CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD MINUTES

Thursday, November 19, 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 11:00 am.

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

Agenda Item II: Closed Session

Discussion: Announcement of Closed Session Actions
The Board convened to discuss personnel and contracting matters and noted there was nothing to report on these matters at this time.

A conflict disclosure was performed and there were no conflicts from the board members that needed to be disclosed. Chairwoman Dooley called the Open Session to order at 12:30 pm.

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 October 8, 2015 meeting minutes.

Presentation: October 8, 2015, Minutes

Discussion: The minutes presented at the November 21, 2015 Board meeting referenced that the Board approved the October 8, 2015 minutes at the October 8, 2015 Board meeting. The correction should be that they approved the August 20, 2015 meeting minutes.

Public Comment: None

Motion/Action: Chairwoman Dooley moved to approve the October 8, 2015, Minutes.

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

Agenda Item IV: Executive Director's Report

Presentation: Executive Director's Update
Peter Lee, Executive Director, welcomed the forum to the first board meeting of the third open enrollment period. He briefly addressed the closed session action items which included the appointment of a new External Affairs Director, Kelly Green. He also announced the appointment of Mavilla Safi as the Director of the Service Center. He called attention to the complexity of the Service Center and how, unlike many other states' Exchanges, the Covered California Service Center is staffed by state employees.

The Board also approved amendments to several contracts including Ten2Eleven for customer relationships and management to support our sales force; Shaw Valenza for internal investigations; and Ted Von Glahn for services related to the quality reporting system.

The Board also reviewed an update on the Request for Proposal for Vision benefits. Vision services is not a subsidized benefit, but Covered California wants to make these benefits available to its consumers. On November 17, 2015 an RFP was released. Comments and questions on the request are due on November 23, 2015. The plan is to address those concerns in December and choose plans that meet the requirements by the very beginning of 2016.

Mr. Lee then discussed the agenda for the November Board meeting. On the agenda are: findings from the University of Chicago survey of Californians, an update on the open enrollment period, highlights on Covered California for Small Business and the 1332 waiver process. In terms of action or policy items, there will be discussion on laying out the 2017 Recertification, New Entrants and Design considerations. The 2017 contract has already had an incredibly rich and robust set of engagement for many months that is building towards the new contract and the timeline around that contract. There are also two action items; the readoption of the Individual Eligibility and Enrollment and Appeals regulations and the repeal of the Certified Insurance Agent regulations.

Discussion: Press and Media
There are many news clips included in the Board material. Amy Palmer, Director of Communications, will be discussing why Covered California has been getting so much media attention as of late. There were over 17,000 news hits regarding Covered California with particular visibility on the launch of open enrollment and the spotlight on coverage. This is really a testament to good work done in communities across the state by local organizations, Covered California's Communications team and our partner Ogilvy.

Discussion: Reports and Research

Mr. Lee called attention to the two dozen reports and research articles included in the Board material. He encouraged the forum to read through many of them. In particular, a report from Robert Wood Johnson on how to improve the 1095 process. Covered California was one of the contributors that contributed recommendations for other states and how to improve the 1095 process. Second, a preliminary report from the Government Accountability Office (GAO) regarding investigations that the GAO sponsored in exchanges, including Covered California, where they used fake shoppers and fraudulent documentation. Covered California will comment on the final report when it is published. There were concerns voiced when the report was presented in Congress on the ability for exchanges to know if a driver's license is real versus a fraudulent one, et cetera.

Third, the Hamilton Project produced a very well done report on how to choose plans. Similarly, Families USA published a report on improving provider directories. Both of those are issues Covered California looks at constantly, and will continue to look at in particular for refreshing our consumers' experience on how they choose plans in 2017.

The California Healthcare Foundation distributed a report on the role of counties. Many people do not realize the important role the counties play in the healthcare system particularly with the Medi-Cal program. The counties partner with Covered California and work very closely with the staff. It is refreshing to see an overview of the county program done by CHCF is a very good primer for the role of counties.

Board member Art Torres is very happy that the foundation he created with legislation in 1994 is doing a good job and that Dr. Sandra Hernandez, Director of the Healthcare Foundation is wonderful.

Next, there were several reports Mr. Lee labeled as wonky, including a report from the National Bureau of Economic Research on the impact of deductibles which highlights the dangers of deductibles. This article received a lot of press. It is very important for those in California and generally to read that with a conscious eye on what is different in how Covered California structures deductibles. The last three to note are, the Mckinsey Center report on exchange markets and their pricing nationally. Their approach was different than California's when they released their rates. For example. Covered California reported rate increases by the average increase if anyone stayed with their plan, their existing product. This way, the average rate increase in California was 4%. Mckinsey looked at the weighted average change in the lowest-priced silver product. Under that guise, in California, the rate increase was only 2%, one of the lowest in the nation. There are different ways to show this. Covered California doesn't want to make things look better than they are, but there are a lot of ways you can look at the numbers.

In contrast, there are two documents in the Board material, one of which was just posted this morning, Avalier's report on the patients' access to HIV drugs in exchanges. This report noted the drugs are limited compared to other sources of coverage. Covered California was surprised to find that California was highlighted as one of the number of states that had "restricted access to HIV drugs". After taking a very close look at both

2016 and 2015 data, it was revealed that people with AIDS and HIV and people with other chronic conditions had access to drugs in an affordable way.

