CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD MINUTES
Thursday, May 12, 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

Board members attending meeting virtually in Fresno:
Genoveva Islas

Board members en route during roll call:
Paul Fearer
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 April 7, 2016 meeting minutes.

**Presentation:** April 7, 2016, Minutes

**Discussion:** None.

**Public Comment:** None

**Motion/Action:** Board Member Fearer moved to approve the April 7, 2016, minutes. Board Member Torres 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 Yolanda Richardson, Chief Deputy Executive Director, will be leaving Covered California and thanked her for her contributions.

Closed session contracting matters included the review of a quarterly report of all contracts, which will be posted publicly. The Board also approved amendments for existing contracts with Natoma and Maximus. Interagency agreements were renewed with the Department of Social Services and the Office of Systems Integration. RFOs were approved to solicit system analysis and development support consulting services, and to contract for an RFP consultant for CalHEERS.

## Executive Director's Update

### Discussion: Reports and Research

Mr. Lee encouraged attendees to read the reports and research articles included in the Board material. He referred to a Health Affairs study that looked at the role of negotiating, having better price, better competition, comparing California to New York. It found that Covered California's efforts are keeping prices down for consumers. It also noted the important role of provider consolidation on prices.

### Discussion: 2016 Special Enrollment Outreach Kickoff Meetings

Mr. Lee thanked the Outreach & Sales team, which held 13 special enrollment outreach kickoff meetings across California throughout the month of April. More than 600 people participated. Participants included insurance agents, navigators, and community partners.

### Discussion: Covered California for Small Business (CCSB)

Mr. Lee shared that CCSB closed out the first quarter, with almost 5,000 new lives. CCSB now has over 27,000 people enrolled. There is a big opportunity in the fourth quarter of 2016 because many small businesses will turn over their plans. Additionally, many small businesses will need to a convert to Affordable Care Act compliant plans.

**Public Comment: None**

# Agenda Item V: Covered California Policy and Action Items

## Discussion: Preliminary Forecast and Market Analysis 2017-2022 Report

Mr. Lee shared that Pricewaterhouse Coopers (PwC) was selected through an RFP process to help Covered California do three things. First, provide counsel on how to look and understand Covered California's business model. Second, to help Covered California understand what the futures look like in terms of a baseline for projections of potential enrollment and ensuring

reserves are adequate for that. Third, to advise on potential operations improvements. PwC will finalize their report in the coming weeks and it will be made public.

**Discussion: (PwC) Covered California 2016-2022 Market Analysis and Planning**

Sandra Hunt, Pricewaterhouse Coopers, explained that the focus of the presentation would be on baseline enrollment and then go into a range of scenario models that look at what things might look like in the future under different circumstances. The presentation will also cover opportunities to manage some of the turn over that occurs in Covered California, as well as the churn between Covered California and Medi-Cal and opportunities to enhance retention.

Ms. Hunt provided an overview of the characteristics of Covered California. She noted that in going through this work, they were always cognizant that what Covered California does in terms of creating a competitive market, patient-centered benefit designs, extensive marketing, improving the risk pool, affects not only Covered California's enrollment, but also affects the entire individual health insurance market and is bleeding into the small group market. In thinking about the policy implications of various options, she noted that three quarters of the premiums in Covered California are paid through the federal subsidy, and that is key to the enrollment levels. In addition to the premium subsidies, 60% of the enrollees are receiving cost-sharing subsidies, so that further reduces the cost to the enrollees of obtaining health care services. One key point that came up repeatedly in going through this work is the importance of effective outreach and marketing in maintaining a stable risk pool and improving the risk mix of the enrollees. Again, not only in Covered California itself, but also to the individual market. California's overall risk mix is about 25% better than the risk mix nationally of the individual markets.

There is structurally high turnover in the individual market, and that was true before the Affordable Care Act and continues to be true now. As a consequence of that, and when thinking about opportunities for Covered California and the available revenue for its tasks, tenure of enrollment and the lifetime value to Covered California of each enrollees needs to be considered. Lifetime value is the amount of revenue needed to pay for operations. Given the fact that the federal grants are largely expired, there are some reserves can be used this year to partially cover the cost of operations. Going forward, the budget needs to be self-supporting. Looking at lifetime value is a way to help think about that.

An overview of pre and post-Affordable Care Act individual market acquisition costs was provided. Given the importance of marketing and acquisition to the stability of the market, PwC wanted to look at how that looked before the Affordable Care Act and how it looks today. The prior acquisition costs were running at an average of 7.6% of premium. Assuming Covered California will increase the participation fee to 4%, that number will be 5.8% on average. Currently the split is about 50/50, between individual enrollees on the exchange and off the exchange.

In terms of looking at the lifetime value, the calculation was split between subsidized and unsubsidized individuals. The lifetime value of subsidized enrollees is $440 and their average length of enrollment is longer than the average length of enrollment for unsubsidized individuals. The average life of enrollment is about 25.5 months.

