2013-11-07 -- COVERED CALIFORNIA TRIBAL CONSULTATION
PART I

PETER: It's a real privilege to be with you today. I had the chance to meet some of you a year ago. This has been both a very, very fast-passing year—a lot has happened—and we are right now at the edge of, as Mark noted, a really historic event. Those of you that I had a chance to meet last year know that I've got a little bit of familiarity with Native Americans in my family. My uncle was the Assistant Secretary of Health under Bill Clinton and spent a lot of his time focusing on how to make the Indian Health Service work well. I've actually had the privilege of talking to him as an elder to me that I've learned a lot from. Before starting my remarks, though, I'd like to take a moment to honor and recognize one of your elders, which is Jim Crouch.

Jim, as you all know far better than I, has been a champion for many years, and is retiring, giving leadership to Mark, a great leader. I think he's going to do a wonderful job. While you know what he's done for the last 30 years, I know something about what he's done in the last couple years. Jim has played a really crucial role of helping Covered California get off the ground in a way that aggressively and positively engages in partnership with the Native American community. He's been crucial in helping us shape what I think is a model of how we work together. Jim, I'd like you to come up. We actually have a shirt for you that is Covered California for American Indians, because that's what you've helped lead us to do and what we will try to practice. And we know that you will be sort of looking over our shoulder and have our back, but you have been such a leader to help us be a model of how to work together, we wanted to give this as a tribute to you. [applause]

JIM: I'm recommending retirement to all of my aged peers. Everybody is so nice to you. Peter, I'd like to give you a pin that we handed out at the CRIHB annual meeting a few weeks ago. It's "I ♥ ObamaCare." [laughter] [applause]

PETER: Thank you so much. And I do. It's true. We very much look forward to working with Mark, and we've enjoyed our working relationship already with Mark. I think today is a very full day. We have a lot to do. Before jumping into the slides and giving you some background and context, I want to introduce some of the other people that you have the names of. One of our chief deputies, David Maxwell-Jolly, is with us today. He's going to be with you throughout the day. I do note I'm going to need to leave, but I'm going to try to come back for the wrap-up portion. As you can imagine, I have a few balls in the air right now. But we also have, in particular, two people that have just been great, I think—and we need to hear it from you—in working in partnership with you on a day-to-day basis, with is Jessica Abernathy and Natalie Chavez, who are both here with us. Can you stand up, Jessica? You might've seen an email from Jessica. This is Jessica. Do make a point to meet her in person. But also you'll be hearing from

staff, Leah Morris. Again, we are here not just to talk at all to you, but to talk with you, to hear from you. So this is an opportunity for us to learn, to listen, as well as to share where we are.

I would note, before going into the presentation, which sort of frames things, is there's a lot of talk nationally about computer glitches and that we aren't having them in the way that the rest of the country is. That's important, I think, that having the enrollment system work, though not perfectly, and there's actually some little bumps in the road, specifically to some of our Native American enrollment issues. But overall our system is working great. That's not why things are working really well in California. Things are working well in California because for two years we've been working in partnership with tribes. We've been working in partnership with community clinics, with local organizations in rural areas, in cities. I've been doing a lot of public speaking. I've been at town halls. Of the innumerable town halls I've been to, I've been heckled one time. We don't live in Texas. We don't live in Florida. That one time I was heckled was by someone who said, "Don't invade Syria." "Excuse me?" So the point of that is that here in California, we're all about making this thing work, and that's why it's such a privilege to be with you, who are partners with us in making this thing with us for the 70,000 American Indian and Alaska Natives who can benefit specifically by their eligibility for subsidies under the Affordable Care Act with Covered California.

With that, I'm going to go through some context and background. Again, I know that for some of you this will be old hat. Some of you are new. How many of you were at last year's consultation? Can you raise your hands if you were here at last year's? So that's about a third. So two-thirds of you weren't at last year's big consultation. We're going to be going through, pretty quickly, some of the basics in my overview. You'll be hearing much more detail for Leah, and we'll be going through details throughout the day. All of this, though, is framed in engagement of: Are we getting it right? How do we improve? That's our modus operandi.

We have no glitches generally. But every now and then, when we have a glitch, we rock right through it. So let me start with the goals. Again, the main thing that I would note—and again, I'm not a PowerPoint reader. PowerPoints are up here so you can get copies of them and refer back to them later. The two things I would note about our goals is consultation is, first, engagement and partnership. This has got to be about a partnership with you. You know your tribes. You know your communities. You know how to communicate, how to reach out to them, how to build the tools to reach out. We don't. So how do we work with you? That's number one. And number two is the last one, the last bullet, which is the common goal is we want to maximize participation of American Indians in Covered California. This is all about helping people get coverage if they need it and get access to care when they need it. That's our job one. All of our goals are around this. We're sort of a results-oriented organization. That result is all about what we're looking for.

Let me remind you of some of the benefits specific to American Indians and Alaska Natives under the Affordable Care Act. They are very, very big and very substantial. First, the Affordable Care Act provides health insurance that may pay for services that are not otherwise provided, things like medical specialists, tests, emergency room visits, hospital care. Absolutely—and it's very, very important to underscore that American Indians and Alaska Natives can keep using their tribal and urban clinics. We know that the tribal and urban clinics are vital parts not only of the community, but of making sure your tribe members get and stay healthy. This isn't an initiative in any way that's doing anything but reinforcing and supporting that. But also it's very important for folks to understand that the benefits to American Indians are to have zero cost-sharing plans through Covered California. That is a very big deal benefit. You're going to hear more about that later in the day and some of the details of benefit design. But it is a very substantial benefit.

So, writ large—these are issues that are specific across the nation and across California—what are the improvements the Affordable Care Act has done for the nation? First, I'd like to remind us that starting January 1, we are at a new era of healthcare for America. Up until now, when you look at the patchwork of coverage, we as a nation have not said, "Healthcare is a right." It's been a privilege. If you can afford it, or fit into a particular category, you get healthcare. That's changing. As of January 1, 2014, healthcare is now a right, not a privilege, and a number of things make that happen.

First, guaranteed coverage—that means you cannot be turned away based on your health status. The health insurance game of last year was insurance companies avoiding sick people. No more. So health insurance can never turn someone away for pre-existing conditions if it's in open enrollment. We'll talk about that. For people who get coverage and have coverage, no annual limits—huge. Rates are not based on health status. So outside of the tribes, the issues—when you look at how rates are adjusted, it's based on age and income. That's it. And where you live. But not health status. Large employers are required to offer coverage. That actually starts next year, 2015, not 2014. And individuals are required to have coverage. And if they don't, they will have a small penalty.

But the other element that's not on the slide that's very important, the number one name of the Affordable Care Act is "affordable." The other thing the Affordable Care Act does it provide financial support to make healthcare affordable. Based on incomes, sliding scale, financial support to all Americans can actually afford healthcare. So what can they afford? The Affordable Care Act actually lays out what are called "essential benefits." Ten essential health benefits. So whatever health plan you get will cover these ten standard things. They're the things you'd expect, which is not just outpatient care and inpatient care, but mental health services, prescription drugs, rehab. And every plan is covering the same mix of benefits. So it's not that, "Oh, I thought I had insurance." But then when I have to

get care, “Oh, that’s not covered?” All essential benefits are covered under the Affordable Care Act. Now, it’s a national standard but it’s implemented state by state. Our roster of how these are covered is specific to California. But basically, consumers can know, if you get coverage, it’s going to have your back when you need to get care.

Let me tell you a little bit about Covered California. The first thing I'd note is we are a part of the State of California. I report to a five-member board. That board is two members appointed by the governor, two by the legislature, and one is the Health and Humans Services secretary. That’s my boss, that five-member board. We aren’t part of the executive branch, so we don't actually report up to the governor. We’re an independent agency who have one job and only one job, which is to help expand coverage for people throughout the state. That’s our job.

Now, our board, over two years ago, established a vision statement and a mission statement. I think they’re both important to frame how we engage in what we do. The first element was to say that our vision is one of all Californians having access to care. That’s important when we think about the role of tribal clinics. It’s not about coverage; it’s about people getting care. And it’s not about coming through us. It’s about, wherever people are in the state, we need to recognize: How do we reinforce existing delivery systems? How do we be mindful of unintended consequences for that endpoint of care?

Our mission, though, what we do day in and day out, is try to expand health insurance coverage. We do that with an eye on two or three core things. First is affordability, to keep healthcare in front of people, it needs to be affordable. But it’s not just about the dollars. It’s about quality, in particular looking at disparities of care. Members of the American Indian community are hit differently by health conditions than are other parts of the community. Our board says that’s a core element of our mission, to look at how disparities of care play out across the state. It’s also, though, about giving consumers the ability to make choices that are right for them. So that’s our mission. We’re all about expanding coverage to California.

As I noted, we are state based. We’re a state agency. California was actually the first state, after the passage of the Affordable Care Act, to say, “We are going to do this a California way.” There are now 16 states and the District of Columbia that have said, “We are going to run a marketplace and implement the Affordable Care Act for our state.” So Oregon, Washington, Colorado. Now, 34 states have said, “You know, we don't really want to play. We’ll let the federal government administer the marketplaces there.” So when you all hear about the HealthCare.gov website not working, that is because 34 states said, “We aren’t going to make sure to take care of our citizens.” They left it to the federal government, in many ways without telling the federal government early enough they were going to leave it to them, so the federal government was left late in the process to figure out how to serve a huge sector of Americans. It wasn’t it for us. Over two years ago, we said, “We’re going to do it right for Californians,” and

we've been doing it for the last two years. And we've started enrolling people as of October 1. We are, as you'll see, a dotcom, but are very state run, and we offer private health plans.

So, what do we offer? Well, it's health insurance that is affordable. And you're going to hear some of the numbers later. It's premiums based on income, which means lower-income Californians get a huge leg up. Now, in particular, one of the other things California did—and this is not under Schwarzenegger and the democratic legislature that actually founded Covered California and the exchange, but under Jerry Brown and the legislature, is to say, "We, in California, will also expand our Medi-Cal program." So about 1.4 million Californians will get access to expanded Medi-Cal. About 2.6 million Californians will get access to a financial subsidy to help them buy health insurance. That's four million Californians getting financial help to make healthcare affordable.

You're going to hear more later about the benefit designs. But the thing that I would underscore is we spent a lot of time designing the benefits. What are the co-pays? What are the deductibles? The health plans through Covered California can't make it up on their own. They have to offer our standard benefit design. We designed the benefits to be about encouraging consumers to get access to care, not to have, what has historically been the case, sadly, having benefit designs being so confusing and so gobbly-gooky they actually deter people from getting care. So the designs are very specifically oriented to make sure that a consumer will get care at the right time, all the time.

Now, for American Indians, the benefit designs are actually not as significant because of the zero cost sharing. We'll talk more about that. But for non-American Indians that are out in the market—so when you talk to your friends, the issue of having standard benefit designs is a very, very big deal, because every plan has the same deductible. Every plan has the same rules. So consumes that are shopping can do apples-to-apples comparisons.

So what do we offer? There's 11 health plans available throughout the state, but it's different depending on where you are. Now, many of you are in tribes that are in relatively rural areas. In those areas, you probably are not going to have six health plans to choose from, as you would in Los Angeles. You might have two, you might have three, or you might have four. But across the state, there are these 11 health plans. And what you see among these plans is the biggest plans that serve the individual market today, plans like Kaiser Permanente, Anthem Blue Cross Blue Shield and Health Net, but also plan in some of the urban areas that are anchored in serving low-income communities, that have a history of doing that, plans like Molina, LA Care, and ValleyCare. You'll see plans that are anchored in their regions, plans like Sharp in San Diego area and Western Health Advantage in the Sacramento area. We went through a process to select these plans, being what's called an "active purchaser." We did not say, "If you want to be in Covered California, come on down; we'll take everyone." We said, "We're

going to kick the tires hard. We're going to make sure you're going to put in place systems to make sure people get care when they need it." And we ended up selecting these 11 plans, as well as 6 dental plans. The dental coverage, out of the gate, is only for kids. I noted those essential health benefits. There are two elements of essential health benefits that relate to pediatric care, to children. One is dental care and the other is vision care. Those are essential benefits for children. Now, this is not to say that dental coverage is not important for adults. But it's not eligible for the financial subsidies. And Covered California is going to be looking at adding dental in 2014, we hope, but we focused on getting started with our core offering, which is dental coverage for kids.

To underscore a couple of the elements that are special for American Indians and Alaska Natives, reduced or no cost sharing. This no cost sharing is saying instead of having a $45 office visit, it may be zero. And that's a very important, special set of benefits. Consistent care from community providers—now, we've done a lot of work to encourage plans to work with tribal clinics. I know one of the issues we've had, very clear and direct advocacy is not just to encourage but to require. That's not something we'll doing right now. It's something we'll be willing to talk more about. Our general philosophy, with the plans we contract with, is not to require them to do specific contracts with anyone. As you can imagine, this isn't just an issue with tribal clinics. We hear this with federally qualified health centers. A range of providers say, "You must require them to have us in." We've gotten a lot of encouragement and so far have not said "require." As soon as you say "require," what that means for negotiations, etc., makes things a little off kilter. But it's something we're happy to talk about more.

There is, for American Indians and Alaska Natives, special enrollment processes. I noted the issue about pre-existing conditions. For non-American Indians, open-enrollment period is a very consequential thing. So starting October 1 and going through March 31st, that is the period in which you cannot be turned away for a pre-existing conditions. That's the period during which you can get that federal subsidy. Well, for American Indians, the ability to enroll is year round. So it's a different rule on enrollment. And there is also an exemption from the tax penalty. So individuals—I noted the penalty for large businesses will take effect next year. But for individuals who have access to affordable coverage, they will be subject to a penalty starting in 2014. That penalty will be $95 or 1% of your income, whichever is greater. So if you make $30,000, you'll have a penalty of $300. American Indians are exempt from the tax penalty. But I would encourage you that a core part of our partnership with you is the penalty is not the issue. The issue is getting people into affordable coverage, and that's whether or not you're a Native American or someone else. There's talk about the penalty. People want and need health coverage. The real penalty is to actually need care and not be able to get it. And that's what we're focusing a lot of our outreach on.

So let me talk to you a little bit again about going back to the core element of affordability. I noted 2.6 million Californians will be eligible for subsidized care.

About 70,000 of those are members of your tribes. We would like to see every single one of them sign up to get their subsidized care. How does the Affordable Care Act make their care for affordable? Well, first my premium assistance, to lower the cost of what the premium is. And that is on a sliding scale. Lower income gets federal support that goes directly to the health plan people choose. Lower-income people, bigger subsidies. But also—and this is a very important element—it reduces out-of-pocket costs. These are specific benefits to the Native Americans and American Indians. So, if you're a federally recognized Indian and your income—again, there's different income points, but the basic point is 300% of poverty, which is about $34,000—then no cost sharing. So you'll hear more about the benefit designs that have when you pay $40 for a visit, etc. But if you make less than 300% of poverty and are a federally recognized Indian, no cost sharing. There's never any cost sharing for tribal members seen at tribal urban clinics. You guys know that. The other piece, though, for American Indians that are above 300% is they benefit from the sliding scale benefits of support and potentially reductions in their cost sharing.

The other thing we work on is to make sure it's all as transparent as possible. So this goes through the eligibility to help with the premium, to give you some sense that—the main thing that I would highlight—again, you have copies of these slides, and I'm not going to go through them—is I want to underscore that the Affordable Care Act is not a poverty program. First, access to Medi-Cal is expanded under the Affordable Care Act, with now clean and simple rules. There's no asset test. It's just income. That's it. But access to the financial support for subsidies through Covered California goes up. For a family of four, for potential eligibility, for a family that makes $94,000. That's a lot of money. And that's because the Affordable Care Act is about helping all Americans get access to healthcare.

Now, if you have healthcare coverage through your job, you might actually not understand how expensive healthcare is. It is expensive. The Affordable Care Act has not made healthcare cheap in America. What it's done is give millions of Americans a financial leg up that many of us who have employer-based coverage get through our job or get, when we get old enough, on Medicare. So it's just important to note that what the Affordable Care Act does is sliding-scale financial support—which doesn't mean it's free; lower-income people will pay a much smaller share and it can be virtually free or free to them. As you make more money, you're going to pay more.

The premium rates are very simple. There's not asset tests. There's not health screening tests. It's age. It's where you live. It's your household size. And then what you pick. So you can pick one plan that costs a lot because it's got a lot of benefits or another with less benefits. It's your choice. It's not based at all on health status. It's not based at all on gender. This is an issue and other states have actually dramatically different rates based on gender. California has not, but you'll hear people talk about ending the fact that being a woman is no longer a

pre-existing condition. For many states, that's the case. Rates will be much higher for women. It's crazy, to my mind. So it's very simple what the rates are based on.

So we've got what we think are very affordable products with the financial support. We then need to get out there and enroll people. I'm actually going to pause here and talk about something that's not on the slides, which is something that we need you in partnership with. Our success in the end is anchored in three things: Having affordable care, which we have; doing really good outreach, so every single person that is eligible knows about the benefits; and then smooth enrollment. Now, there's not slides on outreach, but this is where you come in. This is where we hope that you, going back to your tribe, will make sure that every single member of your tribe knows about the benefits, whether you communicate through email, through meetings, through Facebook. By the way, how many of you are on Facebook? Raise your hand if you're on Facebook. When you guys get back to your hotel room or get home, like us on Facebook. Over 100,000 Californians have liked us. And send that link to everyone in your tribe. We're out there on social. But the outreach is critical, and this is one of the core things we need from you. The benefits of the Affordable Care Act to American Indians are huge, but only if they know about them.

You help make sure all of your tribes know about them. What do we then do? Smooth enrollment. So let me talk to you briefly about enrollment. First, you'll see on our website at CoveredCA.com—which, I must say one more time, is working just fine—under programs and partnerships, there's a section for California's tribes that has material, background material you can get access to. We designed, right out of the gate, tools specific to your community. Also you'll see on here this "shop and compare." It's easy to find out what your plan benefits are, what they cost, based on your region. And we've done a lot to make it easy. So you'll see also, when you go and click on "start – get covered," information about coverage, a pull-down, one of the key things you can find out more about are American Indian tribes. We have taken a very concerted effort to have concrete information available that is specific, because the benefits are different. The benefits are specific. And the benefits are very, very big. Then you'll see resource materials specific to American Indian tribes.

The website is good. It's not perfect. But I will note—and I don't think there are reporters here, but if there are, this is on background—we actually survey everyone who goes through the enrollment process. 70% say it's easy to enroll. You hear a lot of horror stories about glitches and websites not working. 30% either somewhat difficult or difficult. I don't know how many of you did your taxes on TurboTax or had to fill out an insurance form. I find those difficult right out of the gate. The fact that we have 70% of Californians that have gone through the process saying it's easy is good news. That said, we think a lot of people need help from human beings. So there are five ways that you can help members of your tribe get help. They can go online. But they can call our service center. We

have, right now, 650-700 people trained, and we're actually opening an office in Fresno by the middle of this month, so we'll have like 800 people ready to answer the phone. If someone in your tribe is confused, give them the phone number.

We also, though, have certified agents. This is licensed insurance agents that have been certified to help people out. We also have certified enrollment counselors. You're going to hear more about the opportunities for tribes to have certified enrollment counselors to help people enroll. And finally, we work very closely in partnership with counties. So at every county in the state, the Social Service office has people trained to help people enroll. And it's very important to note that any of these work. There's no wrong door. All of them have been trained to understand the issues with regard to the American Indian community.

Some of the enrollment dates that I've already underscored are: First, open enrollment, which is a very big deal generally, ain't such a big deal for American Indians. But getting coverage is a big deal. So encourage people to sign up because they won't be able to get access to that specialist or those hospitals through a particular plan unless they're insured. So getting signed up sooner is better. But it's not limited to the open enrollment period, number one. Number two, and this is a very specific, different benefit than is there in general, is American Indians and Alaska Natives can change their health plan. Now, this is not the standard rule. I generally think it's a bad idea, because you generally want to have continuity of care. You want to get a relationship with a doctor, with a hospital, etc., but you have the right to change your health plan. Not three times a month, but once a month. But again, I'd encourage folks to think about their relationship with their clinicians in terms of keeping continuity of care. I noted we have a call center. It's open Monday through Saturday. We have [..?..] languages.

Now, I want to sort of do a quick review of what's coming down the track for the balance of today's consultation. My goal was to set up generally what's coming down the track and give you a basic orientation. But you have a very full agenda for the balance of the day. You're going to hear from experts in a number of the areas about issues, specifically plan management, what are the rules in terms of the health plans we're contracting with, what are the rules for access and the benefit designs? You're going to actually, after lunch, see a demonstration of the website to actually show you how it works and how the pull-downs work, etc. and a couple things that I would note in all areas—you're going to be hearing from us, but we do not think we are perfect by a long shot. The reason we think we're pretty good is that we've been listening to you for the last two years, you and others. And so as you go through the day, this is a consultation, so we'll be presenting information to you, but in the spirit of saying, "How do we improve this? How do we do a better job?" Because what we are doing right now is starting what is going to be the healthcare system of the next generation. We are, right now, midway through month two of an enrollment process for coverage that won't start until January 1. We are already spending time back at the office thinking about, "Huh, how are we going to change things for 2015, for 2016?"

Because what we are doing is truly historic. Just as 50 years ago we embarked as a nation on Medicare, we're now embarking on a system that's going to cover all Americans. So we will need to be nimble. We'll need to make adjustments. And the way to do that is to hear from you. These are some of the elements you're going to hear about throughout the day. I am worried about going over time. Mark, do I have any time to take questions? I do. I've got time to take a couple questions, but I'd remind you that looking at the agenda, many of the issues that I covered at a pretty high level is exactly what the rest of the agenda is going to get through. But I would welcome any questions or comments as we get going into the day. If you have an overall observation of how you think we've been doing in the last year, or how we can improve, I'd welcome that. And if you don't mind, reintroduce yourself.

MARK: For this agenda item, we're working with Peter until 10:15, so we have a pretty good time to talk with him. And then immediately at 10:15, we have to have Cynthia, the governor's tribal liaison, come on. She has to go back to a cabinet meeting, so the timing of this session is really key. So yeah, definitely you're welcome to stand at the mic. Introduce yourself, your tribal representation or tribal organization, and share your information.

MICHAEL: Good morning. My name is Michael Garcia. I'm a vice chairman for the Ewiiaapaayp Band of Kumeyaay Indians, and I'm also a board member for the Southern Indian Health Council. I just had a quick concern that I was asked to bring to you guys. I don't know if you're the ones that need to address it. Say, for instance, I'm a 20 to 25-year-old Indian male, no family, occasional work. What happens if I decide that I only want occasional coverage?

PETER: Well, you might be occasionally stupid, to be a little direct. Let me respond to that a couple of ways. The whole point of insurance is you don't know what's going to happy next. Let me actually distinguish two things. Again, I'm not an expert in Medi-Cal. How Medi-Cal works is if you're eligible for Medi-Cal and something bad happens—it turns out you're 24 years old, but you've got cancer. You go to the hospital. Coverage could actually be retroactive for Medi-Cal. It's not for the Covered California programs. So if you're young or old and say, "Oh, I've heard that a health plan can never turn me away, and I've even heard that since I'm an American Indian, open enrollment doesn't matter. So I'm great. I'll wait until something happens." They are taking a huge risk because what that means is to get into coverage, you need to complete enrollment. If you enroll before the 15th of the month, you can have coverage that starts the beginning of the next month. But after the 15th, your coverage will start the next month.

Now, if you think, "I'll wait 'til I have cancer and then I'll apply for coverage," you will have racked up a half-million dollars in bills. One of the things I'd encourage you—you often hear the young folks are the "young invincible." And I like to say, "Yeah, but they're not the young and stupid. If you show them what it will cost them to have coverage," even someone that's working some and then not

working some—that means they don't have much income, which means there's a huge financial support to make coverage affordable. So I think we need to educate them to don't be young and stupid. Thank you, Michael. Please, sir?

SILVER: Good morning. I'm Silver Galletto(?). Yesterday, CRIHB hosted a meeting and a lot of the tribal clinics throughout the state, north and south, met. We drafted a letter. We had tribes sign it. I'll just give you a summary of what it is.

"Dear Mr. Lee: We, the undersigned representatives of Indian Tribes Health Programs and Urban Indian Clinics and Indian Communities in California, do hereby request the decision makers of Covered California, to fully support and expedite the adoption of the tribal recommendations outlined in this letter. These recommendations are designed to improve the Covered California, system for American Indians and Alaska Natives, tribes, tribal clinics, Indian communities, and Indian urban clinics. We believe that the implementation and maintenance of the following recommendations by Covered California will enable tribal and Indian entities in California to better support and serve American Indian and Alaska Native patients and would help ensure that Covered California meets its unique obligation to Indian people in the state."

