



Comments to the Board

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January 15, 2015 Board Meeting

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DAVE JONES
Insurance Commissioner

December 15, 2014

Diana Dooley, Chair and Board members
Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

Dear Secretary Dooley and Board members,

On Thursday, December 11, 2014, Covered California staff informed staff of the Department of Insurance (CDI) that Covered California intends to cancel the health insurance coverage of approximately 95,000 people who signed up for health insurance coverage through Covered California effective December 31, 2014 because Covered California believes these individuals are eligible for Medi-Cal. It is my understanding that you intend to send letters this week to these individuals who are enrolled in private health insurance that they purchased through Covered California to notify them that their policies are being cancelled.

I write to urge Covered California's Board to direct its staff to halt the cancellations of coverage. The cancellation of coverage in this instance is contrary to state law.

The Department understands that you need to notify these individuals and families that based on the information you have, you believe they are eligible for Medi-Cal and that if they are Medi-Cal eligible, they are not eligible for a premium subsidy for products available for sale through Covered California.

However, neither Covered California nor the health plan or insurer from whom these policyholders purchased coverage have the right to cancel or non-renew the insurance coverage of these policyholders. State and federal law guarantee that these policyholders can keep their insurance coverage if they choose to do so. If they are Medi-Cal eligible, they would be required to pay the full premium for the policy they wish to keep, but the policyholder gets to make that decision.

The consumer has the right to decide whether they want to keep their QHP coverage. Under Insurance Code 10273.6, individual health insurance must be renewable at the option of the insured. Insurance Code Section 10273.6 provides only a few specific circumstances in which insurance is not renewable at the option of the insured. Eligibility for Medi-Cal is not one of the circumstances specified that would allow for

cancellation by anyone other than the policyholder. Even if eligible for Medi-Cal, an insured who wishes to buy private insurance is still eligible to do so, even though they may not be eligible for federal premium subsidy. State law in this regard is consistent with the federal regulation at 45 CFR 155.430(b), which provides that an Exchange must provide an insured with the option to remain in a QHP, even if the customer is otherwise eligible for other minimum essential coverage.

In addition to the the legal prohibition of Covered California's proposed cancellations, there are also important policy reasons to stop the cancellations.

First, existing health insurance coverage must be maintained until final determination of Medi-Cal eligibility, including appeals, in order to prevent breaks in coverage (Welfare & Institutions Code sec 15926(h)(1)). This is particularly important as the final determination of whether the individual or family is Med-Cal eligible has not yet been made. Particularly for those individuals whose eligibility was determined by Covered California based on their 2013 income being compared with the updated Federal Poverty Level figures, you may not be using up to date information about their current salary. Moreover, you are not giving the consumer the opportunity, where their income is actually different from the information you have, to keep their current coverage, while they appeal your determination.

Second, there is concern about whether these consumers, even if ultimately determined to be Medi-Cal eligible, will be temporarily without coverage and thus without access to health care services as they are being processed for enrollment into Medi-Cal.

Covered California is not permitted to cancel health insurance coverage for someone who has enrolled in a QHP because the policyholder is likely eligible for Medi-Cal. Health insurers and health plans do not have the authority to cancel policyholders simply because they may be or are Medi-Cal eligible. These policyholders should receive notice of their potential eligibility for Medi-Cal and the opportunity to seamlessly transfer to that new coverage.

However, the consumer has the right to pay their premiums and keep their existing coverage if for whatever reason they choose to do so. Covered California should not cancel the health insurance coverage of those you believe are Medi-Cal eligible without their consent.

Sincerely,



DAVE JONES
Insurance Commissioner

cc: Peter Lee

DEPARTMENT OF INSURANCE

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300 CAPITOL MALL, SUITE 1700
SACRAMENTO, CA 95814
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(916) 445-5280 (FAX)
www.insurance.ca.gov



December 22, 2014

Sent via Electronic Transmission and First Class Mail

Chairperson Diana Dooley
Covered California
1601 Exposition Boulevard
Sacramento, CA 95815

Re: Cancellation or Non-Renewal of Covered California policies for
persons who may be eligible for Medi-Cal

Dear Chairperson Dooley:

On December 11, 2014 Covered California advised the Department of Insurance for the first time that Covered California planned to cancel or non-renew on December 31, 2014 approximately 95,000 policyholders who Covered California believed were no longer eligible for premium assistance because their incomes made them eligible for Medi-Cal. On December 15, 2014, I sent a letter urging you not to move forward with the cancellation or non-renewal of the policies of approximately 95,000 Californians because such cancellations or non-renewals were contrary to California law. The Department of Insurance also testified at your Covered California Board meeting that the planned cancellations or non-renewals violated California law and urged Covered California to stop the cancellations or non-renewals.

Since that time, some progress has been made in facilitating the seamless transfer of those who wish to move to Medi-Cal to be able to do so effective January 1, 2015. Further, your staff have told mine that individuals who are determined to be eligible for Medi-Cal by Covered California will be made presumptively eligible for Medi-Cal pending final determination of their eligibility, that these approximately 95,000 individuals will be processed into the Medi-Cal system and able to use their Medi-Cal coverage on January 1, 2015 and that those who are later determined not to be Medi-Cal eligible will be held harmless for the care they sought from Medi-Cal providers during the time they had Medi-Cal coverage. A seamless transition to Medi-Cal for those who wish to move to Medi-Cal and preventing any gap in coverage for these individual and families is important. I appreciate the work you have done to make this possible.

However, this does not change the underlying legal issue that neither Covered California nor the health plan or health insurer with whom these individuals and families currently have coverage is permitted to cancel or non-renew the health policy of these individuals and families on December 31, 2014. State law allows these individuals to keep their current coverage and pay the non-subsidized premium even if they are Medi-Cal eligible. For Covered California to notify health plans and insurers that these individuals are to be canceled or non-renewed on December 31, 2014 is contrary to law.

While I recognize the role that Covered California has in assuring a seamless transition between Qualified Health Plan (QHP) coverage and Medi-Cal under Government Code section 100503(a), Covered California's direction to its QHPs will cause them and Covered California to violate the law if they comply with Covered California's instructions. California health insurers and health care service plans are required to renew policies in the individual and group market (see Health & Safety Code section 1365(a) and Insurance Code sections 10273.4 and 10273.6). The only legally permissible reasons for a company to cancel or not renew a policy (absent cancellation by the policyholder) are nonpayment of premiums, fraud or intentional misrepresentation of material facts, failure to meet group participation or contribution rates, movement of an individual out of the service area, or a carrier's withdrawal of a product or withdrawal from the market. A covered person becoming eligible for Medi-Cal is not a permissible reason for a company to fail to renew a consumer's QHP coverage through Covered California.

I understand that Covered California intends to mail letters to these approximately 95,000 Covered California policyholders in the next few days to notify them that their premium assistance will end on December 31, 2014. This notice to policyholders is, in itself, insufficient without Covered California also instructing its contracting QHPs that coverage for these policyholders should not be canceled unless the insured requests cancellation, or until after the appropriate grace period if the consumer does not pay their January premium.

Under Government Code section 100504(a)(7), Covered California is obligated to allow persons who become eligible for Medi-Cal and who are no longer eligible for premium tax credits the option to remain enrolled with their QHP carrier and provider network. Cancellation of their policies would be inconsistent with this obligation, and would place Covered California and the insurer and health care service plans implementing the cancellation or non-renewals at risk for violation of the law. When you share information with the health plans and health insurers about which of their policyholders may be eligible for Medi-Cal, please make clear that these policies should not be cancelled on December 31, 2014.

Additionally, for Covered California to notify CMS to stop the federal premium assistance before the final income verification and eligibility determination are made is disruptive for those policyholders for whom the financial information you have is outdated or where a mistake was made in doing the initial eligibility determination. It is my understanding, and your staff confirmed, that in the Federally Facilitated Exchange

(FFE), policyholders are keeping their current coverage with the premium subsidy they have now pending final determination of Medicaid eligibility. Californians who may be eligible for Medi-Cal, but wish to keep their current coverage, should be able to hold on to premium assistance until a final eligibility determination for Medi-Cal has been made. A transition to Medi-Cal and then back to private coverage for those who are not income eligible for Medi-Cal will be disruptive and could make it more difficult to seek timely care if the medical provider network for each coverage is different.

Please let me know whether Covered California will reverse its prior direction to QHPS and instead require QHPs to comply with the law and refrain from cancelling or non-renewing the coverage of these individuals and families. Thank you.

Sincerely,



DAVE JONES
Insurance Commissioner

cc: Peter Lee



January 2, 2015

The Honorable Dave Jones
California Department of Insurance
300 Capitol Mall, Suite 1700
Sacramento, CA 95814

Dear Commissioner Jones,

Secretary Dooley asked me to respond to the concerns you addressed to her in her capacity as Covered California's board chair regarding the potential transition of consumers from health care coverage in Covered California to Medi-Cal. I hope the following overview of our process addresses those concerns.

Covered California is working closely with the Department of Health Care Services (DHCS) and our county partners to implement a process to help consumers currently enrolled in Covered California and transitioning to Medi-Cal. Federal law bars eligibility for Advanced Premium Tax Credits (APTC) when an individual's income makes them eligible for Medicaid. Relying on this law, Covered California is allowing current health plan contracts for the 2014 plan year to expire on December 31, 2014 when the consumer's income information indicates eligibility for Medi-Cal while providing the consumer the option of maintaining 2015 coverage without subsidy.

Furthermore, Covered California is collaborating with the California Department of Managed Health Care, which has legal responsibility for overseeing plans that cover over 90% of Covered California's insureds, and working with the Department of Insurance.

The reality is that a majority, if not all, individuals who are no longer eligible for APTC will not be able to afford their coverage without the federal subsidy. Nonetheless, we are allowing consumers the option to keep coverage under their old plan if they can pay the full premium for that plan.

We previously sent a notice informing consumers that based on the information they had provided us, they or their family members would qualify for low or no cost Medi-Cal coverage beginning January 1, 2015. We recently sent an additional notice advising these consumers of our re-enrollment process—which leaves no gaps in healthcare coverage, and is consistent with state and federal law. In addition to our notice, we have worked with our participating health plans to send notices addressing these same issues. Key elements of our re-enrollment process include the following:

- **Medi-Cal Coverage Begins January 1, 2015.** We have reached an agreement with DHCS and county officials to ensure that consumers are enrolled into Medi-Cal beginning January 1, 2015. Through this process, we have ensured continuity of coverage—there will be no gaps in coverage for these people, as their Medi-Cal coverage will begin immediately.
- **Continuity of Care.** If an individual receiving treatment for certain health conditions qualifies for Medi-Cal and their current doctor is not under their new Medi-Cal plan, they may be able to keep seeing their current doctor.
- **Option for Keeping Covered California Health Plan without Premium Assistance.** Consumers have the option to keep their Covered California health plan in 2015, but without the benefit of any federal premium assistance. This means that consumers can keep their old plan if they want to pay the full premium for that plan.
- **Right to Appeal.** Consumers have the right to appeal Covered California's coverage determination, in which case they may keep their Covered California plan with premium assistance until a final determination is made.

We have developed our re-enrollment process to best serve our consumers who relied on federal premium assistance to afford their Covered California coverage, and most likely would not be able to afford unsubsidized coverage. The process is also grounded in the belief that the law requires us to seamlessly move consumers from one program to another. Accordingly, we give consumers the option of deciding whether they want to keep coverage with their Covered California health plan without any premium assistance, appeal their Medi-Cal determination while continuing in subsidized coverage, or be enrolled in Medi-Cal. Further, we have ensured continuity of coverage by working with our state and county partners to ensure that Medi-Cal coverage begins January 1, 2015.

I hope this addresses your concerns. I appreciate the work our staffs have engaged in together to improve the consumer experience, including the notice process for insureds that are subject to Department of Insurance oversight. If you wish to discuss this process in more detail, please feel free to call.

Sincerely,



Peter V. Lee
Executive Director

Cc: Secretary Diana Dooley, Chair, Board of Directors
Shelley Rouillard, Director, Department of Managed Health Care
Toby Douglas, Director, Department of Health Care Services

United States Senate

WASHINGTON, DC 20510-0504

<http://feinstein.senate.gov>

November 18, 2014

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

Dear Peter,

I am writing to ask that Covered California help former foster youth enroll in Medi-Cal by providing easy-to-access, comprehensive information on Medi-Cal eligibility and enrollment in a designated portion of the website.

