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

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

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

Board members present during roll call:
Diana S. Dooley, chair
Kimberly Belshé
Paul Fearer

Board members absent:
Susan Kennedy

Agenda Item II: Closed Session

Chairwoman Dooley called the meeting to order at 1:30 p.m. A conflict disclosure was performed; there were no conflicts from the board members that needed to be disclosed.

Agenda Item III: Approval of Board Meeting Minutes

After asking if there were any changes to be made, Chairwoman Dooley asked for a motion to approve the minutes from the meeting held December 15, 2014.

Presentation: December 15, 2014, Minutes

Discussion: None

Public Comment: None

Motion/Action: Board Member Fearer moved to approve the December 15, 2014, minutes. Board Member Belshé seconded the motion.

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

Agenda Item IV: Executive Director's Report

Discussion: Election of Board Chair

Motion/Action: Board Member Fearer moved to reappoint Chairwoman Dooley as Board Chair minutes. Board Member Belshé seconded the motion.

Discussion: None

Public Comment: None

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

Chairwoman Dooley accepted the appointment.

Discussion: Announcement of Closed Session Actions
Peter Lee, Executive Director announced the appointment of Lizelda Lopez as Deputy Director of Public Affairs. Ms. Lopez has been working for Ogilvy. Juli Baker is retiring from her position as Chief Technology Officer. Sue Johnsrud has agreed to serve as acting Chief Technology Officer in the interim.

The Board extended John Bertko's contract for actuarial services through 2016. The Board also discussed contracting matters regarding Accenture and referred issues to staff.

Discussion: Executive Director's Update

Presentation: Executive Director's Report

Staff shared a range of material in the appendix online. One report among the posted research reports examines window-shopping for insurance. California is one of two states that provides a standardized total cost estimate, which he sees as critical. The report also identifies good things other states are doing. Colorado has drug lookup, for example.

Discussion: Open Enrollment 2015 Update
Mr. Lee said that we are two-thirds of the way through the second open enrollment period. January 15 was the last day to enroll for February 1 coverage. There is exactly one month left.

Covered California is learning and applying its lessons. The system is working four times as fast as it was a year ago in high-volume times. There are now landing pages in Chinese, Vietnamese, Tagalog, and Vietnamese, containing translated materials. Mr. Lee thanked Asian Americans Advancing Justice for their help.

Every seat is filled in the state service centers, and there are also hundreds of temporary service center staff members to help with the call volumes through the end of open enrollment. In the beginning of January, 50 percent of the calls were answered in thirty seconds. Average hold time is down. Between 91 and 99 percent of quick-sort transfers happen within thirty seconds. The partnership with the counties is incredibly productive.

The federal government continues to report on early renewal figures. However, those are not paid (effectuated) renewals. California won't know if people have actually paid until late February so there will be no report yet on effectuated renewals. However, there has been high engagement and good follow-up by staff. Staff is working to ensure those determined eligible for Medi-Cal have continuity of care. The organization has also clarified that those who want to stay with their own plans can, but at their own expense. They would not receive subsidies. Next year, staff would like to send out notices earlier.

As of January 12, 228,766 new individuals signed up and chose a plan. Of those enrolling, 88 percent are subsidy eligible, which is consistent with last year's numbers. Mr. Lee presented a chart of the ethnic demographics represented in the enrollment numbers. African-American enrollment is similar to what it was last year, but he noted that many more African-American consumers have been determined eligible for Covered California but have not yet chosen a plan. This means investments in African-American media have paid off. Twice as many in the African-American community have been determined eligible and have picked a plan. People are coming in the door, but they need help getting across the finish line. African-American consumers are also enrolling in Medi-Cal. They expect the demographic to get younger as open enrollment proceeds.

There has been a decrease in self-serve enrollment. This is good news. People are being encouraged to obtain help. The large number of enrollers on the ground are prepared to do this work.

The percentage of people enrolled in the various metal tiers is the same as last year.

