that it is important to have competition not based solely on price but also on quality. The plans are in different places. Given where they are, the initial focus on quality should focus on questions more specific to plans themselves than to provider networks. She asked Dr. Rideout to elaborate on the ten measures to be used as the starting point.

Dr. Rideout explained that CAHPS measures tend to measure elements that are more under the plans' direct control. In general, the CAHPS measures reflect on the plans' organization and direct activities. Covered California excluded measures that would not apply to Medi-Cal plans.

Board Member Belshé reiterated that this is not as far as we would like to go and would aspire to go, but it sounds reasonable and responsible.

Chairwoman Dooley is still troubled by the question of different networks and patient populations and the relationships between plans and subcontractors. There are important elements that don't line up. It is necessary to move forward, but she is mindful of the plans, especially those that are new to the commercial market, and is concerned about the

failure to give truly accurate information to consumers. She is willing to go forward with this recommendation but is still uncomfortable with the issue of not having apples-to-apples information.

Dr. Rideout said the suggestion from many plans has been to find a way to accelerate exchange-specific data. A sub-group is currently being formed to work on this.

Public Comments:
Beth Capell, Policy Advocate, Health Access California, noted they support the staff recommendation. She commended Chairwoman Dooley's observation and urged moving forward with the CalHEERS interface as a priority. It is important that consumers have some quality information, even if imperfect. Sometimes the difference in premiums is only a few dollars, and then quality information can help consumers with decisions. Without this action from the Board, it would have taken two or three years for consumers to have access to quality ratings.

Betsy Imholz, Director of Special Projects, Consumers Union, supported the new recommendation. She also voiced her support and recognition of the importance of aligning Medi-Cal and exchange data.

Cary Sanders, Director of Policy Analysis, CPEHN, supported staff recommendations. Individual consumers are being required to purchase health insurance, so Covered California has a responsibility to provide data to help them make their choices. There are limitations to this data, and they look forward to continuing to dialog about how to measure disparities and other important information.

Linda Leu, California Policy and Research Director, Young Invincibles, thanked them for the quality ratings.

Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law and Poverty, agreed that work on the SAWS-CalHEERS interface should come first, but the quality ratings work should come next. She thanked the Board for moving forward on this issue.

Doreena Wong, Project Director, Health Access Project, also supported the recommendation and appreciated having quality ratings in January. Although it is not in the CAHPS rating, she urged the Board to consider including information about language assistance services, including interpreters and translation of services. They worked with the Office of the Patient Advocate (OPA) to ensure that the HMO report card included this information. A survey was created to collect that information from health plans, and they'd like to work with Covered California toward having that be included in the future.

Board Member Ross said he had the opportunity to attend the national Asian Americans Advancing Justice conference on the Affordable Care Act, and he commended Ms. Wong's organization for doing a great job. It was well-attended and included great participation.

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

Discussion: Pediatric Dental Policy Issues
Mr. Lee pointed out that pediatric dental has been one of the stickiest issues. Given the complexity, he would like to present recommendations, but hold action until January. A January decision won't imperil the 2015 timing and would enable the best possible recommendation from the Board. He expressed appreciation to Casey Morgan, Leesa Tori, and the team from Wakely Consulting for all their hard work on this issue.

Leesa Tori, Interim Director, Plan Management, and Jon Kingsdale, Managing Director, Wakely Consulting Group, jointly presented on the pediatric dental policy in relation to embedded, bundled, and standalone plans.

Mr. Lee noted that when Mr. Kingsdale said "we," he meant it was the staff recommendation. His firm has been great at developing material, and staff has shared this with a range of stakeholders. Mr. Lee clarified that it was not his intent to "eliminate" cross-subsidization but to "moderate" it. Moderation, which relates to the issue of having childless people subsidizing those with children, is the point of having embedded plans. The cost to families with children would be lower because families without children would pay a small portion. This issue is a good reason to have more time to engage stakeholders.

Board Member Belshé thanked Mr. Kingsdale for his presentation. She asked him to elaborate on the rationale for offering both embedded plans that include dental and .5 standalone dental plans.

Mr. Kingsdale explained that some employers, those above the small group cutoff, are not required to offer a full 10.0 plan. Many do not offer dental coverage, so the standalone plans might be helpful for those employees. Others might want to combine them with adult dental. Offering plans in this format would simply make that benefit available. Also, someone might decide they want to maintain a relationship with dentists that are embedded in another plan, so they might choose to buy a .5 dental plan in addition to the 10.0. But if Covered California moves dental into APTC-eligible coverage, then the family buying an additional .5 plan would not be paying more for dual dental plan coverage after their subsidy than they are currently paying for single-plan coverage.