"Our first recommendation was to support the Definition of Indian Bill, recently introduced in the United States Congress, by issuing a letter to all relevant federal agencies encouraging them to also support this legislation. Our second recommendation was take a leadership role similar to the State of Washington's Health Benefit Exchange by mandating the qualified health plans offer to subcontract with all Tribal Health Programs and Urban Indian Clinics. Our third recommendation: Assist in ensuring Covered California's expedited and smooth adoption of aspects of the new state law regarding tribal Medi-Cal administrative claiming processing using the California Healthcare Eligibility, Enrollment and Retention System, CalHEERS. Fourth recommendation: Continue providing support to Covered California's Tribal Consultation Program. Implementation of these recommendations will result in expanded access to healthcare services for all Indians and increased revenue to tribal and Urban Indian entities. It is especially urgent to ensure that the definition of Indian is implemented to include a sizable population of Indians that the ACA was intended to benefit and protect. Increased access will decrease the morbidity and mortality of Indians in California. It is imperative that Covered California continue to convene meaningful tribal consultations and take action on requested tribal recommendations."

"We thank you and other Covered California decision makers for your attention to the issues outlined in this letter. We look forward to working with Covered California to implement and maintain support for the tribal recommendations within the structure of the state's health insurance marketplace. Should you require further assistance, please contact Mark." Then below we have signed by United Indian Health Services, Elk Valley Rancheria, Smith River Rancheria,

Yurok Tribe, Maidu Tribe, Greenville Rancheria, Santa Ynez Tribal Health, American Indian Health and Services, Inc., Santa Barbara Urban, Wiyot Tribe, Susanville Indian Tribe, Sonoma County Indian Health Project, the Cloverdale Rancheria, Tolowa Nation, Greenville Rancheria, Karuk Tribal Health Program, Ewiiaapaayp Band of Indians, and Riverside San Bernardino County Indian Health. Thank you.

PETER: Great. Thank you very much. I'll actually ask for an electronic copy, because one of the things I will do is not only take it myself, but share it with our board. It's good education and engagement for them, as well as engagement for us and our staff. I will, at some risk, respond quickly and immediately to quick reactions, working backwards from four up to one. We are very committed to this consultation process and will continue to build on what I think has been a successful consultation process. And it's not just the once a year, but it's ongoing the advisory committee I think has been vital, and we are very committed to that. The issue of tribal Medi-Cal—we partner very, very closely with the Department of Healthcare Services, which is the agency that implements Medi-Cal, and we're committed to continue partnering with them to make sure that Indians get all the benefits of Medi-Cal. But some things are their job, not our job, but working with them. We'll digest these in much more detail as well, but I'm just giving you a quick off-the-cuff so you can either say, "Are you crazy?" Or you at least know I heard you(?).

Third, working backwards, the issue of mandating participation of clinics with our plans—as you know, that is not our current policy. And it's something we'd review, but, quite honestly, my strong take is—I'm a data-oriented guy, and let's see how many plans have contracted without a requirement. Let's see where tribal members go without that requirement. Let's compare our experience to the State of Washington. That's my gut. We want to make sure that tribal members get timely access to care. That's the end we're looking for. So we're very big on measurement. We're very big on having information that we can use and review. In some ways, we have two states, Washington and California. And I talk frequently with the director of the Washington Exchange that each have a substantial number of tribes that have taken different approaches that I think are both philosophically the same. How do we make sure that tribal members get access to care and get good care in a timely way? We actually have an ability to sort of see how the different policies work out. We'll think more about this and absolutely engage in more discussion around it, but that's a leaning of where I am on that.

And the first issue is if this is support for a specific law that is being proposed—is that what this is? Is it a proposed piece of legislation?

MSPKR: Yes.

PETER: Covered California actually cannot lobby or take positions on bills. It's one of the things that we are supported by federal funds, and one of the restrictions on our activities is to not take positions on legislation. We do provide expert assistance in California to legislators that are working on legislation. But it's one of the things that we actually can't do. But we will look at this very closely and see if we can provide expert counsel and advice. But we cannot cross the line and actually take any specific positions on legislation. I very much appreciate the signers of this that spent the time and effort. We'll look at it with more care, but I wanted to give you my off-the-cuff on these. Very fruitful and appreciate your time on those, so thank you. Sir?

DANNY: My name is Danny Jordan. I'm from the Hoopa Tribe, Northern California. I can just tell you that any time anybody comes to us and says, "We're here to help," coming from Hoopa, we say, "Trust but verify."

PETER: Absolutely. You should. I'm a big believer in trust but verify.

DANNY: We're in that mode right now. But we're looking at this Affordable Care Act from really a couple of different perspectives. We have Indian Health Service programs, 90% of our employees are Indians entitled to Indian Health Service benefits. But they're also covered by the tribe's self-insurance program. Now, we're self-insured because we're sitting way up in Northern California, and not too many people or insurance companies are interested in traveling up into the mountains and insuring a tribe that's sitting up there all by themselves. So we have evolved into this self-insured status, and we don't know how to break that without going back into the same problems we had before we got into self-insured.

But my point is, we were looking for the trapdoor in the Affordable Care Act. We haven't found it yet. We see all upside, especially where we fit in as an employer, as the Indian Health Service program. Now, unless the Affordable Care Act benefits end up being reductions in Indian Healthcare Improvement Act budget, we have a concern about that. That should never be allowed to happen. But that's not what's on the table yet.

So my question is, and kind of the landscape of this meeting today—we are looking at it from multiple viewpoints, from the Indian Health Service program benefit—can and obviously will, the Affordable Care Act will actually be an enhancement of funding for tribal clinics. But as a self-insured tribe, we also provide insurance to our employees, 90% of which are Indians. Where do we have this discussion? When we look at it—and this is a discussion we're having back at Hoopa. When we look at all these options now, the tribe's insurance, the unemployed individual that now has options under the Affordable Care Act, the Indian Health Service money—this is a matter of us organizing for the benefits as opposed to trying to find problems with it. My question is: Are we going to have

that discussion here today, the tribal governments as employers? Because this has got some interesting things for us.

PETER: I'm not sure. I don't think that's on the agenda, but I would actually encourage you to organize yourselves around those tribal governments as employers. Where I would turn, if I were you, is to your brokers or agents that help you structure your self-insured program, and have those of you tribes that have self-insured programs together say, "How do we sort through this?" Obviously, you've done some of that tire-kicking, so to speak, and I totally applaud your note of "trust but verify." And along those lines, I noted at the beginning, this is a huge change to health insurance in America. There will be unintended consequences. So the fact that you're reviewing these in great detail, including looking at: How are you making sure that tribal clinics are not undercut? Right thing to have an eagle eye on. Absolutely.

The specifics—I don't think the conference organizers have breakouts of tribes as self-insured employers, but I would strongly encourage you to have those discussions. You're absolutely right. And also, if and when you find trapdoors, so to speak, let us know. Writ large, there are elements of the Affordable Care Act that are far from perfect. There's elements that Congress should revise in future years when they start becoming functional—that's Congress, which may be a long time. But we're now implementing the law, which means there will be opportunities to do cleanup. So I would encourage you to think about issues that are, as you say, trapdoors, that may be in the law or may be in how it's implemented. And we'll partner with you on either of those. Thank you very much. Sir?

RICHARD: Richard Mechas(?), San Pasqual Band of Mission Indians, San Diego, California. The CFO of the tribe, I'm charged with getting insurance for our tribal members. We have 206 tribal members. So we're considering a group health plan. I was on CoveredCalifornia.com, and your insurance plans are very attractive. They're affordable and there's a lot of selection.

PETER: Let's just stop there then. I'm just kidding. Sorry.

RICHARD: Getting a group plan is more expensive because tribal members, they're older than an employer group, and they have health problems, and it's more expensive to buy for the tribe. I'm wondering, is it your advice that I should have my tribal members enroll in CoveredCalifornia.com? The plan look great. Or is it just—are they going to have enough physicians that are going to be able to take care of them? Or should I take the safe, easy route and enroll in that group insurance plan that's very expensive, and I know that they have carriers because they've been doing this for year—Anthem Blue Cross, for example. I know they're on one of the insurers here, but I'm just worried that I'm not going to have real coverage for these individuals when January 1st comes around, and then I'm going to get

terminated because I recommend CoveredCalifornia.com and it didn't come through for me. [laughter]

PETER: Well, two things. One, the two of you should talk. The issues about how you as employers offering group coverage—there's a range of issues.

RICHARD: It's for the tribal members.

PETER: Both for members or—the issues are the benefits and pros and cons of group coverage, whether it's for employees or tribal members. They're similar issues. I would say, by and large, the concerns you raised I would toss right out the window, quite honestly. So let me go through a couple of things. The health plans that you can get through Covered California and in the San Diego area are the best plans in the market. For instance, it's Kaiser, it's Blue Cross, it's Sharp. I think Health Net's down there. I don't have 'em all memorized, but you know them; you've looked at them. And the networks that they have of physicians, I want to note, is most of them—with regards to the network, they cannot be on our shelf if they don't have enough doctors to take patients today and if they don't have enough doctors across the full range of specialities, that if you have something that goes really bonkers bad, you're gonna get to the best specialist that you need to get to. There's been a lot of brouhaha around, "Are there networks? Is it second-class care?" The networks that we contracted with were to assure that every plan on our shelves has doctors today ready to take patients, has hospitals in reasonable distances, etc.

I think that the concerns you've addressed wouldn't be the concerns that I would have. The same plans or better. Maybe not the exact same networks. So the thing I'd counsel you to is some of the health plans have different networks for their group products than they do in the individual market. The issue of, how big is the network and what's that work? That would be a factor to look at. But I'll tell you, we are going to be on it like a dog on a bone making sure that every plan in Covered California provides accessible, ready access to doctors when patients need them. This is another area where the issue of trust but verify—I love that note—is I hope and expect you'll work to hold us to account. Before they fire you, they should be firing me. We're out there. Our vision is people getting care. We will be looking at this all the time. If it appears that a plan can't handle more patients, we'll shut that plan down and say, "Sorry, we aren't going to sell more business to you until you get your stuff together and add more physicians." We are quite confident that all the plans will have a solid network of doctors. Thank you, sir.

JESSE: Jesse Montoya, CEO from Riverside/San Bernardino. You were talking about how people have been going to the website and enrolling, and 70% really get it and the 30% don't get it. I just want to indicate that I'm going to be talking briefly about the 30%.

PETER: Great. That's what we learn from. I love that.

JESSE: So one of the things is we sent nine staff people to the training in Temecula, the southern part of California. What our staff came back with were some concerns, and so they outlined those, questions and concerns I'll give to you and your staff here today. I think the biggest issue that came out of it was that while the people maybe understood the program, they really didn't understand what the ramifications were or the linkages to the Native American community. So they didn't understand the waiver process. So our staff put these questions together. I don't think they really understood that. Now, I know CRIHB is going to be offering classes, so we're going to send some staff here. But for us to send nine staff up here as well is somewhat problematic that we still do it for the certified enrollment counselor program.

But just to give you a sense of it—and I don't want to take a lot of time—does the Native American exemption apply to enrolled tribal members? Are Native American descendants going to be exempt? How do Native Americans prove that they are Native Americans if they're not federally qualified? Will there be a class through Covered California offered for Indian programs only? Which we know CRIHB is going to offer that. Are the Native American programs going to provide services to outside non-Natives? Some of the reservations have stations where you can't actually go on the reservation unless you have some specific business or you're actually a patient of our system. Are California State recognized tribal members exempt from signing up? Will gaming revenue be considered as part of income? When applying for Covered California, do the plan automatically include dental and vision? It sounds like you talked about it's going to be covered for children, so we can take that back, and I'm sure we'll spend a little bit more time on that. And then, Riverside/San Bernardino County Indian Health System has not been contacted by any of the insurance plans in our area.

So I just wanted to share that these are some of the things that came from our staff. Now, the other thing that came up in our meeting yesterday is that when some of us have contacted our Social Services Departments with the various counties—and there are 58 counties in the state—they may not clearly understand how this program will apply to Native Americans. I think there's been a lot of work done, but I think there are some areas that your staff will want to take a look at.

PETER: Let me actually just quickly go through. The answers are: yes, yes, no, no, yes, no, and we're working on it. These are great. I appreciate the questions. The thing that I would note—there's a couple. One, we've been working in very close partnership with CRIHB. But also, one of the things to recognize is that, on the one hand, we've been working for a couple of years. One the other, two years ago, when I started at Covered California—David how many of us were there, seven people? And we've been getting up to speed very quickly. And part of getting up to speed very quickly—back to my absolute ownership of

imperfection—some of our training has not been as complete as it should be, and we're doing catch-up.

For instance, we're developing, as part of what we are calling In-House Covered California University. Learning is an ongoing thing, including developing new materials. And we're developing fact sheets not for consumers so much, but for people that work in the 58 counties, for the certified enrollment counselors. And one of the things we have track, and we'll work with CRIHB on this, is a fact sheet on issues very specific to exactly these sorts of questions. Again, not so much for consumers, but for enrollment counselors, people on our phones. I can tell you, we've got a great staff answering the phones. And my bet is if you asked all of these questions, or selected five of them, you wouldn't get the same answer from every single person right now, today. So we need to work on that, and that's one of the things we're doing as part of our improvement. So you flagging these questions is incredibly helpful, and we appreciate it.

KATHY: Hi, I'm Kathy. I'm from Redding Rancheria. Just as kind of an FYI, I met this week with some local people in Shasta County. From what we were being told, the two plans that are offered that far north, one of them is on the website and it hasn't even been approved by the State of California yet. So how can we build trust if that's the case and if that's what we're being told. So we have Blue Cross and Blue Shield, and I can't remember which one was which now. But one of them says it's one there but they're still not totally approved, so you can't see the benefits and the details behind that plan. That causes some trust issues there.

PETER: I'm very confused by that because both those plans are licensed and approved.

KATHY: By the state?

PETER: By the state.

KATHY: Okay, because that wasn't what we were told, and so that—and just to let you know, Social Services, insurance agents, and certified enrollment counselors were all in that meeting, and they all were telling us the same thing. So you just might want to look into it.

PETER: Okay, we absolutely will. And this is a great example. Shasta is a rural area and is one of the few areas that has two plans that are part of what's being offered. San Diego would have four or five, etc. But absolutely it's my understanding that both are approved by, in those cases, the Department of Managed Healthcare, are up and running, have standard benefits, have contracted clinicians, etc. I would also note—and one of the things that I—and Leah will speak to this some more. If your tribal clinic has not been talked to at all by a health plan, I'd like to know that. Let Leah know that instead of me. But this is one other thing. Back to the note of right now we are not requiring, but we're doing a lot of encouragement. And we have done matchmaking, saying, "Have these discussions. Work

together." So the note of saying, "No one's reached out to our clinic yet," we like knowing that and we want to know that. Leah will speak to that some more when she talks about some of the network and plan-related issues.

MSPKR: When we had our advisory meeting, we brought that up about six weeks ago that we had not had any outreach, and we still haven't had any outreach.

PETER: Okay. Again, we are a constantly improving organization. Six weeks ago was October 1st, which was kind of a busy time for all of us on lots of issues, so I'd appreciate—continue to write us and provide suggestions. But also in the frame of what's happening generally, which is a lot. With that, Mark, I really appreciate you having me here and joining us in this process. Because, again, our success is your success. Making sure your tribal members get access to timely care. That's what we look forward to working with you together on. So thank you very much. I hope to come back at the wrap-up time today. But if I don't, I really appreciate being here now. Thank you. [applause]

MARK: Thank you, Peter Lee, for providing those opening remarks. And thank you, tribal representatives, for working to stick to the timeline. One of the things that we've taken note of over the course of the last several years in working with Covered California, a lot of the tribal reps are very enthusiastic about this work, about the leadership of Covered California to work collaboratively with the tribes and the clinics to ensure that Indian patients in California, all of them, have access to affordable healthcare coverage. As we're working together, the tribal reps, we sit around and we talk and we contemplate and we figure out, "What we can do to assist Covered California?" Certainly, Peter, you've been instrumental in this partnership.

One of the things that the tribal reps noticed is that, well, Peter's working quite well with the tribal representatives, and he wants to work with us going forward as well. And so some of the tribal reps said, "Well, then he has a couple of choices. One, if he wants to continue to work with tribal reps, one, he either needs to grow long hair—"

PETER: When I was younger, it was down to here.

MARK: Like many of the tribal fellows have, or two, he needs a necklace. So, Peter, the tribal reps give you the option of whether or not you'd like to grow your hair long—it's up to you. [laughter] But certainly under tribal custom and Indian law, you're not allowed to not accept this gift. So, on behalf of the tribal representatives in this room, my particular tribal advisory committee, the California Rural Indian Health Board leadership, we present this necklace to you, Peter Lee. [applause]

PETER: I am so touched and honored. We'll see. Next time I see you, we'll see how long the hair is. But you'll definitely see this necklace on when I see you next, and I

am so appreciative. The spirit of partnership and doing this together is very dear to my heart. And it's something that clearly you have passion for. That we share. So we're on this road together, and I very much appreciate this, Mark. Again, I want to say thank you to Jim. I know Jim's still on the board, and everyone's going to retire now, but it's really been such a pleasure working with both Jim and Mark. You've got good leaders to partner with, and we look forward to working together with you. So thank you very, very much. [applause]

MARK: Next, it's my privilege and honor to introduce Cynthia Gomez. She is Governor Brown's tribal liaison. She is a citizen of the Tule River Tribe. So without further ado, I'd like to call Cynthia forward to please provide some additional opening remarks on behalf of Governor Brown. [applause]

CYNTHIA: Good morning. Good morning! I know there's Starbucks out there, and that Starbucks is really some potent stuff to keep us awake. First, I want to say thank you for having me here again. You probably get tired of me sometimes showing up, but I'm always pleased to be here because it gives me the opportunity to listen to what the concerns are when I'm able to attend. And also it also gives me the chance and the opportunity to thank all of you. Because, quite frankly, the healthcare in our Indian communities would just not be where it's at, or improved, without all of you out there working so hard and being the front people in our communities to better healthcare. So I'd like you to give yourself a hand. [applause]

I know Jim Crouch has retired. I've said this many times, and he has been a very esteemed leader in our health services in Indian country. And I am so pleased to see that he is continuing to work with Mark. I know Mark's going to be a fabulous director. I've worked with him for the last couple of years. He's very thoughtful. He's very articulate. And he has the passion to improve healthcare in our Indian communities. That's one of the main ingredients we need when we have leaders in our tribal communities.

I'd also like to give recognition to our honorable tribal chairman, vice chairman, and council members. Would you please stand? I know we have a couple here. Excellent. Thank you all for making the trip. [applause] Sometimes our state leaders don't recognize that the amount of work and responsibilities and obligations that you have at home. And so coming to a session like this is pretty significant, because it takes you away from all the other duties that you have at home. So I'm really pleased to see that we have as many tribal leaders here as we do, particularly because it's a consultation session.

I also want to give recognition to all of our esteemed health professionals. And I know many of you out there have been doing this for a long time. Without your dedication and your passion and your commitment to your own tribal communities, we just wouldn't have the kind of healthcare that we have today. We have come a long ways in our healthcare.

I grew up on the Tule River Indian Reservation. Some of you have heard this story before and say, "Oh, there she goes again." But I've gotten to that status where I get to tell my walking in snow ten miles position, you know? But really, I grew up on the Indian reservation, and we didn't have a health clinic when we first started. I remember our family having a lot of healthcare issues, without having the ability to get the proper healthcare. And some of that had some long-lasting effects. The first clinic we had was up in our adobe building that we used for a chicken coop and storage and everything else. And we had to clean it up real good. And we were just thankful that we were able to have a physician come up once a month. So we've come a long ways. I went home a couple of weeks ago, and I went over to the Tribal Health clinic, and it's a beautiful building. There's wonderful healthcare, and a lot of dedicated people to make sure that there is that healthcare for our people. So I'm really pleased to see the improvement over the years.

Governor Brown signed Executive Order B1011 back in September of 2011. It did a couple of things. One, it created my position. The other thing it did, it gave not only permission but mandate to all of our state agencies to do a better job in communicating, consulting, and collaborating with our tribal communities. And that's what I see happening here today. I was here last year, when you had your first consultation session, Covered California had their first consultation session. And I was very pleased to see the kind of turnout we had, the comments that we had, and the response that we had from Covered California. And, quite frankly, I heard from a lot of you that were at that first consultation session, and many of you said, "You know, you need to make sure that this kind of consultation happens in other agencies, and we need to have this kind of consultation happening in other areas of California. And that's one of the things I'm trying to make happen. I just want to applaud Covered California for your efforts to do a job that has been well received to improve health services as well and get that coverage out to our tribal communities. So thank you very much.

I received an email a few minutes ago, and it was from Herb Schultz. Apparently, there were quite a few health clinics that were just announced being funded for additional funding to help with the effort of doing outreach for tribes and other health clinics to [..?..] culturally competent, quality primary healthcare services. I couldn't bring up the list, so I don't know who was actually funded or not. All I know is that there were 46 health clinics that were funded with over $30 million dollars. That's to help cover the 42% of our three million people in California that are uninsured. I was really glad to see that happening, that there's still an effort to get more funding into California, to make sure that we continue this effort, that we have a good program and we improve the services. So I applaud all of you.

Before I go, I also want to introduce someone who's very important to me. She is my chief deputy. Heather Hostler, would you please stand? [applause] Heather is from the Hoopa Indian Reservation. I hired her about a year ago, almost to the

day. And it was one of the best things I ever did because she keeps me sane, and that's why she's so important to me. But she actually helps me out with quite a bit of the research and all of the duties that we have in our office of two. She's going to be here the rest of the session, and we'll collaborate later on to look and see if there are things that not only we could be more aware of, but also if there's something that we're going to be charged to do in our office. And we'll also check in with many of our leaders, as well as CRIHB.

Thank you very much. I wish you a wonderful consultation session. I'm glad that you're all here. I wish you a safe ride home as you make your way back to your communities. Thank you. [applause]

MARK: Thanks, Cynthia. I know you know this, but it's really very helpful to know that you are in the governor's office, there for the tribes, the tribal clinics, and the Urban Indian Health clinics as well. We're very pleased to also work with Heather Hostler in similar regards. Your leadership in the tribal office there definitely assists in the healthcare arena, and I know that you're tasked with multiple other issues, education, housing(?), Department of Corrections, so on and so forth down the line. So the fact that there are two staff that are working in all of those agencies and all of those departments and all of those offices, working to ensure that consultation is carried out—I just want to thank you for your diligence in that effort. And also express to the folks in the room that I believe that the governor's tribal liaison office needs our support. Maybe our tribes could send resolutions and additional(?) support staff. We could maybe talk about that on the side. I'm sort of moving into the advocacy realm, but I'm not supposed to do. There I go again, being an advocate.

That being said, I am equally pleased and honored to introduce Vicki Macias. She is an outstanding Cloverdale Rancheria representative. She is one of our leaders on the Covered California Tribal Advisory Committee. Vicki wears multiple hats as well. She also serves on the California Rural Indian Health Board of Directors. Ladies and gentlemen, without further ado, I give you Vicki Macias to provide the tribal report on Covered California. Thank you. [applause]

VICKI: I was trying to make them hurry so I could say what I wanted to say before Mr. Lee left. I'm a little bit stupid and I am a little bit crazy, but the first 45 minutes actually felt like a consultation because we had dialogue back and forth. No offense to his people, his staff; it's just sometimes when we have that back and forth with the person who can make the decision, it makes us feel like our presence here is worthwhile. I wanted him to hear that, but he walked out the door. That's as Cloverdale Rancheria, because I have something to say from the advisory.

I was lucky because I came to the meeting today. I'm taking the spot of someone else. I'm not a reader, just so everybody knows; I like ad lib. They have something very nice here that I want to report. On behalf of the Tribal Advisory Work Group

to Covered California, we want to welcome tribal leaders, Indian Health Program representatives, as well as leadership representing the State of California to the Second Annual Covered California Tribal Consultation.

We are fortunate to have established a positive partnership with Covered California under the leadership of Peter Lee. I want to thank him for his guidance in ensuring Covered California develop a tribal consultation policy to guide the organization's work. Tribal consultation is paramount to ensuring successful government-to-government relationships. In a presidential memorandum in 2009, President Obama issued the following statement: "The United States has a unique legal and political relationship with Indian tribal governments established through and confirmed by the Constitution of the United States, treaties, statutes, executive orders, and judicial decisions. In recognition of that special relationship, pursuant to Executive Order 13175 of November 6, 2000, executive departments and agencies are charged with engaging in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications and are responsible for strengthening the government-to-government relationship between the United States and Indian tribes. History has shown that [..?..] include the voices of tribal officials in formulating policy affecting their communities has often led to undesirable and at times devastating and tragic results. By contrast, meaningful dialogue between federal officials and tribal officials has greatly improved federal policy toward Indian tribes. Consultation is a critical ingredient of a sound and productive federal/tribal relationship."

Unfortunately, in the State of California, we can cite examples where tribal consultation has not occurred, and our Indian people have suffered. For example, the federal termination of over 30 tribes occurred without proper and adequate consultation with tribes. This has lasting devastation implications of our Indian people. On this issue, tribes have worked to right these wrongs and hold the federal government accountable for its actions in solving this problem to the benefit of tribes.

In 2012, tribal leaders met with Covered California staff and made the following recommendations: Create a mechanism to identify qualified Alaska Native and American Indian—we're used to just saying "Indian people." We don't distinguish because you're from Alaska, you're different. I just wanted to point that out. But for your benefit, we're going to use American Indian and Alaska Native. See why they don't really let me read? [laughter]

I am pleased to inform you that this mechanism is currently in the system and will be demonstrated by Covered California [..?..]. Develop a payment system to set up up-front group payment mechanism, similar to the mechanism used by some tribes to enroll members in the Medicare prescription drug program. This capacity has not been built, nor are there any Covered California regulations yet. Tribes are

looking forward to working with Covered California to develop this payment system.