As of January 5, media coverage will be enhanced. Messages are being sent out to reassure those feeling insecure about immigration status.

The penalty is twice as high this year as it was last year. It is now 2 percent of annual income. Messages will be sent out about this and the value of subsidies. Tax forms 1095 and 1095A are going to be sent out. Service Center staff will be increased to help people with 1095 and 1095A tax issues. They are trying to ensure that the notices about penalties go out before it's too late for people to enroll.

Discussion:
Board Member Belshé asked if self-service enrollment included those applying online and via paper application.

Mr. Lee clarified that self-serve means mailing in an application with no assistance, or applying online. They encourage people not to do paper applications, which are more likely to be incorrect.

Board Member Belshé would like to see data on those two methods of enrollment broken out. She also wondered if IT problems could be causing the drop in self-enrollment.

Mr. Lee noted that the drop in unassisted enrollment correlates with an increase in people being helped by the service center or other enrollment assistance. They are monitoring problems with the website. Usually enrollment assisters quickly let them know about problems. They are sure this isn't just IT problems.

Board Member Belshé wondered if there was a breakdown by service channel about those who are not completing applications.

Mr. Lee said they are analyzing that data now, on those who have eligibility determinations but have not chosen plans. They would anticipate that most of these people are self-serve. Assisters will largely be trying to get people to the end point. They will focus on reaching out to those who are subsidy eligible but haven't completed enrollment.

Board Member Belshé would like to hear reports back on that.

Mr. Lee noted they have been logging and reporting how long people spend on each page, as well as where they tend to drop off. Most fall off at a natural point that shows it's not an IT issue; it's a cognitive issue. They are pausing to think about what plan to choose. Staff will be doing outbound calls and working with their partners to get people into plans that work for them.

Board Member Fearer wanted context for the numbers. There will be no comprehensive picture for a while. He does not know how to interpret the numbers—is there any early sense of if it's likely that total enrollment will grow or not? Will we reach our goals? He worries about misinterpretation or misrepresentation of the numbers.

Mr. Lee stated that they know that many people wait until the last minute. They expect a spike before open enrollment closes. The goal was to enroll 500,000 new members. Mr. Lee feels it is likely they will meet this. On the renewal front, there are 1.2 million eligible for renewal. It is estimated that 85 percent of those enrolled will pay and effectuate coverage, but it is not known for sure yet how many will. It would be 1.7 million enrollees, minus the 15 percent that don't pay. The organization is confident that there will be substantially more people enrolled this year because of renewals and growth.

Discussion: Legislative Update

David Panush, Director of External Affairs, presented a legislative update. The legislature is back in session and bills are being introduced.

SB4 is a reintroduction of legislation from last year, attempted to provide coverage for undocumented Californians. SB 26 would create an all-payer claims database. SB 43 becomes a senate vehicle for a discussion on reauthorization of the essential health benefits.

Mr. Lee noted there are updates on payment to agents and enrollment assisters in the appendix. California now has over 450 storefronts. As of now, the service center staff will be working seven days a week until February 15.

Public Comment:
Betsy Imholz, Director of Special Projects, Consumers Union, congratulated the Board on the enrollment numbers, and especially on its success in reaching Latino and African-American communities. Regarding those who haven't chosen a plan yet, it's a health literacy problem and it's only going to get worse. About 26 percent go into bronze plans, as they did last year, and a good percentage of those are eligible for cost-sharing reductions and should be in silver plans. They want to steer people to the right plans. There's more work to be done to guide people. This should be a priority.

Jen Flory, Senior Attorney, Western Center on Law & Poverty, congratulated the Board on the numbers. Ms. Flory spoke about their concerns about those transitioning into Medi-Cal last month. Staff has been good at trying to resolve problems as they arise, but they are still working to ensure that that happens and those cases are resolved. The notices were insufficient and did not build in enough time. At the last meeting, they also voiced concerns about the notices. The notices are still going out in the same manner, but they appreciate that staff is getting together a work group. Hopefully these notices will be greatly improved. Many advocates have been trying to work with DHCS and Covered California to get a say in what the CalHEERS programming priorities are. Many people with unique situations need various workarounds. They would like to continue to work with staff to ensure everyone gets health care.