John Burco, Chief Actuary, authored a letter that is included in the board material calling to question a number of the ways Avalier did their analysis. Aside from the report being funded by the major producer of HIV and AIDS drugs, Gilead, there were several problems within their research. This is an area where Covered California has the capacity to react to items in the headlines and raise questions in the hope they will help improve Avalier's work in the future so that they do not appear to be reaching for headlines by publishing a study which may be accurate for the benefit of pharmaceutical companies. Covered California's job is to be active on behalf of consumers. Covered California is doing the right thing by looking at what is the experience of people living with HIV and AIDS and others with high-cost drug potentials. This is a good example of the dangers of shoddy research and the importance for Covered California to set the record straight.

Finally, yesterday the American Medical Association called for a ban on direct to consumer advertising on prescription drugs. This is outside of Covered California's ambit but an example of what others might be doing that are in the public policy sphere on the complex issue of high cost drugs. Covered California has been out front on saying our patients come first and need to have access. However, we recognize this is a larger issue, which is why we included that report in the material.

Comments to the Board:
There were letters from a number of members of Congress on privacy protection practices, with a full and robust response from Covered California. These are some of the same issues Mr. Lee addressed at the House Energy and Commerce Committee the month before last on oversight issues in general. Covered California is doing a very strong job in making sure that consumers' privacy is well protected in and responding appropriately to requests for oversight from Congress about our activities.

There were also a range of comments from stakeholders. Two were relate to how Covered California addresses healthcare disparities, which will be addressed shortly, and one was a letter from the Health Consumer Alliance to both the Department of Health Care Services and Covered California with regard to the issue of the inability of consumers to effectively transfer from Medi-Cal to Covered California without a gap in coverage. Mr. Lee noted that he disagreed with the letters claim that there had been "little tangible progress in improving transitions". He noted that working in partnership with DHCS, the notices to consumers have dramatically improved. He also noted that the team has dramatically improved the transition of Covered California beneficiaries that move into Medi-cal. Ensuring continuity of care is important and Covered California is focused and has been improving. The issues of transitioning from Medi-Cal to Covered California are important and complicated. We continue to work very closely with the Department of Health Care Services, to whom most of these issues are directly addressed. Covered California takes these issues in partnership with DHCS critically and works closely with the department and will continue to do that.

Discussion: Californians' Awareness of the Affordable Care Act
Mr. Lee summarized the results of a survey that was conducted by NORC at the University of Chicago. NORC was retained by Covered California to complete the survey. In fact, this was their third for Covered California. They did one before we opened our doors, after the first open enrollment, and this is what they did after the second open enrollment. The results have informed much of our marketing and planning.

Mr. Lee highlighted that in comparison to 2013, Covered California is now very well known. Eighty-five percent of Californians know about Covered California and even more know about the Affordable Care Act. This awareness is spread with strength across ethnic groups, with high awareness of Covered California in the Latino community, African-American, Asian and Pacific Islander. The Latino community, which is the largest population eligible for subsidies had the highest awareness of any community of ads that we were running. The targeted approach of running materials in Spanish, in English, targeting this community, paid off. As did investments in using media that reached the African-American community. These were both specific targets in open enrollment period two.

Another "a ha" moment was even though tens of millions of dollars were spent on advertising, which will be detailed shortly, more consumers heard about Covered California through news coverage – tv, radio, print – than through our ads. About 60% of those that saw us on the news, then talked about us with their friends and family, thought about purchasing, et cetera. This reconfirmed the multi-track outreach approach, which is both on the ground, earned media and paid media.

On the flip side, what do people know about the affordable care act? People know that there's a penalty. Eighty-four percent of those we surveyed knew that there was a penalty if they did not buy coverage but only 64% knew there was financial help. Over a third of the Californians eligible for subsidies don't realize there is financial help. This is a key part of our focusing our advertising, on some levels on back to basics, to tell the story of the subsidies.

Lastly, Mr. Lee noted the survey's results is the satisfaction with our website. Eighty-five percent of those that purchased actually said it worked either somewhat or very well. There are other surveys and focus groups that talk about the website. It's not perfect, but it has been improving every year with new releases every couple of months.

Discussion: Open Enrollment Launch: Spotlight on Coverage
Amy Palmer, Director of Communications reflected on what Mr. Lee stated in regards to the research and focus groups. She also presented on the new advertising campaign, branding and quality of the insurance products consumers were receiving. She spoke briefly about the 590 Covered California storefronts, which the Sales team is working hard to grow; the Shop and Compare tool; the bus tour and the Spotlight on Coverage campaign, where we launched open enrollment by lighting up iconic buildings across California with "Enroll Now", which generated some attention. The bus traveled more than 2,000 miles in about 14 days and visited 42 diversified communities. She spoke

about the thoughts that went in to messaging for the bus, the stops and the opportunities along the way. The bus made stops at hospitals, insurance agencies, and iconic locations like San Francisco's City Hall.

The tour was used also to educate the press. Fact sheets were presented to reporters to drive home the care that our consumers are getting. For example, 4,000 Covered California consumers got treatment for broken bones, 227 people got treatment for cancer, and 14 people got organ or bone marrow transplants at Scripps facilities alone in San Diego in the first 18 months that we opened our doors.

