CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD MINUTES
Thursday, April 7, 2016
Covered California Tahoe Auditorium
1601 Exposition Blvd.
Sacramento, CA 95815

Agenda Item I: Call to Order, Roll Call, and Welcome

Chairwoman Dooley called the meeting to order at 10:00 am.

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

Board members attending meeting virtually in Fresno:
Genoveva Islas

Board members absent
Art Torres

Agenda Item II: Closed Session

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

A conflict disclosure was performed and there were no conflicts from the board members that needed to be disclosed. Chairwoman Dooley called the Open Session to order at 12:00 pm.

Agenda Item III: Approval of Board Meeting Minutes

After asking if there were any changes to be made, Chairwoman Dooley asked for a motion to approve February 18, 2016 meeting minutes.

Presentation: February 18, 2016, Minutes

Discussion: None.

Public Comment: None

Motion/Action: Board Member Morgenstern moved to approve the February 18, 2016, minutes. Board Member Fearer seconded the motion.

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

Agenda Item IV: Executive Director's Report

Announcement of Closed Session Actions

Peter V. Lee, Executive Director, announced that the Board discussed personnel and contracting matters. The Board approved three amendments for existing contracts with Faneuil, Inc., Robert Half International, Inc. and the Office of Systems Integration (OSI) with the County Welfare Directors Association (CWDA) to support integration between the CalHEERS system and Statewide Automated Welfare Systems (SAWS).

Executive Director's Update

Discussion: Reports and Research

Mr. Lee called attention to the several reports and research articles included in the Board material. Reports included an Urban Institute and Robert Wood Johnson Foundation report that examined how important price is in plan choice across five states. There is also a report from the Congressional Budget Office (CBO) that examines federal subsidies for health insurance coverage for people under the age of 65. Another report that is consistent with that is from the Kaiser Family Foundation on assessing the ACA marketplace enrollment. Additional reports included a Georgetown University Health Policy Institute report on getting enrollment right for immigrant families, which Mr. Lee notes is important in context of the 1332 Waiver discussion; a report from Oliver Wyman on special enrollment periods, which found that cost in special enrollment was 24% higher than open enrollment; a report from Express scripts on 2015 drug trends; a Health Care Cost institute report on study that looked at consumer shopping for "shoppable" services and found that 43& of health care spending is "shoppable"; and finally, a Commonwealth Fund report that looks at how deductible exclusions improve access to many health care services.

Discussion: PR News Diversity Heroes 2016 Award

Mr. Lee shared that Covered California took top honors in being named a 2016 "PR News Diversity Hero" by PR News. The award acknowledged outstanding public relations practices aimed at reaching diverse audiences and efforts to promote diversity in the public relations industry.

Discussion: Section 1332 State Innovation Waiver Initial Recommendations

Mr. Lee thanked range of stakeholders that have been involved for the last three months. He also thanked Jennifer Kent, Director of the Department of Health Care Services, Covered California Board members Diana Dooley and Genoveva Islas, who participated in the February 23rd forum. Covered California will present its analysis, and how proposals relate to guardrails that are established by federal guidance and Covered California. Mr. Lee reviewed the core federal guardrails. Also reviewed Guardrails that the Board endorsed. The State now needs to pass legislation.

Mr. Lee noted a couple of things about the proposals. First, staff supports a phased approach when looking at waiver potentials. Second, legislation will be needed in 2016 that would authorize the state to submit a waiver. Once the application is submitted, the federal government will have 180 days to review the waiver application, prior to approving or denying it.

Member Islas commended staff for the report and personally believes that that Covered California's ability to allow undocumented individuals an opportunity to purchase health insurance through Covered California is the right thing to do. She also fully supports the recommendation and for it to be presented to the legislature.

Chair Dooley commented that her reservations have been generally addressed in terms of the focus, the administrative distraction. She also acknowledged that symbolism is important. She remarked that this is a thoughtful and appropriate report that she expects to get the right consideration from the legislature and the governor.

Mr. Lee noted that in the last two days, Covered California received comments from a range of organizations that are now posted on the website,

Public Comment

Anthony Wright, Health Access California, appreciates the work that went into the report and further appreciates the recommendation of a phased approach for the Section 1332 Waiver. Concerning the proposal around immigrant inclusivity, it is important symbolism that Covered California mean all Californians. There is also practical benefit. 70% of undocumented families are mixed status and the ability to provide health to entire family is tangible benefit to many Californians. He also appreciates the emphasis on timing and believes the disposition will be favorable. It is inherent to the goals of Covered California that everyone be included.

Jen Flory, Western Center on Law and Poverty and the Health Consumer Alliance, echoed her support on moving forward with looking into the enrollment of undocumented immigrants. She was disappointed that the analysis did not include two proposals that WCLP put forward to address current problems, namely the transition between Covered California and Medi-Cal. They have tried having conversations with staff to solve the problem. A solution is needed to solve that transition.

With regards to the Newly Qualified Immigrant (NQI) Wrap, Ms. Flory stated that they have worked with staff at DHCS on the problems of the implementation, and how some of it does not seem to work. WCLP did include have a proposal for that and would like to start discussing how to make that work. When regular people cannot transition from Medi-Cal to Covered California, the idea of enrolling a new immigrant population in both programs at the same time, yet with a strange way of getting services, the state is not ready for that. WCLP would rather sit down and talk about some serious proposals that could either make that happen or take that off the table.

Betzabel Estudillo, California Immigrant Policy Center (CIPC), echoed Mr. Wright's comments on the 1332 Waiver. She is excited this is moving forward and will give immigrant families an opportunity to purchase a health plan for everyone through one door. Although undocumented people can purchase health plans outside the marketplace today, it is a lot easier for families to come in through one door. It is also symbolism to rest of nation that Covered California is available to everyone, regardless of immigration status. As advocates, CIPC will work hard to help move legislation forward to make this a reality.

