

California Health Benefit Exchange Board
May 21, 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

Board members at second location in Palo Alto:

Paul Fearer

Board members absent:

None

Agenda Item II: Closed Session

Chairwoman Dooley called the meeting to order at 12:20 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 April 16, 2015.

Presentation: April 16, 2015, Minutes

Discussion: None

Public Comment: None

Motion/Action: Board Member Islas moved to approve the April 16, 2015, minutes. Board Member Morgenstern seconded the motion.

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

Agenda Item IV: Executive Director's Report

Presentation: Executive Director's Report

Discussion: Announcement of Closed Session Actions

Peter Lee, Executive Director, announced the hire of Dr. Lance Lang, the new Chief Medical Officer. Dr. Lang be the first permanent staff medical officer. Dr. Rideout did a great job and has moved on. The Board also approved the new Project Director for CalHEERS, James Duckens. Karen Ruiz, the former CalHEERS Project Director, is now Chief Technology Officer.

The Board shares contract details on the website. The Board approved an amendment to contracts with Richard Heath and Associates and KP (print material vendor). The Board will announce the selections for the marketing vendor and the communications vendor next week. Those were competitive bid RFPs. The Board amended four contracts (interagency agreements) for CalHEERS. Lastly, it approved an amendment of the interagency agreement with the Department of Health Care Services.

Discussion: Executive Director's Update

Among the Board materials, Mr. Lee drew attention to a California Healthcare Foundation survey on consumers and health care. Covered California consumers face many of the same issues as those with employer-based coverage. The study found that four in ten consumers delayed getting care due to cost, even though they were insured. Covered California has worked to develop benefits so that cost wouldn't be a barrier. Another study is a report on pricing, power, and health care. It discusses transparency, network adequacy requirements, and limiting out-of-network-provider charges. It provides a policy roadmap that staff will be evaluating. A previous study found that even though our networks are somewhat narrower than the networks under employer-based plans, the quality of care is the same or better.

Mr. Lee reviewed special enrollment period numbers. As of May 10, since open enrollment ended, more than 115,000 Californians have enrolled in coverage. This is good. Staff decided to allow those who didn't understand that there was a penalty to still enroll, and over 43,000 Californians signed up because of that. There was a monthly enrollment rate of about 47,000. That's approximately 30,000 a month without those who hadn't known about the tax penalty. Staff estimated 25,000 a month, and this is higher. This is different than effectuated coverage—about 20 percent don't pay.

Covered California is now one of the largest purchasers of health insurance, far greater than a number of large employers combined. This means we can have a large impact on the market. Mr. Lee shared a breakdown of those enrolled by tier and by subsidy status. Many people have additionally subsidized silver plans. Even those in bronze have additional office visits available to them. Over 500,000 people had been covered by Covered California and no longer are. They've been able to benefit from its coverage. Staff has been analyzing the experiences of those enrolled.

The 1095-A form is the tax form reporting tax credits. Additional corrected forms had to be sent to consumers. People don't have to file updated returns; they only have to if they want to because it results in financial benefit to them. Staff is looking at improvements

since this has been a rough area. However, the IRS and US Treasury have been surprisingly flexible in their policy determinations. The large and small tax preparers have told clients that they'll amend their tax returns for free. This shows the support of the broad public.

Covered California for Small Business ("CCSB"), the program formerly known as SHOP, is considering a significant outreach and marketing budget. This fall will be a big enrollment time for CCSB. There are currently about 17,000 enrollees. The agent community will be a critical piece of enrollments in this program. Agents have enrolled more than 43 percent of the enrollees. Covered California is still behind on payments to the Agents, and now have a schedule to catch up on those payments by July.

Mr. Lee shared a Board meeting calendar. There will possibly be no meeting in July, September, or December.

Mr. Lee mentioned payments of fees for the Medi-Cal program. The terms of the contracts have needed to be updated. While more than \$15 million in payments have been made to assisters and agents to date, there is still \$8–9 million outstanding. In the month of April, service center levels did not go down. Most of the surge vendors were let go, but still the vast majority of calls were answered in 30 seconds or less. The right staffing numbers are still being figured out.

Discussion: None

Public Comment: None

Agenda Item V: Covered California Policy and Action Items

Mr. Lee thanked the staff for their hard work on the budget.