She also noted the diversity of the Covered California community… real people on the tour telling their stories. At Crenshaw Health Partners there was a lot of the intensive work in the African-American community and in San Jose and Milpitas, there are a lot of agents working to enroll consumers in Cantonese and Vietnamese.

Ms. Palmer also shared a couple of headlines and a video clip from one of the events to give a flavor for the coverage we generated on the bus tour and then thanked the Covered California team that made the tour possible and contributed along the way.

Discussion: Marketing Update
Colleen Stevens, Director of Marketing, presented on the upcoming marketing campaign. They launched a comprehensive advertising campaign in nine separate languages: English, Spanish, Cantonese, mandarin, Vietnamese, Korean. There are special efforts for the African-American population and the LGBT population, and a slightly smaller campaign for the Laotian, Cambodian, and Hmong populations.

This marketing campaign is based on extensive, both quantitative and qualitative research completed over the summertime. Ms. Stevens goes on to introduce the 2016 Enrollment taglines, "Its life care." or "More than just healthcare, its life care." which resonated with the test groups. She then showed four of the advertisements: "Moments," "Perspective," the call to action ads "Candy" and Heads" and "New Family". The advertisements apart of a larger multi-cultural campaign re in multiple language and in many communities and Covered California can track how effective these ads are in each community.

Next, Ms. Stevens showed a variety of examples of print and outdoor ads and another allotment of TV, print and digital outlets used. She also thanked the staff involved in the effort.

Discussion: Open Enrollment Update
Director Lee presented on early results for the third open enrollment. The three key dates are November 1st (OE begins), December 15th (last day for January 1st effective date) and end of January (OE closes). In the first two weeks, more than 34,000 people have enrolled in health coverage. Also, over 33,000 people who have signed up for dental coverage. This is higher than staff anticipated.

Discussion: Covered California for Small Business Update

Covered California for Small Business is exceeding initial quotes for 4th quarter in responses to advertising and in generating leads and this next year is going to be a major opportunity for Covered California for small business.

Discussion: Covered California 2015 and 2016 Board Calendars
Mr. Lee spoke briefly about the upcoming Board meetings of 2016, noting that even though December is marked as tentative, it could happen at a moment's notice. He also made note of the upcoming Advisory Committee meetings. In particular, the December and January Plan Management Advisory Committee meetings where quality issues will be discussed.

Discussion: Executive Director's Report – Appendices
Mr. Lee reported on the ED report appendices which included information on Covered California's sales force numbers and compensation and service center metrics and call volumes.

Public Comment:
Elizabeth Lansberg with Western Center on Law and Poverty congratulated Covered California on their early enrollment numbers. She went on to highlight the stakeholder letter the Health Consumer Alliance sent to the Board and agrees that generally the transitions from Covered California to Medi-Cal are working better, and she appreciates the efforts made there. The key challenge of going from Medi-Cal to Covered California is a consumer doesn't effectively have coverage a plan has been picked and the premium has been paid. The concern is that consumers aren't understanding and/or are not being told about the timing and about the process of transitioning. The notice telling a consumer that they are losing Medi-Cal says that they have been referred to Covered California and will hear from Covered California. However, the notice that Covered California sends, thanks people for applying for Covered California, which they actually haven't applied. It then goes on to tell them they have 60 days to pick a plan, when in fact, they only have until the end of the month to pick a plan or they will go uninsured. She is most concerned about that possible break in coverage. State law requires that Covered California and the department work together to ensure people aren't having a break in coverage. She is engaged in a second work group process to keep working on these issues. They laid out some very specific recommendations and hope to work with staff to make sure that people aren't having that break in coverage and aren't rolling the dice.

Cori Racela with National Health Law Program and member of the Health Consumer Alliance echoed Elizabeth Lansberg's comments about some of the pitfalls in the transition, especially from Medi-Cal to Covered California. The timing is absolutely critical to ensure access to healthcare during the transition period. Ms. Racela requested that the board and Covered California use its effective and high impact branding and image to increase public education and awareness about selecting a plan on time before losing coverage. The notices still could use more clarifications and her organization encourages translation of the notices so that everyone gets the message.

Dorena Wong with Asian Americans Advancing Justice, Los Angeles supported the comments of Ms. Lansberg and Ms. Racela about the transition issues. She appreciates the efforts that Covered California has made to target and reach out to certain limited English populations, especially the expansion of the media to the smaller API communities, Cambodian, Lao and Hmong communities. She was also glad that it was acknowledge and that it will hopefully be addressed about the long waits for the CEC dedicated line.

Julianne Broyles with California Association of Health Underwriters voiced appreciation from the agent community for the kick off tour making the effort to stop at so many agent store fronts. Thanks to Kirk and his staff for helping to arrange discussions between stakeholders on the Medi-Cal issue. Her organization will be responding to the vision are RFP that was released on the 17th. Like dental, they want to make sure that licensed agents are there and noted on the website as certified agents to help people with that coverage.

Kate Ross with Delta Dental of California, expressed their gratitude for the amount of work and effort that went into the very successful launch of family dental. Really appreciate being given the opportunity to be a part of the process.