Cori Racela, National Health Law Program (NHLP), supports access for immigrants who purchase insurance through Covered California. She is also disappointed that some of the proposals did not make the analysis list. She is particularly concerned about the transition proposal between Medi-Cal and Covered California, as well as the issues with pediatric supplemental services to the essential health benefits. Currently, Federal regulations do not allow pediatric services to be covered. NHLP recommends that the 1332 Waiver be used to supplement pediatric services to same extent that Medi-Cal covers children.

Ms. Racela also commented on the CalHEERS 24 Month Roadmap. NHLP, along with a number of other consumer groups have been involved in user acceptance testing. It was been an illuminating process and they encouraged Covered California to use its influence to be engaged and to prioritize issues that persist. Some of that is the usability of application and interface as well as basic eligibility rules that could be improved, such as income

Michael Lujan, California Association of Health Underwriters (CAHU), echoed interest and support of removing barriers for undocumented immigrants. As agents who serve both the commercial and the public health options in the marketplace, they are very familiar with the barrier in the conflict that happens between having to move part of the family through one option and the rest through another. He also applauded the measured approach Covered California is taking.

Kristen Golden Testa, Children's Partnership, echoed their support for the 1332 waiver proposals and for the immigration inclusion proposal. It is not just symbolic, but also very pragmatic. Undocumented families will be able to get coverage through one place. She also echoed her disappointment with the proposals on gap coverage and pediatric services not being included. California is in a difficult position because the Federal government has not defined essential pediatric services. As a result, if states like California try and supplement once benchmarked, they are going to be stuck with the cost, given that the feds have not adjudicated on this situation. The 1332 offers an opportunity to look at this in a way that does not put the state at risk for those costs, and the Federal government may be able to work with California in providing those benefits that should be provided under the ACA.

Danielle Kilchenstein, United Ways of California, encouraged the Board to move forward with the 1332 innovation waiver to expand coverage to all adults regardless of immigration status. In support of the no wrong door approach of the ACA, families

should be able to apply for the same portal. Data shows that kids are more likely to have health coverage when parents do so all parents should be able to apply to same portal. Almost half of the uninsured kids live in immigrant families in California, and to ensure our values of health access for all, United Ways of California recommends moving forward with the 1332 waiver application.

Linh Chuong, Southeast Asia Resource Action Center (SEARAC), supports the proposal and echoed thoughts already expressed, as the Vietnamese community would be impacted. She added that what is known about undocumented Southeast Asian community members points to a lot of stigma and fear. For example, rates of Asian American community members applying for deferred action is lower than what SEARAC would like. This is connected to a lot of historical stress of government, war, genocide and state sanctioned persecution. Beyond the symbolic ramifications of the 1332 Waiver, there is a sense of safety for families to purchase coverage, including those that are in mixed status families.

Jana Castillo, California Primary Care Association, supports Covered California's recommendation and is excited to pursue the development of a 1332 waiver to allow undocumented Californians to purchase a health plan with their own money through Covered California. This will make it possible for entire families to have access to health coverage, and to choose the same plan and providers.

Mike Odeh, Children Now, echoed Ms. Golden Testa's comments from the Children's partnership.

Kate Burch, California LGBT Health & Human Services Network, echoed the comments of Health Access and COPC. She supports expanding access to undocumented people through Covered California because equal access to health care is a very important part of equality.

Doreena Wong, Asian Americans Advancing Justice Los Angeles, expressed her support for many of the comments of the other advocates and colleagues. She agreed that it would be good to do a phased approach and to focus on undocumented people. However, she hopes that consideration will be given to the other recommendations that were provided, perhaps in a later phase. As navigators, and as a collaborative that is also implementing the SB 4 the expansion of full scope Medi-Cal for children, regardless of immigration status in both LA County and Orange Counties, this is much more than symbolic. It will be much easier to get the kids into full scope Medi-Cal if the parents have an option.

Cary Sanders, California Pan-Ethnic Health Network (CP-EHN), appreciates staff recommendation to move forward with 1332 Waiver, phased approach and allowing undocumented people to purchase coverage through the Exchange. It is the right message, right time, will make it more welcoming for immigrant communities who are shopping for coverage. She would like to continue working Covered California on some of the other proposals, such as the ones put forward by WCLP with regard to NQI Wrap and transitions. Would like to have further conversations. If there were a way to keep

things simple for these individuals but take advantage of federal funds through a process like this, CP-EHN would like to have further conversations about that.

Michelle Cabrera, SEIU, supports using the 1332 Waiver process to allow undocumented Californians to purchase coverage through the exchange.

Chair Dooley explained that everything that has been suggested is still on the parking lot list of things that need to be addressed. It is simply a question of priority and time and resource.

Mr. Lee explained that federal guidance is very clear about needing to deal separately and distinctly with the marketplace and its funding, as distinct from Medicaid programs. He added that some of the proposals did not look at that very distinctly. In addition, Covered California's commitment to work with DHCS on transitions is a commitment that is regardless of the waiver. Covered California has been working very closely with DHCS and will continue to do so. What staff has put forward is what is a baton passing for this year now, to revisit in future years, with new guidance from the federal government. Next year there is going to be a new administration, which will very likely have a different set of guidance. Covered California's ongoing commitment is to continue to address its mission to serve Californians.

Agenda Item V: Covered California Policy and Action Items

Discussion: 2017 Qualified Health Plans: Recertification, New Entrants, Standard Benefit designs and Quality Framework

Mr. Lee noted that two contracts are before the Board for action. One is for the individual business. The other is for our small group business. They have separate contracts with different terms. Staff will be asking the board to act on the individual contract and the dental, and carry to next meeting the small group contract, to make sure that plans and advocates have time to digest.

Anne Price, Director of Plan Management, reported that since the February Board meeting, there have been no changes to the 2017 medical benefit designs presented. She presented changes were made to embedded pediatric dental benefits for both individual and Small Group, as well as an update on base changes to the 2017 – 2019 Qualified Health Plan contract since the February Board meeting.