Board Member Belshé noted that Mr. Kingsdale said "if" they can manage option B, and wondered if he could elaborate on the uncertainty.

Mr. Kingsdale said they have not fully developed how that would be accomplished, and it depends on their conversations with health plans. A lot of issuers said it would be easier to maintain a 10.0 plan in and outside the exchange than both a 10.0 and a 9.5. That may not be a huge motivating factor. One advantage of the Affordable Care Act is that it enables plans to simplify their offerings. If Covered California were to convey the

message that it really wanted 10.0 plans but found that was not achievable, then it could structure future bidding to encourage the carriers to do the right thing so that there are no unfair cost advantages for some carriers.

Board Member Belshé observed that the first option was problematic because of the challenges of working through CMS. Is option 2 compliant with the guard rails that CMS has put around pediatric dental?

Mr. Kingsdale was careful to say they have not included a legal review and thus he hesitated to answer that question definitively. He believed that it would be compliant because Covered California would not be asking CMS for a waiver. They would be structuring the bid dynamics so that the issuers did not propose a 9.5. That brings in the element of chance, so there may be a need to go back for a CMS waiver if the bid dynamics did not work. It would not depend on an interpretation of the rules; it would depend on the issuers not bidding a 9.5.

Mr. Lee clarified that this would still allow issuers to bid but would not solicit the bids.

Board Member Ross asked if this would apply to the SHOP.

Mr. Kingsdale clarified that this only pertains to the individual market.

Board Member Kennedy asked if option B would include only embedded plans.

Mr. Kingsdale replied yes, but standalone plans would not go away as a separate offering. Standalone .5 plans would be offered in addition to 10.0 plans with the hope that there would not be any 9.5 plans available.

Mr. Lee explained that option B would not allow for a mix-and-match scenario.

Board Member Kennedy asked if they were forcing people out of their current pediatric coverage and forcing them to buy through the exchange.

Mr. Kingsdale explained that people won't be forced to buy through the exchange. People that are in the exchange, however, would have to buy a separate pediatric dental plan if they did not want to use the one already embedded in their health plan.

Board Member Fearer recommended adding to the objectives page the recognition of the importance of continuity of care. It's clearly another consideration in the report, but he would like to see it clearly built into the objectives. When he considered the myriad of options, he landed on these same three, but he had concerns he would like to see addressed over the next couple months. On the first option, why not try to get the CMS waiver and find out if CMS would be open to it? On the age curve, the fine print pointed out that the 15 percent of consumers that benefit from this only pay 6 percent of the cost, and those who don't benefit pay 94 percent of the cost. Mr. Lee had said it would be spread out, but that proportion does not seem to make sense. Also, for 10.0 plans, he

estimated that 95 percent of consumers will make their choice based on their health plans and then will accept whatever dental networks they get stuck with. It's important to push the dental networks in 10.0 plans to have very broad networks so that consumers don't face serious disruptions in care. He would also appreciate a more robust discussion of the third option.

Mr. Lee said Mr. Fearer's comments are good ones. The direction given by the Board at the last meeting was to focus on embedded plans in particular. It's a challenge to offer embedded plans next to 9.5 plans. If the Board is varying from its original direction to staff to focus on embedded pediatric dental plans, this would be an important change of course that staff would need to hear. While a final decision is being moved to January, staff is already indicating to the health plans that they should carefully consider dental partners.

Public Comments:
Betsy Imholz, Director of Special Projects, Consumers Union, this is one of the most difficult issues she has ever worked on. They support the staff recommendation of the 10.0 embedded and the .5 standalone, along with a separate deductible for medical and dental and the two separate out-of-pocket maximums. It achieves all of the goals that they had set out: getting the advanced premium tax credit for pediatric dental, spreading premium cost, getting consumer protections, and the continuity of care is taken care of by the standalone feature.

