Comments to the Board

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Assembly
California Legislature

BRIAN NESTANDE
ASSEMBLYMEMBER, FORTY-SECOND DISTRICT

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January 23, 2014

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

RE: Second Request for Information on Privacy Protections

I am sending a second writing to request information regarding the privacy protections adopted and implemented by Covered California. On December 10, 2013, I requested the information outlined below. A swift reply from your office would be appreciated.

As you know, Assemblywoman Conway authored Assembly Bill 3 in the First Extraordinary Session. This measure would have prohibited anyone who has been convicted of felony crimes of dishonesty or breach of trust from being hired by or contracting with Covered California. This was applicable only for the purposes of facilitating enrollment of persons in a health plan in the Exchange where he or she will have access to the financial or medical information of enrollees.

Covered California took issue with the strict prohibition of employment, and gave assurances that they would adopt and implement a robust policy that protects California residents. Instead of AB 3 another measure, Senate Bill 509, was signed into law. This bill required background checks to be conducted on individuals that would have access to personally identifying information. This measure did not include the prohibition of employment

Given the amount of personal information that Californians must provide to sign up for plans through the Exchange and the very real risk of identity theft or other financial abuse, coupled with the recent news accounts exposing the fact that Covered California forwarded personal information to agents without permission, I ask that you please provide answer the following questions:

1. Please provide me with a written copy of the specific policy used by Covered California to conduct background checks for all prospective employees and contractors, who will have access to any private medical, financial, or personal identifying information, and when that policy went into effect.
2. Has Covered California authorized anyone with prior felonies to contract with Covered California or any organization contracting with Covered California? If so, who makes that determination, and what were the circumstances that Covered California believed warranted that exception?

3. Please provide me with a written copy of the specific policy used by Covered California for receiving complaints from consumers regarding potential misuse of their private medical, financial, or personal identifying information? When was this policy adopted and implemented?
4. Is there any prohibition in the law or in Covered California contract provisions, which prohibits contractors from using any personal identifying information gathered as part of the application process unrelated to health insurance? If so, what are those prohibitions and how are they enforced?

Californians that sign up for health insurance through the Exchange must not only provide their tax returns and other private financial information, but they must also provide information on their health history. It is vital that the State of California protect consumers as part of this process. Thank you and I look forward to your prompt and complete response to my inquiry.

Sincerely,

BRIAN NESTANDE
Assemblyman, 42nd District

COVERED CALIFORNIA

February 4, 2014

The Honorable Brian Nestande
California State Assembly
California State Capitol
Sacramento, CA 94249-0042

Dear Assemblymember Nestande,

Thank you for your recent letters seeking an update on Covered California's background check and privacy procedures. I welcome this opportunity to update you about the policies, procedures, and practices Covered California has put in place to protect consumers and ensure that they can shop, compare and enroll with confidence in new affordable health care options. I apologize for the delay in responding to your earlier letter.

Regarding the criminal background check process, Covered California's policies and protocols are based on Government Code § 1043, enacted by urgency legislation last year through SB 509 by Senator DeSaulnier (Chapter 10, Statutes of 2013), and the implementing regulations that were subsequently adopted by the Covered California Board, California Code of Regulations, Title 10, §§ 6456, 6658, and 6708. The policies also conform to the Equal Employment Opportunity Commission guidance on the use of criminal background checks in employment screening. In response to your first request for a written copy of the specific policy used during the background check process, I have enclosed a document summarizing our current procedures for performing these checks (Attachment 1 - Summary of Covered California Criminal Background Check Procedures).

The background check program has provided an important safeguard for consumers by deterring those with criminal histories from applying in the first place. Early on in the application process, we inform interested applicants of the background check process and require disclosures of prior convictions and administrative actions. A copy of the disclosure form is included in the enclosed summary of the background check results (Attachment 1).

By law and consistent with other state agencies' practices, when a background check returns a potentially disqualifying conviction, Covered California must make an

individualized assessment of the applicant's qualifications in light of that criminal history, considering the age and nature of the offense, the applicant's age at the time of the offense, the relation of the offense to job duties, the performance of similar duties in other jobs, and evidence of rehabilitation. A blanket zero tolerance approach to these reviews would be unlawful under the Civil Rights Act of 1964.

In response to your second request for information about the authorization of individuals with prior convictions, I am including a summary of our background check policies and results (Attachment 2 – Covered California Criminal Background Check Results as of November 25, 2013). As you can see in the attached document, out of over three thousand applicants screened, thirty-five had a potentially disqualifying conviction. These individual cases were then reviewed by our legal staff, weighing the specific factors identified by the Equal Employment Opportunity Commission guidance, as described above. Thirty-one of these applicants were approved after an in-depth review of their histories.

With regard to the privacy of consumer information, Covered California guards its consumers' information carefully. Enforcing our policies to protect consumers' privacy is a collaborative effort between our privacy office, information security officer, our office of consumer protection, and our legal team. Complaints from consumers are taken very seriously to ensure compliance throughout all of Covered California's operations. In response to your third request, I am including two documents: the Notice of Privacy Practices from CoveredCA.com, which describes the complaint process for a consumer (Attachment 3A – Covered California Notice of Privacy Practices), and a copy of our privacy complaint process form our internal Privacy Policy and Procedures Manual, which details our internal procedures for processing these complaints (Attachment 3B – Covered California Privacy Policy and Procedures Manual, Section G).

Subject *at all times* to federal and state law governing the privacy of consumers' confidential information, Covered California's contractors sometimes require access to some of a consumer's information in order to perform their work with Covered California. These contractors include, for example, the information technology firms that are helping to build CoveredCA.com. Whenever any contractor may have access to sensitive information in the course of their work for Covered California, we include a confidentiality agreement. As an example, and in response to your fourth request, I have attached the business associate agreement signed by all of Covered California's Certified Insurance Agents (Attachment 4A – Covered California Certified Insurance Agent Agreement, Exhibit D). A similar agreement is binding on all the organizations who contract with Covered California and who receive confidential consumer

information. As you can see, use of consumers' information by our contractors that extends beyond the scope of our agreement with these contractors is strictly prohibited.

As part of our enrollment follow-up program, Covered California may share limited consumer information with our Certified Insurance Agents and Certified Enrollment Counselors to ensure that every consumer who needs enrollment assistance receives that help. The information shared for this program is limited only to the minimum necessary contact and other information to make contact with a consumer – social security numbers and personal tax information are not shared. In addition to signing the confidentiality agreement referenced above, all certified representatives must be fingerprinted and background checked. They also undergo extensive training and pass an examination administered by Covered California. This training includes a comprehensive module on privacy and security, including a review of the legal requirements that bind all contractors who come into contact with sensitive information. I am attaching the relevant pages on the law governing privacy from our training materials (Attachment 4B – Covered California Privacy and Security Training Manual, Participant Guide).

I appreciate the opportunity to provide you with this update about our efforts to protect consumers as they enroll in new health care coverage options. Please feel free to contact David Panush, our Director of External Affairs at (916) 323-3616, if we can provide any additional information.

Sincerely,

Executive Director

Attachments

cc: Covered California Board of Directors

Attachments

1. Summary of Covered California Criminal Background Check Procedures, (including legal review matrix and copy of disclosure form)

2. Summary of Covered California Criminal Background Check Policies and Results as of November 25, 2013

3A. Covered California Notice of Privacy Practices (showing consumer complaint procedure)

3B. Covered California Privacy Policy and Procedures Manual, Section G (approved October 22, 2013)

4A. Covered California Certified Insurance Agent Agreement, Exhibit D (confidentiality / business associate agreement)

4B. Covered California Privacy and Security Training Manual, Participant Guide (pages 23-28)

Attachment 1

Summary of Covered California Criminal Background Check Procedure
(including legal review matrix and copy of disclosure form)

Summary of Criminal Background Check Procedure

Covered California's criminal background check policies and processes are based on Government Code § 1043 and the Equal Employment Opportunity Commission's guidance on use of criminal background checks in employment screening. Before certification by Covered California, any individuals applying to be engaged in enrollment assistance functions on behalf of Covered California who, if approved and engaged, would have access to certain enrollee data contained on Covered California's information technology system, known as the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), must pass a fingerprint-based criminal background check conducted by the California Department of Justice (DOJ). The types of access that require a background check include:

- Access to Federal Tax Information
- Access to Personal Identifying Information
- Access to Personal Health Information
- Access to confidential or sensitive information provided by a member of the public including, but not limited to, a credit card account number or social security number
- Access to cash, checks, or other forms of payment and accountable items
- Responsibility for the development or maintenance of CalHEERS and other critical automated systems of the Exchange
- Access to information technology systems of the Exchange

Applicants also must submit a disclosure form including all criminal convictions as well as administrative actions and, if desired, an explanation.

The Exchange's implementing regulations permit Covered California to disqualify an applicant based on criminal history only if the applicant has been convicted of or has a pending charge for a crime of moral turpitude that is substantially related to the qualifications, functions, or duties of the job. (10 CCR § 6456(e)(1).) Covered California sorts offenses into three categories, as outlined in the attached spreadsheet. An applicant's screening follows a different process based on which of three types of convictions or pending charges, if any, the applicant has suffered.

First, Covered California considers some crimes not to be potentially disqualifying if the date of conviction is more than five years before the application date. These crimes are outlined in yellow in the spreadsheet containing potentially disqualifying offenses. Second, other crimes do not have a look-back period and may be disqualifying offenses regardless of when the conviction occurred. These crimes are outlined in red in the spreadsheet and may always form the basis for disqualifying an applicant. Third, some crimes are not crimes of moral turpitude or are not substantially related to the qualifications, functions, or duties of the job. These crimes are outlined in green in the spreadsheet and are never potentially disqualifying offenses.

Because there are many criminal prohibitions, it would be impractical to list every offense in the spreadsheet under one of the three categories. The list is intended to include the most frequently-occurring offenses. Any offense not listed in the spreadsheet is a potentially disqualifying offense, and an applicant who has been convicted of such an offense would require further review.

Once the criminal history response comes back from the DOJ (in the form of a Criminal Offender Record Information ("CORI")), the custodians of records who have been legally authorized to view those responses determine whether the applicant has been convicted of or has a pending charge for any potentially disqualifying offense. Only those individuals who have been approved as custodians of records by the Department of Justice may view the CORI responses; disclosure of those responses, or information derived from those responses, to an unauthorized individual is punishable as a misdemeanor.

Applicants' criminal history responses include all state and federal convictions and pending charges in their DOJ and FBI summary criminal history information documents. This means that any conviction or pending charge from any state or at the federal level appears on those responses. If an applicant has a potentially disqualifying conviction or pending charge on his or her criminal history response, the application is forwarded to dedicated staff on the legal team for review. If not, the application is considered to have passed the criminal record screening.

If an individual application is sent for legal review, an analyst reviews the criminal history response and any supporting materials, then makes a recommendation to a senior attorney about whether the individual should be approved based on the nature of the job held or sought; the age, nature and gravity of the offense; and any evidence of rehabilitation, including evidence provided by the individual, including, but not limited to, participation in treatment programs. If additional

information is required, the analyst requests court records and/or arrest reports to discern in greater detail the nature of the offense.

Special consideration must be given if an individual does not have a conviction for a potentially disqualifying offense but does have a pending charge for such an offense. Under Labor Code § 432.7(a), no employer may make an employment decision based solely on the fact that the employee or applicant has been arrested. In these cases, the analyst performs additional research to determine if there is a basis to substantiate the charges pending against the applicant.

Once the file has been fully briefed and the recommendation has been completed, the senior attorney may either accept or reject the analyst's recommendation. If the senior attorney determines the applicant to be unqualified, the applicant receives a notice of interim disqualification, including the specific offense or offenses that formed the basis of the disqualification and a copy of the applicant's criminal history response. The applicant also receives a notice of his or her right to appeal the interim disqualification and the means for doing so.

If an applicant believes that his or her criminal history is inaccurate, our regulations provide a process for the applicant to correct the information. (10 CCR §§ 6658, 6708.) If the applicant determines that the record is accurate, the applicant has 60 days to dispute the interim disqualification by providing the Exchange with additional written evidence of rehabilitation and/or mitigating circumstances related to a potentially disqualifying offense. (10 CCR §§ 6658, 6708.) A senior attorney other than the individual who made the interim disqualification then examines the record, as supplemented by the applicant, to determine if final disqualification is warranted. If the applicant does not appeal an interim disqualification within 60 days, the interim disqualification becomes final.

FORM 100

COVERED CALIFORNIA

CRIMINAL RECORD DISCLOSURE

INSTRUCTIONS TO INDIVIDUALS APPLYING TO BECOME CERTIFIED ENROLLMENT COUNSELORS:
In order to become a Certified Enrollment Counselor, the law requires that you complete a background check (Government Code section 1043) and fill out this form (California Code of Regulations, Title 10, Section 6654(d)(8)).

You MUST disclose convictions and administrative actions even if:

1. It happened a long time ago;
2. It was only a misdemeanor;
3. You didn't have to go to court (your attorney went for you);
4. You did not go to jail or prison or the sentence was only a fine or probation;
5. You received a certificate of rehabilitation;
6. The conviction was later dismissed, set aside per Penal Code Section 1203.4 or the sentence was suspended.

A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty for any crime. Criminal convictions from another State or Federal Court are considered the same as criminal convictions in California. The fingerprints you provide will be used to obtain a copy of any criminal history you may have.
Certified Enrollment Counselors shall report to Covered California any criminal convictions and administrative actions taken by any other agency within 30 calendar days of the date of the conviction or action.

NOTE: IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) OR ADMINISTRATIVE ACTIONS THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) OR ADMINISTRATIVE ACTION(S) WILL RESULT IN A DISQUALIFICATION TO BECOME A CERTIFIED ENROLLMENT COUSELOR.

Have you ever been convicted of a crime in California?..... YES NO

Have you ever been convicted of a crime from another state, federal court, Military proceeding or jurisdiction outside of the U.S.? ..... YES NO

Have you ever had an Administrative Action against you from another State Agency? ..... YES NO

If you answered YES to any of the above questions, give details on the back side of this form indicating the date and location of each crime or administrative action and, if desired, the nature and circumstances of the offense. If you need additional space or have more than three offenses or administrative actions to declare, you must use additional sheets and mail in all sheets to the address listed above.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

Covered California will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.).

NOTE: IMPORTANT INFORMATION: Under the California Public Records Act, Covered California may have to provide copies of some of the records in your file to members of the public who ask for them, including newspaper and television reporters. Covered California must also tell people who ask the name of a Certified Enrollment Entity that has a Certified Enrollment Counselor with a criminal record exemption.

This form is available at: www.healthexchange.ca.gov/documents/CECdisclosure.pdf
If you have any questions about this form, please contact (888) 975-1142.

WHAT WAS THE FIRST OFFENSE OR ADMINISTRATIVE ACTION?		
WHEN DID IT OCCUR?	WHERE DID IT OCCUR? CITY:	STATE:
TELL US WHAT HAPPENED (optional):		

WHAT WAS THE SECOND OFFENSE OR ADMINISTRATIVE ACTION?		
WHEN DID IT OCCUR?	WHERE DID IT OCCUR? CITY:	STATE:
TELL US WHAT HAPPENED (optional):		

WHAT WAS THE THIRD OFFENSE OR ADMINISTRATIVE ACTION?		
WHEN DID IT OCCUR?	WHERE DID IT OCCUR? CITY:	STATE:
TELL US WHAT HAPPENED (optional):		

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and accompanying attachments are true and correct.

EMPLOYER NAME		EMPLOYER ID NUMBER (EIN)
YOUR NAME (*PRINT CLEARLY*)		SOCIAL SECURITY NUMBER
YOUR ADDRESS		CA DRIVERS LICENSE OR I.D. #
CITY	ZIP	DATE OF BIRTH
SIGNATURE		DATE

Do NOT return this form to your employer.

This form must be completed by all individuals applying to become a Certified Enrollment Counselor and mailed directly to Covered California by the individual applying. Other than the individual applicant, no one may view, collect or mail this form.

THIS FORM MUST BE MAILED TO:
Covered CA
PO Box 1199
Sacramento, CA 95812

This form is available at: www.healthexchange.ca.gov/documents/CECdisclosure.pdf
If you have any questions about this form, please contact (888) 975-1142.

LEGAL REVIEW MATRIX

No legal review required Legal review required No legal review required if over 5 years since conviction[1]

Offense	Code	Crime Type	HBEX Lookback Period
Fraud, general		Fraud, Theft, Dishonesty	Unlimited
Juvenile Offenses* Adjudication Conduct If honorable (California Youth Authority) CYA discharge per W&I 1772		Juvenile Offenses	Never a disqualifier if not a COMT. *Juvenile offenses not a conviction for DOJ response.
False representation, securing a loan	11 USC 523	Fraud, Theft, Dishonesty	Unlimited
Citizenship, fraudulent claim	18 USC 1001	Fraud, Theft, Dishonesty	Unlimited
Mail Fraud	18 USC 1341	Fraud, Theft, Dishonesty	Unlimited
False statement, application for passport	18 USC 1542	Fraud, Theft, Dishonesty	Unlimited
Bribery, attempted of an immigration officer	18 USC 201(b)(3)	Fraud, Theft, Dishonesty	Unlimited
Counterfeit money, possession with intent to defraud	18 USC 473	Fraud, Theft, Dishonesty	Unlimited
False statement, student loan application	20 USC 1097	Fraud, Theft, Dishonesty	Unlimited
Contact with a minor to commit sexual offense	288.3	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Meeting with Minor for Sexual Purposes	288.4	Crime against Person, Sexual Morality	Unlimited

[1] 5 year look-back period is from the date of the conviction.

Offense	Code	Crime Type	HBEX Lookback Period
Aliens, encouraging unlawful entry Aliens, smuggling willful or knowingly	8 USC 1324 8 USC 1324	Theft, Fraud, Dishonesty	Unlimited
Attorney Misconduct	BP 6068 BP 6103 BP 6106	Fraud, Theft, Dishonesty	Unlimited
Controlled Substance: Possession for Sale			
Heroin	HS 11351	Crime against Governmental Authority	Unlimited.
Cocaine	HS 11351	Crime against Governmental Authority	Unlimited.
Cultivation	HS 11358	Crime against Governmental Authority	Unlimited.
Marijuana	HS 11359	Crime against Governmental Authority	Unlimited.
Controlled Substance: Transportation	HS 11352	Crime against Governmental Authority	Unlimited.
Controlled Substance: Opening and maintaining a place for purpose of unlawfully selling, giving away or using narcotics	HS 11366	Crime against Governmental Authority	Unlimited.
Controlled Substance: Possession for Use			
Marijuana Heroin	HS 11357 HS 11350	Crime against Governmental Authority	Never a disqualifier if not a COMT. Never a disqualifier if not a COMT.
Weapons of Mass Destruction	PC 11418(b)(1) or (b)(2)	Crime against Governmental Authority	Unlimited
Perjury	PC 118	Theft, Fraud, Dishonesty	Unlimited.