Changes included new language that required carriers to use best efforts to identify potential subsidy-eligible individuals for enrollment through the exchange, as well as new language regarding expectations for agent commission payments. Additional changes were made concerning expectation for implementation of appeals, meeting timelines for uploading carrier rates, as well as language on remedies for non-material default and breach. The issuer-default breach language does not apply to a plan if they do not meet a target attachment 14 and reasonable efforts would be made to resolve any non-material breach prior to instituting any of those interim remedies. She noted there are performance

standards in Attachment 14, and the 2.2, 2.3, and 2.6 changes reference that there will be a pilot period prior to implementation and assessing any penalties. There were also revisions to the quality requirements.

Mr. Lee noted that there has been a lot of attention and focus on our efforts at Covered California to address the Triple Aim. Covered California have been successful at keeping costs down by getting a good, healthy risk mix. Over the long term, costs are about getting people the right care at the right time from the right provider. Putting consumers first means putting high expectations on the plans Covered California contracts with and selecting plans that will address quality. He highlighted Covered California's core building blocks for improving quality and lowering costs. He noted that it is the right time to have the focus on what we are doing as part of the Affordable Care Act to remind us it's not just about an insurance card, and it's not just about getting care. It is also about changing how care is delivered to make it more cost effective long term.

Ms. Price presented the issues that the contract requirements related to quality are looking to solve. Specifically, as it relates to promoting the triple aim, getting the right care at the right time, promoting and rewarding quality care at the best value, reducing health disparities and promoting health equity, and giving consumer tools to make the best choices.

With regards to promoting the triple aim, currently many consumers do not receive effective care or recommended care. Additionally, health care costs are far higher in the United States than any other developed country and have historically risen twice the rate of GDP. Market forces have not been effective at getting consumers the best value. Covered California's solution to address this issue includes promoting robust changes in measurement, payment, and consumer tools; align payments with those of CMS, CalPERS and other major private and public purchasers to send a coordinated market signal; and put the consumer at the center of solutions.

With regards to ensuring the right care at the right time, currently many consumers do not have an entry point for care. Care is often fragment, resulting in inconsistent outcomes. In addition, payment has been based on the fee-for-service model and not payments that reward outcomes and effective coordination. Covered California's solution will require all plans, regardless of model to assign a primary care clinician to Covered California enrollees within 30 days of their health plan coverage date. Plans must also change payments to incentivize enrollment, and pay to reward advanced models of primary care. Lastly, implement patient centered benefit designs that improve access to care when it is needed.

With regards to promoting and rewarding quality care at the best value. Currently, payments for volume provide no rewards for hospitals and other providers to improve care. Many patients receive unnecessary or harmful care. Studies show a wide variation in both cost and quality, and there is no correlation between higher cost and better care. Covered California's solution includes requiring plans to disclose information about providers' clinical quality, patient safety, and patient experience. Covered California will

also work with stakeholders to develop tools to address cost and quality on outlier hospitals and require plans to implement payment reform that that reward outcomes and results in hospitals.

With regards to reducing health disparities and promoting health equity. Currently there are significant health disparities, but the specific quality gaps vary dramatically by income level and ethnic group. Also, not all health plans or health systems are effectively measuring health outcomes for California's most vulnerable populations or targeting groups for improvement. Covered California's solution will require health plans to improve the collection of self-identified racial-ethnic information. The plans will also be required to track, trend, and improve over time care that is related to diabetes, asthma, hypertension, and depression across all payers, to achieve some targeted improvement within reasonable timelines.

With regards to giving consumers tools to make the best choices, currently there is a wide variation in costs, even for covered services. Additionally, consumers without the right tools are unable to pick a provider based on cost and quality. Covered California is asking that plans (with over 100,000 members) develop tools that enable consumers to compare costs and quality when choosing a provider. Smaller plans will be required then to have other options for members to understand costs. Plans will continue to be required to promote consumers' access and use of personal health record, and patient engagement and shared decision making between patients and their providers.

In conclusion, Ms. Price noted that significant changes have been made in the quality requirements and plans will be expected to adhere. She recognized that Covered California is asking a lot. However, there will be improvement in the care that is delivered over the next three to five years. It is something that the ACA requires, and ultimately it is what is best for the member in terms of having quality care for our consumers.

Dr. Lance Lang, Chief Medical Officer, walked through the detail of all nine articles in Attachment 7. He explained that Attachment 7 is a general statement of a vision of what was required to improve quality and reform the delivery system. The first three years, Covered California requested that QHPs tell what they were doing. There has been a lot of good work, but it was not coordinated across plans. Covered California is now setting common expectations that align with the CMS and other purchasers so that progress can be measured. Plans that have been in the Exchange for at least two years are required by CMS to begin developing a quality improvement strategy and to report in their application for 2017, a work plan around improving health outcomes, reducing hospital readmissions, improving safety, reducing health disparities, promoting health and wellness. Dr. Lang noted that the strategy is to "track, trend, and improve." You cannot improve what you do not measure, so it is necessary to track of it over time, across the board.

Article 1 states that Covered California expects plans to help provide networks that are built on affordability and quality care. If providers do not meet quality goals by 2019,

they will be excluded from the network. Quality goals have been tied to improvement strategies that are available for any provider to take advantage of. Performance standards will be established by Covered California based on: national benchmarks, analysis of variation in performance across California, existing best science of quality improvement, and effective engagement of stakeholders. He noted that the criteria for defining "outlier poor performance" changed to clarify that outlier poor performance will include consideration of hospital case mix and the services provided. The performance standards were also changed to clarify that with the exception of health disparities, only Covered California enrollees will be measured in terms of performance guarantees.

There have been no changes to Article 2 regarding Provision and use of data for improvements in quality of care delivery. Dr. Lang noted that Covered California is in the process of building the Enterprise Analytics Solution (EAS). Much of the information people would like to see will come out of that data warehouse.

Requirements of the health plans to reduce health disparities will include tracking, trending and improving quality measures by ethnic/racial group using a combination of self-reported and proxy identification by gender. The initial focus will be on diabetes, hypertension, asthma, and depression. Currently, much of the data is not available, therefore will not be due until the end of the third quarter of 2016. Health plans are currently required to collect self-reported under SB 853 since 2013. In looking at the application data, 73% of Covered California enrollees have self-identified in the process of signing up. If this supplemented with proxy information based on surname and zip code or geo access information, a 93% accuracy rate can be achieved in predicting race and ethnicity. Covered California will be looking at the baseline document to see what the disparities are, and then setting goals in a mutual process as to how to narrow those disparities, recognizing that the health care system has limits.