Three: Create a mechanism to ensure qualified American Indian and Alaska Native that the appropriate cost-sharing calculations are built into the system. I am pleased to inform you that this mechanism has been built into the Covered California system. However, there are outstanding issues surrounding households that include members of federally recognized tribes and non-members termed "mixed households." Tribes are looking forward to working with Covered California to resolve these issues.

Four: Ensure the Covered California system will identify and exempt certain types of Indian income that under the Affordable Care Act should not be calculated into the gross(?) income. The Tribal Advisory Work Group has not seen the system to know if this is sufficiently addressed. We have reviewed the paper application and aware that the appropriate income questions are addressed. We are looking forward to continuing to work with Covered California on this part of the system.

Five: Covered California needs to facilitate full participation by Indian Health clinics, tribal clinics and urban clinics, and covered programs, including designated ITUs as essential community providers. Covered California needs to maintain openness to modify network contract terms to accommodate the unique circumstances of the federally created ITU system. The issue of ITU as providers remain and outstanding issues. The Tribal Advisory Work Group has addressed this issue at length with Covered California and will continue to recommend Covered California mandate the qualified health plans offer contracts to ITU in California.

Six: [..?..] to include tribal and Urban Indian entities as navigators in the exchange. The work group looks forward to working with Covered California in the implementation of the navigator program.

Seven: Covered California needs to provide planning, implementation outreach and other grants to tribal organization. Covered California issued a request for proposals to develop a tribal community mobilization program. This request was responded to by California Rural Indian Health Board and has been successfully awarded to CRIHB.

The Tribal Advisory Work Group is pleased to report that several of the tribal recommendations submitted to Covered California in 2012 have been addressed. However, there are some outstanding issues that have been brought to light by the work group, as well as other tribal leaders. The Tribal Advisory Work Group has convened four meetings in the last year and addressed various issues concerning unique Indian provisions of the Affordable Care Act as they apply to Covered California. We look forward to working with Covered California to work towards

evaluating the health issues of all Indians in California. And I apologize—I'm not a reader. That's that little bit of stupid and craziness of me. I like ad lib. I like to talk to the people, you know? Thank you guys for being patient. [applause]

MARK: Thank you again, Representative Vicki Macias. That's really an integral part of this partnership we're doing, to have a representative who serves on the Covered California Tribal Advisory Committee provide a report out to all of the tribal representatives that are in this room, noting issues, working to resolve issues, so on and so forth. So thank you for providing that official report.

Next we have on the agenda at 10:45 sharp—we're a little bit early—Leah Morris, and she's going to provide a presentation on qualified health plans. We've talked a little bit about that this morning, quite a bit about it yesterday afternoon. Is Leah read to come forward and present the material? Without further ado, I give you Leah Morris. [applause]

LEAH: Well, thank you for having me here today as part of the Covered California team. I also wanted to point out a couple of other folks on the Covered California team. Molly Tamashiro, here in the front row, sitting with me, is our plan management liaison to the policy team, who works with all of the issues regarding Native Americans and Alaska Natives. She's happy to also be here today and gather information and learn your questions. I wanted to also point out that though Peter has left, there are other people here today who are senior leadership at Covered California, David Maxwell-Jolly for one. So we are still here, present to hear all of your concerns and issues. Peter will be back later, but you definitely have the attention of Covered California.

So I am with the plan management team. My name is Leah Morris. And I'm also a provider. I'm a nurse practitioner, and I work a couple of days in hospice. So I am not always at Covered California, but I do my best to keep in touch with you all and understand questions and concerns. But that's another reason why Molly is here today, to make sure we stay on top of your questions.

As you know, there are 11 health plans that are now under the relationship with Covered California, called "qualified health plans." You may hear me use the term "QHP." That's sort of our in-house shorthand for these 11 health plans that you have the opportunity to potentially enroll in, depending on geographic region where you're located.

FSPKR: Do we have that in our packets?

LEAH: I'm going to get to the interactive part of the presentation. Thank you for the question. We'll get to that in one second. And I appreciate the fact of not just being a reader. I'd rather have us talk together. Let me just hit a couple of points here. As we've talked about quite a bit, the idea of affordability is important, the idea that there are no or low-cost health plans available to your communities is

important to us. We also want to talk about access to care, that having enrollment into these local and statewide plans is a way for us to have statewide health insurance companies that offer approved networks. You asked about something in Shasta. All of the networks have been approved by the regulators, Department of Managed Healthcare. So if there are specific questions, we should probably follow up on that and make sure we understand what your specific questions are. But those plans have arranged a network of providers that includes medical specialists, includes hospitals, includes other services that have been approved. So if you have questions, we need to make sure we follow up on those.

Also, coordination—I want to point out that these plans have committed to coordinate care with your communities, with other facilities, with facilities outside of your region if that's necessary, if there's a need for care that's possibly at a tertiary medical center or a high-specialty type of service. Those plans have committed to coordinate care with all of the enrollees.

I want to start to get us some really concrete information about how this program is working and the health plan relationship. It's important for individuals to understand that there are what we call 19 grading regions. So if you look at this map, you might start to look at where you're located, where your clinic may be located, and understand which region you're in, because that is important for understanding which qualified health plan is available. I'm just going to take your attention to Region 3, the blue region in the middle. That's where we are today. That's the Sacramento, Placer, El Dorado and Yolo County region, so it's a four-county region. You're sitting there right now.

And here's the interactive portion. You all should have at your chair a copy of the health plan booklet. I'm going to ask everybody to take a look at that health plan booklet and turn to page 12, where you will see Region 3. Now, obviously, I'm just talking about where we're sitting today; later you can look up your own region of where you are. But if you look at Region 3, you see that the health insurance plans that are available in that region are Anthem, Blue Cross, Kaiser Permanente, and Western Health Advantage.

I noticed the Chapa-De folks were introduced earlier. I know also that there's Sacramento Native Indian Health on J Street here in Sacramento. These are the health plans that you would want to be focusing on talking to, in terms of which networks are being offered to the residents of your area. So as you're learning about what might be an opportunity to talk to a health plan. Be sure you take a look through this book and make sure you understand which plans are offered in the area where you're serving your clients.

The term was brought up a little bit earlier about "essential community providers," or ECPs. The concept about coverage for people who are medically underserved, low-income individuals. The Affordable Care Act set a requirement that qualified health plans would include these essential community providers to

serve predominantly low-income, medically underserved people. In the ACA, there was a reference to 340(b) providers. Some of you may be familiar with the 340(b) program. It's a program that sets up some subsidy for pharmaceutical programs, some discount subsidies. Entities that qualify under the 340(b) program are non-profit entities. So that was a starting point for what would be considered an essential community provider.

In August of 2012, the Covered California board adopted a policy that expanded upon that definition of 340(b) in terms of essential community providers. We looked beyond, into other types of providers that might be serving the low-income, medically underserved population. And, in particular, we identified very specifically the Tribal Indian Health Programs and the Urban Indian Health Programs. I'm going to say that for the most part those entities are 340(b)s, but we felt it was important to specifically identify those types of providers as essential community providers so there would be no confusion about whether we understood their relationship to serving the low-income, medically underserved population.

Jill Marden(?), I think who might've just left the room, was critical in teaching me about the different clinics and the different provider names and addresses and how we could list those providers. We made sure that we were comprehensive in understanding [..?..]. You'll see a document—yours is blue; mine is green. This is what we believe to be a comprehensive list of the Native American Alaska Native clinics throughout the state. We'd ask you to take a look through this and give Molly any corrections. We worked on this with Virginia, I believe, and we've tried to make sure we have a comprehensive list of contact people for each of your different sites and your satellite sites. So please take a look through this and let us know if we have any mistakes on this document.

In our essential community provider discussions, we required a few things. We required that each of the networks would have 15% of those 340(b)s in their networks. We also required that they had to demonstrate an array of types of providers. So it couldn't just be a couple of hospitals. They had to have clinics. They had to have other providers who were available geographically in the region. And we did also require that they had at least one essential community provider hospital in their network. The list of hospitals was part of the 340(b) list, and we also turned to the California Disproportionate Share Hospital list, the DISH list that's maintained by the Office of Statewide Health, Planning and Development. Some of you may recognize that list. There are a few hospitals on that list that are not 340(b) providers. We wanted to be sure that we included providers who see the low-income and medically underserved populations.

So what have we done in terms of working with the Native American community and trying to facilitate and support contracting with your providers? As I said, with Jill Marden's help and folks from CRIHB, we specifically got a list of the Tribal and Urban Indian sites and we included that in our solicitation that went

out last November so that when the health plans were bidding—there were 33 plans that bid—they all had the information about the health centers that were part of the ECP program. Since that time, I personally, and Molly, have distributed this list to our qualified health plans to engage them in contracting with the Native American health centers. We've twice distributed this list, along with the addendum, and encouraged those different clinics to understand the addendum and to use the addendum in their contracts, if they're looking at different relationships, and to under how the rules apply to them in terms of the Native American community. As I said, we've also twice distributed the addendum. So we're trying to learn together about some of the rules that might apply and working through some of the information that the addendum helps clarify, in terms of payments, in terms of requirements around malpractice insurance and the fact that there is not a requirement for that. The fact that some of your providers are licensed in other states; they come to this state so that they don't have to have a license in California [..?..]. So we're trying to make sure that we work with those health plans to understand some of the special attributes of your provider offices.

We also invited some of your representatives to a meeting in September that we held with our health plans. At that meeting, we had the chance to talk about some what I'll call "pithy" issues related to provider relationships. The topic of grace period and the topic of provider network adequacy and essential community provider relationships came up. We had a discussion with our qualified health plans about these issues, who qualifies to be an ECP and why an ECP is important. That's not the first or last time we will talk to our plans about that, so more down the line.

We also asked our qualified health plans to provide us a list of contracted clinics so that we could put it onto our provider director, when the provider directory is ready to be populated with clinics and facilities. Some of you are aware of the online provider directory right now. At the current point, it's listing strictly physician names on the directory. There have some of those [..?..] about some of the things to get loaded on our provider directory, and we are definitely working through and trying to improve the online provider directory so that we'll list clinics and other facilities. We've asked for the health plans to give us that information, which is another way of putting pressure on the health plans to look to your facilities and work with your facilities.

A couple of things about what we might be able to do together to improve contracting, because there are some concerns, and we've heard them today, about the idea about needs for contracting between your clinics and our health plans. Before we leave today, we have a list of contacts—I call it "the grid." I put together a grid of qualified health plan contacts, and we'll hand it out today before you all leave, but I'll just pull it out here and give you a quick visual. It's on a Covered California memo format. We will distribute it today at lunchtime. This is going to give you the name of the person at the health plan for you to contact and

talk to about a contract. Again, I would ask that you go back to the booklet, look at your region, understand which plans are serving your market, and then contact the individuals in this list. I will also say that I have spoken to all of the individuals on this list about working with you and putting contracts in place, and would reiterate what Peter said: We want to hear from you whether you're having any questions or concerns in reaching out. I've talked to a variety of the folks about doing such a thing as a conference call with the clinic and the health plan representative if you're having trouble getting in touch with one another, and I've had commitments from each of the plans to engage in discussions with the Native American and Alaska Native clinics. So we want to move forward with that.

Another thing that we are learning about, or I am learning about—and Katie Ravelan and Jessica Abernathy(?) are really helping—is we are learning more and more about what the out-of-network relationship is. So we heard earlier today that Native Americans can continue to get services at the clinics that are in their communities, and there is not a problem with that. So at this point, if you don't have a contract and that's an out-of-network service, we need to work with our qualified health plans to understand: What is their responsibility to you, for a member that's enrolled with one of them and goes to one of your clinics, and you're an out-of-network clinic? Obviously, the member is entitled to go there. We need to make sure that we educate our health plans about what's expected from you all in terms of referral to other services, in terms of compensation, in terms of any authorization for procedures, etc. So we've got some more work to do on that. We look forward to you all teaching us a bit more about your expectations in that arena.

The provider directory is going to be an ongoing thing. I want to set expectations here. The online provider directory is not going to be fixed in a couple of weeks. So please understand and work with us, as we are working to reprogram some of the aspects of the online provider directory to do the displays as you all would like it to be. It's coming. We have a lot of really talented people working really hard to get it, but it's not going to happen in a few weeks. So keeping your expectations reasonable or working with us on that will be important, because it's a challenge that we're trying to resolve, and a lot of people are working hard on it, but it's going to take us some time to do that.

Katie and Jessica and I were talking about the idea of possibly facilitating a meeting with the qualified health plans and representatives of your clinics to see whether we could help move some of these discussions along. I know that you have the Tribal Advisory Work Group meetings. We thought that maybe at your next upcoming work group, we might do something like that. I will tell you that some of the representatives from the health plans have attended other similar meetings with some other parties that were interested in having dialogue and having us facilitate some dialogue. So I've talked to some of the health plans about that. They've agreed to participate in a meeting like that. So we need to

kind of figure out how we would do that, and what would be a good timing to do something like that.

There are very strict rules around what can be talked about in public dialogue. We had a meeting with a group of physicians, asking some of the health plans very specific questions about the terms of the contract, payment rates, etc., etc. The health plans cannot answer those questions in group settings. That potentially can be construed as price setting or anti-trust. So if we get together and facilitate you into a meeting with our health plan representatives, they will not be able to give you an absolute specific answer to possibly a pricing question or some credentialing question, or some other specific thing. So please don't think that they're being resistant or difficult. They're trying to work within the laws that they have to work with, in terms of what they can share in a group discussion. The idea would be to get you together to meet the people, understand if you're in a region that's served by Anthem or Blue Cross, etc., and that you know who some of the contacts are. And we'd do what we could to facilitate the relationship there.

I think the last point that we wanted to talk about was—I think Peter raised the point, which was potential changes coming down the path for future contracting and our model contract. The model contract is the document that we hold between Covered California and our qualified health plans. Generically, we call that the model contract. The variety of terms that are in that contract have everything to do with their relationship with Covered California, how they enroll people, what are the quality requirements, what are the telephone answering pick-up timing—a whole host of things between us and the qualified health plans.

We've had some additional legal review. I know that there has been some request to have the addendum as part of our model contract, the Indian Addendum as part of our model contract and require that qualified health plans would use that addendum when they contract with Indian Health Service clinics. We have been told by our legal team that that would be acceptable and that we could do that. So we anticipate in 2015 putting that into our model contract. [applause] I'm glad to hear something worked [..?..]. I think that's probably it for me. Questions about our qualified health plan program?

MSPKR: I was looking at the plans that are being offered in our area, and some of our staff and myself were having a discussion a couple of days ago. We were doing it in relationship to another issue, where, if it's a PPO, it's pretty straightforward. The plan owns it. So if you pull us together and you facilitate a meeting, that part of it will go really well. But in Riverside County, I saw that we also have HMOs. One of the concerns that came up in our meeting is that the IPAs really are the owners of the HMOs. So will they be at those same meetings, the leader of the IPA in a certain area? Or is that even on your radar screen? And do we have to do more research and bring it to you?

LEAH: That's a good question about the model of the health plan. Some of them are PPOs and some of them are HMOs or EPOs. With the IPA model, where the health plan delegates out to the IPA and then looks to the IPA to develop the network under them, one of the things that we are talking about with our qualified health plans is we need to educate the IPAs—the independent physician associations, for those of you who don't know IPA—to talk to those IPAs about potentially subcontracting with your organizations. Because ultimately the patient gets signed to the health plan and then assigned to the IPA. And so if that patient goes to your clinic, as they're entitled to do, a part of that claim payment would be the responsibility of the IPA. We need to the IPAs to understand our relationship, Covered California, is with our qualified health plans. So that's who I can somewhat direct to come to a meeting. We need to work with them to educate their IPAs. I do know, particularly in the Medi-Cal world, in Medi-Cal managed care, there's been a lot of work with IPAs and understanding about working with clinics beyond the level of the IPA. So I think that we can build on some of those relationships.

MSPKR: I guess my other comment is that it's nice that you raised those points. But I think that when you take a look at Peter's opening remarks, how he talked about the goals of Covered California, our concern is that the qualified health plans or the IPAs are not really mandated. They're encouraged. But when you take a look at the volume of patients—and taking his statistics, there's four million people that potentially could qualify. That's about 1.7%. Native Americans represent about 1.7% of that total four million. But if you look at the patients that are going to be subsidized, the 2.6 million, that represents a little bit more than 2%. Because we're a very small portion of the overall pool, this is not something that they probably are going to want to spend a lot of time on. So I think that's one of the reasons why we really need to have language in there that would mandate that they actually have to contract with us.

You've already provided in your documentation a provision where they have to contract with 15% of the community providers. And under managed care they have to contract with at least [..?..] QHC. So there are provisions that have been established in managed care and now here. But I think, in my mind, it needs to be mandated because of our small numbers and our different responsibilities and the different relationship to state government. It should be mandated that they contract with us.

LEAH: Thank you for sharing your thoughts. We appreciate it.

VIRGINIA: Hi Leah. My name is Virginia Hedrick, Associate Health Policy Analyst at the California Rural Indian Health Board. My question is in regards to the September work group advisory meeting. Andrea Rosen had brought a document to the meeting that we believe, in how she communicated, was a list of ITU providers. The tribal leaders present at that meeting, as well as Tribal Health clinic directors, requested a copy of that list. I followed up several times, and Molly has been

really great in working with me to look at the provider directories. Obviously, there are shortfalls in it. But I do know that there was a document in her hand at that meeting that was requested by tribal leaders to have a copy of that. When will that document be available, and what is in that document?

LEAH: So that document was put together from the solicitation materials that were submitted by 33 health plans in February of 2012, when we asked all bidders to submit to us their essential community provider networks. So for purposes of some internal understanding about where things were standing with contracting, I asked Molly to do some analysis of what had been submitted in terms of being contracted as essential community providers. So we created a CRIHB list of contracts between the plans that we were aware of for purposes of our discussion back in February. Since that time, I'm very aware that the qualified health plans have been doing a lot of contracting. We can talk about what your experiences are, but I, for example, have been on the phone with Blue Shield, Hugo Flores, and he's the name on the list you'll get. And Hugo has been—pretty much, he tells me he's got almost all the different clinics on the list contracted. Now, there may be different people talking, but he's telling me that he's actively working on contracting with those plans.

I had Health Net on the phone the other day. We talked about their contracting activities. And one of the things that Health Net raised is that they're seeing that American Indians are choosing their plan and enrolling into their plan. So they're very aware that those members will be part of their enrollment, and that they want to have relationships with the clinics that serve those members. So on a case-by-case, an individual qualified health plan by qualified health plan, we've been having discussions. What I would like to do—what I am asking you and your clinic providers to do, is to take that list that will be distributed and talk to the health plans that are in your area. Because what I am really hoping to encourage here today is a relationship between the clinic provider and the health plan.

And we are not in the position of creating a list of all the hospitals that are contracted. We don't create a list of all the FQHCs that are contracted. We're not putting those kinds of lists together. What I would like to do is help facilitate your various Native American clinics to talk to the health plans that are in their market areas.

VIRGINIA: So if I'm understanding you correctly, Covered California will not be issuing a list of ITU providers that are networked with qualified health plans?

LEAH: No, there is not a plan to do that. What we are looking to do is the provider directory online to be sufficient enough to be able to look up the relationships.

VIRGINIA: And at this point, the provider directory is insufficient; you do have to do it by physician. I know at the California Rural Indian Health Board, we have a list of all of our member physicians, and so we've been compiling that list. I believe

Stacy Kennedy is bringing the most up-to-date list we have by physician, but we have concerns on how those contracts work, what happens when the physician leaves the clinic, which is a common occurrence in Indian Health Programs. And then for those who are not member clinics and we don't know all those physicians, which is still a number of clinics, we won't be able to provide anybody that list. And therefore, down to the consumer level, the Indian person who's trying to buy a plan and wants to be able to continue to receive culturally competent and relevant care at their Indian Health Program is at the risk of selecting a plan that may or may not be one that they can take to their Indian Health Program.

LEAH: I want to reiterate what Peter talked about this morning, which is the Indian community is fully entitled to continue to receive services at the clinic, their traditional source of care at that clinic, which is an important point in terms of the relationship that we're teaching the qualified health plans about. Again, if enrollees are in one of their plans and receive services at a clinic that is not in their network, they need to understand about what their responsibility is for payment and what their responsibility is for additional referral relationships. So it's important that we learn from you and teach together our qualified health plans.

VICKI: Thank you. It's kind of hard, because I was sitting back there and I couldn't see, and I was trying to take notes. That's why I asked if we had that. I have that bad memory. So you were giving some explanation of stuff. So I wanted to be able to have that, whether it's on the web or something for us to read. But that's not why I'm up here. The question I have is—we had a tribal meeting, and I went to our tribal people and I'm telling them about Covered California, but the one question they asked me is, "Well, when should I start?" And I'm telling them, "I don't know," because the main things that we are looking at is the networks that are going to provide with our clinic. And if I can't tell them that, they're not sure what plan they want to take. And then you said that the physician names are going to change, and you guys are going to try and put the clinics on there. That's great. And I heard you say it's going to take a while.

So in my mind, I feel like I should tell my members, "Don't apply yet, because it's going to take a while for you to find a clinic on there," because not all of our doctors are always the same doctors we see. We're a clinic. We have rotating doctors. Sometimes we have temporary doctors. How is that going to affect those health plans? If we have somebody we get from a temp agency, is it our contract that they're going to abide by the payment to us, or they're going to say, "This doctor isn't in our list. We're not going to pay you for that visit." That's a big concern.

And I just heard what you said about, "Well, you guys have your clinics and your IHS money." I don't know if you guys in Covered California are aware. We are never funded properly. We are never given enough money to serve all of our people, [applause] so that isn't really an option. I'll let you talk. I'll just throw this

all out so you can tell me everything I need to know. That out-of-network is a big problem, because when we refer people out, if that health plan isn't going to be included as their network, and we send somebody and refer them out and we don't get monies, that has to come out of contract health support, which is even less funded for us in our clinics. So these are matters to us and why we wanted that. That strong letter really didn't feel like it was enough, but we wanted that recommendation because if we don't have the funds, our clinics close. And then our Indian people aren't even a part of the affordable healthcare. And as you know, being even the tribal consultation you did, there's a special thing in there for us Indian people, that we are kind of now getting concerned. We don't want our clinics closed because we're not getting the proper funding because those health providers are not contracting with us. Thank you. [applause]

LEAH: Thank you for sharing your comments and your concerns. I want to make sure that—I think one thing I was referencing maybe was misunderstood. I was not saying that an enrollee of a health plan would go to the clinic, and that clinic would not be able to bill the plan. So the issue around internal payment, in terms of Indian Health Services payment for that member—we understand that if a member is enrolled in, say, Blue Shield, and they seek services and receive services at one of our clinics, that your clinic is entitled to bill the health plan and receive compensation for that. So those are messages that we're sharing with our qualified health plans. We're talking to them about how they need to understand that and how they need to understand that it's in their interest to have contracts with you in order to create relationships that are more smooth, so that everyone understands referral expectations, understands compensation expectations. And so I was not suggesting that the payment for that patient would come from your already challenged funding resources.

DENISE: I'm Denise Paget(?) from [..?..]. Our concern is also with locums. We live in a very rural area, so we don't have permanent providers. We just go through locums like crazy. So can the contract be made just for the clinic specifically and not the individual provider?

LEAH: Thank you for the question. Yes. This is actually one of the things that is part of our discussion with the whole world of clinics, whether they're your clinics or federally qualified health centers or 1204(a) clinics. There's a lot of recognition and awareness that the member goes to the clinic not to the traditional physician provider, per se. And I think what you're raising is, well, if that provider, that physician or whomever moves on, in some circumstances the patient then continues to be assigned to that provider and they move on to whatever is the next source of services that that provider is working for. In the clinic world, the patient stays with the clinic. And we at Covered California have been having a lot of dialogue to ensure that our systems of provider directory allow that to be shown.

I'll reiterate again. The directory is not what I would like it to be, absolutely not what I would like it to be. But we are very clear that the member stays with the

clinic. Particularly—thank you for pointing out in your circumstances that there are physicians who come from our places. They're locums. They're only there for a short period of time. They're working for some particular window of time. And again, that point in the addendum that talks about the license, that they could be licensed in North Dakota or Florida or whatever and they're here for a period of time. Some really important points. Some of this is an education to our qualified health plans, and it makes me even more looking to Katie over here. I think that a meeting that specifically tied having our qualified health plans and some of your—whomever you would like to send to a meeting to help educate those QHPs about those points would be valuable. I appreciate the point.

JIM: Jim Crouch, California Rural Indian Health Board. I appreciate that you're doing some great work, and you're moving in the right direction. And I think facilitating those conversations is a good next step. I guess one clarifying thing, to follow up on Denise's question: There's nothing in your master contract that prevents your qualified health plans from contracting with clinics, not providers, not doctors.

LEAH: There's nothing in our model contract between us and our qualified health plans that would prevent that.