Nicole Stefko, Senior Program Coordinator, California Primary Care Association, voiced that it was exciting to hear that the call times are lower. The CECs are still experiencing forty-five-minute to one-hour wait times with consumers in front of them. It might be important to divert some staff to the help line.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), congratulated the Board on greater enrollment numbers. CPEHN would love to see more data. They are interested in disaggregated data in ethnic groups and whether it is clear that there needs to be more of an emphasis on health plan selection within particular groups. You can't tell what's going on with the API number. It would be good to see what types of follow-up information is needed. They still want to help increase the response to the ethnicity and language question. It looks like up to 1/3 of newly eligible did not respond. They would like to identify strategies for encouraging more responses to those questions to help tell us more about quality and access. Ms. Sanders said they are pleased about the service center information, though there are still waiting times. One person called into the Chinese line, and there were twenty-five people ahead of her on the line.

Sonal Ambegaokar, Senior Attorney, National Health Law Program and the Health Consumer Alliance, thanked the staff for all its work. Ms. Ambegaokar said they were disappointed not to have seen renewal numbers. They would like to find out in February

if those who were auto-enrolled changed plans and if people who had formerly received subsidies ended up without subsidies. The notices about Medi-Cal eligibility were found to be insufficient. People only had a few days to take action. Consumers need to know they can appeal and keep Covered California coverage if they are in the middle of treatment. They can do so with premium assistance. Former foster care youth are not being properly screened for Medi-Cal. She urged the board to step up the training for reconciliation.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, voiced that the health plans are starting to think about the upcoming special enrollment period and the need to create a verification process. There are challenges with regards to CalHEERS priorities. They are hoping to see a presentation to the Board in March.

Doreena Wong, Project Director, Asian Americans Advancing Justice, thanked Mr. Lee for coming to Los Angeles for a press conference to reach out to the community. The conference included interviews in over a dozen languages. They are seeing many community members coming in with issues regarding the transition between Medi-Cal and Covered California. Maybe some nonresponses are because of the way the ethnicity question is asked. Insurance agents may not know to ask the question and may require further training. The disaggregated API data should be shared before open enrollment is over. She agreed with Mr. Lee's statement that it's harder to do the outreach and enrollment during this open-enrollment period. Their navigators are spending a lot of time on renewals. A lot of them have questions and issues dealing with insurance agents. It's important for us to understand why people aren't choosing plans.

Sonya Vasquez, Policy Director, Community Health Councils, echoed the comments about data. At the advisory committee meeting the new marketing contracts were introduced, and it was exciting to see their work, specifically in communities of color. But since this was the first time that they had heard about the new organizations involved, Ms. Vasquez would like to be better connected with them. Covered California has been talking about tax information since day 1, and this will be so important to get it out soon. It would be nice if there were a link to local programs for the purpose of personal referrals.

Linda Leu, California Research and Policy Director, Young Invincibles, was excited that the numbers looked great and was thankful for all of the improvements, including the landing pages and websites that are now available in multiple languages. Not everyone is familiar with tax forms. She echoed Ms. Vasquez's point about providing resources for free tax help. Many people don't have access to tax preparers. Ms. Leu's organization would love to see the disaggregated data too, especially as it relates to the ethnic breakdown of young enrollees.

Brett Johnson, Associate Director of Medical and Regulatory Policy, California Medical Association, echoed Ms. Flory's and Ms. Ambegaokar's comments regarding transition to Medi-Cal and the notices. Many members are having trouble with the sharing of information on primary care physicians—Covered California should make sure that data

is being passed along. This would go a long way in regards to improving continuity of care.