On Article 4, regarding promoting development and use of care models, Covered California structured standard benefits to minimize enrollee cost share for primary care visits. Additionally, plans will ensure that enrollees either select or be assigned a primary care clinician within 30 days of their coverage becoming effectuated. Dr. Lang clarified that this is not to be interpreted as requiring that primary care serve as a gatekeeper. Plan will also be asked to implement a payment strategy that creates a business case for primary care physicians to adopt accessible, data-driven, team-based care with accountability for improving the triple aim. He noted that Covered California would be working to figure out how to define when a physician or clinician is practicing in one of these advanced primary care models and then looking to have over time, progressive increased enrollment in those medical homes. Currently, CMS has an innovation program with five awardees in California working with 8,000 primary care clinicians and over the next four years, to help with that transformation process. The requirement for plans to have an increasing enrollment in medical homes is tied to an improvement strategy that is being funded by the federal government, which should make that very achievable.

For Article 4, regarding promoting development and use of care models – Accountable Care Organization (ACO) or Integrated Health Care Model (IHM), Covered California

adopted has with stakeholders to define this as a system of population-based care, coordinated across the continuum, including multidiscipline physician practices, hospitals, and ancillary providers, integrated information systems and accountable for the triple aim. This is a functional definition and is aligned with CalPERS. Each health plan is doing this differently, so in an effort to encourage innovation, Covered California is asking plans to report their model for implementing ACOs or IHMSs. Plans will also be asked to report how many Covered California members are participating, and how they are structuring payment so that the accountability for triple aim is rewarded. Covered California will then be setting targets for increasing enrollment in these models.

On Article 5, regarding hospital quality and safety, plans will implement a payment strategy for acute general hospitals that places reimbursement at risk or subject to a bonus based on quality performance. This was modeled on CMS, where 6% of reimbursement to hospitals is tied to quality performance. However, after stakeholder input, staff was convinced that 2019 was too soon to achieve 6% and it has now been spread out to 2% by 2019 and an added 1% every year thereafter, reaching 6% by 2013. Each plan will structure this. If readmissions are included as one of the criteria, they will not be the only measure. Plans will also be required to report the performance of contracted network hospitals managing avoidable complications. Only contracts with providers and hospitals that demonstrate they can provide quality care of Covered California enrollees will be allowed. Plans have the opportunity to explain why they might make exceptions to that requirement, but it will be released to the public.

There has been a dramatic increase in the C-section rate without an increase in quality outcomes. In fact, some increase in NICU admissions and maternal complications. Article 5, regarding hospital quality and appropriate use of C-sections will require plans to report performance of network maternity hospitals in meeting the national Health People 2020 goal of 23.9% delivery by C-section for low-risk first pregnancies in the 2017 certification application. Covered California will be defining the 2019 goal together with stakeholders, based on science. The California maternal quality care collaborative (CMQCC), is collecting data, reporting that data, and with funding from the California Health Care Foundation, providing quality improvement, which is now proven in pilots to help hospitals reduce their rate from well above the 23.9%, to below, in one year. Letters have been sent to hospitals, asking the hospitals join the CMQCC program.

Dr. Lang reported that not much has changed on Article 6, regarding population health and preventive health. There is a lot of effort now around engaging the community in medical care, recognizing that social determinants are a major part of health and that resources in the community are important. Plans will be asked to report what they are doing. Covered California is following initiatives from the state and federal government in this area as this will inform requirements later on. Additionally, plans will ensure that appropriate protections are in place for information provided by enrollees through risk assessments.

Dr. Lang noted that there was some controversy over Article 7 and that providers were concerned about exposing private contract terms. However, Covered California insists

that patients' share of their cost be made available to them given the variation in provider contracts. Plans will also be required to monitor care provided outside their networks, to ensure that consumers are going outside intentionally. Shared decision in looking at choices in care is critical in reducing overuse or misuse of clinical interventions. Plans will join Covered California in partnership with DHCS and CalPERS in a statewide multi-stakeholder workgroup to support reduction of overuse through Choosing Wisely. Targeted conditions include C-sections, opioid prescriptions, imaging for low back pain.

Mr. Lee stated when we talk about making health care more affordable and higher quality; these are the changes to the core that need to be made in California and the nation. He thanked Dr. Lang, health plans, the provider community, and the advocates.

Chair Dooley commended Ms. Price and Dr. Lang for reading an extraordinary process. Covered California is making it clear that it is more than just getting coverage, and it is looking to assure that enrollees get the right care when they need it. She is proud of the work that has been done and the immense collaboration. Everyone is working together to improve quality and strengthen the health care delivery system. There is a lot of flexibility baked into it and Covered California will be reasonable.

Member Morgenstern echoed Chair Dooley's comments. It is an amazing and very ambitious effort, and he looks forward to seeing results back with the progress.

Dr. Lang noted that it is ambitious, but also practical. Covered California has really tried to leverage the improvement capabilities that are available in California to ensure Covered California takes advantage of them.

Member Islas is delighted with the ambitious steps that are being outlined. It is exactly these type of bold, ambitious steps that we need in California to really make an effect at reducing the health disparities that are burdening many in our communities. She is very proud about the bold steps being taken to promote health and ensure that everybody has access to care.

> **Motion/Action:** Board Member Fearer moved to pass Resolution 2016-09. Board Member Islas seconded the motion.
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> **Motion/Action:** Board Member Fearer moved to pass Resolution 2016-10. Board Member Islas seconded the motion.

Public Comment

Cary Sanders, California Pan-Ethnic Health Network (CP-EHN), supports Covered California's quality proposals in Attachment 7, particularly Article 3 of the health disparities reduction in key target areas where disparities are documented. Chronic diseases are the leading cause of death and the biggest contributor to health care costs, and communities of color disproportionately impacted by those conditions. These contract requirements will save lives and result in better health outcomes for communities of color and all residents in California.