Thousands of former foster youth live in California and are eligible to enroll in Medi-Cal coverage until age 26. Many of these young adults are navigating independent life for the first time as they struggle to find employment, housing, and educational opportunities. Ensuring that these youth have access to healthcare while they confront these challenges should be a priority.

I commend Covered California's work in educating specific groups about enrollment and special programs. For example, your website includes several targeted pages under the "coverage" tab: one for pregnant women, with information about Medi-Cal and the Access for Infants and Mothers program, and one for American Indian tribes, with information about reduced cost-sharing for low-income families that purchase private insurance. I ask that Covered California build on these efforts by adding an additional page under this section for former foster youth.

At a minimum, I suggest that this page include information on eligibility, benefits, and enrollment, and provide answers to frequently asked questions. I have attached more detailed suggestions for topics that this section could include.

Executive Director Peter Lee
November 18, 2014
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In addition, I urge you to continue efforts to train call-center employees, enrollment counselors, enrollment entities, and navigators on how to assist former foster youth seeking coverage. As open enrollment begins, I am concerned that enrollment assisters who are unfamiliar with the unique eligibility standards for these youth may incorrectly advise them that they are not eligible for Medi-Cal coverage based on income or availability of employer-based insurance.

Thank you for your continued and outstanding work to connect Californians with healthcare. I hope to continue working together to reach and enroll emancipated foster youth, and I look forward to another successful open enrollment this year.

Sincerely,

A handwritten signature in black ink, appearing to read "Dianne Feinstein", written over a horizontal line.

Dianne Feinstein
United States Senator

DF:nz/mt

Enclosures:

Suggested Former Foster Youth Webpage Topics



December 8, 2014

The Honorable Dianne Feinstein
United States Senate
331 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Feinstein,

Thank you for your letter regarding expanding information about Medi-Cal eligibility and enrollment opportunities for former foster youth. I appreciate the concern and share your commitment to ensuring that all Californians have access to quality affordable health insurance.

I will be sharing your letter with Mr. Toby Douglas, the Director of the California Department of Health Care Services (DHCS). The California Healthcare Eligibility Enrollment and Retention System (CalHEERS) is the state's online gateway to the single, streamlined application that lets consumers know if they qualify for Covered California or Medi-Cal coverage. The site is co-managed by DHCS and Covered California, however DHCS takes the lead on all issues related to Medi-Cal. As needed improvements to CalHEERS are identified, changes are reviewed and prioritized by a Change Control Board co-chaired by myself and Mr. Douglas. We will coordinate with the Department on a response to your recommendations.

Thank you again for your continued support and leadership on Affordable Care Act implementation issues.

Sincerely,

A handwritten signature in blue ink, appearing to read "Peter V. Lee", is written over a horizontal line.

Peter V. Lee
Executive Director

Cc: Mr. Toby Douglas, Director, DHCS
Ms. Carol Gallegos, Deputy Director, Legislative & Governmental Affairs

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California State Senate

SENATOR
CATHLEEN GALGIANI
FIFTH SENATE DISTRICT



STANDING COMMITTEES

AGRICULTURE
CHAIR

BUSINESS, PROFESSIONS &
ECONOMIC DEVELOPMENT

GOVERNMENTAL
ORGANIZATION

TRANSPORTATION &
HOUSING

November 4, 2014

Mr. Peter V. Lee
Executive Director, Covered California
1601 Exposition Blvd
Sacramento, CA 95815

Dear Mr. Lee:

I am writing to request that you assist me and the Legislature in promoting economic development in California through your agencies activities, including your public contracting for goods and services.

California has a long history of promoting economic development in the state through the use of small business and disabled veteran programs and outreach activities established to increase California business participation in state contracts. I would like to ask that you keep these goals in mind as you pursue the letting of contracts necessary for the implementation of the Affordable Care Act.

Thank you,

Cathleen Galgiani

Cathleen Galgiani
Senator, 5th District



December 15, 2014

The Honorable Cathleen Galgiani
31 East Channel Street, Suite 440
Stockton, CA 95202

Dear Senator Galgiani,

Thank you for your letter regarding the participation of local California businesses in Covered California's public contracting for goods and services.

As a state agency, our contracting practices and processes are consistent with the requirements of state law and federal guidelines. These rules are intended to assure a fair and level playing field for bidders, and to ensure that public funds are used to get the best value. We recognize the added benefits of contracting with California vendors and their employees, and we make every effort to do so. Here are two examples of recent Covered California contracts that have led to new jobs in California:

- In Greenhaven, Sacramento, 600 people have been hired through our contract with Faneuil. These local contract employees will supplement the work now being performed by our public employees at our three existing service centers in Rancho Cordova, Fresno and Contra Costa.
- In Folsom, 200 people have been hired through our contract with MAXIMUS. Under the scope of the contract, MAXIMUS will provide training to Covered California staff and other stakeholders, as well as provide readability assessments for all outreach and informational materials.

Again, thank you for raising the importance of contracting practices that lead to economic development throughout the state.

Sincerely,

Peter V. Lee
Executive Director



January 13, 2015

Diana Dooley, Chair, Board of Directors
Peter Lee, Executive Director

California Health Benefit Exchange
1601 Exposition Blvd.
Sacramento, CA 95815

Re: Conditions for Participating Qualified Health Plans and Insurance Agents

Dear Ms. Dooley and Mr. Lee,

The California Labor Federation and Health Access California, the statewide health care consumer advocacy coalition, seek a change to the recertification and new entrant policy for the 2016 plan year.

We seek a requirement that participating qualified health plans that offer large employer coverage do not offer coverage to large employers that is less than 60% minimum value. We seek a similar requirement for insurance agents or brokers that sell coverage to large employers and that seek to serve Covered California enrollees, including SHOP employers.

While no current qualified health plan would be excluded from this rule, we think it is crucial for Covered California to actively discourage this practice of offering substandard coverage, a loophole in the minimum benefit guarantees and the employer responsibility section of the Affordable Care Act.

We understand there are health plans seeking to enter Covered California that do offer large employers coverage under 60% minimum value, which should be barred for three reasons:

- Covered California has a strong interest in making sure the Affordable Care Act works in California—and by allowing substandard plans that allow large employers to avoid their obligations, it undermines the

sustainability of health reform and the market that Covered California operates in.

- Covered California wants qualified health plans that will be good partners with the Exchange in fostering a marketplace that benefits consumers, rather than plans that use loopholes to undermine the goals of health reform.
- Covered California should use its active purchasing power to benefit and represent its potential enrollees—including the workers of large employers who would under this practice be barred from subsidies in Covered California if their employer offers such a plan.

Background

State and federal law set a floor on the benefits that can be offered by health plans and insurers to individual and small employers, requiring that coverage sold to individuals and small businesses provide at least 60% actuarial value and include essential health benefits.

The employer responsibility requirement, now in effect, applies to large employers whose full-time, non-seasonal employees obtain subsidized coverage through an exchange. However, nothing in state or federal law prohibits a health insurer or plan from offering a large employer coverage that is less than 60% minimum value. Nothing in state or federal law prohibits an insurance agent or broker from offering a large employer coverage that is less than 60% minimum value. Large employers may offer coverage that is below 60% minimum value and does not include the essential health benefits.

The employer responsibility requirement is foundational to the Affordable Care Act: the financing of the Affordable Care Act was built on the assumption that virtually all employers with more than 50 employees offer those employees relatively comprehensive coverage.

Why This Matters

Unfortunately, current federal guidance creates a loophole that may be attractive to large employers with low wage workers or high turnover workforces, allowing such employers to avoid the employer responsibility requirement while putting workers at risk of medical debt and not getting the care they need.

If an employee of a large employer accepts coverage from an employer that is less than 60% minimum value, the employee is put at risk in a number of ways. The worker who has accepted subminimum coverage is barred from receiving subsidies through Covered California. If the worker has a major chronic condition or a serious illness or injury, the employee will be exposed to thousands of

dollars in costs, plunging the individual into medical debt or bankruptcy and adding to hospital bad debt. An ample literature demonstrates that those who are underinsured avoid seeking care when they need it precisely because of the inability to pay.

Employees with such subminimum coverage would still be eligible for Medi-Cal if they were otherwise eligible for Medi-Cal—and would likely end up on Medi-Cal if the employee had a significant health need, further increasing state spending on Medi-Cal.

Large employers, particularly of lower wage workers, may be tempted to offer those lower wage workers sub-minimum coverage because such coverage is less expensive and may allow the employer to avoid the employer responsibility requirement. The attached power-points from Crawford Associations and United Healthcare clearly offer employer guidance on how to avoid employer penalties by offering subminimum plans. The consultant describes offering skinning plans as a “loophole” in federal law that the federal government has not yet clarified.

Small businesses are disadvantaged because state and federal law requires that the coverage they offer to their employees must be no less than 60% actuarial value while large employers can offer their employees sub-minimum coverage.

Current QHPs, New Entrants

To the best of our knowledge, no currently contracting Qualified Health Plan offers large employers coverage that is less than 60% minimum value. We have confirmed, and re-confirmed, this fact with the commercial plans that are currently QHPs.

We have recently become aware that at least one major insurer which is seeking to be a new entrant to the Covered California marketplace is offering large employers coverage that is less than 60% minimum value—and encouraging large employers to offer the non-management employees such sub-minimum coverage while providing additional benefits to management employees. We are also aware that there are insurance brokers offering such coverage to employers, particularly in San Francisco which has a longstanding employer responsibility requirement unique to the City and County of San Francisco.

We have been pleased that Covered California has repeatedly recognized that employer coverage is foundational to the success of the Affordable Care Act. We ask that Covered California assure that its contracting Qualified Health Plans not engage in behavior that would undermine the employer responsibility requirements of the Affordable Care Act by offering large employers coverage that is less than 60% minimum value. We ask for a similar requirement for

insurance agents and brokers that serve Covered California enrollees and SHOP employers.

Sincerely,

A handwritten signature in black ink, appearing to read "Sara Flocks", with a stylized flourish at the end.

Sara Flocks
Public Policy Coordinator
California Labor Federation

A handwritten signature in black ink, appearing to read "Anthony Wright", with a stylized flourish at the end.

Anthony Wright
Executive Director
Health Access California



SENATE COMMITTEE ON HEALTH QUESTIONS FOR COVERED CALIFORNIA

1. What kind of monitoring and tracking is Covered California doing for consumer complaints and inquiries coming directly to Covered California and participating qualified health plans?

Covered California receives inquiries and complaints in several ways and from a variety of partners. Inquiries can be received from:

- Consumers calling the Covered California Service Center
- The California Department of Health Care Services
- The California Department of Managed Health Care
- The California Department of Insurance
- The California Health and Human Services Agency
- Elected officials
- The Qualified Health Plans in the Covered California Marketplace

Once a complaint is received, it may be routed to one of the following departments for monitoring and resolution:

- Covered California Office of Consumer Protection
- Covered California Service Center Research and Resolution Unit
- Covered California Appeals Unit

Covered California currently utilizes both SharePoint Solutions and RightNow Customer Relationship Management (CRM) to track consumer inquiries and resolutions. Within our CRM system, we are in the process of developing and refining an organizational model for coding to accurately catalog complaints, including non-jurisdictional issues.

2. With the first round of open enrollment it became clear early on that course corrections were necessary, what contingencies and resources does Covered California have in place this time around to course correct, if necessary?

In developing Covered California's marketing, outreach and enrollment approach for the 2015 open enrollment period, we have built on the lessons we've learned in 2013 and 2014. In addition, our program reflects new challenges which include the first ever program to encourage those who did enroll to renew their coverage. The process of providing our consumers with tax information related to their federal subsidies is another complexity that will begin January 2015. The three month open enrollment window will require both flexibility and agility if adjustments to our outreach and enrollment effort are required. We will be monitoring our progress closely, and will be working with our statewide and local partners to maximize our effectiveness.