Betsy Imholz with Consumers Union remarked regarding the issue of awareness about the ongoing struggle of financial assistance, it is hoped that Covered California is utilizing, in addition to the agents, the community groups.

Carrie Sanders with CPHEN congratulated Covered California on Open Enrollment three. We echo the concerns of others raised about people cycling in between Medi-Cal and Covered California and hope those concerns are address to that folks can enroll easily and seamlessly into Covered California. CPHEN has enjoyed the preview of the marketing materials and diverse outreach, particularly in diverse communities.

Beth Capell with Health Access California also voiced concern about the transitions from Medi-Cal to Covered California. Making it easy for people to stay covered is a goal we all share. Ms. Capell was pleased to see the evolution in earned and paid media and the targeting of communities in an increasingly effective way.

Member Islas sought clarification regarding meeting language requirements. Ms. Islas understands, from the presentation by Colleen and Amy, that Covered California is doing outreach in nine languages, but in terms of the letters and communications that are going to folks enrolling, are we ensuring that we meet the language needs, or is there any way to improve that process?

Mr. Lee stated that there are always ways to improve the process, but the notices that are sent are in multiple languages and we continue to work to have them in more languages. Mr. Lee asked for someone from staff who could speak more on that status – no one was available. Mr. Lee said he would report back on the issue. Many of the notices and formal communications are joint notices with Covered California and DHCS. DHCS has

13 standard languages. We know that, in terms of our enrollment, when you get below seven languages, it's very small numbers, but even small numbers are important. That's why our focus on much of our outreach and engagement materials are in those top seven to what Colleen spoke to.

Mr. Lee also noted the "enroll now" button from the bus tour. This is want is literally on spotlights around California. He thanks the folks that hosted Covered California on this spotlight on coverage tour. There were many agents, but also community organizations, community clinics, hospitals and it really showed the depth and breadth of interest. It was very exciting as we drove down community streets looking for the storefront we would be stopping at, and see many more along the same stretch which actually consumed us many times as to which one we were stopping at. In Eureka, the open door clinic executive director noted that prior to the Affordable Care Act, 40% of the people they saw at the community clinic were uninsured. Today it's 6% - that is a mammoth reduction. This is changing many people's lives in incredible ways. And in visiting the community clinics, we saw that they are exceptionally well run, practicing what we want to have our patients get, which is patient-centered care, well organized and well delivered. The community clinics were rightfully proud of what they were doing on the service side as well.

Discussion: **1332 Waiver Process**
Mr. Lee called out a thank you to Zachary Goldman, Katie Ravel and others on the team that have helped pull this together, along with our working with Jen Kent at DHCS.

Mr. Lee gave a little background for everyone. The 1332 waiver is something that is in the Affordable Care Act that allows states to pursue innovative strategies for providing residents with access to quality, affordable insurance while retaining the basic protections of the Affordable Care Act. There is not a specific deadline, but proposals can start on or after January 1, 2017. The proposals must not add to the U.S. Treasury's 10-year deficit; it requires authorizing state legislation; and the waiver is for 5 years, but can be modified or amended. Mr. Lee noted further that within the guardrails of what is and can't be done, there is much we can be and are doing independent of the waiver. Our ability to raise the bar, so to speak, on contractual requirements on our health plans, our ability to analyze the clinical care received by our patients using claims, our ability to have standard benefit designs to build on quality delivery reform elements, are independent of the need to get a waiver. And these really go to how California's exchange was founded, giving our state the ability to have an active purchaser exchange, which is something our board has endorsed for us. So we have more latitude than do other state exchanges, because of California's framing of what we do. We have had discussions internally and are bringing this forward to the board for its consideration for what we will come back with in January and beginning of 2016, which is that we have done, we believe, California a good job of implementing the Affordable Care Act. But that implementation is not done, and we have many rough edges still to polish. Pursuing a 1332 waiver would require significant resources to vet, craft, do actuarial work, and would necessarily, given our limited resources, divert attention from other areas of improvement, marketing,

outreach, and policy focus. In considering what we should pursue, we believe we should look at the following.

First, does the proposal specifically relate to Covered California's mission which is to increase the number of insured Californians, improving health quality, lowering costs and reducing health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value? We think it's a robust and strong mission statement that the board established a little over three years ago.

So first, does the proposal directly relate to that? Second, do the proposals achieve cost savings or administrative simplification for our enrollees, potential enrollees for Covered California or the providers of health plans we contract with? And given our priorities, we think the focus should be on improving processes rather than redesigning or creating new ones. In addition, in the note that while the 1332 waiver is specific to exchanges, it is very hard, as we have heard today, to have anything we do be independent from its effect on the Department of Healthcare Services and Medi-Cal. How people move back and forth between them is integral, which is why we are partnering with DHCS to have a 1332 process, and we believe another integral element of considering proposals would be that they violate neither the treasury's budget neutrality requirements or add liabilities to California's general fund. We know that's been a significant concern for the administration, and we think as we look at the waivers, we should consider those as well. Our process is to, one, partner with DHCS. In the beginning of 2016, we will launch a webinar of going through not just more details on the guardrails and guidelines, but to have a forum to get what are the potential waiver elements we should consider to, by summer of 2016, come to this board on renewing what our steps should be, which would be entailing either to go forward with the waiver, on which issues, or to say let's wait awhile and do it six months or whichever. But we are looking at a six-month process to see what our next steps would be for the board and the administration. So that is, again, a high-level review. We would have a public process that would kick off in January, but in many ways this is the kick off of the kick off.