Cary Sanders, Director of Policy Analysis, CPEHN, also supported the staff recommendation. They believe that continuing to provide 9.5 plans is confusing. If pediatric dental is not embedded, people may not purchase it. Offering the .5 plan as an add-on option allows for continuity of care.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, noted they are concerned that this proposal has not been explained very well. They are concerned about state and federal laws and what state regulators will approve. Last year, plans were required to make last-minute changes on two separate occasions due to lack of clarity on state and federal laws. Their most important request is to not be forced into a similar situation this year. They request that Covered California first determine what is permissible, tie down any loose ends, apply for any necessary waivers, and make a final policy decision by the end of this year or early January so that plans have time to develop products that are in compliance. Please make the decision quickly, but also make the requirements for pediatric dental consistent across all qualified health plans, allow plans to contract with dental carriers of their choice, and make pediatric dental a required purchase. They continue to appreciate the work that has been done on this issue and urge the Board to move quickly.

Allison Barnett, Government Relations Director, Anthem Blue Cross, submitted their comment letter in which they recommended that this benefit be fully embedded in all products in the exchange. All ten EHBs should be there. They believe this approach drives down premium costs so it can be spread evenly across populations, and it will have

little impact on those who won't need it. They understand the need to push this decision off to January, but please don't push beyond that. Qualified health plans need to know how to design their standardized benefits for next year.

Pam Loomis, California Association of Dental Plans (CADP), expressed disappointment with the staff recommendation. It would result in an embedded-only market because there would be no 9.5 plans to pair with a .5 plan. They also believe that option B would violate Covered California's own legal analysis. In a June 8th letter to the Office of Administrative Law (OAL) and the California Department of Insurance CDI), Mr. Lee stated that the statutes are clear that the exchange must permit standalone plans in the exchange, and if these are present, the exchange must allow 9.5 plans. Covered California cannot side step these potential legal problems. The dental plans believe that option A is the best option. However, their letter to the Board proposed an alternate solution which is very close to option C. They believe that option C would avoid the legal problems of option B, maximize the APTC, maximize child dental enrollment, preserve consumer choice, and preserve plans' ability to offer other products. Other states have already rolled this out, so they do not believe assertions that it would be too complicated. They urge the Board to consider option C.

Chris Hathaway, Director of Government Relations, National Association of Dental Plans, said they have been working on this issue since 2008. They also are the one that have been discussing the APTC issue with the IRS. All they need to do is get the IRS to put it on the front burner, and they'd appreciate a letter from Covered California directing the IRS to focus on it. The embedded option is a no-starter. They have worked with both CCIIO and Congress, and it was the clear intent of the law to make sure that the marketplace options of today are available in the exchange. They concur with Ms. Loomis from CADP that they have an excellent alternative option and have proof that it is working well. Both Kentucky and Nevada have mandated a pediatric dental purchase and they offer 10.0, 9.5, and .5 plans. They have not seen any complexity issues or consumer confusion issues. That's an option they would like to discuss. They are pleased to have more time and would like to review the Wakely report.

Ben Ruben, Health Policy Associate, Children Now, appreciated the diligence from the Board for maximizing affordability, robustness, and adoption of this benefit. While they cannot make a specific recommendation on everything discussed, they agree with staff recommendations of requiring all health plans sold for children to include the dental benefit. It's critical that the number of individuals enrolling in pediatric dental be tracked by age and reported regularly.

Kathleen Hamilton, Director of Sacramento Governmental Affairs, The Children's Partnership, acknowledged extraordinary partnership and work between stakeholders and staff. In their view, the ACA is intended as a 10.0 proposition. The idea was that all ten essential health benefits would be offered in all QHPs and everybody buys one. So they'd be troubled by any direction that would make an exception for children. They support option B to proceed with 10.0 embedded plans as the only QHP option. They are, however, inclined to support the companion standalone.5 plans for those who want

continuity of care with a provider that they already have. There are downsides to standalone plans. For those reasons, the embedded plans are a superior offering for families.

Serena Kirk, Senior Policy Associate, Children's Defense Fund, supported the staff recommendation because it gives children access to all ten essential health benefits and it ensures continuity of care.

Autumn Ogden, Policy Coordinator, California Coverage and Health Initiatives, agreed with Ms. Hamilton and supported the staff recommendation.