Offense	Code	Crime Type	HBEX Lookback Period
Perjury resulting in the execution of an innocent person	PC 128		Unlimited.
Conspiracy: Commit Crime	PC 182.1	Crime against Governmental Authority	Unlimited
Weapon, possession of dangerous or deadly	PC 12020	Crime against Governmental Authority	5 years
Firearm, possession by ex-felon	PC 12021	Crime against Government Authority	5 years
Firearm, enhanced sentence for listed felonies where use of Firearm	PC 12022.53	Crime against Government Authority	Unlimited
Firearm, concealed weapon	PC 12031/recodified as PC 25400 (*See* SB 1080 (2009))	Crime against Government Authority	5 years
Exploding or Igniting Commit Murder, Destructive Device or Explosive with Intent to and attempted	PC 12308, 12309, 12310	Crime against Person, Property	Unlimited
Falsifying document, of evidence	PC 132, PC 134	Fraud, Theft, Dishonesty	Unlimited
Failure to appear	PC 1320(b), PC 1553/VC 40508	Crime against Government Authority	5 years
Intimidation of Witnesses and Victims/Gang Related	PC 136.1	Crime against Person	Unlimited
Obstruction - Resisting, Delaying or Obstructing Officer	PC 148	Crime against Person	Unlimited
False statement, to a peace officer	PC 148.9, VC 31	Fraud, Theft, Dishonesty	Unlimited
Contempt/Disobey Court Order	PC 166	Fraud, Theft, Dishonesty	Unlimited

Offense	Code	Crime Type	HBEX Lookback Period
Murder, 1st degree	PC 187	Crime against Person	Unlimited
Murder, 2nd degree	PC 187	Crime against Person	Unlimited
Murder, attempted	PC 190, PC 190.4, PC 664/187 (DSS cite)	Crime against Person	Unlimited
Manslaughter, involuntary	PC 192 PC 193	Crime against Person	Unlimited
Manslaughter, voluntary	PC 192, PC 193	Crime against Person	Unlimited
Mayhem (any)	PC 203; PC 505	Crime against Person	Unlimited
Torture	PC 206[2]	Crime against Person	Unlimited
Kidnapping	PC 207, 208, 209, 209.5	Crime against Person	Unlimited
Robbery	PC 211; 212, 212.5, 213, 214	Fraud, Theft, Dishonesty	Unlimited
Carjacking	PC 215[3]	Crime against Person, Property	Unlimited
Assault, with intent to commit murder	PC 217	Crime against Person	Unlimited

[2] **206.** *Every person who, with the intent to cause cruel or extreme pain and suffering for the purpose of revenge, extortion, persuasion, or for any sadistic purpose, inflicts great bodily injury as defined in Section 12022.7 upon the person of another, is guilty of torture.*
The crime of torture does not require any proof that the victim suffered pain.

[3] **215.** *(a) "Carjacking" is the felonious taking of a motor vehicle in the possession of another, from his or her person or immediate presence, or from the person or immediate presence of a passenger of the motor vehicle, against his or her will and with the intent to either permanently or temporarily deprive the person in possession of the motor vehicle of his or her possession, accomplished by means of force or fear.*

Offense	Code	Crime Type	HBEX Lookback Period
Train Wrecking	PC 218, 219	Crime against Property	Unlimited
Assault, with intent to commit rape, sodomy, mayhem or oral copulation	PC 220	Crime against Person	Unlimited
False imprisonment, felony	PC 237	Crime against person	Unlimited
Assault, Simple	PC 240	Crime against Person	Not a disqualifier if not a COMT.
Battery, simple	PC 242	Crime against Person	Not a disqualifier if not a COMT.
Battery, by a jailed inmate upon a non-inmate	PC 242	Crime against Person	Unlimited
Battery, Felony	PC 243(d)	Crime against Person	Unlimited.
Battery, sexual	PC 243.4	Crime against Person, Sexual Morality	Unlimited
Assault, with a deadly weapon	PC 245	Crime against Person	Unlimited
Assault, force likely to produce great bodily injury	PC 245	Crime against Person	Unlimited
Firearm, possession of loaded weapon	PC 246	Crime against Government Authority	5 years
Firearm, discharge at an inhabited dwelling or occupied building	PC 246	Crime against Government Authority	Unlimited
Firearm, discharge in grossly negligent manner	PC 246.3	Crime against Government Authority	Unlimited
Rape	PC 261, PC 262	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Rape, Statutory, felony (and possible misdemeanor – unpublished)	PC 261.5	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Rape, in concert and attempted	PC 264.1	Crime against Person, Family Relationship, and Sexual Morality	Unlimited

Offense	Code	Crime Type	HBEX Lookback Period
Enticing minor into prostitution and attempted	PC 266[4]	Crime against Person, Sexual Morality	Unlimited
Pimping/Pandering	PC 266a	Crime against Person, Sexual Morality	Unlimited
Induce to sexual intercourse, etc. by fear or consent through fraud	PC 266c	Crime against Person	Unlimited
Pimping a minor/Pandering a minor	PC 266h(b), 266i(b)	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Providing a minor under 16 for lewd or lascivious act	PC 266j	Sexual Morality	Unlimited
Abduction for Prostitution, and attempted	PC 267[5]	Crime against Person	Unlimited
Assault, aggravated of a child	PC 269	Crime against Person	Unlimited
Contributing to the delinquency of a minor, and attempted	PC 272	Sexual Morality	Unlimited
Battery, upon spouse or cohabitant	PC 273.5	Crime against Person, Family Relationship	Unlimited
Corporal injury, on spouse/cohabitant (felony, misdemeanor) (domestic violence)	PC 273.5	Crime against Person, Family Relationship	Unlimited
Child Abuse/Endangerment	PC 273a	Crime against Person, Family Relationship, and Sexual Morality	Unlimited

[4] 266. *Every person who inveigles or entices any unmarried female, of previous chaste character, under the age of 18 years, into any house of ill fame, or of assignation, or elsewhere, for the purpose of prostitution, or to have illicit carnal connection with any man; and every person who aids or assists in such inveiglement or enticement; and every person who, by any false pretenses, false representation, or other fraudulent means, procures any female to have illicit carnal connection with any man, is punishable by imprisonment in the state prison, or by imprisonment in a county jail not exceeding one year, or by a fine not exceeding two thousand dollars ($2,000), or by both such fine and imprisonment.*

[5] 267. *Every person who takes away any other person under the age of 18 years from the father, mother, guardian, or other person having the legal charge of the other person, without their consent, for the purpose of prostitution, is punishable by imprisonment in the state prison, and a fine not exceeding two thousand dollars ($2,000).*

Offense	Code	Crime Type	HBEX Lookback Period
Willful cruelty to child	PC273A(B)	Crime against Person, Family Relationship	Unlimited
Corporal punishment, on children resulting in traumatic condition (willfully inflicting any cruel or inhuman corporal punishment or injury on a child)	PC 273d	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Bigamy	PC 281	Crime against Family Relationship	5 years
Incest	PC 285	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Sodomy	PC 286	Crime against Person	Unlimited
Lewd Conduct, with child under 14	PC 288	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Distributing Lewd Material to Children, and attempted	PC 288.2	Crime against Person, Sexual Morality	Unlimited
Continuous sexual abuse of a child and attempted	PC 288.5	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Sexual abuse of a child 10 years or younger	PC 288.7	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Oral Copulation	PC 288a	Crime against Person, Sexual Morality	Unlimited
Oral Copulation, with minor under 16	PC 288a	Crime against Person, Sexual Morality	Unlimited
Genital or Anal Penetration by Foreign Object, and attempted	PC 289	Crime against Person, Sexual Morality	Unlimited
Registration of Sex Offenders	PC 290(c)	Crime against Governmental Authority, Sexual Morality	Unlimited
Child Pornography, sent or brought into state for possession or distribution Child Pornography, sending or bringing into state, possessing for distribution	PC 311.1 PC 311.2(b)-(d)	Crime against Person, Family Relationship, and Sexual Morality	Unlimited

Offense	Code	Crime Type	HBEX Lookback Period
Sexual exploitation of a child, and attempted Child Pornography, using a minor to assist in making or distributing, and attempted Child Pornography, advertising or distributing, and attempted Child Pornography, Possessing, and attempted	PC 311.3 PC 311.4, PC 311.10 PC 311.11		
Indecent exposure, felony	PC 314	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Accessory, after the fact	PC 32		Unlimited
Gambling	PC 330	Crime against Government Authority	5 years
Poisoning or adulterating food, drink, medicine, pharmaceutical products, spring, well, or reservoir	PC 347(a)	Crime against Property	Unlimited
Elder or dependent adult abuse	PC 368	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Treason	PC 37	Fraud, Theft, Dishonesty	Unlimited
Public Nuisance	PC 372	Crime against Government Authority	Never a disqualifier if not a COMT.
Littering	PC 374	Crime against Government Authority	Never a disqualifier.
Disturbing the Peace	PC 415	Crime against Government Authority	Never a disqualifier if not a COMT.
Weapon, brandishing	PC 417	Crime against Governmental Authority	5 years
Firearm or deadly weapon, drawing, exhibiting, or using on the grounds of a day care center	PC 417(b)	Crime against Government Authority	Unlimited

Offense	Code	Crime Type	HBEX Lookback Period
Threats, criminal or terrorist	PC 422	Crime against Person, Governmental Authority	Unlimited
Arson	PC 451	Crime against Property	Unlimited
Escape, aggravated	PC 4530	Crime against Government Authority	Unlimited
Escape, failure to return to custody of state prison after release	PC 4530	Crime against Government Authority	Unlimited
Escape, without force, state prison	PC 4530	Crime against Government Authority	Unlimited
Escape, without force, local minimum security	PC 4532	Crime against Government Authority	Unlimited
Bring control sub/etc. into prison/etc. (felony)	PC 4573	Crime against Government Authority	Unlimited
Burglary, residential	PC 459-1st	Fraud, Theft, Dishonesty	Unlimited
Burglary	PC 459-2nd	Fraud, Theft, Dishonesty	Unlimited
Forgery	PC 470	Fraud, Theft, Dishonesty	Unlimited
	475[6]	Fraud, Theft, Dishonesty	Unlimited
Check Fraud, insufficient funds	PC 476a	Fraud, Theft, Dishonesty	Unlimited
Theft, grand	PC 487	Fraud, Theft, Dishonesty	Unlimited
Tax Evasion, willful	PC 488	Fraud, Theft, Dishonesty	Unlimited
Theft, petty	PC 488, PC 484	Fraud, Theft, Dishonesty	Unlimited
Shoplifting	PC 490.5	Fraud, Theft, Dishonesty	Unlimited

[6] 475.

(a) Every person who possesses or receives, with the intent to pass or facilitate the passage or utterance of any forged, altered, or counterfeit items, or completed items contained in subdivision (d) of Section 470 with intent to defraud, knowing the same to be forged, altered, or counterfeit, is guilty of forgery.
(b) Every person who possesses any blank or unfinished check, note, bank bill, money order, or traveler's check, whether real or fictitious, with the intention of completing the same or the intention of facilitating the completion of the same, in order to defraud any person, is guilty of forgery.
(c) Every person who possesses any completed check, money order, traveler's check, warrant or county order, whether real or fictitious, with the intent to utter or pass or facilitate the utterance or passage of the same, in order to defraud any person, is guilty of forgery.

Offense	Code	Crime Type	HBEX Lookback Period
Receiving Stolen Property	PC 496	Fraud, Theft, Dishonesty	Unlimited
Embezzlement	PC 503	Fraud, Theft, Dishonesty	Unlimited
Embezzlement by employee	PC 508[7]		
Extortion	PC 518, PC 519	Fraud, Theft, Dishonesty	Unlimited
Extortion, gang related	PC 518, PC 186.22		
False Personation	PC 529	Fraud, Dishonesty	Unlimited
Defrauding an Innkeeper	PC 537(a)(2)	Fraud, Theft, Dishonesty	Unlimited
Vandalism, felony (and possible misdemeanor)	PC 594	Crime against Property	5 years
Trespass	PC 602	Crime against Property	Never a disqualifier if not a COMT.
Bribery	PC 641.3	Fraud, Theft, Dishonesty	Unlimited
Stalking	PC 646.9[8]		
Disorderly Conduct (all)	PC 647	Crime Against Governmental Authority, Sexual Morality	Unlimited
Lewd Conduct	PC 647(a)	Crime against Person, Sexual Morality	Unlimited

[7] **508.** *Every clerk, agent, or servant of any person who fraudulently appropriates to his own use, or secretes with a fraudulent intent to appropriate to his own use, any property of another which has come into his control or care by virtue of his employment as such clerk, agent, or servant, is guilty of embezzlement.*

[8] **646.9.** *(a) Any person who willfully, maliciously, and repeatedly follows or willfully and maliciously harasses another person and who makes a credible threat with the intent to place that person in reasonable fear for his or her safety, or the safety of his or her immediate family is guilty of the crime of stalking, punishable by imprisonment in a county jail for not more than one year, or by a fine of not more than one thousand dollars ($1,000), or by both that fine and imprisonment, or by imprisonment in the state prison.*

Offense	Code	Crime Type	HBEX Lookback Period
Prostitution	PC 647(b)	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Loitering	PC 647(e)	Crime against Government Authority	Never a disqualifier if not a COMT.
Public Intoxication	PC 647(f)	Crime against Government Authority	Never a disqualifier if not a COMT.
Child Molestation/Annoyance, misdemeanor	PC 647.6, 647a (prior to 1987)	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Rape, Solicitation of Another to commit rape or sodomy, etc. and attempted	PC 653(f)	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Annoying Phone Calls	PC 653(m)		5 years
Auto theft, attempted	PC 664/10851, PC 664/487d	Fraud, Theft, Dishonesty	Unlimited
Robbery, attempted	PC 664/211	Fraud, Theft, Dishonesty	Unlimited
Rape, attempted	PC 664/261	Crime against Person, Family Relationship, and Sexual Morality	Unlimited
Burglary, attempted	PC 664/459	Fraud, Theft, Dishonesty	Unlimited
Theft, petty with a prior	PC 666	Fraud, Theft, Dishonesty	Unlimited
Felony, any felony punishable by death or imprisonment in the state prison for life without the possibility of parole but not or an indeterminate sentence Felony, enhancement for any felony which inflicts great bodily injury	PC 667.5(c)(7) PC 667.5(c)(8)	Crime against Person	Unlimited
Resisting Executive Officer, by force or threat	PC 69	Crime against Person	Unlimited
Auto theft	VC 10851, PC 487d	Fraud, Theft, Dishonesty	Unlimited
False statement, application for driver's license	VC 20	Fraud, Theft, Dishonesty	Unlimited
Hit and Run, felony	VC 20001, VC 20002	Crime against Person	Unlimited
Driving under Influence, Misdemeanor	VC 23152	Crime against Government Authority	Never a disqualifier if not a COMT.

Offense	Code	Crime Type	HBEX Lookback Period
Driving under the influence, felony with priors	VC 23152	Crime against Government Authority	Unlimited.
Evading Police Officer, with willful or wanton disregard for safety	VC 2800.2	Crime against Government Authority	Unlimited
Fraud to obtain aid	WI 10980 (c)(a)		Unlimited
Food Stamp Program Violation	WI 10980 (g)(2)		Unlimited
Welfare Fraud	WI 11483	Fraud, Theft, Dishonesty	Unlimited

Attachment 2

Summary of Covered California Criminal Background Check Policies and Results as of November 25, 2013

Criminal Background Check Results as of November 25, 2013[1]

This document provides an overview of the results of Covered California's criminal background checks, along with a brief description of the legal framework which governs both the background checks and Covered California's assessment of an applicant's qualifications in light of those checks. Consistent with the law governing the confidential nature of fingerprint-based criminal background checks, the result below are divided into two categories (disclosed and undisclosed).

Legal Standards for Criminal Background Checks: Covered California's criminal background check policies and protocols are based on Government Code § 1043, California Code of Regulations, Title 10, §§ 6456, 6658, and 6708, and the Equal Employment Opportunity Commission's guidance on use of criminal background checks in employment screening as articulated in the Enforcement Guidance on the Consideration of Arrest and Conviction Records in Employment Decisions under Title VII of the Civil Rights Act of 1964. Under this process – which is consistent with other state agencies' practices – Covered California must conduct an individualized assessment of each applicant, considering factors including the age and nature of the offense, the applicant's age at the time of the offense, the relation of the offense to job duties, the performance of similar duties in other jobs, and evidence of rehabilitation.

Disclosure of Offenses: Covered California receives information about the criminal histories of applicants from two sources: an applicant's disclosure as part of the application, and as results returned from a fingerprint-based criminal background check performed by the Department of Justice. The results below include both types of information, but they are presented differently due to the confidential nature of information received through undisclosed background checks conducted by the Department of Justice.

Although California Code of Regulations, Title 10, Sections 6658 and 6708 require applicants to disclose their criminal convictions as part of the application process, nondisclosure alone is not dispositive evidence of an attempt to conceal a criminal history, as applicants may not have understood that they needed to disclose certain convictions or that Covered California would be made aware of them. The overwhelming majority of undisclosed convictions for approved applicants were judicially dismissed or sealed under Penal Code 1203.4. Additionally, as of January 1, 2014, it is unlawful for an employer, including a

[1] Due to a the 60 day appeal period discussed In the Summary of Criminal Background Check Procedures, final results are not yet available for November 26, 2013 to date.

state agency, to consider a conviction that has been judicially dismissed or sealed pursuant to law, including Penal Code 1203.4, in making any employment decision. Labor Code § 432.7(a). In other cases, convictions were very old, and some applicants may have believe they were not required to disclosed very old convictions. These are among the considerations incorporated into the individualized assessment performed as part of Covered California's background checks.

Criminal Background Check Results as of November 25, 2013

Summary of Results: Out of over 3,000 applicants, 35 had *any* potentially disqualifying convictions (~1%). Of these individuals, 24 disclosed their convictions and 9 did not. As a result of the background checks, 4 applicants have been disqualified based on background checks.

Applicants with undisclosed convictions: Table 1 shows the total number of *undisclosed convictions* for applicants who were disqualified, as well as those who were found to be qualified, by age of the conviction. (Note, some individual applicants may have had more than one undisclosed conviction.) Table 2 shows the number of *individual applicants* connected with convictions that were not disclosed.

Table 1 – Number of Undisclosed Convictions

	Age of Conviction					
	0 to 5 yrs	6 to 10 yrs	11 to 15yrs	16 to 20 yrs	21 + yrs	TOTAL
Number of Undisclosed Convictions for Approved Applicants						
Felony			1		1	2
Misdemeanor	1	1	12	1	4	19
Number of Undisclosed Convictions for Disqualified Applicants						
Felony					1	1
Misdemeanor	3					3

Table 2 – Number of Applicants with Undisclosed Convictions

Approved Individuals with Undisclosed Convictions	9
Disqualified Individuals with Undisclosed Convictions	2

Applicants with disclosed convictions: Table 3 on the following page lists the self-disclosed convictions of applicants received to date, and the determinations made through Covered California's review process. Consistent with federal law, each of these applicants had an individualized assessment of their qualifications in light of their criminal histories. For more information on this process, see the accompanying "Summary of Criminal Background Check Procedure" document.

