CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD
August 20, 2015
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 10:30 a.m.

Board members present during roll call:
Diana S. Dooley, chair
Genoveva Islas
Marty Morgenstern
Art Torres
Paul Fearer

Agenda Item II: Closed Session

Chairwoman Dooley welcomed the California Health Benefit Exchange's newest Board member, Art Torres.

Board member Torres thanked staff and the other board members for their wonderful welcome and help as he transitions in to his new position.

A conflict disclosure was performed; there were no conflicts from the board members that needed to be disclosed. Chairwoman Dooley called the Open Session to order at 12:00 p.m.

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 August 20, 2015.

Presentation: August 20, 2015, Minutes

Discussion: None

Public Comment: None

Motion/Action: Board Member Fearer moved to approve the August 20, 2015, minutes. Board Member Morgenstern seconded the motion.

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

Agenda Item IV: Executive Director's Report

Presentation: Executive Director's Report

Discussion: Announcement of Closed Session Actions

The Board discussed personnel and contracting matters. The Board approved two personal service contracts; one for Ana Matosantos and the other for Nancy Kvale of the Service Center. The Board also approved two amendments for existing contracts. One for Covered California's Health Analytics Project Management company, Equamin and Eventus, the Exchange's Service Center team. Both contracts added some additional funds.

The Board also approved two Requests for Offers that will be competitively bid to support the CalHEERS initiative. Covered California had retained these services previously, but will be participating in a competitive process. Because this is a joint effort between Covered California and the Department of Healthcare Services, and managed by the Office of System Integration (OSI), all parties will be involved in the implementation of these requests for both quality assurance consulting and project management.

Discussion: Executive Director's Update

Peter Lee, Executive Director, reviewed the day's agenda. He noted that there would be an update on Covered California's 2016 Health Plans, Dr. Lance Lang, Chief Medical Officer, will be giving an update on quality reporting and then a brief overview of the Navigator program, Small Business and Sales and other issues. In terms of the Policy and Action items for August, there will be discussions on both Vision Plans and how to handle them moving forward; and Agent Plans and responsibilities. This will look at Agent's involvement in Medi-Cal enrollments and how to compensate Agents for Small Business enrollment for business with between 51 and 100 employees. All of the above items are for discussion only and will likely come up for action in September. The only action item is the readoption of the Eligibility and Enrollment Regulations.

As always, there are media clips in the Board materials. One was an article published August 10th in the New York Times noting that California is proving that health reform works. This is a credit to the people in California who have put politics aside and committed to making health reform work in this state. Because of these efforts, California is being recognized as a model for how to effectively engage clinicians, insurance agents, community organizations, clinics, effectively getting people insured in both the Medi-Cal program and in covered California.

There is also a range of articles covering the Exchange's rate release, which will be covered shortly.

There are approximately fifteen reports and research in the board packet that cover topics like premium changes across the country, and issues on estimated and enrollment. One in particular is the report done by the National Health Council's review of all state insurance markets and how patient centered they are. One of the six values of Covered California is to be patient and consumer centered; this report affirms that the Exchange has been doing just that. "California has led other states in its efforts to improve comparability of exchange plans, including standardized benefits." also, "California has taken many actions beyond the federal requirements that better protect patients." California is a very high performing state according to this report. Mr. Lee attests this accomplishment to all that staff, stakeholders and others have done to keep patients front and center. It is also because of the Board's mission and hard work. Covered California is not done working though and can do a better job of helping consumers understand their potential out-of-pocket costs. The Exchange is working towards that by showing, not only the health plan premiums, but also what the likely cost could be.

The Exchange also recognizes the letters, comments and other correspondence it receives from elected officials, stakeholders and private individuals. One such letter came from Congressman Cardenas on the privacy issues surrounding the data the Exchange uses. There was also a letter from Senator Gaines with regard to the spending on outreach and marketing efforts and the sustainability of the agency. There were also letters from consumer groups regarding he vision proposal before the Board that will be heard today. And finally, a letter from the Health Consumer Alliance and Legal Services of Northern California regarding the appeals process.

Regarding the Appeals Process, in March, Covered California provided an update surrounding the internal concerns staff had about the appeals process. Although the number of appeals is small compared to the Exchange's total population, these appeals act as "canaries in the mine" flushing out underlying issues. Since March, Covered California has added appeals staff and resources, enabled the Statement of Positions to go out prior to the hearing with the Administrative Law Judge, and developed a workgroup comprised of staff from CalHEERS, Accenture, Plan Management and Legal to help resolve issues prior to going to hearing. This will help cut down on consumer costs. The Exchange is also looking at problems within its system. The slow process is not something the staff take lightly. At the next Board meeting, there will be another update and a detailed report on the number of appeals, types and turn times.

Next, Anne Price, Director of Plan Management will provide an overview of the new rate plan. The reason rates in California have not gone up substantially is because of the work the staff have done creating a competitive marketplace and getting consumers enrolled.

