CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD
April 16, 2015
Covered California Tahoe Auditorium
1601 Exposition Blvd.
Sacramento, CA 95815

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

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

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

Board members absent: None

Agenda Item II: Closed Session

Chairwoman Dooley called the meeting to order at 11:39 a.m. A conflict disclosure was performed; there were no conflicts from the Board members that needed to be disclosed.

She stated that the Board may periodically notice an offsite open meeting location. This was not necessary today.

Agenda Item III: Introduction of New Board Members

Chairwoman Dooley introduced and welcomed new Board Members Genoveva Islas, from Tulare, and Marty Morgenstern, a labor leader of note. There is a lot to learn for everyone, but we are a nimble and learning organization.

Board Member Islas stated that she was happy to be here and looking forward to contributing.

Board Member Morgenstern was also excited to be here. He read through the prior meeting notes and appreciated Board Member Belshé's parting remarks about how the members of this organization are making history together.

Agenda Item IV: 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 March 5, 2015.

Presentation: March 5, 2015, Minutes

Discussion: None

Public Comment: None

Motion/Action: Board Member Morgenstern moved to approve the March 5, 2015, minutes. Board Member Fearer seconded the motion.

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

Agenda Item V: Executive Director's Report
Mr. Lee, Executive Director, welcomed the new Board members.

Presentation: Executive Director's Report

Discussion: Announcement of Closed Session Actions
The Board discussed litigation.

Mr. Lee announced the appointment of a new Director of Marketing, Colleen Stevens. Covered California has started an RFP process to find a new marketing vendor.

The Board extended its contract with Cambria for IT support for some design issues.

Discussion: Executive Director's Update
Mr. Lee stated that we will be discussing provider networks and quality rating systems. These discussions will inform future policy decisions. There will be no recommended action for standard benefit design at this meeting. This is a complex issue.

Mr. Lee presented a 24-month roadmap. CoveredCA.com is a joint initiative with the Department of Health Care Services (DHCS) and together have worked through an Information Technology (IT) road map plan together. The IT system is big and complex. It touches consumers but also dozens of IT systems. Making changes is difficult. The AB1296 stakeholder group will provide input. He noted that not everything that everyone wants will happen in the first two months.

Media clips are posted online. Many of the clips are related to taxes and tax season. Many research documents are also posted, many related to tax refunds, premium changes, etc. Staff also shared public comments directed to the Board. When individual comments containing personal information are received, those comments are not shared online but only with the Board. Senators Boxer and Feinstein would like pregnancy to be a special qualifying event for the special enrollment period. The federal government doesn't feel that they have the authority to do that, so staff doesn't feel it has the authority either. Staff is gratified that California makes coverage easily accessible to pregnant women. The birth of a child is a qualifying event. But this is an issue that is currently impacted by guard rails.

Mr. Lee presented an enrollment update on the "not knowing about the tax penalty" as a qualifying event special enrollment period. More than 22,000 people have signed up for that reason so far and 52,000 others enrolled because they qualified for other reasons, such as getting out of jail, losing coverage, getting married, or moving. That's a little over 30,000 a month.

Mr. Lee presented a 1095-A (Health Insurance Marketplace Statement) update. Covered California sent out nearly 900,000 forms. Revised forms were sent out in the case of an error. If a revised form is received, you don't have to refile unless you want to. Staff has been working to resolve disputes. For consumers who did not get their forms in a timely fashion, it's a huge inconvenience.

Mr. Lee shared a calendar of upcoming Board meetings. The budget will be up for adoption in June. Today's navigator discussion will have ramifications on the budget.

Mr. Lee presented an update on the Small Business Health Options Program (SHOP), which will now be called Covered California for Small Business instead of SHOP. Next week a new print ad will run. Consumers, employees of small businesses, and small business owners can choose plans that are good for them. About 15,600 are enrolled in Covered California for Small Business so far. There have been great improvements on getting businesses enrolled and online. Staff has also had struggles getting payments out to agents. Hopefully all will be caught up in May and June. Mr. Lee voiced that he looks forward to having an automated system soon so this won't be a problem anymore. Fall will be important for sales. There will be more print ads coming out.

Discussion: Quality Rating System and Essential Community Provider Update
Mr. Lee thanked Dr. Jeff Rideout, Senior Medical Advisor, for his able service to Covered California. He ensures Covered California is working with clinicians and groups. Dr. Rideout will be moving to the Integrated Health Association. Covered California has appreciated his great work. Dr. Rideout said it's been a privilege to have been on board.

Dr. Rideout noted that the quality ratings system (QRS) has been one of the more challenging topics. Covered California is moving through a transition year. In 2016, the federal government will produce a quality rating system for everyone. Covered California has anticipated that for three years.

This system has been Consumer Assessment of Healthcare Providers and Systems (CAHPS (a member experience survey) based and has been based on a regional benchmark. California used the most questions among the various states. The organization stayed away from clinical measures. The survey was based on historic performance and on commercial or Medicare populations, because California didn't have our own experience. They are not split into a category such as HMO versus PPO. Each state can choose what to report publically. California is the only state that will be using this information to report publically. This is the first time California has ever had

exchange enrollee information. Plans are not required to sample the same way. The federal government wanted plans to sample SHOP and the individual exchange the same way. They didn't want to have distinction between off- and on-exchange enrollments. For this year, there are about eight different ways that the health plans are sampling. Staff don't see member-specific information. Staff felt it was important to use this information to avoid having a "dark" year with no ratings system. Staff recommends going from a four-star to a five-star rating system. This is where the federal standards will go and will help differentiate the plans. The site will continue not differentiating into HMO, PPO, etc. Staff recommends starting to use more national benchmarks instead of just regional.