Covered California and all of its partners will be pushed to test and learn in real time as the programs and strategies roll out. Covered California will build on and benefit from all of the experience and resources accrued in 2013-2014, and the lessons learned in the 2015 open enrollment will inform future enrollment and retention efforts as Covered California moves from being a “startup” to what will become the new normal for millions of Californians. Covered California will continue to engage partners and stakeholders to improve systems, techniques and overall effectiveness going forward. The first two open-enrollment periods — the first for 2014 coverage and the second Covered California has embarked upon, which includes the efforts to retain those who enrolled — will serve as testing grounds for strategies and tactics that will be refined for the future.

3. Please explain who are the leads on the implementation team responsible for outreach to and enrollment of Latino, African American and Asian Pacific Islander populations?

Covered California’s leadership team is led by Executive Director Peter V. Lee. Mr. Lee oversees the planning, development, ongoing administration and evaluation of Covered California and its efforts to improve the affordability and accessibility of quality health care for Californians. Yolanda R. Richardson is the Chief Deputy Executive Director of Strategy, Marketing & Product Development and has responsibility for developing and implementing the agency's strategic approach for community outreach, marketing and sales. This includes efforts that focus on Latino, African American and Asian and Pacific Islander populations.

4. How has Covered California responded to issues raised by Latino and Black Caucus members?

Effective marketing, outreach and enrollment efforts in underrepresented communities of color are foundational to Covered California’s core mission, and a goal shared by the Legislative Latino, Black, as well as Asian and Pacific Islander Caucus members. After assessing lessons learned from our first open enrollment, the following are some of the key improvements in our marketing, outreach, and enrollment campaign:

- Enhanced community-based outreach: Both the Legislative Latino and Black Caucuses emphasized the need for increased “on the ground” outreach to reach consumers at an individual level with trusted messengers.
- Addition of Navigator Grantees: Both Caucuses encouraged the unification of education, outreach, and enrollment along with performance requirements to ensure accountability and effectiveness. The new Navigator program reflects these changes. Covered California selected 66 organizations for funding, which includes an additional 161 subcontractors (227 total). Navigator grants total \$17.1 million and are estimated to enroll 93,467 individuals in Covered California. In addition to reaching consumers in 13 languages, the navigators have developed outreach and education strategies to key targeted regions. The following outlines the targeting breakdown by community, out of the 66 lead grantees:

- African American: 7 grantees
- Asian/Pacific Islander: 8 grantees
- Latino community: 14 grantees
- Young adults: 19 grantees
- LGBTQ community: 7 grantees

The chart below provides more information on the number of grantees and the amount of money that was awarded to their organizations based on the ethnicity of their target populations.

Ethnicity	Lead Grantees	Navigator Dollars Awarded	% of Total
Latino	62	\$7,567,468	51.70%
Caucasian	52	\$2,360,174	16.10%
Asian	47	\$1,903,061	13.00%
Cambodian	10	\$98,805	0.70%
Chinese	23	\$382,068	2.60%
Filipino	30	\$247,926	1.70%
Hmong	15	\$126,666	0.90%
Japanese	7	\$19,641	0.10%
Korean	21	\$713,566	4.90%
Laotian	10	\$23,356	0.20%
Vietnamese	27	\$291,033	2.00%
African/African American	54	\$1,854,756	12.70%
African	17	\$313,470	2.10%
African American	44	\$1,541,286	10.50%
Other	40	\$902,290	6.20%
Armenian	6	\$54,052	0.40%
Middle Eastern	20	\$64,127	0.40%
Russian	9	\$50,114	0.30%
Ukrainian	5	\$6,981	0.00%
Other	28	\$727,017	5.00%
American Indian	15	\$61,740	0.40%
Grand Total		\$14,649,490	100%

- To provide additional support for our community Navigators and Certified Enrollment Counselors, Covered California is contracting with community outreach firms that will to provide on-the-ground, grassroots organizing assistance. Covered California posted its Notice of Intent to Award, and is now negotiating with three firms to assist with outreach and enrollment efforts in key target populations: African American, Latino and Asian/Pacific Islander. The three firms are:
 - Lagrant Communications
 - Dakota Communications
 - Links Media

- Increased presence in TV, print and radio ads: For the 2014-2015 Open Enrollment, marketing targeting will have a stronger focus on in-language and ethnic-specific media. Across communities, key messages include:
 - *Affordability* - Covered California helps make quality health care more affordable by offering financial assistance for those who qualify
 - *Accessibility* - Covered California gives Californians the power to access and choose the health care plan that fits their needs
 - *Security/Peace of Mind* - Acquiring health insurance from Covered California protects Californians from the what-ifs of life
 - *How to enroll* - Promote self-enrollment and the availability of local, in-person enrollment assistance that is free and confidential
 - *Immigration concerns* – Promote the fact that immigration information is not shared with immigration services
- Covered California Statewide Bus Tour: Covered California embarked on a 10 day statewide bus tour led by Executive Director Peter V. Lee that visited more than 30 cities across the state to promote the 2015 Open Enrollment Period. The bus traveled to rural and urban communities throughout the state to increase visibility and awareness of the opportunity to enroll and assist individuals with finding enrollment assistance in their communities. Covered California leadership, Department of Health Care Services leadership, elected officials and stakeholders joined with consumers, insurance agents, certified educators and certified enrollment counselors who helped enroll millions of Californian's into coverage.

The bus tour supported Covered California's ongoing marketing and outreach efforts on the ground, the airwaves and social media. Press events took place at each stop, including the historic Grand Park in front of Los Angeles City Hall the day before open enrollment began. Other events took place in Sacramento, San Francisco, Fresno, Chico, Bakersfield, Merced, Modesto, San Jose, East Los Angeles, Carson, Inglewood, San Diego, San Bernardino, Palm Springs, Santa Ana, Salinas and Stockton.

- Covered California redesigned its Marketing, Outreach and Enrollment Assistance Advisory Group meeting to include separate Asian/Pacific Islander, African American and Latino subcommittees.
 - The first meeting of the newly configured advisory group meeting was held on October 29, 2014. Each subcommittee provided valuable feedback on key Covered California outreach and enrollment issues.
 - Legislative caucuses provided recommendations on advisory group membership.
 - Legislative caucus staff were invited to be ex-officio members of the advisory committees.

5. Please explain why Covered California intended outreach grantees to also become certified enrollment entities but less than one third actually did?

In 2013, Covered California designed the Outreach and Education Program a grant program to engage organizations with trusted and established relationships in communities representing the cultural and linguistic diversity of the state. This approach was also intended to encourage the participation of these community organizations in the enrollment process. Proposals from organizations that expressed intent to subsequently become Certified Enrollment Entities were given additional weight in the competitive process for awarding the grants.

Once selected, Outreach and Education grantees went through a demanding training and certification process to become certified educators. In order to become a Certified Enrollment Counselor, Certified Educators were also required to pass a rigorous application process and needed to satisfy several steps in the certification process, including additional training and background clearance.

While many of the Outreach and Education grantees originally stated their intention to become Certified Enrollment Entities, ultimately about one-third actually did. Others decided that the participating in two programs, the Outreach and Education Grant program and In-Person Assistance Program, was too demanding for their organization given the quick timeline for the implementation of the programs. Many acknowledged that they did not fully anticipate the organizational challenges that would be required to become a Certified Enrollment Entity, and opted to remain dedicated to outreach and education activities.

6. Why were grantees slow to meet Covered California's aggressive goals and timeline as noted in the lesson learned document page 47?

Covered California developed a training program for outreach grantee staff, hoping to train 1,000 as Certified Educators. Demand far exceeded expectations. At present, more than 2,000 Certified Educators have completed training. In order to have a ready Certified Educator Workforce, Covered California provided instructor-led training sessions from July through September 2013. The combination of unexpected demand, delays in training materials and time needed to mobilize the trainers necessary to train this workforce led to a slower than ideal start to the program. Despite these delays, Education and Outreach grantees were a critical element in Covered California's strategy: reaching 16.1 million individual consumers, 1.4 million business owners and 1.3 million medical professionals and providing accurate, impartial and culturally and linguistically appropriate information about the Affordable Care Act.

- 7. Covered California relied heavily on uncompensated community outreach networks, 60% of whom served Latino communities and other non-English speaking communities. These organizations assisted with translations of Covered California fact sheets and other notices. The lessons learned report indicates these partners experienced challenges because they didn't have access to the same training and resources as other partners. What is Covered California doing differently to address these challenges?**

The Community Outreach Network was created with the intent of supplementing the work of Covered California's grant funded partners by leveraging the support of other community based organizations that supported the goals of the Affordable Care Act and wanted to help. The network included 162 organizations with varying levels of engagement, from sending out newsletters and e-mails to their membership to providing outreach and education at events. Covered California now includes the Community Outreach Network partners in bi-weekly webinars so they have the same level of information as other partners. On an on-going basis, Covered California continues to provide its Community Outreach Network partners access to additional materials, training and better coordination with other community-based organizations. This will include, for example, making available computer based training modules that are now being used by Navigator grantees.

- 8. Have all payments been made for enrollments to date? The lessons learned report indicates that \$2 million has been paid to enrollment counselors and \$3.6 million in compensation has been paid to Certified Enrollment Entities. Are there outstanding payments pending and if so, what is the reason these payments are outstanding?**

To date, Covered California has paid over \$2.8 million to Certified Enrollment Entities (CEEs) for effectuated enrollments with a Qualified Health Plan. This represents payments that are owed to CEEs for enrollments into Qualified Health Plans (QHPs) through October 16, 2014. We are current on QHP payments and are on a regular schedule to make monthly payments.

Additionally, over \$4 million has been paid to Certified Enrollment Entities for enrollments into the Medi-Cal Program which represents payments through July 31, 2014. However, these payments do not reflect payments for enrollees who have not yet been determined Medi-Cal eligible. Covered California partners with the California Department of Health Care Services (DHCS) to validate payments owed to Certified Enrollment Entities. DHCS approves payments for enrollment into the Medi-Cal Program. DHCS determines which enrollments were found eligible for Medi-Cal and were not in the program in the 12-month period prior to the enrollment. Enrollments where the consumer was enrolled in Medi-Cal in the 12-month period prior to the eligibility determination are not eligible for payment.

	# Certified Enrollment Entities Paid	Total Paid
Covered California Plans	566	\$2,804,764
Medi-Cal Payments	547	\$5,419,578
Total Payments made to CEEs		\$8,224,342

Please note that Covered California only compensates Certified Enrollment Entities. The Certified Enrollment Entities negotiate with their affiliated Certified Enrollment Counselors to determine CEC compensation. Covered California is not involved in that arrangement.

9. The lessons learned report refers in multiple places to the “learning management system” not functioning as intended. What is the learning management system and what are the reasons for its poor performance? How are the issues being addressed?

The Learning Management System (LMS) is a tool to store training courseware, register learners and track their training status. It is used to fulfill the Federal requirements to certify that certain assistors (i.e. Agents and Certified Enrollment Counselors) have completed their required training and have passed a certification exam. Covered California has about 40,000 learners that are tracked by the LMS.

When we selected the LMS Vendor, Meridian Global, we had a short period of time to implement the system and train our internal staff on how to administer the system. Because of this shortened implementation timeline, we experienced several issues that impacted the learners’ experience:

- System functionality
 - The system had several “bugs” during the set up that caused the courses to “time out” when the learner was in the middle of the exam.
 - The system had temporary outages due to the number of users concurrently in the system.
- Administration
 - Our internal administration team was not completely trained when we launched the system. We completed the training over the next 6 weeks, but it impacted learners ability to get their User ID and to help them through some local issues caused by their browser interface.

- User errors
 - Due to the implementation timeline, we were not able to provide advanced training to the learners about how to use the system. The system was less intuitive than what learners are used to on the Web, and they found it difficult to navigate on their own.
 - We have since put together a user guide and a tips 'n tricks guide that helps learners navigate through the system more easily.
- Reporting
 - The Meridian system's reporting capabilities were difficult to use and our ability to report from the system was limited and more time consuming than anticipated. The vendor was not able to fix this issue without Covered California incurring additional costs.

