Comments to the Board - External

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March 5, 2015 Board Meeting

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- N/A

February 4, 2015

Peter Lee, Director
Covered California
1601 Response Road
Sacramento, CA 95814
Submitted electronically to Peter.Lee@covered.ca.gov

Re: Reporting of Covered California Enrollment Data

Dear Mr. Lee:

On behalf of Asian Americans Advancing Justice – Los Angeles (AAAJ-LA), California Pan-Ethnic Health Network (CPEHN) and Consumers Union (CU), we write to share our recommendations for more robust data reporting on the profile of Covered California enrollees and enrollment patterns. As we near the end of the second open enrollment period, detailed data reporting will allow for a more complete analysis of Covered California's success at meeting the demand for quality, affordable health coverage for California's diverse communities and provide data to develop strategies for more robust enrollment as we move ahead.

Demographic Data Reporting

We were pleased to learn that Covered California has enrolled over 228,000 new enrollees into health coverage as of January 12, 2015, with over half of new enrollees from communities of color. The enrollment data, as well as any additional data about the 300,000 remaining applicants who have applied but have not yet chosen a plan, will be helpful in understanding the extent to which Covered California is meeting its enrollment projections and serving the needs of applicants throughout all stages of the enrollment process. As you prepare your next, more detailed report on activity during the second year of open enrollment, we urge you to:

- **Provide the Highest Level of Granularity on Race and Ethnicity:** Granular data is vitally important for Covered California's evaluation, planning, marketing, outreach and enrollment efforts, and its success in reaching California's diverse communities. We urge Covered California specifically to track and report enrollment numbers for the 9 Asian sub-populations encapsulated under the broad race category "Asian," the 3 Native Hawaiian and other Pacific Islander subpopulations, and the 6 Hispanic populations encapsulated under the broad ethnicity category "Hispanic, Latino or Spanish origin." This information is vital

to identifying specific gaps in enrollment and implementing targeted solutions to correct enrollment deficiencies.

- **Provide the Highest Level of Granularity on Written and Spoken Language:** We urge Covered California to report on the written and spoken language preferences of its enrollees, as this data was not included in the January 15th interim report. Further, we urge you to report language data by Covered California's 19 geographic regions as you did in last year's first enrollment period data book released on July 16, 2014. If this information could be provided before the end of the second open enrollment period, there is still time to adjust outreach efforts to ameliorate any enrollment deficiencies.

- **Report Numbers not Percentages:** We appreciate that Covered California data is point-in-time data and subject to change monthly. For your next more detailed activity report, we urge Covered California to release enrollment data by actual numbers of enrolled rather than as a percentage of enrolled. This is especially important since the enrollment numbers are volatile and constantly shifting. Additionally, in order to encourage proper data analysis, each demographic report should note the number of non-respondents and/or "decline to state" so there is a standard denominator from which others may calculate percentages and/or make comparisons.

- **Report Data by Service Channel**: Given the high non-response rates (it appears at least one-third of consumers did not respond to the optional demographic questions during the second open enrollment period), we urge Covered California to track and make public response rates by service channel i.e., via self-serve on the online website; through a paper application, online via the service center, online via a Navigator or other certified enrollment counselor, online via an agent or broker, in order to illustrate any patterns with reporting as it relates to the mode of application. This will help us all understand how best to improve this kind of demographic reporting in the years to come.

- **Provide Granular Data on Multiple Races:** The category "mixed race" should be renamed to "multiple races" to reflect the more conventional name for this category. In instances where the multiple races category is large, we urge you to provide further disaggregated reporting of the data in this category so interested stakeholders can make more appropriate conclusions. Additionally, although there are several different approaches to classifying data on Multiple Races, AAAJ-LA, CPEHN and CU recommend that Covered California use the Office of Management and Budget Appendix B method entitled "for use in civil rights monitoring and enforcement," as it's the simplest and most straightforward method, especially if you are trying to address health disparities: http://www.whitehouse.gov/sites/default/files/omb/assets/information_and_regulatory_affairs/re_app-b-update.pdf

Data Reporting on Issuers and Metal Tiers

We thank Covered California for providing state level data on metal tier selection as part of its interim report. At the end of open enrollment last year, we benefited from seeing the break-out of how many enrollees had chosen specific issuers in each region.

For 2015 and ongoing, we hope that you can provide additional granular data on consumers' chosen plans in each region. We know that in some regions, issuers are offering more than one type of plan (for example, a PPO and an HMO option). Last year's report only provided information with the number of enrollees and/or a percentage of enrollees with the issuer in the aggregate, with no breakdown to specify the type of plan, when more than one type of plan is offered by the same issuer.

Additionally, last year's data was aggregate for each of the metal tiers of the issuers. We hope that this year, the publicly reported data for each region will identify how many enrollees in each of the issuer's plans ***and*** at what tier level. Tier level data is needed to understand consumer trends, to help identify any potential adverse selection, and to help the public's review of rate proposals in coming years.

Cost-Sharing Reductions and Tier Levels

We have appreciated the information Covered California has provided over the past year regarding the number of enrollees eligible for cost-sharing reductions who have chosen bronze, gold or platinum plans, thus losing their access to cost-sharing reductions. To better understand this trend and to try to ameliorate it in the future, we hope to see more detailed public reporting for this population. Specifically, Covered California should report:

- The actual number of enrollees eligible for cost-sharing reductions, broken down into each geographic region;
- The actual number of enrollees eligible for cost-sharing who did not chose a silver plan, by geographic region, issuer, and tier level of choice;
- The service channels that enrollees used to select a plan, particularly for those eligible for cost-sharing reductions who do not choose a silver plan.

Data Stratification

As with most public reporting, the ability to stratify data across categories is vital to understanding consumer decisions at all levels and ensuring the Exchange is meeting its mission of eliminating health disparities. We urge Covered California to track and report demographic data by age, gender, race, ethnicity and primary language for each issuer by geographic region and tier and to begin collecting data on sexual orientation and gender identity of its enrollees as soon as possible. This data is particularly important as Covered

California turns its attention towards improving health outcomes for California's diverse communities.

We hope Covered California will prioritize the reporting of this additional data as it prepares its next enrollment report of the second open enrollment period for the Board. Thank you for your time. We look forward to discussing our concerns and recommendations with you.

Sincerely,

Doreena Wong
Asian Americans Advancing Justice - LA

Caroline Sanders
California Pan-Ethnic Health Network

Julie Silas
Consumers Union

Cc: Katie Ravel
Yolanda Richardson
Mary Watanabe
Covered California Board members

February 23, 2015

TO: Anne Price
Director, Plan Management Division

FROM: Liz Helms, President & CEO
lizhelms@chroniccareca.org
Jerry Jeffe, Public Policy Director
jerryjeffe@gmail.com

On behalf of the California Chronic Care Coalition's thirty two member organizations representing 16 million Californians with Chronic conditions/diseases

RE: Recommended Options for Covered CA Specialty Drug Benefits

The California Chronic Care Coalition (CCCC) is pleased to submit recommendations for options that will improve quality, access and affordability of specialty medications for Covered CA enrollees and in the individual and group insurance marketplace.

On Friday, February 20, the final rule was announced by CMS that modifies how qualified health plans under the ACA will be designed for the future. The CCCC applauds CMS for their actions. The CCCC comments were addressed and we are pleased to see the direction CMS has taken. See below:

> **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, in part, as a prohibition on discrimination by issuers providing EHB. Under §156.125, which implements the prohibition on discrimination provisions, 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.*

As described in the proposed rule, 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 CMS-9944-F 266 should design plan benefits, including coverage and limitations, to comply with requirements and limitations that apply to plans beginning in 2014.53

In the proposed rule, we discussed three examples of potentially discriminatory practices:
(1) attempts to circumvent coverage of medically necessary benefits by labeling the benefit as a "pediatric service," thereby excluding adults; (2) refusal 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, absent an appropriate reason for such refusal; and (3) placing most or all drugs that treat a specific condition on the highest cost tiers.

In this final rule, CMS adopts the same approach as described in the proposed rule. As we indicated in the proposed rule and 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.54

We conduct this examination whenever a plan subject to the EHB requirement 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 documentation to HHS or the State explaining how the plan design is not discriminatory.

We note that 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.

The CA Chronic Care Coalition proposes the following recommendations for access to affordable, quality, RX coverage. Access and affordability are critically important for people with, and at risk for, complex chronic diseases/conditions. When people are not able to afford the care necessary to manage their chronic conditions, they scale back or forego the care they need, which often leads to complications and suffering that could have been prevented. That means an expensive trip to the emergency room and hospital readmissions that could have been avoided.

Recommendations for Option 1

We support Health Access's group letter for option 1, however, these caps should apply to all tiers – and not just specialty tiers (which is what Health Access is currently suggesting). Having the cap apply across all tiers offers more protection for patients. In terms of the dollar value, we strongly support the $150 (or $100) cap. For platinum/gold/silver plans, a $150 cap can be implemented with minimal premium/AV impacts. For Bronze we would support a cap of no more than $200.00. For all of these caps, we want them to apply pre-deductible. Cap should cover all CC enrollees with chronic conditions.

Recommendations for Option 2

Elimination of co-insurance for specialty tiers

Provide Comprehensive Medication Management for better coordination of multiple chronic conditions, improving adherence, compliance and lessening adverse reactions. (See supporting documents - attachment 1 and 2) For 2016 this could follow Medicare's criteria for MTM.

Uncoordinated care costs America an average of $240 billion a year, according to a recently published study based on analysis of more than 9 million insured lives in five states. Those involved in public and commercial health care plan administration, health care policy and reform, fiscal planning and patient care should consider the new insights and methods discussed in this study.

The study, published in the workshop series compilation, ***The Healthcare Imperative: Lowering Costs and Improving Outcomes by the Institute of Medicine****, identifies the subset of the population with the most savings and quality improvement opportunities. That population includes those who are receiving extremely fragmented care and are accessing the system in a very inefficient and uncoordinated manner. The author, Mary Kay Owens, estimated $240 billion annually is wasted on unnecessary and inappropriate delivery of services due to uncoordinated care that compromises quality of care for the entire system.*

Recommendations for Option 3

We support Health Access Option 3 out of pocket maximums but annual caps can still allow patients to have upfront RX costs which we would oppose. Option 1 and a combination of 2 and 3 are doable.

Recommendations for Option 4 (Health Access)

The rates Medi-Cal and the government pay are confidential, so there is no way health plans in the Exchange would be able to have contracts with rates just above that. Why include an option that cannot work?

Lastly, the projected increase of costs to 20% and 30% by 2020, as indicated by the Milliman findings, may not be accurate. Costs reductions can be realized by the path to success: Measuring and Improving Outcomes, Identifying Patients in Need of Integrated Care and Medication Management. This move is supported by a move to a value based system that focuses on quality and outcomes. Studies and data are showing cost savings and ROIs. (See attachment 2)

Thank you for the opportunity to comment, provide solutions and a roadmap that will end discriminatory practices.

March 4, 2015

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

Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

Re: 2016 Benefit Designs: Specialty Drugs

Dear Ms. Dooley and Mr. Lee,

On behalf of our consumer organizations, we offer comments on the proposed benefit designs with respect to prescription drug cost sharing and other modifications for the 2016 plan year. Several of our organizations participated in the workgroup process on this topic and others of us have been briefed on it. We again commend your staff as well as other workgroup participants for their efforts to delve into this issue and come to a workable solution for 2016.

Consumer Perspective

Consumers rely on Covered California to actively negotiate on their behalf. The plans, which vary in size and even more considerably in approach to prescription drug negotiations, should also be expected to negotiate actively over prescription drug costs, balancing safety, efficacy, medically necessary care, and cost, both in terms of premium and cost sharing at the point of use.

Consumers should never be caught in the middle between plans and providers, including pharmaceutical manufacturers. The current benefit design, with co-insurance of 20% and 30%, puts consumers squarely in the middle by exposing them to costs for a single prescription that equal or exceed the annual out of pocket limit: that is, for a single prescription a consumer may pay as much as $6,350. This is wrong.

Consumers have also been unable to obtain accurate or complete information about what drugs are covered on what cost sharing tiers. Definitions of cost sharing tiers vary

by plan and it appears there is no standard definition of what constitutes a specialty drug. In addition, consumers have no way to determine even a range of what their cost sharing obligation might be when they are faced with co-insurance.

Many consumers with very serious conditions such as multiple sclerosis, rheumatoid arthritis, lupus, HIV/AIDS or Hepatitis C rely on medications that they take month after month, year after year. The precise medications may vary as the science changes. For some conditions, the mix of medications is specific to the individual consumer. The new medications for Hepatitis C differ in that they are of time-limited duration (a few months), and they have very high cure rates to date. In some instances, these medications are not only medically necessary but when used effectively also prevent new infections in the community. In others, the drugs slow the progression of the condition or minimize the symptoms.

Finally, we note that people who need specialty drugs often have other substantial health care costs, including not only other medications but office visits, lab tests, and other monitoring. One study of an earlier proposal found that on average, people affected by a $500 cap had 167 claims in a year. Finally, almost 90% of Covered California enrollees have incomes between 138%FPL and 400%FPL, or about $25,000 to $40,000 for a single individual.

Consumer Advocates' Position on Staff Recommendations

Access and Transparency Requirements

The proposed changes on "access and transparency" are steps forward that consumer advocates welcome as providing better consumer information about both formularies and appeals processes for medications. Covered California will again lead the way. The implementation of SB1052 (Torres) on transparency of formularies will provide further improvements in future years.

