



California Health Benefit Exchange
Section 1332 State Innovation Waiver Meeting

**Covered California Tahoe Auditorium
1601 Exposition Blvd.
Sacramento, CA 95815
February 23, 2016
8:30 AM – 12:30 PM**

Welcome and Meeting Overview

Peter Lee, Executive Director, Covered California (CoveredCA): Executive Director Lee welcomed all participants to the meeting, including those in person as well as those participating by telephone from locations across the country and the world.

This 1332 waiver allows states to create innovative strategies to build on the basic protections of the Affordable Care Act (ACA). Current rules are that there are no specific deadlines for a waiver although it can start as early as 2017. A waiver cannot add to treasury over ten years, requires state authorizing legislation and lasts for five years. Importantly, these ground rules could be changed by the new federal administration. There will be opportunities to look at the 1332 waiver option every year going forward. We also have an ability to innovate in the absence of a waiver. The CoveredCA board at the last meeting adopted an updated version of the standard benefits. This is a tool for ensuring that financial exposure is not a barrier to service. We have provided the board with an array of delivery reform elements to promote value and comments are still open for this proposal. We took to the board a framework/criteria for evaluating a 1332 waiver opportunity. The Board's guidance was to continue to consider the potential of pursuing a 1332 waiver in the context of a narrow set of guiderails that build on what we're doing and are cognizant of our existing priorities. We could potentially move ahead this year with a waiver submission, so we are evaluating options quickly. There is a potential for a set of recommendations at the April 7 Board meeting.

Jennifer Kent, Director, Department of Health Care Services (DHCS): Director Kent thanked CoveredCA for inviting DHCS to attend. We have a lot of overlap between the families and communities we serve. We are extremely interested in making the system work as seamlessly as possible.

Diana Dooley, Secretary, Health and Human Services/CoveredCA Board member: Secretary Dooley noted that the lens they look through is a pragmatic lens. California has been very aggressive in opening the full toolbox from the ACA, going farther than many places. California has made close to maximum use of policy opportunities outside of the 1332 waiver. I am very interested in hearing about the possibilities for 1332 to enhance what we are doing. My concern is that we need to be cognizant of the potential to over-reach and to be mindful of the ambitious timeline.

Genoveva Islas, Public Health Institute/CoveredCA board member: Ms. Islas echoed her welcome and interest of exploring the possibilities of a 1332 waiver.

Peter Lee introduced the facilitator and panelists

- Bobbie Wunsch – Founder, Pacific Health Consulting Group (PHCG)
- Ken Jacobs – UCB Labor and Research Center (UCB)
- Larry Levitt – Senior VP Kaiser Family Foundation (KFF)
- Heather Howard – Lecturer at Princeton and Advisor to Robert Wood Johnson Foundation (RWJF) and Michael Kolber, Manatt, Phelps and Phillips
- Lucien Wulsin – Executive Director, Insure The Uninsured Project (ITUP)
- Anthony Wright – Executive Director, Health Access (HA)

Bobbie Wunsch, PHCG, described the process for the meeting today. Panelists will speak, followed by questions and comments from CoveredCA board members and staff. Following all presentations, there will be a period of public comment.

Panel Presentations

- A. 1332 State Innovation Waiver Opportunities**
- B. Market and Coverage Outlook**
- C. California Waiver Opportunities**

Slide presentations are available at

<http://hbex.coveredca.com/stakeholders/Covered%20California%201332%20Waiver/February%202023,%202016%201332%20State%20Innovation%20Waiver%20Public%20Meeting/index.shtml>

Ken Jacobs: California Coverage: Who Remains Uninsured

Mr. Jacobs presented projections of California's remaining uninsured in 2019 after enrollment is maximized and employers move forward with their enrollment efforts. Overall, the projections are that between 2.7 and 3.3 million will remain uninsured with the working estimate close to 3 million. Our numbers for uninsured undocumented are higher than other projections because we assume all undocumented that have Medi-Cal are uninsured because we assume they are on restricted scope Medi-Cal. It is important to note that there will always be some number of uninsured due to job or other transitions.

Looking at the potential market for undocumented, most are low income. The estimate is that if undocumented residents were to enroll like other Californians, taking into account that there are subsidy restrictions, up to 320,000 would be in the individual market. An additional 540,000 that could

enroll but are less likely to do so without subsidies, given costs. These are strong assumptions; there are lots of reasons to assume that this uptake could be lower. It is unclear how many would enroll through CoveredCA compared to the outside market although 74% of households headed by undocumented have family members who are citizens. To the extent they interact with CoveredCA or Medi-Cal, this may encourage others to gain coverage as well.