PwC looked at the budget, including both the revenue from fees and the spending of the federal grant. It was then broken out into the various components. Some are fixed costs, while others are variable. PwC really focused on the acquisition costs, because market and acquisition are still important in maintaining risk mix. They also looked at where the opportunities were for possibly increasing that budget or at least maintaining it.

The individual market is a single risk pool. That means the size and characteristics of those who buy directly from Covered California and directly from a carrier are both critical to the overall market. The same plans are offered both on and off the exchange. They have the same features; they are identical in plan design. Other plans can also be sold off the exchange. There is a combined risk rating on and off the exchange. When health plans do risk adjustments, that looks at their entire enrollment. It is the same price on and off the exchange.

In terms of looking forward, PwC looked at is baseline of enrollment. She noted that the net enrollment projections really are that Covered California will largely remain at its current enrollment levels. There are some opportunities to increase enrollment. They went into a whole number of scenarios to look at what might happen if there was a recession, which would lead to unemployment increasing, if there were high premium trends and so forth. What was found in terms of the economic considerations is that in every scenario, enrollment will remain flat or grow, and in some cases, there is opportunities for it to grow significantly.

PwC looked at current penetration of Covered California for the eligible population. They wanted to look at how much of the eligible population is enrolled in Covered California, what remains and how many people come and go in Covered California. Findings revealed that when looking at a point in time, 69% of the subsidy eligible population is enrolled in the program. When looking over the course of a year, that number gets much bigger. It is right around 85%. A range of 75-95 is provided, because it varies based on kind of the date that you look. Covered California is actually capturing 85% or more of the population that is subsidy eligible, which says Covered California is doing a great job, but it does present some challenges.

There is a lot of turnover, so even maintaining enrollment is a very big job. There is good disenrollment and some not preferred disenrollment. However, there is a natural churn and disenrollment in this program. Penetration for the unsubsidized population is much lower. Again, the interest is not only who is enrolling in Covered California, but also who is enrolling at all in health insurance. PwC looked at who was enrolled at the end of the year and remained enrolled in the next year, separately from those who enroll who were not enrolled at the end of the prior year. In 2016, there is a high retention rate. This reinforces the need to continue enrolling new people in order to stay largely flat in terms of enrollment. PwC looked at the penetration rate by income level and it was roughly the same up until 350-400% of poverty level.

For scenario modeling, PwC did a number of interviews to help develop scenarios. One of the scenarios was the $15 minimum wage. Other scenarios included the unemployment rate; one where the economy continues to grow significantly and unemployment drops and another where unemployment goes up materially. PwC looked at options for how the subsidies might change over time, looking at a reduction in subsidy eligibility as well as an increase in subsidy eligibility, a policy that would close the family glitch in the subsidy eligibility, potentially

eliminating the individual mandate, potentially changing coverage for individuals who are undocumented, and then changes in how employees of small groups and large groups are allowed to participate and whether there's a requirement, and then changes in Medi-Cal and in the premium cost trend. PwC looked at what the impact of those various scenarios are on expected Covered California enrollment for those who are eligible for a subsidy, and then the enrollment of those who are not eligible for a subsidy. The purpose of that was just to see how things come together and what that might mean for overall enrollment.

In terms of the impact, the first scenario has the least impact on enrollment, while scenario two suggests very high upside in enrollment. If the economy weakens, more people would be looking for subsidized coverage. There is a lot opportunity if the ACA subsidies opportunities expand. Impacts would be catastrophic if there were significant changes in eligibility.

PwC did look at opportunities to manage turnover, churn, and retention. They looked at the interface between Covered California and Medi-Cal, as well as where people go when they leave Covered California. A survey was done asking people what happens when they leave the program and why they left. Results indicate that a large percentage of the turnover is to other sources of insurance, primarily employer sponsored insurance, Medi-Cal.

PwC also looked at the opportunities to increase Covered California's enrollment. There are between 270-330,000 potential enrollees. There is a significant opportunity related to greater coordination with Medi-Cal and getting people who are leaving and will become uninsured. There is also some real opportunity for those going from employer sponsored to cobra coverage.

Mr. Lee referred the board to slide 17 regarding the key drivers and noted that none of those drivers are predictions or recommendations. They were presented to help Covered California think about planning. He highlighted that while collecting scenarios of ACA contraction, PwC looked at eliminating subsidies. The reason so many Californians have coverage is because of subsidies. The slide shows that if the subsidies were reduced to 250% of poverty, 80% of enrollment would still be there and fiscally, Covered California's reserves can accommodate changes at that level. He also noted that PwC did not seek to model every political variable, for example, the recent court challenge to the funding of cost sharing reductions.

**Public Comment**

Beth Capell, Health Access California, commented that this was a dense amount of information and noted that it only became available after the meeting had started. Health Access will provide comment that is more detailed in the weeks ahead. She appreciates Covered California looking forward and the projecting various alternatives, and looking for opportunities to grow enrollment. She noted that because of AB 792, signed by Governor Brown, every Californian who loses coverage for any reason, including due to Cobra, is given notice of the availability of Covered California and free care through Medi-Cal.