The three domains being reported on are Access to Care, Doctors and Care, and Plan Service.

One of the hurdles is that Covered California will not get the benchmarks until August and open enrollment begins in October. CalHEERS has its work to do.

Mr. Lee reiterated that having good transparency and reporting enables consumers to make good decisions. Within the Covered California website, the choice display will be updated in 2016. This is an element on the 24-month roadmap.

Board Member Islas asked how we are accommodating the respondents' language needs.

Dr. Rideout stated that surveys are provided in multiple languages. On a related note, CMS is considering including cultural competency as a measure as well.

Dr. Rideout presented on essential community providers. Covered California has been thinking about access and what that means. Provider network adequacy is a regulatory function. Covered California has responsibility for ensuring there are sufficient essential community providers and that low-income consumers have care where they live.

There is broad choice within the range of products offered on the exchange. The regulators and plans are working hard to ensure provider directories are accurate.

In the past, the Board recommended how to administer the federal requirement related to essential community provider (ECP) networks. California was much more specific than the federal government. California chose to focus on the county level, geographically. The Board added several other categories beyond 340B, feeling those were somewhat limited. Staff has mapped every ECP and created a reference list for the plans. We now know by plan and product how each is doing in terms of their ECP networks. Staff meets quarterly with the plans to discuss the standards. There has been tremendous improvement.

There are still challenges with certain types of ECPs. Now most enrollees are enrolled with carriers meeting requirements and who have four or more ECPs. Using the 340B designation may not be the best approach to this issue. All 340B providers are treated the same, though some may be specialty providers. The federal government uses 30 percent

as a threshold, and that may not be the best way to go, to ensure access to primary care. Many safety net providers are still left out because they don't have the 340B designation. Does Covered California want to keep pushing on 340B designation or can we be cleverer about where enrollees actually get their care?

Staff has been asking, what can we do to match where enrollees live to their care? It helps that we know where people live and how much they earn. Have been mapping inhabited zip code based on income level, and have identified those zip codes with the most low-income Covered California enrollees. You can map these with all kinds of services. They examined the zip codes by rating region, not state. As Covered California obtains more sophisticated software, we'll know what health centers are in adjacent zip codes, too. Plan partners can ensure they're contracting with health centers in the lowest-income zip codes. Dr. Rideout thanked NAACP because they voiced that their big concern was having more physicians in these networks who serve low-income individuals. Low-income individuals receive 50 percent of their health care from primary-care physicians.

The 340B and related designations are an important starting point, but we need to understand access at a much more local point and from all providers. Covered California must move the needle in areas that need more access.

Mr. Lee said this kind of deep analysis is a part of ensuring access to care. Covered California will be doing further analysis and receiving comments. But as part of this contract year, the organization will also use this information as part of negotiations with health plans. The organization is not ready to change the standards; more analysis is needed, but this information helps.

Mr. Lee noted that in the last month, the service center staff has been exceeding the service-level targets. This is good and brings up what can we afford on an ongoing basis.

Public Comment:
Betsy Imholz, Director of Special Projects, Consumers Union, welcomed the new Board Members. She represents the policy and advocacy arm of Consumer Reports. They support putting caps on coinsurance and reducing co-pays on specialty drugs. The most important thing is getting it right, so if the Board needs more time to bring down co-pays, then Consumers Union is fully in support of that. In regards to the QRS, Consumers Union is so proud of the Board's decision last year to put quality measures up with premium prices to allow the consumer to choose plans not just based on premiums, but also based on customer service. They hope to be part of the Get Insured displays, making sure that consumers can adequately receive information. In regards to essential community providers, Consumers Union appreciates breaking out beyond the 340B designation; breaking it down by community is very important in negotiations. With regard to special enrollment periods, Consumers Union wants to emphasize the importance of public education and including that topic in the agenda for new marketing firms.

Jen Flory, Senior Attorney, Western Center on Law & Poverty and the Health Consumer Alliance, wanted to echo Ms. Imholz's praise for the Board going ahead with the quality rating system early. Ms. Flory's group are thrilled with how Covered California is really trying to do a deeper dive into the data and particularly how they are looking at some of the access issues and how those affect lower-income enrollees. The largest number of special enrollees are those transferring from Medi-Cal to Covered California. The biggest challenge has been the seamless transfer of individuals from Medi-Cal to Covered California with their plan effective that very next month. Ms. Flory's group are starting to identify what the technical problems are with this transfer and also identifying other issues such as a lack of consumer information for a quick transfer and difficulty due to the payment needing to be effectuated. Looking at the budget, they have identified under-resourcing in the appeals area. There is a backlog of consumer appeals and Ms. Flory's group would like to see more staff dedicated to that.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), welcomed the new Board members. CPEHN appreciates the extra time that Covered California has spent considering the issue of specialty drugs. CPEHN shares the concerns over the affordability of monthly prescriptions for consumers, even with the current cap. They wanted to thank Dr. Rideout for his work on the quality rating system and the essential community providers. CPEHN hopes to continue to have conversations about future results on this data. To answer Board Member Islas's question, the surveys will be offered by CMS in Spanish, English, and Chinese. CPEHN would love to be able to discuss the results of those surveys, even if sample sizes are low. It is believed that the ability to see how people are experiencing their healthcare across subpopulations is important. In regards to the health-disparities-reduction questions about access to interpreters and whether care was culturally competent, CPEHN would appreciate getting a report back about how that testing went this year. These reports would help CPEHN consider the efficacy of using those questions in the quality rating system in the future.