She also strongly supports the requirement that health plans share their performance data for all enrollees. It is estimated that about 40% or more of Covered California enrollees will move between coverage in a given year. This requirement will strengthen broader efforts to improve quality and strengthen the value of care. She also appreciates Covered California's commitment to thinking about and including innovative metrics that will also improve the quality of care and how it is measured.

Betsy Imholz, Consumers Union, strongly supports the contract and the Attachment 7. This will show leadership across the country in improving safety, quality, and value, reduce disparities and move toward delivery system reform. She urged the Board to vote in favor. They strongly support and appreciate the efforts to gather the data. She acknowledged that identifying outliers will be controversial, but it is very important. She supports the disparities measures. Finally, she is inspired that Covered California is aiming on getting to zero on medical errors and infections and preventable complications.

Amber Kemp, California Hospital Association (CHA), appreciated the delay in finalizing the QHP model, allowing much needed time for dialogue on the proposed quality initiative and on the impact that the proposal would have on providers and consumers and on networks. Today's version of the contract is a much more improved and better reflects the perspective of providers and the impact these proposals will have. With these many of the recommendations from providers that are included in today's version of the contract, will better serve to further progress toward our shared commitment of achieving the triple aim. She urged Covered California to continue its collaboration with stakeholders, including providers, as Appendix 2 to Attachment 7 is finalized.

Stacy Wittorff, California Medical Association (CMA), remarked that the postponement of the vote on the contract and Attachment 7 has resulted in a number of productive conversations and stakeholder meetings that have resulted in much more workable proposal. Attachment 7 and the Appendixes will serve as the guiding documents for the implementation of the quality framework and it will have significant impact on CMA's physician members and on their ability to provide care to Covered California enrollees. CMA has concerns about the adoption of a set of not-yet-developed quality and cost metrics and their use as the basis for excluding physicians from networks. CMA's global concern is with regard to the potential impacts of excluding physicians from networks on the ability of patients to access care should significant numbers of physicians be excluded. Our immediate concern is with the approval of the contract attachment with so much yet to be determined.

Doreena Wong, Asian Americans Advancing Justice LA, supports the comments of (CP-EHN) and Consumers Union, and is thrilled that plans will be required to collect year over year data to reduce health disparities. It is known that health disparities affects communities of color. This will help communities understand and encourage plans to strive for reduction in health disparities. She is also happy that plans will be required to collect data for all enrollees. The larger the pool, the better disparities can be evaluated and truly reduced across all populations. Lastly, she is happy about the progress being

made around improvements and reduction of health disparities, but is disappointed that language is not one of the data points collected. She is hopeful that in the future this will be considered. Many enrollees are limited English proficient, looking at language will really help ensure health equity and reduce health disparities.

Jen Flory, Western Center on Law and Poverty, is pleased to see health disparities being measured as part of the contracts. She appreciates the process that staff went through and is happy with the final product. She agreed with Ms. Wong that language, as well as disability status and gender identity should eventually move into the disparities measure. She is thrilled to see that measurements are going across all lines of service, as well as the additional provisions that provide transparency to the consumer. As somebody who has counseled many people with medical debt, those coinsurance numbers can be difficult to decipher. She is thrilled with the quality measures, very happy with staff who worked on getting more particular language about how appeals would be implemented and other decisions by Covered California that affect people's eligibility.

Michael Lujan, California Association of Health Underwriters (CAHU), supports greater consumer transparency tools and activity supports several bills here in California related to that. CAHU also supports the proposed 2017 standard benefit design modifications, most specifically regarding agent compensation and the support of the comments that were already included in Attachment 7. CAHU is hoping to not have to reach legislation that requires defining a floor for compensation. They are concerned and appreciate Mr. Lee's letter to the HHS director expressing his own concerns. CAHU is also supportive of having the same compensation for regular open enrollment and SEP, and across metal tiers. He appreciates those comments making their way into what was presented and urged the board to vote in support.

Cori Racela, National Health Law Program (NHLP), is thrilled that health disparities is a priority for Covered California, and that gender is an aspect that is going to get particular focus. She hopes that language preference and disability are also included in health disparity. She is thrilled for many of the consumer protections that were added, in particular the effectuation of appeals decisions. She urged the Board to consider adopting existing continuity of care protections into the QHP contract. Many of the robust continuity of care provisions in health and safety and insurance codes do not otherwise apply to Covered California, and the contract is a way to remedy that. Secondly, in order to really make the appeals decision implementation best for consumers, the time for plans to implement and report to Covered California should be reduced to four business days. The current contract says 10 business days. For many people who are going through the dispute and appeals processes, waiting an additional two weeks to access care, or to pay an incorrect premium amount is a truly unbearable burden.

Athena Chapman, California Association of Health Plans, appreciates the Board delaying the vote on the contract. The additional time resulted in a much bigger product and provided an opportunity to have some robust discussions with Mr. Lee, staff and other stakeholders that really resulted in a better product. While the contract does not necessarily address all of the concerns health plans still have, such as non-material breach

of contract, it is time to move forward. Extra protections have been added that make health plans feel comfortable at this point. A lot of work lies head in defining outliers and working on the quality metrics, and the health plans are really looking forward to a robust stakeholder process around that.

Kate Burch, California LGBT Health & Human Services Network, strongly supports Attachment 7. She is especially pleased about addressing health disparities. It would be great if sexual orientation and gender identity were included as measures that the plans had to track, trend, and improve. She is hopeful that once there is a new federal administration, the State will renew its request to add sexual orientation and gender identity questions to the application. She also urged staff to work with plans to make it clear that tracking those data will be a part of the plan in the future at some point. Starting to have conversations now about what that looks like and what kind of changes will need to happen is a good idea.