Mr. Lee agreed with Ms. Capell that this is dense material and welcomed comments on this at boardcomments@covered.ca.gov. Comments will be routed to PwC.

**Discussion: 2016/17 Proposed Budget, Forecast and QHP Assessment Fee**

Mr. Lee noted that Covered California has grown very rapidly in the first few years, with nearly 85% of subsidy eligible people getting coverage. Furthermore, most growth in net terms is projected over the next few years, which means substantial growth in newly covered individuals every single year. Although there is a lot of turnover, it is largely turnover that is Covered California welcomes, as people to go to get employer based coverage, move into Medicare or Medi-Cal. He noted that a very small percentage go uninsured and that is Covered California's target. Mr. Lee noted that the proposed budget reflects belt tightening and a change for the first time in establishing an assessment as a percentage of premium. Staff is recommending a 4% plan assessment. Belt tightening efforts are necessary in order to continue to grow. Staff projects spending to be $13 million less, next year on marketing. Staff is proposing cutting back on the navigator funding to fund those organizations that are getting people in at a reasonable dollar amount. Staff also proposes to open a new ombudsman office that would be independent of the service center, to help individuals that have problems resolve those problems quickly and effectively. The budget also reflects some tough calls. This budget reflects this next fiscal year will be the last year Covered California has a contract with Contra Costa County. Staff also determined that with the opening of a new ombudsman office, the contract with the Health Consumer Alliance will no longer be needed.

Chairwoman Dooley clarified that the budget is up for discussion and the board will not be acting it until the June board meeting. Mr. Lee added that revisions might be added to the final proposal.

Jim Lombard, Director, Financial Management Division, noted that the proposed budget is the culmination of seven months of hard work from staff. The proposed budget and assessment fee will be brought back to the June meeting for action.

Mr. Lombard presented 2016-17 fiscal year highlights. This is the first year that Covered California will operate without federal funds. Since 14-15, reductions over $100 million to the budget have been made. The budget is balanced throughout the five-year forecasts with prudent reserves. This budget realigns the service center with resources comparable to 2015-16, and it sustains outreach and marketing to fund statewide efforts. It also includes an assessment rate of 5% of premium for plan year 2017 for individual market.

Covered California guiding principles focused on, growth and retention of membership, showing how exchanges can improve the cost and quality of care, ensuring the assessment fee reflects low burden for consumers and the health plan, continuing to build infrastructure that can reduce future costs, and maintaining adequate reserves.

Mr. Lombard noted that reserves are going to increase over what was projected last year by 24 million, for a total of approximately $222 million. Forecast projects revenue will be $22 million below original estimates, but it will be offset by lower than expected expenditures.

Covered California expects to spend about $298 million of the estimated $335 million budget this year. Less is being spent on the service center, outreach & sales, and marketing, largely due to lower expenditures for postage, mailing, paid media, and lower costs for statewide administrative costs.

Mr. Lombard provided an overview of enrollment forecasts for the individual market and for CCSB. With regards to the individual enrollment, Covered California benefited from a lot of the work done by PwC. It provided a good analysis of the seasonal variations enrollment might come in. The enrollment forecast reflects the most recent open enrollment, with an estimated 1.4 million enrollees. The model is based on actual experience this year rather than penetration into the market. The modest growth related to fundamental demographic and economic factors, and the impact of recent law changes related to minimum wage. An overview was provided on low, medium, and high scenario model results. The CCSB forecast reflects the 50-100 employee market as of January 1, 2016. This assumes about 20,000-25,000 member growth each year for the medium forecast. Staff expects CCSB will break even in 2017-18.

Mr. Lombard presented the 2016-17 proposed $308 million budget and noted that it is about $100 million below the 14-15 budget and 25 million below 2015-16. The budget includes some funding increases for staff benefits, statewide administrative courses, and anticipated employee compensation increases. The budget provides funding to the service center comparable to expected 15-16 spending. It provides almost $10 million to invest in IT infrastructure, which would fund things like consumer verification efforts and expand consumer outreach channels. It provides $93 million for outreach and marketing, $36 million of that for paid media, and $5 million for the navigator program, $2 million for our ombudsman program. He provided an overview the migration of funding sources throughout the years from federal funded program and assessment funded program to plan assessments. Covered California will be spending about $60 million in reserves in 16-17.

Staff is proposing an assessment fee of 4% of premium for the individual market. Mr. Lombard presented the multi-year forecast and noted that for FY 19-20, the premium could be reduced from 4% to 3.75%. By 19-20, it would go down to 3.5% of premium. In conclusion, the budget is balanced and includes sufficient reserves.

**Discussion: Navigator Grant Program Proposed Changes for 2016/17**

Drew Kyler, Interim Deputy Director, Outreach and Sales Division, presented changes to the Navigator grant program as part of the budget discussion. The current contract term runs August 2015 through June 30, 2016 and provides for two optional one-year extensions. Moving forward, the strategy is to amend the existing contracts for a 60 day, no-cost extension. Once the budget has been established, staff will pursue a one-year extension with existing entities who have demonstrated the ability to enroll and renew consumers in a Covered California health plan.