With that, Mr. Lee asked for public comment.

Public Comment:
Beth Capell with Health Access California has spent a considerable amount of time looking at the options available under a 1332 waiver, both in the context of health for all and more broadly. As we look at the recommendations that staff brings before you today, a number of observations. First, as Covered California's own research notes, and as many other studies note, affordability Barriers remain significant for some of those who are eligible. Health Access has spent a considerable amount of time looking at the options available under a 1332 waiver, both in the context of health for all and more broadly. We look forward to the process that staff is laying out. We want to keep in mind that affordability is one of the things that is still impeding people from enrolling in coverage or from keeping their coverage when they discover their out-of-pocket costs are substantially greater than they would have contemplated. We understand that if there

were to be any new spending, that would be a decision of the legislature and the Governor and not within the ambit of this organization.

Elizabeth Lansberg with Western Center on Law and Poverty and the Health Consumer Alliance wanted to float three ideas for a 1332 waiver. First, having undocumented immigrant adults be able to buy into Covered California; second, with the transitions, if there is a way to have people using the waiver to make sure they don't have a break in coverage as they move from Medi-Cal to Covered California, like a bridge; and third, to encourage transitions of more Medi-Cal plans to participate, and the eligibility challenge can also have a continuity of care implication for consumers.

Chairwoman Dooley requested some clarification from Ms. Lansberg. The number of Medi-Cal plans that would become qualified health plans isn't really related to 1332. Is there anything up that you need a waiver for in that encouragement to have more similarity between the plan offerings?

Ms. Lansberg stated that it is something they want to look at more closely. Her group is just aware of the continuity of care problems for consumers. Her group does not have a specific proposal today, but it's something they do want to look at.

Chairwoman Dooley asked to hear what Ms. Lansberg thinks if there's something that needs to be waived in order to do that. And that this should be used as a marker.

Ms. Lansberg agreed.

Carrie Sanders with CPHEN is also are looking forward to the conversations about the 1332 waiver and how we can leverage that to make the marketplace easier and simpler for mixed status families, both in mixed coverage but also for immigrant families with different statuses, to make it easier for folks to enroll and to see Covered California as a place to go for insurance.

Dorena Wong with Advancing Justice LA. Ms. Wong echoed Ms. Lansberg's comments about the notices and as far as CPHEN knows and have seen, they have not seen any of the notices or letters in any other languages other than English and Spanish. They hope to change that. They are supportive of the health for all initiative, and especially now that we were successful in getting health coverage for undocumented kids.

Gil Ojeda, Director Emeritus CPAC. Mr. Ojeda recapped AB-626 from back in 1997. He further stated that Covered California might want to take a look at the implementation of AB-626, as it was implemented very successfully by MRMIB for the Healthy Families program over a six year period.

Cathy Dressler with Children's Partnership stated that despite the fact that children are covered by SB-75, as of May 1st or shortly after next year undocumented children in California will be covered. They know that children are more likely to be covered and have access to good health coverage services if their parents also have the same access.

Ms. Dressler's group will remain in support of that and look forward to working with Covered California on the 1332 waiver to make sure that that happens.

Agenda Item V: Covered California Policy and Action Items

Mr. Lee stated that the first item is not an action item. It is to provide an overview of our thinking process and guiding principles as it relates to our health plan recertification and new entrant actions. Mr. Lee introduced and turned the floor over to Anne Price.

Discussion: **2017 Qualified Health Plans: Recertification, New Entrant and Standard Benefit Design Considerations**

Anne Price, Director of Plan Management presented on the 2017 process. There has been a lot of work that has been done already regarding the 2017 certification process, including meeting internally and externally to review what our 2017 certification will look like. It includes new quality requirements as well as new benefits and the overall certification process. Currently Plan Management is in the process of determining 2017 certification policies and are thinking about it in terms of a three-year or multi-year strategy. There are two subcommittees that meet separately and are taking into account what we would like to see in 2018 and 2019. One talks mainly about benefits, network product. The other talks about quality contract requirements. In addition, we have a dental advisory committee that talks specifically about dental items. The goal is to make a recommendation to the board in January and look to have approval in February. The application process for carriers to complete the application would run through February 1st, negotiations taking place late May to mid-June.

The guiding principles on the individual line of business will be individual dental, family dental, the stand alone benefit as well as small group. For individual, we are looking to provide stability for consumers, having a stable portfolio, looking to have three-year contracts that offer distinct choice and quality healthcare with annual changes that are at or below trend.

Ms. Price went on to say that after the 2000 certification plan year, if a carrier did not apply and a carrier would like to apply to be a qualified health plan in 2018, Covered California would look and talk about if they would like to consider that as an option, promote continued growth and implementation of integrated care models, and implementation of new payment models, including increasing compensation potentially to primary care to motivate folks to get the right care at the right time. Also, revise contract to require continued improvement, hold carriers accountable, require efforts that increase new enrollment effectuation and improve retention, and also identify opportunities to reduce administrative costs. The direction we are going right now is to look at having one application that is open to all licensed carriers. However, when evaluating the applications, we would look at stability as a main point, meaning carriers that have participated in the exchange prior, we would continue to look at that favorably because of disruption potential, along with looking at varying our consumer choice, looking at value and the quality programs that the carriers offer.