JIM: Great. I would like to give you a framework for those conversations that you're trying to engineer. I think we could, aside of your structure, also try to do that ourselves. Tribal Health Programs have always seen themselves as the medical home for the community they serve. They want to case manage those individual clients. If someone is enrolled in a health plan and the health plan's not got a contractural relationship with the clinic, then that relationship is broken because you're requiring—the plan would say, "Our primary care provider is Dr. X." The client, the Indian, and the clinic would say, "No, it's the Tribal Health Program." So, in essence, they would be forced to be managed under the plan by someone that they didn't see in that role. And if they came to the Indian Clinic, they wouldn't have a way to communicate the health problems that were discovered at the clinic, to get access to the rest of that network, the value of the plan. And if they go to the health plan and their primary care doctor doesn't share information with the Tribal Health Clinic, then the client's health status is being changed, but nobody at the Tribal Health Program is made aware of it. That rupture in relationship is terribly important.

One of the reasons that it should be of value to the plans that they establish and maintain that relationship is that part of what we have that the average physician network doesn't have is a huge commitment and investment in public health kinds of services. We have special clinics for diabetics. We have special programs for people with substance abuse problems. We have a lot of community-based outreach home visit kinds of services. If the relationship between the plan and the clinic isn't coordinated and under contract, the value of that IHS and tribal investment in preventive and community health is thrown away.

LEAH: Thank you for those comments. I want to suggest that actually you all have a lot to teach some of the other parts of the healthcare system. I personally am a fan of the clinic world, whether it's a rural or inner-city, urban setting. I recognize that the comprehensive services, the culturally competent services, the onsite pharmacy sometimes, onsite lab, onsite radiology services on some occasions, onsite case management programs, onsite diabetic education programs are all important services that you offer and some of your federally qualified health center partners offer. And these are some of the things that we want to encourage the health plans to be more active and involved with understanding the membership and getting them into those medical home types of settings.

There are requirements in our model contract about moving forward the concept of medical homes and moving forward the concept of coordinated care. There are some health plans that have been doing this for quite a while, and there are some that are learning about it. And I think that they have a lot to learn from you, in terms of especially your population and how to work with them. Again, I think this is one of the education things that we are working to bring our qualified health plans into some understanding. There are some who very much understand this, who totally understand this. And there are some for whom this is brand new. So you teaching them is probably the best way for us to have them understand this information.

JYL: Hi, Leah. Jyl Marden with CCUIH. I had a question about how to operationalize the no-cost-sharing protections at our clinic. How are the Indian clinics going to be held harmless or receive full reimbursement from the QHPs when they don't collect the cost sharing from the Indian patient? Who absorbs the cost? Who pays? How is that going to work?

LEAH: I'm looking over to my policy colleagues for a minute here. We've had a couple of discussions about this. I've had a couple of discussions with the QHPs about understanding that that revenue is coming from the feds, not from the member, and recognizing that they're going to need to operationalize that at the local level, with your clinic. I don't have a specific answer for you, but that's another one of the discussion points to have with our QHPs, if we facilitate a meeting like this.

JYL: I also think it's an integral answer for our clinics that are considering contracts with QHPs. How are they going to be held harmless? So on the patient side then—I just want to get this out, too—how are Indian patients going to be identified in the system and acknowledged by providers as not having cost sharing if they present in a non-Indian-clinic setting?

LEAH: Well, usually how that's done is an ID card, in traditional methods for managed care. It's usually done through an ID card that would identify the patient's cost share on the card, the patient's group on the card. That would be how I'm anticipating that we're doing it, but I will have to look into that and double check for you. But usually that's on an ID card.

JYL: Thank you.

DANNY: Danny Jordan from the Hoopa Tribe. I want to follow up on what Jim just said. We have this thing. We don't need code talk in Indian country, and we definitely don't—and the comments that are made—we have fought more battles than anybody understands to get healthcare systems in California that work, and especially in these rural areas. Jim's point is exactly right on, and that is one of those trapdoors. If the Affordable Care Act becomes a mechanism for outside providers to come in and intervene in our healthcare system and start dividing out, "The Indians are going to apply for this," to carve up our healthcare system, I know at Hoopa we will say, "Keep it out." We don't need a plan that's going to contribute to what has historically been the chopping up of Indian healthcare in California. We need the United States to simply honor their relationship.

Everything we've heard today has been that the Affordable Care Act is an improvement, is a partnership. But if these plans end up being competitors for our healthcare systems, it isn't going to work. And it needs to be understood that that creates this huge trapdoor right at the boundaries of these Indian healthcare programs. If anybody is thinking that anybody can come into Indian country just because they have gotten a status of being one of these healthcare providers in these plans, and they're going to just simply invade Indian country, it's not going to happen. We're dealing with ambulance programs and those kinds of things, real life-saving situations, and we don't get a lot of help. We need partners. We don't need competitors. Jim's comment is a threshold issue in Indian country, that that isn't an understanding from day one, go back and rethink the plan. [applause]

LEAH: Thank you. I think you've actually raised a point that is important for our qualified health plans to understand, which is there are—as I'm learning, and you can correct me—certain… The clinic providers serve the community that they're built to serve. And so non-eligible persons cannot seek services at those providers unless under a set relationship. So the clinic is set to serve the members of the tribe—no? One of the concerns I have about provider directory is ensuring that we don't somehow indicate that your services are available to a broader array and then overwhelm some of your offices or your services. So that's one of the challenges with the provider directory that would display a clinic, and possibly others who see that there may see that think that that's a provider that they can go to, when they may not be eligible for services in one of your clinics. That's a concern I have.

DANNY: I just want to clarify that non-Indians are entitled to services at any Indian clinic on a fee-for-service basis. Again, if the plan comes up, carving out our populations in Indian country to these categories of services, it's gutting our healthcare systems.

LEAH: Thank you.

MICHELLE: My name is Michelle Hayward. I'm from Redding Rancheria in Northern California, and I am the chair of CRIHB. It is very frustrating. I think it's frustrating for all of us, because we are worried about our patients leaving us and going somewhere else. It is frustrating and it's scary for every one of our tribes. Then we have something new, and I'm supposed to like all the healthcare and all these changes. And as long as it benefits us, I would like it. I don't see a whole lot of benefit to me, because I feel like pretty soon IHS is going to say, "Oh, they all have healthcare." To me, this is like underlining something that's going to happen later on in the future that concerns me. This is just me personally. You guys don't have to have tribal consultation with us because you're not part of the feds. We get told we have to deal with the states. It's been very hard to deal with California for many years, for people older than me who have been fighting this same fight for a long time.

So here we are, teaching you guys about us again. It's just like this cycle that's always happened, and we'll continually do it. But I do hope that you just take that letter that we all wrote, everybody did yesterday, in consideration. I think we are all worried about losing all of our people and our health clinic. We're already funded at 56%. We're not even fully funded. We've done a great job. All of our health clinics are great. We do it the best, I think, than we do in other QHPs, or whatever, qualified health plans. So I think Tribal Health Programs have been doing it for so long for their people, I think we do great. I definitely want to see the non-federally recognized Natives—that is in your letter—be in there. I'm looking up you guys' application. It's only federal. I realize that it's the law. But they are Native Americans. It's not their fault they're not recognized. That's all I have to say.

LEAH: Thank you for those comments.

CHARLENE: I'm Charlene Storer with Tolowa Nation (non-federally recognized) a descendent of many people who worked to bring healthcare to California Indians when the Indian Health Service left the state. I think the healthcare that's provided to us here in California is excellent. I hate to see things that come up and divide us again. We've worked so long and hard to get the descendants into the system for the healthcare that we deserve. I hate to see—when the gentleman spoke about the division, because this is what I've seen over the years through governments trying to work with Indians. It's like we have to re-educate. Every time we turn around, we have re-educate. It becomes very discouraging to have changes in the system that make you have to re-educate every time you turn around. Just know that Indians are here. Indians are not going away. We want to take care of ourselves. Sometimes we're in a situation where we can work for each other and work with each other, and sometimes there are situations where we cannot. But know that we're not going away.

I heard someone say earlier, and I don't remember if it was you or if it was Peter that said it, about advising and working with federal government, that you couldn't make policy. And I understand that part. But I do understand that you do have a voice with the federal government through Covered California, through the California Exchange, that you can make known what's happening in California. So I would expect Covered California to step up to the plate and say, "Hey, this is the situation in California." And I have to say that in the rest of the states in the United States, there are other non-federally recognized tribes; it's not just California. So we expect—at least I expect—Covered California, from what I've been hearing, to step up to the plate and say, "This is the situation. This is how we can resolve it." I don't expect you to tell them that they have to do it this way, but give them some options and let them know that we are out here and we expect our federal government to stand up.

FSPKR: I got carried away. I had a question when I came up here. [laughter] That's on your model. And I'm wondering why you guys are waiting until 2015, instead of getting it done by 2014.

LEAH: The answer to that question is those contracts for 2014 have already been fully executed. That was done back in July or August. So those contracts are in place now, and we're working with the plans on those contract terms currently. The next cycle of changes to that contract would be for the 2015 contract, which doesn't mean we're not—as I shared, we put the addendum out to the plans. I've had phone calls with the plans to make sure that they're aware of the addendum, to talk about some of the things that are important, that they need to understand in terms of the terms of the addendum. I think having a chance to have direct conversations with your organizations and those plans is another way to make sure that that addendum is recognized or understood. But the next time to do something in the model contract is for the 2015 contract.

I just want to comment about the idea of the letter that you shared with us. I think I'm going to reiterate that we, at Covered California, take all of the input that we get from stakeholders and review it and consider it. And I know that your letter will come to the team and be reviewed closely. We want to understand what are the challenges and what are the issues. The other thing I do know is that the team at Covered California has been working very diligently to ensure that we meet your requests for consultation and Tribal Work Group. It's a very active part of our weekly discussions amongst the team members at Covered California about this area. So I hope I can reiterate that this is an area that we are very conscious of and very aware of learning and working with you all. David?

DAVID: Could I make a comment? I'm David Maxwell-Jolly, the chief deputy at Covered California. I wanted to respond to the suggestion that while it's true we don't have the ability to advocate a particular change in law, Peter's response to that point in the letter was very much in line with your suggestion. We do have the ability to talk with our overseers in the federal government and to communicate with them

the conditions in California, and give them the facts on the ground, tell them the consequences of the exclusion of non-recognized tribes, in terms of the people in California. I think we very much appreciate your suggestion that we make sure that the folks we're working with in Washington understand those consequences. I think we definitely can do that.

CONNIE: Yes, I just wanted to make a couple of comments. My name is Connie Reitman. I'm Pomo from Big Valley area in Lake County. I think one of the things—I appreciate the comments of the woman before me, regarding the makeup of the Indian healthcare system in California. I think a lot of people ignore the capacity of the tribes to take a serious challenge in our community and work together as tribal people to develop a system that is more responsive to our population. What it was, was the infant morbidity and mortality rate of our Indian children throughout California, including two of my brothers, who were born without appropriate prenatal care, and my aunts and cousins and sisters—everyone looking for how we could stop our babies from dying. And so we went to the Bureau of Maternal and Child Health in Berkeley. Nine projects were started out of that, with 200-something thousand dollars. And the tribal leaders of California took that 200-something thousand dollars and developed it over a period of so many years to 33 multi-million-dollar healthcare systems that Indian Health Service could not provide. The tribes did.

So what we know about what the tribes have also done, not only about healthcare, was to improve the healthcare education of people who were going to be working with our people. In addition to that, we were able to employ healthcare professionals who otherwise would not be employed in rural areas of California. Added to that is the value of the pharmaceuticals, the medical supplies, the equipment and the benefits that are paid out in our local communities that are driving the economy of California's rural areas. From the perspective that I understand this is what we are being told is that irregardless of if we meet federal, state or county standards or exceed them, we are still not allowed to have a voice in this whole process.

We have a tremendous resource in this room of individuals who have worked diligently over the past decade to create a healthcare system that stands above many others. So it is very disturbing to hear that policies and procedures continue to be put into place that create barriers for our tribal governments to participate in healthcare systems evolution, development, design, content, etc., etc. I say this with compassion and due respect to all the leaders in the room that we can't afford to allow these kinds of activities to disrupt the progress that our tribal leaders have made in the past decade. We want to respect the leadership of the California Rural Indian Health Board, who has brought these issues to our attention time after time on behalf of all our people. We are not even remotely close to the end of the trail where we can see our children being raised in safe and healthy environments. It is our hope to achieve that change in our lifetime so that

our people will not continue to suffer the trauma that our ancestors and forefathers have had to bear.

From what I can hear as I listen to these people talk, they are advising you appropriately and adequately beyond the capabilities of other entities to provide the service needed by our people. Our tribal communities cannot depend on Kaiser or Sutter or any other healthcare system, because they're not designed to address our needs. We have multi-million-dollar healthcare systems, governed by California-recognized tribal people and our brothers from our tribes in the urban areas. We seek to be heard. It is our responsibility to provide the healing and care for our tribal people, and our voice needs to be heard. Thank you for this opportunity. [applause]

LEAH: Thank you. Well, I appreciate those words. I appreciate your honesty in sharing your feelings and your concerns with those of us from Covered California. We hear you sincerely. We understand that you have had a great deal of time and history in this arena, and we are attempting to work with you and understand what we can do to support you and be part of your efforts to improve care for your members, and do what we can to facilitate relationships with our partners. We look forward to working with you down the line tomorrow as we continue to develop those opportunities to work with you and learn from you. I appreciate your honesty and your sharing your observations with us. Thank you. That looks like all the questions. Thank you. [applause]

MARK: Thank you again, Leah. I know in the work that we're doing together, there's issues in implementing a new healthcare system. We're working to iron them out together. We're here to do that very thing. I know sometimes it may be a little tense, and it's not always easy, but we need to continue to stick together and work collaboratively and cooperatively towards the goal that the tribal representatives and the urban Indian representatives have, and that is to have the ability to serve their Indian patients going forward in the new healthcare delivery system.

With that being said, I'm the bearer of good news—there's food in the back. We'll go ahead and move into lunch a little early. There's a lot of great sandwiches back there. We had our prayer already this morning, so we'll just move right into lunchtime. Network, visit, debate if you'd like—whatever you'd like to do. This is your time. We'll see you for the next presentation after lunch.

2013-11-07 -- COVERED CALIFORNIA TRIBAL CONSULTATION
PART II

MARK: …And there are definite benefits not only for the patients but also for our trial health programs. Later today we're going to have a presentation on tribal sponsorship and that was mentioned just a little bit this morning: very innovative ability -- brand new federal Indian law, the ability of your tribal clinics and your

tribal governments to pay a premium in Covered California and that person that you pay that premium for will have access to a whole series of essential health benefits, brand new, required services. And so essentially for an Indian person who's maybe making 30 grand a year, maybe there's two people in the household so there's three, you know, that person could essentially wind up paying maybe $50 a month. In the old days before the Affordable Care Act was signed into law that same three family member household would probably have to pay well over $100 or even more. That 50 bucks a month, if that Indian family who's making 30 grand or less can't afford that $50, then guess what? Your tribes, your tribal clinics clearly have brand new federal Indian authority to pay that premium.

And let's think about that. Often I think many of the folks in this room know that about six months into the fiscal year, what do we run out of? Contract health service dollars, right? And why? Because we use those dollars to cover essential or very important healthcare services that your clinics cannot provide, very important healthcare services and we can list them out. Many of those very important healthcare services are on Covered California's list of essential health benefits, so you pay a specialist – say a high cost patient, say a cancer patient, imagine how much money is used in the CHS fund for one cancer patient, right? Radiation, ongoing diagnoses, maybe some additional providers. In the new healthcare system essentially you could use part of your CHS funds, 50 bucks a month for that person, or some other federal funding sources, and pay that premium and then that Indian patient would have access to a whole series of additional services. That's already covered. They just have to literally go there and get the services. The premium's paid, so maybe paying 50 bucks a month, whereas in the old days before the ACA you might shell out a thousand bucks a month or more in CHS costs for specialty care. Has our presenter arrived yet in the room? She's right there. Very good. And she will need to set up. Okay, so I get to keep talking until she's ready.

But yeah, that is an exciting opportunity and I don't want to steal too much of Virginia's thunder but this afternoon we're going to have a tribal sponsorship presentation after Thien's(?) presentation. And for the very first time, we're going to unveil a video and this video was developed by a handful of Trial Health Boards across the country. I think CRIHB kicked in maybe ten or fifteen grand and then I think Northwest Portland Health Board, they kicked in some funding and a couple of other health boards throughout Indian country all pitched in some dollars to build some educational material. And one of those presentations is a video and the video is looking at the Fondulac(?) Tribe in Michigan and they've been building capacity to cover, pay those premiums for some of their tribal members or some of their patients. I think they're especially looking at just covering those that are known as "high cost" patients, the cancer patients, the diabetes patients. But yeah, we have, you know, we have the first time ever in California that I'm aware of, we're going to unveil that video this afternoon. I'm really excited about it. I hope you all are as well. But yeah, that's some innovation and it only exists for the tribal communities, so keep that in mind also.

Maybe I'll open it up since we're still working on setting up our systems. Can we begin now? Are you ready, Thien? Okay, very good. So ladies and gentlemen, without further ado, I'm honored and privileged to present to you Thien Lam. She is the Covered California Deputy Director of Enrollment and Eligibility. [Applause]

THIEN: Thank you. Great. Thank you, Mark. While he's honored to introduce me, I'm absolutely honored and I'm absolutely delighted to be in front of you and very excited with the great work that we're doing here at Covered California for our state but also for the communities, and very appreciative of everybody's claps and welcomes. And again, thank you very much. And I'm here today to talk about our eligibility and enrollment process, particularly some of the general eligibility and enrollment provisions and requirements under the Affordable Care Act as well as images of the paper application just to share with folks how we ask specific questions about our application process, which is a preface for the CalHEERS great demo that will be presented in front of you. What we'll do is, because eligibility and enrollment is tied so closely to the CalHEERS system as well. I'll go ahead and present the eligibility and enrollment components and then CalHEERS will unveil itself and then we'll open it up to questions broadly from a policy perspective and a system perspective. So I just wanted to share that with folks and that's our structure. And if you do prefer a different structure, please let us know. We can definitely be accommodating.

Okay, so let me see if my clicker works and if not, I'll use the laptop. So bear with me here.

[Setting video up…]

So just to share with folks, as we're thinking about our eligibility and enrollment process and the system that feeds into it and from the eligibility and enrollment process feeding into the system, some of the guiding principles is clearly to ensure that there's no wrong door approach and for us to maximize the enrollment of eligible individuals into our program. And it not only starts at the initial application process where it's consumer focused and consumer friendly, but also once an individual or a consumer is enrolled, we want them to stay enrolled during the annual redetermination process. So the seamlessness from initial enrollment, ongoing eligibility and during the annual redetermination process it's very critical to ensure that consumers maintain coverage in our program. It is also very critical that we present information that is clear, concise, accurate and understandable and we present it in a manner which is easily understood by the various consumers in our diverse population in California. Our program, the Affordable Care Act, it is very complicated and it is very important that we present information that is complicated in simple terms so that consumers can be educated, understand their healthcare options. And of course, while we try to do our best day one, sometimes, you know, it's not perfect, to be quite frank, and there will be definitely opportunities for us to readjust our strategies, find ways to

improve our process and to make it better based off of stakeholder feedback, your feedback, feedback from other critical key partners to improve our enrollment process for consumers.

So here is an image of the paper application. The paper application, consistent with some of the federal application questions, which was used as a baseline version to help us customize it to meet the needs of California, is a particular ethnicity/race question about American Indian and Alaska Native. You'll see that in the very left-hand column or checkbox. And then what you'll also note is towards the bottom there we do ask for the community to be able to complete additional information needed in the following Attachment A, which I will be presenting to you.

So here's just an excerpt. It's actually a one-pager in the actual application as a part of Attachment A. The following screen will show the remaining portion. But here this question is not only for Covered California but it's also for Medi-Cal. Because for Covered California, in order to be eligible for specific provisions you have to be federally recognized, and we also know that for the Medi-Cal program you do not have to necessarily be a federally recognized member of a tribe but you can also be a member of a tribe that is recognized within the state. And it talks about some of the additional types of eligibility and benefits that are available to consumers.

The following here asks specific questions because again, it's modeled from the earlier slide because it's for two programs, specific questions for us to better understand whether or not a consumer or representative within the community is federally recognized. It also asks for a series of questions about their ability or have they ever received services from an Indian health services as well as information about their income sources because again, this is where there is some slight differences between our program and Medi-Cal, is for the Medi-Cal program they do not count certain types of income that members received. Whereas for our program, because we rely on the modified adjusted gross income, in accordance to the federal IRS tax rules, we do include those income that are received as a part of the eligibility determination process.

[Loud echo begins here…]

Now during the eligibility and enrollment application process we do require for members to submit some information in regards to whether or not they're federally recognized. We are definitely looking into different opportunities in the near future to be able to develop a process in which we could potentially tap into some electronic data sources to verify one's federally recognized tribal status. So in the event an individual indicates that they are federally recognized members of a tribe, they will definitely get the special benefits available to them and we would offer those special benefits based on their attestation of being federally recognized, as noted in the earlier screens of the paper application, as well as in

CalHEERS, and then they will be given a 90-day period to provide some additional paper documentation which could be uploaded into the system by way of CalHEERS or sent to us via fax, as well as by mail. And so that 90-day period would be a period in which they could continue to have the special benefits and provisions as federally recognized tribal members under the Covered California benefits.

And then what will happen is, whether or not it's included in the upload feature, because they can submit their documentation into CalHEERS rather than mailing or whether it's mailing or fax, what will happen is the service center of Covered California will be reviewing each of the documentation to determine whether or not the information meets the needs of the individual providing and demonstrating the status of them being a federally recognized member.

So federally recognized members are eligible for services and they can actually automatically, because of their status, request for an individual exemption. And right now we are in the process of working with the Federal Government to understand more clearly what the status is in regard to their exemption process. So under the federal regulations we are permitted to work with the Federal Government to have them process individual exemption requests and that is something that we are taking up with the Federal Government, meaning we plan on using, at least initially, them as services to be able to process individual exemption requests. So there's a couple ways in which people can ask for individual exemption requests. One way would be if they were to claim it on their tax return or to fill out an Exemption Request, which will be made available through the Federal Government. Right now the Federal Government did release a draft application of their Exemption Request and we're anticipating probably in January-ish or potentially early February-ish that the application will be made available for requests for individual exemption through the Federal Government. And that is an overview of the eligibility and enrollment process. Again, we'll go ahead and have CalHEERS come and present and then we'll go ahead and then open it up for some great questions that you'll have. Okay. Is our CalHEERS Covered California representative -- There you are.

[Side comments]

FSPKR: I have a question.

THIEN: Sure, yes.

VICKY: When you have American Indian and then you're saying it's only a federally recognized, is there any anticipation that California will have some type of exemption for the way we conduct American Indian under the Indian Health Services, if you're eligible under the California roll(?) to be considered Indian for any of this? I know that hardship will be considered now but will that definition of Indian ever get changed to include that for California?

THIEN: Okay. I'm going to summarize what I believe you're asking just to make sure that I have a very clear understanding. So your question is -- And I'm sorry. Can you introduce yourself, please?

VICKY: Oh, I'm Vicky Macias from the Cloverdale Rancheria.

THIEN: Very nice to meet you. So your question is under Covered California we currently have eligibility and enrollment special conditions and special provisions for federally recognized Native American Indians, Alaska Natives, and we actually have seeked in the past federal guidance about whether or not that definition, the definition of federally recognized could be brought in and expanded to also include state recognized tribal members, consistent with the Medi-Cal program and the former Healthy Families program. And based off of the federal guidance that we did receive -- which we've worked with the Federal Government and our partners at the administrative level over there very closely – we've been informed that the provision for Covered California, not including what's in the Affordable Care Act for the individual exemption, is only applicable towards federally recognized tribal members. So we did ask the feds and that was the direction and final clarification that they provided to us.

VICKY: Okay. Can we work on that?

THIEN: Always. Definitely. Actually, in our other tribal consultation groups it's a huge area of interest and we absolutely recognize and know that it's very important and we will continue to get confirmation from the Federal Government to verify whether or not that has changed or their positioning in regard to that. Yes?

DENISE: Hi. I'm Denise Paget from Smith River Rancheria. One of the things we were talking about yesterday is sometime with tribes it takes a little while before Enrollment Departments accept babies into their tribes. And I was just wondering if somehow there would be a Special Conditions clause for new infants because they need so many appointments at the beginning of their lives.

THIEN: Yes. So the 90-day provision is when documentation, proof of documentation, from a broad perspective, not just with a Native-American or Alaska Native federally recognized status, but other types of eligibility criterias, there are situations and special exceptions where we can extend the 90-day period so long as the individual asks for us to do that and explains the need for the exception. So in that example it would be there was a newborn baby, they're in the process of obtaining the documentation, and that would then give us the opportunity to extend the 90-day period.

DENISE: Okay. So in some cases it takes up to a year before somebody can get into our tribes. So can you – I wonder if that can be extended another three months or…

THIEN: It's typically extended up until the timeframe in which we identify is appropriate for the consumer. So it would be very important – and I don't know if the timeframe – and we'd have to come back and circle back with the folks because I want to make sure that when we provide information, it's very accurate. I'm unsure of whether there is a time requirement to say it's up to a year, but there are a series of some months in order for them to be able to be a part of that exception period. So we will take that back and we will confirm and we'll get back to the group.

