CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD
December 15, 2014
Covered California Tahoe Auditorium
1601 Exposition Blvd.
Sacramento, CA 95815

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

Chairwoman Dooley called the meeting to order at 1:00 p.m.

Board members present during roll call:
Diana S. Dooley, chair

Board members attending meeting virtually in Los Angeles:
Kimberly Belshé
Robert Ross, MD

Board members en route during roll call:
Paul Fearer

Board members absent:
Susan Kennedy

Agenda Item II: Closed Session

Chairwoman Dooley called the meeting to order at 2:00 p.m. A conflict disclosure was performed; there were no conflicts from the board members that needed to be disclosed.

Chairwoman Dooley expressed that a December meeting was going to be necessary to move forward on an important issue. Board Members Ross and Belshé are in Los Angeles, participating virtually.

Agenda Item III: Approval of Board Meeting Minutes

After asking if there were any changes to be made, Chairwoman Dooley asked for a motion to approve the minutes from the meeting held November 20, 2014.

Presentation: November 20, 2014, Minutes

Discussion: None

Public Comment: None

Motion/Action: Board Member Fearer moved to approve the November 20, 2014, minutes. Board Member Ross seconded the motion.

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

Board Member Ross announced that he will no longer be participating as a Covered California Board member after December 31. Senator de León will choose a new Board member. He thanked all of the stakeholders and constituents and Board members for their partnership. He thanked Mr. Lee for his energy and leadership. It has been a joy serving and making history together.

Chairwoman Dooley expressed that there are no words that could properly express thanks and appreciation for Board Member Ross's service and dedication as well as the blessing of the California Endowment. They look forward to a new colleague, but Board Member Ross will forever be a part of the inaugural period.

Board Member Belshé echoed Chairwoman Dooley's comments and hoped Board Member Ross would be able to come to January's meeting to be properly acknowledged.

Chairwoman Dooley noted that a former Covered California contractor raised allegations against the organization last February, citing discrimination, waste, fraud, and abuse. She directed that an independent investigation into those allegations be conducted. They conducted numerous interviews including with the claimant and reviewed thousands of pages of documentation. The investigation has been completed and the findings posted to the Board's website. The investigators found that all of the allegations were not sustained.

Agenda Item IV: Executive Director's Report
Peter V. Lee, Executive Director, echoed the Board members' appreciation for Board Member Ross.

Mr. Lee drew attention to the advertisements posted around the meeting room, featuring real enrollees. A graffiti art mural by Alejandro Poli (aka Man One) was also displayed. He thanked the California Endowment for supporting that piece of art.

Discussion: Announcement of Closed Session Actions
Mr. Lee announced two retirements. Sue Johnsrud, Chief Deputy Executive Director, Operations, will be retiring earlier than planned. Yolanda Richardson will be in the sole role of Chief Deputy. Juli Baker, Chief Technology Officer, will also be retiring. She started the whole IT department and got three service centers up and running. He thanked them and wished them well.

He announced the hire of a new assistant general counsel, Brandon Ross. He has been working as point person for plan management and has been promoted internally.

The Board expanded on the contract with Fanueil and Maximus and entered into a new contract with Fanueil. This will add an additional 500 staff during this peak time to help support phone and paper processing.

Discussion: Executive Director's Update
Mr. Lee noted that open enrollment has been going for one month. Covered California is trying to be very clear that immigration information will not be shared to enforce immigration actions. Some of the leading state and national immigration rights organizations are assisting with this messaging. These materials will be shared with other states as well. Immigration status should not get in the way of enrollment. This is a critical part of the enrollment efforts.

Covered California held an event for providers at UCLA. They sent over 170,000 letters to practitioners encouraging them to partner with the exchange. Physician associations, including ethnic associations, are reaching out to their communities. They have shared providers who are in as Covered California providers. UCLA contracts with Covered California plans, and has seen thousands of patients, including several who received transplants.

Mr. Lee noted that staff has shared many reports. One is a work by consumer advocates, addressing network adequacy. Another is a report on health care costs. Staff also shared important comment letters on translation of notices, the audits on provider communications and networks, Medi-Cal eligibility, and on making sure that the conversion to Medi-Cal maintains people's coverage.