Michelle Cabrera, SEIU, commented that there are several significant barriers to efforts to reduce health disparities, and one of them is the misconception that focusing on improving health care quality more broadly will benefit beneficiaries, when in fact it leaves disparities in place, or worsens them. Another is the collection of aggregate level data versus plan or provider level data on disparities, which puts them in an incredibly frustrating space of knowing that disparities exist while not being in a position to do much about it. And finally, it's really hard to confront that there may be bias at play, but there has been some great research to come out, including some recent research on how pain is treated, that can help inform our understanding that not all disparities emanate from outside of the four walls of the hospitals or clinics. SEIU is thrilled with Covered California's leadership in this area. It is a true testament to the power of the active purchaser. This work is still evolving, and there are other efforts around cost containment or population health goals that are also evolving. Given the demographics both for California as well as Covered California, this work will be especially meaningful, and SEIU also support efforts to expand it to other socio demographic factors such as sexual orientation, gender identity, economic status, as well as disability and limited English proficiency.

Betzabel Estudillo, California Immigrant Policy Center (CIPC), echoed what other colleagues have said. CIPC supports Attachment 7 that would require health plans to demonstrate the reduction in health disparities. It is very important to be able to show this data. The reality is that chronic diseases disproportionately affect immigrant communities and communities of color. Furthermore, Latino communities are disproportionately affected by diabetes.

Micah Weinberg, Bay Area Council Economic Institute, shared that integration needs to remain the focus. Some integrated systems are involved in Covered California, but many integrated products that are available to the large employer market are not yet available to Covered California consumers. Covered California needs to use its active purchasing power to bring these systems, products, and provider groups into the Exchanges and available in greater numbers. One concern is trying to simulate integration within

networks that are not truly integrated, such as requiring 30-day access to a primary care clinician. That policy has benefits, but those benefits are much greater when that primary care clinician is within an integrated network. High-priced health care is not necessarily high quality health care and low-priced health care is not necessarily high quality health care either. The task is not simply to drive the deal towards the lowest cost, regardless of the implications, but rather finding the right cost for the right type of care. Care integration is our ultimate goal, and the only effective means of achieving the outcomes that being sought.

Kristen Golden Testa, Children's Partnership, supports the quality measures, particularly relating to disparity performance, and particularly that they are going to be applied across a plan's business products. It will make a big difference.

Beth Capell, Health Access California, is pleased that we are progressing towards health care system transformation. From a consumer perspective, consumers think health care should be safe, effective, and cost efficient. Those that work on it day to day know that health care is the opposite. On top of that, consumers think that all of us should be treated the same way regardless of our color. Therefore, the notion that people have different outcomes in terms of their health care is equally problematic. She is pleased that Covered California is using its active purchaser authority to drive health care system transformation. She also strongly supports Attachment 7, and will continue to ask for improvements to it year after year.

Mr. Lee expressed his appreciation for the robust engagement over the past four years.

> On resolution 2016-09, related to the Qualified Health Plan Issuer Model Contract for the individual market for plan years 2017 – 2019.

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

> On number 2016-10, approval of the standard benefit plan designs for plan year 2017.

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

Special Enrollment Period Policies

Mr. Lee presented background information on special enrollment and noted that only eligible individuals should be enrolled during special enrollment. Covered California does not want special enrollment to be overly burdensome on consumers and is looking to maximize the use of electronic verification, and have documentation verified prior to effectuation of coverage. Doing this is going to require implementation over time. Draft regulations will be revised based on comments and brought back for action at the next Board meeting.

Covered California Regulations

Discussion: Individual Eligibility and Enrollment Regulations Emergency Readoption

Bahara Hosseini, Office of Legal Affairs, provided a high-level summary of the changes to the regulations. Terms were removed from the definition section that were no longer applicable to the regulations. The definition of a qualified health plan was updated to include qualified dental plans (QDP). The definition of a QDP was also revised. The regulations were amended to include the eligibility requirements for enrollment in the QDP. Covered California also amended language regarding the binder payment to allow carriers to apply premium thresholds to initial payment, as well as pay subsequent premium payments. Language regarding the verbal unconditional withdrawal of an appeal request was also amended, to make the regulations consistent with the current process. Lastly, amended language was added throughout the regulations to comply with the recent federal final regulations set to go into effect on May 9, 2016.

For special enrollment periods (SEP), Covered California added language to specify the random sampling verification process for qualifying life events (QLE) that trigger a SEP. Covered California will accept qualified individuals or an enrollees attestation that he or she meets a QLE that triggers a SEP subject to the following random sampling verification process that is being proposed: Covered California may select a random sample of the qualified individuals or enrollees who attest to a QLE and request in writing that they provide satisfactory documentary evidence as proof of their QLE. The qualified enrollees must provide the requested documents to Covered California for verification. If Covered California is unable to verify the provider documents, then Covered California will determine the qualified enrollees ineligible for an SEP, notify the enrollees and the enrollee's employer as applicable regarding the determination, and implement the eligibility determination prospectively in accordance with the effective, applicable effective dates as specified in the regulations.

Chair Dooley reiterated her positon from the last meeting that for her, this is about integrity. Not having pre-existing conditions, and being able to have universal coverage, requires an open enrollment period and that people enroll during that open enrollment period. Enrollment during SEP cannot be allowed to become an opportunity for people to enroll only when they need the care that they did not plan for. There is not sufficient data at this point about the extent of the problem or how to fix it, but as everyone continues to work on this, a solution will be reached that gets consumers the care they need when they have a qualifying event and is as least burdensome as possible. It is regrettable if a consumer has a need for care and did not have a qualifying event, and they did not enroll in open enrollment, that they will have to pay for that care themselves until they can get to the open enrollment, but that is a reality of the current system. She stated her commitment to do everything possible to be sure that faith is kept with the spirit of the relationship between open enrollment and special enrollment.

Mr. Lee shared that the federal marketplace recently announced their new policies to have a sampling audit review process and implement both documentation and electronic verification over time. Covered California is looking to align with what is happening federally and has been in n discussion with the federal marketplace.