Table 3 – Individuals with Disclosed Convictions

Individual	Program Type	Year of Conviction	Conviction Information Disclosed	State of Conviction	Qualified	Qualified After Appeal	Disqualified After Appeal	Disqualified No Appeal Received
1	CEC	2006	Arrested for not disclosing were a suspect was	Florida	X			
2	CEC	2001	PC 273A(B), Willful harm or injury to child, PC 242 Battery	California	X			
3	CEC	1999	Not listed	California	X			
4	CEC	2001	Infraction	California	X			
5	CEC	1991	Two misdemeanors, one felony	California	X			
6	CEC	1989	Felony possession of controlled substance	California	X			
		1990	Felony sale of controlled substance	California				
		1983	Misdemeanors	California				
7	CEC	1994	Petty theft	California	X			
8	CEC	1994	Misdemeanor battery (Domestic)	California	X			
9	CEC	2006	Not listed	California	X			
10	CEC	1998	PC 273.5(A) Domestic Violence	California	X			
		1988	PC 470 Forgery	California				
		1988	PC 470 Forgery	California				
11	CEC	1972	Shoplifting	California	X			
12	CEC	1993	Transporting marijuana	California	X			
13	CEC	2006	Petty theft	California		X		
14	CEC	1996	Receiving stolen property	California	X			
15	CEC	1996	Perjury	California	X			
		1998	Petty theft	California				
16	CEC	1992	PC 246.3	California	X			
17	CEC	1982	PC 470 Forgery	California	X			
		1992	PC 459 Burglary	California				
		1994	PC 470 Forgery	California				
18	CEC	2001	Evading police officer	California	X			
19	CEC	1997	Petty theft	California	X			
20	CEC	1992	Possession	California	X			
		1997	Driving under the influence	California				
		1997	Willful disobedience of court order	California				
		1993	Possession of paraphernalia	not listed				
		1993	Driving under the influence	not listed				
		1996	Trespassing	not listed				
21	CEC	1988	Shoplifting	California	X			
		1988	Shoplifting	California				
		1999	Welfare fraud	California				
22	CEC	1991	Shoplifting	California	X			
23	CEC	2005	Commerical Burglary	California			X	
24	CEC	1992	PC 211 Robbery	California				X
		2002	PC 273.5(A) Corporal Injury spouse	California				
				Total	21	1	1	1

Attachment 3A

Covered California Notice of Privacy Practices (showing consumer complaint procedure)

Notice of Privacy Practices

This notice describes how medical information about you may be used

The California Health Benefits Exchange, known as the Exchange or Covered California, may get your personal information when you ask us for information about health care insurance or when you apply for health care insurance through the Exchange. We are required by law to maintain the privacy of your personal information, to give you notice of our legal duties and privacy practices ant to notify you following a breach of unsecured protected health information. We must follow the law when we use or share your information. This Notice of Privacy Practices tells you what your rights are and how we use and share your information. We must follow this Notice of Privacy Practices. We have the right to change our Notice of Privacy Practices. If we make changes to our Privacy Practices, we will send a new Notice of Privacy Practices to all the people who are applying for health insurance at that time or whose information we may have.

INFORMATION WE MAY COLLECT

When you visit our website, talk to a representative or send us an application for insurance, the personal information we collect may include, but is not limited to:

- Name
- Address
- Email address
- Phone number
- Social Security Number
- Demographic information
- Health information
- Financial information

HOW WE MAY USE AND SHARE YOUR INFORMATION

We will use your information to help you see what health insurance is available for you and to refer you to health plans and other governmental entities that can help you get health insurance. We will share your information if we are required by law to do so. We may also share your information for these purposes:

- **Treatment:** We may share your information with health care providers to make sure you get health care;
- **Program purposes:** Information will be shared with private health plans and government agencies, such as the IRS, Department of Homeland Security and the Social Security Administration, for use in determining eligibility for insurance programs and providing health insurance to eligible applicants;
- **Payment:** We will share information with the health plans or programs that you enroll with for payment purposes, such as billing you for insurance or submitting bills to these entities;
- **Health care operations:** Information may be shared with health plans and

government agencies to oversee how the insurance is being provided, for quality assurance, audits, for fraud and abuse prevention programs, and for planning and management purposes;

- **Appeals:** If you appeal any of the decisions about your eligibility for health insurance or the insurance provided to you, the information we have may be used in deciding the appeals;
- **Health care oversight:** Information may be shared for audits, inspections, civil, criminal or administrative investigations, and for licensing or discipline activities,
- **Judicial or administrative proceedings:** Your information may be shared with a court, investigator or lawyer if there is an investigation or litigation about the insurance programs, payment for insurance, fraud or abuse. If a court orders us to share your information, we will do so;
- **Planning and research:** We may share your information with other government agencies and researchers for planning and research programs. Information for research will only be shared if the researcher is from a non-profit organization and meets federal and state requirements for research projects;
- **Other limited purposes:** Information will be shared for other purposes when we are required by law to do so, such as for workers' compensation, public health activities and risks, health oversight activities, law enforcement activities, coroners, medical examiners and funeral directors, military and veterans affairs, national security and intelligence activities, protective services for the president and others, and for inmates.
- **CMS:** Information will be disclosed to the U.S. Department of Health Services, Centers for Medicare and Medicaid Services, when requested and when disclosure is required by law;

Some information, such as mental health, substance abuse, services for the developmentally disabled, or HIV/AIDS status, are protected by additional laws and we will follow those laws. Other uses and disclosures of information that are not described here will be made only with your written authorization, and that authorization can be revoked by you.

YOUR PRIVACY RIGHTS

You have the rights listed below:

- **Inspect and copy your records:** You can look at the records we have with your information and for a fee you can get a copy of your records. You may not see all parts of your records if it is allowed or required by law to keep you from seeing them. If your request is denied, you have a right to have the denial reviewed. Your personal representative who has the legal right to act for you can look at your records and get a copy. You can contact us to get a form for requesting a copy of your records or you can go to our website to request a copy of your records.
- **Amend your records:** You can ask us to change or correct information in your records. We may decline to change the information if we did not create or keep it, or if it is already complete and correct. You can ask us to review the denial or you can send a letter disagreeing with the denial and the letter will be kept as part of your records;
- **Accounting of disclosures:** You can ask us to send you a report of who we have shared your information with, when it was shared, and why.
- **Restrictions on uses and disclosures:** You can ask us not to use or share your information in the ways we listed above. We may not be able to agree with your request. If your request is about an item or service that you paid for, we must agree with your request.
- **Confidential communications:** You have the right to ask that we contact you confidentially, at a different address or phone number, a post office box, or in writing or by telephone only, and we will meet all reasonable requests. We may ask you to explain why disclosing some of the information could endanger someone.
- **Copy of Notice of Privacy Practices:** You may get a paper copy of this Notice of Privacy Practices by contacting us at the address below. A copy is also on our

website.

- **Complaint:** You have the right to file a complaint with us and with the Secretary of the U.S. Department of Health Services if you believe your privacy rights have been violated. You can get a copy of a complaint form by contacting us, or you can send us a letter telling us about your complaint. You will not be retaliated against in any way if you file a complaint.

Health Insurance Portabilility and Accountability Act: HIPAA is the aconym for the Health Insurance Portabilility and Accountability Act that was passed by congress in 1996. HIPAA does the following:

- Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or loose their jobs;
- Reduces health care fraud and abuse;
- Mandates industry-wide standards for health care information on electronic billing and other processes; and
- Requires the protection and confidential handling of protected health information.

Please visit the Department of Health Care Services website for more information about HIPAA and Medi-Cal.

Contacting Us

If you would like a copy of our Privacy Policy, please contact us at the address or web site below. You can ask for a copy in another language, Braille or large print.

You can get a form for requesting copies of your records, to amend your records, to get an accounting of disclosures, to request restrictions on disclosures or confidential communications, or a complaint form at the address or web site below.

Phone: (888) 975-1142

Email: privacyofficer@covered.ca.gov

Mailing Address:
ATTN: Privacy Officer (Information Security Office)
560 J Street, Suite 290
Sacramento CA 95814

Website: www.coveredca.com

Attachment 3B

Covered California Privacy Policy and Procedures Manual, Section G (approved October 22, 2013)

G. Complaints.

POLICY:

The Exchange will maintain a system that receives, investigates and responds to complaints from individuals whose personal information is collected or maintained by the Exchange, including employees of the Exchange, concerning the Exchange's alleged non-compliance with applicable Exchange privacy requirements, as reflected in relevant law or regulation (including the Exchange Rules), policies and procedures and/or contract. Based on its review, the Exchange will use the information received through the complaint process to implement or request appropriate corrective action to address the issue identified in the complaint. The Exchange will also use the information received through the complaint process to, improve its safeguards of personal information, and to monitor and improve the Exchange's operations.

PROCEDURES:

An individual whose personal information is collected, used, disclosed or maintained by the Exchange and who wishes to file a complaint, alleging that the Exchange has not followed required privacy laws, policies or practices, must submit a complaint in writing using the "California Health Benefit Exchange Complaint" form.

The Exchange will accept complaints that:

- are filed in writing, either electronically via the Exchange web portal, or on paper by mail, fax, or e-mail;
- name the Exchange or other person or entity involved and describe the acts or omissions believed to violate the Exchange Rules or other applicable requirements, including when the acts or omissions occurred; and
- are filed within 180 days of when the complainant knew that the act or omission complained of occurred. The Exchange may extend the 180-day period if the complainant can show "good cause" for the delay in filing the complaint.

The Exchange shall post information about the complaint process on its website. The website shall include a sample form that may be used for filing a complaint, as well as instructions on how to ask questions or seek assistance in filing a complaint.

The Exchange shall follow the steps listed below in investigating and resolving complaints:

- The Exchange shall maintain a Complaint Status Log that tracks each complaint received and contains the following data elements: (1) complainant, (2) alleged violator, (3) alleged violation, (4) date received, (5) investigation description, (6) determination, (7) action taken. Such log shall be periodically reviewed by the

Privacy Officer in order to manage the complaint process and ensure that matters are being appropriately investigated and addressed.

- The Exchange shall acknowledge receipt of each complaint and request consent to obtain and use information about the complainant, as helpful to facilitate the investigation;
- The Exchange shall conduct an investigation to determine whether such allegation has merit and take follow-up corrective action, as it deems appropriate. The Exchange may use the information obtained through the complaint process to consider potential modifications to Exchange practices.
- The Exchange shall report the conclusion of its investigation to the complainant.

The Exchange shall not retaliate against any individual or entity for the filing of a privacy complaint that is made in good faith.

Attachment 4A

Covered California Certified Insurance Agent Agreement, Exhibit D
(confidentiality / business associate agreement)

(Rev. September 2013)

California Health Benefit Exchange

EXHIBIT D
(Agent Agreement)

Business Associate Agreement

This Business Associate Agreement (this "Agreement") between the California Health Benefit Exchange ("Covered Entity") and Certified Insurance Agent ("Business Associate") is entered into in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as codified at 42 USCA §1320d-d8, and its implementing regulations at 45 C.F.R. Parts 160, 162 and 164 (the "HIPAA Regulations"); and the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and its attendant regulations and guidance (the "HITECH Act").

Purpose of the Agreement

Business Associate provides certain services on behalf of Covered Entity that require the Covered Entity to disclose certain identifiable health information to Business Associate. The parties desire to enter into this Agreement to permit Business Associate to have access to such information and comply with the business associate requirements of HIPAA, the HIPAA Regulations, and the HITECH Act, as each may be amended from time to time in accordance with the terms and conditions set forth in this Agreement. The Parties (Business Associate and Covered Entity) hereby agree as follows:

Definitions: Unless otherwise specified, in this Agreement, all capitalized terms used in this Agreement not otherwise defined have the meaning established for the purposes of Title 45 parts 160 and 164 of the United States Code of Federal Regulations, as amended from time to time, and the HITECH Act.

I. Business Associate Obligations.

1. **Applicable Law.** The terms and conditions set forth in this Agreement shall become effective on the later of the effective date of this Agreement, April 14, 2003, or any new mandatory compliance date established for HIPAA, the HIPAA Regulations and/or the HITECH Act. The parties acknowledge and agree that the HIPAA Regulations and HITECH Act may be amended and additional guidance and/or regulations may be issued after the date of the execution of this Agreement and may affect the parties' obligations under this Agreement ("Future Directives"). The parties agree to abide by such Future Directives as these Future Directives may affect the obligations of the parties. If Future Directives affect the obligations of the parties, then Covered Entity shall notify Business Associate of Future Directives in writing within thirty (30) days before Future Directives are effective. The notification of Business Associate by Covered Entity of Future Directives that affect the obligations of the parties related to the Business Associate relationship shall be considered amendments to this Agreement binding on both parties.

EXHIBIT D
(Agent Agreement)

2. **Permitted Uses and Disclosures.** Business Associate shall not, and shall ensure that its directors, officers, employees, contractors and agents do not, further use or disclose patient individually identifiable health information ("Protected Health Information" or "PHI") received from or created for the Covered Entity in any manner that would violate the HIPAA Regulations, HITECH Act or Future Directives. Business Associate agrees to abide by the HIPAA Regulations with respect to the use or disclosure of Protected Health Information it creates, receives from, maintains, or electronically transmits for the Covered Entity as if the Business Associate were considered a health care provider under the HIPAA Regulations. Business Associate further agrees that it will not use or disclose Protected Health Information beyond the purposes set forth in the Agreement. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in that certain Agreement between the parties, provided that such use or disclosure would not violate HIPAA, the HIPAA Regulations or the HITECH Act if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

3. **Compliance with Business Associate Agreement and HITECH Act.** Effective February 17, 2010, Business Associate may use and disclose PHI that is created or received by Business Associate from or on behalf of Covered Entity if such use or disclosure, respectively, complies with each applicable requirement of 45 C.F.R. § 164.504(e) and the HITECH Act. The additional requirements of Subtitle D of the HITECH Act that relate to privacy and that apply to covered entities also will apply to Business Associate and are incorporated into this Agreement by reference.

4. **Use of PHI for Administrative Activities.** Notwithstanding Section I.2 above, Business Associate may use or disclose PHI for management and administrative activities of Business Associate or to comply with the legal responsibilities of Business Associate; provided, however, the disclosure or use must be required by law or Business Associate must obtain reasonable assurances from the third party that receives the Protected Health Information that they will (i) treat the Protected Health Information confidentially and will only use or further disclose the Protected Health Information in a manner consistent with the purposes that the Protected Health Information was provided by Business Associate; and (ii) promptly report any breach of the confidentiality of the Protected Health Information to Business Associate. Provided further that, Business Associate will notify Covered Entity immediately upon receipt of a request for any disclosure of PHI required by law.

EXHIBIT D
(Agent Agreement)

5. **Accounting**. Business Associate agrees to document disclosures of PHI and collect information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and, if required by and upon the effective date of, Section 13405(c) of the HITECH Act and related regulatory guidance.

    a) Business Associate agrees to provide to Covered Entity or an Individual upon Covered Entity's request, information collected in accordance with this Section, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and, if required by and upon the effective date of, Section 13405(c) of the HITECH Act and related regulatory guidance.

6. **Restriction.** Effective February 17, 2010, and notwithstanding 45 C.F.R. § 164.522(a)(1)(ii), Business Associate must comply with an Individual's request under 45 C.F.R. § 164.522(a)(1)(i)(A) that Business Associate restrict the disclosure of PHI of the Individual if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

7. **Fundraising.** Any written fundraising communication occurring on or after February 17, 2010 that is a health care operation shall, in a clear and conspicuous manner and consistent with guidance to be provided by the Secretary, provide an opportunity for the recipient of the communications to elect not to receive any further such communication. An election not to receive any further such communication shall be treated as a revocation of authorization under Section 45 C.F.R. § 164.508. However, no communication pursuant to this Section may be made by Business Associate without prior written authorization by Covered Entity.

8. **Sale of PHI.** Upon the effective date of Section 13405(d) of the HITECH Act , Business Associate shall not directly or indirectly receive remuneration in exchange for PHI that is created or received by Business Associate from or on behalf of Covered Entity unless: (1) pursuant to an authorization by the Individual in accordance with 45 C.F.R. §164.508 that includes a specification for whether the PHI can be further exchanged for remuneration by the entity receiving PHI of that Individual; or (2) as provided in Section 13405(d)(2) of the HITECH Act and regulations to be issued by the Secretary, upon the effective date of such regulations. However, in no instance may Business

EXHIBIT D
(Agent Agreement)

Associate receive remuneration pursuant to this Section without Covered Entity's written authorization.

9. **Marketing.** A communication occurring on or after February 17, 2010 by Business Associate that is described in the definition of marketing in 45 C.F.R. §164.501(1)(i), (ii) or (iii) for which Covered Entity receives or has received direct or indirect payment (excluding payment for treatment) in exchange for making such communication, shall not be considered a health care operation unless: (1) such communication describes only a drug or biologic that is currently being prescribed for the recipient of the communication and any payment received in exchange for making such a communication is reasonable in amount; or (2) the communication is made by Business Associate on behalf of the Covered Entity and the communication is otherwise consistent with this Agreement. However, no communication pursuant to this Section may be made by Business Associate without prior written authorization by Covered Entity.

10. **Safeguarding the Privacy of PHI.** Business Associate agrees that it shall utilize physical, administrative and technical safeguards to ensure that PHI is not used or disclosed in any manner inconsistent with this Agreement or the purposes for which Business Associate received PHI from or created PHI for the Covered Entity. Business Associate further agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any PHI that Business Associate creates, receives, maintains or transmits electronically on behalf of Covered Entity under the Agreement. Upon request, Business Associate shall provide the Covered Entity with a written description of the physical, administrative and technical safeguards adopted by Business Associate to meet its obligations under this Section.

11. **Security Safeguards.** Business Associate acknowledges that, effective February 17, 2010, 45 C.F.R. §§ 164.308, 164.310, 164.312 and 164.316 will apply to Business Associate in the same manner that such sections apply to covered entities and are incorporated into this Agreement by reference. The additional requirements of the HITECH Act that relate to security and that apply to covered entities also will apply to Business Associate and are incorporated into this Agreement by reference. Business Associate agrees to implement the technical safeguards provided in guidance issued annually by the Secretary for carrying out the obligations under the Code of Federal Regulation sections cited in this Section and the security standards in Subpart C of Part 164 of Title 45 of the Code of Federal Regulations.