David Chase, California Director, Small Business Majority, noted that they are pleased to see that there are over one thousand agents that have successfully enrolled small businesses in the Covered California for Small Business program. Mr. Chase's group are pleased to see that the agent commission issue is being resolved. Covered California is urged to not rely too heavily upon agents for marketing purposes. While agents play an important role in marketing, their hands will be full this fall. There will be small-group expansion during the individual open enrollment period, so Covered California should be out there networking before then.

On phone: Meaghan McCamman, Senior Program Coordinator, California Primary Care Association, thanked Dr. Rideout and Covered California for working at such a granular level. This work will really help guide policies and contracting with QHPs. Ms. McCamman encouraged looking at language and cultural needs. Some who are very embedded within a specific subculture have been passed over. Holding QHPs responsible for ensuring language and cultural competence will be helpful. Ms. McCamman encouraged staff, when assessing what is currently offered in each county, to look at clinics and health centers with multiple sites. Dr. Rideout had only listed one or two

clinics in Kern County, but one of those has 20 sites. Staff should look at those site by site rather than organization by organization.

Doreena Wong, Project Director, Asian Americans Advancing Justice (AAAJ), shared that their organization is a statewide collaborative that does outreach education and enrollment to Asian, Pacific Islander communities. Ms. Wong welcomed new Board members and thanked Board Member Islas for her comments about language issues. The Office of the Patient Advocate has a survey about this and everyone can learn from the results. It's great that providers can be mapped out by zip code; AAAJ would like to see the race and ethnicity mapped with provider lists. For example, San Gabriel Valley has a large Asian community, but only one clinic serving them.

Brett Johnson, Associate Director of Medical and Regulatory Policy, California Medical Association (CMA), concurred with Ms. McCamman's comments and others' in regards to Dr. Rideout's work with ECPs. CMA strongly supports updating the ECP definition. A lot of CMAs members are still worried about the QRS. There are so many metrics out there. CMA does not want this to become duplicative in terms of administrative burdens.

Beth Capell, Health Access California, stated that her group is pleased to see enrollment numbers closer to what they'd expect. Special enrollment will be an important part of the organization's success and business model. Ms. Capell's group appreciated that from the beginning consumers could choose based not just on price, but also on quality. Ms. Capell hopes going forward to look at QRS by language, race/ethnicity, and income, since Covered California has the unusual ability to do that. In regards to ECPs, Ms. Capell's group is pleased to see the progress toward mapping at a zip-code level. Income is only one of the social determinants of health. Race, education, language, and other factors are important too. To the extent that Covered California can encourage the development of provider capacity in what have historically been underserved areas, that will help lead the way on implementation of the Affordable Care Act. That additional demand would encourage additional providers.

Mr. Lee also appreciated and will keep sharing special enrollment figures. The number of people who lost coverage didn't just include those losing Medi-Cal, but also those who lost other coverage. Staff will keep working on smooth transitions. He believes that zip-code specific mapping could be misleading since it's not examined by county; if you are looking at clinics that might be located nearby, there could be another clinic right next to the zip code. These are important works in progress.

Agenda Item VI: Covered California Policy and Action Items

Presentation: Covered California Policy and Action Items

Discussion: Proposed 2016 Revenue Assessment

Mr. Lee noted that this information was presented in March. The reason we're acting on this before the budget is that we need to provide the information to the health plans

before they submit their bids. It also frames what will be presented in May and June, when the budget is brought to the Board. The per-member per-month (PMPM) fee is the revenue for the budget.

Dennis Meyers, Assistant Director, Economic Analysis and Sustainability, noted that this will become Covered California's sole source of funding in 2016, once the federal grant funds run out. They recommended maintaining the same rates for the individual and small business health plans. Mr. Meyers recapped the assumptions used to make the forecast. This forecast is much more grounded in experience than the last one. It reflects greater retention and a lower level of disenrollment.

Mr. Meyers presented a chart with the overall revenue impact with the various revenue scenarios.

There is a relationship between PMPMs and premiums. If Covered California continues to hold the rates constant, they'll be a diminishing percentage of the premium. Mr. Meyers presented a chart of a multiyear financial outlook. These show the years when Covered California is weaning off the federal funds. In 2017-18, it will be the first time PMPMs are enough to fully fund operating expenses, with a sufficient cushion. Going another year with the same PMPM levels is fairly safe. The budget presented in May and June will reveal more on this issue.

Mr. Lee noted that Covered California is still in the establishment phase, with the federal funds supporting operations. The organization has had to educate people on the exchange and the Affordable Care Act, subsisting on federal funds. Fiscal year 2016-17 will be the first where Covered California is not receiving ongoing funds. Covered California is not supported by general fund. There will be some funded out of the reserve, and then the next year Covered California will be at a break-even model. But the budget will reflect a drastic decrease in expenditures. Staff is looking mindfully at a lot of expenses. And then it will step down again. The organization is always balancing what the resources are needed to operate effectively and recognizing that its part of the premium cost. Maintaining the fee is very prudent. There are a lot of detailed elements that will be shared in a background document.

Motion/Action: Board Member Fearer moved to pass Resolution 2015-25. Board Member Islas seconded the motion.

Discussion:
Board Member Morgenstern asked if there is an average PMPM premium across all the plans.

The average monthly premium is just over $300. It's about 3 percent of that. The PMPM is the same for every plan.

