CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD
May 22, 2014
East End Complex Auditorium
1500 Capitol Ave.
Sacramento, CA 95814

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

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

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

Board members absent: None

Agenda Item II: Closed Session

Chairwoman Dooley called the meeting to order at 12:15 p.m. A conflict disclosure was performed; there were no conflicts from the Board members that needed to be disclosed.

Agenda Item III: Approval of Board Meeting Minutes

After asking if there were any changes to be made, Chairwoman Dooley asked for a motion to approve the minutes from the meeting held April 17, 2014.

Presentation: April 17, 2014, Minutes

Discussion: None

Public Comments: None

Motion/Action: Board Member Belshé moved to approve the April 17, 2014, minutes. Board Member Kennedy seconded the motion.

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

Agenda Item IV: Executive Director's Report
In the special enrollment period, thousands of residents are enrolling every day. Medi-Cal enrollment is ongoing.

Discussion: Announcement of Closed Session Actions
The Board approved a change of roles for one of Covered California's leaders. Yolanda Richardson, who has been serving as Chief Deputy Executive Director for Operations, will be Chief Deputy Executive Director of Strategy, Marketing, and Product Development.

Sue Johnsrud is the new Chief Executive Director of Operations.

Oscar Hidalgo, Director or Communications, will be leaving to return to his work in the energy field.

The Board also approved the revision of one of the exempt positions to be the Director of Individual and Small Business Sales. This will enable Covered California to bring on a senior sales professional to support individual and small group sales.

The Board extended its contract with BlueCrane, Inc. It also took action to amend the interagency agreement with the California Department of Social Services to provide resources to the county-based State Automated Welfare System (SAWS).

Discussion: Executive Director's Update
Peter Lee, Executive Director, stated that staff has shared a number of reports, including those that inform enrollment and outreach policy. These are on the website.

Presentation: Executive Director's Report

There will be no Board meeting in July. Mr. Lee hopes the June meeting will be held in the Covered California facilities instead of in the East End Complex. If that does not happen in June, it will in August.

Special enrollment is ongoing. People on COBRA qualify for this special enrollment period until July 15, since many did not understand that they had an opportunity to change. He encouraged those on COBRA to get in-person assistance. Medi-Cal is open year-round. If people think it's possible they are eligible for Medi-Cal, they should apply, just in case. If they are not eligible, their information will be saved for the next Covered California open enrollment period.

Everyone is working hard on the 2015 certification/recertification process. There will be minimal changes to the contracts with qualified health plans (QHPs). In the next week, Covered California will be receiving submissions from the health plans. An evaluation process will follow, and then a negotiation process through the month of July. Rates will be public at the end of July.

It has not yet been determined when the next open enrollment period will start. It will be in line with the federal enrollment period and is expected to be from November 15th until February 15th.

Mr. Lee gave an update on timely access to care. Coverage is not the desired end; access to care is. Covered California is continuing to use individual problem resolutions to address concerns and monitor for problems. It is also doing active monitoring to assure networks are adequate. It continues to monitor and assess care issues to assure consumers are getting timely access to needed care. All plans with significant enrollment (and nearly all others) have processes in place to reach enrollees within 30-60 days for care need purposes. Many of the plans have programs specifically developed for Covered California enrollees including direct outreach, health risk assessment member portals, wellness programs and new analytics/risk stratification processes. In terms of looking at complaints and problems, there has been a low number of reported continuity of care cases since January. For the first quarter in 2014, there were about 1,100 DMHC complaints from Covered California enrollees. Only about 200 of these complaints were related to access to care problems.

Health plans are continuing to expand their networks to assure adequate capacity, including additional clinicians and groups being added by Anthem, Shield, and Health Net.

Board Member Ross asked what triggered the plans' expansion of their networks. Was it the complaints, or was it another data point?

Mr. Lee voiced that it was not in response to complaints. The plans bid a year ago based on estimated enrollment. They were asked if their networks would be adequate if enrollment estimates were too low, and they are responding accordingly. The high enrollment numbers made expansion necessary.

Board Member Belshé asked how Covered California consumers know where to go with complaints.

Mr. Lee stated that plans' benefit packages and ID cards come with information on where to go with problems or complaints. Covered California has not yet sent out a more complete welcome package giving better information on how to be an informed insurance consumer.

Board Member Belshé pointed out that many Covered California consumers are new to insurance, so she's glad that Covered California is going to provide more information.

Mr. Lee said that many people enrolled in March so are only now getting their materials. Those who signed up in March are more likely to have previously been uninsured; thus Covered California is not all that far behind in sending out materials.

Discussion: Legislative Update
David Panush, Director of External Affairs, presented the Legislative Update. Most of the bills have not yet been put in process. One bill conforms Covered California's open enrollment period to the federal open enrollment period. One would have added two additional members to the Covered California Board. It has been amended, but still includes additional criteria for Board membership. A third bill would allow non-grandfathered small-group plans to be renewed for an additional year.

Discussion: Federal Rules Update
Katie Ravel, Director of Program Policy, presented a Federal Rules Update. She noted that the federal government just passed down a set of rules. Staff will continue to update the Board on these rules.

Mr. Lee noted that a number of slides appear on the website in an appendix. Staff is working on getting ready for the second open enrollment period. The service center is moving toward meeting the desired service level standards.

Board Member Belshé would like to hear more in depth about what has been learned, including further information about CHCF's examination of the Covered California user experience. The report is constructive and sobering and calls out the strengths and weaknesses of the program. This document could help provide important lessons.

Mr. Lee noted that the report in question was a panel survey of nine consumers. Larry Bye will present information on the experience of thousands of consumers. The information on the panel survey is included in Yolanda Richardson's presentation.

Public Comments:
Betsy Imholz, Director of Special Projects, Consumers Union, voiced that she understands the need for stability. The federal rules assume that people will renew into the same plan. Consumers need to understand that they can change plans for any reason. Covered California should notify them of this. Consumers Union will keep pressing for design changes in upcoming years. They appreciate gathering as much information as possible. Many people, especially lower-income people who are less familiar with insurance, are not likely to file complaints with the regulators. It's unclear if the network expansions reflect the inclusion of exclusive provider organizations (EPOs). That is a hot spot, meaning it's an issue on which they receive a lot of questions.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), expressed that they are happy to see that call wait times are going down, but they haven't seen performance data for non-English calls. Certified enrollment counselors (CECs) whose consumers used other-language call lines reported call drops. She hopes the CEC focus groups will be conducted in Spanish and possibly other languages as well.

Jen Flory, Senior Attorney, Western Center on Law & Poverty, seconded Ms. Sanders' comments about calls in other languages. They have received complaints. They are glad

to hear about expanded networks, since specialists are in short supply. They would like to participate in more meetings and do everything they can to get the CalHEERS system working. They have concerns about the accuracy of eligibility determinations and want to ensure that people are being adequately screened for both programs. They would also like consumer advocates to be in on the testing process. They are hearing complaints from consumers when they have to go to appeals and would like to hear data on the appeals. Staff has fixed some problems with conditional withdrawals, but they would like to hear what those specific problems are.