Jim Mullen, Manager of Public and Government Affairs, Delta Dental, appreciated the Wakely staff report and Covered California staff. He appreciated that the decision was moved to January because more time is needed on this issue. If APTC is allowed to flow to standalone dental plans, be aware there will be no path back. In a year from now there will be a slew of letters canceling standalone plans, and a dental plan will be decided for consumers by virtue of the medical plan that they choose. Congress's intent recognized the importance of standalone dental plan. Today, 98% of dental coverage is provided through standalone plans. The uptake of the benefits is higher than when dental coverage is combined with a medical plan that is unclear and vague. The Board's decision needs to correlate with the standard design development. The $50 or $60 savings via APTC could go right back out in higher deductibles, so much care needs to go into designing the models. They concur with their colleagues at CADP and urge the Board to either choose option C or the alternative that they have presented.

Nicette Short, Policy Analyst of Government Affairs, California Dental Association, shared concerns about the current state of enrollment and IT issues. They urge staff to work on these and prioritize 2013 implementation issues. They know 2015 is right around the corner, but they are already having problems with people trying to purchase pediatric dental for this year. So they appreciate the Board's suggestion that this vote be put off until January. This is very complicated. Many key problems have been identified and they recommend a further discussion of option C that was itemized in the Wakely report. All options should continue to be explored and vetted before the Board decides on one.

Alicia (?), Premier Access Dental, expressed concerns about the disruption of care that Board Member Kennedy touched on. Option B allows for a duplicated coverage plan. Consumers who are navigating the options today and selecting their new dental policy would then hear at the end of the year that they were going to be terminated from their policy and would have to have whatever dental coverage their medical plan is offering. Very few people will start the shopping process with dental and then choose their health plan secondarily. The disruption of care also applies to the standalone dental plans. Those plans went through all of the renegotiations for rates, entered into contracts in good faith and partnered to see the success of Covered California with regards to dental.

Richard Jones, Guardian, stated that as one of the SHOP partners, they are very relieved that the options in the Wakely report do not apply to SHOP. Small business is a critically

important marketplace that needs to be evaluated on its own merits. A majority of Americans today receive their dental coverage through small business employers. So when Covered California gets to the point of evaluating SHOP, they would be happy to be a resource.

Doreena Wong, Project Director, Health Access, Asian Pacific American Legal Center, wanted to align with other consumer advocates for supporting option B. It's less confusing for consumers because they don't have to figure out all the different options. It's a good compromise between offering consumer choice, continuity of care issues, and not confusing consumers.

Jeff Album, Vice President, Public Affairs, Delta Dental, stated there is no choice for dental when it's embedded. People will select a health plan and be forced into whatever dental coverage happens to come with it. There is a reason why standalone dental plans are the preferred option in the commercial marketplace. In his view, option B takes that choice away. Nevada allows for 10.0, 9.5, and .5 plans. They also have a mandate that everyone with children must purchase pediatric dental. They have 900 confirmed pediatric dental signups and 4,000 applications pending receipt of payment. California has 270 confirmed dental signups. The recommendation that they are making meets all of the objectives of the Wakely report: everyone gets APTC and every child gets pediatric dental. The average dental cost is $10-$12 for the low-cost plans. To lower the cost to $3-$4 by saddling childless adults with higher costs to buy this product just doesn't add up. They are offering a perfectly good option that accomplishes all the desired objectives and they hope the Board considers it.

Beth Capell, Policy Advocate, Health Access California, was pleased to see the staff recommendation fulfilling the Board action of some months ago. They look forward to further conversation about how to structure the benefit and appreciate the idea of a separate or low deductible for dental along with a separate out-of-pocket max for dental. The discussion about the age rating curve is interesting, but it would require a change in state law. The pediatric dental issue has evolved from a place of insufficient discussion to more than ample discussion now.

Discussion: Navigator Program Regulations
Sarah Soto-Taylor presented on the navigator program regulations.

Mr. Lee noted that this year they have invested in two tracks. One track goes toward funding organizations for outreach and education and the other toward funding payments per enrollment. The navigator strategy is grant-based and combines the two. Covered California will be evaluating closely to see which is more effective for future funding. This is not funded by federal dollars. This is funded from revenues generated from health plan fees.

Board Member Ross welcomed any comments or concerns from the consumer and outreach organizations.

Public Comments:
Autumn Ogden, Policy Coordinator, California Coverage and Health Initiatives, thanked the staff for taking their recommendations. They appreciate the expansion of the regions from three to six, but would like to see more on that in order to be sure there aren't gaps in outreach. Given the short timeline allotted for submission of the navigator application, it will be important that Covered California assess what worked and what did not for the outreach and education grant process. They suggest cross-referencing information for those agencies that have already registered for grants or as CEEs to ensure staff can help organizations, especially those with language barriers.

