



Comments to the Board - External

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May 12, 2016 Board Meeting

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Congress of the United States
Washington, DC 20515

April 28, 2016

Diana Dooley
Secretary, California Health and Human Services
1600 9th Street, Room 450
Sacramento, CA 95814

Mr. Peter V. Lee
Executive Director, California Health Benefit Exchange
560 J Street, Suite 270
Sacramento, CA 95814

Dear Secretary Dooley and Mr. Lee,

We write to ensure that women in California have uninterrupted access to health care throughout their pregnancies.

Prenatal care is critical for healthy births and provides a foundation of lifelong health. Your leadership to expand health coverage for uninsured pregnant women has made it possible for countless families to welcome healthy babies. Pregnancy-Related Medi-Cal and the Medi-Cal Access Program (MCAP) provide an important bridge to affordable care for working women.

Optimal prenatal care begins early and includes regular visits to establish a continuous relationship with a team of providers. No woman should have to worry about losing health care while pregnant. That's why we were concerned to learn that a glitch in the system has been terminating Covered California plans for pregnant women without notice. While we appreciate your efforts to ensure women can switch between plans, we remain concerned that until the problem is fixed in late 2016, women will continue to be unenrolled from their Covered California plans and lose access to their current medical providers.

We encourage you to develop a proactive plan to ensure that there are no care interruptions. Specifically we ask that you notify all women before any changes in their health coverage are made.

We thank you for your prompt attention to this issue and stand ready to work together to guarantee that all pregnant women are aware of their coverage options and have access to high quality prenatal care.

Sincerely,



Ami Bera, M.D.
Member of Congress



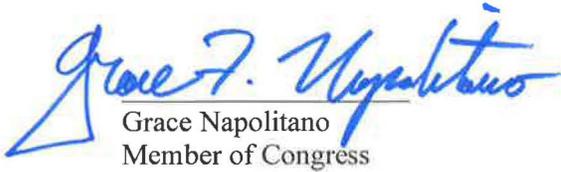
Lois Capps
Member of Congress



Sam Farr
Member of Congress



Loretta Sanchez
Member of Congress



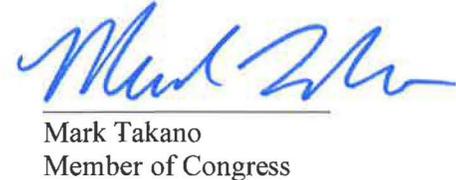
Grace Napolitano
Member of Congress



Tony Cárdenas
Member of Congress



Jared Huffman
Member of Congress



Mark Takano
Member of Congress



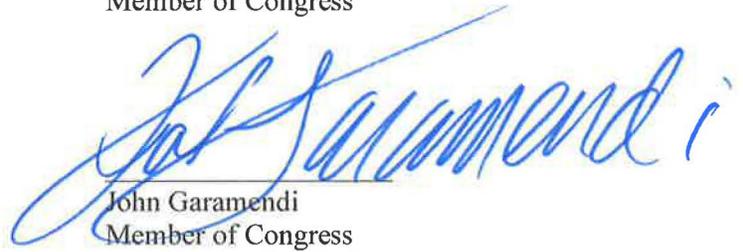
Alan Lowenthal
Member of Congress



Eric Swalwell
Member of Congress



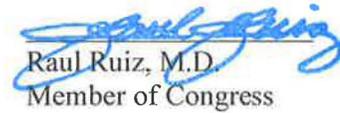
Lucille Roybal-Allard
Member of Congress



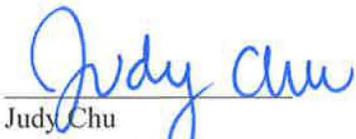
John Garamendi
Member of Congress



Ted Lieu
Member of Congress



Raul Ruiz, M.D.
Member of Congress



Judy Chu
Member of Congress



Michael M. Honda
Member of Congress



Peter V. Lee
Executive Director



Jennifer Kent
Director

May 3, 2016

The Honorable Ami Bera
United States House of Representatives
1408 Longworth House Office Building
Washington, D.C. 20515

Dear Congressman Bera:

Regarding your recent letter regarding maternity care for women through Covered California and Medi-Cal, you may be assured that we share your priority and that we are completely committed to helping them navigate the new health coverage options that have come as a result of the Affordable Care Act. As we have expanded benefits for pregnant women in California beyond the minimums required under federal law, there have been circumstances that must be handled on a case-by-case basis but the vast majority of women are getting the care they need and we are in a constant state of process improvement. As we have always been available to you and your colleagues to answer questions and work together to improve the lives of all Californians, we offer the following response to your specific concerns.

It is important to understand that under Federal law, the standard rule is that a consumer eligible for Medi-Cal must enroll in that program and cannot "opt" to select Covered California with financial assistance. While federal and state regulations dictate that consumers should be placed in the lowest-cost insurance affordability program for which they are eligible, the State of California has chosen to provide special options for pregnant women with household income over 138% and up to 213% of the Federal Poverty Level who enrolled in Covered California before they became pregnant. When a woman is already enrolled in Covered California and becomes pregnant, we are providing more benefits by allowing her to choose which program she would rather be enrolled in: Medi-Cal full-scope coverage, which is comprehensive and not limited to prenatal care, free and has no copays or coinsurance for labor, delivery, and perinatal services; or choosing to keep her Covered California coverage with financial assistance and premium and out-of-pocket responsibilities.

Covered California, 1601 Exposition Boulevard, Sacramento, CA 95815

www.coveredca.com

Department of Health Care Services, MS 0000, P.O. Box 997413, Sacramento, CA 95899-7413

www.dhcs.ca.gov

While there are clear advantages to Medi-Cal coverage, transition to Medi-Cal during pregnancy may mean a transition to new providers. Recognizing this potential disruption and to protect continuity of care -- consistent with federal guidance implemented in 2015 -- pregnant women who are enrolled in Covered California health plans have the option of whether to keep their Covered California health plan or move to Medi-Cal.

Consistent with the federal guidance and in recognition of the heightened importance of continuity of care for pregnant women, Covered California has worked closely with the Department of Health Care Services to implement several preventative and remedial actions to ensure that these women are aware that they may be eligible for full-scope Medi-Cal and have the opportunity to choose the coverage that works best for them.

CoveredCA.com Makes Clear that Reporting a Pregnancy Is Not Required

First, our Covered California website provides guidance in the 'Report a Change' page that emphasizes:

"Covered California does not require members to report a pregnancy...it is not necessary or recommended to report a pregnancy unless you are interested in other coverage options for pregnant women such as Medi-Cal or the Medi-Cal Access Program."

That same page also includes a link to more detailed information. In this way, pregnant women looking to report a change online are alerted to the fact that reporting their pregnancy may result in a change of coverage *before* a change is ever reported.

All Covered California Service Channels Educate Pregnant Women on Their Options

As in the case of women using the website, women who are calling our call center are also told that reporting a pregnancy may result in a change of eligibility. All representatives at the Covered California Service Center have received training and guidance on how to explain to women that reporting a pregnancy may result in a change in eligibility and could result in a switch to Medi-Cal. We have also trained a specialized team of call center representatives to assist women who have complex questions about what a redetermination of eligibility means. Representatives can escalate complex pregnancy cases to that team if they are not able to immediately resolve a pregnant woman's concerns.

We know that many women enroll with Certified Insurance Agents and Enrollment Counselors, and so we have also advised all of our enrollment partners to be aware that

reporting a pregnancy may result in a change to their clients' eligibility. Further, Covered California has worked with our county partners and the Department of Health Care Services to raise awareness of the issue in cases where consumers contact those channels to report a change or discuss their coverage.

Several Notices Give Eligible Pregnant Women the Choice of Medi-Cal OR Covered California, and Give Women the Option to Return to Covered California after New Determination

In the event a woman reports a pregnancy without knowing that doing so would result in a change of eligibility, Covered California and Medi-Cal issue three separate notices designed to ensure that every woman is in the coverage of her choice.

The first notice is an eligibility determination and is generated immediately after the woman's pregnancy is reported and is sent within days. The second is a letter from Medi-Cal informing her of her eligibility determination and welcoming her to free full-scope coverage. Finally, we send out a letter to all women who have been transitioned to Medi-Cal because of a pregnancy which gives them instructions in the event they wish to retain their Covered California coverage and forego the free, comprehensive benefits provided by Medi-Cal. This letter includes a form to fill out to reinstate coverage and will soon contain a phone number for a specialized team at the Service Center in the event the consumer needs further assistance.

Additionally, if a consumer reports her pregnancy online, she will be directed to a screen explaining that she has been determined eligible for pregnancy-related Medi-Cal. If she reports her pregnancy on the phone all Service Center representatives are instructed to inform consumers of their potential eligibility for Medi-Cal.

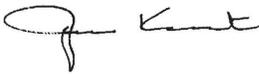
Covered California's Planned Changes Will Make Covered California the Default

Covered California and the Medi-Cal program are committed to providing the best of all possible experiences for pregnant women and their growing families. The current policy of making Medi-Cal the default choice of coverage grew out of a desire to make sure women were automatically provided the lowest-cost and broadest coverage while still giving the option to choose Covered California if desired. Since implementing this policy late last year, we have continued to assess the effects on the consumer experience and reassess future strategies. Covered California has initiated system changes last month that would make Covered California, not Medi-Cal, the default while giving women the option to save money by enrolling in Medi-Cal at any time that they are eligible. This change is now set to roll out later this month.

While this issue has garnered some media attention, what has gotten virtually no coverage is the fact in very broad terms, the Affordable Care Act, through Covered California in partnership with DHCS, is working for women and babies. Preliminary data from just 111 hospitals that serve Covered California patients specifies that 4,807 babies were born to women enrolled in Covered California from January 2014 to June 2015. Those 111 hospitals only represent 40% of inpatient care provided to Covered California patients, indicating that the actual number is closer to 10,000 babies delivered with Covered California coverage. Of those babies, about 8% needed intensive care – providing needed care and protecting their parents from potentially catastrophic hospital bills. All told, nearly 10,000 new families got the best care at the right time for the right price thanks to Covered California. In general, nearly half of all babies born in California are covered by Medi-Cal.

We share your commitment in ensuring that all women have uninterrupted access to health care throughout their pregnancies. In implementing federal regulations and guidance, we have developed policies and practices with that goal in mind. As we continue to improve our program, your ongoing support in meeting this objective is truly appreciated.