Looking at the population of CoveredCA eligible but not enrolled under current law, we see that half are Latino and two thirds are Limited English Proficiency. The majority are in the 201-400% federal poverty level. It is important to remember the subsidies are not tied to cost of living, and housing costs in areas such as Los Angeles and San Francisco can impact affordability considerations. San Francisco has started a program to address affordability concerns for some low/middle income workers through CoveredCA. There are about 80,000 non-subsidy eligible residents above 400% that are aged 50-64 and there could be additional affordability concerns here.

The third major group are those affected by the family glitch. Under federal regulation, children and spouses are ineligible for subsidies if the employer offers coverage and the employee premium cost is not more than 9.66% of household income. Nearly all employers that offer coverage to children also offer coverage to spouses, although many do not contribute to premium costs. This results in families that could pay up to 23% of income in premiums and are not eligible for subsidies. Our analysis in 2011 estimated that up to 144,000 more people could take up subsidized coverage if the family glitch were addressed. We will update this estimate soon but extrapolating a recent national estimate indicates that up to 276,000 Californians could be impacted by this. In addition, this would be a much bigger issue if Congress does not reauthorize the Children's Health Insurance Program (CHIP) in 2017.

CoveredCA board and staff comments and questions

Peter Lee, CoveredCA: The note about the potential market of undocumented in 2019, do we have estimates of how many in the individual market are undocumented today?

Ken Jacobs, UCB: Prior to 2014, there were about 50,000. The main thing that has changed is the ability to get coverage regardless of pre-existing conditions and the changed age rating.

Peter Lee, CoveredCA: And those changes alone are the cause of an increase to 320,000 in 2019?

Ken Jacobs, UCB: Yes, although there are reasons to think that estimate is high.

Diana Dooley, HHS: Is the 50,000 prior to 2014 within the subset of undocumented Californians buying insurance in the individual market?

Ken Jacobs, UCB: Yes, the 50,000 is what we know from those who are purchasing. The 320,000 assumes the same purchasing behavior as those with otherwise similar demographics aside from being documented.

Diana Dooley, HHS: Do we know what the take up rate is with the new rules in the individual market outside CoveredCA?

Ken Jacobs, UCB: That's a question we want to address and we are examining now.

Katie Ravel, CoveredCA: Does the model take into account the family member issues, such as some documented and some undocumented in the family?

Ken Jacobs, UCB: We don't have a good way in our model to project who is going to buy within or outside the exchange.

Jennifer Kent, DHCS: As I understand, the largest change in this model is the change in pre-existing conditions and age rating?

Ken Jacobs, UCB: Yes.

Larry Levitt: National and California market trends on benefits designs, coverage and cost

Mr. Levitt reviewed data on the progress in California and nationally as well as some of the changes in the marketplace. In 2014, California was far ahead of other states on implementing the ACA. Although most states have caught up, California continues to outpace the rest of the country. Looking at the share of the potential market that is now inside the state-based marketplace, it is 53% in California and 46% nationwide. When looking at the remaining uninsured as of early 2015, there is a very similar picture in California as in other states that expanded Medicaid. The biggest difference in California is a larger proportion of uninsured that are unauthorized immigrants. Looking at coverage among the previously uninsured, 68% of previously uninsured had gotten insurance by spring 2015.

Why do people remain uninsured?

- Many Latinos, particularly undocumented, have concerns that it will draw attention to immigration status for them or their families. This may a reason coverage lags somewhat among Latinos – although it does not lag to the degree many expected.
- Affordability is a top concern. For those that remain uninsured, 85% said health care was their greatest affordability concern. For those who gained coverage, health care affordability concerns drop to 49%. In addition, 44% of remaining uninsured say the main reason they don't have coverage is because it is too expensive. However, 23% believe that they are not eligible.

Even when people get coverage, affordability challenges remain. Deductibles in employer plans have risen rapidly – doubling in the past 10 years – far faster than wages or inflation. The data indicate that many low and middle income residents could not meet their deductible costs. Non-poor households have about \$4,600 in liquid assets and would not be able to meet a typical deductible. A consequence of living pay check to pay check and rising deductibles is that 26% of all adults report a problem paying medical bills in the last year. Most of these individuals are in employer plans. We see higher rates among the uninsured and low-income. For those who had problems paying bills,

certainly copays and deductibles are significant reasons (75%), however a major issue is also out-of-network care (32%).

In summary, going beyond the basics of the ACA, there are a number of potential aims. Getting coverage to more of the remaining uninsured – including those who can't afford it today and those who are ineligible today. It is also important to include considerations of affordability for those who are insured. Improving affordability overall may encourage more uninsured to sign up. Affordability problems clearly include both uninsured as well as many who are covered in the employer market.

CoveredCA board and staff comments and questions

Diana Dooley, HHS: We hear a lot about increases in employer deductibles. Do you have anything to correlate the rise in deductibles with how much is from utilization vs. bad debt?

Larry Levitt, KFF: We don't have data but there are signs that hospital bad debt is increasing. Our data on people having problems paying medical bills is an indication that higher deductibles might be affecting bad debt.

