California Health Benefit Exchange

Stakeholder Input:
Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability
August 10, 2012

The California Health Benefit Exchange solicited written stakeholder comments on the proposed Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability which was presented to the public at the July 19th Exchange Board meeting. The proposed policies and strategies are detailed in draft recommendations available on the Exchange website entitled *"Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability."* Feedback was solicited in nineteen specific issue areas as well as other general comments. Sixty-five organizations submitted comments using a stakeholder input form provided on the Exchange website and thirty-seven organizations submitted comments in separate letters. Comments received on the input forms have been compiled in the tables below and are organized alphabetically within each section. Letters will be posted separately on the Exchange stakeholder webpage. Stakeholder comments will be used for consideration of revisions to the Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability. The California Health Benefit Exchange thanks all stakeholders for their valuable comments that will assist in the planning and implementation of this program.

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Organizations Submitting Comments

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Alpert Vision Care	X	
AltaMed Health Services Corporation	X	
American Cancer Society	X	
American College of Cardiology		X
American College of Emergency Physicians		X
American Heart Association	X	
Anthem Blue Cross	X	
Arrowhead Regional Medical Center		X
Association of CA Life and Health Insurance Companies	X	
Bayer Healthcare		X
Behavioral Health and Recovery Services	X	
Blue Shield of CA	X	
CA Academy of Family Physicians		X
CA Association of Dental Plans		X
CA Association of Health Plans	X	
CA Association of Physician Groups	X	
CA Association of Public Hospitals and Health Systems	X	
CA Chamber of Commerce Consortia		X
CA Children's Hospital Association	X	X
CA Coalition for Reproductive Freedom	X	
CA Coalition for Whole Health		X
CA Department of Insurance		X
CA Dialysis Council	X	
CA Dietetic Association	X	
CA Family Health Council	X	
CA Hospital Association	X	
CA Medical Association	X	X
CA Pan-Ethnic Health Network	X	
CA Primary Care Association	X	X
CA School Health Centers Assoc	X	
CA Society of Plastic Surgeons		X
CA WIC Association	X	
California Dental Association		X

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Organization	Input Form	Letter / Attachment
California Optometric Association	X	
Californians for Patient Care		X
Castlight Health	X	
Central Valley Health Network	X	
Children's Health Consortia	X	
Children's Specialty Care Coalition	X	
Cigna	X	
Community Clinic Consortia		X
Community Clinics Assoc of LA Counties	X	
Congress of CA Seniors		X
Consumers Union		X
County Health Executives Association of CA	X	
Covenant Industries	X	
Delta Dental	X	X
Disability Rights Education and Defense Fund	X	
El Dorado County Community Health Center		X
Foothill Community Health Center		X
Greenlining Institute		X
Health Access	X	
Health Exchange Advocacy and Responsibility Team	X	
Health Net	X	
Healthcare Coalition		X
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Kaiser Permanente	X	
Kelch Policy Group		X
Korean Community Center of the East Bay	X	
LA Care	X	X
LGBT Health Consortia	X	
Lifelong Medical Care		X
Livermore Optometry Group	X	
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March of Dimes	X	
Maternal and Child Health Access	X	
Molina Healthcare	X	
Monarch HealthCare	X	
National Association of Vision Care Plans	X	
National Committee for Quality Assurance	X	X

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Organization	Input Form	Letter / Attachment
National Health Law Program and Health Consumer Alliance	X	
National Health Law Reproductive Freedom		X
Natividad Medical Center		X
North East Medical Services		X
One LA		X
Pacific Business Group on Health	X	
Pacific Clinics	X	
Pacific Eyecare	X	
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Planned Parenthood Affiliates of CA	X	
Quest Analytics		X
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San Mateo County Union Community Alliance	X	
Santa Clara Valley Health and Hospital System		X
SEIU		X
SeeChange Health Insurance	X	
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Southeast Asia Resource Action Center	X	
U of Michigan Center for Value-Based Insurance Design - VBUD		X
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URAC		X
Ventura County Health Care Plan		X
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West County Health Centers		X
Women's Health Specialists	X	