Chairwoman Dooley noted that the draft has been made public. There will be no action on the budget today.

Presentation: Covered California Policy and Action Items

Discussion: Covered California Budget

Jim Lombard, Chief Financial Officer, presented. He also acknowledged the staff for their contributions and effort. This budget supports customer service needs and marketing to continue effective operations. A great deal more information has been shared this year. Questions and public comments are welcome.

Many startup expenses are shrinking. Startup funding will also be less over time. The budget contains no job losses. It includes updated enrollment projections based on last year's enrollment as well as experience from other programs. This budget is a balance between funding programs for continued success and moving toward sustainability. This

budget is consistent with our vision and mission, and includes sufficient marketing and outreach and service center staffing.

Covered California received numerous renewals and new enrollments. There is a revised CalHEERS cost allocation plan. There was also an extension of the federal grant through December 2015. The service center handled higher volumes. There should be a positive operating balance in 2017–18. Covered California managed to come in under budget due to staff prudence.

Mr. Lombard shared a multiyear plan showing the expected reserve. A number of factors can be adjusted as necessary, including expenditures and per member per month (PMPM) fees. A pie chart broke down the funding areas. A graph compared the budgets for 2014–15 and 2015–16. Mr. Lombard shared a summary of federal funds received; it will be added as an addendum to the final budget.

Mr. Lee noted that this 75-page document reflects a lot of detailed work. It reflects some achievements and some plans for the future. There is a lot behind this document. This is a proposed budget, and they welcome questions and comments. Comments can be sent to boardcomments@covered.ca.gov. Mr. Lee said they will continue to make significant ongoing investments in marketing, sales, and outreach. There will be a constant need to reach out to those who are newly eligible. Customer service is the second-largest area of expense. This is the only state in the nation with state workers providing the customer service. Staff are still learning which levels are right. Each year, we'll get a better sense of needs. The ten contracted health plans also spent over \$40 million in marketing last year. The more than 10,000 agents also spent outreach money. Agencies with shared missions are also providing outreach. Consumer Watchdog submitted a comment on voter registration—Covered California has all resources necessary to fund mailings for voter registration in the budget. Covered California meets the legal requirements, and staff included postage in the marketing budget. Staff proposed continued funding of consumer assistance.

Discussion:

Board Member Fearer expressed general support for the work that has been done. He has advocated taking a careful, prudent look at our budget. The only source of future funding is the PMPM fees, and that shows the importance of an operating reserve and careful stewardship. He supports the work that has been done. This is a thoughtful and prudent beginning.

Board Member Morgenstern seconded what Board Member Fearer said. What would the budget look like if we enrolled every eligible person in the state?

Mr. Lee said that there are approximately 2.5 million subsidy-eligible individuals. Another 2.5 million are not eligible for subsidies but can still enroll in Covered California. The core market is those who are subsidy eligible. The 1.35 million enrolled are 88 percent subsidized.

Chairwoman Dooley noted that some of those who are eligible for subsidies are currently in employer-sponsored care.

Mr. Lee said they often use the CalSIM model to determine numbers. That 2.5 million includes 500,000 who have poor employer-sponsored care. Many don't know that they are eligible. Kaiser doesn't include them; their estimate is more like 2 million.

Board Member Islas asked about the fiscal year term.

Mr. Lee stated that the fiscal year term is July 2015 through June 2016.

Board Member Islas asked what happens to the funding from our current programs that won't be fully maximizing their grants.

Mr. Lee stated that in the current budget, on slide 9, the projected expense assumes that all of the funding is used. If they said let's spend \$10 million beyond the scope of the current plan, it would reach into the reserve.

Chairwoman Dooley appreciated the comments about the commitment they make to their covered members, and we need to increase our focus on those we already have. She is interested in the consumer assistance and where we are on that. It's going to be difficult for many people they are deeply indebted to. Eventually we'll need less in outreach, but we may need to reevaluate assistance costs.

Public Comment:

Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law & Poverty and the Health Consumer Alliance, remembered the discussion about if they should apply for a Level 1 or Level 2 establishment grant. It's great to see us in this place. Congratulations. They are concerned about the proposal to cut consumer assistance in half. Assistors don't just enroll people; they help people clear up their problems and appeals. They are concerned that this may jeopardize their ability to assist consumers. We need to continue to invest in the currently covered individuals and ensure that they are getting the care they need. If there is an allocation of \$121 million for marketing, why would \$1 million in additional funding for consumer assistance not be a good investment?