Cary Sanders, Director of Policy Analysis, CPEHN, appreciated the presentation and the webinar on this topic. In order to fill the gaps in coverage, good data on race, ethnicities and language will be needed in order to understand how various demographics are not being reached. They hope that data will be available before the RFP goes out so that Covered California and grantees understand what the landscape looks like. The activities make sense for people in this program, but health insurance will be new for many people and they will have questions about how to access the services that they have purchased. Navigators can help consumers navigate the delivery system. This is not a lot of funds. They look forward to working to strengthen the current program to ensure that any gaps are being addressed.

Jim Mullen, Manager of Government Affairs, Delta Dental, requested that standalone dental plans be added as a separate entity in the rules that currently only mention QHPs. The dental plans provide different benefits not tied to metal tiers so there is a need for sufficient training for those who are answering those questions.

Linda Leu, California Research and Policy Director, Young Invincibles, appreciated the staff for calling out young adults as a population, although they are also very diverse. Covered California should be sure to capture enrollment data about language and ethnicity and they look forward to incorporating some of that data into the targeting efforts for navigator work. They also encouraged the Board to consider funding some nontraditional outreach such as online marketing instead of only in person.

Carla Saporta, Health Policy Director, Greenlining Institute, thanked staff for taking into consideration their recommendations. She concurred with comments made by Ms. Sanders and Ms. Leu. The enrollment data should be studied to understand which populations are not enrolling and then limited funds can be targeted toward those organizations that are trusted in their community. One recommendation was that trust should be valued up front above having a robust program or a large organization—for the LEP populations, and communities of color, trust is the number one reason why they are willing to enroll.

Agenda Item VII: Covered California Program Reports

Presentation: Covered California Program Reports

Discussion: Covered California Health Plan Report
Mr. Lee pointed out that the work on the provider directory is continuing. They will also be adding clinic information, hopefully by December 2. Covered California is committed to this, but there are other priorities too.

Discussion: Small Business Health Options (SHOP) Report
The upcoming release of CalHEERS version 2.5 includes online enrollment for employers and employees, financial management, and customer relationship management.

Discussion: Marketing and Outreach Report
Mr. Lee reported on some very good marketing and outreach work being done. Both certified educators and licensed insurance agents are growing in numbers by leaps and bounds. Virtually all who want to be certified will be certified by the end of the month. There will now be twenty-three days for them to help enroll people in December for coverage at the start of 2014.

Covered California has changed some of its marketing ads to reflect that the website is working well, though the federal one is not. They are moving in to a number of marketing initiatives targeting youth. There will be an entirely new set of advertisements in January which will highlight real people affected by health care.

Discussion: Eligibility and Enrollment Operations Report
Mr. Lee went to Fresno during the previous week to announce the opening of the third service center. California is the only state that has public-sector employees staffing the service centers and these employees are doing a great job. They are not hitting the service-level targets because the call volumes are higher than anticipated. They are working to get as many people as possible working.

While Covered California's service centers are currently struggling to reach those service-level targets, the service centers at the county offices are providing an exceptional level of customer service. The target was to have 80 percent of calls answered within thirty seconds. The service centers have achieved a 60 percent target rate and the counties have reached 98 percent.

The consumer website, a partnership between Covered California and DHCS, is a good site, but it is not perfect and is undergoing improvement. The releases coming in the next few days will include the enrollment functions for the SHOP program. Focus groups were conducted in English and Spanish and thousands of people provided feedback about what is and isn't working on the site. The Spanish-language enrollment site is being refreshed and refined, demonstrating a good example of the test-learn-fix process.

Mr. Lee acknowledged the frustration about the single streamlined application and the need to have paper applications available in multiple languages. Federal approval has finally been received, so these are ready to be printed and mailed by early December. It is a challenge to get the paper applications done in the thirteen languages needed.

Discussion: Financial Report
Mr. Lee summarized the financial report by saying that Covered California is doing well and is on track. Audits are ongoing.

Discussion:
Mr. Lee reminded everyone that, as usual, comments to the Board and various reports are posted on the website.

Board Member Fearer asked about the waits on calls. It is good news that there are large volumes. He understands what staff is doing to mitigate it. He would like to hear analysis given to the sources of these wait times. Are higher volumes due to more callers, or to people that have to call back more times, or to the duration and complexity of the calls?