Public Comment

Beth Capell, Health Access California, commented that the letter they submitted was based on what was understood to be the staff recommendations at that time, which reflected a process in which only those who were eligible for the special enrollment would obtain it, and electronic verification would be maximized. She is strongly opposed to the regulation language before the board, and would have sent a different letter had they seen the regulations beforehand. The regulation presented says that people subject to the audit will be denied if they cannot produce a document, even if a document does not exist or is not available in the 60-day timeframe, such as when an individual, a low or moderate wage worker, has lost employment and their employer didn't give them a letter of termination, they just walked them out the door, or when someone has a baby and doesn't get a birth certificate until eight weeks after the baby is born.

Elizabeth Landsberg, Western Center on Law and Poverty (WCLP) and the Health Consumer Alliance (HCA), believes important progress has been made, but reminded the Board that no evidence has been produced showing any wrongdoing or fraud. She added that when someone applies for health coverage through CalHEERS, they are signing under penalty of perjury that they have attested truthful information. The audit approach makes some sense. She still has some major concerns, including the one expressed by Ms. Capell, with other elements of eligibility such as income, citizenship, immigration status. Staff is proposing to deny consumers them coverage until they have come up with a document. She is concerned about people that cannot come up with the documents, for example, when someone moves, is homeless, couch surfing, or does not have a utility bill, or a rental agreement. Work needs to continue on developing what acceptable forms of documentation would be allowed and she appreciates staff looking into electronic verification. Medi-Cal has a process to see who has had health coverage. She doesn't support the satisfactory documentation evidence, which is sort of borrowed from citizenship documentation.

Betsy Imholz, Consumers Union, commented that the phased approach with the audits makes a lot of sense, but there are some particular concerns that she looks forward to working on with staff, including the things raised by Health Access and Western Center. There is a frustration about the lack of data and a blurring in the conversation between fraud and ability to get a document, or negligence or a lost document and we need to hone in on that a little bit better. The dollar penalties that are part of the self-attestation process are a good incentive for people to do the right thing and only sign up if they are eligible. However, there is a $250,000 fine proposal. The federal regulations only say that that is the maximum allowable amount if there's fraud involved. In many of these cases, and we have never heard the plans actually say that it is fraud that they are finding; it just seems to be some other kinds of concerns. It is important to hone in on that a little bit better. The time for open enrollment is shrinking. With six months in the beginning, going down now to less and less times, 45 days in 2018. The assumption about shortening the open enrollment period was that people would understand the ACA better and what the dates were. However, people are ever more confused about what the dates are for open enrollment. That does not mean that people should try for special enrollment if they just forgot and are not eligible. We need to recognize that special enrollment

periods for the coming years will be ever more important for people and to be fully informed about it. This was a major topic at the National Association of Insurance Commissioners and there was no new information revealed from the plan side, but a lot of push back from the consumer representatives.

Athena Chapman, California Association of Health Plans, supports the work staff has done on this. They sent Mr. Lee a letter about some of the data that they have seen, both at the federal level and from the plans at the state level, reporting what are concerning numbers during the SEP period. It is very important to establish some sort of verification process prior of effectuation of coverage to avoid having to rescind coverage and do things that are not consumer friendly on the back end if you find out they were not actually eligible for a special enrollment period. The audit process is a step in the right direction. If the final policy does not require verification prior to effectuation and no self-attestation, it will have holes that will not solve the problem. She stated they want to help everyone get coverage through open enrollment, and help those that are eligible for SEP.

Micah Weinberg, Bay Area Council Economic Institute, echoed Chair Dooley's comments. There is increasing data, the plans have provided some, but it is as of yet incomplete, that folks are in fact fraudulently taking advantage of the special enrollment period. The issue is that the people, who did the right thing and enrolled through the open enrollment period, should not be put at a disadvantage and should not have higher premiums because of people taking advantage of the special enrollment period, if folks are in fact doing this. It is about doing right by consumers that enrolled during open enrollment, doing right by consumers that are correctly enrolling during the special enrollment period.

Kristen Golden Testa, Children's Partnership, has some concerns with the sampling as verification is still going to be an issue for some families. A lot goes on for newborns from when they are born into when they can get their birth certificate. A lot of care is needed in that period, and it is not acceptable not to be covered. She does not believe a problem exists. Many people have transitions in their life and have a legitimate qualifying event. This time of having a sampling, will allow for the gathering of accurate data. How the sampling is designed is also very important to truly get those trying to enroll in the program fraudulently, versus those that really are just trying to get what they deserve and get coverage eligibility and just cannot find the document.

Michael Lujan, California Association of Health Underwriters (CAHU), fully supports policy that removes barriers to coverage, but also allows for reasonable verification of qualifying events. The California agent community can help provide a solution where electronic verification might not be sufficient. Agents are very experienced with the qualifying event verification process and can lend our their support with minimal effort. While the self-attestation process invites some bad actors and non-qualified enrollment, there is some impact to cost, and he appreciates the additional time to understand what that is. CAHU is preparing a white paper about agent compensation, which is related to this SEP, and also share CAHU's thoughts on the role they might play in help providing reasonable verification.

Cori Racela, National Health Law Program (NHLP), reiterated that although there may be evidence that SEP enrollees do have higher health costs, it is speculative to jump to the conclusion that there are problems of abuse or fraud within the system. She encouraged Covered California to use the audit as an opportunity to study whether there is an SEP eligibility problem at all, and if so, what the nature and extent of that problem is. In addition, an audit is a great opportunity to study what challenges and barriers consumers have in submitting verifications or proving their SEP eligibility and what forms of assistance would be most beneficial to them in proving their eligibility. She referred the Board to the letter that the Health Consumer Alliance wrote on this topic, which was written before the proposed regulations were released. The regulations as written do not conform to the guiding principles that Covered California has presented. She is hopeful that that both audit process and any ensuing eligibility verification process does whatever it can to minimize burdens to consumers. Vital to that is the opportunity to provide attestation where verification is difficult to obtain. It's also imperative to provide consumers with clear guidelines of what verifications are acceptable, the timelines that they have to do it, how to access assistance if they are unable to obtain such verifications, and especially what their legal rights are in this process. The regulations are woefully silent on that.