DENISE: Thank you.

THIEN: We have one more question and then we'll go to the -- Are we ready for the CalHEERS' presentation? Yea!

ANDREA: Good afternoon. My name is Andrea Cazares-Diego from Greenville Rancheria. I'm thinking – you know, when you say they need tribal cards, they need tribal documentation, you know, some tribes in California don't have tribal cards. And then another question is that -- How can you tell that they're federally recognized, a list of tribal members, how can you tell that they're federally recognized?

THIEN: Well we do ask for specific questions about the federally recognized tribal name and the tribe in which the individual is a member of. And that information is then used to verify whether or not the individual is in fact a part of or a member of a federally recognized tribe based off of the list that the Federal Government has given to us. What we would then do is we would take a look at the documentation that they provide and would double-check and confirm that it shows their name and that it's from the particular federally recognized tribe.

ANDREA: But you're not checking with the tribes, are you? 'Cause at one time we had three hundred and some tribal members on our tribe. We only have 131 members in our tribe now. So those 300 members were at one time members of our tribe but not no longer are members, but they have documentation saying that.

THIEN: Okay.

ANDREA: So are you checking with the tribes and seeing if they're enrolled with the tribes?

THIEN: We are not checking directly with the tribe. We are using the documentation that is being provided and that's where, if there needs to be some additional steps for a potential verification, it would be very helpful for us to know and be aware of that, and we welcome feedback and thoughts of how we can better improve our verification process. Should we move forward with the CalHEERS? Okay.

LAURA: Hello, everyone. My name is Laura Moreno and I'm on the CalHEERS training team. So today we are going to have a demo of the CalHEERS application.

Specifically, we're going to run through application, eligibility and plan selection, and within that process we'll be pointing out many of the questions that are relevant to AI and AN populations. And a lot of those questions are those that Thien has already gone through on the paper application, but we'll see how we translated those into the system.

So our first demonstration's going to be an individual who is below 300%, is identified as AI/AN and that's a little bit of the background that we'll be going through with this individual. So here we are. When the individual logs in to Covered California they will come here to their individual landing page. So this is the page where they get started on anything having to do with Covered California. You'll see here on the right-hand side, these are many of the actions that you can take right there for you. We have our welcome message. Right here you'll see "Welcome Andrew". This is really a nice welcome message that gives you an update on where you are in the process. So if you were new, you hadn't started your application, that yellow button would say "apply now," an indication to let you know you're ready to go; let's start applying. Right now you can see that we are on "resume". My application has been started already. You'll see here your application process that we visually identify the different steps that you will take in the application, eligibility and plan selection process. And that's why my button is on "resume".

So let's go ahead and get started with the application. So let's imagine that under "resume" we have "apply now". So I will go ahead and click that and here we go. Once you start the application, you come to the "start" page and this is our "overview" page. You'll see a page similar to this at the beginning of each step in the application process. This overview page gives you a summary of what you can expect in the pages to come. So it'll give you background on the type of data we'll be collecting. Some of the documentation you might want at hand to start those pages within that section. So you'll see here on this overview page it gives you a quick breakdown of the three main phases in this process, so you'll enter your information, you'll see your results in eligibility and you will find health insurance plans for yourself. And of course similar to the home page, you see the application progress track at the top. Okay.

So the first page really in the application process is our "apply for benefits; start here" page. So on this page what we ask is if you're interested in applying for any of our assistance programs. These programs would be anything from cost share reduction to APTC(?), and you would answer here "yes" or "no".

[Simultaneous conversation starts in here…]

Keep in mind if you're answered "yes", then you would go through a subsidized application, meaning you would fill in the required details and under "eligibility" you would get results and find out if you qualify for any of those programs. If you were to select "no", then you go through an application that is not subsidized,

meaning you will go through the application process and will not see any of the programs that you may qualify for or a subsidy. And then in addition to – if you would like to see which programs you qualify for, we ask you some simple questions about the number of individuals in your household. You simply identify that from your dropdown. And just a quick "how did you hear about Covered California?"

And then we move on to the next page in that process. The next page is our "consent for verification". So before we get into any data collection, any personal information, we want to let you know some of the verifications we go through. So here, just to let you know, we do submit your information to several federal electronic hubs to verify information such as your Social Security number, date of birth, tax information. We want to make sure that you are aware of that and if you agree, go ahead, select the checkbox and continue. And you are now done with the first step in the process. And you'll see here in the progress track, you'll see a nice checkmark in that section and another introductory page.

So now we're in our household section. Again, the introductory page has an overview of the information we'll want to collect in this section. There is a "you may need" list here so maybe you'll want to get your Social Security card, your birthdates, maybe some birth certificates together for all the members in your household, and then estimate of the time it may take for you to fill out that section.

MSPKR: [..?..] [unmiked]?

LAURA: Sure.

MSPKR: [..?..] [unmiked]

LAURA: Then you cannot move forward.

MSPKR: [..?..]?

LAURA: No, you don't because then you could call -- This is just that we are sending that information and verifying with those hubs online. So if you want that process to be offline, you could call our service center. We could take that information over the phone. Is that kind of what you were…?

MSPKR: [..?..]

LAURA: For that question in particular you cannot move forward on the site.

THIEN: And just to clarify – sorry – if I may --

LAURA: Oh, yeah, go ahead.

THIEN: You do have to indicate that you're giving permission to be able to do the electronic verification process. So you do. And even on the paper application when you sign the paper application y you're also indicating that you give permission for us to check with the Federal Services databases to determine eligibility.

MSPKR: My point is what if an Indian person says, "I don't want anybody checking my verification. I just want to enroll" or something?

LAURA: Then you would select the, probably the unsubsidized application, where we don't collect tax information, we don't collect sensitive information like that. So there aren't any numbers to verify against. But I still believe that we verify their Social –

THIEN: Correct.

LAURA: -- to know that you are who you are.

THIEN: Right, because even for the program where you're not asking for financial assistance, there are still requirements that people have to meet. For example, you have to be a U.S. citizen, lawfully present in the U.S. and you have to provide a Social Security number. So even in the nonfinancial assistance program, we still have to ask for permission because it is a requirement under the Affordable Care Act that we check with the Federal Services, meaning the federal databases, to electronically verify people's information.

LAURA: Does that answer your question, sir?

DANNY: [..?..]…and they just simply say, "Leave me alone." And then they shouldn't be penalized because they just say, "I'm just living on my allotment and I don't want to bother me and I don't want anybody to bother me." And next thing they're doing is getting a penalty because they just want to be left alone. Anyway, that's just a question. I'm sure somebody's going to do that.

THIEN: Right. And I think it's also – that's where it's very important, you know, because the checking of verification, when individuals are applying for coverage, it's just solely for the program. So that's where it's really important that as folks in the community are explaining what Covered California is, for the tribal members to really know that they're only checking just to see if you qualify and that's that. They're not doing anything else with the information. So messaging sometimes – well not sometimes – it's all the time – very important. Words do matter. And so that's where just the education component is going to be very critical.

LAURA: And just to comment on Danny's comment, the individual that you describe, the federally recognized Indian person who doesn't want to engage the system, wants to be left alone and also doesn't want a tax penalty, would be an individual interested in being exempt from the mandate. So currently there's two exemptions, one which is in law, members of federally recognized tribes are exempt from the individual mandate, and there's a CMS regulation that allows IHS eligible to claim a hardship exemption and also be exempt from the mandate. So these individuals are saying we are not going to access Covered California. This isn't what we're choosing to do. They have a right to do that. However, to apply for that exemption, it is not being done by Covered California. They are deferring to the federal system and there's a federal application that the individual will have to complete. It's a prospective application, meaning once they apply for it, it will follow them through their life unless they're in a unique IHS eligibility circumstance that may change. For example, they're a non-Indian who's pregnant with an Indian child or is married to an Indian person and that's how they're getting their IHS eligibility status. And they'll indicate that on the application. So they'll have to fill out an exemption application. It has not been released by CMS yet. There's a draft in the world to be reviewed. I don't know the exact web address to find it but they're soliciting tribal feedback on that exemption form. That form is separate from Covered California, so individuals who are calling Covered California, I'm guessing you all have a script on your help line that will allow people and direct them to that hardship exemption form for those individuals, as Danny described, who do not want Covered California coverage.

THIEN: Correct. And we would be prepared to refer consumers, to explain to them how to fill out the federal application for the individual exemption, so we are prepared to do that.

FSPKR: And again to emphasize some of what has already been said, we worked really hard to streamline and make the application smooth, so we will only ask you questions that we need information for to run verifications, to see if you're eligible for our programs. And we'll see examples of that. So some of the fields are dynamic so if you tell us one thing, we may need more information so you'll see additional fields. If you tell us no, we won't ask you, you know, other questions that are relevant to other people.

MSPKR: [..?..]…that is going to possibly generate that. And I can put names no that – is that box that says "does your income come from a natural resource?" 'Cause there's a lot of Indian people that we know that say, "That's my business, not your business and it's certainly not the United States's business and I don't care about the tribal" -- These are tribal members out there. They're Indian people living, you know, in their own home. They don't want anybody bothering them, including us. I'm just flagging it, saying that may be an issue you probably don't want to take on, is a bunch of renegade Indians that just want to be Indian people and don't want to be dogged by any of these things. I'm just saying these are fishing people or they're woodcutters or whatever. They're just Indian people

and like I say, I can probably put five names on that box on there and that box itself, a lot of people think, Indian people think there's no right to even ask that of an Indian on a reservation. It's just something that we're going to deal with with Indian people.

LAURA: Uh-huh. And I think that's a conversation that should be had with Covered California to see what effects that comes with those that need to be insured, that want to be insured but don't necessarily want to give up that information. And are you talking about the income page?

MSPKR: I come full circle and that box up there and --

LAURA: [..?..]?

MSPKR: -- a person just says, "I don't want to check that box. Just nobody is going to check, do an IRS audit on my income because I'm a fisherman or I'm from a family that lives off the grid." And there's a lot of people like that. "Besides that, if I don't check that box, I can go to the tribal clinic and get services because I'm an Indian entitled to those services. I don't want this." That's the reason why I'm asking about it, is that I expect that to happen.

LAURA: And I think once we get into the income section we'll see where that type of income is input and you'll see what the options are and you wouldn't put any income that you wouldn't put on an IRS form already.

FSPKR: If they don't file taxes, they're not eligible for premium assistance, which is fine, but premium assistance comes in the form of a tax credit, which is why Covered California is asking the tax information. And the reason why they're asking unique specific Indian income, is that Indian income may sometimes be counted on your income for taxes but would not be counted against you in the instance of eligibility for premium assistance with Covered California, which is a bonus and has been advocated that it's very clearly asked in this application, those unique types of income, only for those individuals who are seeking premium assistance and want their income reduced and don't want those types of income. Those commercial fishermen or those type of people who are living off their land and making some income that way, if they want access to Covered California and they don't want that income used against them, this is their opportunity to report it and insure that it's not calculated against them. But I haven't seen the question so I'm not defending it yet.

LAURA: So again here we're on the household section and this is where we gather some information about the people in your household. Here we have the household primary contacts and this information will be pulled, some of it, from the account that you've already created once you log into the account so information we've already collected will be pulled into this application. Underneath that contact information we have the primary contact home address section. This is important

because from this address, this is where we compile and present to you the plans that are available to you in your area and that information comes from the address and the zip code that you provide for us. So let me enter that for this example. Okay. In our example here, we have Andrew, who lives in San Diego, and his zip code is 92103. And then additional contact information, your mailing address and we also want to know your preferred language so if we have any notices, we'll send them out in the preferred language that you select. So once you have that information input, we could go ahead and continue. Once you add your address, we verify that address against the U.S. Postal Service. This is to guarantee that we're sending your notices to the correct address, to the right person. You'll see here that we have one possible address so in the real world you might have several. Maybe the United States Postal Service has your address in a few variations. If you don't like any of those, that's fine. Go ahead and stick with the address that you've already input. So in this example I'm going to say I like the way I put in my address. That's where I live. I will say okay.

The next page is the household authorized representative information page. So if you have somebody in your family, a friend, that you would like to grant access to your application, you trust in them and you would like to give them the ability to act on your behalf, call in the service center and collect information or continue in helping you select plans, you can identify that person on this page. You'll see here if you said "yes", then you would go ahead and enter that person's information. For this example we're going to say, "Oh, it's just me. It's just Andrew. I really don't need anybody for that role." And we are going to continue. So now we get into the section where we collect a few general information points about the members in your household. So here we have Andrew. If I had any additional members in my household, they would be listed right underneath Andrew's name, and once we go through the initial person in the household, then you would just continue answering the same questions for each person in that household.

MARK: I think this is a good place for me to ask the question -- There are special benefits for members of federally recognized tribes and there are household members with that person, who may or may not be members of federally recognized tribes. How does your software handle this situation? In some of the federal exchange they're advising federally recognized people to only use their own – apply on their own behalf in one family pod and then apply on behalf of their non-tribal members in the other family pod, same household. What is the CalHEERS' approach to that?

LAURA: So right now we have, and we'll see once we go into personal information, where we ask you to identify, yes or no, if you are a member of a federally recognized Indian tribe. And that question is asked for each person in the household, so you can identify that mom is and dad isn't, child is, you could identify that for each person in the household. And then that will carry on into our eligibility and those people would be given individual eligibility results and that would move into plan selection.

MARK: Perfect. Thank you.

LAURA: Sure. So here you'll see some general information that we collect about the household member. You'll see we ask about first name, last name, if this person is applying for coverage we say "yes". And like I said, you would answer these questions for each person in your household. So if there's somebody in there that's not applying, you would say "no" and you wouldn't have to answer those questions. So let's go ahead and finish answering the required fields. And this is a test environment so I'm going ahead and just putting in a test Social Security number. We ask if this individual is a U.S. citizen or a naturalized citizen. And once we're done with that information we could go ahead and continue. If we had other individuals in the household, like I said, the "continue" button would go to the next person. You would fill out the same information for that individual and continue. So the last page in this section is our summary section so we get a quick overview of some of the details that we input. If you wanted to modify any of the information, you could do that on this page. You could just click the "edit" button. It will take you back to those pages for you to modify those fields. Go ahead and continue and just go through the process again. So we'll say here our information's correct. I think we filled it out okay, and let's go ahead and continue. And so we are now done with the household section. You'll see the household section has a nice white checkmark.

And now we're on the introductory page for personal data. Again on this page, a quick overview of the information we'll be collecting and some of the documentation you might want at hand in order to complete this section. Let's go ahead and continue. So on the address and contact information page we ask you if there's additional contact information that you would like to provide. If you had several members in your household and they didn't necessarily live at the same address, you could put a different address. Say you stayed late at work or you work in the evenings at a different location and you want to get your mail there. You could also provide that address.

MSPKR: [..?..]

LAURA: Good question. I would assume so since it's -- Yes, yes. 'Cause this is just communication. For your eligibility and your plan selection, that was in our household section where we entered our address. So let's just say the information we entered in our household section, that's where we want all of our information to go. I don't have any additional information I really want to give.

FSPKR: I have a question. If you [..?..] your P.O. Box, do you also need(?) this [..?..] address?

LAURA: No. This is just if you want -- If you have a mailing address, you would say "yes" and --

FSPKR: So you don't need a physical address in this.

LAURA: You do need a physical address. That is where the plans are derived from. So in our household section we asked you for your physical address.

FSPKR: It also indicated that you needed a P.O. Box in there. So in the household section it said, "What is your mailing address?" It didn't indicate [..?..].

[Simultaneous comments]

FSPKR: Okay.

NOAH: I'm Noah, everybody. Hello. Hi. I didn't know I was going to be talking to people in public, which is why I'm wearing a Polo. I apologize. So just to clarify on the question that was asked about whether or not you can enter a P.O. Box, absolutely the system will not prevent you from doing that. What's really important to us when we're talking about addresses is getting the zip code that you live in and in some cases the county that you live in, because that's how we determine the rating region that you're going to fall into so that we can display plans to you. So from a functional perspective, the system wouldn't prevent you from putting a P.O. Box as your, quote, physical address, but we do have to have something in those fields so that we have a place that we can return a rating region for you. So I hope that I didn't a), talk too fast or b), that that made some sense, but yes, you can enter in a P.O. Box for a physical address if you want to.

LAURA: There's another question in the back.

MSPKR: It's around the address issue. Where a person might have another address, the only one that comes to mind immediately is if you have a child that's under 26 years of age, they would qualify under your insurance plan so they might be away at college and have a different address than you might have, as the parent. But I was trying to think of maybe other situations where that might happen. I don't know. Like if maybe a family is divorced, you know, where the child lives with another family, you might put it there as well, I guess.

LAURA: Uh-huh. Definitely.

MSPKR: Would you actually go back to the court order to see, do that kind of verification? You know, like you're claiming the child in your home but yet, you know, the child's living in the mother's home, just for example. So are you going to look at that kind of detail or just accept what we provide there?

LAURA: I think Thien has an answer to that.

THIEN: So to answer your question, we will not verify back to a court order. We're going to assume and believe that the consumer, what they're providing is accurate. What will happen is if there's an issue – and I'm just talking about broadly; I'm not talking about specifically with the federally recognized tribal members – in the event that one does not report information accurately or at one point in time they did and the situation changed through the benefit year, then during the tax reconciliation process, if they received excess tax credit, advanced premium tax credit, then that would have to be reconciled at the end of the year when they filed their taxes. I just wanted to clarify, if I may. Earlier – I apologize – I think it may have been Jim that asked a question, I think earlier, about kind of like where there's members in the home who are federally recognized and maybe members who are not federally recognized, maybe they're state recognized or maybe they're not, you know, Native American/Alaska Native, and the question was in that family composition, how do they submit their application to determine eligibility because of the family makeup. And so we do recognize and know that there's something we need to work on in the system. Right now the system requires people to be in the same plan, which we know is not the way the system should work. So we are in the process of identifying more about what we need to do in order to fix the CalHEERS. So in that particular situation, as a short term circumstance, we are going to ask families who are, individuals of a family who are federally recognized, to submit an application for premium or for financial assistance. And then for those – so that they can get the right plan that is available to them due to their federally recognized status. And then for the other family members – and I know this is absolutely inconvenient; absolutely recognize that – but this is the best that we can do right now until we can get the CalHEERS system functioning the way that we would want it to – whereas the federally recognized other family members could submit an application for the non-premium assistance program so that they can select their plan selection that's available to them. And then for those who are federally recognized, they can select the plan selection that is most beneficial to them under their status. So I just wanted to clarify that. But we know it's not good. I want to recognize that we know it's not good and it's not okay but it's definitely something that we will be working on very soon.

LAURA: Question?

MSPKR: Could I add to that? This is one of the items that was identified by the Advisory Committee on the agenda that was presented before. It's something that your folks have raised and we'll, I'm sure, be monitoring very closely to make sure we get it fixed.

THIEN: Absolutely. Thank you.

FSPKR: One of the questions that I have, the insurance company now – private insurance companies are going out and asking for verification of your children, your spouse. They're actually sending out letters and I received one personally to verify that I

was a spouse to my husband's insurance and the children are my children. Now under this program, are you going to be doing the same thing?

THIEN: Under this program, based off of how you explain that your child is your child and your spouse is your spouse and how you report it, whether it's on the Covered California/CalHEERS system or on paper, we would take your word and based off of that and based off of what type of information is reported on the application about your income and other things, we will say okay, based off of what she provided – I'm sorry, I can't see that far – what Patty provided, here's the eligibility. And it's primarily with the household composition, we will attest –I mean, we will accept what you said, but your income we'll need to verify to say oh, her household is a family size of three. She indicated her income was a set amount. Is the income that she indicated as her household pretty accurate? And then that's where we go through the verification process.

FSPKR: And then in order to receive the verifications and stuff that you're requesting, you get a 90-day window.

THIEN: Uh-huh.

FSPKR: During that 90-day window, if the member cannot produce that information or even with the extensions cannot produce that information, are you going to be penalizing the member from day one that the information was not going to be accepted, or are you going to continue to allow that during that period?

THIEN: So during the 90-day period the member has access to services. They technically have healthcare coverage and they should access healthcare coverage during that timeframe because they qualify – I call it temporarily until they have to provide additional information to us. So during that timeframe they have access as, you know, like they have healthcare. So I'm not quite sure of your question about whether or not they would penalized, but they have to provide the information within that 90-day timeframe or at least submit something explaining why they couldn't provide the information, as I mentioned earlier. And if we grant it, they will continue to have coverage up until the point in which we learn that they should've provided the information to us. And let's hypothetically say someone ended up being terminated for coverage or their end date of coverage because they didn't furnish it. During the end of the year, as I noted earlier, the submission of one's tax return form will indicate whether or not did they, during that timeframe in which they were enrolled with our program, at the end of the year, did they have to – you know, did they take excess of the advanced premium tax credit or potentially did they take less than what they could've taken? So that's something that needs to happen at the end of the year when they file their tax return. Does that answer your question, Patty?

FSPKR: Yes.

DAVID: Could I ask – extend that question to -- It's David here. Was your question would your insurance be rescinded?

FSPKR: [..?..]

DAVID: After 90 days, would we go back and say you didn't qualify.

FSPKR: [..?..], you go get documentation for this coverage to continue, what's going to happen to [..?..] coverage? It's just going to stop?

DAVID: It'll stop. The three months that they did get will remain in effect, so the services they used during the three months, they'll be covered but it will be terminated prospectively, only.

FSPKR: So the clinic where we billed the insurance company for services rendered, the insurance company will not be coming back to us and saying they were not eligible at that time?

THIEN: That is a true statement. So when I'm in January 1, I get January, February, March. I'm in, I'm in. And when I disenroll because I didn't provide the information, it's a future month. We don't go back at all, so that the consumer and the provider, they're basically, you know, held harmless because technically that was an entitlement that they had as they were entering into the program. And I apologize for not understanding your question more clearly.

FSPKR: I actually have two questions. The quickest one is will families always be asked for verification? So should we prepare our patients and clients that this is the documentation you will always need to provide?

THIEN: Okay. May I take that one also?

LAURA: Yeah.

THIEN: Okay. So situations where they may, they may not, okay? Now depending on so when a person says they're a U.S. citizen or lawfully residing, we tap into the federal services to verify. When they report their income, we tap into the federal services, the data sources, to verify. So in the event that when we look there and it shows hey, she is a U.S. citizen, or the income that she provided is close to what we know, CalHEERS – and that's the great part of CalHEERS – you get real time eligibility determination. So CalHEERS will come back and say okay, well she's fine with her U.S. citizen. Thien Lamb says she's a U.S. citizen or lawfully present person, she's good, and her income is good. CalHEERS will tell you that. Now if you receive a message saying oh, you know, Thien Lamb, she needs to turn in her proof of income because what she said didn't match with the information in the federal services – IRS, basically – then you would know that when you use CalHEERS.

FSPKR: So just mostly if there's a substantial difference between the [..?..].

THIEN: Correct. And it's like a 10% rule. And also, as I noted earlier, when one is trying to demonstrate their federally recognized status, because right now – and it's something we're looking into in the future – we don't have a federal services hub or an electronic database to verify, then in those situations it would be very good to prepare the consumer that, "Hey, in 90 days you would need to submit your verification. And I heard – you know, there's probably some better ways that we need to work on that from just a couple feedback, and if there's things that we need to consider, would love to hear about it.

FSPKR: Yeah, 'cause my understanding is that there may be a way to access through IHS and if they're in our system as a client and IHS can access that system, then…

THIEN: So when you're saying "in your system", you're referring to your…?

FSPKR: Like our data system that I can –

[Simultaneous comments]

THIEN: Okay, but individual data systems, right?

FSPKR: I don't know. But that would just be something I had heard. My other question, as you're recommending that if we have a family with members who are not federally recognized and members who are, if we're basically doing two application processes, how do we help them with their income verification? Say they're a family of four, the non-recognized family member is the primary income, then the other three federally recognized family members, so how does that work income-wise?

THIEN: Okay, I'm going to take that one also. So in that particular scenario – and I tend to go very detailed and I think sometimes it's just – scenarios are great because it explains in more simple terms the complex process that we have. So in the scenario where it's a family size of four and then maybe one person is federally recognized, the other three people are not, but all four family members want healthcare coverage – I'm going to just make the scenario that way – then the individual that is federally recognized is then applied for in the premium assistance application. But you would still report the people, the other three people, as part of the application as living in the home. However, they are not applying for financial assistance because we want to make sure – and again, we know this is an issue – we want to make sure that the person who is federally recognized can access the plan and the benefits that are best for them. So you'll report the income as normal.

FSPKR: So is that the box where you check are they applying for…

THIEN: Correct. But then you'll say oh, well his wife here, who's not federally recognized, has an income of whatever. You would have to report information about people's income, because remember, it's household income. Then you'll get a real time eligibility determination and then you'll apply for the other members for the non-financial assistance, where income is not a factor. It's about U.S. citizen, lawfully residing and so forth.

FSPKR: Okay, so two separate applications but all four names are included.

THIEN: Correct, temporarily until we get it all right.

FSPKR: Okay, thank you.