Peter Lee, CoveredCA: Your observations about meeting the deductibles suggests that you need to meet the entire deductible before receiving any care. The CoveredCA policy is that you can receive all outpatient care without meeting the deductible. Would you agree this is an important policy for low and middle income people?

Larry Levitt, KFF: Yes.

Peter Lee, CoveredCA: Referring to the remaining uninsured Latinos who are worried about their insurance coverage impacting their immigration status, that information is after year two open enrollment, not open enrollment period three. We have had an entire additional year to educate about the separation of insurance and immigration. It seems fair to assume that this concern includes a fair amount of Hispanics that are documented and eligible.

Larry Levitt, KFF: Yes, either those who are legal immigrants or in families of mixed immigration status.

Peter Lee, CoveredCA: Is it possible to tease out the question for total eligible Hispanics vs. undocumented in the next survey?

Larry Levitt, KFF: Yes, the next survey will include the distinction.

Peter Lee, CoveredCA: Finally, the survey shows close enrollment numbers between eligible Hispanics and white, non-Hispanics (74% vs.79%) – is that accurate?

Larry Levitt, KFF: Yes.

Heather Howard: Overview of 1332 Waiver Opportunities

Ms. Howard provided an overview of the basics of 1332 waivers and examples from other states. The 1332 waiver is envisioned as a tool to pursue innovation. There are four waiver options. One major waiver option is under benefits and subsidies; to allow states to modify the rules governing covered benefits and subsidies. States that reallocate premium tax credits and cost-sharing reductions may receive the aggregate value of those subsidies for alternative approaches to coverage- aggregate the funding and deploy it in a different way.

Although you can waive many portions of the ACA, waivers are subject to significant consumer protection guard rails. You must cover the same number of people; coverage needs to be as affordable and as comprehensive; and, coverage has to be neutral in terms of increasing the federal deficit.

Ms. Howard reviewed the timeline and process for pursuing a 1332 waiver. It's a lengthy process and one of the keys is engaging stakeholders early in the process. You also need to secure state authority through legislation BEFORE you submit your waiver. Once it is submitted, it is reviewed by both Health and Human Services (HHS) and also by Treasury/IRS. That adds an important wrinkle. We have assumed a six-month federal review, and that's probably optimistic.

The statute has guardrails and federal authorities have twice defined what that statute means through guidance (not actually a rule). The next administration could change this guidance. From most perspectives, the view is that this guidance narrowed state flexibility to ensure consumer protection. It also clarifies that a state cannot combine 1332 with an 1115 waiver for the purpose of meeting the budget neutrality test. It also stated that the deficit neutrality test needs to be met every year of the waiver. Lastly, the guidance limits what states on the healthcare.gov platform can do. It doesn't affect California, but is important to know.

So what does this mean? In the short run, we are likely to see more narrow waivers that meet the test of this recent guidance. As you look ahead to 2017, many states may use this as a planning year because many of the more aggressive waiver programs would not meet the Obama administration standards. For example, you could not coordinate reforms with Medicaid under the current guidance.

As we look at state progress, Vermont, Massachusetts and Hawaii have waiver proposals that are public. Other states have passed authorizing legislation, but haven't submitted the waiver. In California, you are engaged in planning and public discussion. The early states like Hawaii and Massachusetts, have proposals that are fairly narrow, relate to their Small Business Health Options (SHOP) and are unique to their situation. They are important because they are the first in the pool but less relevant to others in their content.

Thinking ahead to next year, some broader 1332 proposals include Minnesota and Colorado. Colorado advocates are looking to create a single payer system using a 1332 waiver. In Minnesota, they are discussing a waiver to smooth out cost sharing proposal to increase amount of subsidies from 200% up to 275% FPL.

Our recommendations for best practices

- Set policy goals before pursuing waiver.
- Use 2016 as planning year – the next administration will likely be more willing to work with states on alternative models.
- Prepare for required actuarial analyses, data modeling and forecasts – without planning grants.
- Start stakeholder engagement early. You don't have to limit to just one waiver. You can start with narrow waivers this year and pursue broader waivers in future years

CoveredCA board and staff comments and questions

Diana Dooley, HHS: It is interesting that you highlighted an issue that most spoke to me from the guidance - the requirement that Medi-Cal and exchange populations remain completely separate. When this opportunity first was introduced it seemed like a possible path to single payer. One of the issues that will be really hard to move through is how to smooth the transitions between Medi-Cal and CoveredCA and rationalize this system for consumers and administrators. Early on, I thought it might be an opportunity to push the envelope to think about using the 1115 waiver to address mixed coverage families. It's a moot question now, but I appreciate your perception that we need to think broadly over time and that this is a longer process, not just a one-time change.