During open enrollment three, 69 grantees provided enrollment support, active renewal, and retention support for approximately 77,000 consumers. When considering the budget funding recommendation, staff targeted a $200 per acquisition for services. He also noted that the current contract is a block grant model, where payments are made every other month. Additionally, the contract requires a monthly reporting of events and touches.

As part of the budget, staff is recommending a $5 million investment in the navigator grant program for 2016-2017. That includes 46 main grantees and 78 subcontractors. The 2015-16 average cost for enrollment was $166. 22 grantees will be referred to the Certified Application

Counselor Program (CAC) and no longer funded as part of the Navigator Program. The average cost per acquisition for these grantees was over $575 per member.

Mr. Kyler noted that staff looked at $3, $5, and $7.25 million as funding level options before ultimately landing on $5 million option. Additionally, he provided an overview of the estimated number of grantees and subcontractors, number of certified enrollment counselors, and estimated number of individuals to be enrolled/renewed at each funding level.

Chairwoman Dooley asked if the difference between five million and seven and a quarter with the same number of contract lead grantees and subcontractors is just the amount per grantee. Mr. Kyler agreed.

**Public Comment**

Elizabeth Landsberg, Western Center on Law and Poverty (WCLP) and the Health Consumer Alliance (HCA), is gravely disappointed with Mr. Lee's recommendation to discontinue the contract with the HCA. Mr. Lee's comment in the budget document indicates that this new proposed internal ombudsman, which would be funded at twice the level the HCA is currently funded, would be an independent, impartial entity. HCA is puzzled by this, as HCA is an external entity. HCA meets with staff monthly to talk about trends and problem resolution. This is an important model moving forward. Having Covered California improve the tools to resolve problems would be a better source than to set up yet another infrastructure to resolve consumer problems. The proposed budget includes $6 million for costs related to appeals. If there is not an independent consumer assistance program to help people resolve problems with appeals, the need for appeals may well increase. Ms. Landsberg also noted that Covered California notices currently refer consumers to the HCA programs for assistance with appeals, and that needs to be looked at moving forward. Renewing the modest million-dollar investment that Covered California currently makes in independent consumer assistance would be 0.3% of the annual budget for statewide consumer assistance. HCA looks forward to continuing the discussion and perhaps reaching a different place next month. HCA is also concerned with the proposal regarding the navigator funding. HCA works very closely with the navigators in the community. They refer many of their more difficult cases to HCA, so HCA is looking at both pieces of that.

Charles Bacchi, California Association of Health Plans (CAHP), noted that premium prices are the most important factor for consumers deciding to purchase coverage and then selecting a plan. QHP's have consistently urged that Covered California's budget be mindful of affordability of premiums. The bigger the budget, the higher the premium costs. Covered California staff have proposed a budget that is mindful of premium impacts, evidenced by the number of tradeoffs that the budget proposes. If something is a priority, it should be funded. For example, QHPs agree that the technology budget is important, for not only improving customer service, but also reducing CalHEERS glitches. Increased spending on that budget item may very well be warranted. CAHP would like to confirm that the technology line item includes funding to make necessary technology investments to ensure that pre-enrollment verification can be adopted. If not, CAHP would like to see that line item increased to do so. On the other hand, CAHP questions whether the proposed plan management increase is mission critical. These initiatives require QHPs to hire more staff and increase administrative costs, which also increases

premiums. He urged stakeholders to think of tradeoffs in their analysis. Lastly, CAHP looks forward to Covered California reducing the fee in the future.

Cori Racela, National Health Law Program (NHLP), is disappointed that there is no funding in the proposed budget for independent consumer assistance. An ombudsman program would be insufficient to meet the needs of consumers. It is unclear whether that ombudsman program would give consumers an independent voice. Through NHLP's many years of health advocacy, there have been variety of challenges with ombudsman programs at the Department of Health Care Services (DHCS). Independent consumer assistance is invaluable in providing comprehensive, individual consumer advocacy. The HCA has done work, both with Covered California eligibility enrollment and has helped consumers with their QHP issues, whether it is premium payments or access to services. Furthermore, the level of service the HCA provides ranges from individual counsel and advice to representation and fair hearing, to identifying systemic issues for policy advocacy. Although the issues raised may appear as though only problems are being pointed out, they are a vital part of the advocates' job and they are raised with the same goals and shared values as Covered California. Independent consumer assistance as provided cannot be replaced with an ombudsman program and should continue to be funded.