Regina Wilson, California Black Media, echoed the comments about the advisory committee coordination with the contractors. There's no comprehensive plan or real structure in place. When the RFP opens again, they should be in that conversation. She is trying to digest what the numbers truly mean right now, especially as they pertain to the African-American community.

Beth Capell, Health Access California, echoed the comments of the consumer advocates. They had a different view than their health plan colleagues regarding self-attestation, which they are in favor of. They would like call center metrics for health care specifically. Last year, they heard reports about people trying to reach health plans, and believes that their county partners might look very good compared to the health plan partners in this regard, but they hope for supporting data. Regarding the transition to Medi-Cal, this problem will never go away, so figuring out how to transition right will be important. After the open enrollment period, lots of people will still have tax questions for the call centers. They look forward to data on gender and sexual identity being included on CalHEERS.

Mr. Lee spoke to the issue of picking the right plan. They are reaching out right now to those who chose bronze plans and are eligible for cost-sharing support or to those who picked platinum or gold and may have another possible plan that better fits their medical and financial needs. California does better at this than other states, but this is a complex and important issue. They did not do a good job this year with the Medi-Cal transition notices. They take those comments seriously. Yesterday they hosted a call with more than 2,000 people on it about reconciliation and the 1095A tax forms. This is new, so there will be many questions. Particularly for low-income individuals and families, the tax issue will be challenging. Many low-income people may have been doing 1040EZs, and now cannot. Mr. Lee noted that they have a comprehensive plan and structure for reaching the targeted communities. They are adding on the ground resources through a competitive bid process. They are now learning how to network them with existing resources.

Agenda Item V: Covered California Policy and Action Items

Mr. Lee noted that meaningful choice does not mean infinite choice. Adding more plans that are not substantially different is not necessarily an advantage.

Presentation: Covered California Policy Items

Discussion: Adoption of 2016 Qualified Health Plan Recertification and New Entrant Regulations

Anne Price, Director of Plan Management, presented. They will consider new carriers that are Medi-Cal managed care plans or newly licensed in all regions. She presented new entrants' selection criteria. Those wishing to enter in underrepresented regions will also

be considered. Regions 3 and 6 have been removed because their existing QHPs have offered to expand into those service areas. During final selection, first consideration will be given to 2015 contracted QHPs who propose expansion of coverage and then to those who increase consumer choice within their given region.

The other policy slides had not changed since December's presentation.

Discussion:
Board Member Belshé wondered about the staff recommendation to consider alternative benefit designs for SHOP plans.

In the individual market, we are interested in having standardized benefit designs for continuity in the first few years. In the SHOP market, it's a different market, and alternative benefit designs will make it more attractive for some groups. This continues in the existing policy.

Mr. Lee noted that altering the policy this year, when they could not be sure there would be three or more plans available, makes sense. In 2017, all plans will be considered. This is the right balance of being consumer-centered. Newly licensed plans can bid and they are encouraged to bid in all regions. The regions they care most about are places where consumers have fewer choices.

Motion/Action: Board Member Fearer moved to accept the staff's recommendation. Board Member Belshé seconded the motion.

Public Comment:
Beth Capell, Health Access California, stated that it's important to add choice for those who have only one or two plans in their regions. In the California Labor Federation, this Board has always recognized that employer coverage is foundational to the success of the Affordable Care Act. Employers providing coverage is critical to the success of the act. The employer responsibility requirement is going into effect this year. Unfortunately, the current federal guidance allows a loophole. This loophole allows carriers that market to large employers the ability to offer subminimum value coverage (coverage that is less than 60 percent minimum value). The Board has in its packet an example of such a carrier offering such coverage to employers encouraging them to offer it to low-wage and high-turnover employees. If they accept this, these employees cannot enroll in Covered California and if they get sick, they will face substantial out of pocket costs. People who would otherwise be entitled to the subsidies will be denied access to them. Some of these will end up in the Medi-Cal program. She asked for a contract amendment consistent with the policy concerns they've raised.