Doreena Wong, Asian Americans Advancing Justice Los Angeles, is disappointed that progress was not made as far as she had hoped. She shared that as navigators that deal directly with clients and consumers; they do not see this problem. They work with hard-to-reach populations. It is already difficult to get them to come in during open enrollment period and even during the special enrollment period. They are very conscientious about informing consumers of the penalties and consequences if they commit perjury, to ensure that all of consumers enrolled through the special enrollment period are fully qualified. She doubts that there is a serious problem with enrollment of ineligible people and would like to see more evidence of that because they have not witnessed it on the ground. When clients attest to something, they fully understand the consequences and penalties.

Jeff Smith, Blue Shield of California, commented that this is about integrity and urgency. Data started to emerge that tells us a lot about what is happening during open enrollment. The problem is real and plans have to take action that does not get to the shared affordability mission, It is about affordable health care for all. This will increase rates for 2017 by 3–5%, a significant dollar amount when it comes to consumers purchasing. He thanked the board for thinking about the integrity and urgency that needs to be taken, and ensuring there is flexibility in using all technology to get there. About the flexibility around when a child is born, there is many ways to understand how that happens, very quickly, without any great deal of paperwork. When a person loses a job, there are other ways than waiting for federal forms, such as last paycheck.

Rick Krum, Anthem Blue Cross, looks forward to reviewing the draft regulations. He agrees that verification needs to happen prior to enrollment. Fraud and lack of documentation are not the same thing and it is necessary to be able to recognize that.

There are many ways to demonstrate a qualifying life event and health plans are willing to work with, and willing to make that work.

Cary Sanders, California Pan-Ethnic Health Network (CP-EHN), believes it is important to understand the problem before rushing to solve it. Vulnerable communities have difficulty getting into coverage to begin with. The barriers that will be in regulation will make it difficult for people to get into coverage when they need it. She is surprised to see that the regulations and the language do not match the tenor of the stakeholder conversations. She is supportive of the audit to get a sense what barriers consumers are experiencing to turning in documentation. Some of the plans have mentioned there are other ways to get birth information. Those types of conversations that should happen before laying out language in regulation that could produce new barriers to enrollment.

Bill Wehrle, Kaiser Permanente, noted that the issue is not fraud. What is at issue is the ability to demonstrate eligibility. Fraud is a criminal standard and very difficult to prove. If we set out the idea that fraud and intentional misconduct is the problem, it will be difficult to come to agreement about how to approach it. He also pointed out that this issue affects Kaiser plan less than the others, yet they still see it in significant numbers, even when controlling the data. We just cannot take the approach that we are unwilling to look at real data. He noted that this is a serious this phenomenon. It brought about the end of PacAdvantage. The board and staff are aware of that, and he hopes that everyone can collectively come to a conclusion on this issue.

Board Member Fearer noted that this is a tough issue. He is sympathetic to many of the concerns that have been expressed. On the other hand, he believes that audit capacity is needed precisely to better understand the extent of these issues. He also agreed with Mr. Wehrle that this is not about deliberate fraud. It is about finding people who are not otherwise eligible, who for whatever reason to have enrolled. It is important to move forward with an audit capacity, but he also like the idea of trying to find a way that is thoughtful, phased, and cautious. He is pleased that this is not being voted on today. It is a very important issue that is going to have to be dealt with. From his experience overseeing employer plans, there were always around 3–5% of enrollees that found ineligible in an audit. It was not necessarily deliberate, but that is what was found. Additionally, the cost of those individuals were disproportionately higher. If nothing is done, there is a risk around the integrity of the process and the premiums. He also added that he believes the biggest risks are probably among the young, affluent, and highly educated, who think it is cool to cheat the system when they can.

Mr. Lee noted that for two years, rates have been between 4.2% and 4% on average. Covered California is looking at a 3% – 5% increase only because of special enrollment. Affordability is a big deal, especially for Covered California enrollees that do not have subsidies. He acknowledged that moving too quickly on draft language is a problem. Documentation is critical and the issue of rescission is a big problem. Staff will work on this to bring back to the board actions that the plans can consider as they are doing rates for 2017 and that address this issue.

Discussion: Covered California for Small Business (SHOP) Appeals Permanent Regulations

Kirk Whelan, Director, Outreach and Sales Division, requested board approval for SHOP appeals regulations, to file a permanent rule making package with the office of administrative law. Changes were brought before the Board in May, 2015. Changes were made based on the comments received. The final package contains minor changes to language in order to ensure clarity and compliance with federal requirements. It also includes some additional requirements to the appeals decisions and notifications that are sent to appellants. There are no other substantive changes. The final product provides appellants with a streamlined procedure to appeal a SHOP eligibility determination and ensure due process.

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Discussion: None.

Public Comment: None

Motion/Action: Board Member Fearer moved to pass Resolution 2016-12. Board Member Islas seconded the motion.

Vote: Roll was called and the motion was approved Chair Dooley, Member Islas and Member Fearer. Member Morgenstern was not present for the vote

Discussion: Certified Application Counselors Regulations Adoption

Kirk Whelan, Director, Outreach and Sales Division, presented a staff recommendation to amend the Certified Application Counselor (CAC) program regulations. The CAC program is a non-compensated enrollment assistance program. For the third open enrollment, this non-compensated program brought in over 12,000 new members to Covered California. There are over 400 certified entities and 2,000 counselors involved in the program that speak 47 different languages. Over 50% of the program entities are nonprofit, community-based organizations and licensed health care clinics. The CAC regulations currently provide for the Exchange to cover the minimal cost to fingerprint and background check the applicants through June 30, 2016. Staff is requesting board support to amend the current regulations so that the Exchange can continue to cover the cost of fingerprinting and criminal background checks. Mr. Whelan presented a slide that illustrated the proposed changes.

Chair Dooley requested clarification on when this recommendation would be presented for action.

Mr. Lee responded that staff will bring this back to the Board for action at the next board meeting. It is will be an appropriate time because it will tie into the budget. He does not anticipate this being an undue expense. Covered California wants community and nonprofit organizations to not have a barrier between them and doing the right thing for Covered California.

Agenda Item VI: Adjournment

The meeting was adjourned at 3:00 p.m.