Standardized Definitions of Formulary Tiers

Consumer advocates support standardized definitions of formulary tiers, but oppose the definition of specialty tiers. Standardizing the definitions is not the same as standardizing the formularies: we recognize that health plans will, and from a consumer perspective should, bargain with pharmaceutical manufacturers over formularies to get the best price possible.

Basing the fourth tier purely on the cost of the drug to the health plan, however, without regard for whether the drug requires special handling, special monitoring or specialty administration, is problematic from a consumer perspective. It has led in some instances to all HIV/AIDS drugs being placed on a specialty tier: the cost of these drugs generally ranges from $900 to $2,900 per monthly prescription and the cost threshold most commonly used for placement in Tier 4 is $600. This has a discriminatory impact for those with HIV/AIDS. Similarly those with multiple sclerosis who are commonly treated with two drugs, one a biologic and another (a DMARD), will find that their drugs are on a specialty tier. These drugs can cost as much as $5,000 or $10,000 for a

monthly prescription. Consumers with MS describe going to the pharmacy never knowing how much they will pay this month.

We ask that the definition of specialty drug be based both on the need for special handling, monitoring or administration as well as the cost, and that it not be based solely on cost.

Access to "Maintenance" Medications Across Formulary Tiers

We appreciate the recommendation that for "maintenance" drugs for chronic conditions, that is medications taken month after month, and in some instances year after year, at least one medication be on a lower tier if there are at least three treatment options that would otherwise be on Tier 4.

We note that while this will benefit some consumers, the proposal has some significant limitations. Specifically, for some conditions, such as MS or HIV/AIDS, some consumers need a specific mix of medications which may remain on Tier 4. Also, this recommendation does nothing to help those consumers who need Hepatitis C medications, such as Sovaldi, that are taken for time-limited duration of a few months (and then people are cured and healthy, good things for consumers).

Caps on Cost Sharing for Tier 4

We strongly support caps on co-insurance amounts required of consumers as cost sharing on the specialty drug tier, Tier 4. In fact, caps are essential to provide some relief for those with conditions whose life-saving, medically required drugs land only on Tier 4.

Specifically, for the 2016 benefit year, for silver and gold actuarial value tiers, we would support co-insurance to a cap of $200 per 30 day prescription for maintenance medications customarily taken over the course of a year and co-insurance to a cap of $500 per 30 day prescription for prescriptions taken for a time-limited duration. Lower cost sharing would apply for the platinum tier and for the cost sharing reduction tiers.

This is not our first choice. But from a consumer perspective, it would be a very substantial improvement over the current cost sharing structure which imposes a cost of as much as $6,500 for a single month's prescription for a single drug.

Consumers who need specialty drugs usually have other health care costs, including office visits, other medications, lab tests and other monitoring. One study of an earlier proposal found that on average, people affected by a $500 cap had 167 claims in a year. The proposed caps of $200 for the maintenance medications and $500 for the time-limited medications recognize the reality of these other consumer costs.

We support co-insurance to a cap for specialty drugs because we recognize that the cost of these drugs varies significantly and thus the consumer may benefit from lower co-insurance if a specialty drug costs less than $1,000.

We recognize that the plans are currently modelling the impacts of such a proposal on actuarial value and premiums not only for 2016 but for the years 2017, 2018, and 2019. The analyses we have seen to date suggest that, at least for 2016, the impacts are very modest. We, therefore, suggest that caps be adopted for 2016. We anticipate that, as a learning organization, Covered California would monitor the impacts on drug regimen adherence as well as premium and actuarial value impact to decide how to proceed in subsequent years.

We also recognize that there are other drugs in the pipeline and that cost sharing may need to be adjusted in future years to account for this. As advocates, we certainly did not anticipate in 2010 when President Obama signed the Affordable Care Act and Governor Schwarzenegger signed the enabling legislation for Covered California, that we would be spending this much time on prescription drug pricing.

Given our serious concerns about the definition of specialty drugs, with the potentially discriminatory impact on consumers with specific health conditions, as well as the significant limitations of the recommendation on access to drugs across tiers, the caps on co-insurance are even more important as consumer protections against excessive cost sharing for medically necessary drugs.

Conclusion

We commend the work of Covered California staff and also the efforts of the workgroup participants, including those from the contracting health plans, as well as the regulators.

We support most of the staff recommendations, but our support for the overall proposal hinges on adoption of co-insurance to capped amounts for both maintenance drugs taken over the course of months or even years and also time-limited duration drugs such as Sovaldi. We support the staff proposal that the cap be different for these to recognize the differing impact on consumer cost sharing and specifically support a cap of $200 per 30 day prescription for Tier 4 maintenance drugs and $500 per 30 day prescription for those Tier 4 with time-limited duration of a few months.

Sincerely,

Sarah de Guia
California Pan-Ethnic Health Network

Betsy Imholz
Consumers Union

Anthony Wright
Health Access California

Anne Donnelly
Project Inform

Elizabeth Landsberg
Western Center on Law and Poverty

Consumers Union
Nonprofit Publisher
of Consumer Reports

HEALTH ACCESS

PROJECT INFORM

February 24, 2015

To: Anne Price, James DeBendetti, John Bertko, Covered California
From: Beth Capell, on behalf of Health Access
Betsy Imholz, Consumers Union
Anne Donnelly, Project Inform

Re: 2016 Benefit Design Option: Specialty Drugs

Health Access, Consumers Union and Project Inform offer a proposal for the 2016 Benefit Design—and some options for consideration for future years.

As we make this recommendation, we are keeping in mind three facts:

- Adherence to medication regimens is reduced if cost sharing per monthly scrip exceeds $200-$250.
- Approximately 90% of Covered California's enrollment makes $24,000-$40,000 for a single individual.
- Uncapped co-insurance for Tier 4 thus results in failure to comply with clinically appropriate drug regimens, particularly for those with low/moderate incomes.

For 2016 Benefit Design:

- Apply a co-insurance-to-cap limit **per scrip** for Tier 4 drugs not to exceed $200 per monthly prescription.
    - Alternative: $200 copay. Question: are there drugs on Tier 4 for which co-insurance of 10% or 20% will be less than $200?
    - Please note: advocates would very much prefer a **per month** out of pocket maximum but we recognize that at this point, it may not be administratively feasible for the plans.
- All carriers, regardless of membership size, have at least 1 drug in tiers 1-3 for the same condition if at least 3 treatment options are available (predetermined by plan through P&T Committee, FDA indications, peer-reviewed medical evidence, nationally recognized professional standards, or generally accepted standards of care)
    - If a drug on Tier 4 is medically necessary, as determined through the exceptions process or IMR, apply Tier 3 cost sharing.
- No HIV/AIDS single treatment regimen on Tier 4: applies to treatments that are the standard of care.
- Standardized Definitions:

- Tier 4: Health Access would support if *both* criteria apply, that is if a specialty drugs are defined as both:
  1) Drugs that are a) FDA or drug manufacturer limits distribution to specialty pharmacies or: b) self-administration requires training or clinical monitoring (*beyond a monthly blood test)* or c) a drug manufactured using biotechnology** ***AND***
  2) More costly than other drugs
- Health Access opposes Tier 4 definition if it is one or the other rather than both.
- The proposed standardized definitions for Tiers 1, 2 and 3: seem unobjectionable.
- Health Access proposes this in the context of the March 5 board decision on the 2016 benefit designs and reserves the right to revise its view based on further research though recognizing this will not alter the 2016 benefit designs for that year.

** We have not discussed biologics and biosimilars. Health Access supports benefit designs that encourage use of biosimilars (once approved by FDA).

- Is the question of biosimilars a 2016 benefit design issue? Or a future year?
- If it is a 2016 question, should biosimilars be on a lower tier to encourage?

What is the impact of this kind of benefit design on the conditions we have reviewed?
My understanding from prior discussion is the following:

- For HepC, one treatment might be on tier 4 but the cost sharing would be limited to $200 per scrip.
- For HIV/AIDS, STRs would be on the preferred brand tier. Additional medications would be spread across the tiers 1-3.
- For RA, which is treated by DMARD and a biologic, consumers would likely have two drugs on Tier 4 with a monthly drug cost of $400 (at $200 per scrip) plus other cost sharing for doctors, labs and any other co-morbidities.
- For MS, almost all drugs would be on Tier 4 but there would be at least one treatment on Tiers 1-3. The exceptions process (with Tier 3 cost sharing) would help those with MS.
- For lupus, there would be a mix of tiers. (Anthem might want to revisit its formulary for lupus since it seems to be a bit of an outlier.)
- For epilepsy, most/all medications would be on Tiers 1-3 and mostly Tier 1.
- For any of these conditions, if the medications on Tiers 1-3 are not clinically appropriate for the specific patient for whatever clinical reason, the exceptions process would apply and the cost sharing for what would otherwise be a Tier 4 drug would be the cost sharing for Tier 3.

Possible Approaches for Future Benefit Designs Related to Drugs

- Maintain elements of 2016 benefit design: adjust based on experience, shifts in market.

- Separate annual out of pocket maximum for prescription drugs of $1,000 or $2,000 but with total annual out of pocket maximum for all covered benefits, including medical and dental, not to exceed federal limit.

- If it is medically necessary (as determined through either the exceptions process or IMR) for an individual to have a drug that is on one of the highest cost tiers, then apply the applicable lower cost sharing.
    - Most or all drugs to treat a condition prohibited from being on highest cost tiers (plural): that is, some drugs to treat a condition must be on lower cost tiers.
    - If a drug that treats a condition is the only drug on the market (as was true of Sovaldi until recently), it could not be on the top tier until a competitor emerges. We should have a discussion about what that does to the ability of the plans to negotiate a good or better price from the Rx manufacturers.

- Require that contracting QHPs pay a price only slightly higher than that paid by the lowest public payer (usually either VA or Medi-Cal).
    - Price savings go to consumer in form of reduced premiums.
    - This option could be combined with other options.

The Health Consumer Alliance

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March 3, 2015

Ms. Diana Dooley, Chair
Covered California Board

Mr. Peter Lee, Executive Director
Covered California

RE: Consumer barriers in the appeals process

Dear Madame Chair and Mr. Lee:

The Health Consumer Alliance (HCA) serves as Covered California's independent consumer assistance program and has a strong working relationship with Covered California. For more than a year, we have helped consumers throughout the state navigate the complex path to obtaining and using health insurance in the age of the Affordable Care Act. This includes advice and advocacy to help consumers overcome application barriers, challenge incorrect eligibility determinations, enroll in or disenroll from a Covered California plan as needed, and overcome delays or barriers in accessing services from their plan. The HCA has been able to resolve many consumers' problems with Covered California's "Research and Resolution" team and the "back office" through our role as Covered California's statewide consumer assistance program. These administrative resolution processes and our regular meetings with Covered California have also helped Covered California identify systemic problems.

For consumers whose Covered California eligibility or enrollment problems could not be resolved by the Research and Resolution team, the HCA represents consumers in formal appeals to Covered California by requesting a hearing with the California Department of Social Services (DSS) State Hearings Division, Covered California's designated appeals entity.[1] However, due to Covered California's lack of adequate responses to these appeals and inability to comply with hearing decisions, eligible California consumers are currently unable to enroll in affordable coverage, access health care services, and are incurring unnecessary medical debt. Over the last

[1] Title 10 California Code of Regulations Section 6606.

several months, we have provided Covered California with specific consumer stories in our monthly reports and in our meetings, but the problems with the appeal process continue today.

We are now raising our concerns in writing with the Board because there is a systemic failure in the current appeal process, at times even beyond Covered California's staff control, which leaves eligible consumers – those represented by HCA advocates and those who are not - without coverage and without any other recourse to address the problem. As discussed in detail below, the HCA has faced multiple, repeated challenges throughout the appeals process and in ultimately connecting consumers to needed care even when they properly request an appeal, present their case at an administrative hearing, and obtain a favorable decision from a DSS Administrative Law Judge. The problems with the appeal process also prevent the HCA from ultimately resolving our clients' problems, providing effective assistance, and meeting our obligations to our clients. Given the difficulties the HCA is currently experiencing with navigating Covered California's appeal process, it is more than likely that consumers without assistance are facing additional hurdles and may have given up attempting to resolve their problem altogether. We know these are outcomes that Covered California does not want for its consumers, but can prevent, with a more effective and efficient appeal process that works for all California consumers.

Background

Under state and federal law, applicants and enrollees of Covered California coverage have the right to appeal:

a) An initial eligibility determination of coverage or premium assistance;
b) A redetermination of eligibility for coverage or premium assistance (e.g., annual renewal);
c) A failure to receive proper or timely notice; and
d) A failure to receive a timely determination.

After a consumer files a valid appeal, Covered California must provide the consumer notice and the opportunity to informally resolve the appeal prior to a hearing, and if that is not possible, the consumer has a right to hearing.[2] At the hearing, consumers should have the opportunity to review all relevant evidence and cross-examine the other parties.[3] After a hearing decision is issued by DSS, Covered California must "promptly implement the appeal decision" either prospectively or retroactively.[4]

[2] 10 CCR §§§ 6606,6612,6614.
[3] 10 CCR § 6614
[4] 10 CCR §§ 6602(b),6618(c)

Violations of state appeal obligations

Based on our clients' experiences, which we have provided to Covered California in our monthly reports and can share with the Board, we outline below the patterns in the violations of Covered California's legal obligations as they occur during the length of the appeal process.