Betsy Imholz, Director of Special Projects, Consumers Union, supported the staff proposal. They appreciated the initial approach and there is such a thing as too much or too little choice. They appreciated the current QHPs who stepped forward to expand. They support deferring alternative benefit designs for now too.

Sonal Ambegaokar, Senior Attorney, National Health Law Program and the Health Consumer Alliance, also supported the staff recommendation. They thanked staff for requiring plans to provide specific network data. Covered California should review this more frequently to require corrective action. It would help to include more stringent standards for network adequacy too. She thanked Covered California for requiring more details in the formulary. They also encourage the adoption of some HEDIS and CAHPs measures.

Janice Rocco, Deputy Commissioner, Department of Insurance, believes that the selection of the 2016 entrants is a key decision for this year. She asked that the Board decide the carriers. The Board's hands can be tied as an active purchaser. The addition of plans in the regions with only one or two is critical, but considering additional carriers in other counties is important too. If you allow more carriers, you might have more people able to access subsidies and keep their doctors. It is currently clear that the existing QHP expansion precludes the inclusion of other carriers. You're protecting the existing QHPs and that may not best serve Californians.

Brett Johnson, Associate Director of Medical and Regulatory Policy, California Medical Association, supported Ms. Ambegaokar's comment about network adequacy standards. He wanted clarification in terms of the network changes—network expansions will be encouraged in some areas. He wondered if we're talking about within or across regions and what would be the circumstances in which Covered California would not approve a network expansion in a region.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, stated the largest issue is the timing of the submission of the rates. We request it be moved back to June. In 2013, they were able to complete it in the timeframe and still have a June due date. For the SHOP, there is no open enrollment and we would like to have those due in the fall for the SHOP like last year. There are requirements with data interfaces with Pinnacle for the SHOP so we wanted to request a more reasonable time frame.

Tracie Stafford, United Ways of California, asked the Board to consider the importance of deductibles and cost-sharing decisions that can make plans more affordable. There are challenges for those who haven't had insurance before. Anything that would increase the expense, especially in the bronze plan, should be carefully considered.

Mr. Lee responded that open enrollment is earlier this year than it was last year. Network adequacy and expansion is less about regional expansion. We are not looking for smaller networks in a region. Making sure that there are enough hospitals and doctors to add enrollment capacity is something that we hope for and will continue to look towards in the coming year.

Ms. Price said the time frame needed to be moved up because all negotiations happened in a few days last year, and that was too fast. The time is needed for the actuaries to do their work and analysis to go into it. Open enrollment will happen October 1, too.

Mr. Lee said their early policy asking people to engage early has served them well.

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

Discussion: Adoption of 2016 Standard Benefit Design Regulations
Mr. Lee said the next meeting will feature a discussion of specialty drugs because that issue needs more time.

Ms. Price asked for approval of the regulations. There is one change in the gold plan. The max out of pocket was reduced, but had to include modest copay increases. The presented AVs are the preliminary AVs. They will have an ad hoc group convene to begin work to review the current specialty drugs across formularies and health plans, particularly where drugs are used to treat chronic conditions. If there are any changes, they will return in March with those and regulations can be done in time for plans to include that in their pricing. She presented a list of the only other changes, which clarify certain areas in benefit categories that were ambiguous or resulted in variability. None of these affect the AV.

She presented updates relating to SHOP, mostly minor changes so that plans would comply with the AV.

Discussion:
Mr. Lee thanked DMHC and the Department of Insurance for working toward clearly stating and resolving complex insurance issues. The changes made on the individual side are anchored in the need to be clear and standardized. California's success is partly making complicated things as simple as possible. Good standard designs so consumers can access care.

Motion/Action: Board Member Belshé moved to approve the staff recommendation. Board Member Fearer seconded the motion.

