CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD MINUTES
Thursday, January 21, 2016
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 11:10 am.

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

Members Absent:
Art Torres

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.

Chair Dooley announced that Member Torres has been appointed to a full four-year term by the Senate.

Chair Dooley also gave a brief update on the Governor's State of the State address. He remarked on how far California has come since 2011. Most importantly, "we have wholeheartedly embraced the Affordable Care Act. As a result, we are now enrolling 3.5 million Californians in Medi-Cal, and another 1.5 million in Covered California. This is an historic achievement, it will provide health security to so many who could not otherwise afford it."

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 November 19, 2015 meeting minutes. There was a typographical error that needs to be fixed.

Presentation: November 19, 2015, Minutes

Discussion: None.

Public Comment: None

Motion/Action: Chairwoman Dooley moved to approve the November 19, 2015 Minutes.

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

Agenda Item IV: Annual Election of Board Chair

After asking if there were any nominations for Board Chair, Chairwoman Dooley was nominated.

Discussion: None.

Public Comment: None

Motion/Action: Chairwoman Dooley called roll on the nomination.

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

Agenda Item V: Executive Director's Report

Presentation: Closed Session Review
Peter Lee, Executive Director, welcomes the forum to the Board meeting. The Board adopted a new contracting manual. State law adopted last year requires Covered California to adopt a contracting manual incorporating all of the various policies, procedures and needs to be substantially similar to the state contracting manual developed by the department of general services. A copy of the contracting manual will be publicly posted following today's board meeting.

The board also approved issuing a Request for Proposal for an Order and Print Fulfillment contractor that will be hitting the streets soon. Staff also reported on a competitive bid that is already in the works to assist Covered California in its meeting the long term financial enrollment and market planning. It was issued in December so that a vendor can be selected as soon as possible to help us with the 2016-17 plan and beyond.

The Board also talked about a number of Qualified Health Plan issues with the board such as plan status. These will be covered in open session as well.

Discussion: Press and Media

Discussion: Reports and Research
Mr. Lee called attention to the several reports and research articles included in the Board material including the Urban Institute report, which looks at premium increases across 20 states, the Commonwealth study on aiming higher, the Commonwealth report on consumer cost sharing, the Urban Institute issued a report on problems paying medical bills, the Kaiser Family report on the penalties for not getting insured, another Commonwealth report on the accuracy of CBO and other projections and finally, a report from Clear Choices, which talks about how exchanges can and should report consumer information. This report has some good information, however, they gave California an "F" for not providing an out-of-pocket calculator, which California has done from day one. Also included in the material is a copy of the letter Covered California sent in response to Clear Choices' report.

Discussion: Enrollment Update
Covered California has almost 300,000 people who have newly enrolled in this open enrollment period, 290,000 people. Staff is hoping to be over the low estimates and closer to the midpoint ones by the close of Open Enrollment on January 31, 2016.

Staff also reports that in both renewing and newly enrolling members, over 140,000 people have enrolled in dental plans. Dental plans are important because it is bringing to mind health insurance for some that started thinking about dental and it brings them in to getting health insurance coverage.

Discussion: Promise of Care
Mr. Lee mentions that included in the board material is a copy of a report that was released at the University of California San Francisco with Leader Pelosi on Delivering on the Promise of Care. The report summarizes care received through 111 of California's 400-plus hospitals. It gives a picture of how Californians are getting the care they require in some of the best institutions in the state, nation, and world. Among the findings of this preliminary report is almost 11,000 cancer treatments, 89 transplants, 65,000 emergency room visits, labor deliveries, and NICUS. People are not just getting needed care in hospitals, but they are also getting preventive services, they are also getting primary care.

Mr. Lee. Sends a huge note of thanks and appreciation to members of the Covered California team who made this report possible, in particular in the communications team, Roy Kennedy and Robert Seastrom, Zachary Goldman in Policy, Dr. Lance Lang and Ahmed Al-Dulaimi in our plan shop. He also thanked the hundred-plus hospitals, from San Diego to Redding, who spent the time to pull together the data for us.

Mr. Lee also noted that at the UCSF event, he was joined by a patient named Anita who is now covered by Covered California. Anita was uninsured but enrolled the first open enrollment period. She was diagnosed with stage four cancer but was able to be seen by Dr. Ueda, and is in very good health now. Anita says that she believes she is alive because of the coverage she got with Covered California and the great care she got at UCSF.

Discussion: 1095 Update
Mr. Lee next highlighted updates on the 1095 process and lessons learned. Last year was bumpy with incorrect reports and getting statements out at the very last minute. This year is different in that Covered California has already issued over one million 1095-a's over the secure website, mailed over 630,000 1095-As to consumers, and staff expects to have 100% mailed by January 31st.

There is a correction process that will begin in February in case of any errors and staff has been working in coordination with the Department of Healthcare Services, which is issuing 1095-Bs to households for service for Medi-Cal coverage. However, there have been a lot of process improvements in terms of standardizing the reconciliation process and working closely with health plans to ensure a smoother process.

Mr. Lee sent a thanks to three individuals at Covered California: Drew Kyler, Thien Lam, and Lisa Howard, who have been doing incredible work for months and months to make sure consumers had a better experience this year than last. He also thanked the team at the service center who are making sure that our service center staff are well trained in handling dispute resolution, handling the details of how to work these things through.

Comments on Federal Regulations:
Health and Human Services published proposed rules on December 2nd, with comments due on December 21st. Covered California responded with rigor and depth on three big issues: Fee Proposal in the Federal Marketplaces, Standardized health benefit designs in the federally facilitated marketplace and allowing web-based entities to do enrollment end to end.

Discussion: Covered California 2015 and 2016 Board Calendars
Covered California will plan on having a March meeting, and tentatively no April meeting and we propose having a May meeting.

Discussion: 1332 Waiver Process Update
Mr. Lee reminded the audience that Health and Human Services has provisions for a state innovation waiver, which would take effect after January 2017. The Federal review could take up to six months, so we want to quickly do a review of what options California might consider. Staff has scheduled a kick off webinar, which would also start our input process for next week, January 26, to review the waiver process, federal guidance, and initial input process. In February, there will be a forum on the waiver options with panels of speakers to present topics, options for us to consider. After that, staff will bring recommendations back to the board.