Edwin Lombard, California Black Media Association, thanked Covered California for its work despite the challenges. They applaud the efforts of California Black Health Network in African-American outreach. They are disappointed in Covered California's lack of commitment to a comprehensive African-American outreach plan. Covered California manages the state's participation in the Affordable Care Act, private insurance elements, and expanded access to Medi-Cal. There is a danger of serious health consequences in black communities if Covered California continues to minimize the importance of increased African-American enrollment. Not enough of this community signed up for Covered California or Medi-Cal. Only 6 percent of Medi-Cal enrollees are African-American, the second lowest percentage among ethnic groups. Education and outreach will be the key to reaching African Americans in the second round of enrollment. Outreach began too late and did not effectively utilize black media. They hope that this will be considered in the upcoming year. They would like to help.

Kevin Knauss, Certified Insurance Agent, noted that he received an agent survey about their experience from Covered California. He asked for more funding for agent education. There are a lot of complicated issues to deal with and they are trying to help people transition. Agents are desperate for training. If they are able to correctly enter consumers into the system, it takes the burden off of the call center staff. Agents also field many complaints about network adequacy and access to care.

Jessica Haspel, Senior Associate, Children Now, noted that the former foster youth population is a high-needs population. Youth who are aware that they qualify based on their status cannot make it through the enrollment process. Some are getting incorrect eligibility determinations or information. Some critical improvements would simplify the process, such as adding a question to the quick sort process, and also ensuring that the call center staff knows that this population does not have to provide income information. CalHEERS does not have the capacity to make determinations based on youth status. Since this is such a high-needs population and they are hearing these complaints from savvy members, they are concerned about those who are not as savvy.

Ruth Liu, Blue Shield of California, noted that there is a great deal of misunderstanding regarding their PPO network. Some physicians are confusing their market conduct with that of other plans. They work with doctors to make quality health care affordable. They asked their entire network if doctors would be amenable to working with them. They went to California Medical Association (CMA), and CMA had no issues with their proposed agreement. They included a provider network satisfying all DMHC

requirements. Many agreed in writing to accept a lower reimbursement rate in order to be able participate. In some instances, they incorporated some physicians under their current agreements. Neither contract includes all-product clauses. Now, many physicians and hospitals provide great access and high quality care to their members. Before open enrollment began, Blue Shield launched a provider education campaign. They sent provider welcome packets, and held direct outreach and webinars and meetings. Blue Shield updates their provider directory on a weekly basis. They look forward to improving their network but wanted to set the record straight.

Brett Johnson, Associate Director of Medical and Regulatory Policy, California Medical Association, noted that Blue Shield is not the main perpetrator of the grievances from their report. The contracts did not identify them as exchange products. Many physicians are just learning about those contractual issues. Going out into the field, California Medical Association staff is hearing about many issues from physicians about finding specialists to refer to. It's not all of the big four plans, maybe half of the big four. It would be nice if Covered California could send more complaints to DMHC. There should be an agenda item on access to care.

Beth Malinowski, Associate Director of Policy, California Primary Care Association, seconded Mr. Johnson's comments. They are hearing similar stories about the difficulty of finding in-network specialists to refer patients to. There needs to be an accurate provider directory. There is confusing opt-out language, and providers aren't sure if they are engaged with a plan.

Gil Ojeda, Director, California Program on Access to Care at UC Berkeley, acknowledged Covered California's widespread, in-depth effort toward listening and learning. The analysis is important. Covered California should issue separate reports on distinct populations. They hope that in the reengineering process, Covered California will ensure that those who have committed major resources to becoming CECs won't be disrupted in their efforts. A number of contractors are at risk of having their work interrupted. He acknowledged UCLA and UCB partners for the data they are about to discuss.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, voiced that the QHPs share Covered California's mission to provide quality care at an affordable price. One key component is controlling provider costs. Using tailored networks allows QHPs to deliver on the shared goals of quality and affordability. Some QHPs have narrow networks and some have broad networks. There has been significant growth in networks in response to consumer demand and desire on the part of the physicians. They are accountable to Covered California and they expect that it will monitor enrollee satisfaction. They are also accountable to the regulators. Some groups are seeing these difficulties as a reason to create bad policy which will be expensive and result in less provider choice. The legislature already rejected a proposal from CMA to require opt-out clauses in physician contracts. Giving providers the ability to "cherry pick" would undermine their ability to offer affordable premiums. The Board should

reject any proposal that would require opt-out clauses for providers and would limit the ability of health plans to offer affordable rates.

Betty Williams, Certified Enrollment Counselor, voiced that she educates and enrolls people and oversees other CECs. During the heavy enrollment period, Covered California should extend the hours not just of customer service personnel but also of IT personnel. These people are needed after hours and on weekends. It will also be important to consider major holidays that impact certain cultures. On Cesar Chavez Day and MLK Day the system was down. The service centers should be staffed up for the 15th of the month. Some CECs have been working since October but have still not been paid. She has been waiting for a check that has been delayed and the enrollers have not been paid.

Doreena Wong, Project Director, Asian Americans Advancing Justice, seconded Ms. Williams's comments and Ms. Sanders's comments about service center issues. Having disaggregated data regarding service center issues would enable them to provide recommendations. They are glad the complaint process will be addressed by having welcome packets, but many notices aren't currently translated. They hope that the welcome packets will be translated and prioritized because they have had to translate notices from Covered California. This information will help people know how to respond to problems. They hope that the special-enrollment-period fact sheets can also be translated.

Beth Capell, Health Access California, voiced opposition to CMA's proposal that physicians affirmatively contract with providers. The California bill of rights for providers gives notice and an opportunity to negotiate when terms change. This would undermine Covered California's active purchasing ability. They are disappointed that Covered California is not considering reevaluating EPOs in the Bay Area, since they led to consumer complaints about network access. They know Covered California is trying to minimize change this year, but they would like the Board to reconsider that.

Julianne Broyles, California Association of Health Underwriters, noted that their members mention network adequacy as a top concern. They are glad Covered California is focusing attention on this issue.

Brett Johnson, Associate Director of Medical and Regulatory Policy, California Medical Association, noted that they are not opposed to narrow networks. However, the current tools of monitoring and enforcement in California are not crafted to handle them. The legislation is focused on the PPO side where all plans have to do is send a material change and it becomes part of the contract (whether or not a physician has read the materials).

Mr. Lee voiced that staff takes comments seriously. They will follow up to get data on consumers' experiences in different languages. People should have similar wait times and experiences. They like sharing data from a variety of sources. Regarding renewal, there will be three months to renew a million people and hopefully sign up another 500,000. They want to make it easy for consumers to keep their plan and to explore other options

if they'd like to. People's financial experiences will change. The second-lowest silver plan will change. Among those enrolled, 60 percent said their financial data could be used to automatically check their eligibility. This year, there will be more people enrolled in half the time. Mr. Lee stated that he is disappointed in Mr. Lombard's disappointment regarding outreach to the African-American community. Covered California's comprehensive outreach program has included advisors from day one. They will consistently look and learn. They think their efforts were helpful, but they will also require some improvement.