Sincerely,



Jennifer Kent
Director
Department of Health Care Services



Peter V. Lee
Executive Director
Covered California

cc: Diana Dooley, Secretary, California Health and Human Services Agency
Covered California Board
The Honorable Lois Capps
The Honorable Sam Farr
The Honorable Loretta Sanchez
The Honorable Grace Napolitano
The Honorable Tony Cardenas
The Honorable Jared Huffman
The Honorable Mark Takano
The Honorable Alan Lowenthal
The Honorable Eric Swalwell
The Honorable Lucille Roybal-Allard
The Honorable John Garamendi
The Honorable Ted Lieu
The Honorable Raul Ruiz, M.D.
The Honorable Judy Chu



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Phone 619-471-2637 Statewide Toll Free 888-804-3536 HealthConsumer.org

May 11, 2016

Ms. Diana Dooley, Chair
Paul Fearer
Genoveva Islas
Marty Morgenstern
Art Torres
Covered California Board
Via email to boardcomments@covered.ca.gov

Dear Covered California Board Members:

We write to you regarding the proposed re adoption of Covered California’s Individual Eligibility and Enrollment Regulations. The Health Consumer Alliance is Covered California’s designated statewide independent consumer assistance program since its inception. Our work with Covered California consumers gives us valuable insight into the consumer experience, which allows us to identify and address systemic issues through policy advocacy. We extend our appreciation to the Covered California Policy, Evaluation and Research division and General Counsel for meeting with us to discuss our comments and for incorporating many of our suggestions to the benefit of consumers. This letter focuses on three outstanding areas of concern: Covered California’s duty to translate its notices and forms, discrimination on the basis of gender identity, and the proposed special enrollment period (SEP) eligibility verification requirements.

The regulations must reflect Covered California’s duty to translate

Covered California’s current regulations and practice do not align with its statutory obligation to translate forms and notices. Specifically, the language access provisions of the proposed regulations §§ 6452 and 6454 do not meet the standard set forth in Welfare & Institutions Code § 15926(k)(2), which requires that all Covered California forms and notices must be translated into all of the Medi-Cal threshold languages, at a minimum.¹ Covered California’s duty to translate is not new. This state law applies to all California’s “insurance affordability programs,”² including subsidized health insurance offered through the Exchange and has been operative, including the translation requirement, since January 1, 2014. Yet, for over two years Covered California has failed to provide written translations as the law requires. It is critical that the Exchange regulations reflect Covered California’s duty to translate, and that these requirements in fact be met.

¹ Welfare & Institutions Code § 15926(k)(2) says: “Forms and notices developed pursuant to this section shall be developed using plain language and shall be provided in a manner that affords meaningful access to limited-English-proficient individuals, in accordance with applicable state and federal law, and at a minimum, provided in the same threshold languages as required for Medi-Cal managed care plans.”

² Welf. & Inst. Code § 15926(a)(3).

Although Covered California often provides Spanish translations, the failure to translate notices into any other threshold language is an impermissible distinction between threshold languages and is contrary to state law. Indeed, the numbers of applicants who speak or read a language other than English or Spanish are significant. According to the AB x1 1 Eligibility and Enrollment Report, jointly issued by Covered California and the Department of Health Care Services, between April and September 2015 over 129,000 applicants reported speaking a threshold language other than English or Spanish, and over 60,000 requested written materials in these other threshold languages.³ Should Covered California begin providing services to very low income immigrants via the Newly Qualified Immigrant wrap, the need for translation becomes all the more urgent.

Covered California's current and proposed regulation at § 6452(c) to provide language access through translated taglines is insufficient because it does not conform to the translation requirement cited above. In our experience, taglines do not effectively inform beneficiaries who are limited-English proficient of their rights because taglines often fail to convey the importance or urgency of a notice. In fact, requiring the recipients of the letter to take an extra step to understand its contents constitutes a barrier, not an invitation, to learning more about their health coverage and how to obtain and use their health benefits.

We urge the Board to include the translations requirements of Welfare and Institutions Code § 15926(k)(2) in the regulation § 6452, "Readability and Accessibility Standards," and § 6454, "General Standards for Exchange Notices."

The regulations should prohibit discrimination based on gender identity.

We urge the Board to include a prohibition of discrimination against gender identity to proposed regulation § 6470. Section 1557 of the Affordable Care Act⁴ broadly prohibits discrimination and the proposed federal regulations implementing that provision, which should be finalized this year, specifically enumerate gender identity as a protected class.⁵ Covered California has been a leader in inclusion and, as demonstrated by the 2017 Model QHP contract, dedicated to studying and eliminating health disparities on the basis of sex. It is therefore imperative that the Exchange regulations also explicitly prohibit discrimination on the basis of gender identity.

2017 SEP eligibility verification audit

We commend Covered California, specifically the Policy, Evaluation & Research division and the office of the General Counsel, for meeting with consumer advocates and releasing greatly improved proposed regulations for the SEP eligibility verification audit process. In particular, the current proposed

³ Department of Health Care Services and Covered California, *California Eligibility and Enrollment Report: Insurance Affordability Programs, For the Reporting Period April 2015 through September 2015* at 19-20, http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CA_Eligibility-Enrollment-Data_April2016.pdf.

⁴ Codified at 42 U.S.C. § 18116.

⁵ See 80 Fed. Reg. 54216-19.

regulations go further in protecting consumers by allowing attestations where documents do not exist or cannot be obtained, allowing extensions to submit documents when the consumer has made a good faith effort to comply, and prohibiting audits based on demographic, claims, or diagnosis data.

Nevertheless, the regulations could do more to achieve the guiding principle of the special enrollment process to minimize burden on consumers. First, there should be a time limit on Covered California's ability to select a consumer for SEP eligibility verification audit. Auditing a person who is many months into plan enrollment decreases the likelihood of obtaining the relevant documents and risks jeopardizing her health care while she spends time dealing with the audit. We urge the Board to restrict the Exchange's request for verification to within 30 days of a consumer's plan enrollment in § 6504(e). We also believe the regulations should be modified to ensure that if an enrollee or applicant is notified that she will be terminated for failure to provide verification, she be given the option to accept eligibility pending appeal.

Finally we believe the audit is an important opportunity to study whether there is in fact a problem of inappropriate SEP enrollment and, if so, the magnitude of it. We therefore urge the Board to add a provision to § 6504(e) to require reporting of audit results to ensure transparency and efficacy of the process.

If you would like to discuss our comments please contact Cori Racela at (310) 736-1646 or racela@healthlaw.org or Jen Flory at (916) 282-5141 or jflory@wclp.org.

Sincerely,

The Health Consumer Alliance



1764 San Diego Avenue, Suite 200 San Diego, CA 92110

Phone 619-471-2637 Statewide Toll Free 888-804-3536 HealthConsumer.org

Bay Area Legal Aid

California Rural
Legal Assistance

Central California
Legal Services

Greater Bakersfield
Legal Assistance

National Health
Law Program

Neighborhood
Legal Services of Los
Angeles County

Legal Aid Society of
Orange County

Legal Aid Society
of San Diego

Legal Aid Society
of San Mateo County

Legal Services
of Northern California

Western Center
on Law and Poverty

Health Consumer Alliance Year End Review for Covered California - 2015 -



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EXECUTIVE SUMMARY

The Health Consumer Alliance (HCA), a statewide partnership of independent legal services consumer assistance projects and support centers, is proud to provide its 2015 Year End Review for work funded by Covered California.

HCA has contracted with Covered California since October 2013, providing individual assistance for consumers throughout California and identifying trends and patterns of problems for Covered California leadership. HCA provides a valuable high quality service to Covered California customers throughout California:

- HCA is a direct referral source for Covered California service representatives as well as enrollment assistors and other community based organizations who rely on HCA's expertise to handle complex matters.
- HCA's work benefits Covered California by addressing systemic barriers that result in statewide improvements.

HCA's mission supports Covered California's vision "to improve the health of all Californians by assuring their access to affordable, high quality care." HCA is able to do this work because of its deep expertise and rich database. This supports HCA's work in our collaboration with Covered California, providing an important contribution to Covered California's efforts to continuously improve quality on a broad level.

At the front line of working directly with consumers every day, HCA is an early warning system for individual problems that reveal systemic trends and plays an effective role in ironing out bureaucratic obstacles that impact thousands of consumers at a time. As advocates who navigate the informal and formal appeal mechanisms, HCA's expertise in ensuring the effectiveness of these systems benefits the many consumers who never even reach HCA.

HCA also conducts extensive outreach and support for consumers and community based organizations to promote Covered California enrollment. This includes in-depth work with local Certified Enrollment Entities and other key community stakeholders. Eighty-eight percent of HCA's outreach includes education about consumers' rights to affordable coverage through Covered California.

HCA formally began providing individual assistance under its Covered California contract in October 2013. HCA is also the state-wide consumer assistance program that has contracted with the California Department of Managed Health Care (DMHC) since 2012. HCA provides

services to all California health care consumers, regardless of their income. HCA's toll free number is on Covered California notices and HCA is a direct referral source for both Covered California and DMHC.

In 2015, HCA assisted 1,671 consumers who had questions about eligibility or access to services through Covered California. Almost one-third came to HCA without any health insurance which was a drop from the prior year when it was almost half. 80% of the Covered California problems were with eligibility; 20% were with services.

This report provides some data highlights on consumers who came to HCA for help with Covered California issues: demographics, top problems divided by eligibility and services, problems with service access categorized by plans, outcomes related to successful problem resolution, and trends related to case examples. In addition, this report identifies progress and outstanding challenges in addressing systemic issues.



A consumer and his family received Advanced Premium Tax Credits (APTCs) in 2014 and enrolled in a Covered California plan. In mid-March 2015, the consumer realized that the family's 2014 income exceeded 400% FPL and reported the change to Covered California. Covered California erroneously terminated the consumer's APTCs retroactively to January 1, 2015. Thereafter, the consumer's plan began billing the consumer for the APTCs the consumer was supposed to receive, even though the consumer did not receive them. The plan repeatedly threatened to terminate the consumer's enrollment for nonpayment of the APTC amount. NLSLA took the case to a hearing and the Judge ordered Covered California to reinstate APTCs and work with the plan to ensure it stops seeking payment from the family and does not terminate enrollment. Covered California reinstated the APTCs from January 1 - April 30, 2015. Despite the hearing decision, the plan persisted in billing the consumer for the APTCs and continued to threaten that it would terminate coverage. NLSLA filed two plan grievances, a DMHC complaint, and, finally, escalated the issue to an executive at the health plan. After extensive advocacy, NLSLA recently received confirmation from the plan that it had rectified its accounting issue and would no longer bill the consumer for the APTCs.

The consumer was extremely grateful and expressed that the NLSLA attorney assisting him is a “lifesaver who went above and beyond late into the evening and on weekends to get coverage through Covered California over the course of several months.”