Discussion: Executive Director's Report – Appendices
In the Appendices, Mr. Lee wanted to point out service levels for the month of December. The average speed to answer phone calls was three minutes, however, more than 50% of the calls were answered within 30 seconds. Staff is always balancing amount of time to respond to calls versus the cost of staffing. Covered California's county

partners are doing an exceptionally good job in terms of the Quick Sorts. Average speeds range from six seconds to 18 seconds.

Discussion: Comments to the Board
Mr. Lee reviewed the letters and correspondence the Board received. They received a letter from CAPG regarding delivery reform issues and correspondence from the California Rural Indian Health Board in reference to the mixed tribal family glitch.

Public Comment:
Betsy Imholz, Consumers Union, commended Covered California for the detailed comments and technical assistance provided on the federal regulations and the letter to issuers. Consumers Union submitted comments also, particularly touting the learnings here in California from the perspective of the work groups that we have been on and the plan advisory committees, particularly on the value of standardized benefit design and some of the particulars and how the choices are displayed as well. It's very wonderful to be able to provide that kind of detailed feedback to the federal government on issues that we have kind of started with here and to see them moving in a direction that appears to be in line with where we have been.

Jen Flory, Western Center on Law and Poverty and the Health Consumer Alliance, commented the 1095-a forms. Last year, their consumers had considerable difficulty, so we are glad to hear that staff has made commitment to improve the process. They are excited about consumers getting notification that the request to change their form was received. They would, however, like to see further commitments for people that just need a simple correction rather than an underlying eligibility appeal issue. This will result in timely filing of tax returns.

She would also like to report that they have been working pretty closely with staff on appeals issues and is seeing compliance with the decisions happening in a much more timely way. They are starting to work on some of the more complex issues that have been issues of overlapping jurisdiction with Covered California and the Department of Managed Healthcare, and we are happy to report that we finally had a meeting with Covered California, DSS, and the Department of Managed Healthcare and are starting to work through some of those issues of overlapping jurisdictions.

Lastly, there is still a problem for people moving between Covered California and Medi-Cal. One piece in particular that they have been asking for since April is that people transitioning between Medi-Cal and Covered California are being told they need to pick their plan before their Medi-Cal ends in order to avoid a gap in coverage. This information is neither on the Covered California notices, nor on the notices that come from the county as approved by DHCS.

Julianne Broyles, California Association of Health Underwriters, thanked the board and staff for helping during the hard push during December and January to resolve agent call center support issues. Staff came to the rescue when Agents were having delays in getting answers to agent issues with their clients. She thanked Kirk Whelan and his staff.

She also commented on the issue of the web-based entity comments submitted to the department at the federal level. They want to reinforce comments have been made in prior meetings, that the web-based entity process should be something that permits certified agents to use one that helps the individual agent and not use one that would instead use a large, out-of-state call center or in-state call center rather than use your independent marketing force that you have with California's small businesses throughout the state.

The California Immigrant Policy Center commented on the 1332 waiver process agenda item. They would like to acknowledge that in California, we have had a lot of achievements and made a lot of great strides with ensuring that we integrate immigrant families in our state, from driver's license for everyone, to protecting immigrant families from deportation raids, to expanding full scale Medi-Cal to undocumented children. She hopes that Covered California will continue with that legacy and that leadership by ensuring that no one is excluded from access to healthcare. As Covered California is engaging in discussions to look at possible waiver options, it's very important to look at removing barriers to access that many immigrant families face because of their undocumented status.

Dorena Wong, Asian Americans Advancing Justice, Los Angeles, supports the comments that Jen Flory from Western Center made about the appeals process. She also wants to support the comments that Betsy made about the inclusion to expand or allow undocumented immigrants to purchase plans under the marketplace. They are really excited that California is taking the lead across the country and has opened up its Medi-Cal program to all low income children regardless of immigration status and to allow the parents of these undocumented immigrants, so that the whole family can have access to health coverage, is really key to making sure that all. This could also increase the number of eligible enrollees or number of enrollees entering in to Covered California's plan and help stabilize the financial sustainability of Covered California.

Erica Cabado, Greenlining Institute, a statewide racial justice and advocacy organization, wanted to uplift your work and your leadership, especially because she was a Certified Enrollment Counselor during the first year of Covered California. She wanted to talk about some of the work she has been doing with undocumented youth here in California, who shared stories about the barriers that they experienced to accessing healthcare for themselves and for their mixed status families. For example, one young man, who has a younger brother who is a U.S. citizen, but who almost never gets to see a doctor because his undocumented mother is afraid that by taking him to the doctor, she puts herself at risk for deportation. She is in favor of allowing undocumented people to access Covered California through a 1332 waiver.

Kate Birch, California LGBT Health and Human Services Network, commented on the always-overlooked appendix to the report, the 24-month road map for updating coveredcalifornia.com is listed in there. She is disappointed that there has not been a version yet that talks about adding sexual orientation and gender identity to demographics

data collection. She has been talking to staff and working with DHCS to comply with the new state law that requires them to ask about SOGI data on all of their forms. She hopes that Covered California will continue to be supportive as they are figuring out how that works with a streamlined application that both agencies used.

Secondly, she discusses the 1332 waiver and that the reason Covered California should open up to undocumented immigrants is because that makes it a one-stop enrollment shop for everybody in the state, not just mixed status families, kids only, that sort of thing.

Lynn, Southeast Asia Resource Action Center, echoed the comments that have already been said about the 1332 waiver. They want to make sure that Southeast Asian Americans also would be part of that pool, right? There are 170,000 Vietnamese Americans who are undocumented and they don't know how many more are in the Lao or Hmong communities but think it's significant.