Public Comment:
Beth Capell, Health Access California, echoed Mr. Lee's sentiment about this being a national model and the changes representing an improvement over what was good work already. She acknowledged the staff's responsiveness to their concerns about specialty drugs. The bronze plan pays nothing until someone pays $6,500 out of pocket. There are a number of key issues, including the requirement that if there's a single tablet drug regimen, such as the AIDs drug cocktail, it must be covered. Most or all of the drugs treating a condition cannot be on the highest tier. Drugs must not be based solely on price, but on medical guidance. These are important policy issues and they have learned a lot. The drug benefits in the individual market are very different this year than those in the employer market. Networks have similarly changed this year. This issue has risen on the agenda because of these changes.

Jerry Jeffe, California Chronic Care Coalition, strongly endorses the creation of the ad hoc committee. They have one of the most extensive databases on specialty drugs and are involved nationwide. In the Governor's budget, there's a call for an ad hoc group to examine this issue. Mr. Jeffe suggested that these efforts be combined, with a liaison or staff member sharing information. In the budget, however, there are no specific details for such a position. On the topic of mental health parity, he ran by the information in the PowerPoint to about 20 legislative advocates, and nobody expressed any objection about the contents.

Janice Rocco, Deputy Commissioner of Health Policy and Reform, California Department of Insurance, echoed the comments of those before her. She thought this would come back to the Board in March if it says "if changes are being proposed." She is hopeful it will come back in March.

Betsy Imholz, Director of Special Projects, Consumers Union, thanked Covered California for all the modeling. The AV calculator is a tough task-master. Affordability will always be an issue. The proposal strikes the right balance. Deductibles are more uniform and co-insurance went down. They volunteered for the ad hoc group, too. They appreciate the staff's dedication to consumer education and reiterate the importance of consumer literacy. Health insurance is really hard, and even the most educated consumers will have difficulty understanding health care plans.

Mr. Lee noted that the issue of drugs and drug pricing will always be with us. He commended an op-ed talking about looking at affordability generally, but also specifically for individuals. The vast majority of Covered California plans cover single-dose drug therapy, not just in the specialty tier. We need to be able to wrestle with the issues of high drug costs, what's too high, and what's the right thing for pharmaceutical companies to do in terms of what they charge. We will come back to the issue of affordability and access, both collectively and individually.

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

Discussion: Revision to Navigator Payment Policy

Mr. Lee noted that this is a great example of our learning. Much work has been done by navigators to help people renew and enroll. As we approach our second enrollment period, the focus will be on supporting navigators to help get people enrolled.

Mary Watanabe, Acting Deputy Director of Sales Division, presented background on the navigator grants. There has been a lot of anxiety out in the field. The amount of support being provided to consumers, particularly in language, is more extensive than anticipated. Staff is thus recommending a change to the policy.

Performance measurement changes are being discussed. They'd like to change from effectuated coverage to enrollment assistance through plan selection. That change alone will allow navigator grantees to get to the next payment. Those who don't get to that

level can demonstrate work progress and goals through a narrative report. They are asking the Board to approve the policy change.

Discussion:
Board Member Belshé asked if this specifically relates to the next 50 percent payment or all future payments.

Peter recognized that program staff is recommending that Covered California consider this for future payments, but this would only apply to this one.

Ms. Belshé is not sure she is comfortable moving away from effectuation for all payments.

Mr. Lee said this is a timing issue but also impacts what Covered California is holding people to account for. Long time lags for nonprofits are a real struggle. The enrollment would be used for this one. Then staff would come back to the Board.

Staff is recommending still basing payments on performance, but on enrollment, not effectuation. They could also demonstrate their work in a narrative report.

Covered California's goal is not to change the enrollment goals, but to change how it is counted. This enables faster payment, and only for the second 25 percent payment.

This is new. Hundreds of groups are out there doing the work, already needing to front money to pay their staffs. Staff is trying to stay mindful of that.

Motion/Action: Board Member Belshé moved to approve the staff recommendation. Board Member Fearer seconded the motion.

Mr. Lee noted that if they do outbound calls, they'll enroll people on the phone when possible. In-language enrollment is critical.