Mr. Lee noted that some health plans have asked if this should be a percentage. If you are a health plan with a lot more enrollment in bronze, it's a higher percentage of the

premium. If you're in a lower-cost area, premiums are about 25 percent less expensive than they are in the Bay Area. Then it's a bigger percentage of the premium. That may be something to consider moving forward.

Board Member Fearer said whether you look at the various scenarios, there's pretty significant growth, and that's surrounded with a lot of uncertainty. If we're at low instead of median enrollment numbers, what goes first? Do operational costs eat into the reserve or do we increase PMPM or cut expenses?

Chairwoman Dooley said we're establishing our revenue today in order to have our budgeting conversation in the next two months.

Mr. Meyers pointed out that these are the decisions we make every year. The conversation will be revisited each year. There will be opportunities to ask those questions for each year's budget and midyear budget adjustments can be made if they need to be.

Board Member Fearer pointed out that in the year we're in, enrollment could decline. So in a case like that, is Mr. Meyers saying we'd have to have a midyear budget revision?

Mr. Meyers stated that yes, we have that flexibility.

Mr. Lee noted that within a particular year, the organization doesn't need to make adjustments, but if the Board decides there should be a different amount of reserve, we can change that. In any given year, we have a lot of room to end the year with less reserve. We're setting the fee with an eighteen-month window. The timing of these issues will be important.

Public Comment:
Anthony Wright, Executive Director, Health Access California, appreciated the discussion and the prudent fiscal stewardship. The revenue is dependent on both the fee and meeting the retention and enrollment goals. Without the budget, it's hard to know if this allows us to invest as necessary to meet those goals. It would be good to allow some breathing room to allow revisiting it as necessary. Mr. Wright is always for lower premiums, but a $1 or 2 investment is modest and might enable better service. Even if you increased $1 or 2, it wouldn't majorly impact consumers, and 90 percent would not be impacted because they're subsidized. It would impact the overall market, but that's part of the consideration.

Jim Mullen, Manager of Public and Government Affairs, Delta Dental, wanted to point out that Resolution 2015-25 does not carry forward the standalone dental fee of $.83. The standalone dental plans in the SHOP today are offering both child and family dental plans. Standalone plans are still excluded from the individual plans. Kids are embedded in the QHPs. Mr. Mullen wanted to emphasize the importance for offering adult dental benefits. There is a large enrollment in standalone benefits. The highest percentage is 18–34 year olds, a demographic that this organization is interested in capturing. This is a

benefit that Mr. Mullen's organization will use. Everyone is ingrained that we go to the dentist twice a year. It's a highly utilized benefit. Mr. Mullen's organization is continuing to work toward that goal. If 100,000 adults sign up in dental, you'll receive another $83,000 in dental revenue.

Doreena Wong, Project Director, Asian Americans Advancing Justice (AAAJ), stated that they hope to get a breakdown of the budget. It would be useful to know allocation for the assistance programs, so that the AAAJ can make the investment that they need. This will help AAAJ to understand how much they should be allocating. It would be helpful to know how much is allocated for media or the service center versus the navigator program. If the proposal is maybe $10,000,000 for the navigator program, that's less than 3 percent of the budget. Is that a good investment to get the hard-to-reach communities?

Mr. Lee noted that it's challenging to talk about the navigator program without a budget. It is staff's recommendation to look at the navigator program when compared to the $50,000,000 marketing budget. There will be very robust discussions about this at the next few meetings. We believe that not increasing the budget and fee structure over the next few years is important. California is a large state and there's a lot we need to do, but believes we can do it within this budget. Family dental is an important piece.

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

Discussion: Proposed Navigator Program Changes for 2015/16
Mr. Lee thanked Mary Watanabe, Deputy Director, Sales Division for all her hard work and announced that she is leaving to work at the Department of Managed Health Care. This reflects the trend of staff moving back and forth between the various state partners. In her work, Ms. Watanabe has embodied the values of Covered California.

Ms. Watanabe hopes to continue this work with her new employer. This presentation was informed by a lot of discussion with existing grantees. There were a lot of challenging, solution-oriented conversations. As a team, staff really tried to put thought into how to do better with the navigator program next year. This will be the only compensated program next year. Staff want to ensure that this program will support all of the great work that the community organizations are doing.

Covered California's navigator grantees have assisted with about 6 percent of our overall enrollment, while in-person assisters produced about 4 percent. Community partner enrollments altogether resulted in about 10 percent of total enrollment.

They're asking for outreach and enrollment, but also case management. Special enrollment will be critical, as well as renewal assistance. This year was performance based, and they're proposing moving to a block grant, which allows planning for staffing and budgeting. The block grant model really supports what these organizations are good at, which is providing all services to everyone who comes in. It is not just performance-based enrollment. They do want accountability, so they'll monitor performance against minimum thresholds and use that as a guide for future funding. They will require monthly

reports on events and touches. The community partners have given a lot of great input, including the gathering of a lot of data.

Staff are not recommending any changes to eligible organizations. They had thoughtful conversations about whether or not they should allow organizations with a self-interest to participate in and be compensated through the navigator program. These entities include clinics, hospitals, and health care facilities. They still see those as our top-performing entities, particularly in reaching Latinos and the low-income populations. Because of this performance record, staff are recommending no changes. Staff will revisit this.

Staff are proposing moving to a three-year contract term. The current navigator grants will end in June 2015. There will still be a two-month gap. Staff would like more continuity for organizations. This will reduce administrative burden in the long term.

Staff are telling organizations they might have an option to contract in future years, but that will be much targeted. People won't be shut out, but the RFAs will be very specific. Staff are not recommending extending contracts with existing grantees. Everyone will need to reapply, but are hoping to make that experience less burdensome.