Sonya Vasquez, Community Health Councils, believes that there are no accidents, and it's kismet that there's a sign behind us that says "all things important are insured." that's what this conversation about the waiver has been about. They agree with all of their partners that have gone on before her. Insuring all of our undocumented children shows that in California we value the lives of children. With this waiver we can also show that we value everyone's life in California, and that everyone should have access to health coverage. Doing so, as Dorena had mentioned, not only ensures that we improve the health of our immigrant adults, but it also ensures that we improve the financial health of Covered California and our plan. She highly support the discussion around opening the doors for Covered California for undocumented adults.

Carrie Sanders, California Pan-Ethnic Health Network, congratulated Covered California on the number of new enrollees and the success of dental. She also demonstrated her support to the previous comments on the 1332 waiver and really strongly urge the board to really look at opening up the exchange to undocumented. She is proud to have been working with Covered California to eliminate and reduce disparities. She believes Covered California has invested quite a bit in culturally and linguistically appropriate outreach and education. Opening up the exchange allows you to really ensure that all the folks that you touch and reach are able to get some type of assistance or coverage. She also noted the letter from the California Rural Indian Health Board and urged staff to prioritize fixing the mixed tribal glitch, and also the zero and low cost sharing provisions so that those families can access coverage in an efficient way.

Beth Capell, Health Access California, commented on the 1332 waiver and echoed the comments of her colleagues about allowing the sale of lookalike QHPs to individuals who do not meet the documentation status for citizenship or immigration, so that all Californians can come in through the front door of Covered California and get coverage. She thinks there are other important things and other opportunities in a 1332 waiver to streamline things. For instance, that pregnancy only coverage, women who are pregnant, are eligible for both Medi-Cal and Covered California and she wants to explore that and see if there are ways to smooth and streamline things for those women. Similarly, we

have mixed families with children on Medi-Cal and their parents in Covered California and we have questions about whether we can make things easier for them. She would also be very interested in conversations about moving forward on adult dental and vision, which gives even more of your enrollees the opportunity to access that.

One of the questions that's raised by the recent federal guidance is whether – you in essence administer a tax subsidy on behalf of the internal revenue service. One of the possibilities that is opened by the 1332 waiver is to restructure how that works as well. and finally, to note with respect to the 1332 waiver, that we look forward to a timetable that moves us forward in this discussion in this legislative year, and so we can move forward to having something in place in January.

Regarding the comments on the federal regulations, we commend Covered California for having so strongly supported the consumer perspective, and that includes with respect to web-based brokers who should not be able to pick and choose how they present products.

Board member Genoveva Islas asked clarifying questions regarding undocumented consumers purchasing off-exchange. Federal regulations prohibit Covered California from selling to undocumented consumers. The Waiver process could be an option to open the Exchange up to this population, however, there is a process that includes a financial analysis to see it did not have a negative impact on the federal budget, the need to have law passed in the State of California saying it's the right thing to do and the Health and Human Services would review the proposal and add whatever other factors and then decide if they would allow it. This is a very brief overview of the steps that would need to be taken in the process. It is a waiver because we have to ask them to waive the provisions of the act that limited services to undocumented. This option that is being discussed would allow Covered California to grant access to purchasing insurance but without subsidy. Proposals for subsidized, but that has been recognized to be very expensive, potentially. If subsidies were brought to the table, funding would need to come from state funds as has been done with undocumented children.

A meeting in February will more fully discuss the requirements with staff and panelists and will be followed with in-depth stakeholder involvement.

Agenda Item VI: Covered California Policy and Action Items

Mr. Lee remarked on Covered California's vision of wanting all Californians to assure their access to affordable, high quality care and the mission is to increase the number of insured Californians, improving healthcare quality, lowering costs, and reducing health disparities through innovative, competitive marketplace that empowers consumers to choose the health plan providers that give them the best value. This has been engrained in staff as they work through benefit designs or contracts. No matter how big Covered California is, if we aren't affecting how healthcare is delivered over the medium to long term, we won't affect cost, we won't affect quality.

Mr. Lee thanked Anne in particular, but also other members of the health plan team that have been working a long time with a lot of other people, including with Yolanda, with Lance, with James DeBenedetti and the entire team to prepare a lot of material here that has sort of been months and months in coming, both to the benefit front, the contracting front, and on the delivery form front.

Mr. Lee introduced and turned the floor over to Anne Price and reminded the audience that the body of agenda on policy and action items are not for action today, these are for discussion.

Discussion: **2017 Qualified Health Plans: Recertification, New Entrant and Standard Benefit Design Considerations**
Anne Price, Director of Plan Management, presented on the recommendations for the 2017 Certification. She mentioned key dates of stakeholder and carrier feedback on the draft proposals by February 4th and are looking to receive an approval of our recommendation at the February 18th board meeting, so that an application can be released and due back from carriers on May 2nd.

She spoke about guiding principles for individuals that will provide stability for consumers by having a portfolio of carriers that have distinct choice, different networks, and all offer quality healthcare with changes in the out years that are at or below trend. Covered California will continue to promote growth of integrated care through ACO's, medical homes, and support primary care. They are interested in our carriers implementing provider payment models that reward higher value and delivery of care to consumers at the right care and right time, by the right provider, they launched significant revisions in our contract requirements, in Attachment seven, which Dr. Lang will speak to that later in the presentation.

In 2017, we want to maintain the policy of having standard benefit designs. All carriers will offer the same benefit designs, and the choice will then allow consumers to make choice based on the provider networks, formularies, health plans, the quality tools, and so forth. They are recommending to have one certification application. The application this year will be for a multiyear contract term through 2019, and there will be annual plan recertification and new entrants may be considered in 2018 and 2019.

Participation fees will be set at a percent of gross premium in 2017 instead of a flat value, which is what we have had for the last three years and will be reviewed annually in 2018 and 2019 with the goal of reducing percentage and not just having that amount we are reimbursed increase with medical trend. Staff is currently evaluating setting that percent at 3.5% of gross premium, which is consistent with the federal marketplace. To put it in to perspective, the $13.95 today which we charge for 2016 is equivalent to about 3.44% of premium and the risk to forecasting when using a premium, although it's not as specific as a flat PMPM, the risk is pretty low considering the size of our market, of 1.5 million, and the retention of members that stay with the existing plan.