A. Prior to a Hearing

1) Failure to contact the designated Authorized Representative prior to and after filing a request for hearing

Consumers may designate an Authorized Representative to represent them in an appeal who Covered California must permit to "act on behalf of the applicant or enrollee in all other matters with the Exchange" once designated.[5] Consumers have the right to choose someone who can best represent their interests. Working with an Authorized Representative can also be helpful to Covered California because the representative is often more familiar with eligibility and enrollment rules than a consumer and can quickly help identify both the problem and a solution.

However, Covered California has repeatedly ignored this obligation by not properly communicating with the designated Authorized Representative during the Research and Resolution process or after a request for hearing is filed by the consumer. This frustrates the ability to resolve cases efficiently and quickly and deprives consumers of effective legal assistance. Specifically, HCA advocates who are designated by consumers as their Authorized Representative sometimes learn from either the consumer or from Covered California that Covered California contacted the represented consumer without an attempt to contact the designated Authorized Representative. In one such instance, the limited-English–proficient consumer was contacted by a Research and Resolution representative who did not speak in the consumer's primary language and did not offer to communicate with the consumer through an interpreter, as required by state law. As a result, the consumer was unable to understand the information provided and could not subsequently explain to her Authorized Representative what information had been provided by Covered California or if the problem was being resolved by Covered California.

In some instances, HCA advocates have had no other option but to file a hearing request just to obtain information about a consumer's case because they were unable to talk to anyone at Covered California about the details of the consumer's case or because Covered California refused to provide the advocate information, even though he or she is the consumer's Authorized Representative. When this has occurred, the HCA reports these problem to Covered California and requests that staff be trained on the role of the Authorized Representative; however, the failure to properly communicate with consumers' Authorized Representatives remains a consistent problem for HCA advocates prior to and after filing a request for hearing.

[5] 10 CCR §§ 6602(e),6508(f).

2) Lack of an informal resolution appeal process

Often, an appeal can be informally resolved without going to a hearing if a consumer or the Authorized Representative can communicate with the appeals specialist handling the appeal. Consumers who are appealing an issue with Covered California "shall have an opportunity for informal resolution prior to a hearing" and the burden is on Covered California to "contact the appellant ***to resolve the appeal informally*** and to request additional information or documentation, if applicable, prior to the hearing date." 10 CCR §§ 6612(a), (b) (emphasis added). This informal resolution requirement is intended to conserve state resources, expedite the appeals process for simple errors, and reserve hearings for more complicated issues that may require an interpretation of law by an Administrative Law Judge.

An example of an effective informal appeal process is the one currently in use by the counties' social services agencies for appeals involving Medi-Cal eligibility and enrollment issues. After a consumer requests a hearing with DSS that involves a Medi-Cal issue, the relevant county's social services agency assigns an "appeals specialist" who provides the consumer and the Authorized Representative written notice of receipt of the appeal and his or her contact information, or his or her contact information to DSS prior to the hearing. That appeals specialist is responsible for contacting the Authorized Representative or consumer to attempt to resolve the appeal prior to a hearing and has the authority to conditionally withdraw the appeal in order to informally resolve the problem while preserving the consumer's right to a hearing. If the county appeals specialist does not initiate contact, a consumer or Authorized Representative can contact DSS to obtain the appeals specialist's contact information. If the appeal cannot be informally resolved, the appeals specialist is responsible for writing the county's position statement and sending it in a timely manner to the Authorized Representative, the consumer, and the Administrative Law Judge who is assigned to the case. The county must comply with the hearing decision in the time required, unless the decision is alternated by the California Department of Health Care Services (DHCS). Whether an appeal is informally resolved or a hearing decision has been issued by DSS, the county appeals specialist remains the contact person for the consumer or Authorized Representative if there are problems implementing the decision. Under the counties' well-established informal resolution process, the HCA is able to resolve the vast majority of our Medi-Cal appeals quickly and efficiently, eliminating the need for time-consuming hearings.

Unfortunately, Covered California's lack of a similar informal appeal process, as described in detail below, has often left consumers and advocates without an effective way to informally resolve appeals involving Covered California eligibility and enrollment issues. For example, the HCA has not seen or received a notice from the Covered California's appeals office confirming receipt of the appeal or providing information on how to contact the Covered California appeals office or the appeals specialist who is handling the appeal, unlike most county appeals offices. The only written notice that HCA advocates currently receive after filing an appeal regarding a Covered California decision is from DSS, which does not identify who to contact at Covered California.

When HCA advocates have attempted to track down the Covered California appeals specialist prior to the hearing, we have been bounced back and forth between Covered California and DSS without success because DSS does not have with the contact information of the Covered California appeals specialist handling the appeal but Covered California refers us back to DSS since we are calling about an appeal. In addition, Covered California's appeals office often does not inform the county appeals specialist who is working on the appeal with Covered California (if the appeal involves a Medi-Cal and Covered California determination), preventing that specialist from working with Covered California to attempt to resolve the appeal prior to the hearing. If no contact information to an appeals specialist is provided, the expectation is that Covered California will contact the Authorized Representative prior to the hearing date to informally resolve the appeal, as is required by state law. Yet in some cases, HCA advocates were never contacted by Covered California prior to the hearing. Without this basic contact information to an appeals specialist, a consumer or Authorized Representative has no way to even attempt to informally resolve an appeal and is forced to wait until a hearing.

In the few instances where HCA advocates attempted to informally resolve an appeal prior to the hearing with Covered California's appeals office, the appeals office was unwilling to connect the HCA advocate to the appeals staff handling that appeal, or provide a contact name or number of any appeals specialist, or allow an Authorized Representative to follow up with the same appeals specialist with whom the Authorized Representative had recently discussed the appeal. To make matters worse, when HCA advocates subsequently contact the Research and Resolution team for help to resolve the consumer's problem because they are unable to informally resolve the appeal with the appeals office, the Research and Resolution staff report that they cannot work on resolving the appeal once a request for hearing is filed. At this point, the only option HCA advocates have to even speak with Covered California about the appeal as well as resolve the problem is at the hearing, even for issues that could easily be resolved with one phone call.

Finally, even when an HCA advocate was able to speak with a Covered California appeals specialist prior to the hearing, the appeals specialist representatives declined to informally resolve the appeal, even if in agreement with the consumer's position. Instead, all parties proceeded to a formal hearing weeks later, during which the appeals specialist subsequently agreed to stipulate to the consumer's proposed resolution, and resulted in the Administrative Law Judge issuing a type of stipulated decision. This is a clear example of an unnecessary delay and an inefficient use of state resources that could have been easily avoided with the same outcome.

Covered California's failure to provide an informal appeal process, thereby requiring almost every appeal to be resolved at a hearing, puts a strain on the state's and HCA's limited resources, creates a backlog of appeals at Covered California that could be resolved without a hearing, and leads to an appeals process that is ineffective and frustrating. We strongly recommend Covered California adopt the same informal appeal procedures already used by county social services

agencies for Medi-Cal appeals and assign an appeals specialist to every appeal, who can be contacted by the consumer or Authorized Representative.

3) Failure to provide a position statement in a timely manner

Covered California must provide a Statement of Position (hereafter referred to as "the position statement") to the consumer, Authorized Representative and DSS at least two business days prior to the hearing date. 10 CCR § 6612(e)(2). However, HCA advocates have received the position statement the night before or ***during*** the hearing. In one instance, the HCA advocate was assured by the Covered California appeals specialist that the advocate would receive the position statement the day before the hearing, but still never received it. The advocate and consumer appeared at the hearing despite not knowing Covered California's evaluation of the case. When the advocate informed the Administrative Law Judge and the Covered California appeals specialist at the hearing that the position statement had not been sent, the appeals specialist sent it to the advocate via e-mail ***during the hearing in progress***.

Without adequate time to review the position statement with the consumer prior to the hearing, the HCA advocate has had to either take time during the hearing to review it with the client, proceed with the hearing without adequate review of the position statement, or request that the hearing be rescheduled for another date. Rescheduling the hearing is unfair as well as inconvenient to the consumer, the Authorized Representative, as well as the Administrative Law Judge when the consumer was otherwise prepared to proceed with the hearing. More importantly, the longer the appeal goes unresolved due to scheduling delays, consumers are unable to access care, may incur medical debt, and may be increasing their potential tax liability if they are continuing to receive premium tax credits during the appeal for which they may not ultimately be eligible.

By failing to provide the position statement at least two business days prior to the hearing date as required, Covered California is interfering with the consumer's right to have the unfettered opportunity to "question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses," or "present an argument without undue interference."[6] It appears Covered California has also been unable to provide position statements to DSS as required by law in a timely manner.[7] In fact, Administrative Law Judges have informed HCA advocates that Covered California is overwhelmed with preparing for hearings and is consistently late in providing its position statements. This may increase the likelihood of a hearing being rescheduled or result in an ineffective hearing.

Covered California must immediately comply with providing its position statement to the claimant, Authorized Representative, and DSS at least two business days prior to the hearing date. We also suggest that Covered California provide on a regular basis to the Board and HCA the number of

[6] 10 CCR § 6614(d)
[7] 10 CCR § 6612(e)(2)

appeals in which position statements were provided within the two business day requirement in order to help monitor compliance. Yet the most effective way to ensure position statements will be provided to all parties in a timely manner is to drastically reduce the number of hearings Covered California appeals staff are preparing for by creating an effective informal resolution process.

B. At the Hearing

1) Inadequate position statement

Covered California's position statements are not only frequently provided late, but are often incomplete or inadequate. Specifically, HCA advocates have received position statements that do not correctly address the underlying facts, fail to explain why the consumer's evidence is not valid, or do not respond to the county's arguments. It appears that because Covered California can only provide the position statement at the last minute, there is no quality control being conducted prior to releasing the position statements to ensure the statements are accurate or complete. If a consumer or Authorized Representative does not receive an adequate position statement, the consumer's opportunity to review Covered California's claims, present an argument, or refute evidence is severely impaired.

2) Inability to cross-examine parties

In many cases, a Covered California appeal requires representatives from Covered California and the county to evaluate the appeal and for each to provide its agency's determination. However, HCA advocates have attended hearings where a representative from either Covered California or the county was not available for the hearing, resulting in the hearing being rescheduled. In some instances, to avoid rescheduling the hearing, the Administrative Law Judge repeatedly attempted to reach the missing agency representative without success. Failure of both parties to attend the hearing creates unnecessary delay for consumers who are eligible for either Medi-Cal or Covered California with premium assistance, but remain without coverage during the appeal process due to an incorrect eligibility determination by one of the agencies. Yet even when both the Covered California and county representatives are present at the hearing, HCA advocates have observed that each agency appeals specialist does not appear to know the other agency's arguments in the case at hand, let alone program rules. This has resulted in the Administrative Law Judge or, at times, the HCA advocate, having to piece together what has happened in the consumer's case because of the lack of communication between the agencies and its representatives. For more efficient resolution of appeals, Covered California must ensure that its appeals specialists are coordinating with the relevant county's appeals specialist throughout the appeal process for appeals that involve a Medi-Cal determination.

HCA advocates have also recently represented consumers at a hearing where Covered California was the appropriate entity at the hearing, but the HCA advocate was not informed until the hearing about information provided by a county representative prior to the hearing and was not given the

opportunity to question that individual at the hearing. While DSS should help ensure this does not occur, the Covered California representative also has a duty to object or raise due process concerns when a consumer and Authorized Representative is not provided the same information that the Administrative Law Judge or Covered California receives prior to a hearing and instead, should immediately share the relevant information with the consumer or Authorized Representative.

C. Post Hearing

Failure to comply with a hearing decision

The most troubling issue HCA advocates are facing is Covered California's lack of compliance with hearing decisions. DSS' hearing decision is final (unless appealed to the U.S. Department of Health and Human Services) and Covered California must "implement the appeal decision effective (A) Prospectively, on the first day of the month following the date of the notice of appeal decision or (B) Retroactively, to the date-the incorrect eligibility determination was made, at the option of the appellant."[8]

Nevertheless, HCA advocates have had multiple cases where Covered California is unable to comply with the hearing decision completely or without additional intervention. Initially, when HCA advocates investigated why their clients' hearing decision had not been implemented in the time required, Covered California often responded that the IT system was preventing implementation of the decision. Covered California staff members are only able to file a "service request" or trouble ticket to the "help desk" requesting the problem be fixed and can only advise HCA advocates to simply wait for a response. When HCA advocates request that the trouble ticket be expedited due to the hearing decision, Covered California staff are not sure if it is possible.

More recently, HCA advocates have at least two cases involving hearing decisions that require action by a Covered California Qualified Health Plan (QHP) to retroactively enroll or refund the consumer for premiums overpaid, but the relevant QHP refused to comply with the hearing decision as required. When HCA reported the lack of compliance to Covered California, staff explained they were not able to intervene and require the plan to comply. Despite repeated attempts to elevate these compliance problems within Covered California, HCA advocates and the consumers have faced numerous delays and responses from Covered California that the issue can only be resolved by the QHP. If Covered California contracts with all QHPs, yet is unable to ensure a QHP complies with the hearing decision, a consumer certainly will not be able to do so.