12. **Breach Notification**. Business Associate agrees to implement response programs and record-keeping systems to enable Business Associate to

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comply with the requirements of this Section and 13402 of the HITECH Act and the regulations implementing such provisions, currently Subpart D of Part 164 of Title 45 of the Code of Federal Regulations, when Business Associate detects or becomes aware of unauthorized access to information systems or documents that contain PHI. Business Associate agrees to mitigate any effects of the inappropriate use or disclosure of PHI by Business Associate.

a) Business Associate agrees to notify Covered Entity, by facsimile or telephone, of any breach or suspected breach of its security related to areas, locations, systems, documents or electronic systems which contain unsecured PHI, including, without limitation, any Security Incident, instance of theft, fraud, deception, malfeasance, or use, access or disclosure of PHI which is inconsistent with the terms of this Agreement (an "Incident") immediately upon having reason to suspect that an Incident may have occurred, and typically prior to beginning the process of verifying that an Incident has occurred or determining the scope of any such Incident, and regardless of the potential risk of harm posed by the Incident. Notice shall be provided to the Covered Entity's representative designated in this Agreement. Upon discovery of a breach or suspected Incident, Business Associate shall take:

i. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and

ii. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

b) In the event of any such Incident, Business Associate shall further provide to Covered Entity, in writing, such details concerning the Incident as Covered Entity may request, and shall cooperate with Covered Entity, its regulators and law enforcement to assist in regaining possession of such unsecured PHI and prevent its further unauthorized use, and take any necessary remedial actions as may be required by Covered Entity to prevent other or further Incidents.

c) If Covered Entity determines that it may need to notify any Individual(s) as a result of such Incident that is attributable to Business Associate's breach of its obligations under this Agreement, Business Associate shall bear all reasonable direct and indirect costs associated with such determination including, without limitation, the costs associated with providing notification to the affected Individuals, providing fraud monitoring or other services to affected Individuals and any forensic analysis required to determine the scope of the Incident.

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d) In addition, Business Associate agrees to update the notice provided to Covered Entity under Section 12(a) of this Agreement of such Incident to include, to the extent possible and as soon as possible working in cooperation with Covered Entity, the identification of each Individual whose unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the Incident and any of the following information Covered Entity is required to include in its notice to the Individual pursuant to 45 C.F.R. §164.404(c):

i. A brief description of what happened, including the date of the Incident and the date of discovery of the Incident, if known;

ii. A description of the types of unsecured PHI that were involved in the Incident (e.g. Social Security number, full name, date of birth, address, diagnosis);

iii. Any steps the Individual should take to protect themselves from potential harm resulting from the Incident;

iv. A brief description of what is being done to investigate the Incident, mitigate the harm and protect against future Incidents; and

v. Contact procedures for Individuals to ask questions or learn additional information which shall include a toll-free number, an e-mail address, Web site, or postal address (provided, Subsection v is only applicable if Covered Entity specifically requests Business Associate to establish contact procedures).

e) Such additional information must be submitted to Covered Entity immediately at the time the information becomes available to Business Associate.

f) If the cause of a breach of PHI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including, without limitation, notification to media outlets and to the Secretary of the Department of Health & Human Services. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to Covered Entity in addition to Business Associate, Business Associate shall

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notify Covered Entity, and Covered Entity and Business Associate may take appropriate action to prevent duplicate reporting.

13. **Subcontractors and Agents of Business Associate.** Business Associate agrees to enter into written contracts with any of its agents or independent contractors (collectively, "subcontractors") who receive PHI from Business Associate or create, maintain, or transmit electronically, PHI on behalf of the Covered Entity, as a subcontractor to Business Associate, and such contracts shall obligate Business Associate's subcontractors to abide by the same conditions and terms as are required of Business Associate under this Agreement. Upon request, Business Associate shall provide the Covered Entity with a copy of any written agreement or contract entered into by Business Associate and its subcontractors to meet the obligations of Business Associate under this Section.

    a) Business Associate shall, upon knowledge of a material breach by a subcontractor of the subcontractor's obligations under its contract with Business Associate, either notify such subcontractor of such breach and provide an opportunity for subcontractor to cure the breach; or, in the event subcontractor fails to cure such breach or cure is not possible, Business Associate shall immediately terminate the contract with subcontractor.

    b) To the extent that any of Business Associate's subcontractors will have access to any PHI that is created, maintained or transmitted electronically, Business Associate shall require such agents and subcontractors to agree to implement reasonable and appropriate safeguards to protect such electronic PHI.

14. **Availability of Information to Covered Entity and Individuals**. Business Associate agrees to provide access and information:

    a) Business Associate shall provide access as may be required, and in the time and manner designated by Covered Entity (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to Covered Entity (or, as directed by Covered Entity), to an Individual, in accordance with 45 CFR section 164.524. Designated Record Set means the group of records maintained for Covered Entity that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for Covered Entity health plans; or those records used to make decisions about individuals on behalf of Covered Entity. Business Associate shall respond to requests for access to records transmitted by Covered

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Entity within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

b) If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable Covered Entity to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. section 17935(e).

c) If Business Associate receives data from Covered Entity that was provided to Covered Entity by the Social Security Administration, upon request by Covered Entity, Business Associate shall provide Covered Entity with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

15. **Access by Covered Entity and Secretary of Health & Human Services.** Business Associate agrees to allow Covered Entity and the Secretary of the Department of Health & Human Services access to its books, records and internal practices with respect to the disclosure of PHI for the purposes of determining the Business Associate's compliance with the HIPAA Privacy Regulations. If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Agreement, Business Associate shall notify Covered Entity and provide Covered Entity with a copy of any PHI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. section 17934(c).

II. Other Obligations of Business Associate

1. **Exchange Privacy and Security Rules.** Business Associate agrees to comply with the privacy and security requirements applicable to Personally Identifiable Information under the Exchange Privacy and Security Rules at 45 C.F.R. Part 155.260 ("the Exchange Requirements"), promulgated pursuant to the federal Patient Protection and Affordable Care Act, (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111 -152), known collectively as the Affordable Care Act. Business Associate shall implement reasonable and appropriate fair information practices that are consistent with the Exchange Privacy and

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Security Rules, as set out below. To the extent a conflict arises between the Exchange Privacy and Security Rules and any other requirements, Business Associate agrees to comply with the applicable requirements imposing the more stringent privacy and security standards.

2. **Definitions.** For purposes of this section, the following definitions shall apply: *Federal Tax Information (or "FTI")*: Federal tax returns and return information, including any tax or information return, declaration of estimated tax, claim for refund, a taxpayers' identity, the nature, source or amount of income, payments, receipts, deductions, exemptions, credits, assets, liabilities, net worth, tax liability, tax withheld, deficiencies, over-assessments, or tax payments and other information related to a tax return, including information in certain written determinations and agreements. (42 U.S.C. § 6103(b).)

   Personally Identifiable Information (or "PII"): Any information, including electronic, paper or any other media, that identifies or describes an individual, or can be used to distinguish or trace an individual's identity, including, but not limited to, his or her name, social security number, physical description, home address, home telephone number, education, financial matters, medical or employment history, biometric records, and statements made by, or attributed to, the individual, that alone or when combined with other personal or identifying information can be linked or is linkable to a specific individual, It also includes any identifiable information collected from or about an individual for purposes of determining eligibility for enrollment in a Qualified Health Plan, determining eligibility for other insurance affordability programs, determining eligibility for exemptions from the individual responsibility provisions, or any other use of such individual's identifiable information in connection with the Exchange. PII includes Protected Health Information (PHI) and Federal Tax Information.

3. **Individual Access.** Contractor shall provide access to, and permit inspection and copying of Personally Identifiable Information maintained by Contractor upon request in either an electronic or hard copy format as specified by the individual and as required by law, within thirty (30) calendar days of such request from the individual. If the Contractor is unable to provide access within the time required by this subsection, Contractor may have no more than thirty (30) additional calendar days to provide the requested access. If Contractor denies access, in whole or in part, Contractor must provide a written denial within the time limits for providing access, which includes the basis for the denial and a statement of the individual's review rights, if applicable. In the event any individual requests access to Protected Health Information, Personally Identifiable Information or Federal Tax Information maintained by the Exchange directly from Contractor, Contractor shall within five (5) calendar days forward such request to the

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Exchange.

4. **Correction.** Contractor shall provide an individual with the right to request an amendment of inaccurate Personally Identifiable Information maintained by Contractor. Contractor shall respond to such individual within sixty (60) calendar days of such a request either by making the correction and informing the individual of such correction or notifying the individual in writing that the request was denied, which notice shall provide an explanation for the denial and explain that the individual may submit a statement of disagreement with the denial. Any request to amend Federal Tax Information shall be forwarded to the Exchange within five (5) calendar days.

5. **Openness and Transparency.** Contractor shall make available to individuals its applicable policies, procedures, and technologies that directly affect such individuals and/or their Personally Identifiable Information.

6. **Choice.** Contractor shall provide individuals with a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their Personally Identifiable Information. Contractor shall allow individuals to request a restriction on the uses and disclosures of their Personally Identifiable Information, and such requests shall be granted if it is reasonably possible to do so.

7. **Limitations.** Contractor represents and warrants that all Personally Identifiable Information shall be collected, used, and/or disclosed under this Agreement only to the extent necessary to accomplish a specified purpose under the terms of this Agreement or as permitted by the Exchange Requirements and never to discriminate inappropriately.

8. **Data Integrity.** Contractor shall implement policies and procedures reasonably intended to ensure that Personally Identifiable Information in its possession is complete, accurate, and current, to the extent necessary for the Contractor's intended purposes, and has not been altered or destroyed in an unauthorized manner.

9. **Safeguards.** Contractor shall have in place administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Personally Identifiable Information that it creates, receives, maintains or transmits pursuant to the Agreement and to prevent the use or disclosure of Personally Identifiable Information other than as provided for in this Agreement, or as required by law. In furtherance of compliance with such requirements, specific safeguards and procedures that Contractor shall comply with are:

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a. Contractor shall encrypt all Personally Identifiable Information that is in motion or at rest, including but not limited to data on portable media devices, using commercially reasonable means, consistent with applicable Federal and State laws, regulations and agency guidance, including but not limited to the U.S. Department of Health and Human Services Guidance Specifying the Technologies and Methodologies That Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements or issued by the National Institute for Standards and Technology ("NIST") concerning the protection of identifiable data such as Protected Health Information and/or Personally Identifiable Information. Data centers shall be encrypted or shall otherwise comply with industry data security best practices.

b. Contractor shall implement a contingency plan for responding to emergencies and/or disruptions to business that in any way affect the use, access, disclosure or other handling of Personally Identifiable Information.

c. Contractor shall maintain and exercise a plan to respond to internal and external security threats and violations, which shall include an incident response plan. Contractor shall respond to privacy and security incidents, including beaches, as set out in section I.12, above.

d. Contractor shall maintain technology policies and procedures that provide reasonable safeguards for the protection of Personally Identifiable Information stored, maintained or accessed on hardware and software utilized by Contractor and its subcontractors and agents.

e. Contractor shall mitigate to the extent practicable, any harmful effect that is known to Contractor of any Security Incident related to Personally Identifiable Information or of any use or disclosure of Personally Identifiable Information by Contractor or its subcontractors or agents in violation of the requirements of this Exhibit or applicable privacy and security laws and regulations and agency guidance.

f. Contractor shall destroy Personally Identifiable Information in a manner consistent with applicable State and Federal laws, regulations, and agency guidance on the destruction of Personally Identifiable Information.

g. If Contractor receives data from the Exchange that was provided by the Social Security Administration (SSA), Contractor shall comply with the substantive privacy and security requirements in the Computer Matching and Privacy Protection Act Agreement between the SSA and the California Health and Human Services Agency (CHHS) and in the

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Agreement between the SSA and the California Department of Health Care Services, known as the Information Exchange Agreement (IEA), which are attached as Attachment B and incorporated into this Exhibit. The specific sections of the IEA with substantive privacy and security requirements to be complied with are sections E, F, and G, and in Attachment 4 to the IEA, Electronic Information Exchange Security Requirements, Guidelines and Procedures for Federal, State and Local Agencies Exchanging Electronic Information with the SSA. Upon request, Contractor shall provide the Exchange with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

10. **Accountability.** Contractor shall monitor compliance with the fair information practices set out in this section and shall take appropriate actions to ensure adherence with them.

III. Termination of Agreement.

1. **Termination Upon Material Breach.** The Covered Entity may, in its sole discretion, terminate the Agreement, including this Agreement, upon determining that Business Associate violated a material term of this Agreement. If the Covered Entity makes such a determination, it shall inform Business Associate in writing that the Covered Entity is exercising its right to terminate this Agreement under this Section II.1 and such termination shall take effect immediately upon Business Associate receiving such notification of termination.

2. **Reasonable Steps to Cure Material Breach**. At the Covered Entity's sole option, the Covered Entity may, upon written notice to Business Associate, allow Business Associate an opportunity to take prompt and reasonable steps to cure any violation of any material term of this Agreement to the complete satisfaction of the Covered Entity within ten (10) days of the date of written notice to Business Associate. Business Associate shall submit written documentation acceptable to the Covered Entity of the steps taken by Business Associate to cure any material violation. If Business Associate fails to cure a material breach within the specified time period, then the Covered Entity shall be entitled to terminate this Agreement under Section II.1 above, if feasible, or, if it is not feasible to terminate this Agreement, to report Business Associate's material breach to the Secretary of the Department of Health and Human Services.

3. **Amendment.** Covered Entity may terminate this Agreement upon thirty (30) days written notice in the event (i) Business Associate does not promptly

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enter into negotiations to amend this Agreement when requested by Covered Entity pursuant to Section VI of this Agreement, or (ii) Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA Regulations and/or the HITECH Act.

4. **Return of PHI to Covered Entity Upon Termination.** Upon termination of the Agreement for any reason, Business Associate shall return all PHI to the Covered Entity. The Covered Entity may request in writing that Business Associate destroy all PHI upon termination of this Agreement rather that returning PHI to the Covered Entity. If the return or destruction of PHI is not feasible upon termination of the Agreement, then Business Associate shall explain in writing, directed to the Covered Entity's Chief Privacy Officer, why such return or destruction is not feasible. If such return or destruction is not feasible, then Business Associate agrees that it shall extend its obligations under this Agreement to protect the PHI and limit the use or disclosure of PHI to the purposes, which make return or destruction of PHI infeasible.

IV. **Conflicts**. The terms and conditions of this Agreement will override and control over any conflicting term or condition of other agreements between the parties. All non-conflicting terms and conditions of such agreements shall remain in full force and effect.

V. **No Third-Party Beneficiary Rights**. Nothing express or implied in this Agreement is intended or shall be interpreted to create or confer any rights, remedies, obligations or liabilities whatsoever in any third party.

VI. **Notice**. Except as otherwise provided in Section I.12(a), any notice permitted or required by this Agreement will be considered made on the date personally delivered in writing or mailed by certified mail, postage prepaid, to the other party at the address set forth in the execution portion of this Agreement.

VII. **Amendment**. The Parties agree to take such action as is necessary to implement the standards, requirements, and regulations of HIPAA, the HIPAA Regulations, the HITECH Act, and other applicable laws relating to the security or confidentiality of health information. Upon Covered Entity's request, Business Associate agrees to promptly enter into negotiations with Covered Entity concerning the terms of any amendment to the Agreement consistent with the standards, requirements and regulations of HIPAA, the HIPAA Regulations, the HITECH Act or other applicable laws.

VIII. **Relationship of the Parties**. The Parties hereto acknowledge that Business Associate shall be and have the status of independent contractor in the

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performance of its obligations under the terms of this Agreement as to Covered Entity. Nothing in this Agreement shall be deemed or construed to create a joint venture or partnership between Covered Entity and Business Associate.

IX. Indemnification.

1. **Indemnification by Business Associate**. Business Associate shall protect, indemnify and hold harmless the Covered Entity, its officers and employees from all claims, suits, actions, attorney's fees, costs, expenses, damages, judgments or decrees arising out of the failure by Business Associate to comply with the requirements of this Agreement, the Privacy Regulations and all Future Directives; provided however that such indemnification shall be conditioned upon the Covered Entity giving prompt notice of any claims to Business Associate after discovery thereof and cooperating fully with Business Associate concerning the defense and settlement of claims.

X. Miscellaneous.

1. **Exception to Limitations and Exclusions**. Business Associate's obligations under this Agreement and any breach by Business Associate of the obligations in this Agreement shall not be subject to any limitations on damages suffered by Covered Entity that may be specified in any agreement, invoice, statement of work or similar document setting forth the services Business Associate is providing to Covered Entity ("Contract"). No limitation or exclusion in any Contract shall limit Covered Entity's rights to recover from Business Associate damages, losses or sanctions suffered by Covered Entity to the extent of amounts recovered by, or sanctions awarded to, a third party which are caused by Business Associate's breach of the obligations in this Agreement, regardless of how such amounts or sanctions awarded to such third party are characterized.

2. **Assistance in Litigation or Administrative Proceedings**. Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to Covered Entity at no cost to Covered Entity to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Covered Entity, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

3. **Modification**. This Agreement contains the entire understanding of the parties regarding the privacy and security obligations of Business Associate

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under HIPAA and will be modified only by a written document signed by each party.

4. **Waiver**. The waiver by Business Associate or Covered Entity of a breach of this Agreement will not operate as a waiver of any subsequent breach. No delay in acting with regard to any breach of this Agreement will be construed to be a waiver of the breach.

5. **Assignment**. This Agreement will not be assigned by Business Associate without prior written consent of the Covered Entity. This Agreement will be for the benefit of, and binding upon, the parties hereto and their respective successors and permitted assigns.

6. **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.

7. **Governing Law**. The interpretation and enforcement of this Agreement will be governed by the laws of the State of California. Exclusive venue shall be in Sacramento County, California.

8. **Headings**. The section headings contained in this Agreement are for reference purposes only and will not affect the meaning of this Agreement.

9. **Counterparts**. This Agreement may be executed in counterparts, each of which will be deemed to be an original, but all of which together will constitute one and the same.

Attachment 4B

Covered California Privacy and Security Training Manual, Participant Guide (pages 23-28)

COVERED CALIFORNIA

Course Name: Privacy and Security

Participant Guide

Version 1.0

6.1. LEARNING OBJECTIVES

At the end of this lesson you will be able to:

- ✓ Describe the penalties under the federal regulation
- ✓ Describe the penalties under the IPA
- ✓ Describe the penalties under IRS rules
- ✓ Describe the penalties under HIPAA
- ✓ Describe the penalties under the California Penal Code
- ✓ Describe employee sanctions

6.1.1. PENALTIES UNDER THE AFFORDABLE CARE ACT, 45, C.F.R. 155.260

Under the Affordable Care Act (ACA), information provided by applicants may be used only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange, and shall not be disclosed to any other person except as provided in the applicable section of the ACA (42 U.S.C. 18081(g).)

If applicant information is disclosed in violation of this section, the following penalty applies:

- Knowingly and willfully use or disclose information in violation of this section
- Civil penalty of not more than $25,000 per person or entity, per use or disclosure, in addition to other penalties that may be prescribed by laws (45 C.F.R. 155.260(g).)