The certification guiding principles for dental for individual and small business. With family dental being a new option for 2016 in the Individual market, the guiding principles for 2017 certification will be focused on stability in products offered and stability in future premium changes as we look to increase enrollment and assure that those who have enrolled in this benefit are getting good value. Focus on strategies to retain members and increase new enrollment, provide stability for consumers by having a portfolio of carriers, products, and networks that offer unique choice and quality at a cost with annual changes that are at or below trend, allow for annual changes to benefit designs that promote preventive care and value, assure the quality of care delivered and require continued improvement in the quality of care provided to consumers.

The recommended approach for 2017 dental, certification for individual and small business is, like medical, will have one application open to all licensed dental plans. It also is for a multiyear contract term that will have a recertification process annually. New entrants may be considered in 2018 and 2019 if the issuer is newly licensed and that carrier brings value. Because of the significant variance in dental HMO and PPO premiums, we will also be changing the participation beyond this line of business to a percent of gross premium at about 3.5%.

She next discussed Covered California for Small Business medical. The guiding principles here are just like individual and dental, and that is to have a competitive portfolio of products that are really competitive in our small group marketplace. The difference here is the flexibility to adjust products, networks, and premiums consistent with small group market and regulatory requirements, which is different from the individual market. The certification and contract requirements, we intend to still include expectations for quality improvement and delivery system improvement. Staff hopes to offer standard benefit designs potentially, as right now they have alternative benefit designs.

For small group certification, the recommendation is that we will have one application open to all licensed health insurers, and these carriers do not have to currently offer on the individual market. The contract term will be a multiyear term, with an annual certification and we will consider new carrier entrants off annual certifications. We will allow for quarterly change in rates, addition of new plans and networks subject to, again, our approval and regulatory approval, and also look to change the exchange participation fee to a percent of premium and at this point we are looking at 4.7%, which is actually equivalent to what we receive today at the 1890 PMPM, we will make that recommendation in February, with approval being sought in march.

Ms. Price next discussed Benefit Designs for the individual, small business, and family dental. Staff has been working with a subcommittee of the plan advisory meeting, and there were two separate committees, one for benefits and network and another for quality.

Key considerations in designs offered are that of course our benefit designs must meet actuarial values for the 2017 AV calculator. Ideally, staff wanted to have 0.5% room in the benefit design to that next year we won’t have to look at an increased cost sharing.

They sought to address benefit design priority areas that reduced financial barriers where they existed and improve consumers' access to care. Any areas that were confusing, we sought to change that would improve consumers' understanding of what cost sharing applied, foster aligned incentives between members, providers, and plans for benefits that generally have wide variation in cost and service. Staff wasn't ready to implement value-based insurance design just yet. Until they have data that we could analyze and really understand what our expected changes in care and cost savings are.

She next went on to the summary of the recommended changes for the 2017 plan year and areas of proposed decreases to cost sharing: continue promoting access to care, promoting urgent care when needed versus the emergency room, improving consumer understanding of benefits, and finally, to meet regulatory requirements needed to apply a drug cap to the HDHP bronze plan. In the areas of increased cost sharing, she spoke about the increase in the deductible and the max out of pocket, an increase x-ray diagnostics cost sharing by $5-15, increase imaging by $25-50, and increase cd facility copay by 75-100 in the silver to gold plans.

Ms. Price then went over the actuarial value tables to show the audience where they have landed for 2017, the recommended portfolios for each plan and clarified some endnote changes that have been made. The goal is to ensure retention, increase enrollment, and maintain our good risk mix of the pool. With that, she proposed two requirements: one is there we will require that health plans use best efforts to enroll also for the eligible members through the exchange and two is non-compliance.

Chairwoman Dooley asked of Ms. Price: On the first point on this slide, what causes us to think that the agents are putting people into off-exchange products instead of the on-exchange products with the subsidies? Are there differences in the commissions in the off-exchange product, or why would we have to call that out? What's the problem we are solving?

Ms. Price answered that the contract today with QHPs require that the agent commission be the same for both off and on exchange members as a contract requirement, so that should not be happening.
It could be a member is on the cusp and a member chooses to go directly to a carrier if they don't want to come through the exchange for one reason or another, meaning their income is not so low that they should be receiving substantial subsidies.

Chairwoman Dooley said, but you have that risk, that there are people that are subsidy eligible that are not buying subsidized.

Ms. Price responded that Covered California received information that that is the case. It could be as high as 180,000, but we don't know that for a fact.

Mr. Lee stated that Covered California has been in very active discussion with plans. Every one of the plans shares this commitment. If people are eligible for subsidies, they

should get them. We need to do better analysis -- and they are all ready to work with us on this – it may be that many of these people are people eligible for small subsidies, but the independent data says there are some number of people eligible for substantial subsidies that just aren't aware of it, that have been confused.

Chairwoman Dooley noted that she knows we kind of dealt with that issue of the 400, and that was one of the glitches and the cliff and the problem, and I can appreciate it on that end. It just struck me as something that would not have occurred to me.

Ms. Price further stated that the majority of the plans do the best job they can educating people, and they are committed to that. Because of the information, we will just be pursuing it, and if there is anything we can do that would bring those numbers over, we will do that.

Member Fearer commented that he doesn't think it's so much a matter of any kind of special intent. It is, particularly for the smaller subsidies, but subsidies in general, it can just be more work. They are just trying to get through their business, and they didn't spend quite enough time.

Member Morgenstern wondered, being not too acquainted with all the processes, and if there is a benefit subcommittee. And given there were some benefit increases in copays, did that come out of the benefits committee?

Mr. Lee explained that the committee makes a recommendation to staff, staff then considers it to bring to the board. It's the board's action which would be taken at the next meeting.