Agenda Item V: Covered California Policy and Action Items

Presentation: Covered California Policy and Action Items

Discussion: Covered California Budget
Dennis Meyer, Deputy Director for Financial Sustainability, presented on the Covered California Budget. The team has been working on next year's budget process in the midst of working on closing open enrollment, launching special enrollment, and moving.

i. 2015 Enrollment Projections

In the individual market in 2015, the enrollment projections are as follows: Low end of open enrollment at 1.3 million, medium end of open enrollment at 1.7 million, and high end of open enrollment at 1.9 million. In the SHOP, at the end of the 2014-15 fiscal year, the enrollment projections are as follows: Low end of open enrollment at 20,200, medium end of open enrollment at 23,400, and high end of open enrollment at 42,600.

ii. Proposed 2015 Revenue Assessment

Mr. Lee noted that staff has done great work, but there are a lot of uncertainties involved. They posted a background document on the assumptions. A range of stakeholders have participated and given input. The recommended budget is based on a middle-ground forecast, framed by reasonable assumptions and informed by estimates.

iii. 2014-15 Interim Budget and 2015-16 Budget Projection

Dora Mejia, Associate Deputy Director for Finance, took over to present on the 2014-15 Interim Budget and 2015-16 Budget Projection.
The budget for fiscal year 2014-15 is preliminary and will be presented to the Board for review and approval at the June meeting. The budget for fiscal year 2015-16 is a projection based on anticipated enrollment and the transition from a relatively new organization to sustainability. Revenue projections reflect maintaining assessments at $13.95 per-member per-month in 2015 and 2016. Assumptions, which are important components in the overall revenue and budget projections for enrollment, can be found in the slide deck posted online. There are major risks that come with the assumptions, including federal actions, and a possible loss of revenues (due to a projected low enrollment level).

Staff will be asking the board to take action on resolution 2014-37, which will allow the Exchange to charge per-member per-month fees to fund its administrative costs for the 2015 plan year. These fees shall be the same as those in effect in 2014.

Discussion:
Mr. Lee stated that the risks presented are very limited risks. When they originally received establishment funds, the assumption was that open enrollment would end at the end of 2014, but it will actually carry over into 2015. All indications they have had is that the federal partners will approve the use of establishment funds into 2015, since enrollment was pushed into 2015.

Board Member Belshé asked why they are being asked to approve a per-member per-month fee before approving a budget. She wondered if they wouldn't have to have this information before budgeting.

Mr. Lee said the plans will need to write the amount into their proposals, which are due before next month's budget approval.

Chairwoman Dooley said staff will adjust the budget according to the approved amount. She feels comfortable with the number.

Board Member Belshé was not clear on why the amount is the same if the enrollment is expected to be higher.

Mr. Lee noted that Covered California is planning to spend significantly less than it did this year. The establishment year requires a lot. Covered California must deliver what it wants with fewer resources. He hopes to lower the per-member per-month fee for 2016, but the organization is building a surplus. He thinks bigger enrollment makes Covered California more sustainable over time. This gives the organization elbow room to eventually lower the assessment.

Board Member Fearer asked about the balances at the year's end. In the early years, some of that is pre-committed money. How does that relate to the reserve?

Ms. Mejia stated that the fund balance, which is the amount of funds remaining after expenditures, will be carried over into the next year.

Mr. Lee noted that the reserve will vary from year to year. At the end of 2014 fiscal year, it's a mixture of federal funds and sustainability funds that have been collected from the premium reserve. In future years, it will all be comprised of all premium assessments. If Covered California were to keep the per-member per-month fee the same, they would end the fiscal year with a more than prudent reserve.

Motion/Action: Board Member Fearer moved to pass Resolution 2014-37. Board Member Belshé seconded the motion.

Public Comments:
Anthony Wright, Executive Director, Health Access California, expressed appreciation for the Board's focus on frugality. There needs to be a balance between frugality and investment. The more that Covered California invests in enrollment, the more it invests in retention. They would err on the side of investments in a range of subjects, whether it's investing in more enrollment counselors, broader outreach and language access, or communication with members. Covered California should develop that relationship with its members. The enrollees wouldn't mind paying another dollar or two a month if they could get in and talk with somebody. Without the budget, it's hard to know. Almost 90 percent of the enrollees are insulated from this assessment because they receive subsidies.

Kevin Knauss, Certified Insurance Agent, felt uneasy with the SHOP projections. Agents are wary of the SHOP. He is not bringing clients to the SHOP because it has not been functioning properly. He can't get clients through the process. Doubling enrollment may be difficult.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), said they signed onto the Health Access letter and supported Mr. Wright's comments. Focusing on the role of the diversity officer would help ensure that the materials and website are up to date and translated. She hopes there will be funds set aside for these elements. Community review of materials will also be helpful.

Jim Mullen, Manager of Public and Government affairs, Delta Dental, suggested a language adjustment to the resolution. They have worked hard with Covered California to offer access to adult dental. That should be assessed as well. He suggested removing the word "pediatric" from the resolution itself to assess all standalone dental plans.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, was pleased to see that the per-member per-month assessment is not scheduled to increase in 2015. They want to be sure focus is on maintaining affordability and sustainability. Increased enrollment should not be seen as a license to spend more money for no reason. It will be even more important, as the Exchange transitions to being self-supporting, to note the impact of increased spending on premiums. As they anticipate continued enrollment and decreases in startup costs, they look forward to a decreased QHP fee in 2016.

Betsy Imholz, Director of Special Projects, Consumers Union, agreed with Mr. Wright's remarks. They also signed onto the letter. They hope for and expect greater enrollment. With higher enrollment, it is nerve-wracking to think of

cutting down on the amount available for the service center and assistance. She pointed out that the education work is not over and will never be over. Half of people nationally still don't know anything about Exchanges and many don't understand insurance. California is better now but there is still a lot to do. There will be a lot of churn and new members.

David Chase, California Director, Small Business Majority, voiced that they were pleased to see the SHOP projections. Being ambitious is good. They feel 2015 will be an important time to educate small businesses, many of which are not yet compliant with the Affordable Care Act. In the fall of 2015, they will be in the market for plans. Only half of small businesses offer group coverage, so they are also working with Medi-Cal and the individual Exchange.

Waynee Lucero, Program Manager, California Hispanic Chambers of Commerce, noted that they are SHOP grantees. She voiced support for Mr. Chase's comments. Her organization and the other SHOP grantees have developed a strong method for outreach. They have done this by partnering with the agent community, Covered California staff, and enrollment entities. Covered California has had great success enrolling individuals in 2014, but the small-group side needs a lot of work. It's important that they continue outreach and education because 2015 will be a key year. She asked that the Board continue the outreach and education program for the SHOP.