6.1.2. PENALTIES UNDER THE STATE INFORMATION PRACTICES ACT (IPA)

The State Information Practices Act (IPA) imposes the following criminal penalties:

- To willfully request or obtain any record with personal information from an agency under false pretenses is a misdemeanor, punishable by a fine not more than $5,0000 or imprisonment not more than one year, or both (Calif. Civil Code, section 1798.56)
- Intentional disclosure of medical, psychiatric or psychological information is a misdemeanor if the wrongful disclosure results in economic loss or personal injury to the individual to whom the information pertains (Calif. Civil Code, section 1798.57)

Civil action: Any person, other than an employee, who intentionally discloses non-public information, which they know or should reasonably know, came from a state agency may also be subject to a civil action for invasion of privacy. In additional to general damages, a minimum of $25,000 may be imposed as exemplary damages, plus attorney fees and costs (Calif. Civil Code, section 1798.53).

6.1.3. PENALTIES UNDER IRS RULES

FTI can be used only for an authorized purpose and only to the extent authorized. The penalties for unauthorized disclosures of FTI can be high:

- It is a violation for any person to willfully disclose FTI without authorization, to willfully print or publish in any manner not provided by law any FTI, or to willfully offer any item of material value in exchange for FTI and to receive FTI as a result of such solicitation;

- These violations are felony offenses, punishable by a fine up to $5,000 and by imprisonment up to 5 years, or both (26 U.S.C. 7213)

The criminal penalties for unauthorized access to FTI are also high:

- It is unlawful for any person willfully to inspect FTI without authorization
- Such inspection is punishable upon conviction by a fine up to $1,000 or imprisonment up to one year, or both, together with the costs of prosecution (26 U.S.C. 7213A)

Civil action for damages: Any person who knowingly or negligently inspects or discloses FTI may also be subject to a civil suit for damages by the taxpayer whose records were seen or disclosed and be liable for $1,000 for each act of unauthorized inspection or disclosure, or the actual damages sustained by the taxpayer, whichever is greater (26 U.S.C. 7431)

6.1.4. HIPAA Penalties for Covered Entities and Business Associates

Under HIPAA, civil money penalties may be imposed upon both covered entities and business associates for violations of the HIPAA rules. The penalties are progressive and a minimum penalty may be imposed even if the covered entity did not know of the violation:

- For violations where the covered entity did not know and, by exercising reasonable diligence, would not have known, of the violation:
  - Minimum penalty of $100 per violation
  - Maximum penalty of $50,000 per violation
- For violations due to reasonable cause and not willful neglect:
  - Minimum penalty of $1,000 per violation
  - Maximum penalty of $50,000 per violation
- For violations due to willful neglect, but the violation is corrected within 30 days after the covered entity knew or should have known of the violation:
  - Minimum penalty of $10,000 per violation
  - Maximum penalty of $50,000 per violation
- For violations due to willful neglect and not corrected:
  - Penalty of $50,000 per violation
- For each tier of penalties, there is a maximum penalty of $1.5 million that may be imposed for identical violations within a calendar year

There are also criminal sanctions under HIPAA that can be imposed on covered entities:

- For knowingly obtaining or disclosing PHI in violation of the HIPAA rules, the penalties include a fine up to $50,000 and imprisonment up to one year
- If the offense is committed under false pretenses, the penalties include a fine up to $100,000 and imprisonment up to five years
- If the offense is committed with the intent to sell, transfer or use PHI for commercial advantage, personal gain or malicious harm, the penalties include a fine up to $250,000 and imprisonment up to 10 years

6.1.5. CALIFORNIA PENAL CODE PENALTIES

The California Penal Code makes it a crime to:

- Knowingly access and without permission alter, damage, delete, destroy or otherwise use any data, computer, computer system, or computer network to commit fraud or to wrongfully control or obtain money, property or data
- Knowingly access and without permission take, copy or make use of any data from a computer, computer system, or computer network, or take or copy any supporting documentation
- Knowingly access and without permission add, alter, damage, delete or destroy any data, computer, software or computer programs
- Knowingly and without permission disrupt or cause the disruption of computer services or deny or cause the denial of computer services to an authorized user of a computer, computer system or computer network
- These offenses are punishable by a fine up to $10,000, imprisonment up to three years or both fine and imprisonment. (Calif. Penal C., § 502(c)(1), (2), (4) and (5), and (d).)The Penal code also defines lesser offense that are punishable by fine and imprisonment in county jail.

6.1.6. EMPLOYEES

Any state employee who violates Covered California's privacy or security policies or procedures will be subject to the State Progressive Discipline Process.

In addition, under the IPA, the intentional violation of the IPA by an officer or employee of any state agency shall constitute a cause for discipline, including termination of employment. (Civil Code section 1798.55)

7. LESSON 6: REPORTING PRIVACY AND SECURITY INCIDENTS

This lesson focuses on the importance of reporting any suspected or actual incidents to protect Covered California's confidential information, data systems, services and networks. Diligence and immediacy in reporting is required to maintain privacy and security in Covered California.

7.1. LEARNING OBJECTIVES

At the end of this lesson you will be able to:

- ✓ Identify a security incident
- ✓ Identify a privacy incident
- ✓ Know how to report a security or privacy incident
- ✓ Understand the importance of immediate action to detect and report incidents

7.1.1. DUTY TO DETECT AND REPORT INCIDENTS

All Covered California staff and all contractors and vendors who have access to Covered California data systems, services or networks, or access to any confidential information (PII, FTI, PHI) that is collected, maintained, used or disclosed by Covered California, must

immediately report any incident that may affect the confidentiality, security or integrity of the data or the systems.

- This includes suspected incidents. You should not wait to confirm the incident happened, or to investigate what happened, but must immediately report any suspected incident.
- When you report an incident, Covered California Information Security Office staff can then take immediate actions to prevent harm and will direct you on what actions you need to take.
- The duty to report includes both security incidents and privacy incidents.

7.1.2. SECURITY INCIDENTS

A Security Incident is defined as:

> Any real or potential attempt (successful or unsuccessful) to access and/or adversely affect Covered California data, systems, services or networks, including CalHEERS data, systems, services and networks, and including but not limited to any effect on data availability, loss of data, disclosure of proprietary information, illegal access and misuse or escalation of authorized access.

Examples of security incidents include, but are not limited to:

- **Denial of Service** – an attack that prevents or impairs the authorized use of networks, systems, or applications by exhausting resources
- **Malicious Code** – a virus, worm, Trojan horse, or other code-based malicious entity that successfully infects a host
- **Unauthorized Wireless Devices Detection** – connecting an unauthorized wireless access point into a Covered California computer system
- **Unauthorized Access** – a person gains logical or physical access without permission to a network, system, application, data, or other IT resource
- **Inappropriate Usage** – a person violates acceptable use of any network or computer policies
- **Lost or Stolen Asset** – a Covered California or CALHEERS asset is lost or stolen or personal belongings of a Covered California employee or contractor are stolen at a work location

7.1.3. PRIVACY INCIDENTS

A Privacy Incident is defined as:

> The attempted or successful unauthorized access, use, disclosure, modification or destruction of Personally Identifiable Information (PII), Protected Health Information (PHI) or Federal Tax Information (FTI) or interference with system operations in an information system that processes, maintains or stores PII, PHI or FTI.

Examples of privacy incidents include, but are not limited to:

- **Fax** – papers with PII are sent to the wrong fax number
- **Mail** – a package containing papers with PII and PHI is mailed using standard U.S. postal service methods, but it arrives damaged and some papers may be missing or may have been seen by unauthorized persons
- **Oral** – two employees discuss confidential application information in a lobby area, where other people walk through and can overhear them
- **Public posting** – a list of service center representatives with their service center contact information is posted on a public website, but the list inadvertently contains their home addresses, phone numbers and names of their dependents
  Unauthorized access – a computer file with personal information on applicants, including income information, is sent to the wrong vendor who uploads it to the vendor's computer system and the file is accessed by the vendor's employees
- **Unauthorized use and access** – an employee wants to work at home to catch up on a backlog so sends files with applicants' personal information to his/her home computer, where a visiting nephew views the file when the employee opens it
- **Minimum necessary violation** – an employee needs to verify what information was received on a specific application, so downloads all applications received that day to make it easier to skim through them, looking for the one application that is needed

7.1.4. Reporting Security and Privacy Incidents

You must IMMEDIATELY REPORT a suspected or actual security or privacy incident to:

Your supervisor
Email: InformationSecurity@covered.ca.gov
Telephone: 916.539.4892

The Information Security Office monitors the email and telephone number several times a day and will respond to all reports of incidents. They will send you an Incident Report Form to fill out, which will ask for basic information about the incident. The Information Security Office staff will alert the Privacy Officer and other executive staff of the incident as needed and will forward reports to them. Either the Information Security Officer or the Privacy Officer will direct you on the next steps to be taken.

7.1.5. Immediate Action is Critical

Based upon the information they receive, the Information Security Officer and Privacy Officer will direct an investigation, determine what immediate action is needed, and develop a plan to identify gaps and to take corrective actions to prevent a future re-occurrence of a similar incident.

- Prompt action may mitigate harm by stopping continued inappropriate access to PII, PHI or FTI. For example, if personal information has been publicly posted, it can be removed and the persons whose information was exposed can be notified so that they can take steps to protect themselves.
- Further damage may be prevented by taking immediate steps to end unauthorized use or access. For example, if an electronic file with personal information has been sent to the wrong vendor, it can be identified and removed before anyone accesses it

Your diligence in immediately reporting any suspected or actual incident is essential to keep Covered California's confidential information and its data systems, services and networks safe and protected. With your help, Covered California can keep its confidential information and systems secure.

COVERED CALIFORNIA

February 12, 2014

The Honorable Loretta Sanchez
House of Representatives
1114 Longworth House Office Building
Washington DC 20515

Dear Congresswoman Sanchez,

Thank you for your interest in Covered California's outreach and enrollment efforts in our state's Latino communities. We appreciate the concern and share your commitment to the successful implementation of health reform. Although we are very proud of our current enrollment numbers, which now exceed 700,000 consumers, we agree that more effort and attention is needed to reach Latinos. I want to take this opportunity to give you an update on our plans to do so.

Based on the enrollment data we have collected on the 500,108 consumers who enrolled between October 1 and December 31, the share of individuals who identified as Latino was below what had been projected. Overall, our projected enrollment by the end March 2014 is expected to be 580,000; of that, 265,000 or about 46% are expected to be Latino. However, during the first three months, Covered California enrolled 74,000 self-identified Latino individuals, about 28% of the total. Enrollment in areas of that state that is heavily populated by Latinos, such as Los Angeles County, the Inland Empire, and the Central Valley, are also underrepresented.

The enrollment data clearly tells us that we need to do a more effective job in outreach, education and enrollment efforts that target Latinos. To help inform us of the changes that are needed in our approach, we've reached out to community leaders, stakeholders, elected officials, media and communications experts and requested input. We are now implementing their recommendations in four key areas:

- Expanding enrollment capacity
- Improving outreach efforts
- Increasing targeted marketing
- Enhancing regional enrollment efforts.

Expanding Enrollment Capacity:

The extraordinary consumer demand for health coverage has strained Covered California's capacity to provide high quality customer service. As a result, we are rapidly ramping up our service channels and adding staff resources to improve our operational performance.

To enhance customer service, Covered California is hiring 350 additional service center employees in order to bring down call wait times. As part of this effort, we are also ensuring that more bilingual staff members are added to support Spanish-speakers who wish to obtain information, or enroll in a plan using one of our three call centers. The hiring will be

accompanied by the expansion of our telephone line capacity, which will accommodate more callers and be able to absorb increased service traffic.

We have also developed additional self-service tools for consumers. Individuals will be able to find subsidized applications in several languages, including Spanish, both online and through our certified counselors. On our phone lines, we are developing interactive voice response applications to help route application-ready consumers to CECs and Agents for assistance. Those phone lines are also continuously updated to provide answers to top questions when callers are waiting for service.

To improve web functionality, we have made significant improvements to the Spanish version of the Covered California website. Major translation efforts have been implemented, and consumers can preview and select plans entirely in Spanish. Additional FAQs, consumer resources, and collateral materials are being created and added to the Spanish website based on post-enrollment survey comments. In preparation for March volumes, Covered California is optimizing network capacity to handle potential increased visits to the website.

Improving Outreach Efforts

Outreach and in-person services remain central tools for successful enrollment in the Latino community. To support in-person enrollment, Covered California has created additional resources in both Spanish and English to help enrollment efforts on the ground. For example, Local Resources Guides listing all available Certified Enrollment Entities, Agents, and County Eligibility Offices have been developed and made available for use at enrollment events, in addition to being distributed in public facilities for consumers. Paper calculators have also been designed and deployed: these guides help consumers understand eligibility for financial assistance and Medi-Cal. Finally, printed applications are also available in Spanish to support offline enrollment.

As of January 21, 2014, Covered California is supported by about 4,000 Certified Enrollment Counselors; 60% speak Spanish. To date, they have helped with over 8,000 events conducted to reach the Latino community. We also have certified over 10,0000 insurance agents, of whom about 14% are bilingual. As we need to do more to facilitate in-person enrollment, Covered California has increased its efforts to add more Certified Enrollment Entities, Counselors and Agents. We are working through our certification pipeline with a focus on adding more bilingual staff, and are adding capacity to existing Certified Enrollment Entities. As we expand our pool of on-the-ground staff, we are also establishing dedicated support telephone lines to help answer questions from our Counselors and Agents.

Increasing Targeted Marketing

In the area of marketing, Covered California has received new federal funding to help supplement our outreach to the Latino community. We have already implemented a revised, more aggressive Spanish Language media marketing plan with a focus on key markets with a high concentration of Latinos. Our partnerships with Weber Shandwick and Axis Agency – marketing firms with significant experience with the Latino community – will help us continue develop effective Spanish language creative content that will be deployed through TV, radio, direct mail, and digital marketing campaigns. Additional partnerships include our work with the popular broadcast network Univisión which will help provide custom content to educate and inform Latino consumers about the Affordable Care Act and Covered California in the form of

personal stories, news segments, health shows, Public Service Announcements and event support and promotion.

Enhancing Regional Enrollment Efforts

Finally, as we enter the final months of open enrollment, Covered California is launching regional grassroots efforts to boost enrollment in key, Latino-focused areas with an emphasis on Los Angeles, the Inland Empire, and the Central Valley. Our goal is to be more effective in reaching Latino's with in-person assistance with trusted community partners. In targeted areas, we are beginning organizing efforts that are bringing together our education and outreach grantees, certified enrollment counselors and agents, community organizations, and elected officials. These grassroots efforts will be driven by local partners to organize events with libraries, churches, cities, colleges and state universities.

Covered California continues to learn from this historic first open enrollment period and we will continue to adjust our strategies to ensure sensitive, appropriate marketing, effective outreach, and successful enrollment. We remain entirely consumer-focused and will use what we have learned to make the last months of enrollment successful.

Again, thank you for raising the concerns about our Latino enrollment efforts. We hope to work with you and other Members of the California delegation who share a commitment to the successful implementation of the Affordable Care Act. Please let me know if I can be of further assistance.

Sincerely,

Peter V. Lee
Executive Director

cc: Zoe Lofgren, Member of Congress
Lois Capps, Member of Congress
Mike Thompson, Member of Congress
Mike Honda, Member of Congress
Linda Sanchez, 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

Diana S. Dooley, Chair, Covered California Board

February 5, 2014

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

Re: CAC Program Regulations

Dear Ms. Soto-Taylor:

On behalf of the following organizations the California Pan-Ethnic Health Network, Consumers Union, Greenlining Institute and Western Center on Law & Poverty, we thank you for the opportunity to comment on the **Certified Application Counselor Regulations** which will help maximize enrollment for low-income communities into Covered California by expanding the scope of organizations certified to provide enrollment assistance. We appreciate the clarification in the regulations that non-QHPs must go through a certification process before they are designated as Certified Application Counselors (CACs). This is necessary to ensure that these entities and volunteer enrollment entities have proper oversight and abide by the same rules and regulations as other enrollment entities, including Navigators, Certified Enrollment Entities and Insurance Agents.

However, the regulations need much more clarification about the intended characteristics of Certified Application Entities. They appear to leave the door wide open to unnamed categories of Counselors. Without a clear definition of the proposed entities eligible to become Certified Application Entities, it is difficult to assess whether the proposed regulations include adequate protections for consumers. ***We respectfully request that the proposed regulations be re-noticed listing the characteristics or categories of organizations to which these regulations apply.***

We are additionally concerned that the regulations do not go far enough to ensure that consumers have access to culturally and linguistically appropriate information, and information that is fair and impartial. Our suggested improvements will strengthen Covered California's ability to assure consumers receive strong assistance in applying and enrolling in coverage for all certified entities and individuals.

Section 6852. Certified Application Entities

Subdivision (a): We appreciate the clarification that the following entities are *not* eligible to become Certified Application Counselors: Certified Enrollment Entities (CEEs), Certified Enrollment Counselors (CECs), Certified Insurance Agents, and Qualified Health Plan issuers.

However, the regulations fail to delineate the characteristics or types of organizations that may become Certified Application Entities (CAEs). The spirit of the CMS Guidance of July 12, 2013 is to include as Counselors only those entities that have experience providing social services to the community. The Guidance provides a long list of organizations as examples of those that could be designated as CAEs including but not limited to "community health centers such as federally-qualified health centers (FQHCs); hospitals; health care providers (including Indian Health Services, Indian tribes and Urban Indian organizations that provide health care); Ryan White HIV/AIDS providers; behavioral health or mental health providers; agencies that have experience providing social services to the community such as Supplemental Nutrition Assistance Program (SNAP) outreach, energy assistance, or tax assistance, which are either non-federal governmental entities or organized under section 501(c) of the Internal Revenue Code; and other local governmental agencies that have similar processes and protections in place such as other health care providers, health departments and libraries."

If these regulations are intended to apply to any entity other than a Local Health Initiative, Local Health Plan and County Organized Health System, Covered California should make that intention crystal clear in Section 6852, and should re-notice the regulations to provide an opportunity to analyze the regulations and to comment on whether we think they warrant more substantial consumer protections than those we seek in this letter.

We, therefore, urge Covered California to include in its proposed language for 6852 (c) the characteristics or list of categories of organizations to which these regulations are intended to apply:

> <u>(c) Certified Application Entities shall include Local Health Initiatives, Local Health Plans and County Organized Health Systems that are not Qualified Health Plans, as well as the following entities…</u>

Additionally, we request the regulations make it clear that CAEs must be capable of serving California's diverse populations as the federal Guidance recommends. Specifically we request an additional provision that states:

> (d) Covered California will include organizations as Certified Application Entities that serve a variety of different populations, such as individuals with limited English proficiency, people with a full range of disabilities, people of any gender identity, people of any sexual orientation, vulnerable, rural, and underserved populations.