We have resolved the issues that we identified during the roll-out of the LMS. However, we felt that we could use a more intuitive, easy to use system and have contracted with a new vendor effective March 2015. The new vendor (Ominplex) will provide an LMS named Absorb, that is simpler, easier to administer and will fit our learners needs better.

10. The lessons learned document includes Figure 20 on page 65 which identifies “Service Channel Use by Ethnic Group.” Does this represent contacts by service channel or completed applications attributable to the service channel? Please explain.

The chart referenced represents applications completed by service channel.

11. The lessons learned report indicates that the San Joaquin Valley, including Fresno, had lower enrollment compared to projection levels, what strategies are being employed to improve enrollments specific to this region?

Although lower than other areas of the state, enrollment of subsidy eligible individuals in the San Joaquin region exceeded baseline projections, and resulted in more than 108,000 people selecting a plan. This was 186% of the UCLA Center for Health Policy Research and the UC Berkeley Center for Labor Research and Education California Simulation of Insurance Markets (CalSIM) base projection of 58,000. The chart below provides this comparison for each region of the state.

	Base Projection for 3/31/2014	Total Enrolled (with plan selection) on 4/15/2014	Difference from Base Projection for 3/31/14	Performance to date (% of 3/31/14 base projection)
Regions				
Northern CA	22,571	51,710	29,139	229%
Greater Bay Area	89,599	289,022	199,423	323%
Sacramento	28,726	69,540	40,814	242%
San Joaquin	58,137	108,183	50,046	186%
Central Coast	32,602	95,500	62,898	293%
Los Angeles	177,602	400,889	223,287	226%
Other Southern CA	170,763	381,078	210,315	223%
Total	580,000	1,395,929	815,929	241%

Specific Counties

Fresno	14,500	23,164	8,664	160%
Orange	44,392	131,804	87,412	297%
San Diego	43,054	121,900	78,846	283%
San Bernardino	35,692	53,623	17,931	150%
Riverside	40,377	69,350	28,973	172%

As we begin this year's open enrollment period, the San Joaquin region remains a key target for Covered California. This was reflected in our recent bus tour, which included organized press conferences and media availabilities in Stockton, Modesto, Merced and Fresno. In addition to our statewide marketing and outreach strategy, we are building on the community partnerships in the region by awarding Navigator grants to organizations that include:

- Clinica Sierra Vista
- California Health Collaborative
- Community Medical Centers Inc.
- Health Access Foundation
- Healthy House with a MATCH coalition
- United Ways of California

12. According to the July 2014 Kaiser Family Foundation Longitudinal Study, the remaining uninsured who are also eligible for subsidies indicates that these Californians are more of a challenge and many have been persistently uninsured. What will be done to reach these individuals?

We believe that the process of health care enrollment is highly individualized and locally based. As such, we recently allocated \$14.6 million in Navigator grants to ensure successful retention, renewal, and enrollment in Covered California health plans in targeted communities statewide. We will support more than 1,402 organizations across the state with a comprehensive advertising and community outreach campaign investment of \$94 million. These new grant funds will employ 227 community based-organizations to do community-level outreach throughout the state. These community organizations will provide in-person enrollment

assistance and establish 200 storefront locations to help people sign up for plans, as well as help existing enrollees with renewals.

With our new Community Outreach Campaign, we are significantly expanding our network of community partners - including more non-profit organizations, schools, businesses, local unions, elected officials and medical providers than ever before -- to reach the state's diverse population. We estimate these new grants will bolster our resources to California's diverse communities by almost 50%.

Our new entities operating with these grant funds will collaborate with local leaders and local support networks in each region to educate, support, enroll, retain and renew consumers from various ethnic backgrounds in both urban and rural areas. Our selected grantees will provide outreach and enroll consumers across the state in 13 languages, which include: Arabic, Armenian, Chinese, English, Farsi, Hmong, Khmer, Korean, Laotian, Russian, Spanish, Tagalog and Vietnamese.

▪ Specifically:

- 14 community organizations are focusing on Latinos communities
- 8 community organizations are targeting Asian communities
- 7 community organizations are reaching out to African American communities

In addition:

- 19 community organizations are targeting young adults
- 7 community organizations are targeting the LGBTQ community

With more than 7,500 Certified Enrollment Counselors and more than 12,000 Certified Insurance Agents, our "new and improved" Community Outreach Campaign will intensify grassroots efforts by providing education, outreach, and post-enrollment support in communities throughout the state.

We are also setting up support networks in each region, to work with our partners to reach into communities on a micro-level. This work is already underway. We've recently met with our key partners and other local leaders in San Diego, Los Angeles, Fresno and the San Francisco Bay Area. Future meetings are planned across the state on a regular basis to continue these important regional dialogues. Additionally, we are also reinforcing the importance of keeping health care coverage for those who are now covered. We will be working with local Navigator grantees to help Covered California members re-enroll into their current health care plans quickly and easily.

13. The Kaiser study also indicates that many of the remaining uninsured are Hispanic. Some are not eligible and others are worried about impact on immigration status. What will be done to message to those who are eligible for coverage?

Covered California engaged leading national and California immigrant rights organizations to create a partnership to spread the word to all communities that immigration status should not

deter anyone who can benefit from obtaining coverage under the law. The partnership involved the Mexican American Legal Defense and Educational Fund (MALDEF), the National Immigration Law Center, Asian Americans Advancing Justice – Los Angeles, the National Association of Latino Elected and Appointed Officials (NALEO) Educational Fund, the Coalition for Humane Immigrant Rights of Los Angeles and the California Immigrant Policy Center.

As part of this effort, the partners have developed and will distribute a fact sheet for California in English and Spanish, as well as a fact sheet for other states. Plans are in the works to produce fact sheets in other languages, including Chinese, Korean and Vietnamese. The available fact sheets are online at the following links:

California fact sheets:

- English: www.CoveredCA.com/news/PDFs/immigration-fact-sheet-ca.pdf
- Spanish: www.CoveredCA.com/news/PDFs/immigration-fact-sheet-sp.pdf

Fact sheet for other states: www.CoveredCA.com/news/PDFs/immigration-fact-sheet-us.pdf

As a matter of process, only those individuals seeking to enroll in health insurance coverage through Covered California will be asked for information to verify immigration status. People who apply for health insurance coverage on behalf of others (such as for a dependent child) do not need to provide their own citizenship or immigration status. Immigration status is verified via the federal data hub through the Department of Homeland Security's database.

All information provided on the online application about immigration status will be kept secure and private and will not be used by any immigration agency for the purpose of immigration enforcement. Immigrants who are not considered "lawfully present" are not eligible to purchase a Covered California plan, but they can still apply through Covered California to find out if they are eligible for health care options through Medi-Cal.

In October 2013, Immigration and Customs Enforcement, an arm of the U.S. Department of Homeland Security, issued a letter assuring consumers that information provided by individuals for coverage at Covered California – and other health care exchanges – would not be used for any other purpose to ensure the efficient operation of the exchange. The full letter can be found at www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf

14. Please explain the retail store front program. Where will these be located? How will they be staffed? Will there be compensation for enrollments?

Store fronts are defined as locations that provide convenient access for consumers to receive free confidential enrollment assistance on a walk-in basis. These should be locations that are open during business hours but extended weekday and weekend hours are strongly encouraged. Our community partners and Insurance Agents will have store fronts in retail locations in a commercial space that is Covered California branded. Others are opening their

clinics, community offices, churches, theatres, libraries etc. on set dates and times throughout open enrollment.

Store fronts will be located throughout the state and a listing will be available on the CoveredCA.com website soon at <http://events.coveredca.com/>. They will be staffed by Covered California Certified Enrollment Counselors, Certified Educators and Certified Insurance Agents. Compensation will be based on the program they are participating in – the Navigator Grant Program, In-Person Assistance Program, Outreach and Education Grant Program, and Agent Program.

15. What kind of training has been done to assist with application renewals?

Covered California's Sales Division conducts bi-weekly webinars with our community partners and Insurance Agents. As would be expected, we have devoted a substantial amount of time and resources to training and information on the renewal process. In addition, we have provided copies of renewal notices, job aids, talking points and FAQs to prepare our service channels to assist with renewals.

16. Will consumers who take no action be auto renewed? Who will not be auto renewed?

Renewal is the time when consumers can update their application information, find out if they qualify for a different program, find out if their costs have changed, and change to a different health plan. Consumers who were enrolled in coverage during 2014 have two renewal options in order to keep their coverage for 2015:

- *Active Renewal:* A consumer actively renews when they log into their CoveredCA.com account and click the "renew" button. It is extremely important for consumers to actively renew if their application information has changed. Changes include:
 - Change in income (employment, self-employment, income tax deductions or other types of income)
 - Adding or removing a household member (birth, adoption, marriage, etc.)
 - Permanent move out of or within California
 - Change in citizenship/immigration status
 - Start receiving health insurance such as through a job, Medicare, etc.
- *Passive Renewal:* For most consumers who do not actively renew, Covered California will redetermine their eligibility based on the most recent information the enrollee provided to Covered California. These consumers will be automatically enrolled in the same plan they had during the 2014 plan year; however, the amount of advanced premium tax credits (APTC) or the level of cost-sharing reduction (CSR), if applicable, and the premium they paid each month will be updated to reflect the 2015 rates.

For 2015, consumers who were enrolled in Contra Costa Health Plan, a Health Net PPO plan, or any Health Net plan in Monterey, San Benito or Mariposa County will not be auto renewed. Covered California, in partnership with the Certified Agent population and our Qualified Health Plans, have engaged in an aggressive outreach campaign to these consumers to help educate

them on the importance of actively renewing and to assist them with the renewal process. The State regulations governing the renewal process are included in the appendix to this document.

17. Are Certified Insurance Agents required to enroll people in Medi-Cal? Is their mandatory training for Medi-Cal enrollments? Who conducts the training?

Certified Insurance Agents (CIAs) are required to enroll consumers in Medi-Cal. The agent contract, which is incorporated by reference into State Regulations at section 6804(d)(2) requires:

In the case that a Consumer is or may be eligible for Medi-Cal or CHIP, Agent shall facilitate the enrollment of interested Consumers without undue delay.

To become certified, an agent must complete the CIA new agent certification training. This mandatory training includes modules on Medi-Cal. Prior to the first Open Enrollment, the original certification training was developed in partnership with DHCS. After receiving feedback that the original Medi-Cal training could be further developed, Covered California and DHCS partnered with key stakeholders to improve the training and materials. The new enhanced Medi-Cal training is available and optional for all CIAs who were certified prior to its approval and is required of all agents who become certified.

In addition, CIAs are trained by Covered California in partnership with DHCS in optional bi-weekly webinars. Covered California and DHCS encourage agents to participate in these optional trainings, which regularly include information about Medi-Cal.

18. Please explain the resolution and appeals process. Is there a flow chart that explains what is handled by the back office and what goes to hearing?

Attached is a summary of the Individual Appeals Process. Pursuant to state regulations, Covered California provides an appeals process for applicants. As part of these regulations, Covered California defined the appeals process, explaining when appeals are allowed, how they may be processed and how they may be resolved, among other things. California Department of Social Services (CDSS) is Covered California's appeals entity and in that role schedules and adjudicates appeals for all applicable eligibility determinations of individuals and accepts appeals on behalf of Covered California from the Department of Health Care Services (DHCS) and the local County Welfare Departments.

19. What plans are there to improve customer service and achieve customer service goals?

Covered California started open enrollment with more than double the number of Service Center representatives — state employed and contractors — to reduce wait times and help consumers enroll. Over the Open Enrollment Period we are expected to have more than 1,300 representatives helping consumers over the phone, by chat or by processing their paper applications or documents. The majority of these representatives are state employees working

in Rancho Cordova and Fresno, but two private vendors — Faneuil Inc. and Maximus Inc. — will operate call centers to boost capacity during this period. Last year, Covered California began open enrollment with 381 Service Center representatives and ended with 709.

While the vast majority of consumers are served in their own languages by Covered California staff, the capacity of the Service Center has been expanded in order to serve callers in Spanish, Chinese and other languages without the use of interpreters. This year Covered California has 254 Service Center representatives able to serve consumers in languages other than English, compared with 55 during open enrollment in 2013.