Heather Howard, RWJF: You put it well. There is a rationale for why they did it, to prevent undermining Medicaid benefits. The Arkansas private model, the exchange benefitted from having Medicaid in the exchange and more health beneficiaries in the exchange. It also deprives you of a tool to limit churn or to pursue broader reforms. It doesn't mean you can't use this time to plan and begin thinking through those options.

Genoveva Islas, Public Health Institute/CoveredCA board member: Going back to the timeline for engaging stakeholders. Are there any best practices about engaging the members/actual beneficiaries?

Heather Howard, RWJF: In other states there hasn't been an approach like this. This may be an area where you get to blaze the trail.

Jennifer Kent, DHCS: How long are the 1332 waivers granted for? You also suggest that you can start on a lighter path and move into deeper waters, does this approach mean you need to have subsequent legislation?

Heather Howard, RWJF: The waiver is for five years. What you need from the legislature is authorization to file a 1332 and authorization to implement the provisions. If you are making changes, you would probably need subsequent authorizations for each bite.

Jennifer Kent, DHCS: Who is the holder of the waiver authority – the exchange? Is it up to each state to decide?

Heather Howard, RWJF: Good question. It is the state who applies. In Massachusetts, the Connector produced the proposal.

Peter Lee, CoveredCA: Going back to the interface between Medi-Cal and the exchange subsidies, we still can do a lot on delivery reform without needing a waiver. The question about the separation of 1115 with the 1332, that's part of the guardrails issued in the recent guidance not the legislation, right?

Heather Howard, RWJF: I agree there is lots you can do without a waiver. Yes, that is right and the next administration could change that guidance. The statute just says deficit neutrality.

Peter Lee, CoveredCA: Regarding planning grants, there is no federal funding to do this planning, right? This is on our dime in California?

Heather Howard, RWJF: Yes, so if you need actuarial analysis, you need to buy it yourself.

Peter Lee, CoveredCA: I know that states can modify the penalty under the ACA for employers under this, right? So part of the things we need to look at is the tax revenue implications from the Employer Sponsored Insurance (ESI) changes? For example, if 10,000 people opted out of employer coverage, we need to show the tax consequence?

Heather Howard, RWJF: Yes, the treasury wants you to show what the impact is on the ESI.

Katie Ravel, CoveredCA: The IRS has indicated some inflexibility about what they will do on the tax credit side, correct?

Heather Howard, RWJF: The IRS said they are not doing 50 different tax forms, so you are likely to run into the IRS saying they won't want to customize for one state. If you try to do something unique, you may have to contend with the IRS saying they won't want to change.

Lucien Wulsin: Waiver Opportunities

ITUP has been thinking about this for some time and speaking with regional workgroup members, our board and other stakeholders. We have a fabulous building block here and our board would say we need to break this down between the short term opportunities and the longer term vision for California. What can we accomplish this year vs. a longer timeline? Some opportunities include:

1. Alignment and integration of purchasing strategies (value based purchasing)
2. Affordability
3. Program interfaces among Covered California, Medi-Cal and employment-based coverage (coverage requirements)
4. The need to develop a unified §1332, Medicaid §1115 and Medicare §1115 waiver

Under affordability, opportunities are short and long term. Examples include more affordable plan choices, smoother and more affordable sliding scale for subsidies, eliminating the family glitch, expanding tax credits and business tax credits as well as allowing state and local funds to help pay premiums such as San Francisco's new program to improve affordability.

In terms of addressing coverage, 1332 may be a floor – not a ceiling and we should think about how far we can go. Some options include considering a pilot for auto enrollment and increasing the size of penalties, changes in the 50 employee threshold and/or the 30-hour threshold and restructuring of the employer ‘fair share’ contribution requirement.

We had some discussion about program alignment, one idea is allowing for a smoother flow between programs and whole family coverage. In addition, how do we allow those outside the exchange to enter and allow mixed status families to purchase through CoveredCA.

CoveredCA has led the way in delivery reform but with 1.5M subscribers you can only go so far without engaging larger commercial, Medicare and Medi-Cal plans/payers. We need to create a more aligned set of contracting strategies.

CoveredCA board and staff comments and questions

Peter Lee, CoveredCA: What I see about affordability, we’ve had guidance from our board we should not be violating the treasury’s budget neutrality or adding liability to California’s budget. It seems the affordability options you offer will do one or the other.

Lucien Wulsin, ITUP: There are three contributors to affordability: premiums, copays/deductibles and rising spending overall. We have to address the third to have any real impact on the first two. That is where we think all the purchasers need to work together.

Peter Lee, CoveredCA: You are raising a really challenging guardrail question – would the federal government accept savings from delivery system change to be combined with affordability changes.

Lucien Wulsin, ITUP: I don’t see restrictions in the 1332 waiver to be limited only to CoveredCA.

Peter Lee, CoveredCA: Can you speak to the affordability strategy about facilitating employer premium contributions for flex workers and small business’ dependents.