Julianne Broyles, California Association of Health Underwriters, voiced that they think the SHOP numbers are conservative. In 2015, there will be an upwelling of interest and enrollment into the SHOP programs. They would like to have extra education materials for agents in a variety of languages. They have started a diversity task force to do outreach in many communities. They would like to partner with Covered California to help create those.

Chairwoman Dooley noted that this is a decision about how much funding Covered California will have. It is going to be a difficult conversation. There was originally a lot of federal funding. Distinguishing between startup costs and ongoing costs, and evaluating data can be difficult. The organization must consider what worked, what didn't work, and what could work differently. Everyone is invested in what they are doing, but they have risen above their own parochial interests to get to where they are today. The sustainability conversation is hard. Everyone has done their best with estimation and speculation, but now there's real data. Chairwoman Dooley is committed to the staff's recommendation on the amount. At the June board meeting, the board will determine how that will be spent.

Mr. Lee suggested amending the resolution by striking the word "pediatric". Mr. Lee noted that the plans are required to charge the same amount inside and outside of the Exchange, so therefore the per-member-per-month assessment gets spread out. The issue thus is affordability writ large. Individuals who have

subsidies don't directly feel that cost. There must be a focus on keeping health care affordable for all Californians.

Motion Amendment: The motion was amended to remove the word "pediatric" from the resolution.

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

Discussion: Initial Open Enrollment Evaluation Findings and Proposed 2015 Program Changes

Mr. Lee noted that a webinar will be offered with more detailed enrollment data. Focus groups will be critical, along with reaching out to consumers and those serving consumers. Staff pays attention to what is happening outside Covered California, including what is happening in other states. They are grateful for the rich data available from CalSIM. California has been reporting on enrollment by ethnicity. Many other states do not have this data. This is brand new data that is still being explored, and these are early lessons.

Ken Jacobs, UC Berkeley Center for Labor Research and Education, presented on CalSIM 1.91 data. He went over changes in latest version of CalSIM. He noted that baseline numbers have changed, and that using new survey data adjusts the starting point for CalSIM 1.91. Projections show that for 2015, the total Exchange subsidy eligible number is 2,530,000 (rather than 2,680,000 with CalSIM 1.8). When looking at overall enrollment (years 2015-2019), base projections are a little lower than enhanced projections. The model has Covered California enrollment topping out at a little over 1.8 million by 2018.

Chairwoman Dooley asked if this means the same number of people are in the marketplace but that they just entered earlier.

Mr. Jacobs responded that eligibility numbers were not that different for the first few years. As the years go by, fewer people are eligible because there's less of a drop in job-based coverage (because that drop already happened). He noted that the assumption is that people are coming in more quickly. They assume that the surveys are right about the population and that people just entered more quickly.

Mr. Jacobs went over projected 2015 eligibility by: Race and ethnicity, age, English proficiency, and income.

Mr. Lee said the numbers represent the target enrollment at the end of the next open enrollment period. The budget is based on aligning timelines with these figures. These enrollment figures are for March or April of 2015. Budget numbers will be seen as total enrollment. The assumptions in these models are only based on subsidy-eligible consumers, whereas the total budget includes those who are not subsidy eligible.

Mr. Jacobs stated that Covered California enrollment will experience significant churn for individuals enrolled receiving subsidies. This includes people that are staying and leaving for other coverage, or becoming uninsured within 12 months.

Mr. Lee underscored Mr. Jacobs' notes about point in time churn. Staff presented budget projections saying that by the end of next open enrollment, Covered California will have grown by 500,000, but that is a point in time estimate. That means about 900,000 would have been enrolled because some will churn back out. It's important to work toward retention, but members will also move on because of positive issues like getting jobs with insurance. Staff wants to understand what is happening if people leave because they don't like the insurance. Base and enhanced projections were always Ken Jacobs' assumptions. Covered California's projections are informed by both base and enhanced assumptions. They will keep trying to articulate this.

Board Member Belshé felt informed about people churning out of Covered California, but wanted to hear more about those churning in.

Mr. Jacobs explained that there is a group of people remaining steadily in the individual market, and a group representing a transitional market. This has been called "bouts of coverage" in the individual market. Some lose job-based coverage, but it may only be for a few months. People may use this as a cheaper alternative to COBRA, and then use it until job-based insurance kicks in at ninety days. There will be some short-term cycling. People will come in through loss of job, divorce, graduation from student health plans, and aging off their parents' plans. Those reasons are important to consider for recruitment and retention. Moving is also associated with loss of coverage, so the DMV could refer people.

Board Member Belshé wondered if there was data about the incidence of those circumstances relative to income. Are the shorter spells more apt to be among lower-income people, for example?

Mr. Jacobs said they would need to look into that. Overall, the Medi-Cal population is more stable in terms of income eligibility as a group. About 25 percent leave Medi-Cal each year.

Mr. Lee noted that staff needs to rerun information by region. He presented slides on the estimated enrollment data. One showed that 25% of enrollees were non-respondents when it comes to ethnicity and race. Staff will try to determine how to find out and distribute the groups these people belong to. Other slides showed a quick comparison of Covered California to CalSIM figures, as well as a comparison to other states. When it comes to subsidy-eligible enrollment, there is more work to be done in the African-American and Latino communities. In June Covered California will release data on service channel by: language, income category, and age category. It will also release data on race and ethnicity details including by Asian sub-population and Hispanic type. Lastly, it will release data on enrollment information by region.

Larry Bye, NORC Senior Fellow, presented findings from consumer surveys. This is their first tracking survey. They included broad sampling to ensure valid assessment of general population and Latinos, with oversampling to ensure more representative mix in Spanish speakers, African American and Asian subgroups. Over time, the surveys will assess trends in Covered California awareness, knowledge, attitudes and enrollment experiences and intentions. They will also assess ad recall and exposure to other campaign elements as well as impact of exposure. Covered California awareness has significantly increased. The Covered California campaign has greatly increased awareness and knowledge through synergy of TV, web & community-based outreach. Awareness is high across all demographics, age, and insurance status groups. The knowledge data trends are positive overall.

Mr. Lee stated that this is a very good set of information, and they expect to receive different information from other groups.

Chairwoman Dooley asked if "community-based elements" included insurance agents.

Mr. Bye said he believes it does.

Board Member Belshé asked how they came up with "unaided" versus "aided" numbers.

Mr. Bye stated that for aided, they described the ad and asked if people remembered it.

Mr. Lee said they were supposed to design cultural and linguistically appropriate materials. The ad designed by a Latino man for the Latino market resonated well, even amongst English-speaking Latinos.

This presentation is a summary of a data-rich document that can be found in the board materials online.

Mr. Lee presented on Applying Lessons Learned in Key Business Areas. When it comes to marketing and outreach, Covered California should: Build on the broad/diverse mix of outreach, earned media, and paid media on multiple channels to promote enrollment; continue paid media and social media that encourages consumers to get in-person assistance from agents, certified counselors and counties; build additional capacity to bolster and support community-based outreach, education and enrollment; do media buys and messaging with enhanced focus on target communities that we still need to reach, primarily Latino and African American; and expand access to customizable local marketing flyers and DM pieces for agents and community outreach partners.