Gil Ojeda, Director, California Program on Access to Care, UC Berkeley, acknowledged the two new appointees to the Board. He has strongly supported pay for the Board Members. That would facilitate the amount of time each must spend doing this. He asked that the Board not reduce the outreach and enrollment amount by so much. We're barely halfway into the second year of implementation. Some key core communities, such as Latinos, have not yet been reached. They need to listen, analyze, learn, and then act. It's not a great idea to skip a September meeting. Things could happen at that meeting that could still be implemented before open enrollment.

Kim Lewis, Managing Attorney, National Health Law Program, supported the efforts of the staff in developing a large and robust budget for a self-sufficient organization. She

appreciated the transparency in sharing the proposed budget. She agreed with Ms. Landsberg with regards to support for consumer assistance and the proposed cuts. They are meeting regularly with their partners and staff to try to address systemic problems and individual problems. Covered California and Medi-Cal serve the majority of their clients.

Doreena Wong, Project Director, Asian Americans Advancing Justice (“AAAJ”), spoke on behalf of grantees, whose efforts in enrollment and post enrollment have contributed to the success of Covered California. In regards to the current budget, they support the comments about ensuring that the budget for the Health Consumer Alliance is increased. They really rely on it and refer members there. The other issue is they’d like to increase the \$10 million for the navigator program. Look at how much grantees request to determine the budget for this for the future. There should be some adjustments to this year’s budget. Many grantees won’t get half of their payment—where is that money going? Grantees should have renewals counted toward enrollment goals, and for those who couldn’t make the 75 percent goal, could they report on their successes to get more funding? For those grantees who had to have the rollover amount, we are at jeopardy of losing that because they can’t get the full navigator payment.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), supported the comments of Ms. Landsberg and Ms. Wong. There should be additional funding for the data/analytics department. Better data will lead to better health equity. The Health Consumer Alliance is integral and their funding shouldn’t be cut. Similarly, the navigators are working with the hardest to reach populations for enrollment and post enrollment work.

Sonya Vasquez, Policy Director, Community Health Councils, stated that they understand the importance of marketing, especially for the small business exchange. But ongoing support is important for existing enrollees. Consumer assistance needs to be fully funded, if not increased. They also hope that the Board will consider increasing funding for the navigator program. They provide not just enrollment, but also education, and their work with the Health Consumer Alliance enables the Health Consumer Alliance to focus on the challenging cases. Covered California could spend a little extra to help people have a quality experience.

Betsy Imholz, Director of Special Projects, Consumers Union, commended the detailed report and commended everyone for the prudent course we’re on. Her colleagues have discussed the outreach dollars in consumer assistance and navigators. The populations those folks serve are hard to reach, and their challenges are great. They perform an important function. Consumers Union is not a grantee, so they are not self-interested. In regards to the Service Center reduction, it is important to understand that the goal is to maximize our consumer experience. The Board should carefully consider the proposed reduction.

Hugo Morales, Executive Director, Radio Bilingüe, spoke about communication issues for the Spanish-speaking population. Those issues have been addressed. But they are still hearing confusion about the system and consistent complaints about the cost of the premium. There’s a cultural illiteracy, a lack of understanding about insurance and how it

works. We need continued outreach. Ethnic media should be a part of that. There is a continued need for navigators, who are important to the Latino community, as well as consumer assistance.

Giezi Bermudez, Project Coordinator, Asian Resources Inc., supported the comments of Ms. Wong. They are navigators in Sacramento, and their work entails a lot of helping people navigate the system, understanding the letters, etc.

Stella Kim, Western Director of Strategic Campaigns, Young Invincibles, stated that they were certified enrollment entities for the first time and discovered that young people found health insurance to be a new concept. Even the savviest consumers have a hard time navigating the system, so the navigator program is a very important piece. They advocate that the Board invest in the program. It's important that young people learn about insurance and the health system.