Public Comment:
Doreena Wong, Project Director, Asian Americans Advancing Justice, appreciated this and felt Ms. Watanabe did a good job of explaining why these changes are so crucial. It is harder this time to enroll people. A lot of their activities are not quantifiable. They appreciate staff's recommendation to make it easier to get credit for the time they are spending and to redefine the assistance they are doing. They are assisting enrollments. Their groups cannot absorb the costs that that work takes. There needs to be payment for the work they are doing now.

Autumn Ogden, Policy Analyst, California Coverage & Health Initiatives, thanked staff for working with them. This has been a challenging process. They strongly support this policy change, which demonstrates all the work being done without credit.

Sonya Vasquez, Policy Director, Community Health Councils, agreed with this. For CECs to do outreach and troubleshooting, it has been very difficult on the application reimbursements. The navigator program provides flexibility to do other unquantifiable services. These changes move the navigator program to allow that kind of work to be done successfully and employees to be paid appropriately.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), supported the comments of colleagues and staff. There is value in the work of the community partners working in language. They have heard the same thing. It is taking longer to enroll people than they thought, and people need more help. Health plan selection takes time. One group in the Bay Area has translated a CMS glossary of terms all on their own without payment. This was done in order to explain to its community. This work is happening, but not being counted. It will be important to look at the definitions of terms and how we talk about health insurance.

Kathleen Hamilton, Director, The Children's Partnership, agreed with Ms. Ogden, voicing appreciation and support for the staff recommendation. These recommendations will provide the flexibility needed to allow the staff to properly evaluate the work that navigators and community assistors are doing.

Nicole Stefko, Senior Program Coordinator, California Primary Care Association, seconded the comments from Ms. Ogden and the other advocates and thanked staff members. They are fantastic staff members and appreciate their footwork that got to this thoughtful analysis. It took lots of time, travel and listening.

Pleshette Robertson, Sac Cultural Hub Media Foundation, said she is a living testimony. She subscribes to Covered California. She applauded this payment policy. There are so many nonprofits that are devoted and committed to this work. They spend so much time helping people. She requested marketing materials by July 1.

Mari Lopez, Policy Director, Visión y Compromiso, agreed with Ms. Wong, Ms. Sanders, and other advocates, and believes that it's going to take time to adjust. Concepts like insurance need clarification, but also financial obligations. This education effort will require continued hard work and dedication to be successful.

Betty Williams, Subcontractor, Sac Cultural Hub, also thanked staff, who addressed all of her concerns. She is excited and her organization supports this. Their staff started in September so they do need to be paid. More training was needed. They talked about the payment that was no longer happening for outreach and marketing. So many things were taken away, and this will help them survive through the next session. They need that extra enrollment. She applauded staff for listening.

Tracie Stafford, United Ways of California, agreed with the other comments. She added how much time is really being spent on customer service. About a quarter of the time they spend results in Covered California enrollment. The rest is just consumer interaction and assistance, renewals, questions, and helping those who go on to enroll online.

Another grant is needed when you take into consideration the amount of work that goes into outreach, education, events, and the follow up to ensure first payment.

Linda Leu, California Research and Policy Director, Young Invincibles, urged support for the staff recommendations.

Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law & Poverty, voiced strong support for the recommendation. Her group has no personal stake, but this is hard work.

Betsy Imholz, Director of Special Projects, Consumers Union, agreed. Her organization are not navigators, but this is hard work.

Mr. Lee said he was on a call with other states earlier in the week. New York has partnered with Marvel Comics to have superheroes promote enrollment. Our superheroes are the navigators and the dream team staff, who are committed to what they are doing. California is succeeding because of what is being done in communities around the state. Over 600 events will happen between now and the end of enrollment, and many are through these organizations, plus hundreds of storefronts.

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

Discussion: Certified Application Counselor Program Regulations

Ms. Watanabe noted that recommendations will be coming out for navigators and in-person assistance in upcoming months.