Service Center hours — including phone service and online chat — have been expanded to accommodate consumers after hours, with representatives now available from 8 a.m. to 8 p.m. Monday through Friday and from 8 a.m. to 6 p.m. Saturday. In addition, the Service Center will be open on many Sundays during the open enrollment when we have the highest volumes.

Covered California is working with health plans to make it possible for consumers to make their first premium payment online as soon as they have selected a plan. This will give consumers peace of mind that they have evidence that their payment has been received and that they will have coverage in place.

To meet high consumer demand, Covered California spent \$22.6 million to upgrade the enrollment portal infrastructure to allow for greater user capacity and speedier page loads so that consumers do not have to return later to complete an application.

For self-service, Covered California is redesigning its interactive voice response (IVR) system to handle more consumer calls while decreasing wait times and updating consumers on wait times when they are placed on hold.

Covered California is continuing to make significant improvements so that notices that consumers receive are clearer, explanations on the website are better — in both English and Spanish — and the consumer experience is more seamless.

20. As tax season draws closer what kind of messaging and consumer assistance will Covered California offer Covered California enrollees who are taking advantage of tax subsidies?

Covered California has engaged in mail and email campaigns aimed at educating consumers about Premium Tax Credits and Reconciliation. Covered California is also working closely with the IRS, major tax preparers such as H&R Block and Intuit, and consumer advocates to develop a “cover letter” to be included with the IRS Form 1095-A. The cover letter will answer questions that will help consumers better understand their responsibilities when they file their taxes. Finally, Covered California continues to provide information and training to our service channels and the carriers so they can educate consumers about Premium Tax Credits and Cost

Sharing Reductions. We're also providing them with contact information for the IRS so consumers know where they can go to get help with filing their taxes.

21. What is being done to address the delay created when an individual loses their website password?

Consumers can reset their password by clicking "Account Login" and then clicking the "Forgot Your Password?" link at the CoveredCA.com site. They can enter their user name, correctly answer their security questions, and then they will be able to enter a new password. If a consumer does not remember the answers to their security questions, it is best to leave them unanswered and call the Service Center at (800) 300-1506. A Service Center representative can help reset their password.

If a consumer answers their security questions incorrectly, their account will be blocked. A Service Center representative can help them, but unblocking an account takes longer than resetting a password and could take a day or two to fix. Consumers will receive an email when their password has been reset, and then they will be able to log in again.

22. Is Covered California considering empowering local Certified Enrollment Entities (CEEs) with the ability to assist clients who have lost their website passwords through a secure password recovery mechanism?

Covered California has worked to streamline the process for resetting a consumer's password (noted above). We believe this improved functionality empowers not only CEE's but also consumers to easily reset their password. CEE's do not have the functionality necessary to unblock an account.

23. How does Covered California group Asian Americans when outreach and tracking outcomes? Are there plans to recognize separate ethnic groups in the future? If not, why not?

In its outreach efforts, Covered California is mindful of the diversity within the Asian & Pacific Islander (API) community. For example, Covered California hosted a Southeast Asian Roundtable discussion in the Central Valley in September 2014 to address outreach and enrollment in the Hmong, Vietnamese, Mien, Lao and Cambodian community. In its Navigator program, Covered California asked applying entities to indicate the breakdown of populations served by ethnicity, and applicants indicated their service to Asian populations including Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, and Vietnamese. Covered California will continue to work with enrollment partners who are targeting those specific ethnic populations, in an effort to identify and address specific health access issues within the API community.

With regard to tracking and reporting outcomes by demographics, Covered California has released data on 2014 enrollments at the most granular level available for specific races and

ethnicities at the statewide level, and language at the regional level, at <http://hbex.coveredca.com/data-research/>. Covered California collects data on Asian American groups through three self-reported, optional fields in the application: “race”, “ethnicity” and language preference. As defined by the OMB standards, “ethnicity” refers specifically to applicants of Hispanic, Latino/a, or Spanish origin. Below is an explanation of our race category roll-up, which follows [federal guidelines](#), as well as the languages categories for which data is available.

OMB standards for race categories:

- Roll up to “Asian”:
 - Asian Indian
 - Chinese
 - Filipino
 - Japanese
 - Korean
 - Vietnamese
 - Other Asian
- Roll up to “Native Hawaiian or Other Pacific Islander”:
 - Native Hawaiian
 - Guamanian or Chamorro
 - Samoan
 - Other Pacific Islander

Additionally, the online application asks consumers for their language preference, which is reported in the following categories:

- Arabic
- Armenian
- Cambodian
- Chinese
- English
- Farsi
- Hmong
- Korean
- Russian
- Spanish
- Tagalog
- Vietnamese

In its outreach efforts, Covered California is mindful of the diversity within the API community. For example, Covered California hosted a Southeast Asian Roundtable discussion in the Central Valley in September 2014 to address outreach and enrollment in the Hmong, Vietnamese, Mien, Lao and Cambodian communities. Covered California will continue to work with

enrollment partners who are targeting those specific ethnic populations, in an effort to identify and address specific health access issues within the API communities.

24. What is the strategy to enroll college students into a plan this year?

Covered California's two primary outreach strategies are: (1) marketing and media; and (2) community-based outreach.

Marketing and media: The marketing and advertising program consist of paid digital and traditional advertising and direct marketing, supportive collateral materials, media relations, coordinated events and social media outreach.

Community-based outreach: The consumer outreach program consists of an outreach and education grant program, supporting more than 250 local groups to do community-based outreach; a community outreach network of uncompensated partners to bolster outreach efforts; partnerships with elected officials, counties and cities; state agencies; community and grassroots organizations such as faith-based, labor, retail and health care organizations; and insurance agents and other in-person assistance programs aimed at directly assisting consumers in accessing and enrolling in coverage.

Specific to college students, Covered California funded the following groups to do outreach, education and enrollment:

- Bienestar Human Services, Inc.
- California State University, Los Angeles
- Physicians for a National Health Program – California
- Unidos Por La Musica
- University of Southern California
- Young Invincibles

APPENDIX

INDIVIDUAL APPEALS PROCESS

Parties Involved	<ul style="list-style-type: none"> ❖ Research and Resolution (R&R), also known as the “Back Office.” ❖ HBEX Appeals Unit, also known as “Headquarters or HQ Appeals Unit” ❖ Department of Social Services (DSS) ❖ Department of Health and Human Services (HHS) ❖ Department of Health Care Services (DHCS) <p><i>Key timeframe to handle appeal from beginning to end: 90 days. – let’s discuss the timeframe beginning to end.</i></p>
Appealable issues	<ul style="list-style-type: none"> ❖ Eligibility Determinations, including the amount of APTC and level of CSR ❖ Redeterminations, including the amount of APTC and level of CSR ❖ Exemption Requests ❖ Covered California’s failure to provide a timely eligibility determination or failure to provide a timely and adequate notice of eligibility determination/redetermination. ❖ Denial of a request to vacate a dismissal made by the appeals entity (CDSS). <ul style="list-style-type: none"> - Note: Exemption Requests will not be reviewed by DSS or Covered California. These appealable issues will be forwarded to HHS directly via secure electronic interface (subject to change after Covered California’s first year of implementation). - Additionally, Employer Appeals will also be forwarded directly to HHS for review and resolution. - SHOP Appeals must be handled by SHOP vendor and/or designated appeals entity.
Appeal is received at DSS.	<ul style="list-style-type: none"> ❖ DSS receives an appeal, validates the request, and sends an acknowledgement letter to the claimant; later a hearing is scheduled. ❖ DSS forwards the appeal to Covered California’s R&R. ❖ Requests for expedited appeals, if granted, are forwarded directly to HQ Appeals.
R&R receives an appeal.	<ul style="list-style-type: none"> ❖ Appeals are received from DSS at the Covered California Service Center by the Research and Resolution Unit (R&R). ❖ Appeals may be received directly by the Covered California R&R Unit. <ul style="list-style-type: none"> ➤ The R&R Unit will forward the appeals to DSS.
R&R begins the informal resolution	<ul style="list-style-type: none"> ❖ R&R will gather all the known/pertinent information, develop a chronology for the case, and start the Informal Resolution (IR)

process.	<p>process.</p> <ul style="list-style-type: none"> ❖ R&R continues the IR process while DSS schedules a hearing. <ul style="list-style-type: none"> ➤ Should the R&R Unit reach a resolution with the claimant, the claimant may withdraw the appeal. ➤ Withdrawal types: <ul style="list-style-type: none"> - Conditional Withdrawal: (verbal or written) This withdrawal is final and binding only after conditions on both sides have been met. - Unconditional/Straight Withdrawal: (verbal or written). This withdrawal can be re-opened if certain timeframes are met and the appellant can show good cause as to why the dismissal should be vacated.
Unresolved case is received at HQ Appeals Unit.	<ul style="list-style-type: none"> ❖ If the case has not been resolved during the IR process within 30 days of receipt, the case goes to the Appeals Unit at Covered California Headquarters. <ul style="list-style-type: none"> ➤ The Appeals Unit will prepare and write a Statement of Position (SOP) and develop an evidence packet for the DSS Hearings Division. ➤ A copy of the SOP is made available to the consumer. ➤ HQ Appeals works with DSS to maintain a calendar of scheduled hearings. - Note: the case can still be resolved informally while at HQ.
Expedited appeal request is received.	<ul style="list-style-type: none"> ❖ HQ Appeals works with DSS to ensure that granted expedited appeals are scheduled for hearing as soon as possible. ❖ DSS must send a notice of approval to the claimant within 10 calendar days from the date the expedited appeal was granted. ❖ HQ Appeals will gather all the known/pertinent information, develop a case chronology, and write an SOP for the expedited case.
Appeal is handled by DSS/State Hearings Division.	<ul style="list-style-type: none"> ❖ The claimant goes through the hearings process with DSS/State Hearings Division. <ul style="list-style-type: none"> ➤ The Administrative Law Judge (ALJ) makes a final decision on the case. <ul style="list-style-type: none"> ▪ The ALJ has 10 days to send notification to the claimant of the decision (approval/denial). ➤ DSS will house the case for 5 years and make it available to the public when requested.
HQ Appeals closes the case.	<ul style="list-style-type: none"> ❖ DSS sends HQ Appeals a copy of the notification of the final decision made on the claimant's case. <ul style="list-style-type: none"> ➤ This notification will give the claimant additional appeals rights (to the Department of HHS). ➤ HQ Appeals is responsible for making case corrections in the event the ALJ is in favor of the claimant.

	<ul style="list-style-type: none">➤ Following case correction, the case will be considered resolved and closed out of the database.
Re-Hearing: Claimant appeals to Department of HHS.	<ul style="list-style-type: none">❖ Claimant appeals to the Department of HHS. – Claimant disagrees with ALJ decision.<ul style="list-style-type: none">➤ This is out of Covered California’s jurisdiction. Any information that the R&R Unit or the HQ Appeals Unit receives that is considered a Re-Hearing shall be forwarded to Department of HHS.

CALIFORNIA RENEWAL REGULATIONS

Covered California will follow the auto-renewal process outlined in its regulations in Section 6498(l) of Title 10 of the CA Code of Regulations (10 CCR § 6498(l)), which provide:

- (l) If an enrollee remains eligible for enrollment in a QHP through the Exchange upon annual redetermination, and he or she does not terminate coverage, including termination of coverage in connection with voluntarily selecting a different QHP in accordance with Section 6506, the Exchange shall proceed in accordance with the following process:
- (1) The enrollee shall be enrolled in the same QHP as the enrollee's current QHP, unless the enrollee's current QHP is not available.
 - (2) If the enrollee is not eligible for the same level of CSR as the enrollee's current level of CSR, he or she shall be enrolled in a silver-tier QHP offered by the same QHP issuer at the CSR level for which the enrollee is eligible. If the enrollee is not eligible for any level of CSR, he or she shall be enrolled in a standard silver-tier QHP offered by the same QHP issuer without CSR.
 - (3) If the enrollee's current QHP is not available, the enrollee shall be enrolled in a QHP offered by the same QHP issuer at the same metal tier that is the most similar to the enrollee's current QHP, as determined by the Exchange on a case-by-case basis.
 - (4) If the enrollee who is currently enrolled in a catastrophic QHP attains the age of 30 before the beginning of the following benefit year, the enrollee shall be enrolled in a bronze-tier QHP offered by the same QHP issuer.
 - (5) If the issuer of the QHP in which the enrollee is currently enrolled has discontinued offering all health insurance coverage in the Individual Exchange, the enrollee's current coverage shall not be automatically renewed for the following benefit year. To keep his or her coverage through the Exchange, the enrollee shall obtain an updated eligibility determination and select a QHP with a different QHP issuer by the end of the open enrollment period.