Discussion: 2016 Individual Plan Rates
Anne Price presented on the 2016 Individual Market Plan Rates. Covered California had a great certification, recertification process for 2016 that resulted in an average statewide increase of 4%. This is slightly less than 2015, which was 4.2%. This is a statewide average across regions and across plans.

Over 90% of Covered California members receive subsidies depending on their age, where they live, and their income. Depending on which plan a consumer chooses, the average rate decrease, decrease, would be 4.5% while the historical average increase in California prior to the ACA was on average about 9.8%. There has been a significant improvement over the last two years. Rates vary regionally, meaning that consumers in the Southern parts of the state see increases of approximately 1.8%, while those in the North see closer to 7%. This is attributed to the underlying healthcare costs.

Two new carriers have been added for 2016, United and Oscar. There are specific regions that they will be offered in. United will be offered in regions where the board had made a decision to allow new entrants because consumers had less than two plan choice. Oscar is a newly licensed plan in California and will be offered on the exchange in two Los Angeles regions, West L.A. and Orange County.

Carriers also played a role in the expanded consumer choices. With the addition of the new carriers and the expanded service area of Blue Shield, Health Net, and Molina, greater than 99% of consumers will have at least three carrier choices in every single zip code of the state. 0.4% would only have two, but 100% of the members will have two.

If members stay with their current plan, 56% will pay a 5% increase or less while some areas will see a premium decrease and about 13% of members will see 13% increase. This is generally in areas of the state where there are typically higher costs due to limited providers. Thirty percent of members will have increases of 5-10% if they were to stay in their same plan. Again, this depends on locality. Premiums are driven by the underlying cost of healthcare, number of providers competing and provider costs in those areas.

Covered California's rate book, found online, outlines all of what has been discussed in the board meeting. It discusses carrier coverage, healthcare premium spending, and risk adjusting the individual markets for carriers are not avoiding enrolling "unhealthy" individuals. Covered California has always implemented standard benefit designs so that consumers can compare apples-to-apples when shopping for plans without limitations. This adjusts the focus on the premium and the network differences as opposed to what the consumer is limited to.

Covered California made changes to the Benefit Design for 2016 like limiting some out-of-pocket expense so members preventative care prior to services being subject to deductible. There is also the selection and oversight of health insurance carriers and data driven negotiations as part of being an active purchaser. Looking forward to 2017 negotiations.

Discussion: Health Plan Quality Reporting
Dr. Lance Lang, Chief Medical Officer, presented on how Covered California is assessing its plans. Covered California has moved from assessing what the plans are doing and towards assessing what improvements can be made. Consumers have benefited from the health plans' care and rates and now it is time to take the tools used in assessing

their qualifications to assess their strengths and opportunities for change. Covered California has met with all 10 incumbent plans and will meet with the two new plans in the next few weeks. The constructive responses have been helpful, collaborative and innovative. Over the next several months, Covered California will be sharing with the consumers the ways it hopes to improve the delivery system.

The rating system is changing in 2016. Previously, the star rating was about the commercial population. This year, the results will reflect a survey of exchange enrollees combined with enrollees in the individual market off exchange, combined with the small business members Covered California has. Also in 2016, CMS will set the rules for how the survey is conducted. Covered California will no longer report their own results, but will be held under the federal guidelines.

However, for 2015, Covered California has looked at preliminary results and have found that only 21% of the surveys were returned. Of that, 70% were Covered California members, another 17% were from off exchange individual coverage and another 13% were the small business group. The response was a little disappointing as the Exchange expected closer to 30% response rate, however, there is enough to report on all of the Qualified Health Plans in the areas of evaluation and satisfaction of care and with the plan. When the results come out, Covered California is be able to group these rating by product type and by a single global rating in a four star system. Staff is expecting to report the results to the public in the October Board meeting.

Discussion: Covered California for Small Business
Covered California for small business has just shy of 20,000 members. This fall will be a major point of growth opportunity as this is when many small businesses current contracts will be coming up. Staff has shown progress in improving automation for payments to agents. Some of those system issues have been stumbling blocks for agents, which are how the vast majority of small group business is sold. Improvements have been made and payments are now current through May. June commissions are in the process of being sent to the state controller's office, and July commissions are in process.

Discussion: Navigator Program
Covered California engaged in a broad, competitive process that brought in over a hundred applications from organizations requesting more than $20 million. The Navigator program brings together support for outreach and education along with enrollment and ongoing support for retention of enrollees. Covered California sought applicants that were diverse within their regions with target populations such as different ethnic groups and the lesbian, gay, bisexual, transsexual and queer communities. Covered California has selected 69 parent entities that represent 132 organizations across the state, many of whom were certified enrollment entities previously or previously had grants. They reflect organizations with a very deep reach into the Latino, Asian, African-American, and the LGBTQ communities.