Staff are seeking to send out RFAs next week. They are looking for organizations that have an existing presence and an established, trusted, and successful relationship with consumers. They anticipate offering $50,000 to $500,000 grants. There will be an application period of six weeks. Staff will announce the recommended funding amount in July, and will have the grant award period afterward.

Motion/Action: Board Member Islas moved to pass Resolution 2015-26. Board Member Fearer seconded the motion.

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

Discussion: Covered California Regulations

Discussion: Certified Application Counselors Emergency Adoption

Ms. Watanabe stated that Covered California has had an assisters program where enrollment counselors (certified enrollment counselors, or CECs) were given a $58 payment per enrollment. This one is a federally required program (certified application counselor, or CAC, program) that looks a lot like the CEC program, but it's uncompensated. Staff have surveyed existing entities and are pleased that people are seeing interest in this program.

Staff presented these regulations last month and have received widespread support and some suggestions.

The description changed to clarify that an entity can't be both in the CAC and the navigator program, but staff are trying to make it easy to transition between them. Staff are trying to maintain access to the online system and cases. The

management training period has been stretched to 90 days. They'll continue covering background check payments until June 2016.

Ms. Watanabe presented a timeline for implementation.

Publically the term "certified enrollment counselors" will still be used when talking about all enrollment entities, just so consumers are not confused. In this new program, there will be certified application entities and certified application counselors. This is because of what the federal government calls it. The regulations will call them CAEs and CACs. We need to keep the consumers from even knowing this is going on so they aren't confused. There will be entities in the navigator program, or counselors who are in the CAC program. The $10 million only applies to the navigator program.

Mr. Lee noted that this is a change of terms in the agreement. Assisters used to get paid $58. The old program had different terms. Compensation now only occurs through the navigator program. Staff has the latitude to change the total grant amount based on the proposals.

Board Member Morgenstern asked if the funding amount covers both programs.

Mr. Lee stated that the funding covers just the navigator program.

Board Member Islas asked if there will be more interest in targeting special communities that are underserved.

Ms. Watanabe stated that if Covered California feels they have not received enough proposals for enough populations or communities, a targeted RFA can be done.

Board Member Islas assumes there will be weighting or preference for new organizations that are trusted and in positions to reach targeted populations.

Ms. Watanabe stated yes. Covered California funded organizations who had not done enrollment assistance, and it was a huge lift to get them up and running. Covered California is looking to partner with those who have experience in this. That doesn't mean new organizations wouldn't be considered, but staff know its more effort to get them up and running.

Board Member Islas is sensitive to this because of where she lives. She wondered if there could be a peer-mentoring effort among organizations.

Covered California tried to bring organizations together last year to provide assistance and share best practices. Coalitions have formed, too. Covered California has heard that more of those are needed. There are some phenomenal

leaders out there. Organizations don't have to wait for Covered California to collaborate.

Board Member Islas wondered about the relationship between increasing enrollment and increasing provider networks. Would increasing enrollment success lead to stronger local networks in those underserved areas?

Mr. Lee said that is the right sort of question to ask. Networks should be based on enrollment, but also potential enrollment.

Chairwoman Dooley noted that the plans have certain network adequacy requirements. When, in the first year, enrollment exceeded projections, the plans went back and contracted with more providers.

Ms. Watanabe said the clinics have gone beyond helping with enrollment but also connecting people to care. Clinics haven't just enrolled people but have been committed to having the systems in place to follow up and help people navigate the system, even with other providers. Especially in areas where provider access is lacking they have been critical navigators.

Mr. Lee said they hear the same thing from insurance agents, that they help walk people through getting connected with the right doctor.

Discussion: none

Motion/Action: Board Member Islas moved to pass Resolution 2015-27. Board Member Fearer seconded the motion.

Public Comment:
Sonya Vasquez, Policy Director, Community Health Councils, wanted to say that her organization is very thankful for the changes to the navigator program in terms of the type of grant that needs to be out there. A small percentage of enrollments are done through these organizations, but so much work is not tracked in terms of education and troubleshooting. They've exceeded troubleshooting issues each year. They help people after they've already enrolled to figure out their coverage, their providers, and solve their problems. This type of troubleshooting work is not captured in the database.

Mari Lopez, Policy Director, Visión y Compromiso, also voiced support for the recommendation. This is a great change. Ms. Lopez's organization is grateful for the recognition that goes into educating folks on their coverage. Without education, people have trouble using their insurance. They hope that some of the issues they experience with regards to help centers and the phone assistance wait time will be better. It is still troubling that there are still a lot of issues. They hope that consumers will be encouraged to use their insurance for continued care and thus work towards the goal of becoming a healthier nation.

Doreena Wong, Project Director, Asian Americans Advancing Justice (AAAJ), thanked Ms. Watanabe for her work that they all appreciate. This wouldn't have been possible without the staff's commitment to working with them. AAAJ will miss her and wanted to reiterate that they generally support the changes. AAAJ appreciates that staff has listened to the feedback and changed it. They appreciate the flexibility of a variety of factors. In regards to doing the on-the-ground work, it sometimes takes seven to eight hours to actually complete an enrollment and consumers come back for more help. We would hopefully maintain the current funding level. If you look at the number of grantees, a funding reduction to $5,000,000 would mean an 82 percent reduction in the number of grantees. That's too much to reach the hard to reach communities.

Pleshette Robertson, Sac Cultural Hub Media Foundation, thanked Ms. Watanabe for her service and voiced how shocked and sad she felt when she learned that Ms. Watanabe would be leaving the organization. Ms. Robertson's organization is pleased with all the changes that have been made. They would like the Board to consider the need for outreach and education materials to be ready to go in advance. They are also asking that the Board consider extending the open enrollment period through February 15.