**Senate Health Committee Hearing: Affordable Care Act Year Two:
Education, Outreach and Enrollment**

**Department of Health Care Services' Responses to Senate Health Committee
Questions**

1. When does the Department of Health Care Services (DHCS) anticipate the Medi-Cal backlog will be cleared?

DHCS Response: DHCS continues to work diligently on pending cases. DHCS has decreased the pending cases from approximately 900,000 in March 2014 down to 44,000 as of December 11, 2014, with nearly all of those being individuals ineligible for Medi-Cal or duplicate applications. DHCS' goal is to work toward determining eligibility within the federally required timelines of 45 days for regular applications and 90 days for those requiring a disability determination. DHCS believes this will be fully accomplished once we have key functionality installed within the California Healthcare Enrollment and Eligibility Retention System (CalHEERS) and the Statewide Automated Welfare System (SAWS). Such functionality is anticipated to begin deployment in December 2014 and additional functionality will continue to rollout throughout 2015. DHCS will continue to update stakeholders through existing processes and reporting to the Centers for Medicare and Medicaid Services (CMS) as required per our mitigation plan on the status of pending cases.

2. Is existing funding for county Medi-Cal eligibility determination-related activities sufficient to meet the increased application and enrollment volume?

DHCS Response: Currently, the county administrative budget does take into consideration funding for Affordable Care Act (ACA) related activities. As part of our ongoing processes, DHCS will continue to work with the County Welfare Directors Association (CWDA) and within the Administration on matters pertaining to county administrative funding. Any change to level of funding provided to counties will be addressed as part of the Governor's Budget.

3. Does the state have a goal of eventually reducing the application processing time for Medi-Cal to less than 45 days given the enrollment simplification required by ACA?

DHCS Response: As noted above, DHCS is dedicated to reducing the application processing time within the federally required timelines of 45

days for regular applications and 90 days for those requiring a disability determination. DHCS believes this will be fully accomplished once we have key functionality installed within CalHEERS and SAWS.

4. Welfare and Institutions Code, Section 14102.5 (Section 24 of ABx1 1) required DHCS to report to the Legislature and the public about the enrollment process for all insurance affordability programs beginning 30 days after the end of each quarter. When will DHCS make the required reports available?

DHCS Response: Throughout the year, DHCS has provided high level application information and enrollment numbers, including required performance measures, to CMS on a monthly basis. DHCS also shared these reports with Legislative staff and stakeholders. Given the significant workload of DHCS regarding ACA implementation and the need to focus on the system issues, policy development and restructuring of Medi-Cal eligibility, focus on the ABx1 1 reports was deprioritized. DHCS is now working to refocus its efforts on the ABx1 1 reports and plans to provide a compilation of the required data in its first report, tentatively planned for release in January 2015. Thereafter, DHCS is planning to report in accordance with the ABx1 1 requirement. DHCS will also be re-engaging stakeholders in the efforts around this report.

5. Why is Covered California, but not counties, allowed to use accelerated enrollment (AE) to expedite the enrollment of children in Medi-Cal? Does the state intend to allow counties to grant AE?

DHCS Response: As a matter of policy and consistent with maintenance of effort requirements regarding eligibility processes, procedures and standards, DHCS designated CalHEERS as the single point of entry for applications where AE is granted to children. Previously, this designation was given to MAXIMUS for purposes of the former Healthy Families Program and Medi-Cal. Counties historically have not had AE capability given their historic role with Medi-Cal eligibility determinations. The use of AE through the county pathway was discussed with CWDA and the Administration during the end of the 2013 Legislative session. Discussions on this policy between CWDA and the Administration have occurred recently. As a result of those discussions and as part of the mitigation plan for pending cases, the department will be using a temporary strategy to preliminarily grant eligibility, based on assessments by county eligibility staff for pending cases which is similar to “AE” to address the pending

caseload through the open enrollment period. DHCS is open to continuing the dialogue on this policy and implications for ongoing use.

6. Does DHCS plan to use Presumptive Eligibility (PE) to grant Medi-Cal eligibility to individuals, who have applications pending beyond 45 days?

DHCS Response: DHCS is using a preliminary determination of eligibility which is similar to PE/AE as a temporary strategy to address the pending caseload. DHCS systems and county staff have worked closely together in identifying and reporting that a majority of the pending cases include individuals with duplicate applications, individuals already being in coverage or individuals who have failed to respond to requests for additional information. This strategy is outlined in the updated mitigation plan submitted to and approved by CMS. DHCS is committed to using all appropriate means to ensure eligible individuals are enrolled into coverage as soon as possible, but these efforts must be done in a way to protect the integrity of the program. Additionally, to the extent an applicant pending an eligibility determination has an immediate need for health care, there are several pathways that can be pursued, including going into the county offices or going to a hospital for emergency needs.

- 7) Senate Bill 1002 (De Leon) proposed to require DHCS to seek any federal waivers necessary to use the eligibility information of individuals who have been determined eligible for the CalFresh program who are under 65 years of age and are not disabled to redetermine their Medi-Cal eligibility. That bill was vetoed by Governor Brown. In his veto message, the Governor stated that “Each department is working with the appropriate controlling federal agency to use existing program eligibility information to accomplish the goals of the bill. I appreciate the support of the Legislature, but this bill is not necessary.” What is the status of administrative efforts to redetermine Medi-Cal eligibility using CalFresh program eligibility information?

DHCS Response: As a component of DHCS’ mitigation plan regarding renewals, DHCS is seeking approval from CMS to allow the use of CalFresh data to redetermine Medi-Cal eligibility, should the renewal functionality in SAWS and CalHEERS be delayed beyond anticipated release schedules. Although federal approval is needed to advance this policy, it does not require changes to state law.

- 8) When individuals have an increase/decrease in income that moves them from Medi-Cal eligibility to eligibility for an Advanced Premium Tax Credit through

Covered California or from Covered California to Medi-Cal, what is being done to ensure these individuals do not have a gap in coverage as required by Welfare and Institutions Code, Section 15926(h)(1)?

DHCS Response: DHCS and Covered California are working closely to ensure beneficiaries transition between programs without a break in aid. The two programs share information seamlessly, and on a real-time basis, with one another and are able to make use of electronic verifications to the greatest extent possible. Currently, beneficiaries can move between programs without a break in aid; however, the two programs are working to ensure this process is as simplified and streamlined as possible. As a matter of policy, Covered California will not discontinue a person from enrollment, who has been referred to Medi-Cal pending the final adjudication of the referral by the county. As always, the coverage under Covered California is contingent upon the individual maintaining his or her premiums during this interim time period. Medi-Cal policy requires the beneficiary be provided a timely notice (10 days) prior to discontinuance which would be at the end of a given month. To the extent a person is moving from Medi-Cal to Covered California, coverage under Covered California is again contingent on premium payment and the timing of such to avoid lapses in coverage.

- 9) The current process set forth in Section of AB X1 1 (Section 14015.5) establishes how paper and electronic applications for individuals who appear to be Modified Adjusted Gross Income (MAGI) Medi-Cal that are submitted through CalHEERS are to be handled, whereby Covered California and DHCS determine MAGI Medi-Cal eligibility for applications that require no further staff review, while the other Medi-Cal applications are forwarded to the counties for an eligibility determination. This section of law sunsets July 1, 2015. How has this process worked in practice? Does the Administration propose to extend these particular MAGI Medi-Cal eligibility determination responsibilities past July 1, 2015?

DHCS Response: This functionality is currently operational in CalHEERS; however, given the system challenges, we have not been in a position to really assess true efficacy of this approach. Thus, we will discuss within the Administration and will engage with our county partners on whether to propose an extension of the sunset date.

- 10) Has CalHEERS programming for Deferred Action for Childhood Arrivals (DACA) been corrected so these individuals' eligibility is appropriately determined? If not, when will this occur?

DHCS Response: CalHEERS is not yet programmed to automatically grant full scope Medi-Cal to DACA children. County welfare departments have been instructed to override the CalHEERS eligibility determination for eligible DACA children and grant full scope Medi-Cal benefits manually. The Medi-Cal Eligibility Division Information Letter I 14-45 provided that policy guidance to counties.

DHCS is moving forward with a request for system changes to update this functionality in CalHEERS. No date has been set for the implementation of those CalHEERS system changes.

- 11) Has CalHEERS programming for former foster youth eligibility been implemented so that these individuals are being determined eligible for Medi-Cal, rather than Covered California, without having to complete the full application, including providing income information? If not, when will this occur?

DHCS Response: No, a CalHEERS change request is in the queue and DHCS is working closely with counties, CWDA and advocates on interim processes and data matching to ensure former foster youth are not required to complete a full application. CalHEERS has a flag for applicants to check if they are former foster youth. DHCS is working with CalHEERS, counties and advocates to track those flagged cases and ensure these youth are getting coverage. Additionally, former foster youth may apply directly to the counties using the MC 250A, which is a one page application that does not require income or other information requested on the Single Streamlined Application and the online portal. DHCS released All County Welfare Directors Letter (ACWDL) 14-41 on December 4, 2014, to provide counties with instructions on an interim process until functionality can be programmed into CalHEERS. The ACWDL includes input from stakeholders.

- 12) Has CalHEERS program been corrected so that when individuals report a change of circumstance (such as an increase or decrease in income or a change in family size) they are not losing eligibility? If not, when will this occur?

DHCS Response: Beneficiaries are able to report changes of circumstance through CalHEERS. Based upon the reported change, an eligibility determination is made and if the beneficiary is still eligible he or she is granted a new 12 month eligibility period. If the beneficiary is determined no longer eligible, the beneficiary is evaluated for eligibility for all other Medi-Cal programs, including consumer protections programs (Continuous

Eligibility for Children, Continued Eligibility for Pregnant Women and Transitional Medical Assistance Programs), prior to being discontinued from Medi-Cal and evaluated for a Covered California product.

- 13) What has been the experience of enrollment for mixed households (including when a child is on Medi-Cal with an income at 250 percent Federal Poverty Level and a parent is enrolled in a Covered California plan)?

DHCS Response: Medi-Cal and Covered California share information between one another. Families only have to apply once, report changes once, and complete one annual redetermination. If information is provided to Covered California, the information is shared with Medi-Cal. Likewise, if information is provided to Medi-Cal, the information is instantly shared with Covered California. Mixed household families should not be experiencing anything different than Medi-Cal only or Covered California only families.

- 14) Have the 2015 Medi-Cal renewal forms been programmed into CalHEERS? When will that process occur?

DHCS Response: No, the 2015 Medi-Cal renewal form is not programmed into CalHEERS. For 2015 renewals, counties are using a pre-populated form if the renewal cannot be processed through an ex parte review. The Medi-Cal renewal forms will not be programmed into CalHEERS as that is county case management functionality.



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ORGANIZATION LISTED
FOR IDENTIFICATION PURPOSES

January 9, 2015

Insurance Commissioner Dave Jones
California Department of Insurance
300 Capitol Mall, Suite 1700
Sacramento, CA 95814

Shelley Rouillard, Director
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Re: Discrimination in Benefit Design: Prescription Drug Formularies

Dear Commissioner Jones and Director Rouillard,

Health Access California, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians, asks that you, in your capacity as the regulators of health insurance and health care service plans, review prescription drug formularies for discrimination in benefit design contrary to recent federal guidance, issued in the Federal Register on November 26, 2014.

We are particularly concerned with discriminatory benefit designs in the individual market though we are told by health plans and insurers that some of the practices in the individual market are spreading to group coverage as well. Standard benefit designs approved by Covered California as well as other products in the individual market appear to us to violate the recent federal guidance.