Doreena Wong, Asian Americans Advancing Justice Los Angeles, echoed Ms. Landsberg and Ms. Racela's comments. Many of the navigators rely on assistance from the HCA. Independent consumer assistance is important for consumers. A letter was submitted on behalf of over a dozen navigator partners, in response to the proposed funding cut to the navigator program. While there is an overall budget cut of 8%, she is disappointed that the navigator funding has been cut by more than half. Last year, the original budget was $13 million, and there was only $10.5 million that was allocated. She hopes the board will reconsider funding the navigator program at least to the current level of $10.5 and not cut it by over 50%. The $5 million funding level was derived without any input from stakeholders. The outreach, marketing and enrollment stakeholder group has not met since December. They would have appreciated an opportunity to discuss this and provide feedback. The navigator program represents 1.6% of the total budget. The navigator program reaches hard to reach, vulnerable populations. Supporting a strong navigator program is important as it becomes more difficult to get new enrollees.

Cary Sanders, California Pan-Ethnic Health Network (CP-EHN), is disappointed to see no funding for the HCA, as well as the cuts to the navigator program. Without their efforts, some of the problems and difficulties that vulnerable communities face in accessing coverage would not have become known. CP-EHN sees the value in an ombudsman office, but not at the expense of consumers. The expertise that the HCA brings to the table in both Medi-Cal and Covered California and understanding how those programs both work together and don't work together is invaluable and something that will be sorely missed without this formal contract. Additionally, the work of navigators and really reaching those hard to reach populations, which is one of Covered California's biggest obligations, is something that needs to have continued investment. CP-EHN has been proud to work with Covered California on plan management and looking at health disparities reduction moving forward. However, in order to have a meaningful impact in those areas, Covered California needs to ensure that people are being reached. She urged the board to look at these groups and to think about the value that they provide to Covered California. Additionally, it would be helpful to give a webinar or presentation to the navigators

and the HCA about budget assumptions, so that they can understand the tradeoffs and they can provide comments on what that would look like in terms of the services.

Jonathan Lopez, San Joaquin Pride Center, expressed the need for the navigator program, especially in the central valley in Stockton. There is a strong focus on LGBTs, and echoed all the other comments about the navigator programs. He urged the board to consider these comments when selecting the navigator programs.

Tara Dooley, Children's Health Initiative of Santa Barbara, a subcontractor of the California Coverage and Health Initiative (a navigation grant), noted that having the navigator grant is key to having happy consumers in Covered California. When dealing with consumers regarding enrollment, it is more about getting questions answered; getting their tax forms, or getting assistance in uploading or faxing their income documentation. Sometimes consumers have a hard time reaching the call center and they are very grateful for any in person assistance they can get. Sometimes the call center refers clients to navigators because they needed to prove their identity. In neighboring counties, few agencies have continued to become CACs and certified enrollment entities. Consumers are grateful to have a space and a person to deal with when trying to resolve their problems. An ombudsman is a bad tradeoff for this for the navigator grant. She would like to keep funding at current level. Additionally, it is going to be crucial to keep the call center at the same level of staffing to achieve growth and retention targets. People get very frustrated when trying to reach the call center to get their questions answered. Navigators are key to achieving that goal.

Kate Burch, California LGBT Health & Human Services Network, is concerned about the cut in funding for the navigator program. The navigator program is what lets community organizations reach the hardest-to-reach populations. These are the people require a lot of individualized help to enroll and troubleshoot some of the problems that arise. With about 77,000 people helped by the navigator grantees, a $200 acquisition cost per person results in a value of $15 million. Covered California received a lot of value for the $10 million funding level. It does not make sense to cut the $10 million in half. The way money is spent is a reflection of values. It is disappointing to see Covered California devaluing these hard-to-reach populations.

Cindy Snelgrove, Ampla Health, complimented staff on their responsiveness to Ampla Health's feedback relative to the navigator grant structure. They are pleased with the changes made and appreciate the decision to invest in CECs to do this work, especially in the hard-to-reach areas. She is hopeful that Covered California allows enough funding to ensure that education, enrollment, renewal, and retention activities can continue with the same momentum through all existing navigator grantees.

Brenda Diaz, California Coverage & Health Initiatives, echoed the comments made from past speakers and highlighted the importance of the navigator grants. Navigators help with the most vulnerable and hard-to-reach populations in California. These are the families with complex family situations, immigration and income statuses, and complex household compositions. Navigators help families facilitate enrollment, access, and reenrollment of coverage. In order to continue the in-person level, they are hopeful the navigator program retains at its current funding.

Kirsten Golden Testa, Children's Partnership, is concerned and disappointed with the budget proposal relating to eliminating the HCA contract. It's hard to imagine how an ombudsman program, even as great as it could be, could replicate the level of expertise, efficiency, effectiveness, and reach really into the community and trust that that community already has in that organization and its partners and to do the same level of work. For example, the HCA contract report shows that one of the main reasons that they are working with some of the clients on delays in processing is related to disconnects between Medi-Cal and Covered California. The HCA are experts in both worlds. Covered California gets the benefit of their expertise on Medi-Cal and in resolving some of those issues without having to pay for it. She asked the board to reconsider the budget proposal.