Section 6854. Certified Application Entity Application

Subdivision (a) (4) (B) (i): We appreciate that the executed agreement will include assurances that the CAC entity will comply with applicable federal and state requirements with respect to privacy and security standards. We urge adding a citation here back to Section 6866 (a) clarifying that entities will be required to disclose potential conflicts of interest on the application, as it is not clear to us that that is intended under the current draft regulations. We encourage Covered California to adopt the following language:

> (i) An executed agreement conforming to the Roles and Responsibilities defined in Section 6864 and conflict of interest standards defined in Section 6866 (a) and provided in the application provided by the Exchange.

Subdivision (b) 11-13: We strongly support the requirement that entities state whether they serve families of mixed immigration status and persons with disabilities including the disabilities served.

Subdivision (b) 15: We appreciate that the Exchange has included a space for applicants to indicate if they have received Outreach & Education Grants and/or the Department of Health Care Services grants for outreach and enrollment. We ask that the applicant's adherence to their contract, including if they met or did not meet performance standards, also be explained in this field.

Subdivision (b) (16) J-M: We appreciate the requirement on the application that entities specify for the primary and each sub-site the languages spoken by staff, written languages, an indication of whether the entity or individual offers services in sign language and ethnicities served. We urge Covered California to require entities to provide percentages or numbers of individuals served in other languages/ethnicities. We also point out, as we have in other contexts, that the term ethnicity in the context of the OMB standard used in the American Community Survey (ACS) and the 2000 and 2010 Decennial Census only refers to Hispanic, Latino/a and Spanish origin. Therefore, the

regulations should require applicants to list race as well as ethnicities served by each entity. Specifically we recommend the following changes:

> (J) Percentage of total individuals served in each spoken languages;
> (K) Percentage of total individuals served in each written languages;
> (L) An indication of whether the entity or individual offers services in sign language and a percentage of the total individuals served in that language;
> (M) Percentage of the total individuals served in each race and ethnicity;

In addition, we think it would be helpful to include, as the federal Guidance suggests, the following questions on the application:

- Whether the organization has already been designated by the Department of Health Care Services as a Medicaid Certified Application Counselor (MCAC);
- Whether the organization screens the employees and volunteers it will certify as application counselors; and
- Whether the organization or the employees and volunteers it intends to certify already handle personally identifiable information, and the organization's experience, if any, assisting individuals applying for health coverage.

Section 6856. Certified Application Counselor Application

Subdivision (b) (7-8): We appreciate that the application for Certified Application Counselors will require applicants to indicate both written and spoken languages.

Section 6860. Training Standards

Subdivision (b) (2): We support requiring CACs to undergo training on the range of insurance affordability programs, including Medi-Cal. We urge Covered California to include experts on public benefits programs such as the Health Consumer Alliance and its support center partners from the Western Center on Law and Poverty and the National Health Law Program, in reviewing and advising on the content of the trainings.

In linking Californians to coverage, it is critical that CACs be equipped to work with the range of diversity we have in our state. This includes families with mixed immigration status and persons with conditions that might be well served by existing government-funded programs. As such, we would also add to this provision additional language:

> (b) (2): "The range of insurance affordability programs, including Medicaid, the Children's Health Insurance Program, and other public programs, including but not limited to county coverage options for those who continue to be medically indigent, and county, state, and federal programs that serve populations with specific illnesses or disabilities;

Subdivision (b) (8-9, 12): We appreciate that CACs will be trained in the provision of culturally and linguistically appropriate services, ensuring physical and other accessibility for persons with disabilities and working effectively with individuals with limited English proficiency, people with a full range of disabilities, people of any gender identity, people of any sexual orientation, and vulnerable, rural, and underserved populations.

As part of the above training, we urge Covered California to ensure that the CAC training include background information on Section 1557, the non-discrimination provision under the Affordable Care Act, as it applies to state Exchanges and entities contracting with state Exchanges including CACs.

Section 6864. Roles and Responsibilities

Ensuring Unbiased Information in the Consumer's Best Interest:
Subdivision (a) (1): As drafted, the regulation appears to allow all sorts of for-profit interests, including non-QHP commercial plans, to serve as Certified Application Counselors. While it is difficult to anticipate the range of possible improper actions by Counselors motivated more by their own interest, the risk exists of inappropriate steering, for example, *away from* Exchange products to capture leads for products outside Covered California.

The more rigorous standards present in other regulations, for example related to plan-based enrollers employed by QHP issuers, are absent here. We urge you to add specific language to make it clear that inappropriate steering is not permissible. Specifically, we recommend the following regulatory language:

(1) Provide information to individuals and employees about the full range of QHP options and insurance affordability programs for which they are eligible. <u>Information presented must be clear and it must be apparent to potential applicants that they are free to choose among all of the QHPs offered. Language encouraging or discouraging potential applicants to select a particular plan or plans is prohibited. CACs will not engage in any activity that results in adverse selection for or against a particular plan.</u>

Marketing and Branding:
Subdivision (a): We strongly suggest adding several bullets specifying that CAEs must, at a minimum, comply with the Covered California marketing and co-branding requirements. Depending on the scope of intended CAEs, not yet defined in the regulation, further conditions may be appropriate. For now, we suggest the following regulatory language:

<u>(8) CAEs shall comply with the Covered California co-branding requirements relating to the format and use of Covered California logo and information. CAEs</u>

shall include the Covered California logo and other information in notices and other materials based upon the mutual agreement of Covered California and CAEs.

(9) In order to promote effective marketing and enrollment of individuals inside Covered California, CAEs shall provide Covered California with marketing materials and all related collateral materials used by CAEs for Covered California and non-Exchange plans on an annual basis and at such other intervals as may be reasonably requested by Covered California.

(10) CAEs and their employees may not: Conduct door-to-door marketing; influence the selection of a QHP or select a QHP for the potential applicant while providing application assistance; receive an application fee; sponsor a person eligible for the program by family contribution amounts of co-payments.

Culturally and Linguistically Appropriate Services:
Subdivision (a): We strongly disagree with Covered California's assessment that there is no requirement for CAEs to provide services in compliance with Culturally and Linguistically Appropriate Service (CLAS) standards when they are unable to do so.

CAEs such as Local Health Plans have an independent obligation to comply with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of national origin. As such, they are required to provide language assistance services to their enrollees. Moreover, these entities are already required to meet cultural and linguistic access standards as part of their Medi-Cal Managed Care contracts (MMCD Policy Letter 99-03).[1] We urge Covered California to clarify in the regulations that all enrollment entities contracting with Covered California whether CEEs, Navigators, Insurance Agents or CAEs are required to comply with cultural and linguistic access standards as set forth in 45 CFR, Section 155.215 (c). Specifically, we urge Covered California to include the following provisions in the regulations for Certified Application Entities:

(a) (7): To ensure that information provided as part of any consumer assistance is culturally and linguistically appropriate to the needs of the population being served, including individuals with limited English proficiency as required by 45 CFR §§ 155.205(c)(2) and 155.210(e)(5), Certified Application Entities and Certified Application Counselors shall:
   (1) Develop and maintain general knowledge about the racial, ethnic, and cultural groups in their service area, including each group's diverse cultural health beliefs and practices, preferred languages, health literacy, and other needs;

[1] Department of Health Care Services, MMCD Policy Letter 99-33: http://www.cpehn.org/pdfs/Policy%2099-03%20Linguistic%20Services.pdf

(2) Collect and maintain updated information to help understand the composition of the communities in the service area, including the primary languages spoken;

(3) Provide consumers with information and assistance in the consumer's preferred language, at no cost to the consumer, including the provision of oral interpretation of non-English languages and the translation of written documents in non-English languages when necessary to ensure meaningful access. Use of a consumer's family or friends as oral interpreters can satisfy the requirement to provide linguistically appropriate services only when requested by the consumer as the preferred alternative to an offer of other interpretive services;

(4) Provide oral and written notice to consumers with limited English proficiency informing them of their right to receive language assistance services and how to obtain them;

(5) Receive ongoing education and training in culturally and linguistically appropriate service delivery; and

(6) Implement strategies to recruit, support, and promote a staff that is representative of the demographic characteristics, including primary languages spoken, of the communities in their service area.

Subdivision (h): We recommend an additional bullet clarifying that the information presented by CACs must be accurate and not misleading:

(h) All CAC representations must be accurate and not misleading.

Additionally, CAE and CAC applications should be tracked as are CEE and CEC applications. We propose the following additional language:

(i) Covered California will track the applications assisted by CAEs and CACs. Covered California will periodically survey new subscribers assisted by CAEs and CACs and conduct preliminary reviews of all allegations of questionable application assistance provided by CAEs and CACs.

Thank you for your time. We look forward to discussing our concerns and recommendations with you. Please contact Cary Sanders at (510) 832-1160, csanders@cpehn.org should you have any questions.

Sincerely,

Caroline B. Sanders, California Pan-Ethnic Health Network
Betsy Imholz, Consumers Union
Carla Saporta, Greenlining Institute
Vanessa Cajina, Western Center on Law & Poverty

February 19, 2014

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

Re: CAC Program Regulations

Dear Ms. Soto-Taylor:

On behalf of the following organizations the California Pan-Ethnic Health Network, Consumers Union, Greenlining Institute, Health Access, and Western Center on Law & Poverty, **we write to express our concerns regarding the current draft Certified Application Counselor (CAC) Regulations and to request that a final vote on the regulations be delayed to the next Board meeting.**

We deeply appreciate staff's willingness to meet with us on two separate occasions to discuss the concerns raised by us in our February 5, 2014 letter. We are thankful to staff for adopting several of our more substantive recommendations, including extending some of the same regulatory protections and requirements as those in the CEE program to the CAE program with regards to: 1) ensuring unbiased information in the consumer's best interest; 2) establishing clear marketing and branding protocols; and 3) requiring the provision of Culturally and Linguistically Appropriate Services.

In choosing to leave out specifics as to the categories of entities for which these CAC regulations are intended to apply, Covered California appears to be leaving the door wide open to unnamed categories of Certified Application Counselors including pharmacies, substance abuse treatment providers, vendors for hospitals specializing in reducing hospital bad debt, or other entities with an inherent conflict of interest, as well as public libraries and other settings. While we appreciate Covered California's efforts to maximize enrollment through partnerships with uncompensated entities we are concerned that the regulations, as drafted, are not adequate to protect consumers, particularly given the very broad range of entities covered by the proposed regulations. Unfortunately, our subsequent conversations with staff only further exacerbated our concerns.

We appreciate the addition of language regarding clear prohibitions on problematic activities as well as conflicts of interest, but the proposed language was provided to us after noon on the day before the Board meeting. In a quick, initial review, we note that the disclosure of conflict of interest requirements should extend to consideration from health insurance agents as well as other entities that have an inherent conflict of interest.

For these reasons we respectfully request that the proposed regulations be re-noticed to allow consumer advocates sufficient time to work with staff to establish stronger consumer protections for the CAC program.

Thank you for your time. We look forward to discussing our concerns and recommendations with you. Please contact Cary Sanders at (510) 832-1160, csanders@cpehn.org should you have any questions.

Sincerely,

Caroline B. Sanders, California Pan-Ethnic Health Network
Betsy Imholz, Consumers Union
Anthony Wright, Health Access
Vanessa Cajina, Western Center on Law & Poverty

cc: Peter Lee
Covered California Board members

February 4, 2014

Sarah Soto-Taylor, Deputy Director of Community Relations
California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814

RE: Stakeholder comments on the proposed Certified Application Counselor Program

Dear Ms. Soto-Taylor:

We at the California Primary Care Association (CPCA) and Latino Coalition for a Healthy California (LCHC) have been actively engaged in educating and enrolling the Latino community, knowing that this community is the key to success for ACA implementation. CPCA represents nearly one thousand health center sites across California that are committed to providing care to all Californians. LCHC, a trusted voice for Latino health for over 20 years, has assisted decision-makers throughout California to develop policies, services and the social, economic, and environmental conditions that improve the health of Latinos. We appreciate the opportunity to provide comments on the proposed Certified Application Counselor program presented to stakeholders on the Certified Application Counselor Program Regulations Webinar on January 28, 2014.

In the overall and section specific comments provided below, you will see that we are hopeful that Covered California will see the program's development and implementation as an opportunity to increase Latino-serving organization's involvement in Covered California enrollment assistance programs with the ultimate goal of increasing Latino enrollment into programs of coverage.

We, like Covered California, are hopeful that Latino enrollment will continue to rise but we continue to be concerned by the lack of on-the-ground support for Community Based Organizations (CBOs) and see the Certified Application Counselor Program as an opportunity to do just that. With heightened interest on increasing Latino enrollment, we strongly encourage Covered California to incorporate financial support for Latino-serving organizations to participate in this opportunity. As we mention below, not only should Covered California pay for the onboarding costs associated with background checks, but money should be directed to organizations with a commitment to hiring Certified Application Counselors that are fluent in the language of their community. Lastly, to attract the small, local community based organizations that have so far steered away from the Outreach and Education Grant and Certified Enrollment Entity Program, funding must be provided to support the day-to-day operations of an application assistance program.

Section 6852 Certified Application Entities

- To guarantee a diverse Certified Application Entity pool that is representative of, and trusted by, the community it aims to serve, we recommend that Covered California initiate a targeted outreach campaign. This work may include revisiting institutions that were subcontractors of Outreach and Education Grants or using the existing network of Certified Enrollment Entities (CEE) to attract their community partners to the Certified Application Entity role.
- With no discussion on the webinar or in the proposed regulations on funds to support this program, we are concerned that financial realities of running a small community based organization may undermine the ability of Covered California to attract organizations to this opportunity. With this in mind we strongly encourage Covered California to designate financial support to this program. In particular, we recommend:
    1. Money should be directed to organizations with a commitment to hiring Certified Application Counselors that speak a language other than English and are fluent in the language of their community.
    2. Recognizing that these organizations may not have the cash on hand to support the startup costs associated with being a Certified Application Entity, we request that all support monies be provided upfront.
    3. Covered California create an upfront grant program that incorporates: (1) all onboarding costs associated with Certified Application Entity and Certified Application Counselor application process and (2) funds to support the day-to-day operations of an application assistance program for organizations that have the geography, language fluency, and cultural competency to reach targeted enrollment groups.

Section 6854 Certified Application Entity Application

- To increase the likelihood of a diverse Certified Application Entity pool, the Certified Application Entity application must be made available in all threshold languages.
- In addition to the online entity application, a paper application must also be made available.
- Recognizing that some of the very organizations that considered, but were deterred from completing, the outreach and education grant application or the CEE application may be pursing this opportunity, we recommend that Enrollment Assistant Support staff, similar to those available for current CEE and CECs, be made available to provide application support to all entities.
- Similar to the CEE application, we are concerned that the “proof of general liability insurance with coverage of no less than $1,000,000 per occurrence…” will again be prohibitive to the participation of community based organizations, we encourage that this general liability insurance requirement be reduced or removed.
- All entity applications should include a question asking whether or not the applying entity is in need of financial assistance to support their application assistance work. Particular attention should be given to providing financial support to those organizations that identify themselves as serving families of mixed immigration status.

Section 6856 Certified Application Counselor Application

- We ask that many of the lessons learned from the cumbersome nature of Certified Enrollment Counselor (CEC) application process be applied to the Certified Application Counselor application process.
- In particular, we ask that the process of having on-site fingerprinting at all counselor trainings continue.
- As mentioned above in reference to the Certified Application Entity application, we request that Enrollment Assistant Support staff, similar to those available for current CEE and CECs, be made available to provide application support to all persons applying to be counselors.
- Recognizing that there are still too many CECs with applications processing, some of whom have been waiting two to three months to get badged, we ask that every effort be made to continue processing those CEC applications and that no resources that are dedicated to that effort be redeployed for the processing of Certified Application Counselor applications until all persons in the system are badged.

Section 6858 Certified Application Counselor Fingerprinting and Criminal Record Checks

- As referenced above, with ongoing challenges in the processing of CEC applications, in particular long delays in the criminal record check process, criminal record check issues must be addressed in order to not only complete the processing of CECs left in limbo, but also to minimize the time from fingerprinting to badging of the future Certified Application Counselor applicants.
- To encourage diverse Certified Application Counselor applicants, make all CEC forms, including forms used for fingerprinting and criminal record check, accessible in all threshold languages.
- As many Certified Application Counselor candidates are already employees of their Certified Application Entity and, as such have already completed a background check, we urge that Covered California honor the background check process of that organization.
- If Covered California is unwilling to honor the internal background check process of that entity, Covered California should pay for the cost of fingerprinting.

Section 6860 Training Standards

- We strongly encourage the prioritizing of training for a geographically and linguistically diverse cadre of enrollment counselors.
- Currently, limited training opportunities for enrollment counselors with limited English proficiency exist. Recognizing this, we encourage Covered California to increase trainings provided to limited English proficiency counselor populations.
- To maximize our success enrolling Latino communities, training materials and support documents such as FAQs, must be available in Spanish.
- Training content must also be updated to be able to address the unique enrollment questions of our Latino community including, but not limited to, enrollment of mixed-status families, enrollment of DACA youth, and other special populations.

We appreciate the opportunity to provide stakeholder feedback regarding the proposed Certified Application Counselor Program. If you would like to discuss these matters further, please contact Beth Malinowski,

Associate Director of Policy, California Primary Care Association at bmalinowski@cpca.org or Rebecca DeLaRosa, Director of Policy and Legislative Affairs, Latino Coalition for a Healthy California at rdelarosa@lchc.org .

Sincerely,

Beth Malinowski, California Primary Care Association

Rebecca DeLaRosa, Latino Coalition for a Healthy California

HEALTH ADVOCATES

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February 3, 2014

Daniel Eliav
Attorney
Covered California
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RE: Draft Regulations, Certified Application Counselors Program

Dear Daniel,

Thank you for allowing Steve and me to review the draft regulations for the Certified Application Counselors (CACs) and Certified Application Entities (CAEs). Below, we have made some general comments and have also addressed specific provisions of these regulations.

GENERAL COMMENTS

Although the draft regulations and the proposed CAC framework address a number of the concerns that we had with the CEE/CEC regulations, we continue to feel that the existing "authorized representative" relationships with applicants for Medi-Cal and other health benefits programs should be supported to continue as they have successfully existed for several decades. We strongly believe that eligibility vendors that act as or employ authorized representatives can incorporate Exchange-related services and insurance options in their scope of services without becoming CACs. In addition, hospitals that have trained their staff to assist patients in obtaining coverage for Medi-Cal and other programs can perform these functions, utilizing the Exchange where appropriate, without becoming CAEs/CACs.

More importantly, we are concerned that many organizations and individuals that get certified as CAEs/CACs will find the proposed CAC rules to be incompatible with how they normally conduct eligibility and enrollment functions and will simply ignore these rules. (This would include most hospitals and experienced eligibility vendors.) This will cause a situation of mass non-compliance and create enforcement responsibilities for Covered California. Moreover, it will punish hospitals and vendors that do comply with the rules, as they will not able to operate as effectively and will be at a competitive disadvantage. We had expressed the same concerns regarding the CEE/CEC regulations, and the problems are repeated in the proposed CAC regulations, albeit to a lesser extent.