Member Fearer commented on the process. There is the plan advisory group, and then it has subcommittees, two of which Ms. Price has mentioned, one around qualities initiatives and the other around plan design. And then it's as Mr. Lee described - it comes back to the committee and back and forth with staff, and ultimately decisions that are made at the board level. Member Fearer stated that he has made a point of, at the plan advisory level, sitting in, mostly to solicit and learn for himself. He has not been part of the subcommittees, those that have met in much greater depth about some of the detail. The membership of these, both subcommittees and the plan advisory group, are quite diverse, with consumer advocates and plan representatives and so on with a broad range of views and interests. Member Fearer further commented that what he has observed is that there's a very strong commitment to both the mission and vision of Covered California throughout the process, and also a willingness to compromise. There are at times certainly disappointments, but overall it's a very robust process. Member Fearer has been very impressed with the degree of collaboration among this wide group of stakeholders. Member Fearer said he thinks it's a great process.

Mr. Lee stated that it's very important to recognize that we still will have in these benefit designs, at bronze, three visits a year, not subject to the deductible. That's very important. Even people that pick bronze – and the recommendation is to go from $70-75

for the visit, but no deductible is applied for that. Similarly, we kept the vast majority of services at silver and above, not subject to any deductible. We are only having one silver plan this year. Each year we have been getting better and smarter and in future years we will be able to inform our revisions to benefit design not only with a very good working process, but with analytics from our work with all of our health plans.

Member Fearer stated that he agrees absolutely with what Mr. Lee said regarding continuity in design, coupled with annual improvement. The other thing to recognize, though, is over time there is an evolution in healthcare delivery itself, and we need to be mindful of that. That's one reason Member Fearer particularly likes putting primary care and urgent care in the same bucket. One thing is urgent care isn't new. It has been around for decades, but more systems seem to be experimenting with front-end care. There is sort of a continuum – one thing he has seen recently, but hadn't heard of before is the notion of immediate care, where they give a patient a menu of choices. Consumers can go to urgent care, make an appointment with their doctor, or see a nurse practitioner, in two hours and they will schedule the time. So to the degree we can facilitate that and give our consumers access to these multiple avenues, Member Fearer believes it's a good thing.

Public Comment:
Beth Capell, Health Access California. Ms. Capell feels Covered California is building on a very strong foundation that really focuses on primary care and making the cost sharing for primary care very reasonable. Consumer advocates are faced time after time with a choice that if you want a better primary care copay, you're going to end up with cost sharing for the emergency room and for a hospital visit that are really quite astonishing to anyone who has dealt with employer-based coverage. We want to acknowledge that already today your staff has taken into account a number of our concerns that were in our letter that they received just this Tuesday and addressed them in the designs that are presented today. Ms. Capell further stated that they appreciate very much the elimination of tiered hospital networks. There had been a very thoughtful and lengthy discussion on value-based insurance design and reference pricing and concluded that they were not ripe for this year or at these actuarial values.

Member Morgenstern asked for clarification from Ms. Capell. He asked if she was suggesting that, say the silver plan, compares very poorly with most average employer-based plans?

Ms. Capell responded yes. The data from the Berkeley Labor Center indicates in general, employer coverage in California ranges from 80-87% actuarial value, sort of in the gold-platinum range. So I find frequently my counterparts in the labor movement, when they look at the cost sharing, are quite horrified.

Betsy Imholz, Consumers Union. Ms. Imholz agreed with Ms. Capell's commending the process. Consumer advocates never like to see increases in out-of-pocket costs and people are paying a lot out-of-pocket generally, but the AV calculator is a tough task master. Overall Ms. Imholz felt the primary care issues are being handled well.

Consumers Union supports hitting the pause button on a couple of things that we did, value-based benefit design, alternative benefits, and tiering, and staff was great in gathering a lot of real data so that informed decisions could be made.

Carrie Sanders, CPEHN. CPEHN also participated in the subcommittee that really looked at the standard benefits designs. In that committee, they really listened and were very responsive to many of the concerns that CPEHN raised and agree with reducing the primary care copay. It's going to be really important for consumers to know what services are covered and what aren't. CPEHN also appreciates and agrees with the direction on value-based insurance design.

Jen Flory, Western Center on Law and Poverty (WCLP). We agreed the actuarial calculator is very difficult. WCLP understands a new calculator is being issued in February. WCLP would like to see the out-of-pocket maximum and the deductible pulled further down. WCLP is glad to see staff looking into non-compliance of contract terms, and we look forward to further conversations with them to how we can come to some of the best resolutions when there's a particular consumer who is not having – or is having a problem with their plan. How they can then compel the plan to do what they are supposed to do in terms of following Covered California's eligibility determinations and do that in a timely way without harming the rest of the consumers that need access to the plan.

Juliann Broyles, California Association of Health Underwriters (CAHU).
Ms. Broyles noted for the record that there has been, in other states, pressure put by plans on different tier levels by reducing or eliminating commissions completely, but she has not seen any strong evidence here, but certainly it's on your watch list.

Michelle Lilienfeld, National Health Law Program (NHLP). Thank you to the Covered California staff for the opportunity to participate in the benefits and network subcommittee, whereas others have mentioned, great work has been done. NHLP echoes many of the comments that have been made by advocates already in terms of the proposed 2017 benefit design. We appreciate and support the elimination of the deductible to original room visits and the merging of the ER sufficiency into the ER visit copay. This will really make it easier for consumers to access the benefits and better understand the costs involved. To the extent possible, we would appreciate, minimizing any increases to the deductible and the out-of-pocket maximums if there's an opportunity for that when the final AV calculator is released. NHLP supports the reduction of primary care office copays as well as mental health and rehab copays to promote access to care, and also support the recommendation not to proceed with a value-based insurance design at this time.

Jerry Jeffe, California Coordinated Care Coalition. Mr. Jeffe echoed the previous speakers' comments. He was a member of the benefits subcommittee work group. The meetings were public, and although there wasn't much of an audience, the process was very open. The staff worked hard and were very responsive. Because of that effort and the high quality of work and how everyone was able to challenge each other, it lends

tremendous credibility to the recommendations by the staff. Mr. Jeffe believes that other exchanges/think tanks would find it hard to match the work that was done by the plan management unit in producing these recommendations for 2017.