Through this grant process, Covered California has committed to over $10 million already with Board approval to spend up to $13 million. This is a learning process for all

involved. If more request for proposals are needed to reach any other target populations that are currently being underserved, then that is what will happen. The organization is excited about these partnerships.

There are also some upcoming changes for Certified Enrollment Counselors. Going in to Open Enrollment 3, with the exceptions of the navigators, enrollment counselors will not be compensated. They will still need to be certified, but they will not be getting the $58 they historically received for helping people enroll. There are over 400 certified application counselor organizations with more than 2600 certified counselors to help people enroll. They are interested in doing that because they agree with Covered California's vision of insuring all Californians. There are also over a dozen Plan-Based Enrollers from Exchange plans and Medi-Cal plans and another 1,300 Certified Counselors to help people enroll in any of the range of options. These service channels are vital to enrollment.

Discussion: Covered California Board Calendar
At the October Board meeting, Covered California will release their 2016 Board meeting calendar. There will be no meeting in September and the October meeting has been adjusted to October 8th. The plan is to not have a meeting in December, however, the advisory groups will still be meeting.

Discussion: Covered California Personnel Changes
The Board and the Exchange would like to say goodbye to External Affair's David Panush and also Community Outreach/ Sales Division's Diane Stanton. Kirk Whelan, Director of Outreach and Sales thanked Diane for her service and efforts.

Public Comment:
Betsy Imholz, Consumers Union, welcomed the new Board member Art Torres. She applauded the very modest statewide increases on the rates and acknowledged the great work Covered California has done to set up a system with a standardized benefits. Consumers Union will make sure to comment on the filings over at the Department of Managed Healthcare before final approval. She also commented on the Quality Rating System and how proud she was of California in that it has been a national leader with regards to putting ratings out. She appreciates the presentations from the plan management advisory committee and looks forward to getting some more detail from Dr. Lang as to methodology, measures that get reported, understand them and dig into the diversity measure.

Jen Flory, Western Center on Law and Poverty and the Health Consumer Alliance, congratulated Covered California on their preliminary rate going up as minimally as they could. She looks forward to continuing their work with consumers; helping them find cheaper plans. She understands that her organization receives the toughest cases, which is why they have a contract with Covered California. However, she points out that it is imperative to get consumers in to plans as quickly as possible when there is an issue. She mentions the CalHEERS 24-month road map and how that some of the system fixes could take up to two years to implement. She also calls out specific issues related to help

desk trouble tickets, adjudicated cases still pending fixes, plan communication issues, continued eligibility errors and 2014 tax issues relating to 1095-As.

(On the Phone) Jan Wesley, San Diegans for Health Care Coverage, congratulated Covered California on the job they have done in negotiating rates in 2016 and providing expanding consumer choice. Although many consumers will be aided by holding the cost down, there is a counterintuitive impact resulting from these rate changes. For example, a significant reduction in the second lowest cost silver plans, resulting in reduced premium assistance and therefore reduced consumer purchasing power. In the San Diego rating region, this means that 99% of the lowest income existing Covered California enrollees will see increases in their share of premiums between 16 and 60% while many more experience 50% or more increase in their share of premiums for their current plan. Her fear is that consumers are not aware of some of these changes and when their bill comes in January, they will not pay it. They may discontinue enrollment or downgrade to a bronze plan. Outliers on either end of the rate spectrum are the biggest concern, especially in San Diego.

Cori Racela, National Health Law Program and member of the Health Consumer Alliance would like to join and reiterate Jen Flory's comments from the Western Center. She would like to enter a plea to the Board not to let technology drive policy and compliance with the law. She insists that the board ask for accountability from their technology partners at Accenture and at CalHEERS. She echoes the problem with trouble tickets and the inability to track the age of a trouble ticket, the subject matter of the trouble ticket, how long it will take to resolve, and which of those are a result of an Administrative Law Judge's decision. It takes two to six weeks for a hearing decision trouble ticket to get resolved through CalHEERS. She urges Covered California to continue working closely with the Department of Healthcare Services to reinforce protections for those Covered California beneficiaries' participants who are at the lower end of the income spectrum, who often have children in Medi-Val or are bouncing between the two programs.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), welcomed the newest board member, Senator Torres. She echoed some of the concerns raised by Consumers Union and others. In terms of the quality ratings system data, she is concerned by the rule of the small sample size that CMS has set and what that will look like and mean in terms of the ability to really analyze quality data by race, ethnicity, and language and to understand how health disparities can be addressed. She believes there is a need for a larger sampling size and over sampling if they are really going to understand how to target disparities. She is excited for the addition of the Cantonese IVR. She also echoes some of the comments of the Health Consumers Alliance about the importance of communication between Covered California and Medi-Cal. Consumers are experiencing a disconnect between Medi-Cal and Covered California and they become stuck in the middle. She also requested an update on the disaggregated data on the languages consumers speak.