A 49-year-old consumer purchased a subsidized Covered California plan for herself and her oldest son in December 2013. The consumer suffers from a painful spinal condition that, without adequate treatment, causes severe pain. Soon after her Covered California plan began, the consumer received over 30 conflicting notices from Covered California, DHCS, and LA County regarding Medi-Cal and Covered California eligibility for all of her family members. Despite her continuing eligibility for her Covered California plan, sometime in November 2014 the consumer learned that she had been enrolled in Medi-Cal. Since her original Covered California application, her household income had increased and she was clearly not Medi-Cal eligible. In December 2014, the consumer's Covered California plan was canceled. She contacted her son's Medi-Cal worker, Covered California, and her health plan but nobody could help her restore her Covered California coverage because she had been enrolled in Medi-Cal. The consumer began to suffer debilitating pain because she was unable to receive physical therapy for her spinal condition as her Medi-Cal health plan refused to authorize physical therapy. After the consumer called NLSLA for help, NLSLA filed for an expedited hearing. After the hearing, the judge issued a decision fully favorable for the consumer. The consumer's Medi-Cal was cancelled and she was re-enrolled in Covered California and able to continue treatment for her spinal condition.

BACKGROUND

HCA partners provide consumer assistance throughout California. The direct service partners are:

- Bay Area Legal Aid
- California Rural Legal Assistance
- Central California Legal Services
- Greater Bakersfield Legal Assistance
- Inland Counties Legal Services
- Legal Aid Society of Orange County
- Legal Aid Society of San Diego
- Legal Aid Society of San Mateo County
- Legal Services of Northern California
- Neighborhood Legal Services of Los Angeles County

In addition, HCA includes two statewide support centers:

- Western Center on Law & Poverty (Western Center)
- National Health Law Program (NHLP)

These support centers provide technical assistance, training, materials, and together with the direct service partners, work on systemic advocacy.

When Covered California contracted with HCA, it recognized HCA's strength as an existing consumer assistance program already supported by The California Endowment and DMHC. HCA has been in existence since 1997 and is dedicated to providing intensive individual advocacy for health care consumers throughout California and pursuing policy solutions to address systemic barriers and trends that emerge from the individual case work. HCA provides direct assistance through a statewide hotline that directs consumers to local HCA partners. HCA provides bilingual assistance in all languages, is committed to linguistically and culturally sensitive outreach and assistance, and can ensure individuals with a variety of physical or mental health disabilities have access.

HCA partners work closely with stakeholders in local communities, such as community clinics and social services agencies, and statewide, to share information, support them with technical assistance and training, and brainstorm about solutions to address barriers. Since the roll-out of Covered California, HCA partners have had close relationships with Certified Enrollment Entities (CEEs) who assist consumers applying for coverage. In each of our communities, we have provided on-going training and technical support to CEEs and we get referrals from them to trouble-shoot their most difficult problems.

HCA has been contracting with Covered California since May 2013. Our latest contract has been extended to June 2016. HCA requests on-going and stable funding from Covered California to keep providing individual assistance to Covered California consumers and developing efficient, consumer-friendly systems for the program.

2015 DATA HIGHLIGHTS

CONSUMERS SERVED:

1,671

**NUMBER OF REFERRALS
FROM COVERED CALIFORNIA**

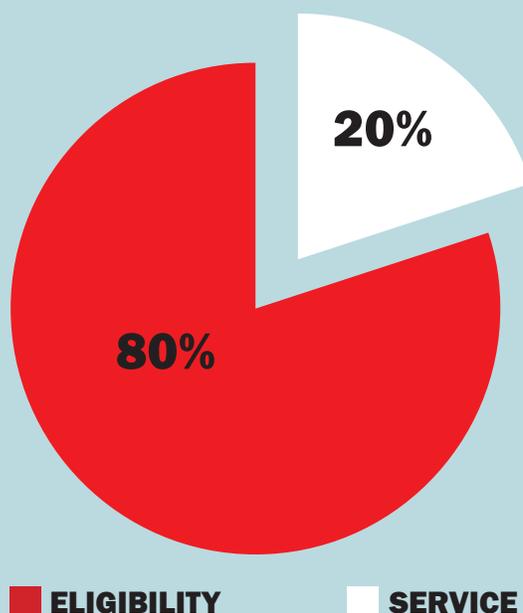
282

**COVERED CALIFORNIA CONSUMERS ASSISTED
WHO WERE UNINSURED AT FIRST CONTACT**

523

32%

COVERED CALIFORNIA PROBLEMS



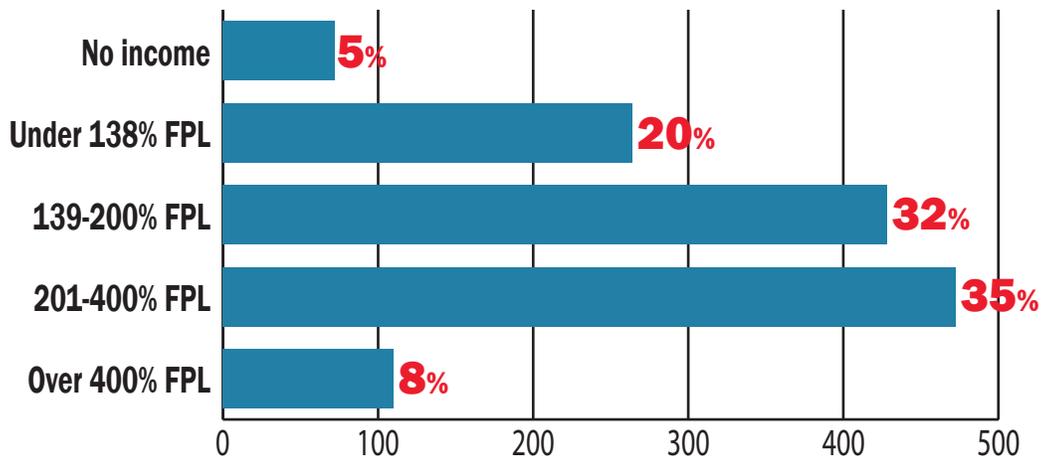
“Eligibility” refers to problems obtaining or retaining public or private coverage, and includes uninsured consumers seeking coverage.

“Service” refers to problems obtaining services and includes “access” barriers such as inability to schedule appointments, obtain approvals for procedures, find appropriate specialists, or afford current or past bills.

DATA HIGHLIGHTS

DEMOGRAPHICS

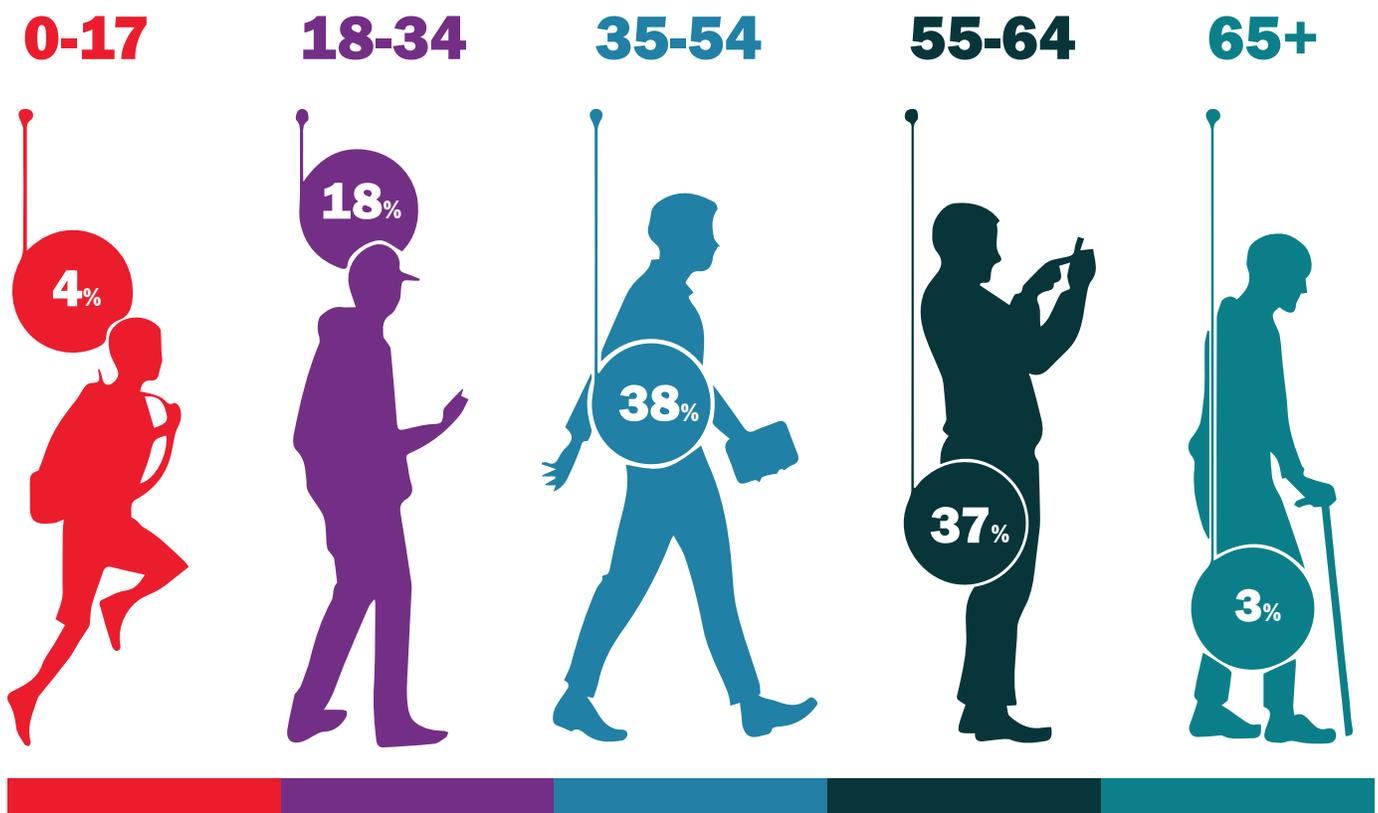
Income for Consumers with Covered California Problems