On phone: Malia Hall, Consumer, has benefitted from the Green Foundation. She confirmed that she has had to contact them a number of times to get extra assistance, and they have been so helpful in getting her enrolled. She spent about eight hours on hold and trying to get assistance with an error that they made with her start date, mostly because the computer system was down. It was down these last five days, and the Green Foundation helped her keep sticking with it through the resolution. She wants to be sure that the budget matches the data. The inner city communities really need Covered California. She is concerned about a possible reduction in these services and would like to see the same $50 million be used to ensure that there is not a reduction. You're not tracking how many walk-bys are influencing the marketing for Covered California.

On phone: Pamela Moore, Navigator Program Manager, Redwood Community Health Coalition, thanked the Board and staff for their great work and for giving them the opportunity to successfully enroll Northern California consumers. They support the changes and encourage the Board to consider post-enrollment services such as health literacy, utilization, retention, and renewal support. In the work they've done with Covered California, they've discovered that the newly insured need the full range of services to fully benefit from the Affordable Care Act.

Kate Burch, Network Director, California LGBT Health and Human Services Network, stated that it is great to have someone who hears them when things go wrong. They really like the new block grant model. The previous performance-based contract fostered a harmful sense of competition among community groups. Several bridges were burned over it. The block grant will help groups return to

their real work. It's important to count outreach and education and post enrollment support in the performance measures.

Anna Hasselblad, California Coverage & Health Initiatives, wanted to say a big thank-you to Ms. Watanabe. Ms. Hasselblad's organization thanked Ms. Watanabe for the acknowledgement and the continuity of the navigator organizations. The new block grant model will really allow it to mirror what's happening on the ground. That's a smart strategic move. They urge the Board to consider that as more people get enrolled in coverage, it's leaving the really hard to reach behind. The investments that they make in the navigator program should be a minimum of $10 million. The work that we all do is not just about enrollment.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), stated that they are sorry to hear Ms. Watanabe is leaving. Ms. Sanders stated CPEHN also appreciated Covered California's commitment to listening to CECs. They monitor the program (though they are not CECs), because the goal is to help enroll special populations and they don't want to see that fall by the wayside. CPEHN was troubled to see that some really strong navigator grantees actually dropped out. They are hopeful that this new grant configuration will bring people back and encourage a renewed focus on diverse racial and ethnic groups, the LGBTQ community, and others. CPEHN urges the Board to ensure that there is adequate funding and not make such a drastic cut. Some of the other services, such as troubleshooting, are a part of sales and are also an extension of the service-center activities. This really straddles both program areas and does not just relate to sales, but also consumer satisfaction.

Betty Williams, One Solution, thanked Ms. Watanabe for being such a hard worker through all the changes in the navigator grant program. Ms. Williams was a subcontractor and she had a hard time. She was never given collateral materials and was often unpaid. Ms. Watanabe talked to her and helped greatly. Ms. Williams also supports the new block grant. This new program will not pit us against each other and allow us to do more of our job.

Betsy Imholz, Director of Special Projects, Consumers Union, thanked Ms. Watanabe. Ms. Imholz is also still learning about the new naming system, and hopes we find an easy way to explain how to get help.

Jen Flory, Senior Attorney, Western Center on Law & Poverty and Health Consumer Alliance, thanked Ms. Watanabe for her helping the Health Consumer Alliance with communication. Ms. Flory's group supports funding the navigator program at the higher level. The navigators are a key part of educating consumers and getting them in the door, while they handle some of the more difficult legal services cases.

Anthony Wright, CEO, Health Access California, appreciated the discussions in the marketing advisory committee and appreciated that staff listened to their feedback. This is a balance between accountability and flexibility. This has been an experiment. Initially, there was a rush of pent-up demand for these services. Then we started to shift to more of a focus on getting people in the door. It has shifted back a little more toward outreach and education. Now we have to find new strategies and new enrollees, and that may require different partnerships and tasks. It will be important to maintain the storefronts and have ambassadors in key communities.

Mr. Lee agreed that Ms. Watanabe is fabulous, and her team, who will be continuing on with Covered California, is too.

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

Discussion: 2016 Standard Benefit Design Emergency Readoption Including Finalizing Specialty Drug Benefit

Mr. Lee noted that this builds on a prior Board action to assure that people with chronic illnesses have access to specialty medications. This would build on that as well as clarify and put consumer guard rails around the potential plans that would have tiers.

Anne Price, Director, Plan Management, presented. Even though staff is requesting that we postpone the action on specialty drugs, it will work hard to bring back a proposal next month.

Part of the consideration is looking to lower members' out of pocket costs when they have conditions requiring medications in Tier 4. Staff is also concerned about the overall affordability of premiums. Staff is considering the cost of premiums in the following years and what kind of impact any changes might have going forward. Staff wants to preserve the plans' ability to use the formulary as needed. The policies related to drugs for patients with ongoing needs versus short-term needs may be different.

Ms. Price presented a list of the changes that have already been approved. Items 5 and 7 will be updated based on the health plans' formulary lists.

Ms. Price offered a list of ways the standard benefit design could be modified to help accomplish the goals.

Chairwoman Dooley noted that the cap numbers are part of what is still being evaluated. This is an estimate. But that's some of why this is not an action today.