Melinda Rivera, noted that as a navigator grantee, her staff has worked with people in the community, to provide extensive case management and navigation services for people who are attempting to enroll, renew, and maintain their Covered California coverage. The navigator funding has proven to be well worth every dollar that has been spent in reaching hard-to-reach populations and those who are most vulnerable.

Evelyn Gonzalez, Community Health Councils, echoed her disappointment regarding the cuts to the navigator program. The navigator program reaches many people that go unreached. The community requires multiple messaging. The budget cuts need to be reconsidered. This real disappointment across the board. She urged the board to reconsider the cuts and renew funding.

Penny Hancock, San Joaquin Pride Center, stressed the importance of the navigation system. They are reaching out to the LGBT community to help them access the best of health care that Covered California and Medi-Cal has to give.

Geneva on behalf of Katie Villegas, Yolo County Children's Alliance, thanked the board for the funding provided over the years and echoed everyone's thoughts and concerns about the navigator program. This program has been very helpful in reaching out to the migrant community, as well as the students at UC Davis, Sacramento City College campuses in the area, as well as immigrant families that are moving to Yolo County. She asked the board to reconsider the proposal.

Juli Broyles, California Association of Health Underwriters, appreciates a budget that looks at the certified insurance agents. She also appreciates Covered California finding new ways to add support the dedicated support help line for the agents for SHOP for small business, and for ensuring that the fair compensation discussion continues.

Betty Williams, One Solution, and supporting the California Black Chamber of Commerce, noted that cutting the navigator grant will definitely impact the community, given it is already more difficult to reach. However, the African American community is definitely a challenge. By not maintaining existing funding, outreach in the community will be impacted. Navigators do many things, other than just enrolling. It takes between 8-15 touches to get a person enrolled because of the ongoing education. She requested the board reconsider the funding cuts to the navigator grant.

Beth Capell, Health Access California, is struck by the high turnover of enrollees. As the budget document acknowledges, Covered California is in some senses a place where people in transition get their coverage, and that will be true for many of the enrollees. She asked the board to think about whether the current levels of service provided by the service center are sufficient to meet Covered California's own standards. Part of the executive director's report suggests that the service center is not currently meeting standards for providing service. The need to provide support and to help consumers through what is a very complicated and still very new process is striking. She noted potential trade off that she hopes staff is exploring, such as squeezing more administrative costs out of the health plans. She questioned whether Covered California has relieved the health plans of some of their administrative responsibilities in the individual market and suggested whether instead of an 80% medical loss ratio, staff might contemplate something closer to the 85% medical loss ratio, which is true in the small group market.

Mr. Lee thanked speakers for their comments and acknowledged that tradeoffs are necessary. Covered California is all committed to effectively serving the very diverse communities in California. The question is how to do that most effectively. Staff looked very closely at that in terms of the alternatives relative to the navigator program. Covered California wants to make sure those individuals that are eligible for coverage are getting it, and being served well, through a range of service channels. Covered California will be having forums in the coming weeks to make clear what Covered California's thinking is.

Mr. Lee agreed with comments made about the different levels of independence, regarding consumer assistance. There is substantial value of having an ombudsman program that would be distinct and separate from the service center. That is different from an outside organization. HCA has provided important value. Staff will look at that and see how they could complement one another if funding was continued with an outside entity. However, the goal is to resolve problems at the lowest level possible. Mr. Lee agreed with the comment about high turnover. Covered California wants someone that has been served in Covered California to leave with a positive experience for when they return. Staff will engage stakeholders in the coming weeks about different ways to address that balance of efficiency, independence and resolving problems at the lowest possible level.

Member Islas noted that these are hard decisions and the board does not take them lightly. She thanked advocates for their ideas and recommendations. She also reassured that none of the board's decisions are based on devaluing any population.

## Discussion: Covered California for Small Business (CCSB) Model Contract

Anne Price, Director of Plan Management, provided an update on the Small Business Model Contract. Changes were made to the model contract as a result of additional Covered California review and comments from QHP issuers. There were no changes made to the attachments. Staff is requesting approval of the 2017-2019 small group contract.

**Public Comment**

Elizabeth Evenson, California Association of Health Plans (CAHP), thanked staff for delaying the Small Business Model Contract, and incorporating some of CAHP's comments.

> **Motion/Action:** Board Member Fearer moved to pass Resolution 2016-21. Board Member Torres seconded the motion.
>
> **Vote:** Roll was called and the motion was approved by a unanimous vote.