At least in the early stages, Health Advocates and other eligibility vendors, as well as hospitals, will rarely use CalHEERS and the Exchange to obtain coverage. Nevertheless, it is extremely important that their access to CalHEERS be efficient. Therefore, eligibility vendors and hospitals should be able to access more than one CalHEERS account in a single sign-on, and be able to directly sign-on, versus requiring the applicant to sign on and then designate an authorized representative somewhere in the middle of the application.

Experienced eligibility vendors and hospitals should not be made to go through the application processes, contracting, training, and reporting requirements that are proposed in the draft regulations for CACs, especially since these groups

will only occasionally use the Exchange when assisting applicants. Below, we have proposed an alternative that would allow some qualified entities to comply with the CAC requirements through self-certified compliance and training.

COMMENTS ON SPECIFIC PROVISIONS OF THE DRAFT REGULATIONS

§6850 Definitions

The term "authorized representative" is only mentioned once in the draft regulations, and that is under the definition of "Consumer" in §6850. It is unclear how an "authorized representative" would act as a Consumer. Could we discuss?

In the industry, an authorized representative can be either an organization, such as Health Advocates, or an individual, such as an employee of Health Advocates. Depending on the line of business and the applicable laws, sometimes an individual person must act as an authorized representative, and sometimes it is required that an organization act as an authorized representative. It appears that under the draft regulations, an authorized representative can be a "Certified Application Entity" or a "Certified Application Counselor." Is that correct? If so, we will need to understand how this distinction will comport with normal practices of authorized representatives.

There are already definitions of "authorized representative" in the new statutes and regulations related to the Exchange. (See tit. 10, ch. 12, art. 2 §6410, and W&I Code §14014.5(g)(1) [which addresses Medi-Cal services under the Exchange].) How will these definitions square with the concept of authorized representatives under the CAC?

§6852 Certified Application Entities

Subsection (a) is not clearly written. Do you mean to exclude the entities listed in (1) through (3) from eligibility to be a CAE? Subsection (b) is not clear as to who needs to have a "valid license, authority, certificate, or registration".

§6856 Certified Application Counselor Application
§6860 Training Standards

For large organizations (e.g., those that have 100+ employees), and that have constant turnover, these CAC application and training processes are extremely burdensome. CAC-type staff experience significant turn-over, and it will be a burden on both the Certified Application Entity and the Exchange to continually process the constant adds and deletions of such CACs and the frequent training of the new hires. Also, when a hospital requests an onsite representative, the need is immediate. The Exchange's processes may be lengthy and Certified Application Entities would not be able to quickly fill the need. For some entities (hospitals and established vendors), there should be arrangements for internal compliance and training (e.g., creating internal "certified" CAC trainers and processes to timely bring on new staff versus each individual being processed via the Exchange). There should be criteria, subject to audit, for such internal administration of compliance and training.

§6864 Roles and Responsibilities

§6864 (a)(1) and elsewhere: CACs provide various services to "individuals and employees" as stated throughout this section of the regulations. What does the concept of "employees" mean in this context?

§6864(b): This subsection refers to an "Authorization Form". Although capitalized, this term is not defined. The Authorization Form is crucial to getting consent from the applicant for the broad scope of services that authorized representatives can perform, and also getting permissions for other facets of the process, not normally known (e.g., permission to use auto dialing when reaching patients, as required by federal law, permission to contact relatives and others who have information necessary for processing Medi-Cal and other benefits applications, etc.). Thus, there are a

number of specific provisions that eligibility vendors need in their authorization forms that could differ from vendor to vendor depending on the individual vendor's scope of services. A "standard" authorization form will not give most individual eligibility vendors the authority to perform their full scope of services. Also, within the CalHEERS system, the Authorization Form first appears after several screens, which is counter to the authorized representative's role of aiding the applicant from the very onset of the process (or even without the applicant present and involved in the application process if the applicant is mentally or physically incompetent).

§6864(f): This subsection prohibits charges to Consumers "for application and other assistance related to the Exchange". The language "related to the Exchange" is very broad. Please note that there are some instances where there is statutory authority for charging applicants for help in applying for benefits once benefits are obtained (e.g., Social Security SSI/SSD, where such fees are approved by Social Security). Because authorized representatives may help applicants in obtaining benefits from various sources, it is not clear whether the language limitation in (f) would prohibit authorized representatives from collecting fees otherwise allowed by law.

§6866 Conflict of Interest

§6866(a): This subsection appears extremely broad and more restrictive than for the comparable provisions for CEEs/CECs, since it includes disclosing to the Exchange and potential applicants "other potential conflicts of interest". Authorized representatives may have relationships with insurers and QHPs, other federal and state programs, hospitals and clinics. Such multiple disclosures will confuse applicants and discourage them from going forward, when there would be no real threat to benefits but only a "potential" of a conflict.

REMAINING UNRESOLVED ISSUES

I hope that the above comments and questions will be helpful in moving forward with the draft CAC regulations. However, we wish to reiterate that eligibility companies that act as or employ authorized representatives have had procedures in place for several decades that work well and benefit individuals, health care providers, and the various government agencies that oversee healthcare related programs. Hospitals themselves also often have eligibility staff that shepherd patients through the Medi-Cal application process.

The regulatory and operational framework established for the Exchange has created numerous pitfalls that will seriously impede the normal processes that hospitals, eligibility companies and the applicants themselves have relied on for decades. The roles that have been assigned to the various stakeholders (the CEEs/CECs, CAEs/CACs, Navigators) and several aspects of the CalHEERS system will create vulnerabilities in the enrollment process that will result in many applicants not obtaining coverage, losing coverage once obtained, and not gaining other related benefits including payments of outstanding medical bills. These vulnerabilities need to be addressed and corrected at the very outset, as procedures are being put in place, in order to avoid continuing problems. Some of these vulnerabilities are as follows:

- There is no system in place for a hand-off of an application to another party when a CEC, a CAC, a hospital, or applicant is unable to complete it, since many applications initiated in the hospital will not be completed without significant follow-up outside the facility (e.g., how to transfer and share volumes of Pins and Passwords between the parties).

- There is no procedure whereby the CAC or CEC will receive notices on behalf of the applicant, and therefore cannot perform follow-up functions. The system leaves the responsibility of following-up solely to the applicant, who often does not have the incentive or the mental or physical ability to so. This will likely result in volumes of submitted but closed applications due to the lack of follow-up.

- Unless faced with a current illness, most individuals do not have incentives to sign up for a QHP or Medi-Cal or to bother to complete the process. CECs and CACs will generally not have the experience or expertise to qualify applicants for other programs where the applicant might see more immediate personal gains inspiring cooperation (e.g., Third-Party Liability, Social Security Disability payments). Authorized Representatives have that expertise and resources. However, the CalHEERS system and the Exchange do not provide the mechanisms to help applicants with these programs that will keep them engaged in the QHP/Medi-Cal process. Therefore, Authorized Representatives will need to continue to operate outside the established stakeholder categories (and using processes and forms outside the Exchange) in order to adequately serve the applicants. Sometimes more than one enrollment or recovery source is pursued concurrently until the certainty of the outcome is known and, therefore, there must remain an efficient means to quickly cancel a submitted application via CalHEERS should another primary source of recovery be confirmed.

- An Authorized Representative must be able to sign up applicants, when acting as an organization rather than signing up applicants acting as individual representatives. A single-sign on will avoid the burdensome process of the organization going through the CalHEERS sign-on process for each applicant rather than a single time to process multiple referrals from the same hospital. Also, a vendor often must coordinate applications and eligibility processing relative to multiple admissions to different facilities and between more than one vendor over an extended appeals or Fair Hearing case.

- Many applications will not be approved for a variety of reasons. CECs, CACs, and other stakeholders do not have the expertise or the staff to conduct appeals through potentially multiple levels. How will handoffs of applications between CECs, CACs, to Authorized Representatives be accomplished logistically via CalHEERs and in a manner to permit the Authorized Representative full access to the complete history on the case to allow appropriate representation to overcome appeal issues?

- The situation will arise where a hospital initiates or submits a Medi-Cal application via CalHEERS and then an Authorized Representative or other party begins a full Medi-Cal application through the County, where two applications then are being processed for the same individual. Is there a process for the County to be able to reconcile two or more of such applications from different sources (and preferably favoring the information on the full application (SAWS2Plus) which is likely to facilitate in a more accurate determination of coverage)?

Thank you again for this opportunity, and we appreciate all of the fine work that your team is doing.

Best Regards,

Tallien Perry
General Counsel and Chief Security Officer

Copy to: Steve Levine
Chief Operating Officer

MOMP
Medical Office Managers of the Peninsula

Kim Griffin, RN

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pedihearts@sbcglobal.net

February 18, 2014

Peter Lee
Director
Covered California
560 J Street
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info@covered.ca.gov

Re: Covered California Website Errors, Errors on Provider Lists, Commercial Plans "Silent PPOs," Request for Reimbursement

Dear Mr. Lee,

As chair and on behalf of Medical Office Managers of the Peninsula I am writing to advise you of the hardships, confusion, and loss of revenue created by recent problems with the Covered California website. Our manager group represents approximately 100 private practice primary care and specialty group physicians in San Mateo County. Several of our offices have learned they have rendered care to patients who present with new Blue Shield insurance cards, but without the Covered California logo on the cards. Many of the patients have advised office staff their physicians were listed as in-network providers; however, our offices are now finding we are in fact not contracted with these plans.

Additionally we have been advised by California Medical Association that Covered California has agreed to allow the insurance companies to sell products through the Covered California website that are NOT Covered California products. Some of those products are being sold under the names of the following: Enhanced Plan, Ultimate PPO, and Basic PPO. We are also aware the provider lists on the Covered California site have been inaccurate.

While some of our practices are contracted with the commercial carriers for Covered California products; many of us have opted out of the products due to poor reimbursements associated with these plans with the exception of HealthNet who is offering the same contracted rate to the physician equivalent to the contracted rates for all of their plans. We are all sorely aware of the inequity in reimbursements offered to private practice physicians in Northern California where it is very expensive to operate a

medical practice. We find Covered California and the insurance companies have created a serious barrier to access to care for the customers purchasing both Covered California plans as well as the commercial plans offered through the website.

All of the plans must be presented with transparency for both patients and providers. There can be no mistakes on the provider lists. The current confusion and errors on the provider lists and plans have created a tremendous administrative burden and financial hardship for the offices who must now try to decipher which plans they might actually be contracted with and in essence; coping with a "Silent PPO" created by Covered California. Many patients must be contacted and advised they saw a physician who was out of network. Ultimately, the physicians are not reimbursed. The extra time now spent on verifying eligibility and resolving all of the problems amounts to significant overhead costs for each practice; therefore, we are requesting reimbursement at the non-contracted rate for patients who our practices saw in good faith. It is our belief that Covered California in conjunction with the insurance companies should accept responsibility and make each practice whole.

Sincerely,

Kim Griffin, RN

CC: Health Care Liaison Gov. Brown
California Medical Association
San Mateo County Medical Association
California Assembly Member Jerry Hill
California Assembly Member Keven Mullin
Dr. Jeffrey Rodout, Covered California

To: Peter Lee, Executive Director, Covered California

Cc: Kimberly Belshe, Board Member, Covered, California
Diana S. Dooley, Board Member, Covered, California
Paul Fearer, Board Member, Covered, California
Susan Kennedy, Board Member, Covered, California
Robert Ross, MD, Board Member, Covered, California

Cc: Governor Jerry Brown
Congressman Henry Waxman
Senator Barbara Boxer
Senator Diane Feinstein
Insurance Commissioner Dave Jones

Date: January 22, 2014

Unacceptable, repeated operational failures and policy decisions at CoveredCa

Dear Mr. Lee,

I'm a 56 year old father of 3. I have been a supporter of Democratic causes and the Affordable Care Act, in principal. I have never been an "activist", and never written a letter like this. But I feel the commencement of Covered California's marketplace is one of the worst managed organizational launch experiences I have witnessed in my life. Even accounting for "start-ups", growing pains and errors made by the Federal government, there are policy and operational failures which should not be tolerated by your ultimate shareholders, the citizens of California. Though the first complaints are primarily due to market (let's say "oligopolistic") forces, others are down to your own operations management failures and policy decisions. For the latter, I feel that you, and the Board, should be held accountable.

1. **A Premium increase of 251% for a family headed by a 56 year old, by any measure, is egregious anywhere outside of Zimbabwe**

   We were told that premiums increases would principally hit the young and healthy in order to subsidize the uninsured and poor. The "on the ground" reality is far worse than the government spin. And please do not lecture me that my prior policy was inferior. It was suitable precisely for our needs.

2. **Given the premium explosions, virtually all coverage Bronze/Silver/Gold is de facto "catastrophic coverage" for the majority of the population, if you look at the economics**

   Given our new premiums and the deductibles, our insurance cover will only benefit us if we have a scenario never encountered in our lives, an annual medical cost in excess of $20,000. Some might say "you've been lucky", but I would argue our case is the same for the majority of individual policy holders. In effect, the only value is if there is a

catastrophic health event. Annually. I know that happens to some with life threatening illness or accidents, but not for the vast majority of the population.

3. **Covered California has rejected numerous reliefs proposed by California's Senators, the California insurance commissioner and the President, while citizens in the vast majority of U.S. have benefited**

Who does Covered California work for? Who's interests do you represent, as it does not appear to be the citizens of California? Citizens in the majority of the U.S., in all Federal marketplace states (35) will benefit from 1 year of relief by being able to keep their existing plan if it was cancelled and no penalties. This is also true for many other state run marketplaces, but not California. Why not?? California is a Democrat majority state - our elected representatives, Senator Feinstein and Senator Boxer, were elected to be our voice. They supported the Presidents proposed relief for the coming year in the way of grace periods, the ability to keep your existing policy, suffer no penalties, etc. The Insurance Commissioner of California, Dave Jones, agreed. You chose to ignore all of them. This will push the burden of growing pains and cost on to the individual consumer instead of the insurance companies. To be blunt, who exactly do you work for? If you go against your shareholders, you should be out of a job.

4. **You and the board have to get out of your ivory tower**

Though the press and legislators may have more ready access, your shareholders, the people of California, do not. Your website and call centers are obtuse as to how to get a message or complaint to management. Getting a message to the board is virtually impossible. Every commercial company I know has "Investor relations" which is easily accessible, where an investor can get a message to senior management or the board. Your investors are the citizens of California. I got nowhere through calling Covered California and had to make numerous calls elsewhere, finally to the California Department of Health and Human Services in order to have Drew Kyler in External Affairs call me back so I could make my observations known.

5. **Complaints go unanswered**

On December 26th I filed a complaint sent to appeals@covered.ca.gov. No confirmation, no response one month later.

6. **Covered California failed at the most critical time, repeatedly**

   With a deadline of December 23rd, I repeatedly attempted to phone from December 19th and was only disconnected. Phoning multiple times per day, I was only able to reach someone on December 26th

7. **Individuals are penalized for non-performance, what is the penalty for insurance companies for non-performance?**

   We paid our premiums on Dec 10th. On January 6th my wife had to get a prescription refilled. We had not yet received any ID cards from Blue Shield (and still have not). She repeatedly tried to phone, finally got through and spoke to a supervisor who promised a call to a pharmacy, then back to my wife. No call came. We paid 100% in cash. On January 10th, still no ID cards, my son was ill and had to see a doctor. Same story, we had to pay 100% in cash, after suffering a premium increase of 251%. Today my daughter has to go for 2 vaccinations. No ID cards, so we have to pay 100% in cash. Similar stories are rife on the news. What is the penalty for the insurer taking our money, then not providing cover and causing the cash flow and administrative burden?

8. **Where is the reporting and transparency about economic impact?**

   You are very quick to quote statistics of the numbers of people that have signed up, though I don't understand your bragging rights, as it is the law, not a reflection of true demand. What about the more interesting side of the statistics everyone is waiting for?

   a. Has the net insurance cost to Californians stayed the same, increased or decreased?
   b. How have average premiums changed for different ages, incomes, zip codes?
   c. What has happened to insurance company profitability?

   The above information should be published quarterly, if not monthly. And it should come from an independent auditing source – NOT the insurance industry. Every individually insured person, family should be surveyed. Then I can report our 251% increase in the 55-65 age group.

The above are the thoughts from someone who supported democratic positions. I wonder what republicans think?

Sincerely,

Robin Nydes, robin@nydes.com

California Association of Health Plans

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February 3, 2014

Ms. Leah Morris
Senior Clinical Consultant
Plan Management
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VIA ELECTRONIC MAIL: QHP@covered.ca.gov

Re: New Entrant and Recertification Policies

Dear Ms. Morris:

The California Association of Health Plans ("CAHP") represents 42 public and private health care service plans that collectively provide coverage to over 21 million Californians. We write today on behalf of the Qualified Health Plans (QHPs) currently contracted with Covered California, which are all members of CAHP, and for several of our members who may submit bids as new entrants to the marketplace in 2015.

Timeline

The draft timelines for recertification and new entrant applications propose rates and networks being due to Covered California in May. We respectfully suggest that Covered California accept networks and rates in early June. This will provide plans with more time to develop networks and to submit approved networks, rather than proposed networks, to Covered California. It will also give plans more time to collect data and build more accurate rates.

We do not believe that moving these submissions to June will hinder the ability of Covered California to meet its deadlines nor will it delay filings with the appropriate regulator or impact the rate review process. It will however benefit Covered California to have more accurate information, save time, and reduce the need for additional plan submissions.

Additionally, it is likely that the federal department of Health and Human Services will make final a proposed rule that would change the open enrollment period for 2015 coverage to November 15, 2014, which will provide an additional month for Covered California and its contracted QHPs to be prepared for open enrollment.

Good Standing Requirements

CAHP is concerned that language in the applications that states QHPs must have no "material" fines or ongoing disputes conflicts with the ability of regulators to determine if a health plan is in good standing. Covered California should defer to the appropriate regulator to make a determination of good standing, including what it means to have "material" fines or ongoing disputes. We request that the application be updated to remove any language that would give

Covered California the discretion to have a different determination of good standing than what is applied by the appropriate regulator.

Cover Page

The application for recertification currently states (emphasis added):

> "On behalf of the QHP issuer stated above, I hereby attest that I meet the requirements in this Renewal Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that Covered California may review the validity of my attestations and the information provided in response to this application and decertify Issuer's Qualified Health Plans offered on the Exchange ***should the information provided is found to be inaccurate***. I confirm that I have the capacity to bind the QHP issuer stated above to the terms of this renewal application."

CAHP and its member plans are concerned that this language is too broad and suggest the following revisions to the underlined portion of this paragraph:

...should any material information provided be found to be substantively inaccurate such that the QHP would not have met the regulatory requirements for recertification.

Section 2.1- Network Adequacy

The last sentence of this section requires QHP's to have "sufficient number and types of providers to ensure that all services are accessible in a timely fashion to [CC] enrollees." QHP's are instructed to either select "yes" or "no" for this entry. It is the responsibility of the regulators to enforce network adequacy standards contained in state law. We request that the application be updated to reflect the role of the regulators and to make it clear that Covered California will not adopt its own access standards.