ISSUE 1

Issue #1: Guidelines for Selection and Oversight of Qualified Health Plans and the Development of the Small Employer Health Options Program	
Organization	**Comments**
AltaMed Health Services	AltaMed supports the Exchange's Guidelines for Selection and Oversight of Qualified Health Plans and the Development of the Small Employer Health Options Program. Most importantly, we support Guideline VI, which advises the Exchange to "be a catalyst for delivery system reform while being mindful of the Exchange's impact and role in the broader health care delivery system."
Blue Shield of California	Child-only options We have concerns that requiring a plan "specifically designed" for those under 21 may go beyond the federal requirement to provide a child-only plan. As HHS has clarified "a QHP issuer could satisfy this [child-only] standard by offering a single QHP to qualified applicants seeking child-only coverage, as long as the QHP includes rating for child-only coverage in accordance with applicable premium rating rules." (77 Fed. Reg. 18415 (March 27, 2012)). This guidance would allow issuers to satisfy the child-only requirement by offering child-only rating on their QHP products, which would also satisfy the requirements in California state law that carriers offer, market, and sell child only version of their individual market policies. Number of plans QHPs should be limited to a certain number of products in each region but should be allowed to offer various types of products (PPO/EPOs/HMOs/ACOs) depending on what is most feasible given provider and facility contracts.
California Association of Physician Groups	CAPG suggests that employees within the SHOP Exchange are not limited to a narrower number of choices than are offered by the Exchange within a geographic region. We believe strongly that if narrower offerings were allowed there would be a greater potential for adverse selection and risk selection among the enrollee population.
California Children's Hospital Association	CCHA agrees with the staff recommendations for the reasons noted in the policy options brief.
California Hospital Association	The guidelines for selection and oversight of Qualified Health Plans (QHPs) and for the development of the Small Employer Health Options Program are clear, balanced and aligned with the mission and vision of the Exchange. Competition will be a key driver in affordability for the consumer. We continue to support policies for an Exchange that will foster competition among QHPs through choice, customer service, price, quality and a broad range of provider networks offering comprehensive services across the continuum of care.

Issue #1: Guidelines for Selection and Oversight of Qualified Health Plans and the Development of the Small Employer Health Options Program	
Organization	**Comments**
California Medical Association	We generally support the guidelines of Section 3 but feel more discussion of the providers' role in achieving the Exchange's goals is warranted. Our specific comments are as follows: ***II. Assure access to quality care for individuals with varying health statuses and conditions*** • We support the criteria outlined in II(b) and want to specifically emphasize our strong support for the Exchange's inclusion of "meaningful access and timeliness standards" as a primary criterion for evaluating QHP proposals. • Recommend this section stress the importance of consumers having accurate and up-to-date information with respect to both reported measures and provider directories. ***III. Facilitate informed choice of health plans and providers by consumers and small employers*** • Recommend this section call upon plans and insurers to maintain accurate, searchable, and auditable lists of participating physicians and their capacity for specific services, including coverage for emergency care, updated on a quarterly or more frequent basis. ***VI. Be a catalyst for delivery system reform while being mindful of the Exchange's impact on and role in the broader health care delivery system.*** • Recommend this section emphasize the need for greater administrative uniformity and simplification among plans so that physicians may devote significantly more time and resources toward patient care, contributing to the value of coverage for enrollees. • Recommend this section include support specifically for physician-led care delivery models, as such models have consistently been shown to provide greater value for patients.
California Pan-Ethnic Health Network	CPEHN agrees with the Exchange's policy guidelines for selection and oversight of Qualified Health Plans and the Development of the Small Employer Health Options Program. With respect to health plan selection criteria V. Reducing Health Disparities and foster health equity, we urge the Exchange to add an additional bullet under examples, c. Offer health plans, plan designs and networks that prioritize strategies aimed at reducing health disparities.
California Primary Care Association	The California Primary Care Association (CPCA) represents more than 800 not-for-profit community clinics and health centers in California that provide comprehensive, quality health care services to low-income, uninsured, and underserved Californians, regardless of their ability to pay.