Ms. Price explained that even though we believe this option would significantly ease burden, there is information to better understand. They'd like to talk to the

health plans to understand avoidance and adherence trends with particular cap amounts. It may be that $500 is too high. They would like to get some more information on that and seeing if they should look at a lower cost ceiling. Premium increases in future years matter. The impact on current premiums is modest, but the impact on future premiums could be substantial.

Board Member Morgenstern asked if we know if these actions will impact drug companies' prices.

Ms. Price stated no, that's one of Covered California's major considerations. As Covered California changes benefits or cost-sharing, we're shifting costs to the plans. The cost of the drug does not change. The underlying cause of the problem is the pharmaceutical companies' prices.

Chairwoman Dooley expressed that the cost is being shifted to other rate-payers, not to the plans.

Board Member Morgenstern understands that these companies want to get their money. Should Covered California consider how that all plays out in the marketplace?

Mr. Lee voiced that actuaries and plans say having higher out-of-pocket costs puts pressure on plans to bring prices down. There is the view that pharmaceutical companies feel pressure the more consumers have to pay out-of–pocket, but that affects adherence.

Board Member Morgenstern asked if there is any reason to believe that actually happens.

Board Member Fearer generally agrees with what is being proposed here for 2016. When we come up with our analysis, we can't guarantee that the plans will conclude that the impact on premium will be as modest as we think. Board Member Fearer is not sure out-of-pocket costs will affect the cost of these drugs. The primary reason for high prices is that they are what the companies can charge and get away with. He is not averse to them making a profit, but these numbers are far beyond that. There are initiatives to address some of these issues and try to come up with solutions, but for 2017 and beyond, Covered California should be an active participant in this process. Far more than co-pays, large purchasers affect this as well as carefully considered analysis and publicizing that analysis. That is a powerful tool that has worked in the past. Covered California can't entirely do this on its own. A lot of work needs to be done. Widespread predictions are that these costs are just the tip of the iceberg.

Chairwoman Dooley noted that the Governor asked her to establish a workgroup to look at these very issues. We're not at the point of addressing them as much as exploring them. No one has good answers for how to address this. Dr. Rideout

and Ms. Price have both been engaged in this. What are the procurement options, aggregated and otherwise? There is a broad community of interest. Chairwoman Dooley shares Mr. Fearer's premonition, that this is where the research and development is in the pharmacy community, around narrower and narrower application of drugs.

Ms. Price said the number given (.7 percent) is from the plans themselves. Greater changes in either direction would likely be reflected in future years.

Next, Ms. Price turned the discussion to Tier 2 facilities in plans. A plan's timely access requirements are all related to Tier 1 facilities. A plan can have a Tier 2 facility network in addition to Tier 1, and if a member receives services there because they have to, they get benefits akin to those they would receive in Tier 1. However, if they choose to go there, they are subject to higher cost sharing. Covered California is reevaluating this for 2017.

Mr. Lee said we are laying out the current policy, and we want to be very clear that Tier 2 facilities are not included in network adequacy requirements, and they aren't described as being part of the network in provider directories. They want to allow this for this year, but they'll be evaluating it. This has not been a widespread problem.

Board Member Fearer is concerned based on his experience with this system. We need to be sure those communicating understand exactly how this works. Sometimes the in-network discount is not applied. If an in-network provider is referring a member for care, it's usually understood to be medically necessary. But sometimes when the provider is chosen from another facility, the referral is not covered as medically necessary.

Ms. Price said this already exists, and Tier 2 facilities are not communicated to members in their searches. If a member were to call the customer service department of a plan, they won't come up. It's similar to having an out of network benefit. If a member did go to one of these facilities, it would be covered.

Board Member Fearer said a lack of complaints doesn't mean it is working. Consumers don't complain because they just don't understand why their bill is high.

Public Comment:
Beth Capell, Health Access California, has concerns like Mr. Fearer's. For today, your Specialty drugs benefit is a 20 percent coinsurance in most instances. Consumers can expend their entire annual out of pocket limit on a single prescription in the first month of the year. Since 90 percent of Covered California consumers live on less than $48,000 a year, asking them to spend $6,000 on one prescription leads to inappropriate use or skipping of medication. Subsidies help bear part of the cost. Kaiser Family Foundation found that the consumers with

cost-sharing reduction Silver plans have average assets of $326, and they would pay $200 toward each drug. Someone with MS requires two specialty drugs for $1,000 per month. We are asking a lot for prescription drugs from consumers with very little in the way of liquid assets.

Jen Flory, Senior Attorney, Western Center on Law & Poverty and the Health Consumer Alliance, echoed Ms. Capell's comments. Ms. Flory's group encourage Covered California to do what it can with the rates that we have now. Hopefully other factors will bring the cost down once the population is healthier. We can review these benefits every year. With regards to the tier network, they are concerned with what we came up with and now there's a plan that has decided to do something different, adding an extra tier. They already have a hard enough time explaining the extra policy. It's not just educating staff, but often consumers are working with their providers to figure out which hospital they'll go to, so they need to understand it too.

Terry Hernandez, the MS Society and the Chronic Care Coalition, applauded the idea of spreading the deductible out over the year so it's not as disproportionate. Studies have shown that MS patients tend not take their drugs as prescribed when their out-of-pocket costs exceed $250 per month. A lot of people with chronic diseases are a part of the workforce and pay into the tax system and if they do not take their drugs as prescribed, it puts that part of their lives in jeopardy.

Sonal Ambegaokar, Senior Attorney, National Health Law Program and the Health Consumer Alliance, appreciates the staff's efforts. They believe adherence and compliance is an issue. A newly insured population is coming in. A lot of these patients are newly diagnosed with chronic illnesses, too. To penalize them for getting the care they need is unfair. On the tiered network, they don't see a real consumer benefit. They echo others' concerns. This shouldn't be a way to address network adequacy and confusion. This will create more complexity with less support.