Anthony Wright, Executive Director, Health Access California, congratulated the Board on a structurally sustainable budget. California has done better than other states. It has passed the critical mass of enrollment. They have some built-in IT and operational costs, and your two big variables are outreach and customer service. This is a conservative budget in terms of its enrollment goals. Do you want to try for improved enrollment that would come back in funding? This budget has the reserves so that if you wanted to make some augmentation, you could. There is a need for ongoing assessment of people's experiences, and trying to find people when they're having life-change events, since that will be the bread and butter of enrollment.

Lim, Southeast Asian Action Center, wanted to make sure that Covered California is moving from education and outreach to focusing on those already covered. Those who can help support that work can be the same people as those who performed enrollment functions. Navigators are culturally competent, and they're the ones people come back to. They can be one-stop shops with shifting roles.

Bill Wehrle, Vice President of Health Insurance Exchanges, Kaiser Permanente, hoped to see a budget with declining consumer assistance expenditures. They commend the staff for trying to find a balance. As we try to be sustainable, one big challenge is to uncover and implement systematic ways to reach the subsidy-eligible populations. A strategy is needed that looks at each special enrollment categories—those going through a divorce, etc. It may involve working with EDD. We also need a commercial for the call center, which is indeed expensive to staff. They know that when their performance deteriorates, they see high abandonment rates quickly. You lose many people, fast. Keep a close eye on that. Congratulations on being sustainable.

On Phone: Eddie Barrera, Consumer Watchdog, thanked Mr. Lee for his comments on voter registration as a priority. The public needs more clarity on what Covered California is doing to keep those efforts a priority. Covered California is in a unique position to entice people to register. They're also receptive to becoming civically engaged by navigators—those groups should be adequately funded. Covered California can simplify

the system and keep potential voters on the site. You can create a new generation of voters. Maybe in a future Board meeting we can get more details.

Sylvia Castillo, California Family Health Council, provided comments from Women in Health Care Coalition. They are interested in advancing women's access to health care. They are collaborating to reduce barriers to enrollment and access. They educate vulnerable women and want to help women who have yet to sign up for coverage. But if they're going to conduct more effective evidence-based outreach, they need enrollment data at a county level, stratified by gender, age, race, and ethnicity. Please release this data as part of this dataset going forward so the number of women for each county that have enrolled can be identified. Advocates need this data to help find coverage gaps and produce evidence-based efforts. They'll follow up with a letter. They urge that this be kept in mind in the budget.

Mr. Lee thanked everyone for their comments. We want to lower PMPM rates, which impact those who don't have subsidies. Rates can't be different inside and outside the exchange. We need to be sure we have enough resources to do the right thing. He appreciated CPEHN's comment on data analytics. Plan advisory committee meetings will discuss the data to make sure we are addressing disparities and gaps. He appreciated Health Access's callout on the two big platforms. The \$120 million is marketing, sales, and outreach. The new navigator grant program is about renewal and assistance as well as enrollment. Only about 10 percent of enrollment was through navigators. About 43 percent was through agents, who also provide assistance. Many agents are enrolling diverse communities. There are a variety of service channels. He appreciated the comments about the service center. The Health Consumer Alliance provides a vital service. We want people to have resolution when they call the service center, however. They'd like to increase not just timeliness, but depth of service. The regulators are also key partners and have help lines to help consumers. The range of issues around customer service is complex.

Discussion: Proposed 2016 Family Dental Plan Revenue Assessment

Staff proposes charging \$0.83 PMPM for dental. The individual PMPM will stay the same. The revenue created by additional enrollment is not reflected in our budget at this time. This is not subsidized.

Public Comment:

Jim Mullen, Manager of Public and Government Affairs, Delta Dental, pointed out this oversight last month and was glad to see it addressed.

Motion/Action: Board Member Islas moved to pass Resolution 2015-36. Board Member Fearer seconded the motion.

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

Discussion: Establishment of Audit Committee

Mr. Lombard, Chief Financial Officer, presented. There are a number of audit functions they'd like to consolidate. Staff are requesting the establishment of an independent audit

committee, and ask that there be two Board Members on it. The Committee will receive regular reports on audit findings and recommendations from internal auditing staff.

Chairwoman Dooley voiced that the committee needs to be established by a resolution.

Chairwoman Dooley and Board Member Islas will be on the committee.

Motion/Action: Chairwoman Dooley moved to pass Resolution 2015-37. Board Member Fearer seconded the motion.