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	CPCA and our member health centers believe that successful implementation of the Affordable Care Act (ACA) means transforming how we deliver health care. As such, CPCA supports the Exchange's Guidelines for Selection and Oversight of Qualified Health Plans and the Development of the Small Employer Health Options Program. In particular, CPCA supports Guideline VI, which advises the Exchange to "be a catalyst for delivery system reform while being mindful of the Exchange's impact and role in the broader health care delivery system." This guideline parallels CPCA's own strategic plan, which compels the Association to ensure that California's CCHCs are at the forefront of health delivery system transformation. **CPCA and our member CCHCs look forward to working with the Exchange to reform the health care delivery system in California while remaining mindful of the impacts of Exchange policies on those essential community providers who provide care to the underserved and remaining uninsured.**
Covenant Industries	Small business owners are accustomed to requiring assistance from brokers, third party administrators, consultants, CPA and Professional Employer Organizations to help them gain access and choose the best qualified health plans that falls within the amount that the small business can afford to pay. If the Exchange promotes ongoing relationship between small business owners and brokers, who guide the small business owners in making the best choices the business owners will have a minimal impact. This will avoid waits at the Customer Service Center, where unless the representatives are licensed brokers, they will not be able to competently help a small business owner who needs an expert in making suggestions for the best plans. I also believe that plans should be limited in the SHOP. We need about 3 comparable choices from each carrier. The business owner can make an employer contribution and process the application for any qualified tax credit.
Health Access	On Affordability: The guidelines are not aimed at maximizing affordability for individual consumers: instead most of the discussion focuses on the appropriate mix of QHPs, an important but different goal than affordability. The guideline also does not recognize the need for affordability at the point of care in terms of benefit design. The cost sharing designs need to be reviewed in terms of persons with significant health needs (e.g. breast cancer, diabetes), to ensure that the coverage permits access to the care the patients need. During a webinar on August 1, 2012, the Exchange staff frequently stated that their approach was they are not to be a regulator, but that they wanted to work cooperatively with the health plans, and in some cases would be willing to not publicly release information provided by plans. While Health Access recognizes that the Exchange is not a regulator and must and should work cooperatively with health plans, we believe they must also work closely

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	with other state and quasi- state purchasers to share information regarding contracting and performance issues. They also must coordinate closely with our state regulators regarding compliance, rate-setting, financial solvency, and performance measurement. We believe all of these connections are important for the Exchange to function effectively and they should attempt to achieve balance between these relationships of the Exchange with health plans, other public purchasers and the regulators.
Korean Community Center of the East Bay	KCCEB agrees with the Exchange's policy guidelines for selection and oversight of Qualified Health Plans and the Development of the Small Employer Health Options Program. In regards to V. Reducing Health Disparities and foster health equity, we urge the Exchange: 1. To add an additional bullet under examples, c. Offer health plans, plan designs and networks that prioritize strategies aimed at reducing health disparities. 2. To add "staff (such as patient navigators) and informational materials" to example b, so it would say "offer a sufficient number of providers, staff and informational materials with linguistic and cultural competence to serve diverse enrollment"
LGBT Health Consortia (Transgender Law Center; Center for American Progress; Equality California; National Center for Lesbian Rights; and L.A. Gay & Lesbian Center)	The guidelines for selection and oversight of qualified health plans include **assuring access to quality care** and **reducing health disparities.** As part of assuring quality care, the Board Recommendation Brief points out that plan design, provider network and access standards should consider language and *culturally appropriate care* for Exchange enrollees. Culturally appropriate care must take into account the distinct experiences of the lesbian, gay, bisexual, and transgender (LGBT) community. A provider's lack of LGBT cultural competence has been shown to negatively affect not only provider-patient interaction and caregiving, but also the patient's care-seeking behavior and overall health outcomes. There are many different components to creating an environment welcoming to LGBT patients, including outreach, office space, intake forms, confidentiality policies, and staff training on nondiscrimination and elimination of bias. As part of reducing health disparities, we encourage the Board to be mindful that the LGBT population is disproportionately uninsured and underinsured and experiences significant health disparities as a result. *See* Institute of Medicine, "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding" (Washington: National Academies Press, 2011). Therefore, Exchange policies that promote health equity and the reduction of health disparities should ensure that qualified health plans offer a sufficient number of providers with cultural competence in serving LGBT individuals.