[8] 10 CCR §§ 6618(a)(7),6618(c)

Unfortunately, during the time that a favorable appeal decision remains unresolved, consumers continue to be without access to services and continue to incur medical debt or tax liability if incorrectly receiving premium tax credits.

However, QHPs are legally obligated to comply with DSS hearing decisions that deal with eligibility and enrollment under existing contracts with Covered California. Specifically, Sections 1.06 and 3.20 of the model QHP contract requires QHPs to comply with the eligibility and enrollment decisions of Covered California. Because Covered California has designated DSS as its appeal entity, QHPs are currently obligated by contract to comply with any DSS decision that involves eligibility and enrollment into a Covered California plan. A QHP's refusal to comply with a DSS hearing decision should be considered a breach of contract by Covered California. If Covered California fails to enforce its rights under the QHP contract on this provision and does not require contract compliance, the QHPs may choose to violate other contract provisions. For future QHP contracts, Covered California may want to ensure this existing compliance requirement is made more explicit, by specifying the penalties and fines for failing to comply, requiring a QHP representative to be present at the state fair hearing as a party or witness, establishing a clear process between Covered California and the QHPs to ensure compliance with DSS decisions, and confirming a consumer's private right of action against the QHP for failure to comply, including for any resulting harms.

Because Covered California currently claims it cannot compel the QHPs to comply with DSS decisions requiring action by the QHPs, the HCA advocates have been forced to file a complaint with the California Department of Managed Health Care (DMHC) against the plan, even though the appeal solely involves receipt of premium tax credits, which is squarely within Covered California's jurisdiction. When the HCA also reported the compliance barriers to DSS, HCA advocates have been asked to notify the Presiding Judge at DSS when a hearing decision is not complied with and recently did so when a QHP failed to retroactively enroll a consumer in a timely manner as required by the hearing decision. Nevertheless, Covered California will often be the only entity that can implement the hearing decision. Covered California is required by law to comply with a hearing decision and its inability to ensure compliance – through necessary IT fixes or intervention with a QHP - violates this obligation and may leave consumers without any recourse.

Covered California must prioritize IT fixes that may be needed to comply with hearing decisions, provide more oversight regarding QHPs' compliance with hearing decisions, and otherwise ensure that hearing decisions are implemented in the time required. Covered California's failure to appropriately enforce state hearing decisions increases the injuries suffered by consumers.

Health Consumer Alliance Partners

Consumer Centers
Fresno Health Consumer Center
Health Consumer Center of Imperial Valley
Kern Health Consumer Center
Health Consumer Center of Los Angeles
Orange County Health Consumer Action Center
LSNC: Health
Consumer Center for Health Education & Advocacy
Bay Area Legal Aid: Health Consumer Center
Health Consumer Center of San Mateo County

Consumer Center Sponsors
Central California Legal Services
California Rural Legal Assistance
Greater Bakersfield Legal Assistance
Neighborhood Legal Services of Los Angeles County
Legal Aid Society of Orange County
Legal Services of Northern California
Legal Aid Society of San Diego ***(HCA Coordinator)***
Bay Area Legal Aid
Legal Aid Society of San Mateo County

National & State Support
National Health Law Program

State Support
Western Center on Law and Poverty, Inc.

Conclusion

Covered California continues to be seen as a model across the nation for a well-functioning and effective marketplace. Unfortunately, the current lack of an effective appeals process for applicants to and enrollees of Covered California jeopardizes its reputation as being consumer-friendly. As a result, the problems with the appeals process as detailed in this letter need to be immediately addressed by the Board.

We understand that there currently is considerable demand on Covered California staff. We also appreciate that Covered California has tried to work with HCA and other stakeholders to resolve these due process issues over the past year; nevertheless, these problems persist. The current failures in Covered California's appeals process violates existing law, inefficiently uses limited state resources, and ultimately prevents consumers from accessing affordable coverage, which is contrary to Covered California's mission. As these problems appear to be systemic, we recommend that Covered California review the problems we have identified and consider adopting internal appeals policies and procedures that are comparable to DSS' Manual of Policies and Procedures and the appeals procedures currently utilized by the counties' social services agencies. We look forward to working with the Board and Covered California staff to address these concerns.

Sincerely,

The Health Consumer Alliance

CC:

Jennifer Kent, California Department of Health Care Services

Manuel A. Romero, Chief Administrative Law Judge
Charles DeCuir, Presiding Judge
California Department of Social Services State Hearings Division

Frank J. Mecca, California Welfare Directors Association

Shelley Rouillard, California Department of Managed Health Care

Health Consumer Alliance Partners

Consumer Centers
Fresno Health Consumer Center
Health Consumer Center of Imperial Valley
Kern Health Consumer Center
Health Consumer Center of Los Angeles
Orange County Health Consumer Action Center
LSNC: Health
Consumer Center for Health Education & Advocacy
Bay Area Legal Aid: Health Consumer Center
Health Consumer Center of San Mateo County

Consumer Center Sponsors
Central California Legal Services
California Rural Legal Assistance
Greater Bakersfield Legal Assistance
Neighborhood Legal Services of Los Angeles County
Legal Aid Society of Orange County
Legal Services of Northern California
Legal Aid Society of San Diego ***(HCA Coordinator)***
Bay Area Legal Aid
Legal Aid Society of San Mateo County

National & State Support
National Health Law Program

State Support
Western Center on Law and Poverty, Inc.

SISKIYOU HEALTHCARE COLLABORATIVE

Member Organizations
ANAV Tribal Clinic
Fairchild Medical Center
Health Alliance of Northern California
Karuk Tribal Clinic
Klamath Health Services, Inc.
Dignity - Mercy Medical Center, Mt. Shasta
McCloud Healthcare Clinic
Mountain Valley Health Centers
Partnership HealthPlan of California
Siskiyou Community Services Council
Siskiyou County Health & Human Services Department

November 12, 2014

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

Subject: Covered California Not Working for Rural California

Dear Director Lee,

The Siskiyou Healthcare Collaborative (SHC) is writing to inform you of the health care access obstacles in Siskiyou County due to the products offered through Covered California's Region One Marketplace and to request resolution to the issues outlined below that severely limit access to care in our rural region. SHC meets regularly to improve the health care delivery system in Siskiyou County and the surrounding, rural region. Over the last year, no meeting has gone without a discussion on how to address the many problems our community members have faced because of a Covered California product.

We are taking this opportunity as your committed partner to follow up on the letter sent on behalf of the northern region community clinics dated July 3, 2014 and offer you the following four recommendations on behalf of Siskiyou County's residents, physicians, provider groups, non-profits and local government.

First, we strongly urge Covered CA to work with Anthem Blue Cross and Blue Shield of CA to encourage them to provide our consumers access to their commercial statewide networks through the Marketplace. The only health insurance options available to residents in Pricing Region 1 are the Anthem Blue Cross PPO and Blue Shield EPO products. Blue Shield's decision to offer only an EPO in our region significantly reduced the availability of its products in Region 1 because many areas within our region do not meet the requirements of the EPO product (primarily distance from contracted hospital). This leaves Anthem Blue Cross as the only option for individual health insurance coverage for many. Anthem Blue Cross, likewise—despite the promotion of it product as a true PPO, which implies choice—created a narrow network exclusively for Individual/Marketplace consumers. Anthem Blue Cross and Blue Shield of CA together have worsened access to care in an already difficult market for rural residents.

We are all well aware of the issues surrounding the published directories earlier this year and the confusion of both individuals and providers regarding actual network status in these narrow networks. While it is understood that the carriers created these networks in an effort to address cost containment, the administrative expense associated with these networks seems to have exceeded any potential cost savings. It is our recommendation that Covered CA work with Anthem Blue Cross and Blue Shield of CA to restore access to the commercial statewide networks available to their group clients. No other carriers in the State have created these narrow networks and because of the limited availability of carriers in our region, our citizens have no choice.

Second, many of our communities migrate north into Southern Oregon for services not available in Siskiyou County. Healthcare is no exception. We feel that adequate networks must include out of state

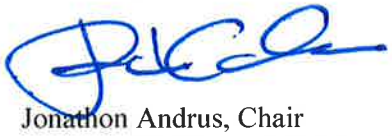
providers. Given our remote location and the difficulty that many face with even basic transportation issues, access to providers in Southern Oregon is not just convenient but in some cases, critical. It is our recommendation that Covered CA work with Anthem Blue Cross and Blue Shield of CA to include Southern Oregon providers in their networks.

Third, we expect a network adequacy study of the HealthNet PPO plans available through the Small Business Health Options (SHOP) program in our region. For benefit year 2014, the only options available to small businesses in our community were Bronze and Silver level plans. The Blue Shield Shop offering was available in only limited counties, leaving HealthNet as the only option for coverage. It is anticipated that the HealthNet PPO network comprises only about 30% of the providers in our region. Furthermore, the rates offered exceed other options available for small businesses in the commercial market. Due to the lack of plan availability and increased cost, it is very discouraging that our small businesses have no real option to receive the small business health insurance tax credit.

Finally, we recommend an examination of the communications system between Covered CA and the insurance carriers. There have been numerous reports of individual policy cancellations due to untimely communication between Covered CA and the carriers. It is our understanding from Covered CA that "tickets" are transmitted once a week to carriers and that carrier backlog means these tickets are not addressed for 3-4 weeks on average. That backlog means that often it takes several requests to Covered CA or several tickets sent by Covered CA to resolve even the simplest issues.

On behalf of Siskiyou County and its residents, we thank you for your commitment to expanding access to health insurance and care in California, including California's rural communities. We would like to have the opportunity to discuss these issues and potential strategies to address them.

Sincerely,



Jonathon Andrus, Chair
Siskiyou Healthcare Collaborative
CEO, Fairchild Medical Center

cc:
Covered CA Board
Kim Belshé
Diana Dooley
Mr. Paul Fearer
Ms. Susan Kennedy
Robert K. Ross, M.D
Legislators
Brian Dahle, State Assembly, 1st District
Ted Gaines, State Senate, 1st District
Doug LaMalfa, U.S. Representative, CA 1st District
State of California
Shelley Rouillard, Director, California Department of Managed Health Care

COVERED CALIFORNIA

February 10, 2015

Jonathon Andrus
Siskiyou Healthcare Collaborative
1140 Mount Schilling Way
Mount Shasta, CA 96067
Dear Mr. Andrus,

Thank you for sharing your region's experience with Covered California and recommendations. We appreciate your comments and share your commitment to improve our efforts in rural areas of the state. To help us better understand the unique circumstances in rural Northern California communities, we have met several times with stakeholder groups in that region. Specifically, our staff has coordinated with California Primary Care Association to meet with partners such as with Health Alliance of Northern California, North Coast Clinics Network, and Mendocino Coast Clinics network. A representative from the Siskiyou Healthcare Collaborative would, of course, be a welcome addition.

With regard to your specific recommendations, we offer the following responses:

We strongly urge Covered California to work with Anthem Blue Cross and Blue Shield of CA to encourage them to provide our consumers access to their commercial statewide networks through the Marketplace.

We appreciate the desire for broader provider networks; however, this consideration must also be carefully balanced with the need for affordable products. Last year, Covered California health plans were tasked with building new insurance products that needed to be affordable and high quality. For this reason, plans did not necessarily use the same networks as their regular commercial products and some plans used selective networks. Recognizing there are still areas of concern with availability of providers, particularly in region one, Covered California, has had multiple discussions with our current contracted health plans and have asked that they look to increase coverage by expanding to areas where there is limited plan choice in 2016. We are encouraged with the positive direction these discussions have evolved and expect to see increased access in region one beginning January 1, 2016.

We are all aware of the issues surrounding the published directories earlier this year and the confusion of both individuals and providers regarding actual network status in these narrow networks.

Provider directories, are constantly changing, meaning it is difficult to capture a fully accurate directory at any point in time. This dynamic nature, compounded with the addition of many new Covered California products and networks in the 2014 marketplace, caused more provider directory confusion than usual. We understand that these issues are exacerbated in areas

where people must travel further to see a doctor. Covered California takes the concern of inaccurate provider directories very seriously and is working hard this year to help our plans communicate more clearly to providers that they are in the Covered California network, especially by enlisting help of provider organizations such as California Medical Association (CMA). Additionally, we require quarterly provider network detail to be submitted to Covered California so we can monitor plan network changes and proactively be alerted to issues that may be problematic to consumers. This will allow us to reach out to plans and work with them to understand network concerns and potentially enrich network availability if possible.

Finally, as you may be already aware, Anthem Blue Cross and Blue Shield networks were recently reviewed in a non-routine survey by the Department of Managed Health Care (DMHC). In November 2014, results of the survey revealed multiple deficiency areas, for which these plans are taking corrective action. There is a follow-up survey planned for six months after the initial report was issued. We will continue to monitor the situation closely.

Second, many of our communities migrate north into Southern Oregon for services not available in Siskiyou County. Healthcare is no exception. We feel that adequate networks must include out of state providers.

Covered California recognizes the need for more choice in region one, both in terms of networks and plan choice. Currently, some Covered California regions have less plan choice than others, and we have proposed to increase choice in your county and similar areas by allowing new health plan entrants to apply to participate in the Exchange beginning January 1, 2016. The recommendation was approved at our January 15, 2015 Board meeting, and represents a change in direction from new entrant and certification policies developed over the last two years, as a reaction to the need for more meaningful consumer choice. We hope that the expansion of plans into this region will bring more extensive networks particularly in bordering states such as Oregon.