## Special Enrollment Period Policies

Anne Price, Director, Plan Management, presented adjustments that were made to the special enrollment policies since the April board meeting. Currently, for special enrollment, there is an attestation only policy versus a consumer having to provide the appropriate documentation. There is a concern that consumers may be enrolling who are not truly eligible. She noted that there is already an expectation that these consumers will be more costly, but there is a concern that they are more costly than they otherwise should be. Staff is looking to amend current policy to ensure only eligible individuals are enrolled. This will preserve the integrity of the risk mix, so that that can lend itself to long-term affordability for consumers. She reviewed the policy guiding principles, which state the policy should not be overly burdensome to members. Additionally, it should optimize use of electronic verification and alternative forms of documentation or attestation will be required with this population, because documentations may not exist in some circumstances. Covered California will look to have documentation verified prior to effectuation down the road. Additionally, the process must consider our technology capabilities, and current resources within Covered California. Covered California will continue using attestations for 2016. However, staff is requesting modification to regulations that will allow for a statistically valid random sampling process for verification of the SEP attestations. This will assess if consumers who enroll during special enrollment in 2016 have appropriate documentation. That process will be done in house and defined by Covered California. Staff will work with stakeholders to further define that process. The results of that will be to understand better if there are issues of selection occurring in this population. Staff will take that information and look to implement further verification processes in 2017, when Covered California has electronic capabilities. She noted that the requested changes to not include recently-issued CMS guidance. However, those changes will be brought before the board next month.

Chairwoman Dooley requested clarification from Ms. Price on the difference between the Special Enrollment Period Presentation and readoption of emergency regulation.

Ms. Price responded that the resolution is a regulation change. Currently staff cannot request documents from the members after they have enrolled through special enrollment. The regulation language would allow Covered California to request those documentations for this statistically valid random sample.

Chairwoman Dooley noted that there would be another proposal next month that will incorporate the new federal requirements that came out on Friday. For today's meeting the board will consider adopting an emergency regulation that will allow staff to ask for documentation consistent with the policies presented by Ms. Price for a random audit.

Ms. Price clarified that the documentation being asked for will not affect enrollment at this time. Members will be enrolled. If they are found to have enrolled when they were not eligible, they will be prospectively terminated. Additionally, if there are areas that appear to look like fraud, those cases will be referred to the federal entity who can look to pursue financial obligation.

Chairwoman Dooley noted that all of this is in the context of the testimony over the last few months about separating fact from fiction. Covered California wants to do an audit to collect the information. Where that audit leads to information that indicates someone has not been eligible, individual action will be taken.

Mr. Lee noted that the issues on random sampling are the near term. An electronic verification, subject to the guiding principles, will be implemented in 2017.

## 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 and terms were added that apply to CCSB. 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 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 statistically valid random sampling verification process for qualifying life events (QLE) that trigger a SEP. Covered California will accept qualified individuals or an enrollees attestation that they meet a QLE that triggers a SEP subject to the following proposed random sampling verification: Covered California may select a statistically valid 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 within 30 days from the date of that written request. However, a good faith effort extension was added to extend the period on a case-by-case basis. If Covered California is unable to verify the 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 including their appeal rights, and implement the eligibility determination prospectively in accordance with the regulations.

An exception was added to the regulations that on a case-by-case basis, Covered California accepts an individual's attestation for their qualifying life event if they can show that the documentation was not reasonably available for them to submit. Qualified enrollees will need to

provide a signed written statement, attestation under penalty of perjury with an explanation of circumstances as to why they cannot provide the documentation. A provision was also added noting that the sampling process cannot be based on the individual's claims past, diagnosis code, or any demographic information. However, demographic information does not include geographic factors.

**Public Comment**

Juli Broyles, California Association of Health Underwriters, expressed concerns regarding information she heard from certified agents that certain plans are refusing to pay commissions on individuals coming in through the special enrollment period. She would like to see this issue discussed in the additional regulations looking to be adopted at a future meeting.

Chairwoman Dooley noted that this would not be addressed, as it is not part of the current proposal.

Cori Racela, National Health Law Program (NHLP), noted great improvements have been made to the policies since their initial draft. Three components should be added to improve the audit process. First, a time limit on Covered California's ability to ask for verifications, which should be no more than 30 days after enrollment; continued enrollment, pending appeal if someone is proposed for termination; and a transparent reporting requirement. More details can be found in Health Consumer Alliance's letters to the board.

NHLP cannot support adoption of the proposed eligibility enrollment regulations without the following two items: The first is Covered California's duty to translate all forms and notices pursuant to California Welfare and Institution Code 15926. Covered California has had over two years to operationalize translations. By including the duty to translate in the regulations, the board can send an important message that language access is a Covered California priority. The second issue is including a prohibition against gender identity discrimination. The proposed federal regulations implementing Section 1557 of the Affordable Care Act will explicitly address gender identity discrimination. By prohibiting gender identity discrimination in the regulations, Covered California has the opportunity to be a leader in non-discrimination. Although Covered California has plans to work on both language access and gender identity in the future, limitations cannot drive policy or priorities on these important civil rights matters.

Jen Flory, Western Center on Law and Poverty, echoed Ms. Racela's comments. She is pleased with many things in the regulations, including changes to the binder payments and retro terminations. With the special enrollment, there are limited times when somebody can show good cause or in very limited times they can self-attest. Having this additional protection makes this a more consumer friendly process. Although she would like it to look more like the conditional eligibility process for the rest of the verifications, this will suffice.