The application will be for a multi-year contract term, and we would have annual recertification that is looking at rates, benefits, networks, and such. We may again allow new entrants in 2018 and 2019 if the carrier is newly licensed or a Medi-Cal managed care plan. It would then be considered to change our exchange participation fee methodology, such as potentially moving to a percent of premium versus a flat PMPM, which is what we have today.

Ms. Price then spoke regarding dental. Because dental is new for 2016, we are looking on stability and also looking how we can continue to grow this line of business, focus on strategies that retain members, increase new enrollment, provide stability for consumers with ample carrier choice, quality dental care, at a cost with annual changes that are at or below trend. It allows for annual changes in benefit designs, like we do today, looking explicitly towards designs that promote preventive care and value, and require continued improvement in the quality of care provided to consumers.

Our proposed approach for 2017 dental plan, which is very similar to the individual certification, is that there would be one QDP certification that is open to all licensed dental plans, looking at a multiyear contract with a recertification that is recertifying, negotiating rates, benefits, networks, and such. There would be no new dental insurer entrants through 2019, except if the carrier is newly licensed, and allowance for changing the exchange participation fee to take into consideration the wide variance in premium of the HMO and PPO dental premiums.

Ms. Price then moved on to small group. The guiding principles behind small group is focusing on and increasing enrollment. We are looking at a strategy that offers long-term cost sustainability for employers, consider how our individual carrier portfolio aligns and complements the small business portfolio, provide a competitive portfolio of products that will offer employees of small groups the choice to enroll with a carrier that is focused on providing quality care, flexibility to adjust products, networks, and premiums that is consistent with the small group market and regulatory requirements of the small group market today.

We are not looking to have one, come-one-come-all approach, benefit designs that promote preventive care, increase management of chronic conditions and increase access to needed care. That's really what is going to control long-term costs, and opportunities to reduce admin, again, looking at our methodology for how we collect the exchange participation fee.

The proposed approach on small group is that we look at one certification application limited to all licensed carriers, multiyear contract term. What is different here is that we are looking to allow a new carrier entrant off annual certification if that carrier is already a certified qualified health plan on the individual product, and allowance for quarterly change in rates, products, plans, and networks. Currently plans can change their premiums. That premium does not go into effect upon a group until that group's renewal date. So if a plan changes the premium quarterly, again that rate won't immediately change for an employer group until that group comes up for renewal. Likewise, if they

were to discontinue a product, that product would be offered to the group until the plan's renewal date. We are looking at recommending a change that we allow potentially this change to occur with new carriers for 2016. The direction we are talking about right now is for 2017, but we would like to look at implementing some of these concepts for small group in 2016, which would require a change in regulations.

Member Fearer asked Ms. Price if she was just introducing things for the future, so it's not time to really debate in any depth of pro or con. Member Fearer had more questions about the notion of the fee on premium. He understood some of the logic in wanting to take a look at a percentage of premium as opposed to a flat rate. Member Fearer had some concerns about the impact on the exchange. He wanted to be sure that the analysis behind this as it's ultimately shared, includes some of these elements. He mentioned three. One, it creates a little more uncertainty about operating revenue for the exchange when we are putting together a forecast and budgets. There is a potential hazard, which is it creates an incentive for the exchange to offer more expensive products, because we get more revenue. He did not think that made sense. It also puts year over year increases in revenue for the exchange on sort of auto pilot. It goes up as premiums go up, if it's a fixed percent, so does our revenue, as opposed to a deliberate decision making process. Mr. Fearer stated he was not arguing the case, just asking that those kind of considerations be included in the assessment.

Member Morgenstern stated that the issues, contract compliance, rates, benefits, networks, all seem to be identical to him to the concerns that he had when he was on the CalPERS Board and that the University of California must have in picking their plans. And that cooperation between the three agencies, to say nothing of maybe other local governments, would seem to triple or quadruple the purchasing power or ability somehow. Member Morgenstern asked Ms. Price if Covered California ever explored that possibility.

Ms. Price asked if Member Morgenstern was asking if Covered California has ever looked into doing some kind of negotiation, contracting, purchasing, collectively with DHCS.

Member Morgenstern replied yes. Such as selecting which plans should be eligible for our program, which plans should be eligible for the other programs? If it were, he understands there are complications, probably legal, but wondered if Covered California could quadruple their purchasing power and would inevitably affect the market.

Chairwoman Dooley responded: If I could, Marty, not a coordinated bargaining issue. But I think we have worked really hard at trying to make the case for the components of our qualifications for health plan and the standards, our quality review, the things we contract. I will use maternity as an example. Where we have worked with Medi-Cal and with CalPERS to put into the contracts certain requirements of their providers around maternity benefits. I think we have a number of places where we try to coordinate across the different purchasers to require the same things of the plans and to try to standardize

the direction that we are moving in the plans. But I haven't given much thought to trying to globally coordinate our bargaining plan by plan or benefit by benefit.