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

Discussion: None

Public Comment: None

Discussion: Covered California Regulations

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

Mr. Lee introduced James DeBenedetti, Deputy Director of Covered California Plan Management, to present. Covered California is entering into its negotiations with health plans. The standard benefit designs set California apart. These apply to every plan in the individual market, even outside the exchange. We're also looking down the road at how to improve quality, how to ensure access to care. We'll keep working on marketing. We are looking at doing minor refinements on choice architecture now and more major refinements in the future.

Mr. DeBenedetti gave a quick review of where we are today. Last year, Covered California engaged consumer advocates and regulators to meet the actuarial value as proposed by the 2016 AV calculator. We're allowed to vary by up to 2 percent. We wanted to strive for the actual target, however, so we won't have to tweak them down the road. We wanted to increase transparency in cost so people will know what they will have to pay. We wanted to lessen barriers to care in the bronze plan. They still want people in that plan to have a decent level of care. We need to keep incentives aligned between consumers, health plans, and providers. Whatever benefit designs we come up with must be operationally feasible.

For the bronze plan, we allowed members to see a primary care provider for three visits with no deductible. We wanted to expand that to include lab, rehab, and specialists. This makes it much more attractive for those who may have occasional problems, but not chronic ones. There were two silver plans. There was a co-pay plan and a co-insurance plan. There didn't seem to be a lot of difference. They brought high-cost imaging into a co-pay plan. We made minimal changes to gold and platinum plans. Many are concerned about the cost of specialty drugs. They are concerned about the exposure to risk that these present. We discussed what the problem was, what the options were, and how we could protect our members from unreasonable cost. Mr. DeBenedetti presented a list of

pharmaceutical benefits already approved and discussed the requirements for consumer education on behalf of the plans.

Mr. DeBenedetti stated they're examining their options, and it seems like a cap may be the best option. Many people are in risk of reaching their out-of-pocket maximum in a single month, and that's an undue hardship. Members ultimately still have to bear a significant cost, but it shouldn't happen all at once. An idea has been landed on that the bronze plan will have a cap of \$500, and the others will have a cap of \$250. The estimate from the carriers is that in the first year the cost difference will be less than 1 percent. The concern is what this will look like down the road. The problem is that there are a lot of unknowns. The plans came up with a wide range of estimated costs three years out. This will probably have to be revisited down the road. Plans were asked what their members were currently using. Bronze plan members used very few specialty drugs; platinum members used many more. Members are aware of their health care needs and they gravitate toward richer plan designs if they have higher needs. They looked at the cost. Most of these specialty drugs are less than \$1000.

Mr. DeBenedetti shared a slide of recommendations with regards to caps, cost-sharing, and separate deductible in the different plans. It allows the cost-sharing to be about the same as it was before, but with a \$500 cap.

In most cases, a plan member will be required to pay their pharmacy deductible and their maximum cap. The first month could cost as much as \$500 (\$1000 for bronze) and successive months would be \$250 (or \$500 for bronze plans). This does not apply to health savings account plans. The small business program's silver health plans had a higher than \$250 pharmacy deductible, so they've reduced it to match the other silver plans'. Comments were received from concerned parties that the actuarial value of the bronze plan would allow for a \$300 cap. But the purpose of a bronze plan is to get the premium as low as possible. People with chronic conditions will move toward richer plans. Lowering the cap would hike costs for everyone in the bronze plan. Insurance carriers who don't contract with Covered California can gain a pricing advantage with lower caps. Our bronze plan members really aren't using specialty drugs. Utilization is almost 1/20th of what is seen in a platinum plan.

Chairwoman Dooley commented that the interaction of all of the goals that have been set illustrates how revolutionary the tier system is in regards to consumer choice and customization of coverage.

Board Member Morgenstern commented that the fault for high specialty drug prices does not fall onto Covered California staff or Board members, but onto the drug companies, who charge what the market will bear. Drugs are far too expensive. He wondered if we could leverage our prescription drug buying power to reduce prices for consumers.

Chairwoman Dooley noted that this topic is out of the jurisdiction of the Board, but is an interesting idea to consider.

Board Member Islas commented that part of our charge is to align our decision making to advance equity.