MSPKR: So going back to the original example of somebody has not submitted all their documentation, so let's say you give them the exemption of 90 days and then they're able to access services. But at the end of the 90 days then, you know, prospectively they wouldn't. So in our programs, we do an annual verification, okay, to verify what their insurance coverage is or has it changed during the year, Medi-Cal or private insurance or those other things. So theoretically then at the 91st day all the way through the end of that year potentially, somebody could originally have signed up, could have received services, but for the next nine months will we get notification, the clinics, that they're no longer eligible? Because in essence we could provide, you know, the remaining part of that year of services, even though they have no insurance coverage. Does that make sense, what I'm trying to say?

THIEN: I believe – I think I'm following you.

MSPKR: So 90 days is equal to one quarter. The remaining three quarters we're operating under the assumption the person has insurance so we're providing the service, but do we get notified if in fact they are not going to be covered, which means that we might have to change our process. Instead of doing an annual verification, we might have to do it on a quarterly basis from a system point of view, you know, from an administrative.

THIEN: And so I – I understand your point. So what we do do is when Thien Lamb is enrolled, the plans get a notification from us to say hey, she's eligible, she qualifies. Here's her start date of coverage. And then in your scenario, Thien Lamb no longer qualifies after 90 days. We will notify the health plans and the health plans will be aware of that but we don't necessarily notify the providers. So I'm not sure in today's world what you currently do, the relationship that you may have with the plans that you're working with and partnering, if there's regular checks with the plans. And it doesn't sound like there are if you're assuming that's a whole annual process.

MSPKR: [..?..]

THIEN: Potentially.

FSPKR: I have a question. So there's a single father who is court-ordered to carry insurance for his child but the child is not in his home. So he has to cover for the whole year and you guys verify at the end of the year on taxes, but they can't claim this child on their taxes. How would he go about getting this child coverage?

THIEN: So I'm sorry. Father does not live with the child.

FSPKR: No, but he's mandated by the court.

THIEN: But he's required to obtain healthcare coverage for his child, but the child is not claimed as a tax dependent. So what will happen is the advanced premium tax credit is tied specifically towards the tax filing, like the dependent identified on the tax filing form. So in that situation potentially he would have to go through a tax reconciliation process at the end of the year, depending if he's trying to apply the advanced premium tax credit upfront, and then at the end of the year you don't see the child claimed on his taxes. There might be some, you know, issues with him having to -- Because technically he's not eligible to get the tax credit because that child has to be a part of his tax filing status as a dependent. Does that make sense?

FSPKR: Kind of but not really.

THIEN: Right. Okay, let me try to explain this. For premium assistance, for any type of tax credits, whether you apply it early or you apply it at the end of the year, the person has to say that they're going to file taxes. And based off of who and how they file taxes, the dependents shown on the tax form needs to be a dependent that they're trying to apply the tax credit for.

FSPKR: So Thien, the question is specific for in a tax household of three, let's say it's an example of a household of three, a man, his wife and his baby, so three, but he has to provide coverage for two children from a previous relationship based on California and how we handle Welfare. So the man has to provide coverage for those two children who he does not claim on his taxes. So he's saying tax household side of three but he wants to buy insurance for five. Does the system allow for that? Because those children are not filed on his taxes. They understand that and they know that. But can you buy coverage for someone who you are not filing on your taxes and can you still get the premium assistance for the two people you can file?

THIEN: Oh, okay. So you guys correct me if I'm wrong, okay? Sorry. So he can still purchase healthcare coverage for the children that he does not claim on his taxes

and the way in which he can purchase the coverage for his children is through the non-financial assistance process.

FSPKR: So separate application.

THIEN: Separate application for the kids there. And then for the children that he does claim on his tax forms, then he can apply for them using the premium assistance application but they would then be two separate types of applications. Is that a true statement, Darrell and Noah? Make sure I'm being honest, please. And I'm getting nods of the head for those who are on the webinar.

FSPKR: Okay, so just – 'cause this is a real example. I'm not throwing out names. So okay, let's say those two children are members of federally recognized tribes, just to throw that in the mix.

THIEN: Okay.

MSPKR: Could I add something here? What you've got to do is you've got to get mom to file an application for coverage for her children – and this would solve the issue of federally recognized tribes. If the kids are members of federally recognized tribes or if, to get access to the tax credit, if those kids are on mom's tax form, mom's got to file. And so when mom files, she can get access to a tax credit and then have absent dad pay the next cost of the premium left over after the tax credit [..?..].

[Simultaneous comments]

FSPKR: I think that when the dad has a job and he's working, Welfare wants – and he has healthcare benefits – I think they require that he provide insurance for --

MSPKR: Child support?

FSPKR: Yeah, first before Medi-Cal.

MSPKR: Child support orders include, generally include, medical support aspects to it. This is something new in the child support world and Child Support Department's looking at it closely. They may well come to an arrangement where you go back to the order and modify it to say that he pays the net premium after the family applies for the tax credit. So I'm not sure where Child Support is going to go with respect to what the rules are there. The other thing is that if the children are in a household where their income's in the Medi-Cal level, they cannot get access to the tax credit. They will be Medi-Cal eligible and they'll be signed up for Medi-Cal. And because they get Medi-Cal, that taxpayer for that household can't get access to the advanced tax credit.

FSPKR: Can I ask my question? So under the CEC agreement, you're told not to create multiple applications and if you create multiple applications it's going to assume that you're trying to do that in order to get more funding for those applications you've completed. Since this is just temporary, will that be noted when we have different applications for the same household?

THIEN: That will be noted because it's right now the temporary solution. And so we would not be raising our eyebrows if we notice that Thien Lamb applied for myself in the non-financial assistance program, and then I had to apply for my child into the financial assistance. We recognize that there's a system limitation there and we would not raise our eyebrows or be concerned about that because we know that that's an issue.

FSPKR: Even if for both applications they are applying for financial assistance only one is federally recognized and one is either not or non-Native?

THIEN: Uh-huh.

FSPKR: That would be okay? And then when that fix is available, how will you be notifying everyone?

THIEN: Yes. That's very important. We would be notifying our folks, our partners and our stakeholders about this new change by way of additional information to the certified enrollment counselors and through the outreach and education grantees and so forth. And we still have our CalHEERS demonstration to go through. May I ask for us to -- I know everybody wanted to take a look at CalHEERS. Would it be okay if we continue? Would that be -- Okay. So go ahead, Laura.

LAURA: Sure. Just one note back to Patty's question about relationships, we do have a relationships page that we ask about under households. But since in this example we have one individual – if we had a number of family members, the relationships page lists all the members and we just say what their relationship is. And that's just to help us calculate eligibility for the programs that we can provide. Like Thien said, we don't verify those relationships. Okay. So let's keep moving forward. And I know we're limited on time and we are --

FSPKR: Laura, it's okay. We do want to make sure that we make it through this whole demonstration. I'm presenting next and most people in this room know that I can go quickly so I want everyone to ask the questions on the CalHEERS demonstration so I will martyr myself.

LAURA: Okay. So let's move forward. I think we discussed the address and contact information page. So here's a good example, if you're going through the application and for some reason you move away from the app and you come back and you need to sign in again. This is just to verify that you are who you say you are. We have security questions. You guys are too good. And again, we're in a

test environment. I don't want to go into prod and, you know, that checkmark about attesting that it's true and actual information. Here we go. So again, like I explained before, if you walk away from your application, don't worry because every time you click "continue" on a page, it saves your information. And so if you do go back and want to continue your application, go ahead and click "resume" and it'll take you back to where you left off. So you'll see here we're at the address and contact information page. But if you did want to leave in the middle of a section, you also have the "save and exit" button. So let's go ahead and continue. So here we have the demographic information page. Here we ask for some information about each of the individuals in the family and we ask about their marital status, if they have any disabilities or any medical expenses in the last three months. You'll also notice we ask here is this person a member of a federally recognized Indian tribe and it's important to note --

FSPKR: [..?..]…[unmiked]

LAURA: Thien? You heard her question?

THIEN: Yes, yes, even though my face was faced this way, my ears were here. So the question was – yes, the past medical expenses for the past three months. That's actually for the Medi-Cal program so I'm not sure if folks are very familiar with retroactive Medi-Cal and that is intended for the Medi-Cal retroactive, going back three months, in case there were medical expenses so that the individual can apply and then potentially be eligible for Medi-Cal and then the bills will be taken care of. Okay.

LAURA: Thanks, Thien. So important to note that the questions here are required, in addition to "is this person a member of a federally recognized Indian tribe". So this question is what triggers the rules for your program eligibility for AI/AN. So for this example we are going to say "yes". And then we get into our tax information. You'll see here that to begin with we are asking very minimal questions and depending on the information that you give us, we'll ask for additional details. So here we'll say that we are the primary tax filer. We did file taxes last year and I filed as a single. I was not claimed as a dependent, I do plan to file again and I would like to take advantage of that APTC. And I will probably file as a single and I will not be -- And I don't expect to be claimed as a dependent. So you'll see the questions are fairly simple. If you were not to file taxes in the following year, then we wouldn't ask additional details. And we would ask this of every person in the household.

FSPKR: [..?..]

LAURA: Yes. So you'll see here under the filing status, "married, filing jointly." And we'll go ahead and continue. Next we have the healthcare information page. This is some general information. We have here "does this person have or has this person been offered affordable, full-coverage health insurance for January?"

You'll see here some of the options are COBRA, Veterans' Health Programs, but we also have Indian Health Services, Tribal Health Programs and Urban Indian Health Programs listed. So if you are offered or are enrolled in any of these programs, you can go ahead and select it. It will not count towards MEC. I think it's for a calculation for Medi-Cal and billing. We'll say no for --

FSPKR: Can I ask a question or clarification?

LAURA: Yes.

FSPKR: So last week I helped – in this example – two separate households. And the first household it was a woman and she was married and she was a member of a federally recognized tribe and she gets her care at our Indian health clinic. So we chose one of the options for Indian Health Programs. I don't know if it was that particular one. So for her, when we got to the end, she was not eligible for advanced premium tax credits.

LAURA: Right. That is something that we've detected in the application and we are already working on and actually have that fix implemented here and it's already being moved into the production environment, the live environment.

FSPKR: So for her particular application, do you suggest that we don't finish it? I mean, we did submit it and now it's pending. She has to upload some verifications. So what should we do for her application?

THIEN: So I'm going to take that one.

LAURA: Go ahead.

THIEN: Thank you. So what I would recommend us doing is making sure – because technically she's eligible, I presume.

FSPKR: Yes. Her husband did get the advanced premium tax credit 'cause he is not eligible for this program but she did not.

THIEN: Okay, and she did not.

FSPKR: Uh-huh.

THIEN: And is he federally recognized?

FSPKR: No, he's not.

THIEN: Okay. And so I'm thinking because earlier our scenario was the other way. Oh, so what I would recommend us to do is for us -- Because right now if we were to go in and uncheck the box, I'm concerned about her not being able to view the

plans that are available to her under the federally recognized status. That's a concern and again that's something that we know we need to work on. So what I would recommend – and I'm not sure where Noah is and Noah can say, "No, don't do that, Thien" – what I would recommend in order for her to have her plan that is available to her under the federally recognized status, is to go in -- Because technically she's eligible for an advanced premium tax credit and to submit another application so that we're not establishing barriers for her and to make sure that we don't check that box where it says "minimum". Because while we're in the process of making that system change, it's very important for her to get the eligibility disposition sooner than later. Does that make sense? And Noah, would you agree with that approach?

FSPKR: That does make sense. I just don't know what to do with the application that has been submitted. It'll show that she's already applied, correct?

THIEN: So right now does it show that she's not eligible for advanced premium tax credit at all and it doesn't say anything about Medi-Cal, correct?

FSPKR: It says she's not eligible for advanced premium tax credits nor cost sharing nor Medi-Cal.

THIEN: Okay. So Noah, from a functional standpoint, I'm going to turn to you. What would you recommend to do? My concern is to ensure that she's able to access her cost-sharing reductions, right, and for her to be able to reap the benefits of being a federally recognized tribal member.

NOAH: I think I've got the details of the application but I think that you said you had one person who's federally recognized and one who's not, correct?

FSPKR: Yes, her spouse.

NOAH: Okay. So we would recommend that you do a second application so that they can each get the benefits that are relevant to them so that they can apply for the federally recognized plans that are available as well as a special cost-sharing reduction that is available to the federally recognized member of that household, while the husband who did receive – I believe it was spouse but I'm going to go with husband – who received APTC on his own would be able to continue with his enrollment on that plan for the time being. And on that new application, I would suggest not indicating the existence of IHS, URHS or otherwise but just – I believe it's going into production this weekend but I can't speak for that.

FSPKR: Okay, so just to clarify, in the current application could I go back and check that she doesn't want any coverage? Would it allow me to edit that?

THIEN: You can go back and indicate that she doesn't want any healthcare coverage. Did they already select a plan, by chance?

FSPKR: No, they didn't.

THIEN: They did not. Okay. So what I would recommend you to do is just submit an application for her, right, as an advanced premium, tax credit premium assistance. What I would like to offer, if I may, is if you can contact us just so that we make sure that things go through just –

[Simultaneous comments]

FSPKR: Call the help desk. Okay.

THIEN: Well, I would prefer for you to contact my team, not the help desk, so that we can monitor and we can make sure that it works very – that it's seamless. Because it's a special and unique situation and we're hoping that the fix will be going in this weekend but we can't confirm that. So we can just absolutely commit that we're doing the best that we can to resolve that situation about minimum essential coverage.

FSPKR: Okay, thank you.

THIEN: Okay.

MARK: So let me do a quick check-in. We're now at 2:15 and technically we're scheduled to move to the next agenda item, which would be tribal sponsorship. This presentation is really important that we're having right now and Virginia and I have talked about this and, you know, one idea would be just to continue on with this robust discussion because it is so important, enrollment and eligibility. We can just continue on if the group would like to do that, or we could move into the really cool tribal sponsorship video.

FSPKR: [..?..]

MARK: Yeah, it's designated for, what is it, in an hour or so? 45 minutes.

LAURA: We have one more section before we get into eligibility. Eligibility is pretty quick. Like Thien said, it's instant and we'll see what are results are and then we could just go and see what the plans look like. If you guys can allow me to jump into income and put in a few numbers so we could run by that.

MARK: Sure.

LAURA: And then you guys could go into the video.

MARK: Okay. Yeah, I think we should just move forward with this presentation. Maybe to verify group, you know, community here, a show of hands. Who wants to

continue with this presentation, raise your hand? Okay. How many want to switch to the sponsorship presentation? Okay. Clearly we're going to move forward with your presentation so take as long as you need, work with the group. Really key information. CRIHB will commit to, if we don't get to the video sponsorship information this afternoon, we'll commit to running it through a webinar, video teleconference, whatever the case may be. So please continue.

LAURA: Okay. So we are finished with healthcare information. We can go ahead and continue to the final page with personal data, which is our optional data page. So this page, the information here is completely optional. The information that you provide on this page will not count against any of your eligibility. It's just information that we collect so we could target our resources and our efforts within Covered California. So you'll see here we ask about the languages spoken, origin in certain situation, we'll say "no". You'll see here that American Indian or Alaska Native is already selected because we had already identified ourselves previously in the application so that information is pulled in. And we also have a question, "is this person a member of a federally recognized Indian tribe?" Again, this question is optional but if you select "yes", then we ask for additional information, where you could select the state. Here I'll say California, and then the tribe that you are associated with. And we have a pretty long list. This is California. If we had selected a different state, we have those as well. And you could go ahead and select "continue". Again optional. You don't have to answer but we would appreciate the information because it helps drive some of our outreach efforts and push our cause. So great. The last section, of course, under personal data is a summary page. Again, you could go through each of the sections we've already gone through, verify your information. If there's anything in there that you wanted to modify, you could click the "edit" button. I think we're good so we're going to continue.

Again, an introductory page for our income and income is the last section in the application before we jump into eligibility. So in the income section we collect a few different income types. So we collect employment income information, self-employment income, other forms of income and income deductions. So let's take a look at each of those. So here we have employment income and to add employment income you just click the "add income" button. You'll come to this "add employment income" page where if you had several people in your household, you could select their names from the dropdown. In this situation we only have Andrew. But here you would just identify your employer, the amount, and how often you'll receive that money. So you could put your hourly wage, daily, weekly. We have several options – every two weeks, twice a month, monthly. So we have the option, if you have two jobs you could put the entry for one job amount there, the certain frequency and then add the additional employer and then the amount and then the frequency. Let's say here this is on a monthly basis. We'll say "okay". So if you had additional family members and they also had employment income, you could do the exact same thing, add income, select their name from the dropdown and then run through the same fields. So once

you're done entering your employment income you could go ahead and continue. Here, if you had any self-employment income you could do the same thing. Again, the household member, the type of work and then how much net income. So we'll say we don't have any of that. You don't have to list it if you don't have it so let's go ahead and continue. Next we have "other income". It works very similar to the other fields we've seen. Here we have Andrew's name. You could select a different family member if you had several listed, what type of income. We have everything from unemployment benefits to farming or fishing income and income from American Indian or Alaska Native sources. So again, this is where you would identify any of that income. You would list the source, title, how much you receive – we'll say 500 – and then how often. We'll say on a monthly basis we get [..?..] and we'll say "okay". And if you had additional sources then you could just go ahead and add them with the "add income" button. We'll say this is all we have for now. Let's go ahead and continue. And then the final income type is income deductions. So this, income deductions listed here would be the same deductions that you would list on an IRS form. So let's say here we don't have any income deductions so we are good to continue. Great.

And like every other section, we come across a summary page. So it's good to keep in mind if you do have a job that does not pay consistently, this gives you a good breakdown of the information you've already input. So if you have an idea of what you would get at the end of the year, you could look at this and see well, that really doesn't reflect the amount of income that I would eventually get, so let me go in there and change some of those numbers. But if it's something that's consistent, then this would already have a good breakdown for you. So you'll see here you have your employment income, you have other income, it gives you subtotals of that number. Yes?

FSPKR: [..?..]…[unmiked] if you're requiring proof, right?

LAURA: Right. Uh-huh. I think it's a 10% threshold. Then it'll trigger verifications for income.

THIEN: And we will also be working on establishing -- We recognize that's a problem because people's income don't stay the same and especially when you're talking about IRS, the income is older. So we do recognize that that's an area that could cause some barriers for consumers because they're in fact reporting the most accurate information, and we will be working with the EDD Department, just to share with you, to at least establish access to a database that has more updated information on a quarterly basis of their data, particularly for wages. So just to share that with you as well.

LAURA: I think you have one more question here.

THIEN: Here. I'm going to give this to you, Candace, and then we're going to put it back on the stand 'cause I feel horrible. I know there are people who have raised their

hand and then it's down before I can get to you. So if we could use the mike stand, that will make sure that we don't miss questions.

FSPKR: Is there an option that they can go in maybe at the beginning of the year, they're employed; mid-year they lose their job – and go in and do like not a full reapplication but change their application so they would have a lower premium?

LAURA: You do report those changes on the application and then you would go through eligibility again. It's important to understand our eligibility results when you get it the first time so you know what you're qualified for as far as APTC, that money that you're getting on a monthly basis or at the end of the year. Because when you go back and you change that information in your income, those results could change. So given those results, you might want to possibly enroll in a different plan. So you can submit that information.

FSPKR: [..?..] [unmiked]

LAURA: Yeah.

FSPKR: [..?..]…[unmiked]

LAURA: You do have the opportunity to update your application. And again, if you wanted to do that right here, you could use any of those edit buttons. So let's go ahead and continue. Now we're in eligibility. Eligibility is fairly quickly so before we go and sign our application, see our eligibility results, we want to verify that everything we've entered in the application is true and accurate. So you could roll down each of the segments that we've already gone through and you'll see it's fairly simple and broken down into easy-to-read sections. If you wanted to update any of that, just click "edit". I think we are good so we're going to continue. So here we have the application signature page and this is before we go into eligibility results. So this is to verify and confirm that yes, I have entered all the correct information. You could go ahead and verify what I've submitted. And this is the section that Thien was pointing out, where we could verify your information on a yearly basis without having to reach out to you every single year. If you want to allow us to do that, you can identify that here under "maintain my consent for" and you could select the years that you want to allow us to do that. If you don't want us to run those verifications on our own, then you could select zero and we will ask you to provide those verifications for us. We'll say yes, I reported all my information and that it's true. I am signing away under penalty of perjury. And now you just sign with your electronic signature and enter your electronic PIN. And your PIN is a four-digit number that you set up when you created your account. And hit "submit". And here what's going on is we are sending that information to our federal hubs. We are running rules in the engine with Covered California and now we get our eligibility results. So here you see we made great use of color coding. Up top we have what programs we are conditionally eligible for. You'll see that information in green. And we're

conditionally eligible because there is still some information that we need to collect from the individual to run some verifications that we weren't able to verify with the exchange in the application, exchange electronically. So you'll see here that Andrew is conditionally eligible for APTC for $1,452.00. He is also conditionally eligible for CSR. You'll see here in the yellow section the documentation that we still need to get as far as verifying your information. You'll see that we need proof of American Indian, Alaska Native status, proof of income, proof of citizenship. And some of these verifications are triggered because we weren't able to verify that information when we do our electronic transfer of information. If you had any of those documents at hand you could already submit those verifications through the "submit documents" link. I'm going to hold off on showing you that 'til the end. Right now I just want to get you guys through plan selection. In addition, we also have this purplish section, which lets you know what you're not eligible for. And then below we have important information options, some of eligibility determination factors, things we took into account to give you the results that you have. We have "appeal decision". If you're not content with the results that you were given, you think there might be a discrepancy, you could appeal the decision. We also have referral for other programs. These are programs, county programs in your area that you also can look into. So great.

At this point, you know, we've had a long day. You can go ahead and save "plan selection" for another day. Your information is saved. But I think we're pretty excited to keep on moving forward so we have our "choose a health plan" button, which will automatically take you into plan selection. So here we have a quick breakdown of the programs we're eligible for. We have APTC, CSR. We're going to select "choose a health plan" to go into our plan selection phase. This is plan selection. You'll see it's very similar to some of the pages we've already gone through. Summary. You're going to tell us what's important to you as far as the medical coverage and prescription coverage, compare and choose plans and then we'll sign away our information. So let's go ahead and continue. We have the "estimate of cost" section. So this is just to give us an estimate of your out-of-pocket costs. So if you feel like you may have high medical use, you can identify that here. We've already selected ourselves as a healthy person. But if you think you might visit the doctor fairly regularly, you could say you have high medical use. In this example I think we're going to say we're pretty healthy. We only see the doctor one or two times a year. Prescription use as well, pretty low. Underneath "estimate cost", we have "find your doctor". So if you have a doctor you've worked with in the past or are interested in working with and find out if that person is in your network or associated with a certain plan, you could go ahead and search for that doctor. We'll say I've worked with Dr. Colick (?) in the past and I want to see if he is in any of the plans that are available to me. You'll see here you could search -- Let me go back one more time. You could search by name or you could search by zip code to get a complete list of those providers in your area. And so you would get a list, if you had searched for zip code, you'd get a longer list where you could scroll down. Here we searched by name so right

away I see Daniel Colick. And yep, that's him. Go ahead and select his name, get a few more details about him, add him to your list and there he is. If you wanted to add additional providers, you would just click the "find your doctor" button. I think we are good to go so we are ready to choose a plan.

Here we go. So here we have our "find our plan" page. You'll see that to begin we have plans listed by threes. And below the plan -- No, first let's talk about the titles. We have the title here. If you hover over the title you get additional information about the plan. You'll see here it'll list your monthly premium after the premium assistance of 121 and that would be different for every person, depending on their situation. And underneath each of those plans we have additional details. See, here we have a summary of that plan. You'll see here this nice checkbox. Means that the doctor that we identified is within our plan. If he wasn't, then it would be red. We could close these little dropdowns and see additional information about deductibles and out-of-pockets. Oh, yeah, go ahead.

FSPKR: I haven't had a chance to speak all day so I'm just going to barge in. So could you, Laura, go where you were before, so because we said we're a member of a federally recognized tribe in the eligibility portion and our income is under 300%, you'll see that we're displaying the, what we're calling AI/AN zero cost-sharing plans. I do want to note you'll see the metal tiers. They're indicated up in the left-hand corner by that triangle. You might think why are we showing all metal tiers, why aren't we showing bronze, which would have the lowest premium? Our metal tiers could vary by provider network so we're showing all tiers and people can make their choice. So that's for the premium piece at the top. When we go down and we look at the summary of benefits, that's where we'll see zero, zero, zero and "not applicable" because that's zero cost-sharing for American Indian and Alaska Native. If we were over 300% or if we hadn't said we were a member of a federally recognized tribe, we would see dollar values there. We would see $15 for prescription drugs or $3 for the doctor, whatever the case might be.

FSPKR: And just a quick clarification. For example, on the bronze plan the primary care visit, you have three visits within bronze per annual year. Are Indians exempt from that maximum visit limit?

FSPKR: Yeah, absolutely. And I think those are the three visits you get without applying the deductible, so that's something for other folks who are not in the AI/AN and plan for this. You can always go without the cost-sharing.

FSPKR: Okay, so looking at bronze plans for federally recognized Indians, there's no limit in the amount of times they can see a primary care physician.

FSPKR: No, and there's no limit generally for folks.