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Monarch HealthCare	Monarch proposes to allow employees within the SHOP Exchange have a larger number of choices than is currently being proposed by the Exchange. We believe strongly that if narrower offerings are approved there would be greater potential for adverse selection – higher risk among the enrollee population.
National Health Law Program on behalf of the Health Consumer Alliance	The National Health Law Program (NHeLP) and the Health Consumer Alliance (HCA) agree that the California Exchange Board should look to its core values when it develops guidelines for selecting and monitoring QHPs and developing the small employer health options program. In general, we believe that the staff's recommendations to the Board on these issues are successful in promoting those values and striking a balance between competing priorities. Our detailed comments and suggestions for improvement follow.
Pacific Clinics	In reference to page 31, Section II (3), we propose the inclusion of mental health outcomes and outcomes that are consistent with principles of recovery/resiliency. With regards to Section VI (c) on page 33, we urge the Exchange to add language that includes Community Defined Evidence. While Evident Based Care/Practices are important, some may not have been tested in all ethnic and cultural communities. It is well known that different ethnic communities have their own "effective" strategies in serving their respective populations. It would be prudent to examine and consider these Community Defined Evidence models in light of Exchange's desire to address health disparities.
SeeChange Health Insurance	While SeeChange Health Insurance recognizes the desire of some to simplify plan selection, we strongly urge the Board to avoid achieving this goal at the expense of innovation and choice. California is a diverse state and there is no one-size -fits-all approach that will satisfy their varying needs. Further, health insurance plan designs and approaches to evolve and improve. While support of this continuous process of improvement is implicit in the Exchange's policy guidelines, we believe it should be elevated to a more explicit goal.
Small Business Majority	We appreciate that "Promote Affordability" is the top policy guideline. This is consistent with the top priority for small business owners. As mentioned in the Board Brief, fostering competition is key to affordability. We support standards and policies that will encourage carriers to participate in the Exchange, rather than enacting unreasonable standards that will discourage their participation. With that said, reasonable, flexible standards for QHPs are essential to promoting competition and cutting costs. We also particularly support #4 (promote wellness and prevention) as we believe wellness and preventative programs should be a key part of the SHOP. Businesses stand to benefit economically by having healthy, productive workers. Lastly, we value the Exchange's commitment to operating with speed and agility. The Exchange will be competing

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	with the commercial market and must be ready to respond to changes in the market, consumer demand, price fluctuations, etc. The standards discussed in the brief should not be set in stone for all-time.
Southeast Asia Resource Action Center (SEARAC)	SEARAC agrees with the Exchange's policy guidelines for selection and oversight of Qualified Health Plans and the Development of the Small Employer Health Options Program. With respect to "V. Reducing Health Disparities" and foster health equity, we urge the Exchange to add an additional references under examples, "c. Offer health plans, plan designs and networks that prioritize strategies aimed at reducing health disparities.
Vision y Compromiso	Vision y Compromiso support the Exchange's policy guidelines for selection and oversight of Qualified Health Plans and the Development of the Small Employer Health Options Program. Under Issue 5, we urge the Exchange to add a bullet; c. Offer health plans, plan designs and networks that prioritize strategies aimed at reducing health disparities.

ISSUE 2

Issue #2: Core Minimum Qualified Health Plan Certification Requirements and Regulator Partnerships	
Organization	**Comments**
Anthem Blue Cross	Anthem does not support the use of eValue8. We urge the Exchange Board to develop processes focused on driving affordability with reasonable expectations that are meaningful and translatable to the purchaser of the exchange products. eValue8 does not accomplish that objective. 1. The tool was designed by large employers to create apples to apples comparisons of national or very large carriers. Therefore, the use of this tool for the Exchange population will not be as beneficial for consumers to conduct comparisons. The Exchanges are being created to provide high-quality, affordable care, promoting prevention and wellness and reducing health disparities. Use of the eValue8 tool does not necessarily lend to that goal. In fact, if plans are required to use eValue8, the result is increasing costs that will make care less affordable. While the principles of eValue8 are sound, they were created by and for large employers and assume a large risk base. That dialogue changes for Exchanges – where employers are not making the decisions, the consumers are. The level of data/information required by eValue8 is far beyond consumer knowledge levels and is too complicated. One example is the Relative Resource Use measure of the tool – how does that get translated for a consumer to understand and make choices about their health care coverage? Plans are struggling to use this information in a meaningful way. A test of consumer understanding and usefulness should be assessed against each module. It is likely that – beyond providing information on if a plan has been accredited and has certain level of benefits – a consumer would fail to be able to absorb and use the majority of the survey. 2. eValue8 continues to be a tremendous burden on Plan resources, an annual process which takes the better part of a year to complete (submission – evaluation – coalition/client meeting). 3. If the intent of the CA HBEX is to augment information from HEDIS/CAHPS, then there needs to be more focus than is provided by the eValue8 tool. This is also where a consumer test of understanding and usefulness would be appropriate to fully understand the usefulness of providing this level of detail. We recommend a correlation to the STARs approach, a method that keeps it simple for consumers. 4. The biggest improvement/advancement that the CA HBEX could steer is the ability to translate complicated quality reporting (whether HEDIS, URAC *(which does not exist yet*) or government mandated metrics) to a language that consumers understand. This could be accomplished by focusing on only metrics that are related to essential health benefits. As an example – if an essential benefit is to cover mammography – then there should be ability to compare plans regarding what programs they offer to encourage such preventive services,