The federal guidance is not a proposed regulation. It is a statement of the Center for Consumer Information and Insurance Oversight (CCIO) in the Centers for Medicare and Medicaid Services (CMS) reiterating Section 156.125 of the Affordable Care Act, which implements the anti-discrimination provisions of the Affordable Care Act. The guidance states:

*Section 1302(b)(4) of the Affordable Care Act directs the Secretary to address certain standards in defining EHB, including . . . discrimination . . . [A]n insurer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on . . . health conditions."*¹

¹ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, proposed rule, Vol. 79, No. 228 of the Federal Register at p. 70722, published on Wednesday, November 26, 2014.

We appreciate CMS' clear guidance to issuers and States that they should not discourage enrollment of individuals with certain health conditions through discriminatory benefit designs. CMS is undertaking an examination of products offered through the federal marketplace to ensure compliance with federal law and guidance. California should do the same for products offered in the individual market, including those that are available through Covered California.

In its guidance, CMS states:

Since we finalized § 156.125, we have become aware of benefit designs that we believe would discourage enrollment by individuals based on age or based on health conditions, in effect making those plan designs discriminatory, thus violating this prohibition.²

The CMS Guidance cites several examples of benefit designs that would amount to discriminatory action prohibited under federal law.

1. Single-Tablet Drug Regimen Not Covered

In its November 26, 2014 guidance, CMS tells issuers to avoid discouraging enrollment of individuals with chronic health needs, stating:

For example, if an issuer refuses to cover a single-tablet drug regimen or extended-release product that is customarily prescribed and is just as effective as a multi-tablet drug regimen, we believe that, absent an appropriate reason for such refusal, such a plan design effectively discriminates against, or discourages enrollment by, individuals who would benefit from such innovative therapeutic options.³

Health Access has information indicating that some or even many of the products in the individual market in 2014 failed to cover the AIDS drug cocktail, which is a single-tablet drug regimen that is the standard of care for persons with HIV/AIDS. Indeed, we are told by activists in the HIV/AIDS community that some individuals have stayed on the AIDS Drug Assistance Program (ADAP) program rather than transitioning to comprehensive coverage in the individual market precisely because some health plans appear not to cover the AIDS drug cocktail in their individual market products. Exclusion of the AIDS drug cocktail, a customarily prescribed product that is just as effective as other regimens, is indicative of a benefit design that effectively discriminates against, or discourages enrollment by, persons with HIV/AIDS, making it a discriminatory benefit design.

Health Access asks that CDI and DMHC direct health plans and insurers to cover single-tablet drug regimen and extended release products that are customarily prescribed and are just as effective as a multi-tablet regimen. The directive should also apply to products offered through Covered California.

² *Id.*

³ *Id.* at p. 70723.

2. Most or All of the Drugs to Treat a Specific Condition On the Highest Cost Tier

In its November 26, 2014, guidance, CMS further states:

As another example, if an issuer places most or all drugs that treat a specific condition on the highest cost tiers, we believe that such plan designs effectively discriminate against, or discourage enrollment by, individuals who have those chronic conditions.⁴

Health Access understands that a number of health plans and insurers have placed on the fourth tier of the drug formulary, known as “specialty” drugs, a number of high cost drugs that meet the criteria enunciated by CMS as “most or all drugs that treat a specific condition.” These include drugs to cure Hepatitis C as well as to treat rheumatoid arthritis, multiple sclerosis and other serious conditions. The standard benefit designs authorized by Covered California include cost sharing of 20 percent and 30 percent of the cost of specialty drugs. In some instances this means that a single month’s prescription can cost more than \$6,500, an intolerable cost to consumers.

Health Access asks CDI and DMHC to direct health plans and insurers to remove from the highest cost tier “most or all drugs that treat a specific condition” and assure that these drugs are drugs on lower tiers of the formulary.

3. Formulary Design Not Based on Clinical Guidelines or Medical Evidence

In its November 26, 2014 guidance, CMS states that:

Issuers are expected to impose limitations and exclusions based on clinical guidelines and medical evidence, and are expected to use reasonable medical management.⁵

As previously stated, health plans and insurers have put a number of drugs to treat a specific condition, commonly known as specialty drugs, on the highest cost tier of the formulary. However, California law does not provide a definition of specialty drug. Health Access understands that some health plans and insurers have a definition of specialty drug that is based solely on the cost of the drug to the health plan without any regard for clinical guidelines, medical evidence, or reasonable medical management. These practices are contrary to federal law and guidance.

Health Access asks that the CDI and DMHC direct health plans and insurers to revise their formularies so that in no instance is the fourth tier based solely on the

⁴ *Id.*

⁵ *Id.*

cost of the drug to the health plan. Health Access further asks that the two departments direct health plans and insurers to develop definitions of specialty drugs that are based on clinical guidelines, medical evidence and reasonable medical management, not the cost to the health plan. Health Access further asks that the two departments direct health plans and insurers to submit justification with supporting documentation explaining how the plan design is not discriminatory.

Covered California: Standard Benefit Designs

Covered California offers standard benefit designs in the individual market that account for 1.4 million of the 1.9 million lives in the individual market segment regulated by the Department of Managed Health Care in the first quarter of 2014.⁶

Health Access California has been an active participant in deliberations regarding these issues. We participated, as a member of the public, in the Covered California Plan Management Advisory Committee meetings and provided testimony at meetings of the Board of Covered California. We also participated in a workgroup on the benefit designs for the year 2016. We have raised issues and offered solutions regarding specialty drug cost sharing in those venues. Covered California has responded by offering to consider the issue of specialty drugs over the course of the next year. As a result, no solution would be in place prior to the year 2017, if then.

Given the guidance issued by CMS on November 26, 2014 and the subsequent action by CMS to investigate health plans offered through the federal marketplace for the 2016 plan year, California cannot wait until the year 2017 to bring its benefit designs into conformity with federal law and guidance. California consumers need action now so that the benefit designs offered in the 2016 plan year are not discriminatory in their design.

We look forward to working with the Insurance Commissioner and the Department of Managed Health Care to resolve these concerns.

Sincerely,


Anthony Wright
Executive Director

CC: Diana Dooley, Secretary of the California Health and Human Services
Agency and Chair of the Covered California Board

⁶ Data for lives regulated by the Department of Insurance not available at this time.

Peter Lee, Executive Director, Covered California

Cindy Mann, Director, U.S. Centers for Medicare and Medicaid Services

Senator Ed Hernandez, Chair, California State Senate Health Committee

Assemblymember Rob Bonta, Chair, California Assembly Health Committee

Assemblymember Rich Gordon, author, AB1917 of 2014.

drugs to enrollees, and may use a mail order pharmacy to do so. While this generally is more cost-effective and more convenient for enrollees than requiring the enrollee to visit a retail pharmacy to obtain prescription drugs, there are circumstances under which obtaining drugs via mail order may not be viable. For example, obtaining prescription drugs through mail order may not be a viable option when an individual does not have a stable living environment and does not have a permanent address. In those cases, individuals may not always have the ability to keep a mail order pharmacy delivery confidential. There are also cases in which a drug needs to be provided immediately (for example, antibiotics or pain relievers). In such cases, we do not believe that making drugs available only by mail order constitutes fulfilling the obligation under 1302(b)(1)(F) of the Affordable Care Act to provide prescription drug coverage as part of EHB. We also believe that making drugs available only by mail order would discourage enrollment by, and thus discriminate against, transient individuals and certain individuals who have conditions that they wish to keep confidential.

Accordingly, under § 156.122(e), we are proposing to add new requirements to the EHB prescription drug definition to require that enrollees be provided with the option to access their prescription drug benefit through retail (brick-and-mortar or non-mail order) pharmacies. If finalized, this requirement would mean that a health plan that is required to cover the EHB package cannot have a mail order only prescription drug benefit. This proposed requirement would still allow a health plan to charge a higher cost-sharing amount when obtaining the drug at an in-network retail pharmacy than he or she would pay for obtaining the same covered drug at a mail-order pharmacy. However, as a part of these requirements, we propose to clarify that this additional cost sharing for the covered drug would count towards the plan's annual limitation on cost sharing under § 156.130 and would need to be taken into account when calculating the actuarial value of the health plan under § 156.135. Additionally, issuers will still retain the flexibility under this proposed policy to charge a lower cost sharing amount when obtaining the drug at an in-network retail pharmacy too. While this proposal requires coverage of a drug at an in-network retail pharmacy, for plans that do not have a network, the enrollee should be able to go to any pharmacy to access

their prescription drug benefit and those plans would, therefore, comply this proposed standard.

We also recognize as part of this proposed requirement that certain drugs have limited access requirements and cannot always be accessed through in-network retail pharmacies. For this reason, we are proposing that the health plan may restrict access to a particular drug when: (1) The FDA has restricted distribution of the drug to certain facilities or practitioners (including physicians); or (2) appropriate dispensing of the drug requires extraordinary special handling, provider coordination, or patient education that cannot be met by a retail pharmacy. For instance, certain drugs have a Risk Evaluation and Mitigation Strategies (REMS) that include Elements to Assure Safe Use that may require that pharmacies, practitioners or healthcare settings that dispense the drug to be specially certified and can limit access to the drugs to certain health care settings.⁴⁴ We propose that additional education or counseling alone would not qualify a drug to be restricted to limited distribution to a non-retail pharmacy within the overall pharmacy network. If the health plan finds it necessary to restrict access to a drug for either of the two reasons listed above, it must indicate this restricted access on the formulary drug list that we are proposing plans must make publicly available under § 156.122(d).

We are soliciting comments on these proposed requirements, including whether additional standards should be adopted to ensure enrollee access to the EHB prescription drug benefit, or whether additional exemptions to accessing drugs at in-network retail pharmacies should be permitted. We are proposing these requirements as market-wide standards to ensure the uniformity of the EHB prescription drug benefit and proposing to implement these requirements beginning with the 2017 plan year. However, we are soliciting comments on this timing and whether it should be implemented in 2016.

In addition to the proposed provisions above, we are also aware that new enrollees in plans that are required to cover EHB may be unfamiliar with what is covered on their new plan's formulary drug list, and how to use the plan's prescription drug exceptions process. Also, some enrollees whose drugs are

covered by the plan's formulary may need to obtain prior authorization or go through step therapy in order to have coverage for the drug. Since new enrollees may need more immediate coverage for drugs that they have been prescribed and are currently taking, we urge issuers to temporarily cover non-formulary drugs (including drugs that are on an issuer's formulary but require prior authorization or step therapy) as if they were on formulary (or without imposing prior authorization or step therapy requirements) during the first 30 days of coverage. We encourage plans to adopt this policy to accommodate the immediate needs of enrollees, while allowing the enrollee sufficient time to go through the prior authorization or drug exception processes. We are considering whether requirements may be needed in this area.

e. Prohibition on Discrimination (§ 156.125)

Section 1302(b)(4) of the Affordable Care Act directs the Secretary to address certain standards in defining EHB, including elements related to balance, discrimination, the needs of diverse sections of the population, and denial of benefits. We have interpreted this provision as a prohibition on discrimination by issuers providing EHB. Within § 156.125, which implements these provisions, we finalized in the EHB Rule that an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

Since we finalized § 156.125, we have become aware of benefit designs that we believe would discourage enrollment by individuals based on age or based on health conditions, in effect making those plan designs discriminatory, thus violating this prohibition. Some issuers have maintained limits and exclusions that were included in the State EHB-benchmark plan. As we have previously stated in guidance, EHB-benchmark plans may not reflect all requirements effective for plan years starting on or after January 1, 2014. Therefore, when designing plans that are substantially equal to the EHB-benchmark plan, issuers should design plan benefits, including coverage and limitations, to comply with requirements and

⁴⁴ FDA requires a Risk Evaluation and Mitigation Strategies (REMS) for certain drugs to ensure that the benefits of a drug or biological product outweigh its risks. The following is FDA's list of currently approved REMS at: <http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm111350.htm>.

limitations that apply to plans beginning in 2014.⁴⁵

We caution both issuers and States that age limits are discriminatory when applied to services that have been found clinically effective at all ages. For example, it would be arbitrary to limit a hearing aid to enrollees who are 6 years of age and younger since there may be some older enrollees for whom a hearing aid is medically necessary. Although we do not enumerate which benefits fall into each statutory EHB category, issuers should not attempt to circumvent coverage of medically necessary benefits by labeling the benefit as a “pediatric service”, thereby excluding adults.