Regarding CalHEERS, Covered California needs: Clearer language within application to clearly communicate navigation to consumers; the addition of initial payment functionality to increase consumer experience and avoid enrollment delays; clearer language within application to assist in accurate completion; improve accuracy of eligibility results; improved site navigation to support consumer use of the various tools on the enrollment website; streamlined instructions and process for renewals; improved

instructions for Medi-Cal to clarify the different timelines for Medi-Cal enrollment; and improved system performance for handling peak website loads.

Mr. Fearer asked what "initial payment functionality" means.

Mr. Lee explained that when people enroll in Covered California right now, they must wait for the plan to contact them for payment. Initial payment functionality is payment at the point of enrollment. The health plans agree that this would be a great benefit, and it would help the fact that there was much confusion last time.

Chairwoman Dooley asked if that is in the queue to get done on the next build.

Mr. Lee said yes. The CalHEERS system is a partnership. The priority right now is Medi-Cal functionality and the upcoming open enrollment period. There is no system for renewal yet.

Mr. Lee continued on his Lessons Learned presentation. When it comes to the Service Center, Covered California wants to: Enhance self-service tools including availability after hours for consumers; adjust and staff to meet the service goal of 80/120 to align with budget capacity; have increased training on Medi-Cal, income policies and CalHEERS functionality for all channels to increase consumer experience; improve notice content to help ensure information being present to consumers is easily understood and minimizes confusion; and maintain and expand dedicated support for certified counselors and agents.

Regarding SHOP, Covered California wants to: Increase service center capacity to provide increased support for agents; increase training of SHOP Service Center staff on the individual exchange; have in-depth training on Medi-Cal for service center; and have deeper and more frequent communication with agents and general agents.

Mr. Lee believes that community-based enrollment is essential to Covered California's success. Covered California is reorganizing its spending in this area. The hope is that it will spend less but more efficiently, with more money going into the community. They have not decided if they will continue per-enrollment payment beyond the next open enrollment period. They are evaluating the best way to structure the payment and oversight of enrollment assistance.

Covered California's certified enrollment entities enroll a lot of Medi-Cal members. The Exchange will continue to partner with the Department of Health Care Services (DHCS). The following presentation is a vision in which Covered California's role is to enroll people into Covered California's programs. That will be done in partnership with DHCS's own efforts.

Sarah Soto-Taylor, Deputy Director of Community Relations, presented on Enrollment Assistance. During the next few months, staff will be focusing on developing culturally appropriate collateral material and work plans that will lay the framework for the next

open enrollment period. They are committed to reaching all communities by building and expanding upon our uncompensated community outreach network and continuing partnerships. Covered California initially invested in two separate programs. One was the $43 million in a workforce dedicated to outreach and education to raise awareness about the marketplace. The other was a separate investment in the certified enrollment counselor program to assist consumers in applying for coverage. As Covered California transitions to a self-sustainability model, staff must look at program expenditures and what is required under the federal rules. The navigator program and the certified application counselor program are both required under the federal rules. Staff recommends incremental changes to restructure the outreach, education, and enrollment program. The focus will be to integrate the core enrollment assistance functions.

Staff recommends a termination of the application that was released in March. In June, they will be asking the board to authorize the navigator funding ($15-20 million range). The request for application will be released shortly after that board meeting. Applications would be due in July. This would give staff about a month to evaluate and select recipients of the navigator grants. They anticipate that September is the earliest they would be able to start a navigator grant.

Staff sees many advantages to program restructure. The most important advantage is the consolidation of the outreach, education and enrollment functions (which are two programs) into one program.

During the last month, staff engaged in dozens of statewide meetings to begin the conversation about this new recommended direction. Over 500 educators, counselors, and other stakeholders participated in these workshops. They were asked what went well and what didn't go well during open enrollment. A lot of useful feedback was received.

Ms. Soto-Taylor finished her presentation by going over major policy implementation issues under consideration. Staff needs to finalize the level of funding for the June Board meeting. Covered California wants to maximize QHP subsidy eligible enrollment. It will also need to develop a process for those groups that apply to "convert" from being either outreach and education grantees or certified enrollment entities. Staff is considering providing: A "bonus payment" for exceeding Covered California enrollment goals, and special consideration for proposals that establish store-fronts and work with retail outlets that facilitate regular enrollment hours. Because of administrative cost, no awards of less than $250,000 will be made. It is clear that providing funding as "Navigator Grants" will result in spending more from Covered California self-sustainability funds instead of federal establishment funds. Staff will be looking at defining primary function of the navigator model. Policies would need to be developed that continue to promote ways for community organizations to work collaboratively with each other and with certified agents. Staff is looking at the policy to allow for limited use of funds for marketing and media to promote enrollment activities. Lastly, while staff is not advocating for this position, the board may conclude that it is prudent to only invest in the original $5 million navigator grant and continue to run the other program status quo.

Board Member Belshé asked if the stakeholder feedback received related to experience to date or to the specific staff recommendation.

Ms. Soto-Taylor said feedback related to both experience to date and the specific staff recommendation.

Board Member Belshé asked if the stakeholders have seen this presentation or only heard word of mouth.

Ms. Soto-Taylor stated that stakeholders were given slides of information, though not to this level of detail. She also mentioned that the marketing, outreach, and enrollment assistance advisory group has met three times in the last eighteen months, but they will be reconvened.

Mr. Lee said they take public comment from those who are not part of the advisory committee at the meetings.

Board Member Belshé said the federal regulations came out and she wondered how those interact.

Ms. Soto-Taylor said that the federal rules are applicable to the federally facilitated exchanges, but left it open to states to continue their models if they would like to.

Mr. Lee noted that the final rules just came out last week. These are consistent with that, but they have latitude to vary their practice.

Board Member Belshé articulated that staff is trying to bridge the gap between outreach and enrollment functions and they have good reasons for doing that. One implication is moving away from a pay for performance, and she would like to know how that bridging can occur but continue to provide important incentives for enrollment. It is clear that the primary function is enrollment, but she wondered if the staff plans to incorporate health literacy as well, to ensure people understand their new coverage.

Ms. Soto-Taylor voiced that it is important not to duplicate responsibilities. Some plans are doing outreach to new membership on how to schedule appointments.

Board Member Belshé clarified that the education message is about availability of coverage.

Ms. Soto-Taylor responded that part of the education is emphasizing the preventative aspect and the benefits of regular access to care.

Mr. Lee said that the central point is to promote enrollment. The burden of informed health literacy and access to care education is on the plans and on Covered California. It is not a core function of navigators.

Chairwoman Dooley appreciated Board Member Belshé's question. Slide 50 addresses the things that Board Member Belshé talks about. The organizations have a mission to provide a range of services to the people they are serving. Covered California wouldn't say they couldn't do those things, but the commitment of resources is to ensure the enrollment function.