Lucien Wulsin, ITUP: A lot of flex employees are not offered coverage by their employers. Can we have the employers contribute to some portion of the employees’ premiums even if they are not offering coverage. This could be similar to what is done with Healthy San Francisco.

Anthony Wright: Waiver Opportunities

Mr. Wright discussed opportunities to implement and improve health reform through a 1332 waiver. The California story has been a great success through efforts of both DHCS and CoveredCA. The question is what’s next. Some have suggested that we have plateaued in terms of coverage – I think there is more we can do. We also know that we have a challenge in covering our undocumented residents. We have taken steps in many counties and at the state level although we would like to see CoveredCA as part of this effort.

I want to discuss one proposal pending in the legislature to allow undocumented immigrants to buy into CoveredCA – not receiving subsidies but purchase coverage. Currently, they must go through a

broker. This is a proposal that did garner broad bipartisan support in California and has been endorsed by both Democratic presidential candidates. This could be something that California is at the front edge of, although other states are considering similar initiatives.

It solves two very real and tangible problems: 1) It welcomes those eligible but unenrolled Latino uninsured. We discuss strategies for educating the population about the separation of immigration and insurance coverage at every CoveredCA board meeting. We also know that 74% of undocumented are in mixed status families and CoveredCA would be in a position to help the whole family; 2) We believe it meets the President Obama's standard not to use federal funds to subsidize undocumented residents.

In terms of other proposals, we see them in three broad categories of system transformations, improved affordability, streamlined enrollment and aligning coverage between programs.

On affordability, we think there is a lot to do in California. It's both affordability of premiums (which is harder if we can't tinker with the Advanced Premium Tax Credit (APTC), though there are a lot of opportunities to address cost-sharing. Other opportunities exist such as the family glitch, broader scope of benefits (e.g. dental and vision). We understand the hurdles to this and recognize the constraints of state funding. We do think there is a path if we can find ways to generate savings we could redirect those savings to reduced subsidies from the federal government to the needed populations. Put another way, if we generate system savings from cost reduction that are now accrued directly to the federal government, we should find ways to redirect that savings to members that need it. Linking those cost savings to a 1332 waiver will allow us to redirect those savings to needs in California.

We propose discreet, surgical options in the current year but we are also modeling affordability and cost/saving strategies that we can pursue in future years. Massachusetts is going forward with its own two-phased process. This could provide a model for what a relatively smaller, first step might look like while also looking at more ambitious system-wide issues in the future – especially affordability, which will be one of the biggest issues in the future.

CoveredCA board and staff comments and questions

Jennifer Kent, DHCS: Can you talk a little bit more about the idea to waive the QHP certification for Medi-Cal plans to become a CoveredCA plan?

Anthony Wright, HA: We had the specific example of Contra Costa Health Plan that was a participant in the first year and then had to withdraw. So there are some issues in terms of the requirements for the public plans. But, there is also an advantage in terms of the churn or family cross-over if the public plan is participating in both Medi-Cal and CoveredCA. It would be a step to address the churn and mixed status family issues and represent progress toward limiting complexity for the patients. This would require policy and technical work ahead but would be a big step toward a goal of streamlining the system for consumers.

Peter Lee, CoveredCA: On cost savings, we are mindful that over the last couple of years that our lower premium increases have saved the federal government money but it also saved money for CoveredCA enrollees with no subsidies. In the area of immigrant inclusivity, one of the more compelling arguments is that in a mixed status family, the undocumented individual may not get covered but the eligible family member is more likely to get coverage. Increasing coverage to eligible individuals is core to our mission, but does it also increase the federal deficit? Does this violate the budget neutrality rule? Michael is on the phone for Heather and I wonder if he can address this? The non-QHPs could have the side benefit of having greater enrollment but it could also increase the federal deficit. Would this fail under a very narrow reading of the guidance?

Michael Kolber, Manatt It sounds like you are envisioning a future where there are more CoveredCA enrollees. In the statute and guidance, each of the guard rails are evaluated independently. The question is what is the baseline that you are comparing the federal deficit to? There is some flexibility to say the baseline is the future-state with and without the waiver, not comparing today and the future without the waiver. You are making an argument that absent the waiver, fewer people will have coverage. I think there is perhaps a good faith argument to be made that the baseline could reasonably include higher uptake, but it could take some doing to make the case. The current rules on residency status limit the uptake for people with eligibility. It does not seem instantly approvable, but there is a good faith argument to be made here.

Peter Lee, CoveredCA: So you are making the point that if making the case actuarially shows larger enrollment and increased deficit, there is a corresponding argument for why that is necessary. We should take this on directly. Clearly, this is a population we want to enroll.