During the renewal process, many people are being found to be Medi-Cal eligible. Consumers are receiving notices that they can continue their qualified health plan coverage at full cost if they do not want Medi-Cal.

Discussion:
Board Member Ross asked if they had received comments about the impact of the president's executive order regarding immigration. Has any guidance been received from the federal government?

Mr. Lee noted they have discussed this with the Department of Homeland Security. They articulated that the new spotlight drawn on this issue because of the executive order would not affect the policies to not use immigration information for anything else. Nothing changes, policy-wise. The main thing this order does is remind people that this is an outstanding issue. It opens the door to protection for 5 million people, but 10 million still face potential deportation.

Board Member Belshé commended staff for working closely with the Department of Health Care Services to ensure people don't fall through the gaps when transitioning between Covered California and Medi-Cal.

Mr. Lee stated that almost 50,000 people were enrolled in the first nineteen days. By December 11, it had increased to 91,000 people. There is a high volume of continued interest. They are trying to get as many people enrolled by the December 15 deadline as possible, and they are implementing a policy similar to that of last year. If people have started the enrollment process, the team will try to help get them enrolled by December 21 for a January 1 start date. Many of those enrolled this year will never have had insurance before and will be applying for the first time. These individuals will need more assistance. The numbers are strong, and they are seeing an outpouring of interest.

There has been a practice of promoting in-person enrollment. The website features a page with enrollment events, storefronts, and various kinds of assisters. There are 14,500 licensed insurance agents now, almost twice as many as last year, 6,300 certified enrollment counselors, and 22,000 county eligibility workers. So far about 23% have enrolled via self-service routes, fewer than last year. More people are getting help from agents, CECs, and service center staff.

Julianne Broyles, California Association of Health Underwriters, spoke about the role of agents. She thanked the Board and staff for welcoming her. They are first and foremost interested in expanding access to affordable health care. There has been a far different tone this year. There are fewer hysterical calls about the service centers. It is much calmer, and people are receiving help from the service centers and resolve issues. The agent-only lines have helped. They see daily improvements as expanded staff comes online. Last year the paper applications caused problems. There are still some issues but the progress is a testament to the staff's hard work. It has created workarounds and is working on other problems. There are still some system glitches but they are mostly the same ones people have been bringing up, related to Medi-Cal and CalHEERS and mixed-status families. She appreciated specific team members, who have been finding solutions for them. The changing agent agreement has improved service for the consumer by mirroring what happens in the private sector. Most agents were terrified of the Affordable Care Act, not knowing what their role would be. But the agents have found a secure place in helping consumers find affordable coverage.

Mr. Lee has seen agents everywhere be a part of the community fabric. He's thrilled to see the increasing number of agents and hear that things are improving.

Mr. Lee touched on the vast array of partners listed in the slides. The millennial population has been targeted. He referred to President Obama's appearance on the Colbert Report. A number of enrollment events will be taking place.

Agents, who serve many individuals, are seeing the service center service improve. They're working on improving everybody's experience. They are bringing on temporary additional staff, including online chat staff. They anticipate a large volume of demands heading into January. The tax notices will be going out at the same time as open enrollment, so they anticipate additional demand then and plan to have resources available.

Service has been better. It is still not perfect. December 8–14, a high-volume week, had an eighteen-minute wait time. However, it is an improvement. They feel good about the progress they are making. The Board's commitment to the best service possible is continuing to show.

They are changing the IT system to reduce duplicative notices. Every day, thousands of people call in and then get their questions answered by recordings. They are also working to ensure assisters can do terminations.

Notices are improving. Covered California will have new notices on the advance premium tax credit, and are working to ensure they are both accurate and clear. They are trying to implement improvements in the notices shared with DHCS. The survey process for those who have enrolled has changed and is now more robust.

Last year, many consumers didn't get their bills. Now most plans' enrollees can pay their first premium upon enrollment.