FSPKR: [..?..] [unmiked] It's only Indian people who are members of federally recognized tribes below 300% federal [..?..]…

[Simultaneous comments]

LAURA: Sorry about that. [Side comments] So again, we could go through each of the sections and you could see zeroes across the board.

[Side conversation; trouble with slides…]

MSPKR: Yes, yes. So this is going back a little bit on one of the screens. You know when you got to the eligibility and there was something that said you're not eligible for Medi-Cal?

LAURA: Uh-huh.

MSPKR: But if you were eligible, would you still be in this application or would you go to a separate application to fill out your Medi-Cal form? And the reason I'm asking that is 'cause there's going to be a lot of people that were like maybe at 100% of poverty to 139 that have not been covered in the past by Medi-Cal and now they'll be covered. So would they fill out their application on this software or a whole separate one?

LAURA: They would not be on this application.

THIEN: So, so --

LAURA: Go ahead.

THIEN: Okay. So right now they are not on -- CalHEERS does not allow, at least for right now, the consumer to select their Medi-Cal plan. So right now when people apply for Medi-Cal, they go through a process where they get separate notification from the Department of Healthcare Services, Healthcare Options. So right now we're still using that existing process. What will happen probably around the latter part or first quarter of 2014 or potentially early part of the first quarter of 2014 would be to make sure that CalHEERS has the ability to allow consumers to select the Medi-Cal plan selection. So right now when they apply and Thien Lamb is eligible for Medi-Cal, what's going to happen is -- You know, the process is we're going to have the information be sent to the Department of Healthcare Services, Healthcare Options, the people that – or the organization or the unit that handles all of the Medi-Cal plan selections, and then they'll contact Thien Lamb to say, "What's your Medi-Cal plan selection?" And then eventually during those quarters that I was talking about roughly, then the Medi-Cal plan selection will be available on CalHEERS where the consumer applies, they can select their Medi-Cal plan and then they're done.

MSPKR: So just to comment then on that, you know, I don't know what I'm going to qualify, whether I'm going to qualify for Medi-Cal or this program. So I get to the end of the process, I go and fill out the application, and it says I qualify for Medi-Cal. Is there going to be something that says you need to – You're going to automatically notify an agency that hey, this person is potentially eligible, but is the consumer going to know that hey, maybe I need to go down to my Social Services department and fill out a Medi-Cal application since there currently isn't the software available? Is there going to be a note there that says oh, you're going to have to go someplace else to apply?

THIEN: Well the system will be generating the notice to say Thien, you qualify for Medi-Cal, and it'll tell me what my steps are. The consumer, they've already applied for Medi-Cal using the paper application or even this, CalHEERS, so they don't need to resubmit any type of additional application at the Department of Social Services because they're eligible. They just need to make sure that they select a Medi-Cal plan and they will be receiving information like they do today to say Thien, you have to submit your Medi-Cal plan.

MSPKR: Okay, so -- 'Cause I'm trying to understand this. So then I went through this process. So then if I qualify for Medi-Cal, then I'm good to go. Then you're going to already give me the documentation – or I've already applied through this process then. So then when you're saying that CalHEERS is going to make some modifications for Medi-Cal, why would they have to if they've already filled out this application? I guess I'm missing something there.

THIEN: No, that's okay. So what CalHEERS does in support is eligibility determinations for Covered California as well as Medi-Cal. What CalHEERS does today also is for plan selection for Covered California but does not allow a consumer to do plan selection for Medi-Cal. Okay?

FSPKR: But this is a Medi-Cal application.

THIEN: But it is a Medi-Cal application.

MSPKR: Okay. So this is either/or right now. If a person is signed up, they're either going for Covered California or Medi-Cal at the same time.

THIEN: Correct.

MSPKR: But then they find out at the end of this application, oh, by the way, I qualify for this so this is probably the way I should go then.

THIEN: Right. And so I just want folks to know and understand that they will – for Medi-Cal, for the Medi-Cal plan selection, will be receiving additional information from the Department of Healthcare Services. And then eventually, in the first or second quarter, again, of 2014, CalHEERS would be able to say, so that the

consumer doesn't have to wait, they can just shop and look for their Medi-Cal plan selection, in support of our guiding principles, seamlessness, and consumer experience, then we'll have the ability for Thien to go in there and say this is the plan that I want under Medi-Cal.

MSPKR: Thank you.

LAURA: So again, you can see the details of each of those plans below. A few methods of viewing the different plans offered. The little arrows will take you through each of the plans, a quick browse, and then you could see those different details at the bottom of the page, you could filter or sort. So if you wanted to sort by monthly premium, estimated total cost, you can also filter by tier. So if you wanted to only look at silver or bronze, you could do that as well. So let's go ahead and filter by monthly premium. And I did a filter by monthly premium. I want to see if my doctor is within this plan. Hmm. I'll say oh, unfortunately he is not. You could see here by the red box.

[Side comments]

LAURA: Oh, sorry about that. Okay. So again, if you wanted to search for a different doctor and see if they are within that plan, you could go back to the "search for doctors" field. If you had the need to compare plans side-by-side, you can use the "favorites" option here, which is a little heart next to the shopping cart. You could select as many plans as you'd like to make that comparison.

FSPKR: We don't see it.

LAURA: Oh, sorry. [Comments about program] So let's say I want to find a plan where my doctor is available. You'll see here that we have two in our favorites so if you did want to do a comparison for whatever your situation may be, you could do that and then see those two plans side-by-side and look at what those plans have to offer. Okay, so for this example let's go ahead and say I like this bronze plan. I'm ready to check out. You could go ahead and click the "checkout" button or the "add" button. This will add the plan into your shopping cart. You'll get a quick breakdown of the plan. You'll see here the premium is 246 with premium assistance of 121. Okay. So we have our shopping cart here, we like what we see, let's go ahead and jump into our cart. And with a quick little adjustment – [Side comments] So here we are in our shopping cart. We'll see we have the monthly premium listed, our assistance and the amount that you will pay. We also have our premium assistance here with the adjustment. So let's go ahead and look at what the -- With a quick adjustment we can see how we can modify the premium assistance that we've been offered. So if you were able to see this page appropriately, you would see the premium assistance page, a quick breakdown of your premium assistance. You have a link for a second page. You'll see here your premium assistance. If you were to take it on a monthly advance, the pros and cons of that. If you were to take your annual credit all at once, you would

also see a breakdown of what the pros and cons of that is. And then on the third link we get to our premium assistance slider. Here you can decide -- We've already broken it down to you where we provide that premium assistance on a monthly basis, but if you decided for some reason you want to reduce that amount on a monthly basis and take some at the end, you could adjust the slider and modify that amount. So if you wanted to take it all at the end, you could do that as well. But we are okay with taking it all on a monthly basis so let's close out of that. So you do have that option under "adjust". So at this point let's say we don't want to make any modifications to our premium assistance. I think if we take it on a monthly basis, it's best for our situation and now we're ready to check out. Then we come to the e-signature page, very similar to the signature page that we had with our application. Here you go through the agreement and verify that we agree to the terms of service and that we agree to file a tax return. And again, to sign your information, you want to enter your PIN and again, you make up this PIN when you create your account with Covered California. And then you provide your e-signature and that's your entire name. You'll see your name displays here with the date and then you click "enroll". Great. And now we get our confirmation page with our health plan listed, the effective dates, the monthly premium. This is a confirmation of the information that was sent over to the carrier and you are enrolled.

FSPKR: [..?..]

LAURA: I will try to.

[Simultaneous comments]

LAURA: One second. Too late. Let's see. Congratulations, everyone. You are now part of our test team.

FSPKR: I have a question.

LAURA: Sure.

FSPKR: How do you enroll if you're a non-Indian parent with an Indian child in your home who's from a federally recognized tribe? Do you have to do two separate applications? How does that work?

LAURA: And I believe for the moment the solution right now is that you are doing two applications, one application you will have for the child, but you will include all family members but you will not -- You will select "no" for insurance for those that you are not requesting coverage for for that application. So two applications in that situation, right? You have the child and the mother. You'll select no insurance for the mother. You're applying for the child at the moment. Run through that whole scenario and then you will do the same for the second application to apply for health insurance for the mother, but you will say that the

daughter's not getting health insurance 'cause you did that in the first application. I hope that was [..?..]. So now that we are enrolled and we go back into our account, you'll see that we have the opportunity to submit a change. But somebody had a question about the confirmation page or…? Okay. I am not sure if I could get back to the actual… I'm going to run through this. I think for some reason it didn't capture our enrollment but I'm going to quickly select one.

JIM: Jim Crouch. Quick question. Policy issue in a way. That confirmation of coverage notice which, if you were being assisted by a certified enrollment assister who's sitting in an office in the clinic and you're doing all this work on the IHS safe wide area network, you could print that out and give it to them, is a good question. And if you could print it out and give it to them, along with the PIN that you're talking about using, I say all that's just normal HIPPA protected PHI. And if the client chooses to invest the clinic with the safekeeping of that information, then it should be amendable or appendable into the medical record and covered like everything else we know about our clients. What do you guys think? Because we're being discouraged in the training for certified enrollment counselors to have any kind of piece of paper and worry about HIPPA and all that, but unlike some street guy with a phone app, our people will be employees of HIPPA controlled tribal health plans, you know, with a lot of HIPPA training, etc. So what do you think about us being the safe keepers of some of this information on behalf of our clients, if they so choose?

FSPKR: Jim, you're talking about the sort of application information. You're not talking about the account and the password, that PIN code?

JIM: No, I'm talking about all of it.

FSPKR: Okay. I'm going to look at our rules folks.

THIEN: Yes. Well, I think that's something that we would need to explore. I don't want to give a definitive answer saying that that's something that we can and cannot do. If we can, there's going to be a lot of requirements that's associated and tied to it, I'm quite sure, because of security policies.

JIM: There's nothing more secure than our own clients' medical record, which this would be part of.

THIEN: No, no, I don't disagree. I don't disagree that what you're trying to do is to help the consumer. What I – at this point will have to take it back, is the scenario and the suggestion of having the ability to be able to store the consumer's information that they -- You know, like for an example, printing the summary page and the eligibility results and the PIN and the e-signature and including it in the file that you have for them. I don't know if that's something that we can do but that's something that we need to determine whether we can or cannot allow that to occur.

JIM: Great.

THIEN: Okay, we'll look into that. Can somebody write that down?

FSPKR: [..?..] [unmiked]

THIEN: So for those on the webinar, the question was can the certified enrollment counselor print out a copy of the eligibility results and give it to the consumer? And the answer is yes, if that's something that's helpful for the consumer and they're okay with it. Printing it out and giving it to them and not storing it in the file that you have on behalf of the consumer is okay. The question is -- the filing part is a policy issue we need to get back on.

FSPKR: [..?..]

THIEN: Right, right. So giving it to them and it leaves your possession, where it's in the possession of the consumer, is okay.

FSPKR: [..?..]…you're going to do all this policy work on if we can help our clients get this and keep a copy of it in their medical records, like we do with Medi-Cal and all the insurances right now. Yeah, we do it right now. So you guys are going to go and spend time doing policy work when to me we could just have them sign something saying that we could have it in our medical records and – individually, for every patient that we have without you guys coming back saying we can or can't, right?

FSPKR: So when we conducted the certified enrollment counselor training we had a module, a specific module on privacy and retention of records, etc. So that was direction that was provided to us from our legal staff with consumer protection as being the primary focus there. So in the role of an enrollment counselor, the enrollment counselors are able to do certain things and that was covered in that training session. We understand that your current practice is not in the role of an enrollment counselor. You are acting in a different capacity currently. So what we're referring to is retention of records while your staff are in the role of an enrollment counselor and what is permissible under federal rules, state rules related to privacy and protection of documents. So that's what Thien was alluding to earlier. So we're not asking you to change your current practice. We are just trying to clarify in the role of an enrollment counselor what is permissible.

FSPKR: So what we could do is when we're helping the client, print this page, give it to them, and then they can choose to return it to our CHS programs by their choice, couldn't they? 'Cause we're requiring information from them so that they can obtain services by CHS.

THIEN: Right, right.

FSPKR: So as an enrollment counselor I could print it and give it to the person.

THIEN: So as an enrollment counselor – and again, until we do some additional confirmation – and I hope folks understand when we're giving guidance or providing clarity, if we don't know the answer definitively and it's kind of a little stick wicky, we want to just make sure we're giving true and factual information. And so what we're trying to explain is we want to make sure if the consumer gives consent to give it back to the certified enrollment counselor, is that acceptable, yes or no, and if it is acceptable, what does the consumer have to do to show that they're giving consent. Does it have to be a form that they fill out in writing? I don't know the answer to that but again, that's something that we'll take back and we'll see what we can do, as long as it's permissible.

FSPKR: In the meantime, we could have CHS staff that aren't certified enrollment counselors, in the course of doing their job would they be able to just take it to that department and hand it in? 'Cause they need that in order to receive services from that department.

FSPKR: [..?..] [unmiked]

THIEN: Okay. And are these referrals from a provider, their capacity, or is it from a CEC capacity?

FSPKR: No, the referrals are from the provider and so they take these referrals to a separate office, the Contract Health Services, which is funded by IHS too. In order to get that service on the referral, they have to follow different steps and show that they have an alternate resource. So this paper would be part of proving that they have an alternate resource.

FSPKR: Okay. So I think what we were trying to respond to, which was a more broader issue that was brought up earlier, i.e., can we print the PIN and the signature and all of the other related information on the application. So your question is much more specific and it's just related to the printout that says the person is now eligible for Anthem Blue Cross, for example, in this example. And so if that is your current practice, where the patient is given information about their current eligibility in a given health plan, and that is your current practice, I don't think we are in a position to provide you guidance on what your current clinic practice is. I think what we were discussing was the more broader issue of printing out, for example, the PIN, the other more personal information that's related to the consumer that has a lot more protections around it. So I hope that clarifies. We don't want to interrupt your current practice, if that's what you're doing, and filing away which plan a consumer is eligible for, is what I'm hearing.

FSPKR: [..?..] the question. However, just to let you know -- I think Jim might have brought it up – we already have access to all their identifiable information. We

actually already have that in our offices, you could say, or in our computers, not the PINs or passwords or security codes.

FSPKR: Okay. I think if we could just be clear on what the ask is -- what are you asking -- and then we can go ahead and do that. So yes.

FSPKR: [..?..]…[unmiked]

FSPKR: Okay. And I think this is just a printout though. They are going to get an insurance card.

FSPKR: Right.

FSPKR: And so that's really the definitive –

THIEN: And there's actually another step, if I may. So now that I'm hearing and I – sorry – it's been a long day and my brain cells aren't working as quickly as they should work -- So here is, off of – on CalHEERS – off of an eligibility determination. Then they go through plan selection. And in order for their coverage to actually be effectuated, right, is the monthly premium payment to the plans, right? Because with the 300% of federal poverty level, you still have to pay for your monthly premiums. However, you don't have to pay for any of the copays, the deductibles and things of that sort. So in order for coverage to actually start, a premium payment to the plan has to occur. So even if the consumer sees this or it's printed and it's stored in a file – let's hypothetically say there's no issue, it's okay – really that's not as accurate as the plan ID card. Because when the plan ID card is set to the consumer, that's when we know that their coverage has actually been effectuated.

FSPKR: That answers it.

THIEN: Okay.

FSPKR: So what if they want to pay at the very end of the year, like she said?

THIEN: Paid at the very end of the year?

[General discussion]

FSPKR: So if you're eligible for a tax credit for this program, you can take it in two ways. You can have it applied up front when you pay your monthly premiums, or you can take it on the back end, like you would take a tax credit for some other program. So you'll still have to pay something every month for the premium; it's just a question of whether you want to apply those federal dollars up front, when you pay the monthly premium, or take them on the back end. Some people may want to take them on the back end because they say, "My income might change. I

don't know. I don't want to be subject to having to pay back at the end." So they may want to take less, or none, and just claim it when they file their taxes. I would take it all up front, personally, but that's just a personal decision that folks would make. So it's how you want to apply the federal dollars. Does that make sense?

FSPKR: Yeah, that's the [..?..] [unmiked].

MSPKR: On the issue of storage of confidential information, this is one of those trapdoors, that if -- I don't know that they're state or not, but if the state, or whoever is thinking this is a requirement, if they think that they cannot trust the intake process of tribal clinics today, then if somehow the Affordable Care Act requires the tribes to hire three or four more staff in an isolated, privatized office, we don't have it. We have intake people. We have those records. If we integrate the Affordable Care Act into what we have, and let our staff do their job, it could work. But if the trapdoors start popping open that we have to hire more staff, we have to get some external privacy group to do this, we don't have the staff to do it.

But again, I'm hoping what we're talking about here is, in effect, code talk of how the state defines intake people for the Affordable Care Act and how tribes define intake people for typical Indian Health Services in Indian country. If we can just bridge them and say—we don't have to tell the tribe, "We're going to audit you on your privacy stuff." Like Jim said—let us take care of our business and integrate this how we can with the resources we have. Unless you're willing to give us more money and more staff and more space. I don't think you're going to do that.

FSPKR: Understood. I think we probably created more confusion that wasn't necessary. We don't want to disrupt your current operations. I think that's the message we want to send to everyone today. What you're doing, you should continue to do. We were just not prepared to answer definitively, "Can I print and keep the PIN of a consumer in that case?" It took us off guard. So I apologize if we've caused a lot of confusion. The message is you can continue to do what you're currently doing. We will go back and make sure that our training is clear on that. That's the commitment that we can give you today.

FSPKR: When your CECs help with an application, do they log onto the program as themselves and help? Or is it logging on with the patient, creating an account with the patient? I was a CAA for Healthy Families, so when I did a Health Families application, I had my own log in, my own password. I'd log in and I would do the whole application based off of my log-in stuff, which then I was able to—I had awesome tracking. I could track all my applications from start to finish, when they had annual renewals. I would get notified that, "Hey, you have this client coming up with the annual." And I was able to assist my clients. Am I going to be able to do this with that?

LAURA(?): The way we currently have the system built is a consumer needs to initiate an application. So a consumer initiates the application by logging in, creating their

password, their log-in information. And once they are in, there is a section where they can search for a certified enrollment counselor. They select the certified enrollment counselor and delegate authority to that counselor to continue the application on their behalf. So that is the way the system is built right now. That's the functionality. Yes?

MSPKR: One really important point is that as a CEC it is important that you accept their request for designation before they finish the application, or you will not get credit for having assisted on that application. So it's very important that you be logging in using your certified enrollment counselor log on, and checking for pending applications and accepting those before providing the assistance, even if it's the person doing it on their own log on. If you haven't accepted that pending designation, then you will not been seen by the system as having assisted in completing that application. So definitely be checking those pending applications.

LAURA: Thank you for that clarification.

MARK: All right, well, I don't see anybody in line, so we'll go ahead and—one more comment? Go ahead.

MSPKR: One more comment. This digital gap, it exists in Indian country. A few years ago—several years ago, maybe eight years ago, there was a study done in Humboldt County about online stuff, computer stuff and telephones. The Klamath Trinity Unified School District, sitting on a Hoopa reservation, reported that at any given time, they cannot contact parents by television, 40% of the time. So when we think that we're living in this digital world of cyberspace communication, there are places in Indian country that it doesn't exist. I'm going back to reinforcing the need to make sure that the resources in Indian country are, in fact, clinics. They are, in fact, tribal offices. Those really, oftentimes, are the only systems available to Indians.

We need to make sure this fits in Indian country and not do something that doesn't fit in Indian country. Because, again, that's what I call "code talk." We say one thing and mean another. And we're sitting there saying, "Why do we do this stuff?" We don't have these resources, the staff or these firewalls of privacy. We help people. And if we're somehow going to get audited, or we have to do it a different way, we don't have the people to do it.

When we go back and talk to an Indian person and say, "Sign up for this. It's going to be good for you." And all of a sudden they're reporting their IRS income and we're asking them to get online and stuff—we're just going to get turned off by a lot of people.

MARK(?): I think we really had a robust discussion on this presentation. I want to thank the presenters. A couple of quick comments before we transition. We're going to have a short version of the tribal sponsorship, three slides. Virginia has promised

to move through Stacy Kennedy's quick presentation. But, yeah, a couple things real quick. One, Covered California is going to make available certified enrollment counseling training. The idea there is to have organizations identify a staff member who you can send to the training. Or you'll even be able to go online to their webinar and learn the ropes about what we're talking about here, how to assist and guide patients into enrolling into Covered California. Or, if a federally recognized tribal member doesn't want to enroll, those counselors will be informed on how to assist those tribal members, too.

A brand-new system, a lot of work that still needs to be done to implement and iron out some of the systemic issues. But, yeah, definitely organizations like CRIHB and I imagine even like Tribal Chairmen's Association in Southern California. They do a lot of great work on social programs with tribes down there. A lot of these different organizations are taking up that opportunity to staff up their staff within their organizations to assist in reaching out to tribes and tribal clinics to help them learn the ropes and then make choices, have their patients make those choices. Ideally, it should be affordable. With that, I'm going to turn the next presentation over to Virginia Hedrick.

MSPKR: One more question I meant to ask. On the slide, there was a renewal box. How often does this information have to be renewed, the application updated?

FSPKR: Annually.

MSPKR: We've got to think about that. The Indian Health system is—what's it called? What's the term? For a visit, it's one visit at a clinic every three years, right?

FSPKR: Oh, the active user status?

MSPKR: Active user. So, we've got to think about making them compatible, because that's where—if, in fact, these have to be updated annually and it has to be done where our resources are, by the clinics, we can't really make them do annual renewals of all their service population. We're talking about thousands of people. It would be far easier to let the clinics update that information when there is a service visit, or whatever they're called, when there's a visit by a user, and let them just update their information anyway. But if we require clinics to go out and search their service unit population get them renewed—that's a tremendous amount of work and really unnecessary work from a clinic standpoint. If we don't do this through the clinic, who else are we going to do it through?

VIRGINIA: I'll take a stab at it, but then you guys can back me. So because this is tied to taxes would be a reason you'd want to complete it annually, right? So you'd want to update your tax information and make sure that is moving forward. Now, if an Indian person that's a member of a federally recognized tribe chooses not to re-enroll after a year and that time period lapsed, the benefit to them is they can enroll monthly. So even if they're outside of the open-enrollment period, they can

enroll in January or February, any point at that service visit when they come in. So say they're a person that only comes into the clinic once every two to three years, and that's really all their medical needs are. Members of tribes have the ability to enroll at that visit. But there will be a lapse in coverage in between. That's federal, so I don't think that Covered California could change anything about their system. What you're asking for would have to be advocated at the federal level. Any other backup on that or additional comments?

FSPKR: Well, I would just note that nothing about this is a clinic requirement. So the individual who enrolls has to make sure that their information is up to date—like Virginia said, consistent with federal law, at least once a year. It's not a clinic requirement. You could do it as a service, and we know that you provide those services when someone comes in. But they could call us. They could go online. They could send in a paper form. There are options for individuals, not requiring the clinics to do something every year.

Katie, keep the mic. Katie Ravel(?) is a brilliant Covered California staff. I have been working with her over the last few months. So what I'm presenting to you is tribal sponsorship. At this point, in the State of California, tribal sponsorship is an idea. It's something that we are capable of doing within the federal law, but it's not a system that's built. It's not a system that's being engaged yet. So what I'm sharing with you all is an opportunity to build the system. Katie's going to back me on this as best—because it's not built in California. In the federal system, there are tribes who are doing this.

So what is tribal sponsorship? Tribal sponsorship, what we've talked about all day, paying premiums, what this looks like for individuals—tribal sponsorship is the ability for a tribe or an Indian Health program to sponsor those premiums. So after the individual goes through the wonderful CalHEERS system and it tells them, "Your monthly premium is $69," the tribe or Indian Health program has the ability to pay that $69 or pay that $112. They can sponsor that premium. And they set this up in a number of ways. Federal funds can be used to do this. So you can use your contract health service money to pay to sponsor the premium, and the payment will be made directly to the health plans.

So what would be a strategy, and why would a clinic or a tribe consider sponsoring a premium? How is it advantageous to the tribe or the Indian Health program? Here are some of the reasons. You would say, "You're all my tribal members, and I'm going to sponsor my tribal members in the room who are going to be offered premium assistance." So for those people who got the $125, some sort of premium reduction, I'm going to offer them that I'll pay the $112. And I'm only going to pay it for—and this is in no way endorsing them, but just so we use a real example. I'm a network provider of Anthem and so for all my members in the room who want to select Anthem and fall within the income guidelines that I select, I'll sponsor your premium under a couple conditions. You come to me to receive your healthcare, so that when you come to me for a visit, I'm not using my

IHS money or my CHS money to provide care for you. I'm going to bill your private health insurance. And then I'm going to make money. So even though I'm investing that $112 in you every month, every time you come, I'm billing for that service. So I'm going to make money back.

There are studies out there, case studies that show tribes have an opportunity for every dollar they invest to get between two dollars and five dollars back. That's a big range, two and five dollars. Why does it range like that? Why it ranges is based on your population. If you have a lower-income population that has access to higher premium assistance, the premium that you pay will be less, so your return on your investment will be greater. If you decide to sponsor a population that's a higher income and their premium assistance is lower, your return on your dollar investment will be less. Does that make sense? Is that clear? I think it's pretty straightforward.