Bill Wehrle, Kaiser Permanente. Kaiser also is in support of the proposed benefit change recommendations. We applaud the reduction in the primary care copayment and equalizing urgent care with primary care in light of the population that we serve. We try to make incremental changes and leave a little room for the future. Kaiser has 1.5 million people renewing, and they certainly care about year-over-year consistency to the extent that we can have that.

Athena Chapman, California Association of Health Plans (CAHP). Ms. Chapman echoed those who spoke before her about the process of the standard plan designs. With regards to the QHP fee, if Covered California does adopt a policy to change to a percent of premium for the QHP fee, we just request that you work with plans early on to develop the reconciliation process for that.

Tim Camer, LA Care. We are excited to be entering our third year as a Covered California health plan, and we would only ask that as the board is considering these potential changes, that they would adopt the staff's recommendation to switch to a change of percent of premium for the gross premiums for qualified health plan certification fee. We prefer that over the flat tax structure.

Anthony Galace, Greenlining Institute. We were extremely shocked at the realization that over 180,000 subsidy eligible consumers could be purchasing coverage without receiving them. Despite the road that we have traveled and the progress we have made, this is indicative of the work we still need to do to raise awareness of what these plans entail, what the benefits are. Mr. Galace urged the board to investigate the matter further, to ensure that it is understood exactly who the patients are who are receiving these subsidies, but also who are the patients and the consumers who are purchasing coverages, high deductible, and who are meeting their needs so we can further cater our outreach methods to address their concerns.

Mr. Lee responded to a couple issues. He joined with the many comments appreciating the hard work done by staff, but also by the committee members. It really was an immense amount of work over a long period of time. First issue -- with regard to silver, it's absolutely the case that a standard silver is a lot less rich than a standard employer plan, but many of our enrollees are in cost-sharing subsidy silvers that are richer than employer-based plans. This is good, because they are low income. We often talk about one variety of silver -- there are really four silver plans.

Second, there was some comment made about different pricing on and off exchange. There is absolutely no different price of what consumers pay on-exchange and off-exchange. Mr. Lee asked that people and reporters listen to this as it's important to clarify. The assessment that is charged to plans is in essence spread across everyone. Because the plans must charge the exact, identical premium to everyone off-exchange as

they charge on-exchange. We do need to investigate the extent to which there are people off-exchange that are not receiving a subsidy, but it is not a reason that they pay something different.

Third, the issue about outreach and marketing is very important. The real challenge we have is we have about 500,000 uninsured Californians that are off-exchange, that are not insured. That's who we have to be reaching out to, but we are very appreciative of the partnership spirit of the health plans to make sure people keep insurance, which having a subsidy might help them do, but our outreach efforts go on many fronts.
And finally, a number of people commented on the issue of the broker commission. The watch list issue is also on our agenda. We don't believe it's the case much, if at all in California, of differential premiums being paid on tier of enrollment. Part of the reason we instituted a policy to say that plans must always pay some commission, we don't want free riders in terms of plans that are riding on others, payment to agents. We also don't want to get back to the old days of risk selection. So, encouraging agents and brokers to enroll more in platinum, less in bronze, or vice versa, is something we would be very concerned about. We will probably be looking at that between now and the next board meeting, to see if that's the case.

We have absolutely heard about that being in place in other markets outside of California. We also do know in other markets outside of California, plans have said they will pay no commission. We are saying in California that doesn't play, not in a level playing field market that we are creating here in California. So with that I want to thank the comments and the staff's presentation.

Ms. Price introduced Dr. Lang. Dr. Lang will be going over bit a bit of changes that we are proposing to make for our contract in 2017. These changes support quality, promote primary care, focus on integrated care management and reduction in variations in care that when done all together will impact both quality and affordability long term. It also serves for us to meet the broader picture of healthcare reform, and that is that many of the things that Dr. Lang will talk about we require on a health plan's whole book of business, not just individual.

Mr. Lee added that the other introductory that he would remind people of -- at a previous board meeting, he said words matter. Words do. We have just released today the full document that we will be commenting on. We know folks will look at those words with great care. What you are going to hear from Dr. Lang is the high-level overview. These are things we want comments on at the granular level because this is a contract. What we are talking about here is not only big picture changes in the delivery system, but at a granular level, a legal agreement between Covered California and today, 12 health plans, maybe more, maybe fewer next year. So, making sure the language is right, clear, meets what you need to do, matters. Dr. Lang will be talking at a higher level than the specific wording, but that wording is something we will be working with over the next few weeks and come back to the board for action on final wording.

Presentation: Covered California Quality and Delivery System Reform

Dr. Lang began by saying there was remarkable convergence around the common vision and common effort to move ahead. Covered California would like to acknowledge and thank many stakeholders for their collaboration in the 2017 quality planning and strategy. The meetings, which started in July 2015, included individual 3 hour meetings with each of the 12 contracted health plans, deep dive 3 hour meetings with all health plans together with other state purchasers, stakeholders and content experts, and public input from advocates, regulators, health plans, and other health policy experts.

Covered California is focused on achieving the triple aim on behalf of all Californians and our contract requirements for 2017-2019 will continue to move us towards achieving that goal. Guiding principles for raising the bar on quality requirements include promoting alignment with other purchasers including CMS, DHCS, CalPERS and employers as much as possible which will allow us to have similar focus and requirements across the delivery system; certain requirements apply to a contracted health plan's entire book of business; requirements will focus on tracking, trending and reducing healthcare disparities in care of chronic disease by race and ethnicity as well as gender; consumers will have access to networks offered through the Contracted Health Plans that are based on high quality and efficient providers; enrollees have the tools needed to be active consumers including both provider selection and shared clinical decision making; payment will increasingly be aligned with value and proven delivery models; and variation in the delivery of quality care will be minimized by assuring that each provider meets minimum standards.

Covered California is evolving its work with Contracted Health Plans from "tell us what you're doing" to a required set of initiatives resulting in demonstrated improvement over time. Aligned with CMS Quality Improvement strategy starting in plan year 2017 which includes improved health outcomes; prevent hospital readmissions; improve patient safety and reduce errors; reduce disparities; and promote health and wellness, with emphasis on aligning financial incentives with improvement strategy. Covered California and Contracted Health Plans recognize that driving significant improvements needed to assure better quality care is delivered at lower cost will need tactics and strategies that will extend over the coming contract period and beyond. Success will depend on establishing targets based on current performance, national benchmarks and the best improvement science conducting rigorous evaluation of progress and adjusting goals annually based on experience.