Mr. Lee thanked the drug work group that worked hard to understand these complex issues. We believe that these recommendations strike the balance between ensuring that consumers get the medications they need while keeping premiums affordable. He agreed strongly with Board Member Fearer's consumer first approach. There is a broader solution needed to curb the possible explosion of specialty drug costs.

Public Comment:

Beth Capell, Health Access California, appreciated the remarks of Chairwoman Dooley in regards to the revolutionary nature of the Affordable Care Act. This public process where the voice of the consumer can be heard is amazing. This proposal takes the consumer out of the middle. Today, some Covered California enrollees pay great costs for prescription drugs, and we appreciate the efforts to reduce those costs.

Janice Rocco, Deputy Commissioner, California Department of Insurance, speaking on behalf of Commissioner Dave Jones, commented that a lot of intense work has gone into this issue. For the bronze plans, we still have a \$500 deductible and \$500 cap, which is far too high for bronze plans members. We don't want people in bronze plans to be unable to fulfill their prescriptions. Please amend the \$500 down to \$300 before making the motion.

Jen Flory, Western Center on Law & Poverty and Health Consumer Alliance, reiterated the comments. They are grateful for this progress and thanked the staff. They were concerned about the enhanced silver plans, because they can't pay the same cap as everyone else. We'd like to see the bronze lower, and we'd like to see that the silver enhanced plans go down. The utilization difference between the silver 94 and platinum plans is because consumers just can't afford to pay the out-of-pocket maximum.

Kim Lewis, Managing Attorney, National Health Law Program, thanked the Board for the efforts to try to reduce the costs of drugs. We are very supportive of the fact that there is a cap. It's not low enough for those subject to the enhanced plan. This has a disproportionate effect on those with high drug needs or chronic illnesses.

Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network (CPEHN), stated that they really appreciate the lower cap and also the transparent, iterative consumer process. The extent that there were public conversations about these important issues reflects well on Covered California. They would like more of a cap on the bronze plans, and this highlights the need for people to be guided to the right plans for them. It is important to make sure people understand and make good choices.

Betsy Imholz, Director of Special Projects, Consumers Union, commented that the constellation of features that staff has come up with really does signal a much better situation than what we have today. It will at least bring some rationality to consumers in the marketplace. Staff has given much care to getting data from plans. The \$500 for bronze could mean \$1000 in the first month, which is a lot. The dream of people

choosing their plans because they know what they need is not necessarily the reality. The message should be that if you have a serious condition, don't buy bronze. There are also unforeseen needs. Could we join forces with other states and get better bargaining power to work on solutions in the long term?

Stewart Ferry, Director of Advocacy, National Multiple Sclerosis Society, thanked the Board for acknowledging the need for reasonable out-of-pocket costs. People living with MS are highly reliant on these medications, in addition to the four to six symptom management systems that are key to their quality of life. When you hit a \$200 threshold, people stop taking their medications. The bronze plan cap is too high and not acceptable. They've received feedback on the need for clarity and understandable language around cost and coverage. Integrated deductibles, for example, are confusing. Medical/pharmacy deductibles are confusing. We need a lot of clarity around what is covered.

Liz Helms, President and CEO, California Chronic Care Coalition, applauded this work and the workgroup. It shows how we can come to decisions together without fighting. She also thanked the health plans. They agree with the proposed amendment to bring down the cap for the bronze plan. They want to help educate consumers on what is the right plan for them.

David Ford, Pharmaceutical Research and Manufacturers of America, noted that we tend to sell ourselves short in California, and we act like we're not doing things. Medi-Cal is negotiating drug prices on behalf of a third of the state. We have been involved in the governor's meetings and been at the table for the conversations. In a Covered California context, it's not quite as apparent because those conversations are happening a few steps removed from the Board. Plans do plenty of negotiating with them. It's an ongoing conversation. There's an incredible amount that's going on right now; it's not that nothing is being done.

Brett Johnson, Associate Director of Medical and Regulatory Policy, California Medical Association, applauded the work that Covered California did on this. They looked at this internally, and have had anecdotal reports from physicians about drug avoidance and non-adherence. They like the staff proposal, which is a good compromise. In terms of drug prices, as Mr. Ford said, there may be relationships there where you can use your negotiating power.