Third, we expect a network adequacy study of the Health Net PPO plans available in the Small Business Health Options Program in our region. The only options available to small businesses in our community were Bronze and Silver level plans.

Health Net currently offers products in all counties in Region one, and all metal tiers are available for *employer choice* in each county. As part of the 2014 SHOP program, employers have the option of choosing what they would like to offer their employees amongst all metal tiers. If small business employers in your community only chose Bronze and Silver to offer to their employees, then the employees would have only seen those options. However, if an employer had an experience where the only options shared with them were Bronze or Silver, please give us the specifics so we can look further into the situation.

In regards to network adequacy, Health Net is regulated by the California Department of Insurance (CDI). Regulators consider number and distribution of enrollees, not percent of contracted providers in network review. If there are providers in your community who would be interested in joining Health Net SHOP networks, we can facilitate a platform for discussion. Also, as we begin the plan solicitation process for 2016, we hope to engage other existing and potentially new carriers in discussions of possible expansion into additional zip codes in Region One.

Finally, we recommend an examination of the communication system between Covered California and the insurance carriers.

Improving the information technology (IT) systems that interface with health plans and Medi-Cal is a critical priority. We are very mindful that more improvement is needed and we are continually working on areas where there appear to be delays in consumers receiving confirmation that their health care coverage is effective.

Eligibility transmittals do occur between Covered California and each of its contracted health plans nightly and to our knowledge there has not been backlog associated with 2015 renewals and open enrollment. This has been an improvement compared to 2014, so we believe this issue has for the most part been resolved. Also, Covered California continues to work with our Medi-Cal partners to have a more smooth transition to Medi-Cal if a member is no longer determined eligible for Advanced Premium Tax Credit due to an income change. This continues to be a work in progress and we understand the importance of ensuring that consumers have peace of mind in knowing that they have coverage either through Covered California or through Medi-Cal. If you are aware of an issues that arise impacting consumers in your region, please do not hesitate to let us know so we can offer assistance.

Covered California appreciates that rural areas are unique and can have unique access challenges, and that these issues are also present in the Covered California networks. We also understand that the challenges of fewer providers available in a community and therefore less competition, and added costs of providing care far from additional specialty or tertiary care resources often make it harder to form contract agreements. We look forward to continue partnering and creative thinking to enable better access for our northern California residents.

Sincerely,

Anne E. Price
Director of Plan Management
Covered California

February 26, 2015

The Honorable Edmund G. Brown, Jr.
Governor, State of California
State Capitol, First Floor
Sacramento, CA 95814

RE: PROPOSED MANAGED CARE ORGANIZATION (MCO) TAX
OPPOSED UNLESS AMENDED

Dear Governor Brown:

Sharp HealthCare (Sharp) a non-profit, integrated regional health care delivery system is San Diego's largest provider of health care including care to the Medi-Cal population. Sharp's non-profit health plan, Sharp Health Plan has long provided coverage to the San Diego region's employers and local governments, and is proud to have been selected to provide coverage to beneficiaries in Covered California and the Small Business Health Options (SHOP) Marketplace.

Sharp Health Plan would be disproportionately affected by the Administration's proposed revision of the Managed Care Organization (MCO) tax, paying nearly the highest per member, per month tax of any commercial-only plan in the state. We write to request that the MCO tax proposal be amended to reflect our concerns. Should the proposal be implemented as proposed, Sharp Health Plan would have no operating margin and coverage to over 100,000 beneficiaries would be in jeopardy.

As you know, Sharp has been a longstanding supporter of the state's Medi-Cal hospital provider fee and mechanisms to maximize federal reimbursement for health care providers. Accordingly, we understand the need to revise the MCO tax to conform with federal Centers for Medicare and Medicaid (CMS) requirements, including making the tax as broad-based as possible. As the Legislative Analyst's Office (LAO) has stated the proposed structure forces several mid-sized health plans to bear the brunt of the highest tax. In fact, the MCO tax would impose a tax burden of $15 per member per month on Sharp Health Plan. That compares to a tax of as low as $2 per member per month on our much larger competitors.

Passing on a tax increase of four percent to Sharp Health Plan's commercial customers is simply not possible in the current environment as it would place us at a serious competitive disadvantage. While Sharp Health Plan has consistently achieved the highest quality and customer satisfaction scores, our customers include small businesses, local governments and school districts that have limited budgets and limited health care dollars.

8695 Spectrum Center Boulevard ■ San Diego, California 92123-1489

Sharp applauds the administration's effort to concentrate the tax burden on Medi-Cal plans, but unfortunately the proposal inadvertently sweeps in mid-size health plans such as Sharp Health Plan and Western Health Advantage in Sacramento. We respectfully request that the proposal be modified to apportion the financial burden in a manner that is fair and transparent. We also request that you follow the LAO's recommendation and delay legislative approval until August to allow all parties to develop a fair tax proposal. We also ask that you delay implementation of the tax until July 1, 2016 so that we can build the tax into our rates for the 2016-2017 plan year.

Thank you for your attention to these concerns. Sharp HealthCare and Sharp Health Plan are willing to do our fair share to ensure that California's Medi-Cal budget is fully funded. But the market distortions created by this tax as currently configured would create an uneven playing field that could destroy local, non-profit health plans that have provided great value and delivered excellent member service.

Sincerely,

Michael W. Murphy
President and CEO
Sharp HealthCare

Melissa Hayden-Cook
President and CEO
Sharp Health Plan

cc: Diana Dooley, Secretary, Health and Human Services Agency
Donna Campbell, Office of the Governor
Jennifer Kent, Director, Department of Health Care Services
Mari Cantwell, State Medicaid Director
Adam Dorsey, Department of Finance
Shelley Rouillard, Director, Department of Managed Health Care
Peter Lee, Executive Director, Covered California

Mendocino County Health & Human Services Agency

Mendocino County Health and Human Services Agency
Advisory Board

747 S. State St., Ukiah, CA 95482
707.463-7823 • Fax: 707.472.2335
www.co.mendocino.ca.us/hhsa/advisoryboard

December 17, 2014

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

Re: Covered California Coverage Not Working in Rural California

Dear Director Lee:

Mendocino County is a rural County in Northern California that is situated along the beautiful coast, three hours north of San Francisco and five hours south of the Oregon border. We are a geographically large county, encompassing 3,878 square miles with a population just shy of 90,000 people, 30% of whom are eligible for Medi-Cal benefits. The Health and Human Services Advisory Board, appointed by the Mendocino County Board of Supervisors, is a body of community members working together to support and advise the Director of the Health and Human Services Agency and the Board Supervisors on a full spectrum of health-related issues in Mendocino County. The Advisory Board has been receiving updates on Covered California and its impact on our community. We have prepared this letter to convey our concerns to you, not only for the residents of Mendocino County but also for the residents of other rural counties.

First, we strongly urge Covered California to search out any other insurance plans and encourage them to develop products for rural areas. In Mendocino County, more than 98% of those enrolled in a health exchange plan selected Anthem Blue Cross. The only health insurance options available to Pricing Region One are Anthem Blue Cross PPO and Blue Shield EPO plans. Blue Shield's EPO is problematic in our county because the distance to a contracted hospital does not meet the EPO requirements. As a result, very few individuals have selected that plan. This leaves one plan with a virtual monopoly in our area and in the position of being disinterested in any sort of negotiations about services, plan design or rates.

Our second concern is the provider network that Anthem Blue Cross has claimed for our area. The networks are woefully inadequate and, more importantly, inaccurate. One of our communities searched Anthem Blue Cross' provider directory website for in-network providers serving Fort Bragg. The results of that search and a modest amount of research are included with this letter and clearly illustrate our cause for concern. As you can see, there are a number of issues with the directory. The most significant flaws are: 1) Providers who have not resided or practiced in this area for many years, 2) multiple listings for the same facility or provider - one facility is listed 10 times in the three page directory, and 3) the long distance to many of the providers, exceeding the 20 mile request. While we understand that the Department of Managed

Care sets the standards for health plans, we believe that Covered California should advocate for all consumers to ensure access to services. Covered California should help develop a mechanism to verify both the accuracy and adequacy of the networks that their plans offer.

Third, the lack of specialists is an ongoing problem in rural areas. While we understand that specialty providers are a challenge for many insurance plans, we have noted that some specialists are Anthem Blue Cross providers for "other Anthem products" but not the Covered California product. This information was not available to consumers when they were purchasing these plans. The consequence of this inequity is patients having to try and locate specialists out of the area. This is not an easy process, and when Anthem Blue Cross is contacted about assistance with referrals, consumers have been frustrated about Anthem's lack of staff knowledgeable about our area, the resources available and the distances to those resources.

Finally, all of these challenges have caused some residents of our communities to opt to continue to rely on the sliding scale discounts offered by Mendocino County's health centers. We believe in the goal of health insurance for all, but are concerned that without changes to the plans and how they operate, more eligible people will forgo coverage of any kind.

We thank you for your commitment to expanding access to health care and do hope our comments and suggestions will help to improve Covered California. Please contact us to continue the discussion of these issues in an effort to continue to make Covered California responsive to those who live in our rural areas.

Sincerely,

Susan Baird Kanaan, Chair
Health and Human Services Advisory Board of Mendocino County

cc: Covered California Board of Directors
Senator Mike McGuire
Assembly Member Jim Woods
Assembly Member Wes Chesbro
Senator Noreen Evans
Mendocino County Board of Supervisors
Carmel Angelo, CEO, Mendocino County
Stacey Cryer, Director, Health and Human Services of Mendocino County

Anthem. BlueCross

Find a Medical Group Search Results - Prepared Wednesday, October 01, 2014

Provider Search Criteria: **Role/Specialty:** Medical Group/Multi-Specialty **Location:** 95437, 20 miles **Plan Type:** All Plans

MENDOCINO COAST FAMILY HEALTH CENTER
OB Site Gone > 10 years
Multi-Specialty Clinic
6.4 miles away
445 N Mcpherson St,
Fort Bragg, CA 95437
707-961-4906

PACIFIC PHYSICAL THERAPY
Physical Therapy
7.4 miles away
121 Boatyard Dr Ste A,
Fort Bragg, CA 95437
707-964-1208

ADVENTIST HEALTH PHYSICIANS NETWORK
Multi-Specialty Clinic
35 miles away
19.1 miles away
88 Madrone St,
Willits, CA 95490
707-459-6115

MENDOCINO COMMUNITY HEALTH CLINIC (7MA)
Multi-Specialty Clinic
19.1 miles away
45 Hazel St, Listing 1 of 10
Willits, CA 95490
707-456-9600

EMILY MIRAIE (19C)
Left community > 10 years ago
Professional Management Group
6.6 miles away
510 Cypress St Ste D,
Fort Bragg, CA 95437
707-964-5696

HINSON LARRY D
Closed
Physical Therapy
7.8 miles away
18661 Old Coast Hwy,
Fort Bragg, CA 95437
707-964-5645

GARY MAES (21J)
Does not practice in county
Multi-Specialty Clinic
Listing 1 of 2
19.1 miles away
84 Madrone St,
Willits, CA 95490
707-459-6855

MENDOCINO COMMUNITY HEALTH CLINIC (FQB)
Multi-Specialty Clinic
19.1 miles away
Listing 2 of 10
45 Hazel St,
Willits, CA 95490
707-456-9600

All Same Clinic 35 miles Away

JEFFREY KRAUT MD (16N)
Retired 2011
Professional Management Group
6.6 miles away
510 Cypress St Ste D,
Fort Bragg, CA 95437
707-964-5696

HACKLEY PHYSICAL THERAPY
Listing 1 of 2
Physical Therapy
7.8 miles away
18661 Old Coast Hwy,
Fort Bragg, CA 95437
707-961-6191

GREGORY ROSA (24X)
Listing 1 of 2
Multi-Specialty Clinic
19.1 miles away
Does not practice in county
84 Madrone St,
Willits, CA 95490
707-459-6855

MENDOCINO COMMUNITY HEALTH CLINIC INC (1DD)
Multi-Specialty Clinic
Listing 3 of 10
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-263-7725

WILLIAM MAHON MD (16P)
Retired 2013
Professional Management Group
6.6 miles away
510 Cypress St Ste D,
Fort Bragg, CA 95437
707-964-5696

HACKLEY PHYSICAL THERAPY INC
Listing 2 of 2
Physical Therapy
7.8 miles away
18661 Old Coast Hwy,
Fort Bragg, CA 95437
707-961-6191

NORTHERN CALIFORNIA MEDICAL ASSOCIATES (CM3)
35 miles away
Listing 1 of 2
Multi-Specialty Clinic
19.1 miles away
84 Madrone St,
Willits, CA 95490
707-459-6855

ST ELIZABETH COMMUNITY HOSPITAL
Multi-Specialty Clinic
Adventist Hospital located in another county
19.2 miles away
1 Madrone St,
Willits, CA 95490
707-456-3093

Multiple Locations
Multiple Locations do not account for the total number of listings on all providers

While we make efforts to ensure that our lists of doctors are up to date and accurate, doctors do leave our networks from time to time, and these listings do change. There may be higher fees associated with visiting a doctor who is not in our network or for obtaining a service that is not covered by your plan. You may be responsible for those costs. To avoid higher fees we recommend that you confirm your doctor is in network and that the desired service is covered when scheduling your appointment.