Public Comment:
In Los Angeles: Carolina Coleman, Insure the Uninsured Project, voiced hope for the open enrollment process. They have received a lot of feedback from people having trouble with the identification process. Young people with no credit histories can't get through the Experian process. They want to partner to help people get through that process, since it's required by law.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), thanked Board Member Ross for serving on the Board and articulating the needs of California's diverse communities. She hopes someone who can similarly represent Californians will be selected to replace him. They are excited about the large enrollment numbers. They would love to get more details on the breakdown by community segments and on what sort of assistance enrollees used. They would like more detail on what the survey will capture and wondered if the survey would also be given over the phone. They would like to know more about different Californians' experiences.

Jen Flory, Senior Attorney, Western Center on Law & Poverty and the Health Consumer Alliance, thanked Board Member Ross for his job at Covered California and at the California Endowment. They sent a letter with the plans and health access regarding the transition into Medi-Cal. They hope that since people are already in the system it can be more seamless. "Likely eligible" is not a real determination. If we can get them in on January 1, that would be great. For anyone who's not getting Medi-Cal after all, they should still be getting premium tax credits. They are frustrated by the prioritization of CalHEERS fixes. The wrong notices are going out to people still. Some of the core functions should be prioritized.

Linda Leu, California Research and Policy Director, Young Invincibles, thanked Board Member Ross. They are also concerned about the Experian process allowing identity

verification since so many young people have trouble with that. They wondered if there was an update on when they would receive the data breakdown on enrollment numbers. Since this is such a short enrollment period, it will be important to do course corrections quickly.

Nicole Stefko, California Primary Care Association, thanked Board Member Ross for his service. He was truly a visionary for the Affordable Care Act implementation in California. He never shied away from raising issues. They echoed the concerns already stated. She thanked the exchange for the increased transparency, voicing that they are hearing the same messages on the ground that they hear in Covered California's meetings. The enrollment numbers speak for themselves, which is wonderful. They would also like to adjust the prioritization. In addition to Young Invincibles having trouble getting through the identity-proofing process, mixed status families are having trouble. They don't want to see a shift to paper applications.

Janice Rocco, Deputy Commissioner of Health Policy and Reform, California Department of Insurance, noted that their department learned late last week about the potential cancellation issue associated with Medi-Cal determinations. Neither Covered California nor the health plans has the right to cancel or non-renew coverage. Mr. Lee had said these people would be told they won't lose coverage, but that doesn't clarify if Covered California will cancel their policies effective December 31 if they don't contact Covered California in time to prevent that. That would run contrary to the law.

Julianne Broyles, California Association of Health Underwriters, asked for clarification regarding the time extension for effectuating coverage on January 1. Does the application have to be started by December 15 or December 21?

Beth Capell, Health Access California, thanked Board Member Ross as well as the rest of the Board. It seems like just yesterday the exchange started. They are concerned about the 95,000 people who are likely eligible for Medi-Cal. Anyone who is likely eligible for Medi-Cal is not in a place where they can pay the full premium, even for a month, so should not be put in a position where that would be necessary. She asked that the organization err on the side of giving these members the affordability help they need within the constraints of the federal guidance. If the federal guidance must be altered to make that possible, the various stakeholders can help lobby for that.

Mr. Lee said demographic breakdowns of enrollment would be released at the January meeting. They are working with the issues relating to identity proofing. Some other states had a very rocky time last year, and California has been able to learn from that. Covered California wants to help insure there will be no gaps in coverage. The real issue regarding cancellation is making sure people don't go without coverage. If people must pay for coverage for a month, they will only be able to do that through Medi-Cal. They will have the right to keep coverage, and that's why they appreciate the partnership they have with DHCS. They will follow up with the Department of Insurance to ensure notices and communications are clear and compliant. The extension is to complete enrollment by December 21. They know many thousands have been deemed eligible but have not

completed plan selection. Sometimes those providing assistance are booked up, and those who have appointments on December 16 will still get enrolled.

Chairwoman Dooley recognized that there will be issues with transitions in both directions. They are still learning how to make this work. The subsidy is an issue that Covered California must seek guidance on. The goal is always to get as many people coverage as possible. They are concerned about continuity of care and aware of all the laws. We will continue to figure this out together. In January there will be another issue with notices when the tax notices go out. Part of it is that it is complicated and part is that the rules change and part of it is that they must be translated. They are thankful for all of the partnerships that they have that help them overcome all the hurdles. The backlogs in Medi-Cal are nearly resolved. They are working hard to keep these people in the system even if their cases are not resolved.