Gil O'Hara, UC Berkeley, announced that this is his last meeting representing UC and the School of Public Health, because he is retiring on September 1st. He thinks the rate structure is good but is concerned about the waivers that are out there. There are over $150 billion worth of proposed waivers that could impact California over the next couple years and the relationship between Covered California and the plans could go through an adjustment. He also reminded the Board that they need to continue to utilize the UC's reservoir of expertise. Covered California has entered in to contracts with entities like UC Berkeley, UCLA and the CalSIM model, and it is important to continue with these relationships rather than just relying on the private sector.

Kate Birch, California LGBT Health and Human Service Network, commented on the Navigator grant. She is pleased that one of their previous subcontractors is now a navigator grantee. The San Joaquin Pride Center is a very clear LGBT Navigator that is going to be very helpful for LGBT people across the state looking for enrollment assistance. She also commented on the 24*month roadmap and how great it will be to see data collection on sexual orientation and gender identity in order to see how many LGBT consumers we are actually signing up for Covered California and if the insurance gap is actually being addressed. Lastly, she commented on the Quality Rating System and the direction it is moving towards. She did, however, echo some concerns regarding the star rating and the need for a more interactive way to access the data. She mentioned the Office of Patient Advocate's quality rating system and its ability to really click in and see what was rated at different levels. She hopes we are moving towards something similar.

Dorena Wong, Asian Americans Advancing Justice, Los Angeles also welcomed Senator Torres to the Board and thanked David and Diana for their leadership and commitment to Covered California. She reiterated the comments already made by Kate and Cary from CPEHN and Betsy from Consumers Union regarding the quality ratings and how to get to the kind of break downs in race, ethnicity and primary language. Each population has a really unique experience that are different based on those categories. She also wanted to show her support for the comments from Jen Flory from Western Center and Cory from the National Health Law Program in that she also sees a lot of consumers get stuck between Medi-Cal and Covered California, problems getting released from one or the other programs. This process can sometimes take months to get resolution. She also commented on the inaccurate 1095-a forms they are still working to resolve. Finally, she congratulated Covered California because she does think of them as a model for other states and they want to help Covered California be that model so she hopes her recommendations are taken seriously.

Alexandra Selson, the Silicon Valley Leadership Group, an organization that represents nearly 400 employers in the Silicon Valley region also welcomed Senator Torres to the board and wanted to acknowledge the leadership of the board in making health reform work in California and their continued success. She introduced her colleague Emily Lam who represents the leadership group. The represent the small businesses and the interests of small businesses in the Silicon Valley region. Their region faced some of the largest premium increases in the state. Even within their own organization, they had to downgrade their plans as a result of rising increases. Although they are excited about the

statewide increase being only at 4%, Northern California is seeing as much as 12% or more. She is looking forward to working with the board to find ways to increase competition within the area. She is encouraged that Covered California is adding value to the region by adding competition to the marketplace and giving consumers more choice. They would like to see more of that.

Beth Monowski, the California Primary Area Association thanked Senator Torres for joining the Board, and thanked David and Diane for the incredible roles each played in making sure their health center has been well engaged with Covered California since day one. She commented on the changes happening to the outreach and enrollment infrastructure. She is excited that so many of the navigator grantees include health centers and leadership roles. Over 30% of lead applicants are either community health centers or have close ties to them, which is great. She also mentioned transitioning the Certified Enrollment Entities into these new unpaid assister roles. She complimented Covered California staff Elsa Ruiz-Duran and her team for the great job they have done holding the hands of the health centers through that process. There is still a lot of anxiety among the health centers that still want to play important roles in this process. It is August, but the centers want to hear what the fall will look like and want to hear more about the training schedules to make sure they are prepared for the enrollment period.

Cathy Dressler, the Children's Partnership, is pleased about the appointment of Senator Torres to the Board. She comment that he is unfailingly honest, forthright, and committed to the health and safety of people in the State of California, and she couldn't be more pleased. She also joked that Covered California stole David Panesh from them at the Pro Tem's office and acknowledges what a tremendous asset he has been to this work and to the product here in California. She views the whole Covered California experience as collaborative and she really appreciates it. She also thanks Diane Stanton for her work with the "All In" campaign partnership.

Beth Capell, Health Access California echoed the comments of many in welcoming Senator Torres to this role. With regards to the rate book, before 2014 it was literally impossible for a consumer to find out what premium they would be charged. As policy advocates, they are glad to see rate increases to be so modest. They share the concerns that were voiced by the advocate from San Diego about the unexpected implications of the second lowest cost silver plan on subsidies in San Diego because of the way the market has settled there. Regarding quality, they hope that this will actually start targeting disparities reductions. Covered California enrollment is two-thirds communities of color, it is 95% adult. Some real progress can be made in improving the health of these communities with the Exchange's bargaining power.