NORTH MENDOCINO COAST FAMILY HEALTH CENTER
Listing 1 of 2

Multi-Specialty Clinic
6.7 miles away
700 River Dr,
Fort Bragg, CA 95437
877-747-5050

LARRY D HINSON RPT
Physical Therapy
Closed
7.8 miles away
18661 Old Coast Hwy,
Fort Bragg, CA 95437
707-964-5645

NORTHERN CALIFORNIA MEDICAL ASSOCIATES INC
35 miles away
Listing 2 of 2
Multi-Specialty Clinic
19.1 miles away
84 Madrone St,
Willits, CA 95490
707-459-6855

BAECHTEL CREEK MED CLINIC
Multi-Specialty Clinic
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

ADVENTIST HEALTH PHYSICIANS NETWORK

Multi-Specialty Clinic
6.8 miles away
721 River Dr Ste C,
Fort Bragg, CA 95437
707-962-0731

GARY MAES (21J)
Does not practice in county
Multi-Specialty Clinic
Listing 2 of 2
12.4 miles away
45081 Little Lake St,
Mendocino, CA 95460
707-937-1055

MENDOCINO COMMUNITY HEALTH CLINIC (2XW)
Multi-Specialty Clinic
Independent Practice Association
Listing 4 of 10
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-263-7725

All Same Clinic 35 miles Away

BAECHTEL CREEK MEDICAL CLINIC (32W)
Multi-Specialty Clinic
Professional Management Group
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

All Same Clinic 35 miles Away

NORTH MENDOCINO COAST FAMILY HEALTH CENTER
Listing 2 of 2

Multi-Specialty Clinic
6.8 miles away
721 River Dr # A,
Fort Bragg, CA 95437
707-961-4631

GREGORY ROSA (24X)
Listing 2 of 2
Does not practice in county
Multi-Specialty Clinic
12.4 miles away
45081 Little Lake St,
Mendocino, CA 95460
707-937-1055

MENDOCINO COMMUNITY HEALTH CLINIC (FQC)
Multi-Specialty Clinic
Professional Management Group
Listing 5 of 10
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-9600

BAECHTEL CREEK MEDICAL CLINIC (RHE)
Multi-Specialty Clinic
Professional Management Group
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

NORTHERN CALIFORNIA MEDICAL ASSOCIATES INC

Multi-Specialty Clinic
6.8 miles away
721 River Dr # A,
Fort Bragg, CA 95437
707-573-6166

NORTHERN CALIFORNIA MEDICAL ASSOCIATES (CM3)
Listing 1 of 2

Multi-Specialty Clinic
12.4 miles away
45081 Little Lake St,
Mendocino, CA 95460
707-937-1055

MENDOCINO COMMUNITY HEALTH CLINIC INC
Listing 6 of 10
Behavioral Health Center
Multi-Specialty Clinic
Fed Qual Hlth Clin
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-9600

DONALD MATHESON MD (07A)
Multi-Specialty Clinic
Professional Management Group
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

Multiple Locations
Multiple Locations do not account for the total number of listings on all providers

While we make efforts to ensure that our lists of doctors are up to date and accurate, doctors do leave our networks from time to time, and these listings do change. There may be higher fees associated with visiting a doctor who is not in our network or for obtaining a service that is not covered by your plan. You may be responsible for those costs. To avoid higher fees we recommend that you confirm your doctor is in network and that the desired service is covered when scheduling your appointment.

SANFORD BROWN (19F)

Professional Management Group

6.9 miles away
815 Sequoia Cir Ste B,
Fort Bragg, CA 95437
707-964-9168

JOHN GALLO MD (15E)

Professional Management Group

Wrong Address
6.9 miles away
855 Sequoia Cir,
Fort Bragg, CA 95437
707-964-7844

MENDOCINO COAST CLINICS INC

Multi-Specialty Clinic

7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251

PACIFIC PHYSICAL THERAPY

Physical Therapy

7.4 miles away
121 Boatyard Dr,
Fort Bragg, CA 95437
707-964-1208

FREDERICK DUMAS MD (16K)

Professional Management Group

13.0 miles away
940 Ukiah St,
Mendocino, CA 95460
707-937-4202

NORTHERN CALIFORNIA MEDICAL ASSOCIATES INC

▲ Listing 2 of 2

Multi-Specialty Clinic

13.0 miles away
45081 Little Lake St,
Mendocino, CA 95460
707-937-1055

LONG VALLEY HEALTH CENTER

Multi-Specialty Clinic

42 miles Away
17.9 miles away
50 Branscomb Rd,
Laytonville, CA 95454
707-984-6131

BROOKTRAILS PHYSICAL THERAPY

Physical Therapy

19.1 miles away
1253 Magnolia St,
Willits, CA 95490
707-459-6772

MENDOCINO COMMUNITY HEALTH - LAKESIDE CLINIC (FQD)

Listing 7 of 10

Multi-Specialty Clinic

19.1 miles away
45 Hazel St,
Willits, CA 95490
707-263-7725

MENDOCINO COMMUNITY HEALTH CLINIC (2XX)

Listing 8 of 10

Multi-Specialty Clinic

19.1 miles away
45 Hazel St,
Willits, CA 95490
707-263-7725

All Same Clinic
35 miles Away

MENDOCINO COMMUNITY HEALTH CLINIC (7ED)

Listing 9 of 10

Multi-Specialty Clinic

19.1 miles away
45 Hazel St,
Willits, CA 95490
707-263-7725

MENDOCINO COMMUNITY HEALTH CLINIC (7EE)

Multi-Specialty Clinic

19.1 miles away
45 Hazel St,
Willits, CA 95490
707-263-7725

Listing 10 of 10

JOHN GLYER MD (09P)

Left Area

Multi-Specialty Clinic

Professional Management Group

35 miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

MARGARET ARNER MD (06Z)

Multi-Specialty Clinic

Professional Management Group

35 miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

MONTE LIEBERFARB MD (09Q)

Multi-Specialty Clinic

Professional Management Group

35 miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

JOHN WILLIAMS (23B)

Professional Management Group

35 miles Away
19.6 miles away
1712 S Main St Ste C,
Willits, CA 95490
707-459-5585

Warning

▲ Multiple Locations

Multiple Locations do not account for the total number of listings on all providers

While we make efforts to ensure that our lists of doctors are up to date and accurate, doctors do leave our networks from time to time, and these listings do change. There may be higher fees associated with visiting a doctor who is not in our network or for obtaining a service that is not covered by your plan. You may be responsible for those costs. To avoid higher fees we recommend that you confirm your doctor is in network and that the desired service is covered when scheduling your appointment.

Anthem. BlueCross

Find a Doctor Search Results – Prepared Wednesday, October 01, 2014

Provider Search Criteria:

Role/Specialty: Doctor/Medical Professional, Family/General Practice, Internal Med

Location: 95437, 20 miles

Plan Type: All Plans

PAUL M LAGOMARSINO MD Retired - not family practice

Family Practice
Orthopedic Surgery (B)
Sports Medicine
6.6 miles away
515 Cypress St,
Fort Bragg, CA 95437
707-961-4560

JOHN GALLO MD Listing 1 of 6

Family Practice (B) Wrong Address
6.9 miles away
855 Sequoia Cir,
Fort Bragg, CA 95437
707-964-7844

CARLA P LONGCHAMP MD Listing 1 of 4

Family Practice 42 Miles Away
18.0 miles away
50 Branscomb Rd,
50 Branscomb Road Number 870
Laytonville, CA 95454
707-984-6131

BARBARA LISA DEFIRMIANE MD Listing 1 of 2

Family Practice (B) Does not practice in area
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-9600

JOHN T WALLACE MD

Internal Medicine
Geriatric Medicine
Retired 2010
6.6 miles away
510 Cypress St Ste A,
Fort Bragg, CA 95437
707-964-4048

LAWRENCE M GOLDYN MD Listing 1 of 4

Internal Medicine
7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251

BRUCE ANDICH MD Listing 1 of 3

Internal Medicine 35 Miles Away
19.1 miles away
88 Madrone St,
Willits, CA 95490
707-459-6115

JOHN GLYER MD Left Area Listing 2 of 5

Family Practice
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-9600

JEFFREY A BERENSON MD Listing 1 of 5

Internal Medicine
6.7 miles away
700 River Dr,
Fort Bragg, CA 95437
707-961-4740

WADE GRAY MD Listing 1 of 3

Family Practice (B)
7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251

BRUCE ANDICH MD Listing 2 of 3

Internal Medicine (B) 35 Miles Away
19.1 miles away
88 Madrone St,
Willits, CA 95490
707-459-6115

MARGARET ARNER MD 35 Miles Away

General Practice (B) Listing 1 of 2
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-9600

JOHN COTTLE JR. DO Listing 1 of 3

Family Practice (B)
6.7 miles away
700 River Dr,
Fort Bragg, CA 95437
707-961-1234

GARY J PACE MD

Family Practice Left Area in 2005
7.0 miles away
205 South St
Fort Bragg, CA 95437
707-964-1251

JOHN GLYER MD Left Area Listing 1 of 5

Family Practice (B)
19.1 miles away
88 Madrone St,
Willits, CA 95490
707-459-6115

THOMAS BERTOLLI MD Listing 1 of 2

Family Practice (B) Does not practice in area
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-9600

(B) =Board Certified Multiple Locations

Multiple Locations do not account for the total number of listings on all providers

While we make efforts to ensure that our lists of doctors are up to date and accurate, doctors do leave our networks from time to time, and these listings do change. There may be higher fees associated with visiting a doctor who is not in our network or for obtaining a service that is not covered by your plan. You may be responsible for those costs. To avoid higher fees we recommend that you confirm your doctor is in network and that the desired service is covered when scheduling your appointment.

JEFFREY BERENSON MD Listing 2 of 5

Internal Medicine (B)

6.7 miles away
700 River Dr,
Fort Bragg, CA 95437
707-961-1234

FREDERICK J DUMAS MD Listing 1 of 5

Does not practice at this site

Family Practice (B)

7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251

Not family practice

BRUCE RANDICH MD Listing 3 of 3

Internal Medicine (B)

35 Miles Away
19.1 miles away
88 Madrone St,
Willits, CA 95490
707-459-6115

MARSHALL KUBOTA MD Listing 1 of 2

Family Practice (B)
HIV/AIDS Specialist

35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-9600

Does not see patients

DAVID NEWELL MD Listing 1 of 4

Left Area

Internal Medicine (B)
Endocrinology & Metabolism (B)

6.8 miles away
721 River Dr,
Fort Bragg, CA 95437
707-961-4631

TARA E MCLEER MD

Family Practice (B)

7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251

THOMAS DUNLAP MD Listing 1 of 5

Cardiovascular Disease (B)

Internal Medicine (B)

35 Miles Away
19.1 miles away
84 Madrone St,
Willits, CA 95490
707-459-6855

GLENN T ROGERS MD Listing 1 of 3

Internal Medicine (B)

35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-468-1010

JOHN COTTLE JR. DO Listing 2 of 3

Family Practice (B)

6.8 miles away
721 River Dr,
Fort Bragg, CA 95437
707-961-4631

LAWRENCE M GOLDYN MD Listing 2 of 4

Internal Medicine

7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251

THOMAS DUNLAP MD Listing 2 of 5

Cardiovascular Disease

Internal Medicine

35 Miles Away
19.1 miles away
84 Madrone St,
Willits, CA 95490
707-459-6855

SARAH F ALVORD MD

Internal Medicine (B)

35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-467-2269

Does not practice in area

JOHN GALLO MD Listing 2 of 6

Family Practice (B)

6.8 miles away
721 River Dr,
Fort Bragg, CA 95437
707-964-7241

PAYNE M LEVENTHAL MD

Retired 2019 - not family practice

Family Practice

7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251

GENA MADAIR MD

Family Practice

35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-3900

Does not practice in area

ACE BARASH MD Listing 1 of 4

Internal Medicine (B)

35 Miles Away
19.2 miles away
1 Madrone St,
Willits, CA 95490
707-459-6801

JENNIFER KREGER MD Listing 1 of 2

Family Practice (B)

6.8 miles away
721 River Dr,
Fort Bragg, CA 95437
707-961-4631

LAWRENCE GOLDYN MD Listing 3 of 4

Internal Medicine
HIV/AIDS Specialist

7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251

GUY TERAN MD Listing 1 of 3

Internal Medicine

35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-9600

Does not practice in area

ACE BARASH MD Listing 2 of 4

Internal Medicine

35 Miles Away
19.2 miles away
1 Madrone St,
Willits, CA 95490
707-459-6801

(B) =Board Certified

Multiple Locations

Multiple Locations do not account for the total number of listings on all providers

While we make efforts to ensure that our lists of doctors are up to date and accurate, doctors do leave our networks from time to time, and these listings do change. There may be higher fees associated with visiting a doctor who is not in our network or for obtaining a service that is not covered by your plan. You may be responsible for those costs. To avoid higher fees we recommend that you confirm your doctor is in network and that the desired service is covered when scheduling your appointment.