Attachment 7 has the following 9 Articles: Article 1 -- improving care, promoting better health and lowering costs. Covered California supports provider networks that are designed based on quality satisfaction and cost efficiency standards to insure that enrollees have access to quality care. Article 2 – provision and use of data for improvements in quality of care delivery. Covered California will coordinate annual reporting of all quality and delivery system reform requirements and targets using several mechanisms. Article 3 – reduce health disparities and assure health equity. Covered California recognizes that promoting better health requires a focus on addressing health disparities and health equity while recognizing that some disparity results from determinants outside the control of the health care delivery system. Article 4 –

promoting development and use of care models – integrated healthcare models (IHM). Covered California places great importance on promoting integrated/coordinated care and is adopting a modified version of the description of an Integrated HealthCare Model (IHM) from CalPERS. Article 5 – hospital quality. Covered California and Contractor recognize that hospitals have contracts with multiple health plans and are engaged in an array of quality improvement and efficiency initiatives. Hospitals play a pivotal role in providing critical care to those in the highest need and should be supported with coordinated efforts across health plans and purchasers. Article 6 – population health – preventive health, wellness and at-risk enrollee support. Covered California and Contracted Health Plans recognize that access to care, timely preventive care, coordination of care and early identification of high risk enrollees are central to improving each part of the triple aim. Article 7 – patient-centered information and communication and cost transparency decision support tools. Contracted Health Plans negotiate agreements which often result in varied reimbursement levels and difference in quality performance for identical services and or procedures. Improving the transparency of the consumer's share of cost and quality of providers offers significant benefit to Covered California enrollees. Also under Article 7 – promoting higher value care and reducing overuse through choosing wisely. Covered California requires deployment of tools to support enrollees in understanding their medical diagnosis and treatment options to aid in discussion with their provider. Shared decision-making is a powerful evidence-based approach to reducing overuse or misuse of clinical interventions. Article 8 – promoting higher value care. Covered California requires that quality and delivery system improvement strategies include payment models that align. Article 9 – accreditation. All contracted health plans are required to be accredited by NCQA, URAC or AAAHC.

Mr. Lee encouraged both stakeholders and board members to spend the time thinking about all of these items as it is a big deal for Covered California to propose to the board considering taking this active of a step of requirements of health plans. This is a next big leap forward we are proposing the board to consider for action at the next meeting.

Chairwoman Dooley echoed a couple of things. She is very supportive of the concept of having people have an assignment of knowing that they have got someone they can go to until or unless they choose someone for themselves. She wants to be very careful that we are distinguishing from the problems of the 90's, when they became gatekeepers. This is a starting point, and there will be comments over the next few weeks in the stakeholder engagement process that we have been so proud of and that Jerry Jeffe talked about being transparent, and credibility is going to go on. This is very ambitious, and she is very pleased to see us with this as a starting point, but thinks that there are going to be some modifications before it comes back with something to adopt.

Member Fearer stated there's an awful lot here, a lot of substance. When he read the CAPG letter, he didn't quite know what to make of it. He is curious if either Dr. Lang or Mr. Lee has any comment on that.

Chairwoman Dooley asked they also please explain what the California Association of Physician Groups has been an advocate for and how we are addressing or not addressing that.

Dr. Lang responded to the part about integrated delivery systems, which is the core of what they were commenting on. They were referencing the Berkeley Forum work, which is really superb, which is in two parts: a board report that set an agenda for delivery system reform that was published in 2013, and then a follow up on ACOs in 2015. Our requirements address that it could either be a provider organization or the health plan that acts like an IPA, and provides that integrated function. Chairwoman Dooley thanked Dr. Lang for the information.

Mr. Lee responded that relative to CAPG's letter, we look forward to getting other comments. There are stakeholders who don't come to all these meetings and will see this as a bell weather report. We have worked very well with the California Hospital Association, which raises a high bar, potentially, for hospitals. We actually took a somewhat different approach than the CAPG letter, which called for us "immediately setting hard targets to drive meaningful transitions". The Berkeley Forum basically picked a model which is more a medical group all risk model. There are different ways to address integration and different ways to address payment, and we are doing somewhat more eclectic in the mix than saying there's one path forward.

Member Islas had comments, in particular, around Articles 3 and 6. One thing she called out is the fact that there are varying definitions in terms of what we describe as a health disparity. It would be very important for Covered California to be clear in what we are considering and how we are communicating to the health plans in terms of what we want them to track.

In her opinion, how she sees health disparities is that these are affecting groups of people who have systematically experienced greater challenges in achieving optimal health and it can be tied to a number of things. Certainly racial, ethnic, and gender are some of the things that we immediately gravitate to. But we are not always gravitating to the fact that there are also disparities that arise from sexual orientation, gender identity, physical disability, and even geography. It's important to that we as a board come to some standard of understanding of what we want to convey to the health plans in terms of the standards that we are using to measure.

Member Islas then commented on Article 6, in terms of population health and preventive health, and that's that sort of where we are starting in the measure really needs to guide the intervention and the expectations of what we want them to achieve. It's those interventions that will ultimately help us to achieve health equity.

Dr. Lang responded to Member Islas. He assured her that, as relates to Article 3, that we start with racial, ethnic, and gender. But as you read Attachment 7, you'll see that we call out four or five additional criteria that we could address in the future, including

income, and that we add geography, and we certainly include gender identity as things that we could address in the future. This is a place to start.