Bill Wehrle, Vice President of Health Insurance Exchanges, Kaiser Permanente, noted he has participated in the specialty drug workgroup, noted their advocacy on this issue has been to urge the Board to bring cost sharing for drugs in line with other types of services, and this is a way to do it. If we were to adopt the proposal to go further for bronze, we would be going the opposite route. Services are expensive for bronze plan members. It's important as we focus on this area not to lose sight of all of the other services that are covered. When we talk about sharing the burden and trying to provide for the few, in last month's testimony someone commented that one of the major manufacturers has a drug-assistance coupon program with \$300 caps. If that company, which has seen its profits go from \$3 billion to \$12 billion in one year, were to amend its caps to \$500, their profit

margin would go from just over 48.5 percent to just under 48.5 percent. These are the kinds of solutions that have to be part of the dialogue.

Discussion: Hospital Tiering

One carrier has a hospital network with multiple tiers. Tier 1 hospitals are the preferred hospitals, Tier 2 carry a higher-cost share, and then there's out of network. In order to meet the requirements, the plan focuses on Tier 1. Tier 2 really gives a break on out-of-network costs for those who end up in a Tier 2 hospital. We asked the plan to reverse this system for 2016, but rewriting their contracts for 2016 would cause a premium hike. We don't want this in 2017 and told them they should start renegotiating contracts now.

Mr. Lee noted that no plan should assume that allowing this is a multiyear policy. It could be, however.

Chairwoman Dooley asked why this was being discussed only now.

Mr. Lee noted that this should have been brought forward earlier. Counsel advised staff that we should make it clear that this is a one-year policy and we need to make it clear that this does not affect network adequacy requirements.

Public Comment:

Beth Capell, Health Access California, voiced that this is really confusing for consumers, who can suddenly be slapped with large out of network bills. A number of consumer protections have been recommended, which they appreciate. They had not been aware that this was in existence. They don't like this and think it results in people making errors. Out-of-network charges do not count toward the out-of-pocket maximum. With respect to the standard benefit design, staff is recommending that qualified health plans not be allowed to cover nonessential health benefits. They are generally supportive of this, but it did not go to the workgroup for vetting. This is the sort of thing that should be discussed in the venue that allows for participation and a more thoughtful process.

Jen Flory, Senior Attorney, Western Center on Law & Poverty and Health Consumer Alliance, agreed with Ms. Capell. They don't like tiering. They are happy that plans are hearing this won't work in the future. Their partners at National Health Law submitted a letter on how to monitor this in the future. They read the footnotes and like to vet these things so they can connect with their partners with regards to what they're seeing on the ground.

Kim Lewis, Managing Attorney, National Health Law Program, voiced concern about the tiering structure. We would like to see it changed for 2016, but it seems that's not happening. Consumers are very confused by tiering. They are concerned that people will end up in emergency rooms in Tier 2 hospitals and not realize it. Covered California will need to monitor that carefully. They submitted a letter of monitoring recommendations. That monitoring will help you have a better understanding of the problem.

On Phone: Michelle Lilienfeld, National Health Law Program, noted that endnote 12 seems to include a change with qualified health plans not being able to offer nonessential

health benefits. This seems to sound like they can't cover benefits beyond the essential health benefits. The essential health benefits should be the floor. Obviously the cost of a richer plan may be passed on to an enrollee. That seems like a material change to the regulations.

Betsy Imholz, Director of Special Projects, Consumers Union, voiced that they know only one plan has tiering, and that that plan is out of compliance with the standardized benefit, but they look forward to a robust conversation on the topic. They just completed a survey, and people are incredibly confused about out-of-network providers. It's a big issue and they look forward to a more robust conversation.

Chairwoman Dooley noted that the out of network issue goes way beyond Covered California, and consumers outside of the exchange are confused too.

Francene Mori, California Exchange Director, Anthem Blue Cross, voiced that their plan does this. They appreciate that they can include this feature in 2016. This is the second year in which it will be considered. They've educated their consumers and previously mentioned that there are minimal complaints about it. If a person goes into a Tier 2 hospital for an emergency, it's covered as a Tier 1 hospital would be. It would be a challenge to change directions for 2016.

Motion/Action: Board Member Islas moved to pass Resolution 2015-38. Board Member Morgenstern seconded the motion.