JOEL SHEBOWICH MD
Family Practice (B)
6.8 miles away
721 River Dr,
Fort Bragg, CA 95437
707-961-4631
Does not practice in area

GRAY WADE J
Listing 2 of 3
Family Practice
7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251

BARRY R SHEPPARD MD
Family Practice
35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-3900

JOHN R GLYER MD
▲ Left Area
Listing 4 of 5
Family Practice (B)
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

JOHN COTTLE JR. DO
▲ Listing 3 of 3
Family Practice (B)
6.8 miles away
721 River Dr # A,
Fort Bragg, CA 95437
707-961-4631

LARRY I HEISS MD
Listing 1 of 2
Internal Medicine
7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251
Retired 2012

JOHN R GLYER MD
▲ Left Area
Listing 3 of 5
Family Practice (B)
35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-3900

MONTE I LIEBERFARB MD Listing 1 of 3
Family Practice (B)
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

DAVID NEWELL MD
▲ Listing 2 of 4
Internal Medicine (B)
Endocrinology & Metabolism (B)
6.8 miles away
721 River Dr # A,
Fort Bragg, CA 95437
707-964-7241
Left Area

DAWN CORTLAND MD
Internal Medicine (B)
7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251
Does not practice in area

THOMAS W LUCK MD
Internal Medicine (B)
Allergy/Immunology (B)
35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-3900
Left Area

MARGARET ARNER MD
Listing 2 of 2
General Practice (B)
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

DAVID C NEWELL MD
Listing 3 of 4
Internal Medicine
6.8 miles away
721 River Dr Ste A,
Fort Bragg, CA 95437
707-964-7241
Left Area

LAWRENCE GOLDYN MD Listing 4 of 4
Internal Medicine
HIV/AIDS Specialist
Infectious Disease
7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251

GUY TERAN MD
Listing 2 of 3
Internal Medicine
35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-9600
Does not practice in area

CARLA LONGCHAMP MD Listing 2 of 4
Family Practice (B)
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

DIANE I HARRIS MD
Family Practice
6.8 miles away
721 River Dr Ste A,
Fort Bragg, CA 95437
707-964-7241

PAUL M LAGOMARSINO MD
▲ Retired - not family practice
Family Practice
Orthopedic Surgery (B)
Sports Medicine
7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251

STEVEN WIRTH MD
Family Practice (B)
35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-9600
Does not practice in area

DONALD MILLS MATHESON MD
Listing 1 of 3
Family Practice (B)
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

(B) =Board Certified ▲ Multiple Locations

Multiple Locations do not account for the total number of listings on all providers

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JOHN GALLO MD
Listing 3 of 6
Family Practice B
6.8 miles away
721 River Dr # A,
Fort Bragg, CA 95437
707-964-7241

LARRY I HEISS MD
Listing 2 of 2
Family Practice
7.0 miles away
Retired 2012
205 South St,
Fort Bragg, CA 95437
707-964-1251

BARBARA DE FIRMIAN MD
Listing 2 of 2
Family Practice B
35 Miles Away
19.1 miles away
Does not practice in area
45 Hazel St,
Willits, CA 95490
707-456-3900

GLENN T ROGERS MD
Listing 2 of 3
Internal Medicine B
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

WENDY G MARTIN MD
Family Practice
6.8 miles away
Left Area 10 years ago
721 River Dr Ste A,
Fort Bragg, CA 95437
707-964-7241

GRAY WADE J
Listing 3 of 3
Family Practice
7.0 miles away
205 South St,
Fort Bragg, CA 95437
707-964-1251

JORGE A ALLENDE JR MD
Does not practice in area
Internal Medicine B
35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-3900

JOHN GLYER MD
Left Area
Listing 5 of 5
Family Practice B
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

JOHN L GALLO MD
Listing 4 of 6
Family Practice
6.8 miles away
721 River Dr Ste A,
Fort Bragg, CA 95437
707-961-4631

DUMAS III FREDERICK J
Listing 2 of 5
Internal Medicine
13.0 miles away
940 Ukiah St,
Mendocino, CA 95460
707-937-4202

GUY R TERAN MD
Listing 3 of 3
Internal Medicine
35 Miles Away
19.1 miles away
Does not practice in area
45 Hazel St,
Willits, CA 95490
707-456-3900

MONTE I LIEBERFARB MD
Listing 2 of 3
Family Practice
Emergency Medicine
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

GALLO JOHN L
Listing 5 of 6
Family Practice
6.8 miles away
721 River Dr # A,
Fort Bragg, CA 95437
707-961-4631

DUMAS III FREDERICK J
Listing 3 of 5
Internal Medicine
13.0 miles away
940 Ukiah St,
Mendocino, CA 95460
707-937-4202

JETHRO T RITTER DO
Internal Medicine
35 Miles Away
19.1 miles away
Does not practice in area
45 Hazel St,
Willits, CA 95490
707-456-3900

ANGUS D MATHESON MD
Listing 1 of 2
Family Practice
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

GALLO JOHN L
Listing 6 of 6
Family Practice
6.8 miles away
721 River Dr,
Fort Bragg, CA 95437
707-964-7241

JEFFREY A BERENSON MD
Listing 3 of 5
Internal Medicine
13.0 miles away
45081 Little Lake St,
Mendocino, CA 95460
707-937-1055

VANESSA L MALLO MD
Family Practice
35 Miles Away
19.1 miles away
Does not practice in area
45 Hazel St,
Willits, CA 95490
707-456-3900

DONALD MATHESON MD
Listing 2 of 3
Family Practice B
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

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JANICE L KIRSCH MD Left Area 10 years ago
Internal Medicine
6.8 miles away
721 River Dr Ste A,
Fort Bragg, CA 95437
707-964-7241

JEFFREY BERENSON MD Listing 4 of 5
Internal Medicine
13.0 miles away
45081 Little Lake St,
Mendocino, CA 95460
707-937-1055

MICHAEL A CARNEVALE DO Left Area 5 years ago
Internal Medicine B
35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-3900

CARLA P LONGCHAMP MD Listing 3 of 4
▲
Family Practice
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

JAMES W SWALLOW MD
Internal Medicine
6.8 miles away
721 River Dr Ste A,
Fort Bragg, CA 95437
707-961-4631

DONALD HOPKINS MD Listing 1 of 2
Cardiovascular Disease
Internal Medicine
Interventional Cardiology
13.0 miles away
45081 Little Lake St,
Mendocino, CA 95460
707-937-1055

STEVEN C WIRTH MD
Family Practice B
35 Miles Away
19.1 miles away
Does not practice in area
45 Hazel St,
Willits, CA 95490
707-467-2269

MONTE LIEBERFARB MD Listing 3 of 3
Family Practice B
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

RICHARD E SACKS WILNER MD
Internal Medicine
Left Area
6.8 miles away
721 River Dr Ste A,
Fort Bragg, CA 95437
707-964-7241

FREDERICK DUMAS III MD Listing 4 of 5
Internal Medicine
13.0 miles away
940 Ukiah St,
Mendocino, CA 95460
707-937-4202

ACE BARASH MD ▲Listing 3 of 4
Internal Medicine B
35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-9600

ANGUS MATHESON MD Listing 2 of 2
Family Practice B
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

BENJAMIN GRAHAM JR MD
Internal Medicine
6.8 miles away
721 River Dr Ste A,
Fort Bragg, CA 95437
707-964-7241

DONALD HOPKINS MD Listing 2 of 2
Cardiovascular Disease B
Internal Medicine B
Interventional Cardiology
13.0 miles away
45081 Little Lake St,
Mendocino, CA 95460
707-937-1055

ACE BARASH MD ▲Listing 4 of 4
Internal Medicine
35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-9600

DONALD M MATHESON MD Listing 3 of 3
Family Practice B
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

DAVID NEWELL MD Listing 4 of 4
Internal Medicine
Left Area
6.8 miles away
721 River Dr # A,
Fort Bragg, CA 95437
707-964-7241

FREDERICK DUMAS III MD Listing 5 of 5
Internal Medicine
13.0 miles away
940 Ukiah St,
Mendocino, CA 95460
707-937-4202

CHARLES J SEAGE MD
Internal Medicine B
35 Miles Away
19.1 miles away
Does not practice in area
45 Hazel St,
Willits, CA 95490
707-456-3900

CARLA LONGCHAMP MD Listing 4 of 4
Family Practice B
35 Miles Away
19.3 miles away
1245 S Main St,
Willits, CA 95490
707-459-6861

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JENNIFER KREGER MD
Listing 2 of 2
Family Practice (B)
6.8 miles away
721 River Dr # A,
Fort Bragg, CA 95437
707-961-4631

JEFFREY BERENSON MD Listing 5 of 5
Internal Medicine (B)
13.0 miles away
45081 Little Lake St,
Mendocino, CA 95460
707-937-1055

GLENN T ROGERS MD
Listing 3 of 3
Internal Medicine
35 Miles Away
19.1 miles away
45 Hazel St,
Willits, CA 95490
707-456-3900

JOHN P WILLIAMS DO
Listing 1 of 3
Internal Medicine
35 Miles Away
19.6 miles away
1712 S Main St Ste C,
Willits, CA 95490
707-459-5585

~~**PAUL D ABRAMSON MD**~~
~~*Family Practice*~~
Hasn't practiced in > 10 years
~~6.8 miles away~~
~~721 River Dr Ste A,~~
~~Fort Bragg, CA 95437~~
~~707-964-7241~~

SHARON PALTIN MD
Listing 1 of 2
Family Practice (B)
42 Miles Away
17.9 miles away
50 Branscomb Rd,
Laytonville, CA 95454
707-984-6131

~~**MARSHALL KUBOTA MD** Listing 2 of 2~~
~~*HIV/AIDS Specialist*~~
~~35 Miles Away~~
~~19.1 miles away~~
~~45 Hazel St,~~
~~Willits, CA 95490~~
~~707-456-9600~~
Does not see patients

JOHN WILLIAMS DO
Listing 2 of 3
Internal Medicine
35 Miles Away
19.6 miles away
1712 S Main St Ste C,
Willits, CA 95490
707-459-5585

SANFORD BROWN MD
Family Practice
Occupational Medicine
6.9 miles away
815 Sequoia Cir Ste B,
Fort Bragg, CA 95437
707-964-9168

CINDY NORVELL MD
Family Practice (B)
42 Miles Away
18.0 miles away
50 Branscomb Rd,
50 Branscomb Road Number 870
Laytonville, CA 95454
707-984-6131

~~**THOMAS A BERTOLLI MD** Listing 2 of 2~~
~~*Family Practice* (B)~~
~~35 Miles Away~~
~~19.1 miles away~~
~~45 Hazel St,~~
~~Willits, CA 95490~~
~~707-456-3900~~
Does not practice in area

JOHN WILLIAMS MD
Listing 3 of 3
Internal Medicine
35 Miles Away
19.6 miles away
1712 S Main St Ste C,
Willits, CA 95490
707-459-5585

~~**CLAIRE P WILLIAMS MD**~~
~~*Family Practice*~~
Does not practice in area
~~6.9 miles away~~
~~850 Sequoia Cir~~
~~Fort Bragg, CA 95437~~
~~707-964-0259~~

SHARON PALTIN MD
Listing 2 of 2
Family Practice (B)
42 Miles Away
18.0 miles away
50 Branscomb Rd,
50 Branscomb Road Number 870
Laytonville, CA 95454
707-984-6131

Warning
Visit the following link to know more about "how Blue Precision works" (or read the full program details).

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COVERED CALIFORNIA

February 2, 2015

Ms. Susan Baird Kanaan
Health and Human Services Advisory Board of Mendocino County
747 S. State St.
Ukiah, CA, 95482

Dear Ms. Kanaan,

We appreciate your comments and share your commitment to improve our efforts in your county and in all rural areas of the state. To do this, it takes meaningful feedback from rural partners. With regard to your specific recommendations, we offer the comments below:

First, we strongly urge Covered California to search out any other insurance plans and encourage them to develop products for rural areas…

Covered California recognizes some regions have less plan choice than others, and we have proposed to increase choice in your county and similar areas by allowing new health plan entrants to apply to participate in the Exchange beginning January 1, 2016. The recommendation was approved at our January 15, 2015 Board meeting. Additionally, Covered California, as an active purchaser model, has had multiple discussions with our current contracted health plans and have asked that they look to increase coverage by expanding to areas where there is limited plan choice. Our current contracted plans will be given first consideration in the 2016 applicant pool. This would represent a change in direction from new entrant and certification policies developed over the last two years, as a reaction to the need for more meaningful consumer choice.

Our second concern is the provider directory network that Anthem Blue Cross has claimed for our area. The networks are woefully inadequate and, more importantly inaccurate…

Because provider directories are dynamic, it is difficult to capture a fully accurate directory at any point in time. Additionally, there were new products on the 2014 individual marketplace from our contracted health plans, with varying networks, that caused more provider directory confusion than usual. These issues are further exacerbated in areas where people must travel further to see a doctor. Covered California takes the concern of inaccurate provider directories very seriously and is working hard this year to help our plans communicate more clearly to providers that they are in the Covered California network, especially by enlisting help of provider organizations such as California Medical Association (CMA). Additionally, we require quarterly provider network detail to be submitted to Covered California so we can monitor plan network changes and proactively be alerted to issues that may be problematic to consumers. This will allow us to reach out to plans and work with them to understand network concerns and potentially enrich network availability if possible.

It is important to note that the Covered California Anthem and Blue Shield networks were recently reviewed in a non-routine survey by the Department of Managed Health Care (DMHC). Results revealed in November 2014 showed multiple deficiency areas, for which these plans are taking corrective action. There is a follow-up survey planned for six months after the initial report was issued. We will continue to monitor the situation closely.