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	the benefit level (i.e., 100%, no-copay, etc.), and how the plan performed on the HEDIS metric for the previous year.
Blue Shield of California	We support recommendations that reduce redundancy, utilize the current regulatory standards, use existing measures to determine good standing requirements, and use existing quality and performance measures.
California Association of Health Plans	CAHP is in support of recommendations that reduce redundancy, utilize the current regulatory standards, use existing measures to determine good standing requirements, and use existing quality and performance measures.
California Children's Hospital Association	While CCHA generally agrees with the staff recommendations ,it remains a significant concern that the dual regulatory structure in California is regarded as so difficult to reconcile that the products in the Exchange will continue to reflect differential criteria that in good probability will contribute to adverse selection.
California Hospital Association	The core principles of a health benefit exchange are to provide a platform for plans and consumers to compare plan products and purchase the type and level of coverage that meets their needs at a price that is affordable for purchasers and sustainable for plans and providers. In order for this to happen, it is the Exchange's responsibility to ensure that plan products are uniform so that purchasers know up front they are comparing like products. Since California has two insurance product regulators, it will be important to choose the participation criteria carefully so that products regulated by the California Department of Insurance (CDI) offer the same level of protections as products regulated by the Department of Managed Health Care (DMHC). Without this uniformity as a cornerstone principle in designing the criteria for QHP selection and certification, DMHC (or CDI) plans will be subject to stricter criteria, cost more to offer, and therefore more to purchase. Correspondingly, CDI plan products may be subject to lesser criteria, offer a lower price-point (or higher profit margin) and provide less protections to consumers. The end result is that consumers will not know what they are purchasing. For example, DMHC network adequacy criteria are currently more robust than CDIs. Knox Keene Act plans must provide a range of services, coverage, options, network adequacy and protections that are not required of CDI regulated plans. In fact, DMHC plans have the more robust consumer protections and Help Center options and advocacy. ***CHA urges the Exchange to choose eligibility criteria that apply equally, regardless of the regulatory agency that monitors the QHP.*** This will ensure that consumers are comparing products and not unknowingly selecting a product with fewer requirements and protections. Full transparency to all participating in the Exchange – plans, regulators, providers and most importantly, consumers, is essential. With regard to plans "in good standing," DMHC plans must file extensive documentation with their license application or change in plan design and benefit structure. These filings undergo significant analysis and evaluation by

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	DMHC. Ultimately, many of the modifications are subject to "Undertakings" that are specific, require unique informational or data updates, and can apply for years. ***Please clarify where or how these conditions in plan modifications would be characterized for purposes of good standing.***
California Medical Association	For a meaningful "in good standing" standard, we strongly support the Exchange's addition of a requirement that there be a finding by the regulator that the proposed QHP issuer does not have any "material or grievous statutory or regulatory violations," including penalties levied, in the past two years" of any of the statutes or regulations tied to the "in good standing" criteria. Such a requirement could have a significant deterrent effect for those issuers with or hoping to have QHPs, encourage proactive issuer compliance departments, reinforce the Exchange's partner agencies' enforcement efforts (as well as potentially save enforcement resources through increased and earlier settlements with state agencies by plans), and send a message to consumers that they can trust Exchange products on account of there being little tolerance of bad actors.
Health Access	• "In good standing" is a very minimal requirement as defined by Exchange. If not using higher standards for financial solvency, timely claims payment and network adequacy, then Exchange should plan for issuer failures with the concomitant disruptions of care. • In key areas like network adequacy, the Exchange should seek to be better than the minimum standards required by law. This would be a way for the Exchange to distinguish itself in the marketplace against plans not in the Exchange-a "Good Housekeeping" seal, if you will, that the coverage sold in the Exchange meets certain standards of value to provide enhanced security for consumers. • Health Access supports inclusion of a finding by the regulator on material or grievous statutory or regulatory violations. Health Access also encourages close communication with the two regulators about possible issuer failures. • California regulators impose financial penalties and administrative sanctions where necessary and appropriate. In the past, these actions were ultimately shared with other plans and made publicly available to consumers. The purpose of making this information publicly available is to provide a deterrent to other plans who might be tempted to engage in similar practices and to alert consumer as well as those that advise consumers of potential pitfalls. However, California regulators sometimes accomplished this notice more than 4 years after the infraction occurred. The Exchange should work with the regulators to ensure that these results are promptly communicated to the other plans as part of an effort to communicate at the earliest point in time and to the widest audience to promote proper health plan performance and to share information with consumers and other information intermediaries. The Exchange (and DHCS) should assure that recent experience with the failure of DMHC to provide adequate oversight of Medi-Cal managed care plans is not repeated with respect to Exchange QHPs. • ACA requires consideration of whether issuer rates are "reasonable": this should be incorporated in minimum