Liz Helms, CEO, California Chronic Care Coalition, voiced appreciation for being part of the stakeholder group. They believe that we can get to the right number, and they believe in Covered California. The new pairing and caps are way too high. People won't be able to afford their meds or will make terrible decisions. She personally went through a medical bankruptcy and lost her home and doesn't want others to go through that. They also feel that there's a lot of waste in the system, and they want to get people where they need to be. They don't want to see discriminatory practices continue, and this is a discriminatory practice.

Athena Chapman, Director of Regulatory Affairs, California Association of Health Plans, stated that while they don't have a position on the recommendation, they reiterated that any caps on drug co-pays don't address the underlying costs. Our health care system can't support the weight. The flurry of new expensive

drugs is alarming. Meaningful cost savings start with drug companies lowering prices and providing greater transparency.

Brett Johnson, Associate Director of Medical and Regulatory Policy, California Medical Association, stated that their concern in all of this is ensuring patient access. For the future presentation, they would certainly be interested in seeing attention paid to drug adherence and avoidance. In terms of the tiering of networks, they know there are some entities that want to be part of the exchange and that those entities tier their own hospitals.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), stated that communities of color that are disproportionately affected by diseases will be impacted by high costs. They understand that Covered California is trying to be conservative, but there's no cost difference in 2016, so why can't we consider a greater cap this year? On the issue of the Tier 2 network, Ms. Sanders still finds it confusing despite her education. They encourage Covered California to take more time on some of these really complicated issues.

Anna Hasselblad, California Coverage & Health Initiatives, echoed what her colleagues said about the specialty medications cap.

Janice Rocco, Deputy Commissioner, Department of Insurance, urged the Board to adopt the $200 cap, not the current staff recommendation. We need to be guided by state law that talks about discrimination based on health conditions. We need to keep in mind that it is not just premiums that are impacted. They were told last month that they needed to collect information on premium impacts, and they discovered that the impact is negligible. The design applies both inside and outside of the exchange, so it impacts the policies that millions of Californians will be buying.

Michael Prosio, Anthem Blue Cross, stated that they look forward to helping finalize the details of the proposal. Covered California needs to be one of the voices in a chorus examining drug pricing. In regards to tiering, they are the plan that currently has tiering. They support this proposal. As Mr. Lee pointed out, there have only been two complaints about the issue. When done properly, tiering allows additional access to other hospitals that don't go toward network adequacy requirements. They are considered in-network; they are not an out-of-network benefit. It does go toward the max out-of-pocket costs. Most of the consumers in these tiered products are using Tier 1 facilities. They are not getting complaints. They want to keep examining it.

Monica Johnson, Public Policy Advisor, International Foundation for Autoimmune Arthritis and the California Chronic Care Coalition, thanked the Board for all their work to address the needs of chronically ill patients. They support Commissioner Jones's recommendation for a $200 cap on specialty medications. Ms. Johnson is a specialty medication patient herself. There are

numerous patients who rely on two or more specialty meds. They urge the Board to keep patients from deciding between life necessities. People forget that the autoimmune/arthritis community has extra financial burden. They pay extra out-of-pocket costs to take taxi rides, rent medical equipment, etc. Their diseases already cost a lot of money. It's discriminatory to set prescription prices too high.

Betsy Imholz, Director of Special Projects, Consumers Union, stated that they appreciate all the challenges involved with the specialty drugs issue. A new study out this week provided more data about reduced adherence for diabetes drugs in 2014 for anyone with out-of-pocket costs over $125. They would like to have costs be as low as possible and still be responsible. The issue of tiered networks is extremely confusing for consumers who may not understand networks in the first place. They agree with Mr. Fearer. Consumer Reports is about to come out with a report on confusion about where to address complaints and on out-of-pocket costs. Hearing there aren't many complaints is thus not a comfort. Tiering is a key feature of alternative benefit designs. They appreciate the consumer protections in making this a one-year policy. Some limitation on the number of years or multistate plans would be beneficial.

Discussion: Individual Eligibility and Enrollment Readoption
Thien Lam, Deputy Director Eligibility and Enrollment, said the revisions to the regulations were presented last month. The revisions are in response to federal regulations and a need for clarification. Today staff are requesting the Board's approval for readoption.

Ms. Lam presented the items that are different. For enrollees who have passed away, no death certificate is needed to prove their death as long as the individuals requesting cancellation are in the home or are authorized representatives.

Ms. Lam added that they must comply with a grace period.

The appeals language was modified to be more consumer-friendly in applying the different coverage months. Language was added about employers' right to appeal, and that the employer appeals process will be overseen by HHS.

Motion/Action: Board Member Fearer moved to pass Resolution 2015-28. Board Member Islas seconded the motion.

Discussion: none

Public Comment:
Jen Flory, Senior Attorney, Western Center on Law & Poverty and the Health Consumer Alliance, thanked staff for working with consumers and accepting compromises to make things consumer-friendly.

Sonal Ambegaokar, Senior Attorney, National Health Law Program and the Health Consumer Alliance, echoed Ms. Flory's sentiments, particularly when it comes to the verification of a death. They have concerns they want to raise in regards to appeals, and she also wanted to remind Covered California that we can always do better than the feds.

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

Agenda Item VII: Adjournment

The meeting was adjourned at 3:06 p.m. The meeting was followed by a reception for new and outgoing Board members.