Agenda Item V: Covered California Policy and Action Items

Mr. Lee noted that the spirit of collaboration in California is amazing. It's all been focused on assisting the Board in putting consumers first.

Discussion: 2016 Standard Benefit Design and Qualified Health Plan Recertification and New Entrant Policies

Anne Price, Director of Plan Management Division, presented. Both topics will be presented for approval in January.

The Board originally decided that in general, new QHP entrants would not likely be accepted in 2015. New entrants would be limited to those in the Medi-Cal market and service area expansions. They are revisiting this policy. They are considering addressing areas with limited carriers (fewer than three). It would be an option to allow new carriers into those regions. The proposal is that Covered California could review applications and allow newly licensed carriers, Medi-Cal plans, and current contractors expanding into new areas. Preference will be given to existing carriers. They will give first consideration to their 2015 carriers before accepting new entrants. Covered California will take into account a variety of considerations.

She shared which regions currently have limited (fewer than three) carriers. Some areas only include one or two choices. She shared additional proposed policies for 2016 certification and recertification.

For the SHOP, new applicants will be considered. The 2016 benefit designs in SHOP would apply to all plans and they would consider product changes and alternative benefit designs.

They do not propose new dental applicants in 2016. Benefit changes would not be likely. Product changes and expansions of networks would be allowed.

Mr. Lee noted that there are three classes of new entrants. Existing plans cannot apply to participate in the exchange, but they are encouraged to expand into regions they had not served before, with preference given to those applying for regions currently lacking in plan choice. Medi-Cal public plans can apply as new entrants, as can newly licensed plans that were not around in 2012. Those plans can apply anywhere, with preference given to those applying for currently underserved regions. There are challenges confronting Medi-Cal plans, but Covered California is in discussion with several of those.

Discussion: None

Public Comment:
Betsy Imholz, Director of Special Projects, Consumers Union, noted that they are in favor of the suggested tailored approach. Covered California had enough interest during the first year to encourage a vibrant, competitive marketplace. There are regions, however, with insufficient provider networks and insufficient competition. Covered California should remind the plans that its active purchaser role still applies. It should pick through the plans and choose based on premium, consumer satisfaction, and quality.

Jen Flory, Senior Attorney, Western Center on Law & Poverty and the Health Consumer Alliance, concurred with Ms. Imholz. They hear from consumers in underserved regions, so they are happy to hear that existing plans will be encouraged to expand into those regions. If the quality and price are comparable, they'd love to see new plans in those areas.

Beth Capell, Health Access California, echoed the comments of the other consumer advocates and voiced concern about ensuring network adequacy and timely access to care. The Department of Insurance has started an informal process addressing these issues; she hopes that well before the 2016 standards are in place, carriers licensed by them would meet the standards of the Department of Managed Health Care to ensure people get the care they need when they need it.

On phone: Doreena Wong, Project Director, Asian Americans Advancing Justice, thanked Board Member Ross for his vision and service and commitment to implementing the Affordable Care Act for all Californians. She commended Covered California for their outreach and education of the immigrant community regarding immigration status and privacy, accomplished using immigration fact sheets, translated materials, and partnering with community-based organizations. She appreciated that this work has been done on a national level too.

Janice Rocco, Deputy Commissioner of Health Policy and Reform, California Department of Insurance, noted that the Department of Insurance expects to submit new regulations in January, and those include network adequacy standards. She appreciated the clarification that newly licensed plans can apply to serve anywhere in the state. While there may be new entrants who are happy to apply to the underrepresented areas, they may need to sell statewide to be viable. This will help ensure an even playing field.

Brett Johnson, Associate Director of Medical and Regulatory Policy, California Medical Association, supported Ms. Imholz's and Ms. Capell's comments. They support the network expansions, and they encouraged the Board to review their comment letter, which contains suggestions for clarity in contracting language. They would like to avoid the same miscommunications that led to the poor survey results.