Anthony Wright, HA: At the end of the day, we believe that it is in the State's interest to get as many people in coverage as possible. I asked this question directly to the federal government and their answer was not definitive. They recognized that the goal of the ACA is to have more enrollment. I think the question of baseline is important. I don't want to represent any conversation as definitive and it is not something that is written out explicitly – they will need to evaluate it. We may want to compare ourselves to other states that have higher enrollment. Also, while we think this is important, the relative impact will still be fairly small. In California, small changes can be many, many people. But there is a question about whether it would even impact a 10-year budget forecast.

Jennifer Kent, DHCS: Did the model account for the shift of undocumented purchasing on the exchange creating savings to limited scope Medi-Cal?

Ken Jacobs, UCB: That is not something that we looked at in the model under the assumption it is a low number but it is worth looking at.

Peter Lee, CoveredCA: Questions to both Ken and Larry, we've looked to both your organizations for estimates, projection numbers, but we understand there is a wide range of uncertainty. Do you have a sense of the potential impact of having more subsidy eligible individuals sign up because of having undocumented family members also signing up?

Ken Jacobs, UCB: I would see this as a marginal impact and it would be hard to pick up in a formal model.

Larry Levitt, KFF: I agree and frankly I think that Ken's current projections are very high. The savings should be viewed as accruing to the federal government from the 1332 waiver not necessarily from the 1115 waiver. As we look 5-10 years out, it might be negligible to the total growth in enrollment. You can also make the argument that even a small increase in enrollment improves the risk pool and reduces premiums.

Yolanda Richardson, CoveredCA: Anthony, your paper speaks to the fact that not everything requires a waiver. Can you talk about that?

Anthony Wright, HA: On all these issues, there are things that we can do without a waiver. We have appreciated CoveredCA work recently on quality initiatives. There are things we can do on marketing/outreach, alignment of systems between CoveredCA and Medi-Cal, CoveredCA joint purchasing with other major purchasers such as CalPERS. From the view of 1332, the issue of affordability is essential to everything we do. In a world where we have state restraints, how do we find the dollars to put toward affordability? To the extent that we can address that, even if they are hard or require sophisticated modeling and development over a year, we don't want to lose that. We believe we need to continue forward on all fronts. This is our best shot to do that.

Peter Lee, CoveredCA: We should be reminded that Asian Pacific Islanders are a significant number of our enrollees and also have mixed status families. In your surveying at KFF, have you had a big enough sample size to see perspectives on either an individual ethnic group or collectively grouped Asian populations? Just a reminder that it is not just a Latino issue, it is an immigrant issue.

Larry Levitt, KFF: I have to check but I'm pretty sure we do not have that data.

ii. Public Comment

- A. Exchanges, QHPs and New Populations**
- B. Benefits and Subsidies**
- C. Individual or Employer Mandate**

Public Comment: Exchanges, QHPs and New Populations

Elizabeth Landsberg, Western Center on Law and Poverty: We are in strong support of SB10 and making sure that the 1332 waiver does allow undocumented immigrants to buy coverage through CoveredCA. We urge CoveredCA to move with speed on that issue. We have also looked at what can be done to encourage Medi-Cal plans to participate in CoveredCA. We would like to explore waiving requirements to participate in the individual market, collect premiums, meet QHP requirements and the requirement to serve all consumers, including subsidized and unsubsidized. This is particularly important for kids who are in Medi-Cal and parents are in another plan.

Sara Guia, California Pan-Ethnic Health Network: I want to acknowledge the efforts of CoveredCA to address disparities. We want to express our support for SB10 and encourage you to consider the

1332 waiver as an avenue for undocumented residents to purchase care through Covered CA. Today, our state's values reflect the contributions of immigrants to our economy and social fabric of society. We do have a number of Latino families that still don't feel that they can pursue coverage options because of the stigma/threats to the status of their family members. Offering the option for families to enroll through CoveredCA as a no wrong door approach will further our goals for improving enrollment and improving the health of all Californians.

Kristen Golden Tesla, The Children's Partnership: We strongly recommend the inclusion of immigrants in the 1332 waiver for all the reasons previously noted. On the issue of budget neutrality, I would suggest the baseline could argue that we will do a wonderful job via SB75 implementation creating new eligibility for undocumented kids. This will create a welcome mat effect bringing in siblings who are eligible with new eligibles in the baseline. A comment about bringing the Medi-Cal plans into CoveredCA. I don't have a problem with that but raise a question about the premise that there is an issue with the mixed coverage programs. The programs are very important to retain as the guardrails outline. We see that parents really do value having their kids in the CHIP program. It is worthwhile to evaluate the opportunities for the long term.

Doreena Wong, Health Access Project, Asian Americans Advancing Justice: I am here on behalf of the Health Justice Network, a collaborative of over 50 community organizations, providers and business organizations. The Asian population does have a large undocumented population. About 15% in California are undocumented. We estimate that there are about 416,000 undocumented Asians in California, with 50,000 likely uninsured. Having those statistics would be helpful. We are in support of using the 1332 to allow undocumented immigrants to buy coverage through the marketplace and there is the interest in the community to purchase through the marketplace. If you can get the undocumented enrolled, you can get the whole family enrolled.