There are tribes in California who buy health insurance for their members. Somebody asked this scenario earlier. I can't remember right now. But they buy health insurance for their members as a service to their members. That's sponsoring their health insurance, right? So if you were going to do this, that tribe would ask their members to sign up with Covered California, accept any premium assistance that's offered, and they will pay the premium. They'll pick up the tab on the rest of it. You would do this also for patients who are expensive to you. They have a chronic condition or they're referred out a lot, and if they had a private health insurance, it would save you a lot of contract health money. That would be another scenario that you would select.

So those are scenarios to make it advantageous. You would consider only sponsoring Bronze plans, the cheapest of the plans, because they're not going—and if you select a lower-income population that's below 300% federal poverty, for those who are members of your tribe, they'll have no co-pays or deductibles anyway. So everything we kind of talked about has led up to why tribal sponsorship might make sense. There's a question in the back of the room.

FSPKR: [..?..] [unmiked] the tribe just works with the clinic then?

FSPKR: Yeah, the tribe would have to work with the clinic. And at this point, from what I know, it's very difficult for a tribe to cut out their portion of contract health. I'm looking at Jim, because he knows that issue more intimately than I do. There is a—it becomes really complex if the tribe, like Cloverdale, who's standing in the back, wants to sponsor only Cloverdale members. Their access to contract health service is not a question that I can answer or probably Covered California staff. I just know that technically you can do it.

MSPKR: I have a question. If we do purchase the bronze plan, but then we send them out and then we're going to have to turn around and pay that higher co-pay, is it really going to save us that much? And that's only for the federally recognized, right?

Like if we do it clinic wide and we buy all of our patients' service, you have to see which ones are going to go out and which ones aren't going to be covered, because it's only the federally recognized, right?

FSPKR: Yep, exactly. That's one of the strategies you'll have to consider.

MSPKR: Because if we send them out, we're going to have to end up paying that, if they can't, and that's going to eat up our other monies.

FSPKR: Yep, that's a strategy you have to consider. I think on my next slide—so this is what tribal sponsorship would cost people based on the premium caps. We've talked about premiums, and in CalHEERS you saw it. But this slide is pretty awesome, I think, but I like charts. So the first column is federal poverty level. The second column is income. Third column is premium limit. So this is the limit on how much a premium can cost an individual based on their income. So for those people who fall between 138 and 150% federal poverty, the Covered California premium that's offered can be no more than 2% of their income. That premium limit increases as the income increases. So based on that, we come to column number four, which is the annual individual premium. So in the strategy suggested, if you decided to sponsor your tribal members between 138 and 150%, you would annual pay no more than $345/year per individual to buy those members health insurance, after their premium assistance. That's a lot to wrap all into one statement, and I hope everyone followed me around that whole, big circle.

MSPKR: Is the concept of tribal sponsorship a way to avoid the annual renewal requirement on an individual basis?

FSPKR: No, because the responsibility is still on the individual. So even though I offer it to all of my members in this room, the members have to log into Covered California and select the plan. Now I'm going to ask Katie to talk a little bit—we don't have to talk about revenue assumptions—about how this will actually work. Because now I've told you this really great idea, but she's going to tell you how it could work.

KATIE: So I think on the next slide we say that this is a beginning conversation, so we're excited about it. So we're going to put up an interest form. Virginia had some great resources. We want to gauge what the interest is. We want to provide some technical assistance. We want to have a discussion about what tribes are interested, how they might want to do this. What I can say is that our online system is not built in a way that could take your entire tribe and send one bill to you for all of the different ways that all of your members would have signed up for. So when we launch out of the gate, if tribes are interested, this would be: You take your bill to the tribe, and the tribe would pay on your behalf. So it would be a little manual process. And what we can talk about over the course of the upcoming years and after we see the interest form is if we built something more

automatic so that you can enroll as a group and you can get an aggregate bill, that type of thing. Right now, that functionality does not exist. But there would be nothing right now that would prevent you from paying the premiums for your members. It would just be writing checks for those premiums and those members.

FSPKR: So this website, nativeexchange.org, has information built by some of the brightest minds in the country on Indian healthcare contracting and revenue of tribal sponsorship. So if you go to nativeexhange.org, on the right there are two places. You say you're a community member or you say you're a tribal health director. If you say you're a tribal health director, it'll ask for the password. I'll tell everybody the secret password. It's Native1. When you get into this password-protected area, it'll say, "What do you want to look at?" The very first thing is tribal sponsorship. It's a blue-highlighted click, and you say "click here." I guess we could log in, but I don't want to take more time. When you say "click here," there's a video by Fond Du Lac. Fond Du Lac is leading the way in the United States on tribal sponsorship. They are doing it. They have helped build spreadsheets and how-to videos on how to calculate if this is something that will work for you.

There are spreadsheets, intense Excel spreadsheets. But for billers, I'm told that this is like their fun. They love spreadsheets like this. So the spreadsheet will ask you very real questions: How many patients do you have? What's the amount of money you spend in contract health service? It'll ask you to pull census data on the income of your Indian population to give an estimate about their premiums, what they'll potentially be offered in premiums. And in the end, it'll calculate at the very bottom what your return on every dollar you spend in sponsorship will be. For some tribes, being very fair and honest, there's no return. It's not worth it for them. Their population has a higher income, so it wouldn't work for them. It's not going to work for everybody. But for some people, it will really work. Another question?

FSPKR: Hypothetically, what about service areas? So you're familiar with our tribe. There's a state line across it. Tribal members don't live in our service area. Does that affect anything?

VIRGINIA: So Oregon has tribal sponsorship as well, and they're a lot further along in the process than California. Nothing against California, but they are.

FSPKR: I mean, we also—I'm sure with every tribe in here, have people that live in Washington, D.C. or Portland or Sacramento.

VIRGINIA: You would have to engage that unique state marketplace. So if you wanted to sponsor your members that life in the state of Oregon, they'd be going through Covered Oregon, and it's a different—all the same federal rules guide them. So we're all bound by the same federal guidelines, but you'd have to sponsor them through Covered Oregon.

So this is the video, "Building the Fond Du Lac Experience."

MSPKR: Virginia, I just had a question. I'm all for investing a dollar to make five and all of that. But I think in our area the average income is a lot higher. There's not going to be many that have that 300% poverty level. If we go through and select certain people of certain age groups, is there like some sort of discrimination that we're doing by doing that? Because if you offer it to me but not my brother because of the age or because of something like that, there's no—what's the law in regards to that, since we're not giving it to all of our patients that we should all be treating equally?

VIRGINIA: You can do it. Let me tell you this. There's no discrimination. I'm looking at Jim, who's telling me, "Yes, go with yes." The answer is yes. There's no discrimination in it. What I recommend is that you politically, being a good Indian person, set up strategies that are so clear that nobody is saying, "Silver, you guys are picking this family over another family," that you can clearly say, "This family is fitting within the guidelines, and this family is not fitting within the guidelines that we've set forth." But there's no restriction that you're only sponsoring this age group or this income level. Those are your strategies that you select. And for people who do not engage sponsorship, there's nothing that stops them to continue to receive services at your clinic in the way they always have. There's nothing that changes about that. It doesn't change their eligibility for contract health if they choose not to engage tribal sponsorship.

So this is a great website. In the interest of time, I'm not going to show the video. But you all have access to it now. And we'll share all of these sides as well. Are there any other pressing questions on tribal sponsorship? It is a really exciting program. If you call me, I can walk you through more of it, send you the spreadsheets, and we could talk about whether it's viable for you. If not, Stacy Kennedy is up next.

MSPKR: I've got a question.

VIRGINIA: Yup, hit it, Chris.

MSPKR: Are the tribes that have the capability of providing the health coverage to their members, are they obligated to go through that Covered California? Or can they deal with a provider by themselves?

VIRGINIA: Nope. You can continue to buy group coverage the way you've always done it, as long as the coverage you're buying… Here's a couple things. Because it's a tribe and they are members of a federally recognized tribe, they're all exempt from the mandate should they want to be. But if you have the tribe that you're describing who has the resources to provide health insurance, they can continue to buy the plan through X health plan that they've always done. Nothing changes about that.

MSPKR: Okay. So at the end of the year, or anything like that, for the IRS purposes or anything like that, mum's the word on that?

VIRGINIA: Absolutely.

MSPKR: The tribe takes care of it. As a member of that tribe, that's a benefit that you get.

VIRGINIA: Exactly. And as members of the tribe, if the plan that you're offering your members doesn't meet minimum essential coverage as required by the Affordable Care Act, at that point the member would say, "I'm exempt from the mandate," and fill out the exemption form, if the plan that's being offered doesn't meet minimum essential coverage. If you wanted to be super thorough and straightforward, the plan that you offer your members you would ensure meets minimum essential coverage, then they would never think about an exemption form and say, "Yes, I have health insurance, and, yes, it meets minimum essential covers."

MSPKR: Awesome.

SARAH: Okay, thanks, Virginia. We wanted to give you guys an update on our outreach and education efforts at CRIHB. We are doing outreach and education under a grant through Covered California, out of the Department of Family and Community Health. We are contracted to do education. So under this project we are not doing enrollment; we're just doing outreach. And we're trying to provide clear, consistent, accurate information out there. We're trying to provide Indian-specific information as well.

The activities that are being conducted—so these are services that are available to all communities throughout the state—is we're doing booths at tribal events. And I'll go into a little more detail on everything that we're doing. We're doing presentations at tribal meetings and conferences. We have what's called a "patient kiosk" available. We're creating culturally appropriate print media and display materials. And those are the materials that you guys have today. They're the materials that are in the back, the display piece that's in the back. There's posters out there. And all of that we have put together with Indian-specific information.

We are doing some training, and I'll talk about our next training, although Mark did touch on it. And we're contracting with CCIUH to do an American Indian training module, and I'll touch on that a little bit more as well. Consuelo, she's the one that's been sitting the back by our booth, is going out all over California. She is setting up those booths at all kinds of events—health fairs, powwows. She's going to community meetings, anything that you might have going on in your community and you would like your patients, consumers to be educated, there's an actual app that's on the iPad, and we bring that out there so that we can show them how Covered California might benefit them, help them make decisions if

they'd like to enroll or not. We're doing that at the booth. She's got materials. We have [lead] cards so that if they want further information or they want someone to contact them, they fill out a lead card, slip it in our box, and then someone will personally get in touch with them. So that's going on.

We've done 15 community events and presentations since August. She's heading to San Diego and Ione in the near future. We have 15 patient kiosks that have been funded through Covered California, and this is actually sort of an all-in-one computer setup, and it will have the Covered California website on it. Hopefully it'll be placed in the waiting room. They've just been ordered. They come with a stand and a banner, print material, and people can actually walk up to it, use the Covered California website to get more information, see what's going on out there as far as health plans, and what it might cost them. So we're hoping that those will be user friendly. They're not at the clinics yet, but they have been on order. I have the list of all the clinics that requested them if anyone's interested.

Again, our print materials—we have an ACA-specific portal out of the CRIHB website. We have a Facebook page that anyone can access. We're trying to tell people where we're going to be, where our next event or booth is going to be on that Facebook page. We're hoping everything we've created has got the information we need, but we're open to any input or anything else that might be missing as far as print materials. This is just a sample, but you guys have seen them.

We are doing training for providers and communities. So if you are looking for someone to come out and give a presentation—it could be a half-hour. You could work it into something you're already doing. We are willing to come out and do that, or something longer, whatever you might need. We are working with providers to try to get as much information out as possible. I'm trying to send out email blasts at least once a week. This is our updated qualified health plan sheet. What we're trying to do is figure out which health clinics are in which network and that has been a challenge, as we've already talked about earlier. What I did recently was I took a provider list that Rosario had and I put the individual providers into the Blue Shield provider search to figure out which providers were in network. And that's how I came up with a lot of this information. So most clinics in the state had at least one provider that was in network for Blue Shield. The Anthem list we got from Covered California, so that's how we got that information. So it was tedious and challenging, but we're trying to get that information. I'm trying to ask clinics, whatever we can do to keep this chart up. There are copies of it back at that table if you want to see in what region, who we have listed as a provider. It's certainly not complete and comprehensive, but we're doing the best we can right now.

Mark mentioned we're doing our certified enrollment counselor training next week, so we are taking registration for that. I will also say that the first day of this training we're really trying to provide a lot of Indian-specific information and

background information. So if you have staff that can't attend a two-and-a-half-day training and you want to send them to one day, they won't be a certified enrollment counselor, but they will get training. And that's the goal here as well in outreach and education.

We are working on the American Indian-specific training module for Covered California. We're contracting with Sekooi(?). Jill is here, and Virginia and Mark and everyone have put a lot of content into this training module. It's been sent over to Covered California. We're waiting for some key pieces to be included. We're waiting for that come out of draft form. And then hopefully it'll be used in the certified enrollment counselor training as well as be available, be a webinar for other people that need this information.

This is just like a sample slide that's in the training. It's got a lot of great information. A lot of the questions that were asked today are answered in this training. These are our contacts. Like I said, Jill Marden(?) as well from Sekooi(?) is working with the Urbans under this outreach and education grant. Does anybody have any questions? See how fast I was? All right, thank you. [applause]

MSPKR: Good job, Stacy. Thank you. Well, we're moving into the home stretch, folks. Next up we have Sarah Soto-Taylor. She's the Covered California deputy director Sarah Soto-Taylor. She's the Covered California deputy director of community relations. She's going to be presenting on certified enrollment entities, the navigator program, very key information for our Tribal and Urban Indian organizations. Without further ado, here's Sarah.

SARAH: Thank you. So I wanted to go ahead and take some time to briefly go over the certified enrollment entity process and where we are. I know that this is key information for many of you as you start to make your decisions on whether or not you want to participate in our enrollment entity process. So this flow chart basically just outlines the process and the recruitment process that we started back in July. We have a number of enrollment entities that are currently participating throughout California, and we really do encourage all of you to at least consider becoming an enrollment entity with Covered California.

Generally speaking, the way the process works is you fill out an application that's available online on CoveredCA.com. That initiates the process. Once we review the application and you identify the staff members that you want to become counselors, you go ahead and submit their counselor application. They can then access the free training. The training is two-and-a-half days, and that is currently being offered for clinic staff via our partnership with the California Primary Care Association, who is also partnering with the local organizations to provide very specific Indian Health Clinic training that was just discussed.

The clinic staff that you identify as a certified enrollment counselor, when they go to the training, we are also providing fingerprinting services, so all of our

counselors do need to go through fingerprinting and background check. We have streamlined the process. So once you're in the training session on that first day, you also get fingerprinted, so that moves along the process quite a bit. And then once the training is complete and an exam is taken and the person completes the exam and passes the exam, we get their fingerprinting clearance back, the person is then ready to provide that enrollment assistance to consumers.

I did want to point out that the enrollment process for the entity itself—we are providing a 1-800 helpdesk number that's available Monday through Friday, and I can give you that number if you're interested. But we are also providing technical assistance through the enrollment process. So if you start an enrollment process, an entity application process, and you get stuck along the way, that helpdesk is available via phone to help you complete that enrollment entity application. And on the CoveredCA.com, where you'll be able to access that enrollment entity application, we also have checklists there and some other tools to help you through the enrollment entity process.

Once you go into the actual application—we just wanted to provide you a screen shot here of what that enrollment entity application looks like and where you would select your organization type. We did get a request that we were able to address and modify that application screen so that you're able to identify your licensed healthcare clinic, and then with a sub drop-down menu, you're able to clearly identify which Indian Health Services clinic your particular organization belongs to. So you see there that we have the two options of the direct services clinic as well as the 638 contracting or compacting clinic option there, as well as the Urban Indian Health Centers as an option.

So we have right now 11 certified enrollment entities that have identified themselves as being a tribal affiliation. There's the ones that are listed there. And we hope that that list grows by the next time we meet.

The Navigator Grant Program—I'm going to pause right now because I really want our discussion to be focused on enrollment entities, and then I can take navigator programs at the end. So if there are any questions right now about the enrollment entity process, I can take them.

Another grant opportunity that is coming our way is through the Navigator Grant Program. We had our outreach and education grant program right now. CRIHB is one of the recipients. As we mentioned earlier, the focus of that grant program is strictly outreach and education. The enrollment component is through our enrollment entities and the process that I just described. But the Navigator Grant Program really is a more encompassing program. This is also going to be a competitive grant program, and it will be a grant that will encompass outreach education as well as enrollment activities.

And so what you see here is the general timeline for that Navigator Grant Program. We're going to be releasing the application in February of 2014. There'll be roughly about a month period in which organizations can submit their proposals. And we hope to begin the training and certification in June, so sometime around the end of April we'll be notifying those grant recipients of those awards. The grant period is actually very short. As many of you know, for the general population we have an open-enrollment period, and that begins in October. This slide was actually taken from a recent Navigator webinar that was conducted, so this is the general timeline for that grant period. And here again is the proposed timeline for that very short grant program.

The minimum duties of the navigator are listed here, very similar to what we are asking our enrollment entities, which is basically to maintain expertise in Covered California, conducting public education to raise awareness, but also providing fair, accurate and impartial information and services to our consumers. And primarily, again, to facilitate that enrollment into the insurance affordability programs, whether that's Medi-Cal or our premium assistance options. We also are asking our navigators to provide referrals as necessary to health insurance consumer assistance offices with any grievances, complaints or concerns. And then we are asking all of our navigators to make sure that their staff is competent and conducts services in a culturally and linguistically appropriate manner.

This slide is primarily recommendations. So on the webinar we had the other day we presented some of our recommendations, our preliminary thoughts on how we think the Navigator Grant Program should be structured. We are currently soliciting stakeholder feedback, which is due tomorrow, actually, but we will extend that if any of you have additional comments. But here you'll see our general recommendations are to have two separate pools for the Navigator Grant Program. And I think what is most relevant to this audience is the targeted funding pool, and that's really where we're going to be asking organizations to submit proposals for specific target populations and to demonstrate the need and the ability to reach those target populations, to provide them outreach, education and enrollment assistance.

Again, that target population, populations that you serve, could be described in your grant proposal regardless of geography. So you could submit a proposal maybe that covers a specific region, statewide, or some other geographic distribution. Again, we're looking for organizations that have already established or demonstrated trusted relationships with the target population.

With that, that completes my quick update on the Navigator Grant Program. If you wanted to see the entire webinar, which was about an hour long, it is posted up on our website on CoveredCA.com under the Navigator Grant Program. So I'll take questions at this time if you have them. None? Okay. Thank you. [applause] Everyone's just tired.

MSPKR: That was very thorough. Yeah, maybe we are getting a little tired—a lot less questions. We've reached really the final agenda topic. It looks like we may be able to close down a little early, which might be nice. One of the things that I want to ask you to do is fill out the evaluation form. There is an evaluation form in the packet with the agenda. It's the last page. If you can pull that apart, fill it out, what you liked, what you didn't like, what should've been here, what wasn't, what should be in the future, that type of information will really help Covered California to make determinations on next year's—maybe it will be the Third Annual Tribal Consultation. But, yeah, please do fill out that evaluation form.

One of the things I'd like to ask is that—there's been a lot of CRIHB staff members that are here. There's a lot of CRIHB staff members back at the office who aren't here, that have all worked as a team to put together this event. So I'd like to ask for a round of applause, please, for all of the CRIHB staff for the great work that they've done. [applause]

One of my takeaways from today is definitely additional outreach is needed. We need to continue to go out to the tribal communities, and we need to continue to go out to the urban Indian communities, engage tribal councils, engage the Indian Clinic Board of Directors, go out to the Tribal TANF programs. We didn't talk about Tribal TANF today. We have gone out and met with a number of Tribal TANF programs, talking with them about the ability to have their participants enroll in Covered California. And essentially the way the Affordable Care Act is developed is that that should assist them in identifying their eligibility for other programs. So not only Covered California, but Tribal TANF and many other social service programs. So I think that's going to help our Indian families quite a bit.

Ideally, in theory, no longer will those Indian families have to go from office to office to office, carrying their documents, carrying their files, submitting paperwork to a series of offices in order to receive social service assistance. In theory, this "no wrong door," this ability to eligible-ize patients and families into Covered California, that should provide the detail necessary to determine their eligibility for other services as well. That was a discussion last year and the year before, and it's one of the key things that I think will really help our Indian families in California that need those social service programs. I'm a big fan of the Tribal TANF programs in California.

One of my takeaways of today also is to please call. Call the CRIHB office. We have a number of staff that will schedule their time to match your time, and come out to your communities and talk with you more in depth about what we've covered here as it relates to outreach and education. We're ramping up the ability to outreach and provide training for certified enrollment counselors in your communities. We're having a training next week, for example. We have a master trainer of trainers at CRIHB now, thanks in part to Sekooi, the California Urban Indian Health Association. Sekooi is a member of what's called CPCA, California

Primary Care Association. That association worked with Covered California to provide the ability to establish master trainers that can go out and assist organizations in educating their staff members to assist patients in enrolling into Covered California.

We are very thankful to CCUIH for allowing CRIHB to have a staff member go to that training. Our staff members spent like five—I think it was like five-and-a-half days. So if you think of how long we're spending here together, a room full of Indians all day, one day—we had one of our staff members spend five-and-a-half days in a small room, going thoroughly through the Covered California certified enrollment process. So, yeah, at this moment, we have one Indian certified counselor master trainer in the state, and we have it here for us, all of us, all of our tribes and all of our clinics. So I really urge you to take advantage of our new ability, our shared ability. That master trainer is behind us. Her name is Antoinette Medina, and she's there. Swing by and talk with her. We will be having a training, our first training next week, here in town at the CRIHB office.

But definitely a lot of the American Indian and Alaska Native provisions that we've gone over today are really unique to our tribal and urban Indian communities. And we really know this information the best. And so we're really thankful to have Antoinette ramped up and ready to provide next week's training. There will be webinars also. We'll provide those trainings. But a key, key thing, one of my takeaway points, again—I can't harp on this enough—is call the office. We have staff that will come out to your communities and engage your tribal councils, your tribal clinic board members, your tribal clinic staff, your tribal and urban Indian patients.

We showed some presentations here today—we probably have at least a dozen presentations specifically designed for tribal leaders, tribal health board members, Indian patients, so on and so forth. Over the course of this last year, we've traveled probably to about 18 tribal communities. We went up 101, met with Elk Valley, went up and met with Yurok Tribal Council, swung over, went down to Toiyabe way and met with Bishop Tribal Council, met with the Timbisha Shoshone representatives. They heard we were in Bishop that day, and they scheduled a meeting for us the next day. Then we went down to Lone Pine and met with their tribal community. We've gone down to Riverside/San Bernardino area twice. So, yeah, we've been hitting the trails, trying to get the word out on the new abilities for tribes and Indian patients through the Affordable Care Act. Again, it really relies on the individual person to make that choice, to make that call if they want to be involved or not. There are special protections for those federally recognized tribal members. They don't have to maintain coverage. And it's similar. We want an exemption for the California Indians as well.

One of the challenges, of course, is that that determination, through what's called Center of Medicaid Services, back in Washington, D.C., that special exemption we have for California Indians, that's an administrative fix. And so what happens

if there's a change in leadership at CMS? What happens if that new CMS director back in Washington, D.C. decides that that special exemption that the previous director determined as appropriate is deemed inappropriate? And then we'll be back to square one, fighting for the ability for California Indians, for those tribes that were terminated by Congress in the 1950s or the '60s. We'll be fighting to have them have some access and some equality through the IHS system.

So that's why at this point we're also pushing. We're pushing for support of a Senate bill that was introduced recently. And we did bring that up with Covered California in our letter today. For those of you that want to take a look at that bill, it's S1575. It's known as the Definition of Indian Bill. It was introduced in Congress recently. And again, the request from the Covered California Tribal Advisory Committee this morning is simply to urge Covered California to weigh in with relevant federal agencies on the importance of that legislation, or at least educate them if you can't advocate, because I know that education is appropriate.

So that is a key issue that we need to be mindful of. Earlier this morning, we've heard some of the unrecognized tribal people in this room talk about their concern. They are worried, and rightly so. And so even though we have an administrative fix at this point that they don't have to have coverage, and they will not be penalized when they go to file their taxes, similar to federally recognized tribal members, nevertheless, it's an admin fix, and I'm really a big fan of if we can receive an act of Congress to protect California Indians in that way, then let's work together to accomplish that. That's another takeaway point that I'd like to share.

Well, folks, we've reached the point in the agenda where we've completed what we set out to do. We completed our objectives for today. On behalf of the California Rural Indian Health Board, the tribes and the clinics that are members of that organization, on behalf of Covered California as well, I want to thank you for coming here today, for working with Covered California in particular on these very key issues. They are available to us. Let's fire off letters to them. Let's say what we need to say to them. And we did some of that today.

This is a good step. We had a step last year, in 2012, through the consultation process. We've had a series of Tribal Advisory Committee meetings over the course of this year. Now we're taking this next step today. But we have a lot more steps we need to take to ensure that Indian people in California have access to the healthcare coverage that, one, they have a right to, and, two, that they deserve. So it's really important that we continue to work with Covered California to assist them in building the infrastructure needed to serve our Indian patients and to maintain it in a way that will work for us as experts of our Tribal and Urban Indian clinics. Again, I want to thank you all. Have a good evening. Just leave your evaluations on the table, if you would, please. Thank you. [applause]

[END OF RECORDING]