Mr. Lee said it's important to note that stakeholder feedback informed the staff's structuring of the program. We all believe having a more health-literate consumer will help with retention. The staff recommendation is about getting people in the door. However, one can't help people choose a plan if they don't understand things such as coinsurance, so there needs to be information given about the various products.

Chairwoman Dooley hoped for a fuller sense of what it would take to do these things in the June meeting. Would that mean fewer navigators? Would it mean less enrollment? She wants a menu of options around the things that people have suggested they want Covered California do for this program. Staff has determined it would be best to do enrollment only, but it would help the Board to see the spectrum of options.

Board Member Belshé noted that Covered California has trained and certified a lot of enrollment counselors. That took a lot of time and resources. What's going to happen with those 5200 people? How can Covered California deploy that rich asset?

Ms. Soto-Taylor said they are encouraging those organizations to move to the navigator model. There are about 150 organizations providing about 80 percent of enrollment assistance. They have the infrastructure in place. The other organizations who feel like that's not their business model can continue (throughout the second enrollment period) to provide assistance on the per-application model. At the end of the second enrollment period, Covered California will have to decide if it should continue to fund the per-application enrollment function.

Chairwoman Dooley clarified that one would still have to be a certified enrollment counselor to provide that assistance.

Ms. Soto-Taylor said that staff expects the organizations to make staffing decisions. Organizations could choose to take on a salaried staff member, for example.

Board Member Fearer said it would be better to be informed about how individual enrollers and enrolling organizations line up. He asked how many of those 5200 counselors were associated with those 150 organizations.

Ms. Soto-Taylor said she will make sure they provide that data point.

Mr. Lee noted that 80 percent of enrollment is through 20 percent of the groups. Staff's recommendation is to not do small grants. They want to create administration resources that are more efficient. The most targeted thing is paying $58 singly for applications. There is less specificity and micro-targeting associated with this model. Staff is still

looking at the potential role of web-based agents and entities. It's a challenge for CalHEERS work that is queued up. Staff has a request for information out, and will come to the Board with a potential RFP (request for proposal).

Public Comments:
Nenick Vu, Hmong Health Collaborative, suggested that Covered California should focus on building deep partnerships. These would not be yearly grants, but would be sustained contracts or some sort of relationship that can allow organizations to specialize in supporting Covered California enrollment. Their staff would be helping people with Medi-Cal and social services in addition to enrolling them in Covered California. Mr. Vu would love to see a focus on finding key organizations that want to become invested and become resources for other organizations. The organizations that are doing other kinds of work with these communities can focus on that.

Sonya Vasquez, Policy Director, Community Health Councils, thanked the Board for asking the staff to consider what it might look like to fund a comprehensive program. They are still helping people who enrolled through them. They are engaging with plans to make those connections. They would like funding for that. People will say they think consolidating the programs is good, but we need to figure out what that should look like and what consumers need. It's important that DHCS come to the table and talk about how they can support the program too. It will be important to have conversations with existing grantees to figure out what structure is right for them. Her geography for the two kinds of work is very different and the structures of those efforts are very different. To consolidate that would mean losing important partnerships, but not consolidating would mean she couldn't participate in the grant program. The Board should think about what's going to work for existing programs.

Autumn Ogden, Policy Analyst, California Coverage & Health Initiatives, appreciated how much Covered California reached out in the last week. She asked that the Board not make any broad policy changes until after the next enrollment period. They support moving toward an integrated model, but things are moving too fast. It would be good to compare the programs and see what works. They would like to ensure that the CEEs and CECs that they have invested so much in have a place in this "new world." These people have spent significant time being trained and providing critical services and we shouldn't lose any of them. It will also be important to make sure to fully and fairly fund the navigator program. As Covered California continues to develop a no-wrong-door approach, they want to ensure there are equal credits for enrollments into Medi-Cal and Covered California. California Coverage & Health Initiatives supports the option of supporting smaller grants for more focused areas. They also support developing an umbrella program for CECs who don't get in with the navigators.

Betsy Imholz, Director of Special Projects, Consumers Union, voiced that everyone supports the idea of bridging the different functions, which have been artificially distinct. She agreed with Ms. Vasquez's point about not creating artificial distinction between Medi-Cal and Covered California. She also mentioned that those who self-enrolled did have help often. If it's possible, it would be great for there to be a focus group or inquiry

about those who enrolled to find out what their experience was. The kinds of help people got in their communities might help inform the process. They don't want to lose momentum or good resources.

Tahira Cunningham, California Pan-Ethnic Health Network (CPEHN), expressed that they have been waiting for a robust formalized engagement process around CECs, and they haven't really seen that. It was good to hear that there was some kind of process, but they were disappointed to hear that it was just for grantees and that others were left out. They went around the state and met with educators, community organizations, and CECs to hear about their experiences (particularly for communities of color). They then developed key recommendations. The CECs did not always feel heard during the engagement process.

Lisa White, California School-Based Health Alliance, expressed that they and their eleven subcontractors have done a great deal of outreach and enrollment. Through the process of this past year, they have learned that consumers still need a lot of educating and convincing before they will enroll. Their partners are uniquely positioned to provide this education. Continuing enrollment without funding won't be possible or sustainable. Most of their subcontractors who provided outreach and education were also enrollment entities or worked closely with enrollment entities. A year ago it did not make sense for them to become navigators, so they may lose some of their subcontractors who can't commit staff time to become navigators. They would like more clarity on what would be expected of navigators.

Doreena Wong, Project Director, Asian Americans Advancing Justice, acknowledged that Ms. Soto-Taylor had shared some information with them. They shared it with their partners, being one of the major grantees reaching out to the disadvantaged Asian community. They oversee the Health Justice Network. Even though they had some time to check with their partners, they believe they need more time because this is a big decision. They would like some kind of input process. They submitted a letter with some concerns. They also would like more of a hybrid program. About half of their partners are CECs, but not all outreach and education partners have the capacity to do enrollment. There should be an opportunity for those who want to keep doing outreach to continue doing so, and those who want to do enrollment can get that additional funding. They are glad the fee-per-application funding will be continued until the end of the open enrollment period, but the smaller groups need more income to sustain an enrollment program. They want to continue fee-per-application funding.

Kathleen Hamilton, Director, The Children's Partnership, said that it's premature to be redesigning California's enrollment assistance program. Covered California hasn't even launched the navigator program yet. Certain avenues of assistance were used less frequently during open enrollment not because people don't prefer them, but because they weren't fully up and running. It would also be important to assess consumer preference. The Latino community is best assisted by in-person community-based, in-language assistance. Research is needed to show how other communities enroll.

Mari Lopez, Policy Director, Visión y Compromiso, noted that her organization was another grantee. They appreciated participating in the discussions mentioned by Ms. Soto-Taylor. She seconded Ms. Wong's and Ms. Vasquez's comments, and highlighted the need for education on insurance use. Her community (and other communities of color) needs to understand how to utilize coverage. They have been emphasizing this.