Agenda Item V: Covered California Policy and Action Items

Mr. Lee commented that Covered California is very mindful of the fact that for about 90% of the consumers, premium is part of the equation. It is also their advanced premium tax credit. When looking at the rate book, every single rate area has a

description of impact of consumers after subsidies are considered. Staff wants to make sure people understand that they have better opportunities.

Mr. Lee further commented on the issue of disaggregated data. He agrees it's critical and important. Covered California looks forward to releasing data by language and other categories in early September.

Mr. Lee stated that the community clinics have been vital partners in enrollment. They, like many other groups – faith organizations, organizations in local communities – are looking at this next open enrollment period as a new one, where they might not be any more a certified enrollment center -- they are an application assister.

Mr. Lee also said he wanted to take this opportunity to acknowledge a partnership that is in Covered California's press material, which is the "All In" campaign. This is a great example of Covered California working in partnership. This partnership includes with Superintendent Torlakson, the children's partnership, to try to build on good work we have done throughout the State in schools to encourage those as important venues to get outreach and enrollment information.

Mr. Lee commented that the vision coverage information proposal is not an action item, but would note that staff have been following the direction previously given by the board, which was to implement a system with deliberate speed to make some vision services available through Covered California. The board has also said to not do this in a way that would impede the core offerings of tax subsidized health benefits, but this was a charge that was given and that is being worked on.

Chairwoman Dooley clarified. The Exchange is not, and has not been looking to provide services. Covered California is providing access through technology, because that's an issue that has been discussed many times. James will go through it in terms of the distinction between adult vision and dental and child vision and dental and the essential benefits. But Covered California wouldn't be providing services, rather providing access to the providers of services, and that's been the struggle.

Discussion: None

Presentation: **2016 Individual Plan Rates**
James DeBenedetti, Deputy Director for Plan Management, presented.
Vision has been discussed by this organization since its inception. It's been a demand from both consumers, employers, and of course the insurance industry as well. But due to the way the Affordable Care Act is structured and written, there is no way Covered California could find and implement a vision plan with the program. The main issue is that adult vision benefits are not considered essential health benefits. Because they are non-essential health benefits, they are not eligible for the tax credits or tax subsidies that other programs are.

Pediatric vision benefits are essential health benefits, so pediatric vision benefits is included in the standard health plans. When looking at a standalone vision plan, a plan that includes adults, parents and so forth, it is not considered an essential health benefit. Basically none of our staff, none of our consultants, none of our systems, none of the resources we have access to can be used to support a vision plan.

What about dental? It's similar in some respects, in that again, pediatric dental coverage is considered an essential health benefit and it's offered in all of our health plans. But in the case of standalone dental plans, where adults, parents, etc. are included, that actually has a provision in the affordable care act where it is considered a qualified health plan. Standalone dental plans are supportable within this program.

Staff has been working with federal regulators to see if there is some way around this catch-22. It may be possible with an approach that the exchange in Colorado has taken and now offers. The Colorado exchange does not enroll people in a vision program. They merely provide a link to a vision plan vendor from their website. If someone wants to enroll in a vision plan, they click on the link, they are sent to the vision plan vendor's website, and that vendor handles the enrollment, all the communications, customer service, and explains the benefits. All of it is performed by the vision plan vendor, not by the exchange. However, the vision plan vendor does send a commission back to the Colorado exchange so that they can use that to administer any other aspects of the vision benefits program they need to.

There will be a Request for Proposal ("RFP") to see which vendors would like to participate with this program and which ones are determined most appropriate to have in the program.

The vision benefits page will include a list of factors and information that consumers should consider when selecting a plan. Covered California will work with consumer advocates and potential vision plan vendors at the September Plan Advisory meeting to go over what kinds of things consumers are most interested in, what areas are they most likely to utilize, what factors should they consider, what should they focus on, what should they not pay attention to, because it's not as useful or essential for most consumers with this benefit.

Now, the revenue potential. Covered California is looking at doing things differently than Colorado did. One is we would like to have an RFP application fee, so we can spend some decent resources evaluating these RFP's. We would like to have an implementation fee to implement the links and other things. We will have to educate the call center staff on where people should be directed if they have questions and things of this nature. We would like to have ongoing monthly revenue, so we could in the future establish a more robust vision benefits plan administration program.

The focus can be on price, rather than all the different variations of benefits. We would also be able to look at utilization-specific benefits and provider networks, with the idea

that maybe we could work with vision plan vendors to customize plans, either benefit designs or networks to better meet the needs of Covered California consumers.

After the board reviews the proposal and a decision is made, assuming we do go forward with vision plan options for our consumers, we would like to do a final evaluation and selection of those vendors.

Peter Lee stated the board's direction in 2012 was actually a motion that directed us to offer vision benefits. So we are continuing on the path, this is from our perspective, how to do it. We are seeking to move quickly to have these links up as soon as November this year. There is no direct, automatic link with open enrollment because this link is not built into the CalHEERS system. I want to be really clear about that.