Member Morgenstern stated he thought coordination is good. Although coordinating marketing might be difficult. But given that just bringing in CalPERS doubles the numbers, just about.

Ms. Price responded that where Covered California can align in terms of improving healthcare and the quality that is offered to consumers – one thing with CalPERS that would be difficult is that they are a self-insured employer group so they take financial risk for the most part for all of their carriers, whereas all of our carriers are fully insured. That is just one of the various issues that she thought would be difficult.

Member Morgenstern then stated that it galls him that the government spends what we spend just in California government, so much on healthcare, that if we could coordinate the purchasing, we would save a lot of money.

Mr. Lee interjected to underscore both of the responses. According to the purchasing, it's a matter of what is the risk mix and the health status of the people you have got, whatever pool you are in. The big thing that we are investing in is coordinating how to change the actual delivery of care. As Chairwoman Dooley noted, we are working very closely with DHCS and CalPERS. So wherever – whether that care is then delivered to someone in CalPERS or Covered California or DHCS, it is more cost effective, higher quality care, which will reflect on our cost and rates as well. We will look more at issues of group buying as well.

Mr. Lee asked if there is another element that is still in this element before going to public comment, relating to the specific benefits and contact – this is a package. Maybe Anne, you could run through those before we go to public comment on this block?

Ms. Price then stated that the group has been meeting with external stakeholders, both for network benefits and then also for quality. For 2017, Covered California is to have benefit designs that are standardized, promote access to care, and are easy for consumers to understand. Thereby we can impact the trip aim: Improving consumer experience of care, improve health of populations, and ultimately reduce costs of healthcare. The benefit design goal for 2017 is for the group to provide input to Covered California staff as we develop recommendations for the 2017 benefit plan designs, and in that we are considering a progressive strategy of potential benefit design changes through 2019.

The subcommittee objectives are to look at the priority areas in our standardized benefit designs that may have barriers to receiving care and areas where we can improve consumers' access to needed care. We want to consider benefit changes that align with value and improve health outcome, and identify and recommend benefit changes that may be necessary to meet actuarial value, and we will get into that in January. All of our plans have to satisfy an actuarial value requirement and identify benefit design areas that

can be improved for consumer understanding and coverage as they compare the benefits across all plans.

For quality, this group is looking at how Covered California can continue to be a catalyst for change in our overall healthcare system using our market role to stimulate new strategies, providing high quality affordable healthcare, promoting prevention and wellness, and reducing health disparities.

The subcommittee goal is providing input to staff as we develop requirements for our 2017 contract in the quality area arena and what we will require of our carriers in terms of aligning participation with some other large purchasers and also areas that the carriers can work on that align on goals that are particular to our population that we serve. The subcommittee members are providing feedback on goal setting, looking at targets that we would aspire to have in 2020 and then backing into, if we want to get to that place in 2020, what are we going to need to get too incrementally, 2017, 2018 and 2019, to reach that goal.

This is a preliminary timeline. There has been a lot of work that's gone in with the subcommittees to date. We are, again, looking to bring a recommendation of all of this in one big package in January and looking to have, and receive, board approval of this direction in February. The application, if we go along that timeframe, would be open shortly thereafter (March 1st) allowing the plans really two full months to prepare their applications and submit rates. Covered California can then assess the applications, prepare our negotiations and actually have our negotiations in the June 6th through June 17th time period, with a goal of announcing publicly the preliminary rates July 4th, allowing our regulatory folks to have adequate time to finalize the rates.

Ms. Price went on further to thank staff that have been working very hard on this with herself and Dr. Lang and James DeBenedetti. They make this all look easy for us – Taylor, Allison, Lindsey, and Ahmed. Thank you all very much.

Mr. Lee joined in Ms. Price's praise and thanking the team and noted that we are developing staff recommendations and are very thankful and appreciative of the subcommittee work. The roll-up-the-sleeves engagement of advocates, of the health plans, which have had clinicians involved, actuaries involved of other stakeholders. Staff is looking broadly, not only at the subcommittee's work, but casting a net to see what our other exchange is doing and what is happening in the private sector in large. We look forward to the recommendations in January being the product of a lot of good work.

Public Comment:
Carrie Sanders with California Pan-Ethnic Health Network, has been participating in the subcommittees and look forward to have more in-depth conversations with Covered California on the recommendations in January. Ms. Sanders directed the board to CPHEN's letter that they submitted (it was a joint sign on letter) that included their recommendations for reducing health disparities through the QHP contracts in 2017. CPHEN hopes that in future years Covered California would consider adding other target

areas that are comorbid with these conditions, such as mental health, tobacco use, that there will be specific benchmarks for plans. It is also hoped that Covered California will make publicly available information on disparities by conditions and progress being made towards those disparities as well as the quality improvement strategies of plans.

Jen Flory with Western Center on Law and Poverty and Health Consumer Alliance, stated that they has been rather tangentially involved in the benefit design subcommittee, but did want to appreciate the staff's sensitivity to pricing and how products can be made better. In particular, looking at percentages versus price per member and dental HMOs. She appreciated board member Fearer's concerns and Ms. Flory's group does not want anything that is going to automatically keep increasing the budget. As for quality – they are eager to see Covered California setting the specific goals and targets as part of the 2017-2019 contracts and agree with CPHEN's recommendations and hope to see concrete targets and goals in those contracts.