With regards to the translation of the notices of action. Welfare and Institutions Code 15926 has been law since 2014. Consumers have been very patient in not having these all translated. She understands it is being operationalized. However, policy needs to be dictated by the statutes and state law, rather than what is technically feasible. She encouraged the board to include that

authority in this round of regulations before approving. Prohibition of gender identity discrimination should also be included, since it is about to be included in federal regulations.

Elizabeth Evenson, California Association of Health Plans (CAHP), noted that the implementation of a verification process was a decision made by the board in 2014. CAHP would like to see a commitment in the 24-month Road Map to implement a pre-enrollment verification process by next year. This includes funding for the necessary systems, changes, and a specific period for completion. Pre-enrollment verification is necessary to ensure the stability of the marketplace and maintain affordable coverage.

Cary Sanders, California Pan-Ethnic Health Network (CP-EHN), aligned her comments with Western Center on Law and Poverty on the regulations. She urge Covered California to consider including additional provisions in the regulations around language access and gender discrimination.

Doreena Wong, Asian Americans Advancing Justice Los Angeles, echoed Western Center and NHLP's comments. Translating notices and forms would help reduce the significant amount of time navigators are currently spending translating documents to clients. Prohibiting discrimination based on gender identity should be included. Lastly, with regard to the special enrollment period verification requirements, she is appreciative of the changes that have been made around the attestation and the electronic verification. It is difficult to help clients go through special enrollment period when navigators are not sure what the process is. Special training should be conducted when any changes are made to ensure that navigators and certified application counselors understand the rules.

Kirsten Golden Testa, Children's Partnership, appreciates the changes made to the policies and that there will be an analysis looking at the information gathered. It is important to not classify all those that do not have documentation as not eligible, because it may be that they are in fact eligible, they do have a triggering event, they just could not find the documentation. These two should be distinguished in the analysis. She questioned section 5b of the regulations, which state that Covered California verifying as best they can. However, there is no verification system.

Kate Burch, California LGBT Health & Human Services Network, echoed concerns regarding the importance of prohibiting discrimination based on gender identity. She is also pleased with the direction of special enrollment policies, and looks forward to seeing what comes out of the statistically significant random sample.

Anthony Wright, Health Access California, noted that the regulations before the board address the lack of reasonably available documentation and are a considerable improvement. The proposal goes in the right direction, relying on the audits to determine whether these problems actually exist. It is reasonable to take this step before embarking on developing a system of electronic verification. Health Access has legitimate concerns about whether the examples provided by the plans biased. It is a cherry picked data set, which is why Health Access made a big deal about having a statistically valid random sample for any audit methodology, where both consumer advocates as well as plans can respect the results. Health Access does not oppose using the information that is provided by the plans as areas of investigation. Lastly, Health Access

appreciates that the marketing outreach and enrollment committee will focus on looking at what can be done capture people in life change events for special enrollment periods.

Evelyn Gonzalez, Community Health Councils, echoed concerns around the translation requirement. Communities need to be reached in the language that they understand. Health concerns are already a language in itself. It is not in the language they prefer and understand, making it more difficult to access needed care. She also supports concerns regarding gender identity. Many of these issues are connected, and communities cannot be left behind.

Mr. Lee responded that Covered California takes issues raised about translation and gender equity seriously and looks forward to reviewing those for future regulations. He noted that the regulations before the board are ready for action.

> **Motion/Action:** Board Member Torres moved to pass Resolution 2016-22 regarding Individual Eligibility and Enrollment Regulations Emergency Readoption. Board Member Fearer seconded the motion.
>
> **Vote:** Roll was called and the motion was approved by a 4-0 vote. Member Morgenstern was not present for the vote.

**Discussion: Certified Application Counselors (CAC) Regulations Adoption**

Drew Kyler, Interim Deputy Director, Outreach and Sales Division, noted that slight modifications to the Certified Application Counselor (CAC) program regulations were presented to the board in April, which allowed Covered California to pay for the fingerprinting costs associated with background checks for uncompensated counselors. Public input was solicited, but none was received. Staff is requesting board support adopting the regulation changes.

**Public Comment:**
Doreena Wong, Asian Americans Advancing Justice Los Angeles, noted that there were couple of issues around the CAC rights and responsibilities. One is in reference to a CAC requirement to refer consumers to applicable consumer assistance, agencies, or ombudsmen, which was not in the list. She is hopeful the CAC responsibilities could include informing consumers on how to appeal. Secondly, although there is training on how to provide consumers with assistance with voter registration, there is no requirement for the CAC to provide that assistance to the voter. She recommended it be added so that CACs realize that they must provide information and assistance to the consumer to register to vote. Lastly, she is pleased that Covered California is covering the cost of the background checks for the CACs. She also recommended that Covered California consider covering the cost of the background checks for the certified enrollment counselors.

> **Motion/Action:** Board Member Torres moved to pass Resolution 2016-23. Board Member Fearer seconded the motion.
>
> **Vote:** Roll was called and the motion was approved by a unanimous vote.

## Agenda Item VI: Adjournment

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