Mr. Lee further stated that it is Covered California's intent to, when we issue the RFP, to require it to come in with a thousand dollars. We would be getting very discrete reactions in the RFP on these dollar amounts, as well as from others to sharpen what our final proposal would be.

Chairwoman Dooley stated, I'm assuming even if that is considered later, it would have to be fully self-funded by the beneficiaries of that offering.

Mr. Lee stated absolutely. But this is where, even if self-funded, we could have funding for something, but it still could be an opportunity cost and distracting some of our key leadership staff time. So we would still need to trade that off.

Member Fearer made a couple of requests. In the context of our making a decision of this sort, as well as getting feedback from our various stakeholders, he thinks it is important to lay a foundation of common knowledge and understanding. So what are these benefits that are being linked? Because there are a variety of things they are not. Consumers may not be so clear about what is in the "not" category, it's not about eye disease. That is covered through your regular medical insurance. It's not about Lasik surgery, because vision plans don't cover that. It is about, contact lenses, eyeglasses, and eye exams. It's important for people to know what it is, what it isn't, as we are going through a decision process.

Another important element is to understand that it's outside of the Affordable Care Act. So there aren't the now customary protections under the Affordable Care Act, like the medical loss ratio and so on and so forth. I think it's important as we consider this that there be a sort of common foundation of understanding.

Public Comment:
Betsy Imholz from Consumers Union. Consumers Union shares the belief I know of the staff and the board in the importance of vision care and vision coverage. In our letter and at the advisory committee, we did put forth some of the concerns. One is the idea of the implied seal of approval, even with the disclaimer. We have worked so hard from the beginning of setting up the Exchange, I think all of this, to make sure that this is a trusted

place that people would go to for their choices to choose comprehensive coverage. Our other concern is a general principle in web design. You don't want to put too many external links. We want people to come to the Covered California site, stay there, drill down, use the tools, and make the best choice.

Dawn Costco, Market Director of Vision Service Plan
Welcome, Senator Torres. James, thank you for the great overview on the vision. We appreciate the opportunity to support the board's decision to make the first step to look at vision benefits as an option for adult members. The consideration we feel ensures critical access to eye care for adults throughout the state. We feel strongly that this is an opportunity to help participate in the Covered California goals of having a healthier population, increasing access to care, and really contributing to lower cost.

Jen Flory with the Western Center on Law and Poverty.
We did submit a letter issuing our concerns, together with some other consumer groups. So I will reiterate largely what my colleague Betsy from Consumers Union said. We feel one of the biggest gains that Covered California had was standardization of health plans and the gains that we have had in explaining to consumers what exactly they are purchasing, so that they can compare apples to apples and that they know what's included. We do have concerns about this proposal.

Carrie Sanders with CPHEN. Just to reiterate some of the same comments raised. We also appreciate the importance of vision care for adults, think there are some potential benefits. But we share the concerns of our colleagues about branding issues, lack of control over quality of products sold or the services provided, adequacy of networks, all of the things that Covered California is able to really negotiate around with, their regular insurance products, whereas these fall outside of that.

Dorena Wong, Asian Americans Advancing Justice Los Angeles.
We also support the idea of including vision care and expanding it and having it part of overall health, access to health coverage generally. But again, we do also share the concerns that Carrie from CPHEN and Jen Flory, and Betsy from Consumers Union expressed around the issues of confusion, especially for the populations that we work with. And we want to stress that especially for limited English speaking populations, they will not probably understand that it's not part of Covered California.

Kara Corches, The California Optometric Association. We support the creation of this pathway that will increase access to adult vision coverage. As stated before, good eye and vision health greatly contributes to an individual's overall health, and we welcome the opportunity to be involved in any future stakeholder meetings.

Beth Capell, Health Access California. We not only support adult vision, we hope both adult vision and adult dental will be essential benefits and that we will no longer have to go through such contortions to provide access to adult vision.
We were one of the consumer groups that signed on urging caution because of the concerns about the impact on your brand. We are pleased to see that you are thinking

ahead to the possibility of maintaining your tradition of being an active purchaser with standardized benefits.

Julianne Broyles, California Association of Health Underwriters. Regarding the vision plan process being laid out today, there has been legislation of course on this issue twice already, and we have had issues that had gone to the vision service providers and ensured that if they were going to go forward with a vision plan product within the exchange, that the certified agents would be also part of that process. Because today we are their producers. We are the people who explain to consumers what the product is, we service them after the sale, and it seems to have been ignored in this particular proposal as it's been laid out before you. We are very concerned about how this is moving forward so quickly.

Peter Lee noted that staff has been taking the direction from the board, which is move forward with all deliberate speed. We will continue to do that, but all deliberate speed moves similar to rates, not too much or too little, not too fast or too slow. November 1 is not a drop-dead date. We are seeking to have that happen, but will not move forward and come to the board until we have well thought through and had good dialogue and discussion. The board can look forward to a proposal worked through to addressing many of the issues we have heard today.