67% OF CONSUMERS WERE BETWEEN 139-400% FPL

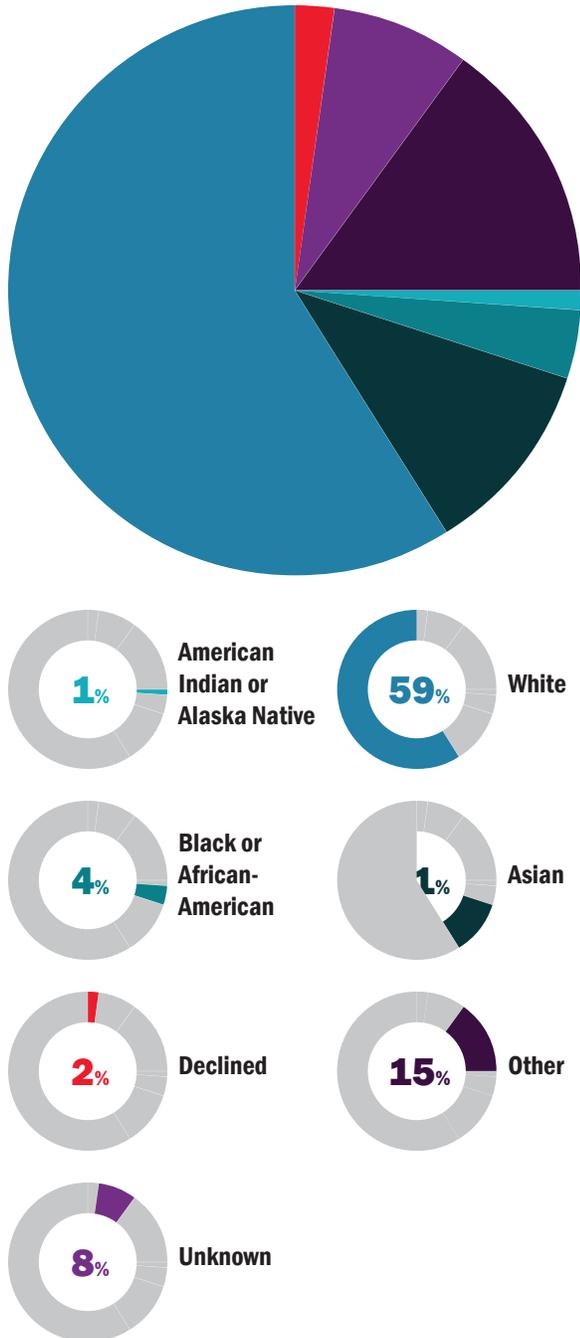
The majority of consumers were between 139-400% FPL (67%) who are eligible for Advanced Premium Tax Credits (APTCs). The majority of individuals under 138% of the FPL sought services due to the following reasons: a) they applied thinking they were eligible for Covered California and once determined eligible for Medi-Cal instead, sought our assistance explaining the program rules to them; b) they applied through Covered California but had trouble having their Medi-Cal processed correctly or timely; and c) they dropped income and had trouble with the transition to Medi-Cal.

Age Group of Consumers with Covered California Problems

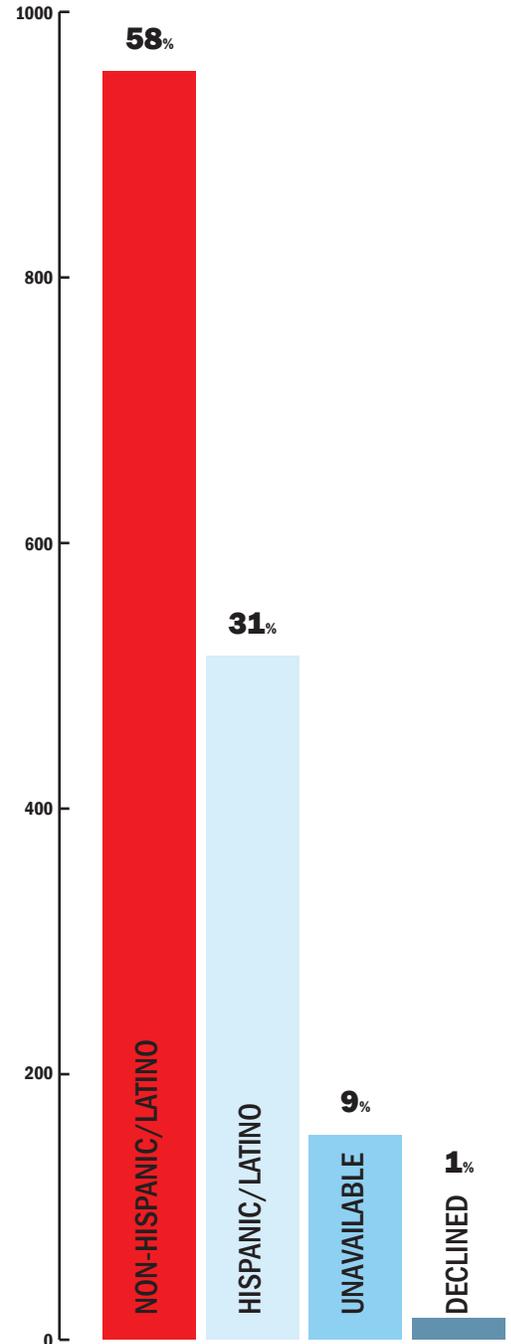


* 31 consumers did not provide age information

Race of Consumers with Covered California Problems



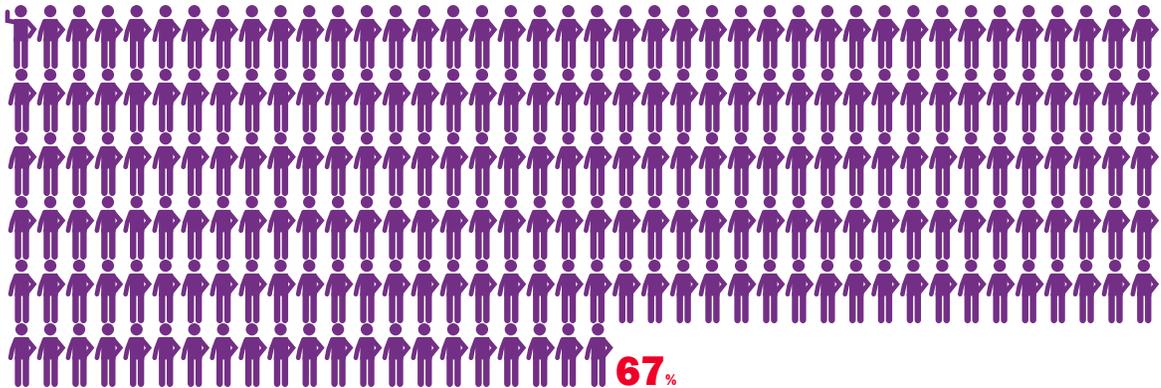
Ethnicity of Consumers with Covered California Problems



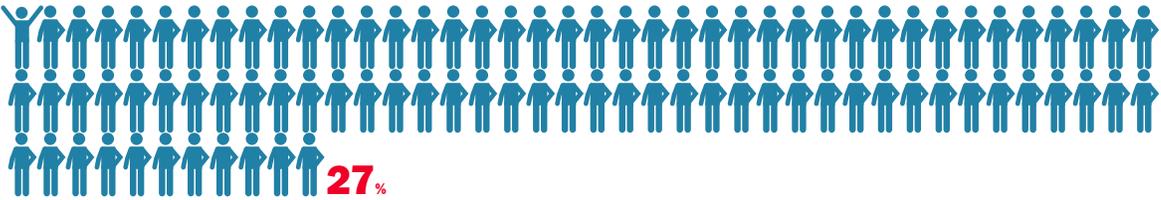
*Consumers are asked separate questions on racial identity and ethnicity. Many consumers who identify as Hispanic in response to the ethnicity question identify as white in response to the racial identity question but some consumers choose Hispanic/other. Because these categories give us limited insight into the diversity of our consumers, the question about Hispanic & non-Hispanic provides us further information about our consumers.

Languages of Consumers with Covered California Problems

ENGLISH



SPANISH



API LANGUAGES



The most common were Korean, Vietnamese, Hmong, Cantonese, and Mandarin.

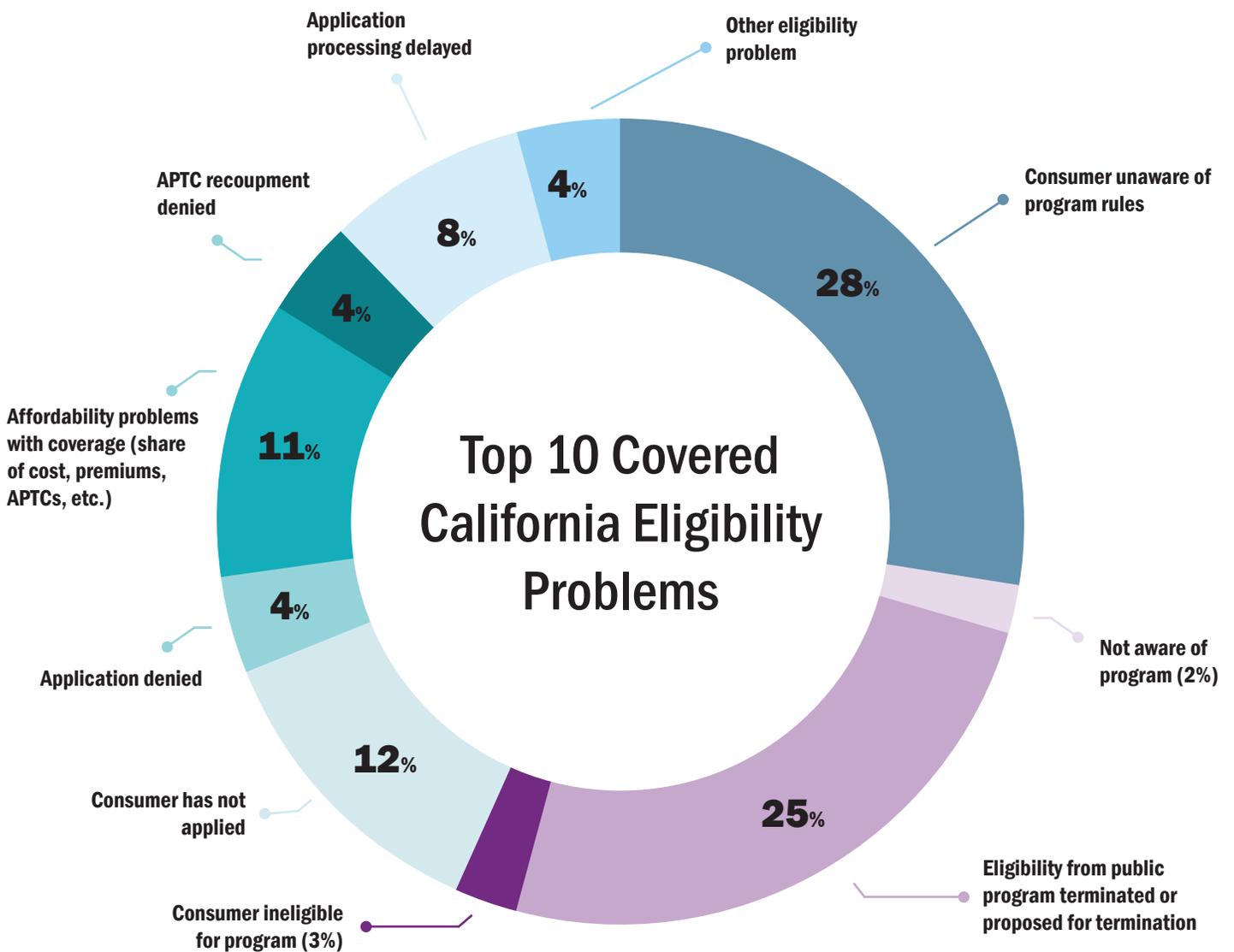
OTHER



A 63-year-old monolingual Vietnamese-speaking consumer contacted the Legal Aid Society of Orange County (LASOC) because he was confused by the notices he received from Covered California. The consumer and his spouse were on Medi-Cal until September 2015. The consumer then learned that he could not access medical care because his Medi-Cal was inactive. Later, he received two conflicting notices from Covered California: the first notice indicated his wife and he qualified for Medi-Cal and the second notice stated that they were not eligible for Medi-Cal. LASOC reviewed the consumer's financial information and determined that the consumer should have been found eligible for Medi-Cal. LASOC then contacted the county requesting a re-evaluation of the consumer's Medi-Cal based on his change of income. Soon after, LASOC confirmed that his Medi-Cal had been reinstated.