Discussion:

Mr. Lee agreed that footnotes matter. He apologized that this was not discussed. They've had good improvements to footnotes by a collaborative process. Staff thinks this is the right thing to do.

Mr. DeBenedetti apologized, noting they will try to be more forthright in the future. The concern is that nonessential health benefits cannot be covered by the tax credit. The complexity of plans covering services that are not covered by the credit is difficult. They are evaluating what they should do to change the essential health benefits in California.

Chairwoman Dooley wondered how this came to our attention.

Mr. Lee noted that, for example, one or two plans provide benefits for vision services for adults. These are not part of the standardized package.

Chairwoman Dooley doesn't feel comfortable with this. She does not want to jeopardize the tax benefit. Now we know about this, but she wishes that other people would come to this conversation with insight. She doesn't want to send something to the Office of Administrative Law that we don't agree with. She is going to vote to adopt this resolution, but this illustrates that we missed something.

Board Member Morgenstern asked if there are benefits the subsidy can't apply to.

Mr. Lee and Chairwoman Dooley said yes, you can't have other benefits in among the essential health benefits because of this tax issue. That means competition with employer-based plans suffers.

It's not just the tax issue, it's what offered off exchange. If you're getting a silver plan that is a qualified-health-plan designed plan, it's the same benefits across the board.

Chairwoman Dooley wants the committee to work on if additional benefits can be provided with no impact on the premium. If benefits are added, even in small increments, it will affect the premium. How do you desegregate those?

Mr. Lee asked Janice Rocco to discuss the issue.

Janice Rocco, Deputy Commissioner, California Department of Insurance, noted that she won't make a statement about if essential health benefits are the floor and the ceiling. But sometimes you can add a benefit without adding cost because adding a benefit might make it so you don't have to use other more costly essential health benefits. The standard benefit plan design is about cost-sharing, not the benefits in the plan. If you are selling outside the exchange, you can certainly add benefits.

Mr. Lee asked if plans must offer at least one product that is identical.

Janice Rocco said the standard benefit design is a cost-sharing design, so she didn't understand that to be the case.

Christine, Department of Managed Health Care, noted that last year they allowed chiropractic care and non-essential health benefits for SHOP. She didn't know if they were allowed for the individual market.

Board Member Morgenstern knows for sure that Anthem pays for hearing aids.

Chairwoman Dooley asked if we can omit that disclaimer for one more year.

Counsel said yes. The regulations have to move forward. But footnote 12 can be omitted for the time being. This would allow the regulations to remain the same for the time being.

Mr. Lee stated that this would reinstate the old footnote 12, saying the issue is not addressed.

So the resolution did not need amendment, but the footnote was being removed from the proposed language.

Mr. Lee said they will look forward to having a more thorough discussion about this topic. With regards to the tiering, consumer cost-sharing in either tier must apply to the deductible and out-of-pocket maximum. The motion is on the tiered networks and the

specialty drugs. Mr. Lee noted that part of the rationale for the caps was spreading the out-of-pocket cost through the year. He underscored the agreement that there's a need to analyze and review this policy over time. He noted that the National Health Law Program letter has been posted now.

Board Member Fearer said he shares the concerns but for now doesn't see an option other than allowing tiering for the current year. There are lots of things to monitor. Treating the pharmacy element differently than other elements in the bronze plan does not make sense. He is uncomfortable with last-minute changes. The truth is actuarial work is not simple arithmetic but involves assumptions and such. He would rather uphold the staff recommendation at this point.

Board Member Morgenstern will also uphold the recommendation. However, putting caps enables costs to rise. The only alternative appears to be penalizing Covered California members. The drug companies' negotiators have done pretty well. He assumes we have no choice. He agrees that staff has worked over the statistics and the mathematics on this.

Board Member Islas appreciates the caution. She likes the idea of having a more thorough discussion later.

Chairwoman Dooley noted that the discussion that will be held later is with regards to footnote 12, which will be removed.

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

Mr. Lee thanked the range of stakeholders in California. We are the first state in the nation to put caps on drugs. This will allow people to have access to drugs when they need them but will also be part of keeping an eye on drug costs and premium trends. This shows great leadership from the Board and Covered California.

Agenda Item VII: Adjournment

The meeting was adjourned at 3:18 p.m.