We also caution issuers to avoid discouraging enrollment of individuals with chronic health needs. For example, if an issuer refuses to cover a single-tablet drug regimen or extended-release product that is customarily prescribed and is just as effective as a multi-tablet regimen, we believe that, absent an appropriate reason for such refusal, such a plan design effectively discriminates against, or discourages enrollment by, individuals who would benefit from such innovative therapeutic options. As another example, if an issuer places most or all drugs that treat a specific condition on the highest cost tiers, we believe that such plan designs effectively discriminate against, or discourage enrollment by, individuals who have those chronic conditions.

As we indicated in the 2014 Letter to Issuers, we will notify an issuer when we see an indication of a reduction in the generosity of a benefit in some manner for subsets of individuals that is not based on clinically indicated, reasonable medical management practices.⁴⁶ We conduct this examination whenever an EHB plan reduces benefits for a particular group. Issuers are expected to impose limitations and exclusions based on clinical guidelines and medical evidence, and are expected to use reasonable medical management. Issuers may be asked to submit justification with supporting document to HHS or the State explaining how the plan design is not discriminatory.

Other nondiscrimination and civil rights laws may apply, including the Americans with Disabilities Act, section 1557 of the Affordable Care Act, Title VI

of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, section 504 of the Rehabilitation Act of 1973 and State law. Compliance with § 156.125 is not determinative of compliance with any other applicable requirements and § 156.125 does not apply to the Medicaid and CHIP programs, including EPSDT, and Alternative Benefit Plans.

We also note that all non-grandfathered health insurance plans in the individual and small group market that are subject to the EHB requirements are also subject to the guaranteed renewability requirements under § 147.106, which allow issuers to make uniform modifications to a product only at the time of coverage renewal. For example, an EHB plan may not change cost sharing for a particular benefit mid-year.

f. Cost-Sharing Requirements (§ 156.130)

We propose to amend § 156.130 to clarify how the annual limitation on cost sharing applies to plans that operate on a non-calendar year, and to make a technical correction to the special rule for network plans. First, we propose to add a new § 156.130(b), which would provide that non-calendar year plans that are subject to the annual limitation on cost sharing in section 1302(c)(1) must adhere to the annual limitation that is specific to the calendar year in which the plan begins. That annual limitation amount would serve as the maximum for the entire plan year. We propose this requirement to clarify that non-calendar plans subject to § 156.130 are not permitted to reset the plan's annual limitation on cost sharing at the end of the calendar year when the end of the calendar year is not the end of the plan year. The purpose of this proposed change is to ensure that the enrollee should only be required to accumulate cost sharing that applies to one annual limit per plan year. We believe that this requirement ensures an important consumer protection and we solicit comments on this proposal.

Under section 1302(c)(3) of the Affordable Care Act, the term “cost-sharing” includes deductibles, coinsurance, copayments, or similar charges, and any other expenditure required of an individual that is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) for EHB covered under the plan. Expenditures that meet this definition of cost sharing must, under section 1302(c) of the Affordable Care Act, count toward the annual limitation on cost sharing incurred under a health plan that is required to cover EHB. The term “cost-sharing” does not include premiums,

balance billing amounts for non-network providers, or spending for non-covered services. This definition was codified in § 155.20.

In this proposed rule, we propose to make a technical correction to the text of § 156.130(c) on the special rule for network plans to replace “shall not” with “is not required to.” This correction is in accordance with the Affordable Care Act Implementation FAQs (Set 18) that was prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury.⁴⁷ This proposed amendment is to clarify that issuers have the option to count the cost sharing for out-of-network services towards the annual limitation on cost sharing, but are not required to do so. This out-of-network cost sharing would not count toward the calculation of actuarial value under § 156.135(b)(4) or meeting a given level of coverage under § 156.140.

In addition to the above proposed changes to § 156.130, we also propose clarifying that the annual limitation on cost sharing for self-only coverage applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only. In both of these cases, an individual's cost sharing for the EHB may never exceed the self-only annual limitation on cost sharing. For example, under the proposed 2016 annual limitation on cost sharing, if an other than self-only plan has an annual limitation on cost sharing of \$10,000 and one individual in the family plan incurs \$20,000 in expenses from a hospital stay, that particular individual would only be responsible for paying the cost sharing related to the costs of the hospital stay covered as EHB up to the annual limit on cost sharing for self-only coverage that is proposed to be \$6,850 for 2016. However, for a plan with other than self-only coverage, as long as the plan applies an annual limitation on cost sharing that is at or below the annual limitation for self-only coverage (proposed to be \$6,850 for 2016) for each individual in the plan and at or below the annual limitation for other than self-only coverage (which is proposed to be \$13,700 for 2016), the issuer has flexibility on how to apply the plan's annual limitation on cost sharing between the individuals in the plan.

We seek comments on these requirements and clarifications. We also seek comments on whether other requirements and clarifications are

⁴⁵ Guide to Reviewing EHB Benchmark Plans—http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#review_benchmarks.

⁴⁶ Letter to Issuers on Federally-facilitated and State Partnership Exchanges, April 5, 2013, page 15 and 2015 Letter to Issuers in the Federally-facilitated Marketplaces, March 14, 2014, page 29.

⁴⁷ http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html. (January 8, 2014).



Oscar Insurance Corporation
295 Lafayette St, 6th floor
New York, NY 10012
hioscar.com

December 15, 2014

Board of Directors
California Health Benefit Exchange
1601 Exposition Blvd.
Sacramento, CA 95815

RE: New market entrants in Covered California in 2016

Dear Board of Directors:

Oscar Insurance is in the process of seeking licensure in California and hopes to participate in the 2016 Exchange. Oscar was formed with the goal of creating a new health insurance experience for individual consumers, and our experience to date in New York and New Jersey demonstrates that consumers welcome our new consumer-centric model. We hope that the Board will maintain its current policy of allowing new market entrants to be considered for participation in Covered California in all service areas so that we can offer this new experience to consumers in California.

Oscar was created by people with a background in technology. Oscar's founders were frustrated with the available health insurance choices and thought there was a better way to provide health insurance coverage. Oscar seeks to do things differently -- to make health insurance simple, human, smart and transparent. We offer an innovative and distinct alternative to the traditional insurers that participate in Covered California. Every aspect of the Oscar experience -- from enrollment to the ID card to the Explanation of Benefits to the tools we give consumers to enable them to access quality care -- has been reimagined and simplified with the consumer in mind. Among many other features, Oscar members have the ability to log into a website or mobile application and access a personalized search engine that, based on a member's medical information, will provide the member clear cost information on quality treatment options. Additionally, Oscar members have 24/7 access to board-certified doctors via Teledoc and can easily access useful information about services the member has received.

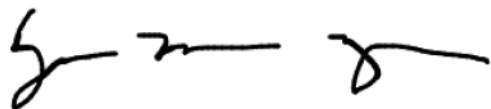
Over 20,000 New Yorkers, both on and off the Exchange, have signed up for Oscar in just over a year. We are especially proud that 40% of our newest members signed up because they heard about us through word-of-mouth. For 2015, we also will be participating in the federal exchange in New Jersey.

We seek to participate in Covered California because we share your goal of enhancing competition among health insurance plans and improving consumer choice by offering a different model of coverage. While more isn't always better -- especially when it is more of the same -- meaningful choice among health insurance companies leads to a more competitive and robust market. This is true for areas with multiple health plan options as well as those with only a few plan options.

We recognize that the board seeks to strike a balance among those plans that went into the market in the first year and plans that now seek to enter. However, a newly-created company such as Oscar is different than a company that chose to sit out Year 1. We were not in a position to enter in Year 1 but, having now launched in two other states, we are excited about the possibility of offering our unique products to California consumers. Thus, we hope that you will determine that consumer choice is best served by allowing at least some new market entrants -- for example, those with a differentiated consumer experience -- to participate in Covered California in 2016 in all geographic markets.

Thank you for the opportunity to present this information. We at Oscar look forward to working with you in the coming months.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kevin Nazemi', with a stylized flourish at the end.

Kevin Nazemi | Co-Founder
kevin@hioscar.com
424.429.2345

Diana Dooley, Chair
Members of the Board
Covered California
California Health Benefit Exchange
1601 Exposition Boulevard
Sacramento, California 95815

Dear Chair Dooley and Members:

I am pleased to be able to address the board and staff on the issue of the QHP new entrant application criteria policy for 2016.

As a California resident and long-time professional in the healthcare industry, I want to begin by saying how impressed I am by your organization. Covered California and the Health Benefit Exchange have helped millions of Californians obtain insurance, many for the first time. As a health care carrier doing business in all 50 states, we understand the tremendous challenges that have come with implementing health care reform. Covered California is certainly a model for the country and many lessons can be taken from how well the program has been implemented across the state.

While UnitedHealthcare's initial participation in the Federal and State Exchanges was limited, we were able to take the time to carefully evaluate and better understand how the Exchanges would work to ensure we were best prepared to participate in a more meaningful way. UnitedHealthcare has a long history in California, with more than 10,500 employees and 84 office locations across the state we serve more than 3.1 million Californians. As a leader in innovation, we have introduced new technology that has changed the way health care is delivered and made it easier for consumers to make more informed health care decisions. A few examples include:

- **Health4Me**, a mobile app for iPhone and Android devices, provides millions of UnitedHealthcare plan participants with accurate, easy-to-understand provider look-up and health benefit information in the palm of their hand.
- **myHealthcare Cost Estimator** – free to all UnitedHealthcare plan participants online at myuhc.com or through the Health4Me™ mobile app – enables consumers to compare health care costs and access quality information before they receive treatment. UnitedHealthcare research shows consumers who use MyHealthcare Cost Estimator are more likely to choose a higher-quality care provider. Users have received more than \$2.8 billion in estimates since the online and mobile tool launched in 2012, enabling them to make more informed health care decisions and manage their health benefit costs.
- **Just Plain Clear (en Español)** is a glossary in English and Spanish that defines thousands of health care terms in plain, clear language to help them make better health care decisions.

We appreciate the significant commitment that a number of our colleagues made to participate in the California Exchange in 2014 and continuing into 2015. UnitedHealthcare is currently participating in 23 exchanges across the country and we look forward to sharing our expertise as we expand into new markets in 2016 and beyond.

We understand the hesitancy that our competitors may have as well the Exchange Board to allow new entrants prior to 2017. However, we strongly believe that expansion of new carriers in 2016 will greatly benefit California consumers by expanding choice and affordability, specifically, for those who have gone without health care coverage. We encourage the Board not to limit expansion to certain markets as this

will greatly limit the ability to provide greater access and more cost savings to underserved communities. If Californians can possibly benefit from additional plan choices, we would encourage this board to take action and allow those plans the opportunity to demonstrate the value they can bring to the marketplace. In our opinion, more choice would mean greater support for the Triple Aim of improving care, health and cost and ultimately benefiting more consumers. UnitedHealthcare has a proven track record for serving the Hispanic and Asian American communities with unique products and services specifically designed to meet the needs of these growing communities throughout the California.

I respectfully request the board consider adopting a policy allowing an opportunity for new entrants in 2016. As the staff has noted, even under the limited exceptions outlined, opening the door to applicants doesn't guarantee a place on the Exchange, it is only the first step. The plan must bring value to the consumer, consistent with the mission of the Exchange.

Our preliminary due diligence suggests UnitedHealthcare will support the triple aim by providing not only more product choice, and competitive rates, but also greater transparency through premium designation based on quality and cost, and innovation with our premium designation tiered benefit plans, health care cost estimator, mobile applications and more. We are prepared to enter the market statewide, in all regions for both the Health Benefit Exchange and Small Business Health Options Program including those where little or no choice currently exists for consumers. Additionally, we are planning to enter the Medi-Cal market in select geographies.

Your stated mission is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value. I am asking for the opportunity to work with your staff to show that UnitedHealthcare can and will help you achieve that mission.

Thank you for the opportunity to comment.

A handwritten signature in dark ink, appearing to read 'Brandon Cuevas', with a stylized flourish at the end.

Brandon Cuevas
CEO, UnitedHealthcare of California