DATA HIGHLIGHTS

Eligibility & Application Problems

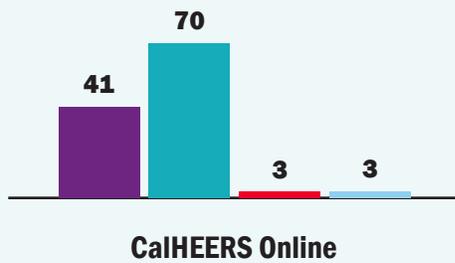


Compared to last year, the percentage of consumers who contacted us who were unaware of program or of program rule decreased to 28% (down from 40% last year). One of the top three problems which was not in the top three last year was “Eligibility from public program is terminated or proposed for termination” at 25%. Finally, the percentage of consumers who had not applied dropped dramatically to 12% (down from 30% last year).

DATA HIGHLIGHTS

Eligibility & Application Problems

Application Problems by Application Type



- Application Denied
- Application Processing Delayed
- Procedural Problems with Application
- Excessive Verification Required

Reasons for “Application Denied”

Income	22
Non-financial reasons	14
Covered California/ Medi-Cal disconnect	9
Not assessed for all proper programs	3
Failure to provide requested information	2
Application made but not processed timely, including payments not processed timely	1
Excessive verification required	1
Premium payment problem	1
Other	1

The top reason this year was income as opposed to non-financial reason: income is 22 (42%) and non-financial reason is 14 (26%) which is down from last year where it was 56%.

Reasons for “Has Not Applied”

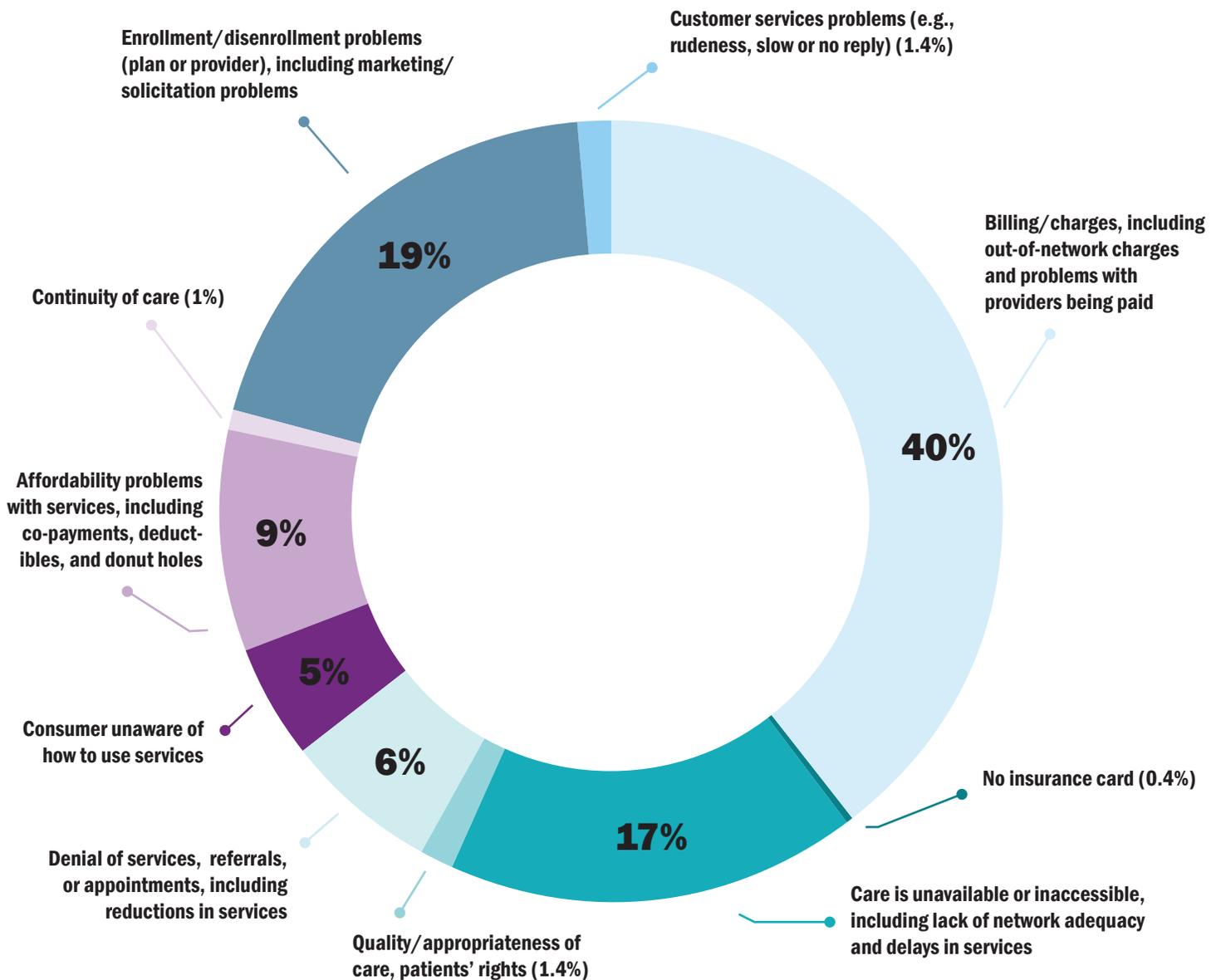
Not aware eligible for program	59
Needs additional information	56
Didn’t know how or where to apply	31
Other	18
Application too confusing	4

Reasons for “Application Processing Delayed”

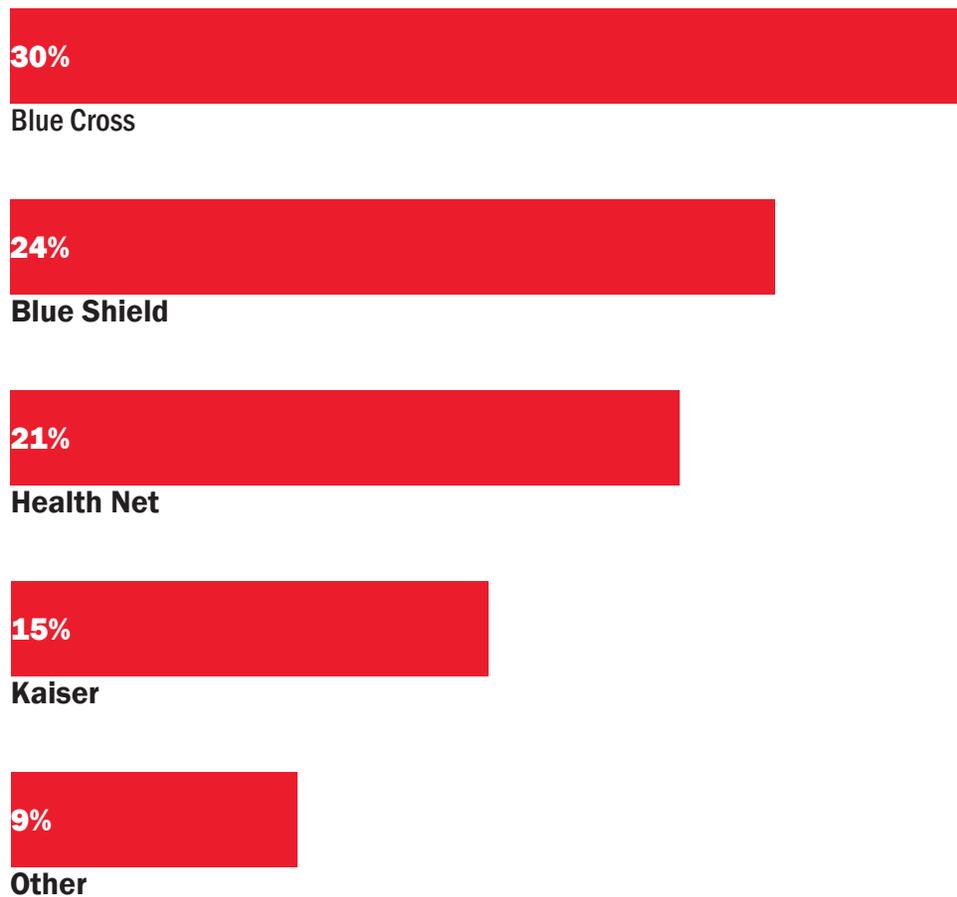
Covered California/ Medi-Cal disconnect	28
Application made but not processed timely, including payments not processed timely	27
Non-financial reasons	26
Income	10
Citizenship verification	5
Failure to provide verification	3
Website problems prevent application from being submitted	3
Website problems prevent confirmation that application is being processed	3
Other	3
Not assessed for all proper programs	1
Premium payment problem	1

DATA HIGHLIGHTS

Service Problems



**Covered CA
 Service
 Problems
 by Health
 Plan**



The number one problem is still billing/charges, 201 (40%) but this is a jump from last year when it was 28%; #2 was enrollment/disenrollment, 98 (19%) - close to the same last year at 20%; and care is unavailable/inaccessible, 86 (17%) - close to the same last year at 16%