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	QUP certification. An issuer with a pattern of unreasonable rate increases should be barred from the Exchange, as the ACA allows.
Health Net, Inc.	Health Net strongly supports the concept of the Exchange partnering with regulators to utilize the existing regulatory framework. Making use of existing well-established requirements, including quality and performance measures, will be simpler for the Exchange as well as issuers, and therefore help keep costs down.
Kaiser Permanente	We are in support of the Exchange staff recommendations to rely upon existing regulatory structures for determining rate reasonableness, compliance with allowable rating factors, accurate calculation of actuarial values, network adequacy, etc. We note that one issue for the Exchange, however, will be consistency in the application of these regulatory tasks between CA's two regulators. For example, it is vitally important that a CDI-licensed PPO reporting a product meets the 70% actuarial value test for a "Silver" metal tier product is demonstrating this conclusion with the same methodology as a DMHC-licensed PPO.
LGBT Health Consortia (Transgender Law Center; Center for American Progress; Equality California; National Center for Lesbian Rights; and L.A. Gay & Lesbian Center)	When considering whether an issuer is "in good standing" for the purposes of QHP certification, the Board must consider issuer compliance with nondiscrimination requirements established by Federal regulations implementing the Affordable Care Act, and by California law on nondiscrimination in insurance. Federal regulations issued in March 2012 prohibit qualified health plans (QHPs) and QHP issuers from discriminating against any QHP consumer on the basis of race, color, national origin, disability, age, sex, sexual orientation, or gender identity. *See* 45 CFR 156.200. In addition, California's Insurance Gender Non-Discrimination Act (IGNA) expressly prohibits insurance carriers from discriminating on the basis of gender identity in benefit design or coverage determinations. IGNA removes gender identity, including transgender status and related diagnoses (such as gender dysphoria or gender identity disorder), as a basis for insurance carriers seeking to deny transgender individuals coverage for services that are routinely covered for other populations and other conditions. To ensure that California's QHPs and QHP issuers comply with these regulations, the Exchange should include the following nondiscrimination provisions in the consideration of whether an issuer is "in good standing" and eligible for certification: **Prohibit QHP issuers, with respect to their QHPs, from arbitrarily discriminating in any of their activities against any consumer on the basis of race, color, national origin, disability, age, sex, sexual orientation, or gender identity.** This proposed standard implements the nondiscrimination requirements in federal regulations and California law, and is essential to ensuring the exchange serves all Californians equally. Federal regulations cover activities such as marketing, outreach, rate setting, benefit design, conditions of coverage, and coverage determinations by QHP issuers with respect to their QHPs, and IGNA covers benefits, rate setting, and other terms of coverage. For example, QHP issuers may not deny transgender enrollees coverage for benefits offered to similarly situated non-transgender consumers, as this would constitute unlawful discrimination on the basis of gender identity.

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Organization	**Comments**
	Model language: *NO DISCRIMINATION IN ENROLLMENT OR COVERAGE. Any issuer certified by the Exchange as a Qualified Health Plan issuer shall not, with regard to a Qualified Health Plan, refuse to insure, refuse to enroll, refuse to continue to insure, refuse to renew insurance, cancel insurance, or limit the amount, duration, or scope of coverage or benefits available to an individual in a manner arbitrarily discriminating on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, disability, diagnosis, or medical condition.*
National Health Law Program on behalf of the Health Consumer Alliance	NHeLP and the HCA appreciate the work that the Exchange staff have done to collaborate with the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to coordinate plan monitoring and oversight. We support the proposed process of identifying plans "in good standing" that will be permitted to bid for QHP status.
Pacific Clinics	We want to underscore the importance that qualified health plans that meet the definition of "good standing" are committed to meeting the federal requirements for mental health parity. We would like to see this emphasized more in the draft document.
SeeChange Health Insurance	We applaud the Exchange's effort to avoid duplicative regulation. A determination by the DOI or DMHC that an insurer is "in good standing" should suffice for the Exchange without the necessity of additional administrative steps by the carrier. SeeChange Health would not object to taking into account a finding by the regulator that the proposed carrier does not have any "material or grievous statutory or regulatory violations" in the previous two years.