Kate Burch, Network Director, California LGBT Health and Human Services Network, voiced that she was speaking from conversations she has had with 11 partners, some of whom do outreach and education, and some of whom do enrollment. Going toward a navigator-only plan would be mostly a good idea, but it would be a mistake to have no avenue to compensate enrollment counselors outside of that program. If you take $20 million and split it into $250,000 grants, that's 80 grants. The presentation mentioned 150 organizations doing the bulk of the enrollment. Covered California should also have ways for people to continue doing enrollment and get compensated.

Beth Malinowski, Associate Director of Policy, California Primary Care Association, commented on the speed of the changes being proposed. They feel a lot more comprehensive stakeholder engagement is needed before decisions are made. They are glad to see an incremental approach to implementing the changes, but are concerned with the landscape as it might look after 2015. For an expanded navigator program to work, more funding is needed, especially if Covered California wants to capture a larger number of partners. The program structure itself is made for large organizations with multicounty and statewide reaches. A lot of the best entities with the best local touch would be lost. Keep in mind the need for ongoing education and translating coverage into care. This work supports renewal and reduces churn. Covered California can't rely on the plans for that kind of work; it requires a local touch.

Carla Saporta, Health Policy Director, The Greenlining Institute, seconded many comments. They are concerned about the speed with which Covered California is moving on this proposal. Various grantees and CECs have brought up communication barriers between organizations. It's not clear that forming everything into one program is the result we really need. It would be helpful to examine the best practices of this area. When different organizations were going to apply for the original program, smaller grassroots organizations didn't qualify as grantees. They want to ensure smaller organizations are still able to participate.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), commented that Covered California has reached out to them on imputing data and assigning race and ethnicity categories. They urge that the data on a high number of non-respondents continue to be recorded and that Covered California not use estimation techniques to assign race and ethnicity. They think this can skew data and be confusing. No other categories are being imputed. They urge Covered California to do a better job on educating applicants and assisters on the importance of answering these questions. They appreciate the commitment to transparency and reporting data. They would like to continue in dialogue on recommendations for how to increase response percentages.

David Chase, California Director, Small Business Majority, wasn't clear if it was staff's intention that the new navigator program would include outreach and enrollment assistance for the SHOP. There should be something for SHOP in 2015. Currently, only agents are doing actual enrollment, and some business groups are doing outreach education. Also having other groups doing enrollment would be a large shift, and they would like to discuss how to most effectively perform outreach and enrollment for the SHOP.

Brian Burrell, California Policy and Organizing Manager, Young Invincibles, noted that if outreach and education are rolled in with enrollment, they would like to see information on health literacy and preventative care included. They would like to see this especially for young adults, many of whom are buying health insurance for the first time. In order to re-enroll, they will need to understand what they are getting out of health insurance.

Kathy Ochoa, SEIU-UHW, noted that enrollers must already reach twice the people in half the time. The staff's recommendation puts the burden on them to enroll people in a quarter of the time. They are also a listening, learning and adaptive organization, and that is why they applied for the first navigator program. It is now in danger of being thrown out. That delay is a disservice to Covered California's partners, who have already thought through the best strategies for reaching people. They support many of the policy recommendations, but they noted a major difference between the programs, which is that the navigator program enables enrollers to count Medicaid enrollments. That is disingenuous. Those who merited an award for the first navigator program could serve as a bridge between the status quo and 2015. They urge the board to reconsider and move forward with the grant process for the first navigator program. They do agree that the funding is inadequate.

Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law & Poverty and the Health Consumer Alliance, agreed with Ms. Sanders' concerns about imputing race based on zip code. They think having a functionality for initial payment on the website is important, though not more important than Medi-Cal functionality. They have been pleased with the amount of dialogue they have had with Covered California, DMHC, and CalHEERS staff to get the next application ready. They support the comments of their colleagues about using caution when changing the navigators program. The education component is very important, and while they wish the health plans would play a role, community-based organizations play a large role in this. They are concerned about the suggestion that special consideration would be given to those working with retail establishments. There are important ramifications for the Medi-Cal side, as their assistance program was modeled on Covered California's.

Beth Capell, Health Access California, noted that when they spoke earlier about creating a budget that looks to the future, they were thinking about outreach and enrollment. Covered California won't have a sustainable budget if it does not sell the product.

Chairwoman Dooley voiced that the organization has been working on this topic for years. No matter how much the Board anticipates a difficult decision on how to use resources, it will still be difficult. The organization will not have as much to spend on outreach and enrollment in the future as it had in the first year and a half. They will have to prioritize, and the prioritization process is difficult. The Board must consider what it thinks will be effective. It will rely on the data gathered, and some people will be disappointed. As always, Covered California will rely on its partnerships, on stakeholder engagement, and on evidence to do the best it can to continue the success it has had up until this point.

Mr. Lee commented that the staff proposal is about enhancing and providing more resources. It's about not diminishing and it's about supporting community-based outreach and enrollment. There are tradeoffs with any route that the organization takes. Staff is still working out the details. He also noted that the staff is not designing the program with the intent of keeping this model ten years down the line. The current effort is designed to get people enrolled for the first time ever. He is aware that this may cause stress for other organizations, but Covered California's goal is to get the maximum number of people enrolled for coverage.

Discussion: Covered California Regulations

Presentation: Covered California Regulations

Katie Ravel, Director of Program Policy, presented on Covered California Regulations. Staff wants to readopt four sets of regulations. Staff is working to make these permanent, but staff has run up against the ninety-day deadline for emergency regulations. No changes have been made to these regulations since the last adoption by the Board. This is the last readoption before they must become permanent.

i. 2014 Standard Benefit Plan Design Readoption

Motion/Action: Board Member Fearer moved to pass Resolution 2014-38. Board Member Kennedy seconded the motion.

Discussion: None

Public Comments: None

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

ii. Certified Plan-Based Enrollment Program Readoption

Motion/Action: Board Member Fearer moved to pass Resolution 2014-39. Board Member Kennedy seconded the motion.

Discussion: None

Public Comments: None

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

iii. SHOP Eligibility and Enrollment Process Readoption

Motion/Action: Board Member Fearer moved to pass Resolution 2014-40. Board Member Kennedy seconded the motion.

Discussion: None

Public Comments: None

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

iv. Certified Insurance Agents Readoption

Motion/Action: Board Member Fearer moved to pass Resolution 2014-41. Board Member Kennedy seconded the motion.

Discussion: None

Public Comments: None

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

v. Eligibility and Enrollment Process for the Individual Exchange
This item was for discussion only. Staff will accept comments through June 6. There are changes in a few areas. These areas include: Verification of the special enrollment triggering event, alignment with new final federal regulations, and changes for clarity and technical conformity.

Board Member Fearer expressed that he hoped the information had all been run by Covered California's plan partners. He wondered if there would be any liability associated with the Exchange if people were wrongfully enrolled.

Mr. Lee said there is currently no liability to Covered California. Staff will examine the issue to ensure that there would be no new liability if Covered California staff made errors during the verification process.

Board Member Fearer asked if this means accepting more responsibility for verification.