Julianne Broyles, California Association of Health Underwriters: Our membership has three areas of interest related to the 1332 waiver: 1) enrollment process simplification, 2) more affordability of coverage, and 3) simplicity for small businesses. One of our goals is to simplify the enrollment process. Some surveys have indicated that it is too hard to finish the enrollment process online with CoveredCA. We saw that over 60% were not satisfied with their experience with the online enrollment process. We know there have been efforts to improve this but there is more to be done. You can align eligibility rules for Medi-Cal and CoveredCA – 1332 in combination with the 1115 waiver can address this. We also agree with the enrollment of undocumented residents.

Mari Lopez, Vision Y Compromiso: The spirit of this work is no wrong door. With 1332, we are asking you to create another door to allow the undocumented to obtain coverage for themselves and their families. We support the remarks and appreciate the framing from Anthony to provide services for the whole family. Also, affordability continues to be a huge issue for families and want to impress upon you the need to address this via the 1332 waiver.

Noe Paramo, California Rural Legal Assistance Foundation: We thank you for these efforts. We are in support of using the 1332 waiver to give opportunity for mixed status families to gain coverage through Covered CA.

Imelda Plascencia, Latino Coalition for a Healthy California: It is worry and affordability that limits our families from being able to enroll. Not being able to enroll parents also affects eligible children in the family who may not be enrolled because of fears around information being shared with immigration officials. The 1332 waiver is an opportunity for us to address this issue and include undocumented immigrants in CoveredCA and have California lead in this issue.

Gina Da Silva, California Immigrant Policy Center: I want to underscore and agree with my colleagues' comments to seek a 1332 waiver so that all Californians regardless of status have access to coverage. We urge action on this in the waiver to fulfill the vision of the ACA to ensure coverage for all.

Allison Buist, Children's Defense Fund: As a national organization, we are excited to see a state address issues like the family glitch that have been a problem at the national level for a long time. Whatever happens you need to protect the cost-sharing and coverage protections for children in Medi-Cal. Our hope is that we want to increase coverage through CoveredCA to move up to the Medi-Cal level. We want to make sure that the distinct benefits and affordability that are offered to children are preserved. We also strongly support using 1332 to expand access to undocumented residents to purchase care through marketplace.

Beth Capell, Health Access: We support SB10 and the effort to use the 1332 waiver to let all Californians come in through the front door of CoveredCA. Secondly, we hope to find ways – and believe there are opportunities within the guardrails - to improve affordability. Thirdly, we urge alignment of the rules to improve simplicity for populations, like pregnant women and mixed status families who experience churn between CoveredCA and Medi-Cal.

Christina Yip, NICOS Chinese Health Coalition: We include more than 30 organizations and have assisted Chinese to enroll in health coverage. We strongly support the 1332 waiver that allows undocumented residents to purchase care through marketplace. Increasing access to health care will improve overall health outcomes for all of our communities, the waiver is a great opportunity to be the first state in the nation identify innovative solutions and address disparities.

Sandy Valenciano, California Immigrant Youth Justice Alliance: We represent undocumented youth and support the efforts on the 1332 waiver. We can't improve the overall medical system if we are not at an equity level where everyone has access to health care. Health should be considered a basic right. The 1332 waiver is a great opportunity for California to be an example.

Beth Malinowski, California Primary Care Association: We are supportive of this effort and excited for the dialogue to continue. This is an opportunity to move toward inclusion of all families in affordable coverage. We should also think about continuity of care; how do we make sure that families have the opportunity to stay with their provider of choice?

Michael Lujan, California Association of Health Underwriters: We also are very supportive of allowing the enrollment of undocumented residents. We submitted comments and I want to emphasize the need to include policies to address the subsidy cliff. There is too steep of a cliff in terms of qualifying

for subsidies. We also support the program to address the viability of the small business health options program.

Public Comment: Benefits and Subsidies

Jen Flory, Western Center on Law and Poverty: While it's true the guardrails don't allow for budget coordination between CoveredCA and Medi-Cal, there are some things we can do for the transition population as long as we adhere to the budget neutrality requirements. For example, provide individuals losing Medi-Cal with a bridge month so they can transition to CoveredCA. Right now there is a 10-day notice and they then have to pick their CoveredCA plan before they lose Medi-Cal. Could CoveredCA send the tax credits the consumer is eligible for over to Medi-Cal to support the bridge month and give them more time. Also, we are about to implement the qualified immigrant wrap. An idea we have is to keep them in Medi-Cal and draw their generated subsidies to apply to Medi-Cal. We think the cost is similar. We would really like to stabilize this population and keep them in one place and we think the 1332 waiver can help with this.