Presentation:
Peter Lee stated neither of these issues are for action today, but both are important issues. One is the establishment of our commission structure for groups 51-100. So it will give you both the background and what we are proposing. Kirk will also present some of the background on the issues we are looking at for agent's responsibility for Medi-Cal enrollment.

Presentation: Establishment of Covered California for Small Business Agent Commission Level for Groups with 51+ Employees

Kirk Whelan, Director of Individual & Small Sales, presented. I am going to go over the small business commission issue, and then Katie Ravel will talk to the Medi-Cal.

As you may or may not be aware, the small business market is going to be expanding from 1-50 employees, to groups with up to 100, which will be effective January 1, 2016. This will have a big impact on certified agents and will require a board decision at the board meeting in October. Stakeholders are a big part of our decision today. We met with our large carriers, and they are anticipated to be at 4.5-5% in terms of agent commissions on that 51-100 segment.

We have also met with agent stakeholders, who also support the recommendation. And then we also have to be thoughtful of our competitor exchange, private exchange. We anticipate the private exchange to be at 5% or more.

So for your consideration and discussion today, our recommendation is to go with a 5% agent commission for 51-100 employees. We are not planning to make any changes to the commission level for groups of 1-50 employees.

Our recommendation then is consistent with the Covered California for small business commission goals, which is that they are competitive in the market, being reasonable, fair, and competitive and that they meet our budgetary considerations.

Public Comment:
Julianne Broyles, California Association of Health Underwriters. We do want to say thank you for all of the outreach that was made by Kirk and his staff, Diane, David, and everyone else in talking about the commission levels as we move into the new world of 51 plus in the commission levels. They are competitive with what we think is the rest of the producer market and paid right now by the plans.

Mark Herbert with Small Business Majority. I just want to echo some of those comments on behalf of small businesses. The role of agents, obviously, in enrolling folks is a huge one when it comes to small businesses and who they turn to. And so to ensure the agents are at the table and are compensated at industry standard levels is essential. We support this proposal.

Peter Lee stated a note of reminder, some of us have been to these meetings for the last three-plus years and so remember these items. What we went through three years ago, were very intense policy discussions around the responsibility of certified enrollment counselors, agents, and others with regard to Medi-Cal.

And with the aspiration of having one-stop shopping and no wrong touch environment, the board adopted a policy of requiring agents and others to assist people regardless of what they were eligible in. That was a policy adopted prior to the State having the mechanism to provide payments of $58 per Medi-Cal enrollment. That happened after that fact. But this issue, we have actually had a lot of lessons over the last few years. It's the right time to revisit this issue, which is what we are considering doing now.

Presentation: Medi-Cal Enrollment
Katie Ravel, Director of Policy, Evaluation & Research, presented. We don't have a per application program anymore, so we are revisiting this policy, which Peter said does go back to 2012. So what we want to tee up, and what we are going to be working with stakeholders on over the next couple months, is two options.

First is maintaining the existing policy, which requires agents to help consumers enroll in Medi-Cal as a part of their business. But then the alternative would be to allow agents to refer applicants to county eligibility workers or other certified enrollers for Medi-Cal enrollment. This just summarizes why the board made the decision in 2012 to require agents to perform Medi-Cal enrollment. It does allow consumers to access enrollment assistance from all of our channels and allows a one-step enrollment process. The con

that we have listed here is something that we have found out in the course of this work. It says agent may be less skilled in Medi-Cal issues.

In the second option, agents would be encouraged still to help perform the Medi-Cal enrollment, but we would be allowed to prescreen applicants and refer them to county workers or other enrollers if they are likely Medi-Cal eligible.
Covered California does have a couple of approved tools that we can use for this. The main pro that we are looking at here is it connects the consumers up front with the service channel that is in the best position to help them throughout their enrollment. I think a con for us is if a consumer goes to an agent and gets referred, they may not follow through on that enrollment.

We are going to have a stakeholder meeting on August 28th, and we will return to the board at the October 8th meeting with a final policy recommendation. We will be evaluating the options based on what we think is really in the best interest of the consumer, to make sure that they get application assistance and ongoing enrollment support. To the extent that we do change the policy, we would amend the agent agreement as appropriate.

Chairwoman Dooley: Katie, when you come back as a result of this additional information gathering and recommendation to us, would you also give us a picture of what we know about our experience to date in terms of the proportionality of Medi-Cal enrollment that is resulting from insurance agent's vis-à-vis other certified enrollment counselors? And another question that I have as a result of your presentation is how option two would be similar to or different from our quick sort. We spent a lot of time on our website figuring out how we could get Medi-Cal eligible consumers to the county office for the assistance that the county offices provide and how this would be like that or not like that. Those are things that occurred to me from your presentation.