ISSUE 3

Issue #3: Plan and Network Design Issues	
Organization	**Comments**
AIDS Health Consortia	Issue 1: Standardization of Cost Sharing Provision: We agree with the staff recommendation to standardize cost-sharing with some limited flexibility. Although it is not clear that this issue belongs here we wanted to ensure that within cost sharing considerations, the Board considers the feasibility of limiting co-sharing on life saving drugs in the Medicare six classes of protected drugs, including anti-retrovirals. The insurance industry practice of tiering HIV and other high cost life-prolonging drugs on specialty tiers with associated extremely expensive co-pays and/or co-insurance has resulted in people having difficulty or being unable to access necessary treatments. People with HIV can face co-pays of more than $1000.00 per month for drug costs alone. Although cost sharing caps on out of pocket expenses required under health care reform will limit annual cost sharing, cost barriers to necessary medications in the first months of a plan year would likely violate the ACA's anti-discrimination provisions and will result in sub-optimum health outcomes for people with HIV and other life-threatening chronic conditions. In addition people with HIV who are not able to access adequate treatment are more likely to transmit HIV to others. In order to prevent this, we urge the Exchange to require that the co-pay amounts for drugs in all six Medicare protected classes, including HIV drugs, be kept to a reasonable level. Issue 2: Standardization of Benefit Exclusions and Limits: We agree with the staff recommendation to standardize benefit exclusions and limits but allow for some limited flexibility for the reasons outlined. Benefit limitations, medical necessity determinations that are not held to high standards, and drug utilization management practices could result in discrimination against vulnerable populations. Regulations and guidance that prohibit insurance companies from limiting access to lifesaving care and treatment through visit limits on essential services, condition-specific restrictions, and unduly burdensome utilization management and prior authorization practices will be essential to ensure adequate access to care and treatment. Service limits are harmful to individuals with HIV infection and others with chronic conditions who rely on routine medical visits and laboratory monitoring to stay healthy and prevent disease progression. Protections must be in place to prevent insurance plans from making it too difficult to access specialists, for example by requiring higher co-payments for specialty care. Issue 3: Standardization of Drug Formularies:

Issue #3: Plan and Network Design Issues	
Organization	**Comments**
	Neither option A or B provides adequate drug access for people living with HIV/AIDS and other complex chronic conditions. People with HIV require access to all anti-retrovirals (ARVs) and the drugs should not be subject to utilization management. HIV treatment must be individualized in order reach and maintain full viral suppression and optimum health outcomes. The standard of care for people living with HIV/AIDS is a minimum of three drugs from the anti-retroviral drug category, including more than one from within the six classes to effectively suppress the virus. Many people who have been on treatment for a number of years have developed a resistant strain of the virus, requiring access to drugs in the same classes with different resistance profiles. Others have side effects from one drug and not another in the same class forcing changes in regimens. In addition, many people who are newly diagnosed with HIV are infected with a treatment resistant virus, requiring a non-standard treatment regimen. This is true for other conditions as well, which is why Medicare established the standard of six protected classes in Medicare Part D. Medicare Part D plans must offer access to "all or substantially all" drugs in the six therapeutic classes, including ARVs, anti-depressants, anti-psychotics, anti- convulsants, anti-neoplastics, and immunosuppressant's, and they are not allow to employ utilization mechanisms such as prior authorization and step therapy. At a minimum, the exchange should adopt the Medicare Part D program protections. Explicit protections, such as those provided under Medicare Part D, are needed to ensure that people with life-threatening chronic conditions, such as HIV infection, have access to all drugs necessary to treat their condition as recommended in the federal treatment guidelines. In addition, the Exchange should limit the co-pay obligations in these six protected classes to a reasonable amount.
California Association of Health Plans	CAHP and our member plans are not in support of any standardization of age or family tiers in the Exchange that would be different from the outside marketplace. There is a serious risk that QHPs inside the Exchange could be disadvantaged due to the proposed standardization requirements resulting in adverse selection, increased premiums, and an uneven playing field for plans inside and outside the Exchange.
California Dialysis Council	The CA Dialysis Council urges adoption of a geographic standard of 15 miles/30 minutes for dialysis clinics as noted on page 106, table 27 of the Board Recommendation Brief and DMHC regulations, Title 28, California Code of Regulations, Section 1300.51.
California Family Health Council	California Family Health Council (CFHC) champions and promotes quality sexual and reproductive health care for all. CFHC accomplishes its mission through its umbrella of services including advanced research in sexual and reproductive health technologies, provider training, public policy and clinic support and consumer awareness initiatives. As the lead California administrator of the Title X federal family planning program, CFHC partners with a