Mr. Lee said the average call is about what they expected. Calls can range from fifteen minutes for a single individual to an hour or longer. The majority of calls are three minutes or less, but some very long calls are included in that mix. They are constantly analyzing the mix and know that they receive more calls on Mondays and at predictable times during the day. Volumes were anticipated to pick up in mid-November, and this has happened earlier than predicted. The Fresno service center opened just in time with 60 staff members and another 150 new staff in training. Last week, they received 70,000 calls, the highest call volume in a single week to date. He is optimistic that service center calls may not keep going up because they now have 20,000 certified enrollment counselors and licensed agents that are trained and available to assist in their communities.

Board Member Kennedy inquired about the average wait time.

Mr. Lee noted that the average wait time was twenty minutes last week. He was unsure what percentage of the thirty-second target was achieved last week; the numbers provided were from several weeks back. A waiting time estimate is provided to callers and consumers can opt to get a call back. If the call back takes twenty minutes, that time is tracked in the service center's average wait time. Consumers may not get through in thirty seconds, but they aren't necessarily on hold listening to music for forty minutes.

Board Member Ross would really like to see the multiple-language applications actually done in December.

Public Comments:
Julianne Broyles, Legislative Advocate, California Association of Health Underwriters, voiced thanks for the leadership on agent portal functionality issues. Agents are now listed on the website and, within the last 24 hours, they have been able to access their accounts. It's improving. They have been informed by their own internal helpline that when agents have questions on individual applications, they are sent to a SHOP representative and there's nobody on the individual side as a point of contact. They need accurate information on the individual side. When a new applicant selects an agent, they

still cannot access that account. They have heard multiple complaints from the employer and individual communities that the cost estimator is not working correctly. The premiums and subsidies are not always matching up. The cost estimator says one thing, and when the consumer clicks the button to buy, a higher amount is shown. Accuracy is critical in building trust with consumers, and staff is urged to investigate and correct this discrepancy. Agents are good partners and can be an answer to some of the problems in pushing enrollment higher on the exchange.

Mr. Lee thanked the agent community across the state for its patience. It has been such a pleasure to have agents, counties, and certified enrollment counselors partnering alongside Covered California. The enrollment they expect to see will be because of the assistance of these multiple service channels.

Cathy Senderling, Deputy Executive Director, County Welfare Directors Association, said they are very pleased about the counties' performance. It demonstrates the persistence and the work they did leading up to October 1. Sometimes it was hard to answer all the questions, but they got there with Covered California's support. They are still working through some glitches on the quick sort issues and are working to share data. They are open on Saturdays, for example, and want to make sure Covered California call center reps are trained and giving correct information when they forward calls to the counties. They are pleased with the partnership and performance. She thanked them for their attention on the importance of the interface between the CalHEERS and SAWS systems.

Tia Orr, Senior Government Advocate, Service Employees International Union, thanked the Board for their support of the county and state workers. County workers have been flexible, working overtime, doing paper applications, and have proven us right and proud. There has to be continued work on training. We'll get there, but there are some hours of operation that may not yet be known.

Ben Ruben, Health Policy Associate, Children Now, said they are focused on the health needs and barriers of former foster children. Covered California's comprehensive and aggressive outreach campaign provides opportunities for collaboration to promote outreach for former foster youth who qualify for Medi-Cal and to maximize their enrollment. There are two simple ways to increase knowledge about Medi-Cal opportunities for this population. First, ensure certified educators are trained to help foster youth by including this information in trainings. Second, ensure that youth-facing media and the website provide information about eligibility for former foster youth. They offer themselves as a resource to provide feedback.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, touched on the QHP recertification timeline that will be up for discussion in coming months. They understand the need for an aggressive timeline to get everything loaded for 2015, but suggest that for plan standard benefit design, any changes for 2015 be kept to a minimum. Currently, changes are to be adopted in February when there will be very little consumer or plan data available. Data collected from 2014 should then be used later to

make more robust changes. They suggest the Board may want to consider pushing back submission of rates for 2015 in order for plans to be able to collect and analyze early data.

Autumn Ogden, Policy Coordinator, California Coverage and Health Initiatives, echoed Ben Ruben regarding support for former foster youth and the extra efforts needed to ensure they don't lose coverage.

Agenda Item VIII: Adjournment
The meeting was adjourned at 4:18 p.m.