In Los Angeles: Brandon Cuevas, CEO, United Healthcare, congratulated Covered California for all its good work and Board Member Ross for his contributions. They understand how challenging this work has been. This period, during which United Healthcare's participation has been limited, has allowed it to watch and see which regions of the country the Affordable Care Act has been working in. California has been successful. The company is participating in 23 exchanges nationwide, and this has given them a unique perspective. They ask for reconsideration of the policy for 2016. They appreciate the investment by the exchange and their peers, they can appreciate the hesitancy to add new plans on a statewide basis. While adding more isn't always better, United Healthcare has unique experience, networks, and technologies. They appreciate the comments on the different criteria for entry, but they would like to ask for a broader definition. They will follow up with more formal communication.

Anne Price presented on 2016 benefit design. She recognized the workgroup, which has worked tirelessly on this issue. Covered California has standard benefit designs, which makes things easier for consumers. The goal of the workgroup was to provide recommendations to help improve on those standard benefit designs, particularly with regards to access. The principles that they worked under were to maintain standard benefit designs, to evaluate them as a multiyear deal, revising as data comes in. Any changes should promote improvement in consumers' understanding and simplify training for enrollers.

The different metal tiers have different requirements for how much the plan pays. They would like to aim toward the bottom of the actuarial value scale to ensure there is some flexibility built in for the future. They wanted to increase transparency in cost and maintain aligned incentive for all parties while maintaining operational feasibility. They wanted to further revise the benefits in the future.

She reviewed the details of the impact on the bronze plan which has a lot of cost-sharing. They would have liked to have made more changes but were confined by the actuarial value. The deductible and maximum out-of-pocket cost are both $6,500.

She reviewed the details of the silver tier. They combined the co-pay and coinsurance plan designs, going from six CSR plans to three.

The gold tier features a reduction in the out-of-pocket maximum, but everything else is the same. The platinum tier includes no recommended changes.

She showed a table with the changes in actuarial value. These are preliminary, and are undergoing actuarial review and certification. Critical areas of need are specialty drugs

and standard benefit display. A special group should focus on specialty drugs, to define them and solve some issues relating to them. Some benefits aren't on the table or files that the plans upload, and they need to be since they affect the value of the plans. The mental health parity law requires some changes.

Mr. Lee noted that we take for granted that standard benefit design will be an aspect of the exchange. This is not true most other places around the country. In Miami, some individual carriers may have as many as nine or ten separate silver products. That is confusing. Every one of the Covered California plans is designed to facilitate access to care. They are not proposing alternate benefit designs. The workgroup learned a lot. Mr. Lee appreciated staff and consultants who worked long and hard. This has been challenging work.

Discussion: None

Public Comment:
Betsy Imholz, Director of Special Projects, Consumers Union, strongly support the staff recommendation to keep standardized designs for 2016. The group was quite an education, a crash course in actuarial science and benefit design. She thanked staff for their education. They wanted to make things more understandable while keeping within the actuarial value standards and attaining the organization's other goals as well. This was hard to achieve, but this proposal strikes the right balance. The first goal was to keep the standardized designs and the good features that we have. Another goal for a long time was eliminating coinsurance. It has been greatly minimized but not eliminated. They wanted to simplify products. They wanted to give something of value for the bronze plans but also clearly convey their limitations. They wanted to simplify deductibles, but it's still a difficult concept. It's more uniform but not perfect. They want to do more work on the drug benefits, to ensure people have access to lifesaving drugs, and on the web presentation. The displays are so important.

Jerry Jeffe, California Chronic Care Coalition, voiced that they are thrilled by the mention of discrimination in the report. They believe that specialty tiers are contrary to the Affordable Care Act. He brought this up at the advisory group meeting. He complimented the staff and advisory group members for their work. They have compiled a vast amount of research on the issue of specialty tiers. They have started monthly webinars on the topics, including the HHS rules for 2016. They want to make their expertise available. The planning advisory group had a recommendation for gathering stakeholders—they would like to be a part of that. The HHS regulations include a recommendation that they do not go into effect until 2017, and that would mean asking people to wait a year to have access to lifesaving medications.