Betsy Imholtz with Consumers Union, agreed with prior comments of Ms. Flory and Ms. Sanders and has been on both the quality and benefit design subcommittees. She appreciated the efforts for quality improvement coordination with DHCS, CalPERS and others and think that's the way to really make an impact. More can be accomplished working together.

Cori Racela with National Health Law Program, supported CPHEN's letter to reduce health disparities and to look at the elements of gender and language access as well as race and ethnicity.

Beth Capell with Health Access California, gave more detail about what is coming the board's way after the discussions with staff, both formal stakeholder processes well as in other processes and to look at the Plan Management PowerPoints. Ms. Capell stated that her group are very supportive of targeting racial and ethnic disparities and thing that this is Covered California's opportunity to play the transformative role in terms of reducing costs, improving quality, improving the safety of health care, and really trying to move us into a different era. She looks forward to discussions in January and February.

Presentation: Covered California Regulations: Individual Eligibility and Enrollment Regulations Emergency Re-adoption

Mr. Lee stated that there are two actions items. He also began by reminding the public that at the plan management and marketing committee, board members sit in on them (although never more than two at any one time). Member Fearer is a frequent participant and observer to the plan management committee; Member Islas has participated in the marketing outreach committee. Mr. Lee also stated that he sends out to the board links to the meetings and how easy they are for anyone to find. Ms. Katie Ravel will discuss the first re-adoption of our eligibility enrollment regulations.

Ms. Ravel stated that this is a re-adoption of our eligibility and enrollment regulations. These are adopted periodically as we continue to evolve and refine our processes. These proposed changes were discussed at the last board meeting and are looking to finalize

them today. They mainly gear around our appeals process and some important improvements that we have made to that process, working closely with our advocates and with the Department of Social Services. The Department of Social Services runs our appeals process for us. In particular, these changes clarify our language regarding expedited appeals. These are cases where people need a very quick appeal to retain coverage. It gives good clarity regarding the process for when they will get a notice of their appeal and how quickly that appeal will be scheduled. Ms. Ravel gave some additional clarity about how an appeal will be implemented. The options the consumers have when they choose the date that an appeal will be implemented and finally, this is new, we have adopted a time frame for implementing appeals decisions.

Covered California is committing to implement those decisions, including any system changes, within 30 days of the appeals decision. One additional item that we had to add is the non-tax filer attestation. We spoke about this at the last board meeting. For any consumer who is enrolling with us in 2016 who took tax credits in 2014, they have to file their taxes, but they do have an option to attest. We will have an electronic data source that will give us an indication of whether they filed taxes or not. But in the case that that data hasn't caught up, they can attest to us that they filed their taxes.

Chairwoman Dooley asked for any questions on the re-adoption of the regulations. She stated she would take a motion, and then will act after the public comment.

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

Public Comment:
Jen Flory with Western Center on Law and Poverty and Health Consumer Alliance, stated her group is in support of the language regarding the appeals regulations. With regard to the expedited appeals, a lot of it is really codifying what DHCS has already been able to do, so we just want to make sure that consumers have this protection going forward. Ms. Flory stated they are happy to see Covered California commit to a 30-day timeline, to make sure that when consumers have made it all the way through the appeals process, they have one more month and they can get into their plan. She was disappointed to see that with regard to the non-tax filer attestations the language went into CalHEERS that was not vetted through the stakeholders and her group believes it is a bit overbroad with regards to what the federal regulations are on tax filer attestations and the rules around filing taxes to reconcile their tax credits. Ms. Flory stated they would like to see the language that is not in CalHEERS that people are actually attesting to when they are online changed to match the regulations.

Chairwoman Dooley asked if there were any more comments or questions from members of the board before taking action on the Resolution, 2015-68, Re-adoption of the Eligibility and Enrollment and Appeal Processes. There were none.

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

Presentation: Covered California Regulations: Repeal Certified Insurance Agents Regulations.
Mr. Lee introduced Kirk Whelan, Director of Individual & Small Business Sales to present.

Mr. Whelan stated that agent regulations were developed to incorporate the terms of our agent agreement. Recent legislation clarifies that Covered California does not need to have those agreements in the regulations. Due to Covered California mending the agent contract, we are seeking board approval to repeal the agent regulations.

Mr. Lee stated that Covered California still has a public vetting of what the agreements are themselves, so agents and others won't be surprised on what the agreements are. But for them to be part of the regulatory process, we do not need, but we still believe in the public vetting process of what those contract terms are.

Public Comment:
Julianne Broyles with California Association of Health Underwriters, stated that her organization agrees with the change being put before the board today and hope that Covered California will continue to use their active manager, active purchaser line to ensure that the producers, sales force, continue to be treated fairly going forward under the Covered California emblem.

Beth Capell with Health Access California, expressed appreciation that the process that Covered California now has under law is that something is discussed at one board meeting before it is acted on at another, which indeed has always been the custom since the first board meeting. And the law now recognizes that and no longer ties Covered California's hands by requiring regulations of things that can be done through policy and normal public process.

Motion/Action: Board Member Torres moved to adopt Resolution 2015-69. Board Member Fearer seconded the motion.

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

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