Katie Ravel responded, that's a great suggestion. Very similar to quick sort, and I think we can look at the experience that our service center has and leverage that and bring it to the discussions and inform the recommendation.

Chairwoman Dooley continued; and just from my understanding, if an agent has a customer who is determined to be Medi-Cal eligible and they enroll from now through the electronic flight, it's very much like that person would do on their own if they were going to the website independent of any assistance. Because it still goes back to the county office, and the county office makes the final determination.
Katie Ravel responded, that's correct.

Public Comment:
Julianne Broyles, California Association of Health Underwriters. On the Medi-Cal issue. As you have heard me say at prior meetings, one of the biggest frustrations for our OCD agents is that they help people. That is their job.
They help people understand their insurance, how to use their insurance, and they help people resolve problems with their insurer after the sale.

This is what we do. And one of the biggest frustrations we have had with Medi-Cal in talking about it is knowing that we have helped people enroll in Medi-Cal, but then there is a moat that appears between us and the counties where the people are getting Medi-Cal services.

Beth Capell, Health Access California. This issue is a product of the fact that we live in a multi-payer world, and we are going to for a long time. People will move from coverage source to coverage source. The reason 95% of your enrollment is adults is so many of the families have the kids on Medi-Cal, where the adults are enrolled in Covered California. That's what your families look like. So figuring out how to get this right so that it works best for your enrollees as family members is an important thing.

Dorena Wong, Asian Americans Advancing Justice Los Angeles. We are concerned about allowing the agents to just simply refer to the county or to other CECs. Because the CECs, as you know, they are not getting compensated either. So I don't want them to take on the burden of also having to enroll the Medi-Cal beneficiaries, although they already do that. But if the agents are not obligated to do that, then I think that is going to put a big burden on the navigators and the other CECs.

Cori Racela, National Health Law Program. I also don't necessarily have a position on the options but do appreciate Katie's pros and cons that she has listed for each one, and like Dorena would like to call for better training and accountability for the insurance brokers. Consumer protections like a greater visibility to how to report broker fraud and/or how to get help would be greatly appreciated.

Kate Birch, California LGBT Health and Human Services Network. I am so strong a believer in the whole "no wrong door" approach for enrollment.
We would prefer if agents were still required to enroll Medi-Cal eligible people.
We would also say if you do amend the agent agreement, it would be great if agents could have to get recertified every year for enrollment, rather than every five years.

Beth Malinowski, Primary Care Association. I want to again second the comments of Dorena and Kate about, thinking about what we are doing with our agent community at the same time that we are conditioning our agent enrollment program as a whole. I think there's a lot of interrelations there and seem to be making those connections. I want to comment about creating a tiered system or tiered infrastructure on how we are providing enrollment assistance and making sure that at the same time that we are thinking about what will be happening next with our agent community, we are thinking about making sure that there really is an infrastructure behind it.

Katie Ravel continued her presentation, Additions to Eligibility & Enrollment Regulations. This is an action item to readopt our eligibility and enrollment regulations so that we can be ready for open enrollment. We are adding two main provisions. One is to align our open enrollment days with the federal dates, and of course that was just passed state law.

Our open enrollment will be November 1st through January 31st this year.
We are adding a special enrollment period, which was added by the federal marketplace for victims of domestic abuse and spousal abandonment. We are going to add that to our complement of special enrollment period reasons. We have two minor technical changes in the Regulations, but those are the two big additions for today.

Chairwoman Dooley asked, if we passed a law, which we did, that set the open enrollment dates, why do we also have to do it by regulation? It's usually the other way around. The law is not specific. I'm not going to make you change the regulation, but it seems a little weird to me.

Katie Ravel responded, I do like that, and I will consider that. We have done it the past, so I think that's why we did it for this time.

Member Torres asked, what triggers the characterization of the victim of domestic abuse? The filing of the complaint? The adjudication of the case?
Ms. Ravel replied this would be a self-attestation. They could call us and they could say that this is the situation they are in.

Member Torres then asked what proof they would have to provide.

Ms. Ravel replied they wouldn't have to provide proof on this one, they could attest to this.

Public Comment:
Jen Flory, Western Center on Law and Poverty and the Health Consumer Alliance. We don't contest any of these changes. One other thing that we would like to see, there some regulations regarding the appeals timelines that don't conform with AB-617 that was passed last year. We would like to get those into confirmation.

Chairwoman Dooley asked Ms. Flory, and the question that you just raised about conforming, is that in this proposal? Or are you asking it be changed?

Ms. Flory responded, we submitted it previously. It should be law right now. But I think the next time we bring up the emergency regulations, we can finalize.

Motion/Action: Board Member Torres moved to adopt the staff-recommended regulations. Board Member Islas seconded the motion.

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

Agenda Item VI: Adjournment
The meeting was adjourned at 2:30 p.m.