Mr. Lee said that the consumer will bear more responsibility for verification. Soon, they would like to be able to use electronic data (when available), but there

are many issues in the queue and that probably won't happen until after open enrollment.

Board Member Belshé clarified that this adds to the requirements on the consumer.

Mr. Lee noted that you can fax, upload, or provide in person any documentation required.

Board Member Belshé asked if the motivation is to ensure that there isn't an inappropriate utilization of special enrollment periods.

Mr. Lee voiced that plans are concerned about people inappropriately using special enrollment periods and increasing costs for everyone. Ideally it would be as easy as possible for those who have a change. Those who don't have a change will be discouraged from enrolling until open enrollment.

Public Comments:
Beth Capell, Health Access California, opposed the staff recommendation. They have worked with the staff and plans and have worked through a series of issues. The Exchange is the sole judge of eligibility for its enrollees. Health Access supports the current regulation, which relies on self-attestation. They are reluctantly willing to consider electronic verification when there is an incompatibility and the consumer must resolve the incompatibility. Even electronic sources are not their preferred approach. That is not the proposal before you, which would require consumers to produce documents each and every time there is a change. This is what ground Medi-Cal enrollment to a halt. This is a burden for consumers, and Covered California does not have the administrative capacity to check the documents and verify them.

Chairwoman Dooley noted that they have suspended the paper verification of residency for Medi-Cal. They are working on the backlog.

Elizabeth Landsberg, director of legislative advocacy, Western Center on Law & Poverty, agreed with Ms. Capell's comments. There will be a lot of people using the special enrollment period, according to the UC presentation. Many people will have changes in circumstances. They worked with staff a year ago to come up with regulations that would allow for self-attestation. Today, if someone applies online, they use self-attestation under the penalty of perjury. Requiring paper documentation would be problematic. The paper documentation required for Medi-Cal did cause problems before it was suspended. There have been technical problems with uploads. They would consider electronic verifications, but there is a backlog of problems to solve already.

Julie Silas, Senior Policy Analyst, Consumers Union, noted that they submitted a letter with Western Center on Law & Poverty, and Health Access California. She

pointed out that the federally facilitated Exchange relies on self-attestation. She also noted that many young people, who are important for the risk mix, are the ones who will be using the special enrollment period most. This is due to changes in life circumstances. They should not discourage those potential members from enrolling.

Brian Burrell, California Policy and Organizing Manager, Young Invincibles, agreed with the prior commenters. Young adults should not be discouraged from enrolling during the special enrollment periods. Some changes are difficult for them to verify. They would like to stick with the current regulations.

Kathleen Hamilton, Director, The Children's Partnership, noted that their founding mission is to achieve health care for all. Accordingly, they cannot support the recommendation. These regulations will discourage and inhibit the enrollment of eligible consumers. That's not an acceptable outcome. The Board found it unacceptable when it adopted the original regulations, which permit self-attestation and specifically disallow requirements for documentation. They appreciate that Covered California is a learning institution. One of the things The Children's Partnership learned during open enrollment is that requirements to provide address verification for Medi-Cal enrollment was a problem. These regulations will only make it harder for people to get enrolled in a timely way. This change should be delayed until electronic verifications are available.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), noted that they did not sign on to the letter, but they were at the meetings with the health plans and voiced their concerns and opposition to this proposal. Limited English proficient consumers get notices after they have applied and they don't receive translated notices. This means they must go back and forth to the community organizations.

Carla Saporta, Health Policy Director, The Greenlining Institute, strongly supported the comments of the prior speakers.

Autumn Ogden, Policy Analyst, California Coverage & Health Initiatives, supported the comments of the prior speakers. They oppose the proposal.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, voiced that they do not support self-attestation. They appreciate that Covered California staff has been working with stakeholders to update the regulations. They are pleased with the proposed regulations, requiring documentation when e-verification is not available. They remain concerned that the draft regulations allow a consumer to enroll into a health plan with pending verification during a special enrollment period. Since very few e-verifications are available at this point, they are concerned that some of these members will only be enrolling because of a need for immediate coverage. This will cause them to be disqualified and will also skew the risk pool. There is a clear distinction between

allowing a consumer to enroll pending verification for a tax credit (which can be reconciled at the end of the year) and allowing a consumer to enroll who has not met the threshold for eligibility in a special enrollment period. This undermines the ability of health plans to provide affordable coverage. State law requires that all eligibility determinations be provided on a prospective basis. There will be no recourse to rescind their coverage based on their retrospective review of eligibility. Eligibility determination must be made prior to enrollment in a QHP.

Bill Wehrle, Vice President of Health Insurance Exchanges, Kaiser Permanente, supported the requirement for documentation. This is the same process that exists for anybody who gets coverage on the job. If you enroll or want to change plans or add a dependent outside the annual enrollment period, you must produce documentation. Kaiser suggests mirroring that process. These are readily available documents. This is the process that is in place in the individual market outside of Covered California. In order to have a consistent application of the open enrollment period, we must do this. California laws don't provide recourse for people who wrongfully enter during the special enrollment period unless the plan can demonstrate to a criminal standard that the person misrepresented information. That rarely happens. We have to get it right up front rather than going after people after-the-fact.

Ruth Liu, Blue Shield, voiced support for Mr. Wehrle's and Ms. Chapman's comments.

Linda Brown, Health Net, noted that they collect documentation from people in the outside market, and they do not think it's a huge burden on consumers. If the Board does not set that rule, people will think it is open enrollment year-round.

Francene Mori, California Exchange Director, Anthem Blue Cross, echoed the comments of the other health plans. Asking for appropriate documentation of qualified events is not a burden. They support the staff recommendation.

Elizabeth Landsberg spoke on behalf of Abbi Coursolle, National Health Law Program, stating that she was in agreement with the consumer advocate groups' comments.

Chairwoman Dooley noted that this is clearly an important issue. She directed staff to research employers' policies. She feels that the Exchange must be committed to the integrity of the enrollment process. She would like to see the issues addressed. There is a significant process between the entitlement process to Medi-Cal and the enrollment of people in an insurance product that should mirror the process in the outside market.

Mr. Lee noted that commenters brought up Covered California's administrative capacity to do the verification process as well as the legal issues involved. Staff's

recommendation is to allow the ninety-day conditional enrollment, and it is concerned that may not be enough. Staff will research the issue.

Ms. Ravel noted that staff is also working with the Department of Managed Health Care, and they will have more information at the next meeting.

Chairwoman Dooley would like to hear answers from staff to all of the comments and questions presented, but especially more information about how the federally facilitated Exchange is operating.

On Phone: Abbi Coursolle, National Health Law Program, echoed the comments of the consumer advocates. She pointed out that applicants are required to sign their applications under penalty of perjury. She also believes that under federal regulations, the Exchange has the authority to terminate enrollment from ineligible individuals, separate from the plans' abilities to cancel. They will continue to partner with staff.

Chairwoman Dooley also wanted to know what the recourse is on the self-attestation. There is a lot of work to do.

Agenda Item VI: Adjournment
The meeting was adjourned at 4:51 p.m.