DATA HIGHLIGHTS

Top 3 Covered California Consumer Problems by Month

MONTH	ELIGIBILITY	SERVICE
January	<ul style="list-style-type: none"> (1) Client unaware of program or program rules (2) Has not applied (3) Application processing delayed 	<ul style="list-style-type: none"> (1) Enrollment/disenrollment problems (2) Care is unavailable or inaccessible (3) Billing/charges
February	<ul style="list-style-type: none"> (1) Client unaware of program or program rules (2) Has not applied (3) Insurance is rescinded or terminated 	<ul style="list-style-type: none"> (1) Billing/charges (2) Enrollment/disenrollment problems (3) Denial of services
March	<ul style="list-style-type: none"> (1) Client unaware of program or program rules (2) Has not applied (3) Affordability problems 	<ul style="list-style-type: none"> (1) Enrollment/disenrollment problems (2) Billing/charges (3) Care is unavailable or inaccessible
April	<ul style="list-style-type: none"> (1) Client unaware of program or program rules (2) Affordability problems (3) Has not applied 	<ul style="list-style-type: none"> (1) Billing/charges (2) Denial of services (3) Enrollment/disenrollment problems
May	<ul style="list-style-type: none"> (1) Eligibility from public program is terminated (2) Client unaware of program or program rules (3) Affordability problems 	<ul style="list-style-type: none"> (1) Billing/charges (2) Affordability problems (3) Enrollment/disenrollment problems
June	<ul style="list-style-type: none"> (1) Client unaware of program or program rules (2) Application processing delayed (3) Affordability problems 	<ul style="list-style-type: none"> (1) Billing/charges (2) Care is unavailable or inaccessible (3) Enrollment/disenrollment problems

MONTH	ELIGIBILITY	SERVICE
July	<ul style="list-style-type: none"> (1) Coverage is rescinded, terminated, or proposed for termination (2) Has not applied (3) Client unaware of program or program rules 	<ul style="list-style-type: none"> (1) Billing/charges (2) Enrollment/disenrollment problems (3) Care is unavailable or inaccessible
August	<ul style="list-style-type: none"> (1) Client unaware of program or program rules (2) Coverage is rescinded, terminated, or proposed for termination (3) Has not applied 	<ul style="list-style-type: none"> (1) Enrollment/disenrollment problems (2) Billing/charges (3) Affordability problems
September	<ul style="list-style-type: none"> (1) Client unaware of program or program rules (2) Eligibility from public program is terminated (3) Has not applied 	<ul style="list-style-type: none"> (1) Billing/charges (2) Care is unavailable or inaccessible (3) Enrollment/disenrollment problems
October	<ul style="list-style-type: none"> (1) Coverage is rescinded, terminated, or proposed for termination (2) Client unaware of program or program rules (3) Affordability problems 	<ul style="list-style-type: none"> (1) Billing/charges (2) Enrollment/disenrollment problems (3) Denial of services
November	<ul style="list-style-type: none"> (1) Eligibility from public program is terminated (2) Client unaware of program or program rules (3) Affordability problems 	<ul style="list-style-type: none"> (1) Billing/charges (2) Affordability problems (3) Enrollment/disenrollment problems
December	<ul style="list-style-type: none"> (1) Coverage is rescinded, terminated, or proposed for termination (2) Client unaware of program or program rules (3) Affordability problems 	<ul style="list-style-type: none"> (1) Billing/charges (2) Care is unavailable or inaccessible (3) Enrollment/disenrollment problems

Data on Appeals

Thirty-five percent of the consumers HCA helped involved either an appeal or agency escalation (585). Fifty-five percent of these consumers resulted in a positive resolution (324) and represented 19% of our case work. The top resolutions for individuals with eligibility problems were preventing a termination, processing an application that had been delayed, and resolving an affordability problem, such as the amount of premiums due or APTCs owed. The top resolutions for service problems were resolving billing and charge issues; maintaining enrollment in a plan and overcoming a denial of services.

1. Cases with appeal outcomes of “granted client claim” and “problem resolved after agency escalation:” 324 (20%).

2. Top 3 eligibility problems with appeal outcomes of “granted client claim” and “problem resolved after agency escalation:” Eligibility from public program is terminated or proposed for termination, 116 (36%); Application processing delayed, 53 (16%); Affordability (share of cost, premiums, APTC calculations), 19 (6%).

3. Top 3 service problems with appeal outcomes of granted client claim and problem resolved after agency escalation: Billing/charges, 25 (8%); Enrollment/disenrollment, 17 (5%); and Denial of services, 8 (2%).

A single 63 year-old monolingual Spanish speaking Covered California member contacted the Legal Aid Society of San Diego (LASSD) after receiving notice that her plan benefits (at \$1 premium per month) would be terminated retroactively due to an increase in income. LASSD staff assisted the client in filing an internal grievance and a State Fair Hearing to dispute the discontinuance while ensuring continued enrollment. Prior to the hearing, the Covered California hearing representative offered to resolve the case by reinstating benefits at the prior level of premiums (\$1/mo) and ongoing at \$78 per month, accurately reflecting her increased income. A subsequent request to re-open the hearing was required, however, when the health plan continued to incorrectly bill the client the wrong premium amount retroactively despite the agreement with Covered California. During the subsequent hearing, Covered California stipulated to the correct amount owed. Following the issuance of the order and extensive advocacy with the plan and Covered California staff, the plan corrected its billing statements and the client paid the full, corrected amount, enabling ongoing coverage and avoiding a break in coverage.



SYSTEMIC ISSUES

Appeals

During 2015, HCA identified numerous issues with the Covered California appeals process. These included: compliance with hearing decisions, lack of contact with appeals specialists, failure to provide position statements before hearings, contacting consumers as opposed to authorized representative, and lack of informal resolution. Because the problems were dramatic and continuous, HCA sent a letter to the Covered California Board in March 2015, alerting them to the issues.

Covered California responded by making some important improvements, particularly with respect to setting timelines and improving the informal resolution process. Covered California agreed to make supervisory level staff available to HCA to facilitate and promote resolution at the informal level.

Covered California also improved coordination in communication between its appeals unit and the 1095A dispute unit.

Many Covered California appeals are extremely complex and require the involvement of multiple entities such as health plans, the Department of Health Care Services, and county Medi-Cal agencies to ensure the appropriate resolution of a consumer's appeal. HCA is working collaboratively with the Department of Social Services, Covered California, and the Department of Managed Health Care to address jurisdictional issues that seem to overlap between agencies.



A consumer contacted Inland Counties Legal Services (ICLS) because of delays in receiving premium statements and then inappropriate retroactive billing by the plan. She first enrolled in a plan in December 2013 but did not receive premium statements until March 2014. She filed an appeal in April 2014 because she had been paying premiums but not showing as enrolled. After she filed the appeal, she did not receive any notice from Covered California until almost nine months later, December 2014. She began working with an appeals specialist in January 2015 (nearly one year after she enrolled) and her case finally went to hearing in March 2015. The hearing successfully resolved the issue, eliminating retroactive charges for premiums and providing her a refund.

SYSTEMIC ISSUES

1095-As

2015 was the first year that Covered California was required to send its enrollees IRS tax form 1095-A to show enrollment in Covered California health plans and receipt of premium tax credits for the 2014 tax year. Enrollees use the form when they file taxes. This form is necessary to enable the IRS to reconcile the amount of premium tax credits consumers received against the amount for which they are actually eligible. It is imperative that these be accurate as inaccuracies can lead to erroneous tax liabilities where consum-

ers are told that they must pay back thousands of dollars that they should not owe. However, there were a number of problems caused by the CalHEERS computer system which led to inaccurate forms being sent to consumers.

As consumers began to contact HCA for individual assistance, HCA advocates immediately informed Covered California of certain patterns of problems and Covered California was able to fix them in 'batches' which helped thousands of consumers at a time. In addition, HCA

advocates worked with Covered California to improve its dispute process for those consumers who needed individual fixes to their forms. Some of these required appeals that HCA handled. HCA has continued to work with Covered California on this process so that this year, consumers are getting immediate responses when requesting a corrected 1095-A form. Those requests are tracked and corrections are issued or denied in a timely fashion.

Improving Coordination and Communications between HCA and Health Plans

In addition to improvements on the formal and informal appeals processes, HCA also has worked with Covered California to improve communications between advocates and the health plans to resolve on-going disputes. In many cases, while the consumer and Covered California come to agreement on what the eligibility outcome should be, the consumer still struggles to get the appropriate changes made with the plan. Even a change as minor as an eligibility start date can have a significant impact on a con-

sumer because it determines amounts owed. While a consumer and a plan are disputing those amounts, the plans can begin collection efforts and even report consumers to credit agencies. HCA is working hard with Covered California to establish and enforce protocols prohibiting plans from sending these bills to collections when the eligibility dates conflict with Covered California orders.

In addition, while Covered California sometimes referred consumers to DMHC

because the complaints were about the plans, HCA identified that some consumer complaints that seemed to be about plan premium payment problems actually had an eligibility issue at its root and needed to be resolved by Covered California. As a result, Covered California began meeting jointly with the Department of Social Services' State Hearings Division and the Department of Managed Health Care in order to create best practices for coordination.

A consumer contacted Neighborhood Legal Services of Los Angeles County (NLSLA) for assistance when Covered California incorrectly terminated her Advanced Premium Tax Credits (APTCs). The consumer suffers from a severe psychiatric condition and the termination of her Covered California plan jeopardized her access to essential medications. The consumer and her husband, who have a one-year-old child, were previously granted Covered California APTCs through a fair hearing in July 2014. In January 2015, the couple received a notice from Covered California stating they were Medi-Cal eligible. The consumer filed an appeal and requested continued enrollment in her Covered California plan. She was not contacted about continued enrollment and was not given enrollment at her 2014 APTC levels but instead, was billed \$150.14 for a Covered CA plan. As of the date of the hearing in her case, the consumer simultaneously showed Medi-Cal eligibility. NLSLA represented the consumer at her hearing but did not receive a Statement of Position from either the county or Covered California until the time of the hearing. Submitting its position statement and income verifications, NLSLA was able to obtain a successful hearing outcome and was able to get Covered California benefits reinstated for the consumer.



Notices

In both 2014 and 2015, HCA assisted numerous consumers who experienced problems enrolling in or keeping their health coverage because they either received no notice or found the notices confusing. HCA raised concerns early in 2015 about the lack of proper notices generated from CalHEERS for those found eligible for either Medi-Cal or Covered California, despite significant work in 2014 on this issue. The NOD01 (Notice of Decision 1) notices inform consumers of their initial eligibility determination but were often inaccurate, confusing, and conflicting notices were sent to the same

consumer. As a result of HCA's letter and testimony before the Covered California board regarding the severity of the problems with the notices, HCA worked with Covered California and DHCS in January to review the text of the notices for all the various eligibility scenarios and was able to get significant changes made to improve the language and reduce consumer confusion. Some of the text changes to the notices were programmed into CalHEERS in March 2016, which will, hopefully, lessen the problems.