Jen Flory, Senior Attorney, Western Center on Law & Poverty and the Health Consumer Alliance, thanked Health Access and Consumers Union for their work on this issue. When they have explained to consumers what all of the various factors are affecting actuarial value, they have lost them when it came to coinsurance. One good way of evaluating where we are is looking at enrollment in CSR silver plans. If those eligible for

CSR silver plans are enrolling in platinum plans, something is wrong. They would like to see the gold and platinum plans combined like the silvers were.

In Los Angeles: Carolina Coleman, Insure the Uninsured Project, support the workgroup's work. They think many of the steps are great, but the bronze tier becomes more like a catastrophic plan, and having both a bronze tier and a catastrophic plan could confuse consumers. She urged additional messaging regarding the deductible-exempt items.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), thanked the workgroup, the staff, and the health plan partners. They agree that the direction seems good. They look forward to working on education and messaging. Covered California has a glossary up with insurance terms, but beyond co-pays and coinsurance, terms like MRI or lab work could cause confusion. This information should also be available in all languages.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, thanked staff for all of its hard work. This has not been easy work. It did a good job of balancing all the factors. They support the proposed plan designs. The next step is regulatory approval and compliance with mental health parity laws. They urge the regulators and Covered California to collaborate to finalize these issues by the end of January so plans can price products. Last-minute changes are problematic for all parties. Specialty drugs do propose a large problem, but capping consumer cost-sharing does not address the underlying problem. The pricing of specialty drugs is unsustainable and puts pressure on government programs and premium costs. Major changes in specialty drug benefits resulted in the need for major increases in other costs or reduced benefits in other areas. Plans care about affordability, and the pressure that these drug prices puts on the rest of the health care system is troubling. The federal government has released a preamble on the topic, but it would not be good to make policy decisions based on preamble language before final rules are made.

Beth Capell, Health Access California, thanked the Board and staff and their colleagues on the workgroups. It was helpful to have the medical director of a plan involved in the process. They echoed what Mr. Lee said about the importance of standard benefit designs for consumer choice. If you look at the appendix with all the products laid out, it is clear that you pay less for services with a platinum plan than with a gold plan, and less with a gold plan than with a silver one, for example. The deliberate stair step of cost-sharing is clear to consumers. There has also been clear incentivizing, as emergency visits are more expensive than urgent care visits, and those are more expensive than primary care visits. Covered California does not take enough credit for these. The workgroup spent most of its time on the bronze and silver plans, because they are really the workhorses. As Ms. Price said, a consumer who has a fourth visit to a doctor and needs an MRI or treatment will have to pay hundreds or thousands of dollars and get no benefit until they hit $6500. Between 90 and 95% of enrollees will not spend $6500 in a year, so they would get no benefits. Thus this tier must be presented very clearly. Those who are eligible for the cost-sharing products must be encouraged to enroll in them. This year, 12% of the

enrollment that was eligible for these CSR products enrolled into the bronze tier. Some significant changes must thus be made. One of the reports indicates that 40% of consumers below 200% of the federal poverty level fail to seek necessary care because of cost-sharing. The bronze plan's deductible is almost 15% of someone's income who earns $45,000 a year. The 60% actuarial value causes this. They are pleased to have a single silver product, which simplifies it for everyone. They are pleased that the coinsurance only applies to facility charges and specialty drugs. This will help consumers get primary care. They have a different view of specialty drugs than the health plans. It seems odd that some of the health plans insure more people in California than are covered in Canadian provinces, but somehow they are not able to negotiate better costs with pharmaceutical companies than the provinces. They do not read the federal guidance as preliminary; the government is stating that the tiers cause a discriminatory impact. People with HIV/AIDS were discouraged from entering the individual market, for example. This should be on a more rapid timeline than is currently contemplated. The current products state that if someone needs that drug in January, they will spend $6500 on it.

Chairwoman Dooley appreciated everyone's participation in this extra meeting before a decision is made in January. She explained that two other Board members' terms also expire at the end of December, but since Chairwoman Dooley knew Board Member Ross would be stepping down, she asked them to wait to maintain a quorum. Both have agreed. On the Covered California Board, they are allowed to remain until they are replaced.

Agenda Item VII: Adjournment
The meeting was adjourned at 4:03 p.m.