We appreciate the submission of specific Anthem provider directory results from your county and compared them with our most recent provider submission from October 24th, 2014, and with Anthem's current website information. It appears many of the inconsistencies have been fixed, either by removal from the directory or updates to the correct provider address. We also provided your information to Anthem so the remaining corrections could be investigated and changes could be made.

Third, the lack of specialists is an ongoing problem in rural areas. While we understand that specialty providers are a challenge for many insurance plans, we have noted that some specialists are Anthem Blue Cross providers for "other Anthem Products" but not the Covered California product…

As you stated, specialist networks are uniquely challenging in rural areas. When building new Covered California products, health plans were forced to balance offering products with affordable premiums while maintaining networks that met regulatory approval. We also understand the challenges of fewer providers in a community (and therefore less competition), and the added costs of providing care far from specialty or tertiary care resources can make it more difficult to form contract agreements. If your group would like to provide examples of specialists in other Anthem product networks that are not included in their exchange products, we can work with Anthem to see if it is feasible to add the specialists to their on-Exchange product. Currently, consumers can search the Covered California Anthem networks, including many specialist categories, through the Anthem provider directory link on our "Plan Preview" feature at covered.ca.com.

Thank you again for sharing your experiences, and we look forward to continued partnering and creative thinking to improve our market offerings where there is limited consumer carrier and network choice that fulfill the needs of your community.

Sincerely,

Anne E Price

Anne E. Price
Covered California
Director of Plan Management

2 March 2015

Jennifer Kent
Director, Department of Health Care Services

Peter Lee
Director, Covered California

Re: CalHEERS 24-Month Roadmap and AB1296 process

Dear Ms. Kent and Mr. Lee,

As consumer advocates we are proud of the successes California has had in enrolling millions of Californians into Medi-Cal and Covered California over the past year and a half and of the partnership we have had with your agencies in achieving these successes. We understand that CalHEERS had to be stood up in a very short timeframe and that the usual processes for testing and input were not feasible. However, we are concerned that core eligibility functionality is still missing from CalHEERS and that there is not sufficient transparency and stakeholder engagement in setting the policies and priorities for CalHEERS.

AB 1296 (Bonilla 2011) requires the Department, Covered California and the Health and Human Services Agency to provide:

> a process for receiving and acting on stakeholder suggestions regarding the functionality of [CalHEERS], including the activities of all entities providing eligibility screening to ensure the correct eligibility rules and requirements are being used. This process shall include consumers and their advocates, be conducted no less than quarterly, and include the recording, review, and analysis of potential defects or enhancements of the eligibility systems. The process shall also include regular updates on the work to analyze, prioritize, and implement corrections to confirmed defects and proposed enhancements, and to monitor screening." Cal. Welf. & Inst. § 15926 (l).

While there have been AB1296 meetings at least quarterly and your staffs have provided some updates regarding CalHEERS changes we have not had an opportunity as stakeholders to give input into these priorities. We have requested for many months a comprehensive list of CalHEERS change requests and an opportunity to give input into those priorities. On February 12, 2015, there was an AB 1296 meeting at which we were given the calendar/chart version of the 24-month Roadmap and a five-page summary list of the change requests (CRs) but without sufficient detail to understand the parameters of the CRs. We requested the definitions/descriptions of the CRs in whatever format your staffs could most easily give them to us but have not yet received those. We hope to receive those as soon as possible and to have a meaningful venue at which to give input into the Roadmap once we have reviewed the definitions. In the meantime offer the following input on version 11 of the Roadmap dated February 11, 2015.

Moving forward we recommend that there be monthly AB1296 meetings and that they be conducted similar to the process we used with you for comments on the Single Streamlined Application, notices, etc. where we receive materials ahead of time, have an opportunity to give our feedback and get a response on what recommendations you are accepting, modifying, and rejecting.

Correct Eligibility Determinations and Enrollments Must Be the Top Priority

While the #1 business goal stated for the Roadmap is to "ensure consumers receive accurate & timely eligibility determination and correct plan enrollment" the Roadmap does not reflect this top priority in a number of places. Correct eligibility determinations for the **Former Foster Youth Medi-Cal program** for former foster youth up to age 26 is not slated to be programmed until February 2016 and the **Medi-Cal Access Program** is listed on the CR list as "TBD." The Medi-Cal Access Program (formerly AIM) is an "insurance affordability program" just as Medi-Cal and Covered California are. It is a CHIP program which is required by federal and state law to be programmed into the Single Streamlined Application. Advocates were not informed until August 2013 that it had not been included at all, we have been repeatedly assured it would be included, and now it is not even scheduled on the Roadmap. Similarly, expanding **full-scope Medi-Cal to pregnant women with incomes up to 138% FPL** which was adopted in the budget last summer, is expected to be approved any day and we were assured already had a CR is not scheduled until release 15.5 in May. As to the Former Foster Youth Medi-Cal program we have repeatedly raised that CalHEERS does not properly enroll eligible youth into the program. These youth should not be asked for income information at all, yet they are currently made to fill out a full application and many are being wrongly enrolled into Covered California coverage when they are eligible for free Medi-Cal.

There are a list of **income-related CRs** which are not scheduled until April 2016. We cannot assess how broad their impact is until we see their definitions. For example, one is simply listed as "MAGI 5% disregard" and we were told it may only impact parents and caretaker relatives but we have not been provided the definition. If these income level fixes impact what program consumers are being determined eligible for – a likely assumption with the information we have – we request that they be implemented more quickly as well. Similarly, we request that **CRs related to immigration status including PRUCOL** be implemented as soon as possible.

There is a significant problem related to plan enrollment that we are uncertain whether it is included on the Roadmap. Currently, when a consumer reports a change such as change in income she is **terminated from and reenrolled into the same Covered California plan**. Unless a consumer is moving in or out of a Cost-Sharing Reduction plan, these are unlawful terminations and cause consumers gaps in coverage and difficulties in tracking deductibles, out-of-pocket costs, and create more complex reporting than required at tax time. Please advise whether there is a CR addressing this problem and when it is scheduled to be employed.

Notices

We have called to your attention through multiple venues the very serious problems with the accuracy and understandability of the Covered California/Medi-Cal notices and the multiple, conflicting notices received by some consumers. We appreciate that some fixes have been implemented to address the multiple notices and that Covered California convened a workgroup to improve the readability of the NOD01s (Notice of Decision 1) which is the first notice a consumer receives after applying through the joint application. We request that DHCS follow-through on convening a similar **workgroup on the NOD02s and that both your departments continue to address the accuracy of the notices**. We sent you notices just last week which indicate some ongoing programming problems resulting in incorrect information.

We are happy to see that SB 1341 (Mitchell) which moves notices from CalHEERS to SAWS is on the Roadmap but we are distressed to see that AB 617 (Nazarian) is not included. AB 617 among other things requires a joint Covered California / Medi-Cal notice as opposed to the current functionality whereby consumers get an eligibility result online, then get a mailed NOD01 advising of Covered California eligibility and likely Medi-Cal eligibility and then get a mailed NOD02 advising of final Medi-Cal eligibility. This is very confusing for consumers. We request that **AB 617 be implemented concurrently with SB 1341** and that consumer advocates be included in the design sessions for this piece.

Lower Priority Items

Your staff fairly told us that we cannot only ask to move items earlier in the Roadmap but that, given how tight the schedule is, we should also make recommendations regarding what can be moved later in the schedule. Accordingly we suggest delaying the following components to allow earlier programming of CRs needed for correct eligibility determinations:

- **Online Medi-Cal Health Plan Selection**. While we would like to see this functionality at some point, because Medi-Cal enrollees have a paper process for plan selection this is not as important as eligibility-related CRs. It is currently scheduled for the September 2015 release – well ahead of CRs needed for correct eligibility determinations.

- **DMV Residency Verification**. This implicates a larger policy issue as well as an IT issue. Consumers going into Covered California can self-attest their residency, e.g. whether they live in California, but the Administration required that Medi-Cal consumers verify their residency. Because residency verification could not be done electronically and was so significantly contributing to the Medi-Cal backlog last year verification of residency was suspended – a decision we support. Given the complexity

of the build of this verification system and the lack of data that self-attestation of residency has led to ineligible people getting into Medi-Cal we strongly urge the Administration to eliminate this verification requirement altogether or at a minimum continue its suspension until core eligibility functionality is programmed.

- **Medi-Cal Programs Already in SAWS**. The Roadmap proposes programming the rules for several Medi-Cal programs including Transitional Medi-Cal, Continuous Eligibility for Children, Continuous Eligibility for Pregnant Women into CalHEERS in September 2015. These programs are very important to consumers but our understanding is that they are already in SAWS and that they can continue to run through SAWS. Given that, we do not understand why they are prioritized over other core Medi-Cal eligibility functionality.

Again, we await the definitions of the CRs which will allow more precise assessment of the priorities in the Roadmap, but wanted to share our initial thoughts based on what we have at this time. We look forward to continuing to work with you to make ACA implementation in California a success.

Sincerely,

Elizabeth A. Landsberg, Western Center on Law and Poverty

Sonal Ambegaokar, National Health Law Program
Jessica Haspel, Children Now
Lynn Kersey, Maternal and Child Health Access
Gabrielle Lessard, National Immigration Law Center
Linda Leu, Young Invincibles
Patricia McGinnis, California Advocates for Nursing Home Reform
Cori Racela, Neighborhood Legal Services of Los Angeles County
Cary Sanders, California Pan-Ethnic Health Network
Julie Silas, Consumers Union
Sonya Vasquez, Community Health Councils
Doreena Wong, Asian Americans Advancing Justice - Los Angeles
Anthony Wright, Health Access California
Silvia Yee, Disability Rights Education and Defense Fund

cc: Diana Dooley, Health and Human Services Secretary; Chair, Covered California Board
The Honorable Susan Bonilla
Karen Ruiz, Director, CalHEERS
Frank Mecca and Cathy Senderling, County Welfare Directors Association
Donna Campbell, Office of the Governor
Marjorie Swartz, Office of the Senate President Pro Tempore
Agnes Lee, Office of the Speaker of the Assembly

February 27, 2015

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

RE: Small Business Health Options Program

Dear Mr. Lee,

As Covered California has just ended its second open enrollment period, we would like to congratulate the board and staff on a job well done. We are pleased to see 474,000 additional Californians selecting affordable, quality healthcare coverage through Covered California. With this open enrollment period now behind us, we urge Covered California to renew its focus on the second marketplace Covered California is responsible for, the Small Business Health Options Program (SHOP).

Only about half of small businesses with fewer than 50 workers currently are able to offer health insurance to their workers. What's more, those that do provide coverage historically have paid 18% more for their insurance compared to larger businesses. And on top of that, small businesses often lack a human resources department, which means offering health insurance is yet another administrative burden borne by the business owner. The good news is that SHOP was created to help correct these inequalities.

We believe SHOP has the potential to make health insurance more affordable and less administratively burdensome. While the first year of SHOP's operation saw low enrollment, a non-functional online enrollment portal, delays in paying agent commissions and other operational challenges, we are encouraged by recent improvements made to the program, and encourage Covered California to continue refining this important marketplace.

This coming year will be an important time for Covered California to focus on making SHOP more functional and competitive. Later this fall, about 70% of the small group market will finally move into plans that comply with the Affordable Care Act (ACA). This is a huge opportunity for SHOP to pick up market share from businesses that have been sitting on the sidelines for the past year, renewing their non-ACA compliant plans. Furthermore, firms with 51 to 100 workers will become eligible to enroll in SHOP at the same time, for coverage beginning in 2016. We urge Covered California to start working now to inform small business owners about SHOP so when it comes time to make a decision later this year, they will understand SHOP's value proposition.

SHOP remains a top priority for the business community, and we make the following recommendations to help ensure that SHOP continues to improve and enrollment continues to grow:

- **Launch an outreach and education program:** Covered California smartly created an outreach and education program in July 2013 to educate small business owners about SHOP by issuing grants to business organizations throughout the state. However, this program has recently ended and there is currently no replacement plan. Given the challenges with SHOP in 2014 and the significant changes coming in 2015, we believe an outreach program should continue. In a few months, many small firms will receive notice that their current insurance policies will be cancelled. This has the potential to cause mass confusion and frustration if a significant outreach and education campaign is not waged.

- **Provide more resources for agents:** As certified insurance agents are the entities responsible for enrolling employers in SHOP coverage, they are SHOP's de-facto sales team. We encourage Covered California to draw from agents' vast experience and seek their input on policy and operational decisions, keep them apprised of all the latest developments and provide them with comprehensive training on SHOP. To date, some agents have expressed a lack of resources and information necessary to help them sell SHOP. We are encouraged to hear that agent commissions are almost on track to be paid in a more timely manner.

- **Launch an online enrollment portal:** SHOP initially offered online enrollment, but that portal was pulled offline after three months of operation proved that the system was not working for employers, employees or agents. More than a year later, no replacement portal has been created, leaving mail and fax the only options to enroll in SHOP. Most state-run marketplaces now have an online enrollment portal, plus the healthcare law requires this feature. We encourage Covered California to commit to launching an improved web portal this year.

Thank you for your consideration. We appreciate the dedication of Covered California and its SHOP team and we look forward to working with you to continue to improve SHOP in 2015.

Sincerely,

John Arensmeyer
Founder & CEO
Small Business Majority

Pat Fong Kushida
President & CEO
California Asian Pacific Chamber of Commerce

Patricia Gardner
Executive Director
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