Section 4.2- Data Sharing

This section currently contains language related to data sharing by the plans that states:

"QHP agrees to submit claims and encounter data in the requested format to a third party vendor selected by Covered California for the purpose of performing clinical analytics."

CAHP requests that the following language be added to the end of this sentence for clarity:

…provided (i) such data sharing is for a purpose permitted under HIPAA regulations and other privacy/confidentiality laws, and (ii) there are reasonable, appropriate and effective technical, physical and administrative safeguards in place to protect the privacy of the shared data. The vendor must comply with HIPAA and will not be permitted to sell that data to other parties, even if de-identified."

Section 4.3- Evalue8

We would appreciate clarification on the timeframe for the submission of the Evalue8 components. We request that this portion of the application be updated to state that the plan will submit the required components of the Evalue8 tool at a time mutually agreed upon, and not May

1st. Plans will need time to collect this information and provide accurate data to Covered California.

Section 5.7- Premium Payments

This section of the application currently states that health plans must accept premium payments no later than October 15, 2014, using, among other forms of payment, credit cards. We would like clarification on if Covered California intends to require that QHPs accept credit card payment. Currently this is not required under federal law, nor is it a current Covered California policy so plans will need to prepare for this change if it will now be a requirement for QHPs.

Section 8.1- Standard Naming Conventions

CAHP and our member plans request that Covered California provide more detail and consult with plans before imposing standard naming conventions for products. Last year this was implemented in CalHEERS at the last minute and QHPs were not provided the opportunity to give input and help develop standards that would work for all plans. There are issues that standard naming conventions raise for many plans and we feel it would be useful for Covered California to work with plans to understand these challenges before mandating this change.

We appreciate you taking the time to review our comments and for considering the changes and clarifications we have requested. We are available at your convenience to discuss any of the issues outlined in this letter and look forward to continuing to work with you. Please contact me if you have any questions.

Sincerely,

Athena Chapman
Director of Regulatory Affairs

cc:
Leesa Tori, Senior Advisor for Plan Management, Covered California
Tim Von Hermann, Covered California
Gary Baldwin, Deputy Director, Plan and Provider Relations, DMHC

February 7, 2014

Via email

The Honorable Diana Dooley, Chair
Covered California
2535 Capitol Oaks Drive Suite 120
Sacramento, CA 95833

RE: Covered California Qualified Health Plan Application for New Entrants and Renewal Application

Dear Chairwoman Dooley and Members of the Board:

The National Health Law Program and the Western Center on Law & Poverty are pleased to present our input on Covered California's draft applications and regulations for Qualified Health Plans. We appreciate the hard work that you and your staff have put into crafting applications that ensure high quality health plans participate in Covered California.

In particular, we appreciate that:

- **Covered California is encouraging plans to offer embedded dental.**

NHeLP and Western Center have urged Covered California to offer plans with embedded dental benefits to ensure children have access to dental care and make coverage more understandable and affordable for consumers.

- **Covered California is encouraging Medi-Cal Managed Care plans to participate.**

NHeLP and Western Center appreciate Covered California's attempts to include as many Medi-Cal plans as possible in the

marketplace when they meet all applicable standards. Including Medi-Cal plans will help to reduce churn and improve continuity of care when enrollees' circumstances change.

- **Covered California will continue efforts to monitor balance billing.**

NHeLP and Western Center appreciate Covered California's continued attention to balance billing when enrollees are required to access benefits out-of-network. New Entrant Application § 6.3. We strongly urge Covered California to monitor this area closely and to develop appropriate consumer protections to ensure that enrollees do not face unaffordable costs when services are not offered in-network in a timely or accessible manner.

- **Covered California will verify plans' compliance with applicable network adequacy standards.**

NHeLP and Western Center highly appreciate Covered California's commitment to performing independent oversight and review of the adequacy of plan's networks. We commend the language in the renewal application that states "provider network adequacy for . . . Covered California products will be determined by the applicable state regulatory agency and verified by Covered California." Renewal App. at § 2.1. We urge Covered California to incorporate similar language into the application for new entrants. We appreciate that, elsewhere in the application for new entrants, plans are asked to demonstrate their compliance with applicable network adequacy requirements, to identify the percentage of board certified providers with whom they contract, and to describe their plans for network development. We encourage Covered California to look closely at this data, and to also collect additional information on the plans' overall networks in order to engage in meaningful oversight of the adequacy of their networks. In particular, Covered California should require plans to document their relationships with Independent Physician Groups (IPAs) or other delegated groups that serve to limit enrollees' access to the plans' overall networks, and should require plans to provide geo-access maps of their providers and IPAs relative to the target population in each region.

- **Covered California will continue to exclude alternative benefits designs from the individual market for 2015.**

We are pleased that Covered California has committed to not allowing alternate benefit for the 2015 benefit year for the individual market. California has taken a huge step in support of standardizing benefit plans. The decision to continue to limit QHP offerings to

the standard plan designs will help to eliminate consumer confusion and will give Covered California more time to evaluate the success of those standard designs. We urge Covered California to similarly exclude alternative benefits designs in the SHOP for at least another year to ensure that it can fully and fairly evaluate the standard designs before adding additional considerations.

We ask Covered California to consider the following changes to the applications for new and renewing plans:

- **Require all plans to ensure continuity of care.**

NHeLP and Western Center are concerned that most, if not all, QHPs may not be legally bound to provide any continuity of care to new enrollees. Already, we have heard reports from consumers who came to Covered California from the LIHPs and the individual market that they are having trouble seeing their existing providers or continuing necessary treatment. This problem has become especially acute given the widespread inaccuracies in Covered California's Provider Directory, which was pulled from Covered California's website just this morning. Even consumers who attempted to choose a plan that contracted with their current providers are finding that sometimes their providers are not covered. While we anticipate that the legislature will extend existing continuity of care requirements to QHPs this year, we urge Covered California to also require plans to, at a minimum, comply with the standards for continuity of care set forth at Health & Safety Code § 1373.96(c). Covered California should give new and renewing plans notice of this requirement in the application, and require their compliance through the contracting process later this year.

- **Require all plans to provide accurate and up-to-date provider information.**

NHeLP and Western Center are extremely disheartened by the continuing problems with Covered California's Provider Directory, described above. We appreciate that both the application for new entrants and renewing plans require the plans to submit provider information for inclusion in Covered California's directory, but we are very concerned that this requirement does not go far enough to ensure that the directory is accurate for consumers. We urge Covered California to require new and renewing plans to assure that the information they provide is accurate and up-to-date. We also strongly urge Covered California to ask renewing plans to account for their performance in this area during the first year, including any corrective action taken to address problems.

- **Prohibit two-tiered network designs.**

NHeLP and Western Center continue to oppose allowing two-tier networks to overlay benefit designs in Covered California. While the application for new entrants states that actuarial value calculations for two-tiered networks will be based on "likely overall use of tiered networks," New Entrant App. at 14, such calculations may be highly prone to inaccuracies and to misleading consumers. For the population eligible for premium tax credits and cost-sharing subsidies, a two-tier network is likely to expose enrollees to significant cost liability in the second tier, which could result in heavy medical debt. To the extent that two-tiered networks are permitted, Covered California must work with plans to ensure that consumers are given sufficient information about the providers included in each tier, and the differences in cost-sharing between tiers, to make an informed decision in selecting a plan. Without this information, it will be impossible for consumers to calculate their likely cost liability in two-tiered networks. Furthermore, Covered California should take steps to ensure that two-tiered networks don't make an end-run around network adequacy requirements and ECP requirements; any two-tier networks must meet those requirements in the tier that exposes consumers to less cost-liability (i.e., the first tier).

- **Require all plans to report on their methods of identifying at-risk enrollees.**

We encourage Covered California to collect more information from both new and renewing plans about their methods of identifying at-risk enrollees and providing them with services such as care management. We appreciate that the application for new entrants asks plans to identify whether they use certain strategies for identifying and assessing the health needs of at-risk enrollees, but we encourage Covered California to collect more detailed information about how these programs will be carried out for plans that are selected to participate in Covered California. The renewal application does not ask plans to provide any information on their progress in identifying at-risk enrollees and creating care management plans for them. At a minimum, renewing plans should be required to provide basic information about how they have identified and assessed the needs of enrollees, what care management services they have provided. To the extent that plans are able to report on any changes in health outcomes for the population that has received care management, they should do so as well. Plans' success at appropriately targeting care management and using it to improve health outcomes must be a part of Covered California's evaluation of their fitness to continue participation in Covered California.

- **Require all plans to meet stringent network adequacy standards.**

In the first month of coverage, NHeLP and Western Center have already heard from consumers who are experiencing difficulty accessing care through their new QHPs. While we believe that many of these problems be solved in the coming months, we urge Covered California to take additional steps to ensure that all enrollees have access to the services they need, when and where they need them.

First, NHeLP and Western Center urge Covered California to require CDI plans to meet the same timely access standards as DMHC plans. The fact that enrollees in a PPO may be able to access needed services out-of-network does not substitute for timely access to services in-network, particularly when enrollees will be subject to significantly increased costs if they access care out-of-network. While we understand that CDI is developing regulation in this area, there is no guarantee as to when this will occur. Covered California should ensure timely access by including standards in its plan contracts in the meantime.

Second, all plans should be required to demonstrate that they contract with an adequate number of providers in all appropriate specialty areas to ensure that enrollees have access to all covered services. We urge Covered California to develop criteria to measure the number of providers that account for variation in specialty type and geography, similar to those used in the Medicare Advantage program. *See, e.g.,* Centers for Medicare & Medicaid Services, 2011 Medicare Advantage Network Adequacy Criteria Development Overview, https://www.cms.gov/MedicareAdvantageApps/Downloads/2011_MA_Network_Adequacy_Criteria_Overview.pdf. Covered California's criteria should account for the needs of special populations who will use its services, including children, people with disabilities, limited English proficient enrollees and women of reproductive age. The goal of developing specific metrics to measure the number of providers in a network is ensuring that enrollees have meaningful access to the health care services they need. Thus, such metrics must account for the range of services offered by participating providers, and whether providers are accepting new patients.

- **Ensure that all plans have adequate customer service capacity to serve enrollees.**

NHeLP and Western Center have heard from far too many consumers who have attempted to reach their new QHPs this year to verify coverage, get information about providers, or to understand the limitations on their coverage but have not been able to reach anyone from their plan. We appreciate that call centers are experiencing

unusually high call volume due to the influx of newly covered enrollees as of January 1. But we are concerned that many participating plans did not adequately prepare for the increase by boosting their customer service capacity. We appreciate that the application for new entrants requests that applicants provide basic information about their capacity and ability to scale up to meet increased demand. Application for New Entrants § 6.2. But we are concerned that Covered California is not requiring renewing plans to provide an assessment of their customer service capacity in the renewal application, but only asks plans to describe how they will "maintain sufficient staffing in the customer service center to meet contractual performance goals." Renewal App. § 5.8. Covered California must obtain sufficient information from renewing plans to understand what went wrong during the first open enrollment period, and use that information to develop appropriate customer service capacity standards for both new and renewing plans for 2015.

- **Ensure that all plans provide full access to people with disabilities.**

Because many people with disabilities will continue to purchase coverage through Covered California, NHeLP and Western Center urge Covered California to take steps to ensure that QHPs are able to communicate effectively with people with disabilities, including by providing reasonable accommodations, when needed.

While QHPs will have the legal obligation to comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 1557 of the ACA (non-discrimination), the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act, and applicable oversight agency regulations and guidelines, a large amount of responsibility sits on the shoulders of Covered California to assure that the required accommodations are made for plan members with disabilities. The Draft applications do not adequately require that the plans provide sufficient information to assure that the required standards are being met. In fact, it does not collect any information about plans' ability to communicate with people with disabilities and provide reasonable accommodations. At a minimum, plans should demonstrate their ability to provide all materials tailored specifically to meet the particular needs of people with disabilities, including the provision of materials in Braille, large font, and other formats that comply with state and federal disability laws.

- **Ensure that all plans provide full access to people with Limited English Proficiency**

NHeLP and Western Center were surprised to see in the materials provided at the January 21 forum on Reducing Health Disparities that some plans reported having very limited data on the primary language of their enrollees – one plan only had data on 6%

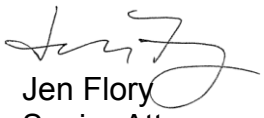
of its members. If a plan does not even know what language an enrollee speaks, how can the plan make appropriate translated materials or translators available?

As Covered California has already identified this area as a current known weakness among some plans, reliance on good standing with DMHC or CDI to ensure language access is insufficient. We urge Covered California to include more specific language in both the renewal and the new entrant applications requiring that such data be required and that consumers be informed of their rights at enrollment. These provisions would ensure that persons who do not speak English as a primary language can actually access health care once enrolled in a plan.

Thank you for the opportunity to comment. We look forward to further discussion of these matters.

Sincerely,

Abbi Coursolle
Staff Attorney
National Health Law Program



Jen Flory
Senior Attorney
Western Center on Law & Poverty

and on behalf of
Kim Lewis
Managing Attorney
National Health Law Program

February 3, 2014

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

SUBJECT: Comments on Proposed 2015 QHP Recertification and New Entrant Solicitation and Policies

Dear Mr. Lee:

On behalf of Private Essential Access Community Hospitals (PEACH), thank you for the opportunity to comment on Covered California's proposed 2015 QHP Recertification and New Entrant Solicitation.

As the organization that represents California's community safety net hospitals, PEACH members have an average patient base that is 70 percent uninsured and government-sponsored and play a critical role in Medi-Cal managed care and Covered California plan networks. California's community safety net hospitals also provide:

- Half of all safety net hospital care to Medi-Cal patients;
- 44 percent of their care to Seniors and Persons with Disabilities; and
- 40 percent of all safety net hospital care to the uninsured.

As Covered California, in partnership with the State, continues to make exciting and unprecedented inroads to expand health coverage to millions of Californians under the Affordable Care Act, community safety net hospitals will continue to be integral to California's health care safety net. During this pivotal transition, community safety net hospitals will provide a significant portion of care to millions of new Medi-Cal beneficiaries, serve as Essential Community Providers (ECPs) in Covered California plan products, and continue to help serve the 3 million remaining uninsured Californians in 2014.

As Covered California seeks to finalize the QHP recertification and certification of new entrants, PEACH supports the Covered California staff-recommended principle that the 2015 recertification process build on the rigorous 2013 QHP selection process and be limited to validating key contract requirements and updating critical issuer and product information where necessary. We also support using the 2014 QHP solicitation as a strong foundation for the 2015 new entrant application.

Additionally, PEACH offers the following comments and recommendations focused on the areas of Essential Community Provider network requirements and provider network adequacy.

1) Strengthening the Standard for Sufficient Participation of ECPs

PEACH greatly appreciates Covered California's efforts to ensure that the Exchange's current plan networks include more than the minimum required participation of ECPs. We also appreciate that the Exchange released physician and hospital provider network data in December 2013 to help shed light on the Exchange's considerable efforts to incorporate ECPs in its 2014 managed care plan networks.

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However, as the Exchange is quickly moving ahead to finalize its 2015 QHP recertification and new entrant application process and policies, PEACH remains concerned that Covered California's minimal standard of what constitutes sufficient participation of ECP hospitals could result in barriers to access to care in low-income communities in the future. Specifically, the very minimal requirement that the Exchange plans include "at least one ECP hospital in each region," continues to raise concerns about whether low-income communities will have adequate and timely access to their local safety net hospital providers. This is especially true in geographically vast counties such as Los Angeles where only two ECP hospitals are technically required in an Exchange plan network based on the minimum requirement. While we appreciate the acknowledgement in the January 23, 2014 draft of the New Entrant QHP Solicitation that "…in populous counties, one ECP hospital will not suffice if there are concentrations of low-income population[s] throughout the county that are not served by the contracted ECP hospital" (page 28), PEACH strongly believes that the "at least one ECP hospital in each region" standard is inadequate and should be amended to reflect a minimum standard that promotes and ensures sufficient participation of ECP hospital providers.

It is critical that all residents, especially in low-income communities, have access to safety net hospitals that are their local providers of choice in their community; To do otherwise raises questions of equitable access to high-quality and medically necessary services among all Californians.

PEACH Recommendation: Modify the Covered California ECP network adequacy standard to require that all ECP hospitals be offered contracts at prevailing commercial rates by Exchange plans.

2) Narrow Networks & Provider Adequacy

PEACH understands Covered California's need to minimize QHP operational/administrative costs in order to maintain affordability for consumers, but we remain concerned about the potential for narrow networks to become barriers to consumer access to cost-effective, local, timely, and high-quality care.

As Covered California moves forward with actively monitoring plan performance through quality measures, we urge the Exchange to closely monitor provider network adequacy and ECP network requirements to ensure that, in actuality, Exchange plans' networks are delivering timely, high-quality and local access to care to all their beneficiaries – especially in low-income communities where there is a higher incidence of chronic disease, comorbidities and other health disparities that must be addressed.

We also continue to be concerned about the lack of robust and transparent oversight regarding health plan networks. Although the provider search function on the Covered California website is a meaningful step in the right direction, it does not allow for an overall view of the adequacy of the network. PEACH is heartened by Covered California's past efforts to work closely with DMHC and CDI and we urge the Exchange to continue to do so to better ensure plan network adequacy and also allow for meaningful stakeholder review of Covered California plan networks.

PEACH Recommendation: Covered California and appropriate regulators should closely and frequently monitor and analyze plan network quality measures to ensure that Exchange plan provider networks are delivering timely, appropriate, and high-quality patient access to care.

3) Attestation Requirements relative to QHP Recertification

PEACH supports the use of attestation for the purposes of 2015 QHP recertification in the areas of provider network adequacy and ECP network requirements. However, PEACH believes that in subsequent years it will be necessary for the Exchange to require documentation – at least on a biannual basis (alternating with attestation) to ensure that the most current networks are documented and verified from the contract outset without imposing an annual documentation burden on Exchange plans.

PEACH Recommendation: That Covered California accept attestation for provider network adequacy and ECP network requirements for 2015 QHP recertification but, for subsequent years, adopt a policy that requires Exchange plans to annually alternate between providing full documentation of provider and ECP networks and attestation.

Thank you for your consideration of our comments and recommendations. PEACH looks forward to continuing to work with Covered California to ensure millions more Californians have access to the health care they deserve. Please feel free to contact me at 916-446-6000 should you have any questions.

Sincerely,

Catherine K. Douglas

Catherine K. Douglas
President and CEO

CC: Diana Dooley, Chair, California Health Benefit Exchange Board
Kimberly Belshé, California Health Benefit Exchange Board
Paul Fearer, California Health Benefit Exchange Board
Susan Kennedy, California Health Benefit Exchange Board
Robert Ross, MD, California Health Benefit Exchange Board