In addition, HCA advocates worked very closely to improve notices for the SB 1341 transition of NOD02 notices from CalHEERS to SAWS for legal accuracy, readability, and accessibility.

SYSTEMIC ISSUES

CalHEERS / AB 1296 Workgroup Process

HCA advocates continued to play a leadership role in identifying and raising issues with CalHEERS to Covered California and DHCS. CalHEERS is the California Healthcare Enrollment, Eligibility and Retention System which powers the online Covered California application and contains the business rules engine with the eligibility rules. HCA advocates attended every AB 1296 workgroup at which CalHEERS changes and releases were discussed with Covered California and DHCS.

Some of the CalHEERS issues HCA advocates have worked on include the following:

- o Pregnant women with incomes that should have made them eligible for the Medi-Cal Access Program (MCAP) were going into Covered California until October 2015. Advocates worked with CalHEERS staff to design the program fixes for this program as well as the interplay between Covered California and Medi-Cal for Pregnant Women. Now, thousands more pregnant women are being correctly determined eligible for MCAP and able to access affordable health care during their pregnancy.

- o CalHEERS programming still has issues with counting non-taxable income (such as SSI and state disability insurance) in eligibility determinations though several changes have been implemented to allow consumers greater ease with providing information about their income, including start and stop dates and frequency.

A Legal Permanent Resident enrolled in Covered California in April 2014 made premium payments every month. In January 2015, he contacted LASSD when he received an \$8,000 medical bill for services received in November 2014 because the provider found that he was not covered. LASSD assisted the client in making several calls to Covered California, the health plan and the county, all of whom found that the consumer did not have any health insurance. LASSD followed up with Covered California and discovered the consumer had three incomplete applications in the system and the county needed to be involved to complete processing. The county finished inputting the consumer's information in the system and determined the consumer was eligible for Medi-Cal. Since coverage was found effective as of March 2014, the consumer's \$8,000 November 2014 bill was covered by Medi-Cal.



- o HCA advocates participate in a workgroup to correct some of the information that is asked of immigrants and ensure that the process is not more burdensome than allowed by law. This is especially critical given California's large immigrant population.

- o In the fall of 2015, HCA advocates participated in the first-ever User Acceptance Testing (UAT) for CalHEERS. We created test scenarios to see whether some of the fixes we helped craft were actually working. HCA advocates worked with DHCS and Covered California to add

questions to the joint application to collect data regarding sexual orientation and gender identity. These are pending federal approval.

Transition to Medicare

HCA advocates raised the issue of Medicare enrollment and APTC eligibility with Covered California which is an increasingly critical issue as more and more of the population ages into the Medicare program. HCA was primarily concerned with outreach to people who are becoming eligible for Medicare and are therefore ineligible for APTCs although they may remain in a Covered California plan without subsidies. HCA also had consumers who called confused about whether to enroll in or decline Medicare coverage because they already had coverage through Covered California. Consumers who do not timely enroll in Medicare may experience long breaks in health coverage because Medicare enrollment is only limited to certain times of the year. Such gaps in coverage can be catastrophic as Medicare-eligible consumers are older adults and persons with disabilities who often have a greater need for medical care. In addition, these consumers are subject to penalties when they eventually sign up, just as consumers who get more APTCs than they are eligible for face a tax penalty. In early 2016, Covered California said they would look into developing an outreach and education campaign for Covered California members who were potentially Medicare eligible.

A Solano county consumer was enrolled in a Covered California plan but contacted Covered California to terminate her policy when her Medicare became effective. At the time, both Covered California and the health plan confirmed that she had been disenrolled from the health plan. However, later in the year, the consumer began receiving bills for several months' worth of past due premiums. When she contacted Covered California and the health plan again, they told her that she was still enrolled in the plan. As a result, the consumer subsequently received an incorrect 1095-A form. Legal Services of Northern California (LSNC) contacted the Covered California back office, facilitated communication between Covered California, the health plan, and the consumer, and was able to resolve the matter. The consumer received a corrected 1095-A form and the health plan confirmed that she did not owe any back premiums.

A consumer had a Covered California plan and paid all premiums for three months until her Medicare became effective. However, the health plan erroneously and retroactively terminated her coverage back to three months before her Medicare was effective. The Covered California plan then denied covering all claims during that three-month period so the consumer requested a Covered California state fair hearing. The judge found that the plan must cover services the consumer had during that three-month period. Despite this decision, the hospital bills were sent to collections. At this point, the consumer called BayLegal, which contacted the collection company on the consumer's behalf. BayLegal spoke to the hospital informing it that the judge ALJ found in favor of the consumer and that the consumer's plan was reinstated for the three-month period. Based on this information, the hospital agreed to send all outstanding accounts to the plan to request payment. The hospital also stated that the six accounts sent to the collection company would be recalled immediately.



CONCLUSION

Covered California realized that there would be value in supporting an independent consumer assistance program which could both help consumers with difficult problems accessing coverage or care and give feedback to Covered California about how to resolve these systemic problems. Through Covered California's support, HCA has met both of these objectives: Covered California has ensured that HCA continues as an indispensable resource for health consumers, CEEs, and agents to assist with individual problems. Covered California integrates and relies on HCA's expertise to seek program-wide improvements and continuously improve quality service to its customers. There is no other resource like HCA. Covered California should continue this modest but important investment.



May 11, 2016

Via E-mail

Attn: Peter Lee
Covered California Board
Covered California
1601 Exposition Boulevard
Sacramento, CA 95814

Re: 2016-2017 Covered California Navigator Program Budget

Dear Mr. Lee and Covered California Board:

Asian Americans Advancing Justice – Los Angeles (Advancing Justice-LA) is writing on behalf of the undersigned Navigator grantees, all of whom are committed to reaching out to, educating, enrolling and assisting consumers so they can enjoy the benefits of Covered California and receive valuable in-person, in-language assistance in hard-to-reach communities over the last year. Some of these grantees have been working to increase access to affordable, high quality health care since the First Open Enrollment Period in over 36 languages to the remaining uninsured and often overlooked communities that truly require targeted, culturally and linguistically appropriate assistance.

As we look toward the 2016-17 Navigator Program, we would like to share some of the challenges we faced and the successes we achieved to demonstrate how Covered California's strong commitment to supporting the work of community-based entities through the Navigator Program has helped even the hardest-to-reach consumers to attain the benefits of the new health care marketplace.

Thank you for taking our concerns under advisement when designing the 2015-16 Navigator Program. The use of block grants, the recognition of the full range of navigator activities, and the more frequent progress reports provided by Covered California have all been helpful to Navigator grantees over the last year. However, as we reviewed the proposed 2016-17 budget for

the Navigator Program, we are very disappointed that its funding has been cut by more than half, from its original budget allocation of \$13 million (or \$10.5 million of the actual funding for Navigator grants) to \$5 million. We strongly hope that the board will consider fully funding the Navigator Program this year at \$13 million as allocated in its 2015-16 budget or at a minimum, maintaining its current allocation of \$10.5 million for Navigator grants and certainly not decreasing it by more than 50%.

Secure, continued funding for in-person, in-language assistance from community-based Navigator grantees is critical to Covered California's success. The Navigator Program supports Covered California's strategy not only to provide equitable access to the most vulnerable and hard-to-reach populations, but its needed ability to retain consumers to ensure the financial stability of the marketplace. We believe that, ideally using the original \$13 million allocated would strengthen the program. In order to ensure the current level of in-person, culturally and linguistically competent assistance that Navigator grantees across the state provide, it must be maintained at its current funding of \$10.5 million rather than being severely cut as proposed by the staff.

It is not clear why the staff considered only three options: \$3 million, \$5 million and \$7 million and decided upon the \$5 million amount - with no notice to the public beyond release of the budget on May 9th and no input from any stakeholders, including its Marketing, Outreach and Enrollment Assistance Advisory Group, which has not met since December 16, 2015. As it was, last year Covered California decided not to use all of the \$13 million allocated for the Navigator Program in its 2015-16 budget but only distributed \$10.5 million in Navigator grants. Thus, there was already a decrease of \$2.5 million from last year's budget, which would have likely increased the numbers of consumers reached through the Navigator Program. When reviewing the proposed 2016-17 budget and the amounts in the 2015-16 budget, the proposed \$5 million for the Navigator Program represents only 1.6% of the total budget for Covered California and only 5% of the total Outreach and Sales, Marketing budget compared to 3.1-4.0% of the total budget for Covered California and 8.6-10.7% of the total Outreach and Sales, Marketing budget. This is both a huge dollar and percentage decrease from last year's budget (the range is dependent on whether one uses the \$13 million total allocated in the 2015-16 budget v. the final distributed amount of \$10.5 million). It would be a terrible waste to lose the experience and knowledge developed by the Navigator Program's culturally and linguistically competent Certified Enrollment Counselors (CECs). Therefore, we strongly feel that \$10-13 million in continued funding for in-person, in-language assistance from community-based Navigator grantees is critical to Covered California's strategy to both target the most vulnerable and hard-to-reach marketplace eligible populations and retain existing low-income, LEP enrollees.

During the consumer coverage renewal period, many Navigator organizations that served low-income limited English proficient (LEP) communities took the initiative to call individuals and families they had served in the past to remind them that it was time to update their income information and renew their Covered California health plan. This was essential to maintain coverage and APTC for the many LEP enrollees who did not understand the Covered California and health plan notices, which were only in English and sometimes Spanish. As you know,

Navigators also provide significant amounts of pre- and post-enrollment support with respect to a wide range of issues, including assisting with the application, selection of a health plan and/or primary care physician, managed care pre-authorization processes, accessing missing documents, such as the 1095-A, inappropriate billing issues, among a myriad of other problems that often arise.

The depth and breadth of support that Navigators provide to California's health consumers is a testament to Covered California's commitment to closing the enrollment gap and reducing health disparities by investing in trusted community-based organizations and bolstering the state's health access infrastructure. However, these services also require a significant investment of staff time and capacity on the part of these organizations. We are aware of multiple instances in which CECs have spent in excess of 20 hours helping a previously uninsured LEP consumer navigate the health care system. Just this past open enrollment period, one of Advancing Justice-LA's CECs needed to assist a LEP consumer through Covered California's entire appeals process, from the initial filing to drafting a statement of position to representing him at a hearing with an Administrative Law Judge (ALJ).

With each passing year, new consumers will be more difficult to identify and enroll. Those still uninsured will increasingly come from hard-to-reach, immigrant and LEP communities, and retention of existing enrollees will also become increasingly important. Covered California had the foresight to invest in the development of over 6,000 CECs with the language capacity and community knowledge to provide that critical in-person assistance to these populations.