She highlighted who the consumer assistance groups are because they are adding two new groups to their list of community partners and enrollment assistance programs. They are proposing adding Medi-Cal managed care plans to the enroller list. She discussed whose payments were governed by federal regulations, state regulations, or neither.

"Certified enrollment counselors" in this case meant those working for a $58 per applicant fee. Though those working under navigator grants are often called that in terms of their role of providing enrollment assistance, they are called "navigators" for this purpose. "Certified application counselors," were also being added to the list, work for organizations who have a financial interest in enrolling people.

She reviewed the regulations, which were presented last January. There was not a significant difference between in-person assisters not working for pay, but federal regulations require the implementation of this program. The changes reflect new federal requirements. They are also trying to align this with the other programs as much as possible. Some changes provide clarity or reduce redundancy.

Staff are recommending that they keep paying for fingerprinting through the end of the year. There are also changes to roles and responsibilities. These are to align with other

requirements. The suspension and revocation regulations are all very similar to those in the existing programs.

Discussion: Medi-Cal Managed Care Enrollment Program Regulations
Staff are hoping to move forward quickly to allow Medi-Cal managed care plans to participate in enrollment efforts. They have a long history of enrolling low-income families. They also have a long history of providing culturally and linguistically appropriate service. They are applying many of the same requirements to them as to the QHPs.

Discussion: None

Public Comment:
Sumi Sousa, San Francisco Health Plan, was happy to see this make its way forward and hopes it will be swiftly implemented.

Sonya Vasquez, Policy Director, Community Health Councils, acknowledged that if the staff had their way, there would be one program, but the federal government added a lot of things. For the most part, the regulations are fine, but there should be a seamless process for CECs who are going to become CACs. There will be a process so that current CECs' training and fingerprinting will be acknowledged. There will likely be organizations that move back and forth between programs, so ensure that that is considered. It would be good to try to make this seamless for the consumer so it's not confusing in regards to new terminology.

Autumn Ogden, Policy Analyst, California Coverage & Health Initiatives, thanked staff for taking their feedback, echoed Ms. Vasquez's comments, and supported the extension of the fingerprinting. This will be an unpaid program, and we need to look at ways to entice people to be enrollment entities. They are also concerned about funding going to Medi-Cal enrollments. We should find ways to maintain that going forward and keep the integrity of that program intact.

Doreena Wong, Project Director, Asian Americans Advancing Justice, supported the comments about the staff recommendations. They appreciate that Covered California is covering the cost of the fingerprinting and checks at least through December of next year, but hope the organization will consider doing it permanently. They hope this would be part of the program to cover those costs and integrate it into the budget. They would like to see managed-care enrollers as closely aligned as possible. A lot of their partners also enroll into Medi-Cal.

Nicole Stefko, Senior Program Coordinator, California Primary Care Association, echoed the prior comments. They support the continuation of AB 82 funding; the data shows how important it is to have a person to talk to about health insurance. We're changing the culture. We should maximize people on the ground that consumers have access to. It would be important to maintain a seamless transition between programs, perhaps with prepopulated applications and fingerprints still counting.

Joann Priest, Community Clinic Association of Los Angeles County, echoed the prior comments. She thanked Covered California for their engagement so far, particularly regarding covering the cost of the background checks. We are asking entities to transition to being unpaid, so the process should be as seamless as possible.

Mari Lopez, Policy Director, Visión y Compromiso, agreed and supported the staff recommendations. A seamless process is strongly recommended.

Ms. Watanabe stated that they want to make it as seamless as possible. They will engage with their stakeholders on the wording.

Chairwoman Dooley voiced appreciation for the acknowledgement that the federal government determines some of what must become policy.

Mr. Lee appreciated the note that we ended up with a long list of entities. From a consumer's point of view though, the organization seeks to have unified terminology that is not confusing. Consumers just want to know where they can get free, confidential, and reliable information.

Agenda Item VI: Adjournment

The meeting was adjourned at 3:55 p.m.