Dan Schauer, VSP Vision Care: We are grateful that CoveredCA decided to offer access to vision care and use VSP for affordable eye care. With the 1332 waiver, there is an opportunity to make adult vision an essential health benefit and give stand-alone vision plans the right to provide care directly through the exchange. While we are not advocating for subsidies to apply to vision we do think it is critical that stand alone vision care plans be eligible to provide care through the exchange. Utilization is double when vision care is offered directly rather than through a QHP. People are more likely to get an annual eye exam than a physical exam and this can help identify first signs of chronic health conditions.

Kristen Golden Tesla, The Children's Partnership: The federal government has not laid out pediatric services essential health benefit other than requiring oral health and vision. We can agree that the essential benefits need to include more. The 1332 waiver offers an opportunity for us to have a full pediatric services benefit in the absence of the federal government making a definition of what that should include. For example, audiology and hearing aids are not covered. We ask you to consider options for how to provide full pediatric benefits within the context of the 1332.

Michelle Lilienfeld, National Health Law Program: We encourage CoveredCA to consider benefit improvement proposals under 1332. 1) improve pediatric EHB by supplementing it with Medi-Cal benefits. The QHP essential benefits were developed for adults and do not recognize separate pediatric services with the exception the oral and vision care. CoveredCA should consider supplementing the benefits with the services received under the Medi-Cal program including EPSDT standards. Medi-Cal will be the standard for dental benefits beginning in 2017 and this would extend the provision. If cost becomes an issue, at a minimum the state can consider supplementing benefits such as hearing aids. 2) Require preventive adult dental and vision services covered as part of state EHB. This can lead to long term health outcomes and cost savings. We will submit these proposals in writing.

Public Comment: Individual or Employer Mandate

No comments

Panel Comments

Ken Jacobs, UCB: My understanding is that in order to count anything as savings, it needs to be included in that waiver. As we are doing things that are going to reduce premium costs and save the federal government money, we need to include that in the waiver so we can capture it the baseline.

Larry Levitt, KFF: I echo Ken's statement. There is a bit of a trade-off, there are things you can do without a waiver and you are anxious to get going. But, to the extent that they do save money it may be worth including them in the waiver, such as employer premium reductions.

Michael Kolber, Manatt: There was one comment about the transition population between Medi-Cal and CoveredCA and using QHP funds to pay for Medi-Cal, which does seem like a great way to preserve coverage. My question is about whether this may trigger a guardrail issue and I don't know that it meets those requirements. It also goes to the baseline question.

Lucien Wulsin, ITUP: We may need to pay more attention to the employer side of the equation. We may need to look at how we get at the employer offer rate. We are really midrange in terms of employer offering compared to other states. How can we increase offering? Our take-up rates are pretty good but it is the offering problem. Perhaps Healthy San Francisco is a model. Also, the whole family coverage is going to take a while to get at but it is a big issue. And lastly, the cliffs. The extent to which we can reduce the rate of growth and get rid of cliffs, we will make progress. Also, when I look at the data, folks are more and more going to bronze. The enhanced bronze concept may be a way to enhance the package for folks who see premium as the biggest concern. Finally, I am not sure how far we can go with auto enrollment, but that might be a way that we can move forward on some of the transition issues.

Anthony Wright, HA: After the ACA passed, I had a list of remaining issues that I wanted to improve or address. What has moved up on my list is how to reclaim a lot of money that we have saved the federal government - money to reinvest back into affordability, care and services. That means our baseline is now set at the point of all those savings. Going forward, to the extent there are savings, 1332 is a way to retain those savings. There is a specific opportunity to move forward with the immigrant coverage program – something discreet that we can do now. There are some other great ideas that can move forward this year.

Ken Jacobs, UCB: One comment about Elizabeth Landsberg's point about including Medi-Cal plans, we may also want to exclude them in the calculation of lowest cost plans. They would be coming in for a very specific bridge/transition purpose.

Yolanda Richardson, CoveredCA: I appreciate the comments around affordability and the focus on the future.

Genoveva Islas, Public Health Institute/CoveredCA board member: Thank you for your contributions.

iii. Closing Thoughts and Next Steps

Peter Lee, CoveredCA: In terms of next steps, we have asked for comments by March 1st to the web site 1332@coveredca.gov. We ask you to speak specifically what our panelists have talked about, not just do this, but how does this suggestion address the guardrails from federal guidance and the CoveredCA board, how would it work and what is your hypothesis for modeling.

One of the cautions we were given by our Board is be careful of diverting resources and time from meeting our goals. This is something we all need to think about.

Be specific about two things: do you see this as a near-term option or something that we should be thinking about later. A year from now, we are going to have a new administration that will provide new guidance and a new Congress interested in improving the ACA.

Thank you to the panelist and to everyone who joined us across the state to build on the ACA to get coverage for all Californians.

DRAFT