The Navigator grantees are proud of how our partnership with Covered California has contributed to its overwhelming success over the last three years. We look forward to our continued partnership with Covered California and our joint efforts to assist vulnerable, hard-to-reach consumers. Thank you for your consideration. If you any questions or need further information, please contact Doreena Wong at (213) 241-0271.

Sincerely,

A handwritten signature in black ink that reads "Doreena Wong". The signature is written in a cursive, flowing style.

Doreena Wong, Project Director, Health Access Project
Asian Americans Advancing Justice – Los Angeles

Mike Watanabe, MSW, President and CEO
Asian American Drug Abuse Program

Njeri McGee-Tyner, Eligibility & Enrollment Director
Alameda Health Consortium

Benjamin H. Flores, President & CEO
Ampla Health

Mark Diel, CEO
California Coverage & Health Initiatives

Sonya Vasquez, Chief Program Officer
Community Health Councils

Lindsay Gervacio, Manager
Families in Good Health

Yeri Shon, Community Engagement and Advocacy Manager
Korean Community Center of the East Bay

Isabel Kang, Orange County Director
Joon Bang, Los Angeles Director
Korean Resource Center

Kent Woo, Executive Director
NICOS Chinese Health Coalition

Manjusha P. Kulkarni, Executive Director
South Asian Network (SAN)

Leafa Tuita Taumoepeau, Executive Director
Taulama for Tongans

April 6, 2016

Via electronic mail to Peter.Lee@covered.ca.gov and
info@coverd.ca.gov

Peter Lee, Executive Director
Covered California Board

Re: Attachment 7 to Covered California Individual Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy

Dear Mr. Lee:

The Disability Rights Education and Defense Fund (DREDF) is a leading national law and policy center that advances the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development. In 2013, DREDF made a presentation to the Covered California Board on health and healthcare disparities experienced by people with disabilities. As DREDF, California Foundation for Independent Living Centers (CFILC), and Disability Rights California (DRC) know, people with disabilities need reliable and comprehensive healthcare coverage to work, live and function fully in their chosen communities. Furthermore, disability status intersects with every racial and ethnic group. Any requirement that Qualified Health Plans help to identify, document and reduce health and healthcare disparities experienced by self-reported racial or ethnic identity groups within the plan has the potential to improve care for people with disabilities within those groups. We therefore applaud the historic proposal in Attachment 7, which requires Covered California contractors to commit to ongoing reductions of certain identified health conditions and annually report disparities in care by racial and ethnic identity and by gender.

We support the health disparities identification and improvement provisions in Attachment 7 and urge the Board to vote for their inclusion in Covered California's contract requirements for Quality Health Plans starting in 2017

Identifying People with Disabilities as QHP Members

While the current focus on race, ethnicity and gender in Attachment 7's disparity identification and improvement program may benefit some people with disabilities, higher rates among people with disabilities in general of Diabetes, Hypertension, Asthma, Depression, and any other improvement measure selected by Covered California for future plan years will continue to go unremarked and unaddressed. The reason for this is simple: after years of successful operation, Covered California still has no way to reliably or accurately identify Exchange consumers with disabilities.

To the best of our knowledge, the single streamlined application contains two questions that could be seen as relating to disability status. One essentially asks the applicant if she or he has a disability. The other asks if the applicant uses long-term care or home and community-based services. In light of historic insurance industry biases against disability and pre-existing conditions, as well as the continuing social stigma of disability and potential uncertainty about how long-term care and community based services are defined, neither question is likely to solicit an accurate answer. Plan attempts to simply ask members or applicants if they have a disability are equally unlikely to obtain accurate results. In contrast, the set of six disability identification questions used in the American Community Survey (ACS) have been thoroughly tested and federally validated as consistently identifying disability status. The questions relate to the following functional limitations experienced by six disability types: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, and independent living difficulty.

DREDF has just released an Issue Brief that supports including either the ACS set of six disability questions or other equivalent functional limitation measures in electronic health records. Available at <https://dredf.org/wp-content/uploads/2016/04/Issue-Brief-March-2016.pdf>, the brief thoroughly explains the critical role that identification of disability status and accommodation needs could play in reducing disability health disparities. As noted in the Brief, “because the ACS six questions set measures functional limitation related to specific impairment categories, the questions are also useful for flagging the need for accommodations that many people with disabilities require in order to receive care, but that are frequently not provided.”

Section 3.03 of Attachment 7 calls on Covered California and Contractors to work together to assess the potential for extending the disparity identification and improvement program over time and explicitly identifies disability as an area of expansion. The section below presents some of the latest evidence on disability health and healthcare disparities, but improvement must begin with the accurate identification of plan members with disabilities. It will take time and conscious outreach to build trust among consumers to voluntarily self-report on functional limitation, just as it has taken time for the public to appreciate the need for, and respond to, race/ethnicity questions. Improving disability health disparities will not be achieved overnight, but it could begin with the single step of requiring Covered California contractors to acquire and share data on the ACS six disability questions.

Disability Health and Healthcare Disparities

For working purposes, “health disparities” in this section can be understood as health and healthcare delivery differences that are closely linked with social, economic, and/or environmental disadvantage experienced by groups of people who systematically encounter healthcare barriers based on a personal characteristic or geographic location that is historically linked to discrimination or exclusion. We agree with the assessment in section 3.02 of Attachment 7 “that some level of disparity is determined by social and economic factors beyond the control of the health care delivery system, [but] health care disparities can be narrowed through quality improvement activities tailored to specific

populations and targeting select measures at the health plan level.” We provide the information below in the spirit of Section 3.02.

While persons with various disabilities and activity limitations encounter attitudinal barriers and failures to provide policy and procedural accommodations that could be regarded as “cultural” or “social,” people with disabilities also encounter unique architectural, equipment, and communication barriers. Covered California’s explicit recognition of disability status in its disparity identification and improvement program would provide much-needed incentive to health plans to undertake any of the following activities that would increase the effectiveness of standard healthcare examination and communication procedures for persons with disabilities:

- Assess and assure physical accessibility of provider facilities (including hospitals, laboratories and all kinds of treatment facilities);
- Assist providers to programmatically accommodate people with disabilities in needs that range from transfer assistance to extended appointment times to the provision of alternative formats like Braille for post-surgery self-care directions;
- Incentivize the purchase, use and appropriate scheduling of accessible equipment such as height-adjustable weight scales and exam tables;
- Develop, establish, and test a mechanism that would allow a plan’s network providers to pool funding and share scheduling for sign-language interpreters.

Historically people with disabilities have not been recognized as a group that experiences health and healthcare disparities, in large part because of the assumption that all health-related issues experienced by this group are entirely attributable to the presence of disabilities and chronic conditions. Over the past decade, there have been increasing reports and studies recognizing that persons with functional impairments and activity limitations attributable to a physical or mental disability experience a poorer quality of health and health care that is **not** necessarily or inevitably linked to the individual’s particular disability. Rather, these individuals commonly encounter physical and programmatic inaccessibility that is measurable and preventable. These references include the following, which are provided mostly as links for your convenience, though we are attaching two published articles where we anticipate that you may have difficulty gaining direct access online:

1. "CMS Equity Plan for Improving Quality in Medicare." Centers for Medicare and Medicaid Services, Office of Minority Health. September 2015. Available at: http://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf
2. Krahn, Gloria L., Deborah Klein Walker, and Rosaly Correa-De-Araujo. "Persons With Disabilities as an Unrecognized Health Disparity Population." *American Journal of Public Health*. Vol 105, No. S2 (2015): S198-206. This article reviews and summarizes approximately two decades of disability disparities work. [Attached].
3. T. Lagu, N.S. Hannon, M.B. Rothberg, A.S. Wells, K.L. Green, M.O. Windom, K.R. Dempsey, P.S. Pekow, J.S. Avrunin, A. Chen, and P.K. Lindenauer,

“Access to Subspecialty Care for Patients With Mobility Impairment: A Survey,” *Annals of Internal Medicine* 158 (2013):441-446. This article reports on the capacity and willingness of select specialty providers to serve a hypothetical wheelchair user. [Attached]

4. Principles and recommendations from HHS Office of Minority Health on assuring health equity for minority persons with disabilities, July 2011. Available at: <http://minorityhealth.hhs.gov/Assets/pdf/Checked/1/ACMHHealthDisparitiesReport.pdf>
5. Three short *Healthcare Stories* compilation videos, produced by DREDF that chronicle some of the most common and widespread barriers to care experienced by people with various disabilities. Available at: <http://dredf.org/healthcare-stories/2014/02/05/barriers%E2%80%8E-solutions/>. (Additional videos of individuals with disabilities sharing their healthcare experiences in their own words is available at: <http://dredf.org/healthcare-stories/>)
6. Article published in the Disability Health Journal Online in 2012, *Physical Accessibility in Primary Healthcare Settings*,” that examines structural and equipment accessibility in over 2300 primary provider offices in California between 2006 and 2011: <https://dredf.org/wp-content/uploads/2015/02/Mudrick-Breslin-Liang-Yee-DHJO-article-V5-No3-2012.pdf>
7. Brief paper that explains and provides examples of the practice and procedural barriers that people with various disabilities experience when seeking common healthcare services: <http://dredf.org/public-policy/health-access-to-care-old/defining-programmatic-access-to-healthcare-for-people-with-disabilities/>
8. *Health and Health Care Disparities Among People with Disabilities in Minority Populations* (addressing the disparities experienced by people who are at the intersection of disability and race/ethnic minority status): <http://dredf.org/public-policy/health-access-to-care-old/health-and-health-care-disparities-among-people-with-disabilities/>

As mentioned in many of the above reports and studies, major American healthcare agencies such as the Institute of Medicine, Healthy People 2010 and 2020, and the Centers for Disease Control and Prevention have all come to recognize disability health disparities, and have issued calls for greater attention and collaborative solutions from all stakeholders in the U.S. healthcare system. Building momentum over the past decade is leading the Institute of Medicine at the National Academies of Sciences, Engineering and Medicine to convene a one day public workshop in June to address the many intersections between health disparities, health equity and disabilities. The workshop will be held in Washington, DC and will feature invited speakers and discussions.

Mr. Peter Lee
April 7, 2016
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As always, we would be happy to address any questions or concerns you have on this letter, and to work further with you to implement the future inclusion of disability status within Covered California's disparity identification and improvement program.

Yours Truly,

A handwritten signature in black ink, appearing to read "Silvia Yee".

Silvia Yee
DREDF Senior Staff Attorney

A handwritten signature in black ink, appearing to read "Teresa Favuzzi".

Teresa Favuzzi
CFILC Executive Director

A handwritten signature in blue ink, appearing to read "Elizabeth Zirker".

Elizabeth Zirker
DRC Associate Managing Attorney

Cc: Covered California Board