Public Comment:
Carrie Sanders, CPEHN. Ms. Sanders focused her comments on the health disparities measures in particular. In terms of the timing, now is the time to act. We are going into year five of the ACA, and this is an opportunity for Covered California to take the lead and to really demonstrate their commitment to health disparities reduction, in particular, by requiring health plans in their 2017 application to provide baseline data on disparities, and then to meet year over year reduction in disparities in 2017 and beyond.
CPEHN also agrees with the focus on the four key areas: diabetes, hypertension, asthma, mental health. Finally, CPEHN agrees wholeheartedly with Member Islas on the health disparities, the need to move forward, and also on population health, and really trying to get a better sense of what plans are doing and try to standardize the interventions so that they are appropriate to the communities.

Betsy Imholz. Consumers Union. Just a reminder that Consumers Union has submitted a letter with some other consumer groups, so you have more detailed comments there, and we will be submitting additional ones as we look closely at the written materials. From the beginning, this board has had a foundational belief in the ability of Covered California to leverage its assets to really improve the quality of health of Californians. Ms. Imholz said she wanted to focus on just three things. First, disparities -- the data analytics is critically important. What gets measured gets fixed.

Secondly, she emphasized strong support and elation about including safety improvements, and some of those measures that you have chosen. Finally, Choosing Wisely is a project that Consumers Union is engaged in with the American Board of Internal Medicine Foundation, in the belief that we can only really improve health by increasing the power of consumers to understand what questions to ask and then to work with their providers on making the right decisions.

Dorena Wong, Advancing Justice LA. Ms. Wong echoed Ms. Sanders and Ms. Imholz comments. One of the other areas of concern is when Covered California is looking at the race and ethnicity to use this aggregated data. That's where the uniformity comes in, to just be sure to collect the different categories, especially in the Native American, Native Hawaii, Pacific Islander Community.

Michelle Lilienfeld, National Health Law Program (NHLP). NHLP echoed the comments made by other advocates regarding the quality initiatives. NHLP supports the work being done by Covered California to require health plans to improve quality and reduce health disparities and to move towards requiring a set of initiatives resulting in demonstrated improvement over time.

Jen Flory, Western Center on Law and Poverty and the Health Consumer Alliance. Ms. Flory echoed Ms. Sanders' and Ms. Imholz's comments. We are very glad to see quality measures and measures on disparity being part of Covered California now. We really

appreciate Member Islas' look at disparities in particular and how to set the baseline for that.

We also appreciate the acknowledgements that for persons with disabilities or with gender identity, sometimes it is the health delivery system that is causing the barriers and not just the external socio-economic issues that are going to.

Athena Chapman, California Association of Health Plans. Ms. Chapman stated her group appreciates all the work that has been done on the quality initiatives, and look forward to working with Covered California on these. We would just like to request that the quality subcommittee be reconvened so we can have some more in-depth discussions with all of the stakeholders on what is some pretty dense and full of new concepts that we just would like to have additional information on. We are working hard to prepare some detailed comments as fast as possible.

Anthony Galace, Greenlining Institute. Mr. Galace echoed previous comments made about the importance of the discussions that have taken place. We all know that access to coverage is one step to reducing health disparities and improving health, but that's not the only step, and to have these discussions is truly inspiring. Mr. Galace believes that once Covered California starts engaging with health plans and begin formulating a more comprehensive strategy for addressing each and every one of these concerns, that you continuously push and set very aggressive and robust benchmarks for how to meet each benchmark – simply because a lot of the corporate social responsibility obligations that these health plans have are in line with every single one of these articles as well. Mr. Galace would like to see the institutions that have benefited the most from the ACA, and their bank accounts have increased exponentially, that they also have some skin in the game to ensuring that communities of color and low income, underserved populations, have the resources they need to improve their health.

Kate Birch, California LGBT Health and Human Services Network. Ms. Birch said she was glad to see in Article 3 that sexual orientation and gender identity, along with disability and income, were called out as areas where Covered California is going to work with plans to hopefully expand the disparities in interventions in the future. She echoed Ms. Wong's comment for disaggregated data. Ms. Birch asked Covered California to consider how this data will be made available to the public.

Beth Capell, Health Access California. Ms. Capell echoed others before her in being generally supportive of the direction that Covered California is moving in. She stated HAC is very pleased that Covered California and its board, has talked from the beginning about the importance of the triple aim and of moving forward from collecting information to actually requiring action. Ms. Capell went on to say that she wanted to build on what CPEHN said and point out that we refer to the quadruple aim. While you have a single article on reducing without taking the disparities into consideration as you look at all of the items in the quality initiatives, you do risk worsening disparities at the same time that you are attempting to reduce them in Article 3. We think specifically of hospital readmissions, where there is now a considerable literature indicating that if you fail to

take into account race, ethnicity, income, other social status, that you can actually harm the institutions that serve those most in need. This organization has been very thoughtful about these things, and we offer these comments in the spirit of improving what you have before you, not delaying or derailing it. What you are proposing is very important and we would very much move forward the discussion.

Mr. Lee commented that he appreciates, again, what folks have already done and what they will now do. The next weeks will be important. Mr. Lee noted that Ms. Price reviewed a timeline, and on February 11th there is a Plan Management Advisory Committee meeting where this will be the topic of that meeting.

Mr. Lee also noted that for Covered California to issue their applications for 2017 on March 1st, it is going to be very hard to think about decisions not being made by this board so applications can consider the board's action at the February board meeting. We have before you what is ranged from material that is either kind of generally supportive to quantum leaps or pretty awesome – I like the mix of the pretty awesome to quantum leaps. We will reach out to some stakeholders who have not traditionally come to our board meetings, in particular the hospital community.

Mr. Lee again called out the request, insofar as possible, the more you can get us comments by February 4th, the more we can digestion them and come back on the 11th in another public process to say here is how we and staff have considered these, to consider what we bring back to the board in a little less than a month from now.

Mr. Lee continued with his last issue. He neglected in any overview of all the material that highlight the 100-plus page of the media clips. He reminded everyone that there are 10 more days of open enrollment -- January 31st is the close of open enrollment. We will not be doing an extension in any way, shape, or form this year.

Mr. Lee expressed appreciation for the work that everyone in this room and who are watching this are doing to continue to get the word out as we go through this third open enrollment period, and we look forward to the next board meeting.

Agenda Item VI: Adjournment

The meeting was adjourned at 2:30 p.m.