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	diverse Title X provider network that collectively serves more than a million individuals annually in 43 of California's 58 counties. Through the Title X program CFHC funds family planning and reproductive health care services for low-income and uninsured clients through 77 health care agencies with 337 clinic sites, including federally qualified health centers, city and county health department clinics, stand alone family planning health centers, school-based clinics and community or free clinics. CFHC supports the Exchange's proposal to standardize minimum out of network benefits offered in each tier of the Exchange's proposed metal system. Standardizing cost-sharing provisions, benefits and benefit design will help bar plans from "cherry-picking" beneficiaries through creative benefit design and reduce customer frustration and confusion, especially among patients seen at Title X funded health centers and other safety net providers that largely serve patient populations with low literacy and no previous exposure to the commercial health insurance market.
Cigna	***Issue 1: Metal Level Tiers of QHP Bids*** Requiring that issuers must offer Platinum, Bronze and Catastrophic in addition to the Silver and Gold, which is required by ACA, is more demanding. This results in additional administrative expense for carriers, potentially expands the number of choices that individuals will need to sift through/evaluate for what is likely to be a very small number of enrollees selecting platinum or catastrophic plans (we believe most individuals will buy silver and bronze – adding more plans in the cat and platinum levels just creates more confusion for buyers). ***Issue 2: Number of Carrier QHP Product Bids*** Additional clarification is needed to confirm whether this is limited to 2-3 legal entities per geographic region. ***Issue 3: Geographic Coverage by Health Plans*** We support the requirement that coverage of a licensed region to be offered on the Exchange but allow sub-regional plans within the same geographic rating area to be able to participate.
Health Access	• CA law requires issuers to ""fairly and affirmatively offer, market and *sell* in the Exchange at least one product within each of the five levels of coverage". The law does not contemplate allowing this to be satisfied by hopscotching around geographic regions. Hence the options do not correctly reflect what is permitted by the law. The intent and plain language of the law is that each issuer shall sell at least one product in each of the five levels of coverage in every geographic region for which the issuer contracts with the Exchange. This is a very important and very deliberate protection against adverse selection against the higher metal tier products. It was debated at length over a number of years and multiple reform efforts here in CA. Health

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Organization	**Comments**
	Access supports abiding by the law. • Health Access supports the sensible suggestion that consistent with existing CA law, issuers provide service in the geographic areas in which they have demonstrated a capacity to provide adequate access to care.
Health Exchange Advocacy & Responsibility Team (H.E.A.R.T.)	We recognize the State has taken some measures to limit the potential for adverse selection against plans in the Exchange (p.38). Nevertheless, the viability of the Exchange remains so vulnerable to adverse selection that…. ***HEART recommends that the Exchange board vigorously monitor the Exchange and the external market for any trend toward adverse selection of the Exchange. In the event adverse selection against plans in the Exchange is detected, the Exchange Board should take aggressive and effective measures to halt the trend, which may include urging the State Legislature to enact additional legislation.***
Insure the Uninsured Project	We agree with staff recommendations.
Kaiser Permanente	We believe the Exchange should use its selective contracting authority to, as much as possible, foster competition among competing networks of plans and non-overlapping affiliated providers, in contrast to today's market where most plans have substantially the same provider networks. We believe this market "rule" or approach will have a much more significant impact on price competition than other strategies, such as "value-based benefit designs" or "reference pricing" because they show the consumer at the time of selection, rather than at the time of care, the quality and price of competing networks. While presenting this information at the time of needed care is not without merit, the power of consumers to act on this information at that particular point is limited. Consumers obviously cannot be expected to engage in this kind of research and comparison at a time of an emergency health need, or in many cases, a very serious diagnosis. Moreover, a large proportion of health care costs are attributable to services received after a consumer has satisfied a deductible, and therefore, has no incentive to consider the relative costs among different providers.
LGBT Health Consortia (Transgender Law Center; Center for American Progress;	To ensure that California's QHPs and QHP issuers comply with federal nondiscrimination regulations and California's Insurance Gender Nondiscrimination Act, the Exchange should include the following nondiscrimination provisions relating to plan design: **Require QHP issuers to incorporate a statement in their QHP materials affirming that the plan provides coverage for all essential health benefits deemed medically necessary for the insured individual, without arbitrary discrimination on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, diagnosis, or medical condition.** This statement should include information for consumers about their rights to grievance and appeals processes

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Equality California; National Center for Lesbian Rights; and L.A. Gay & Lesbian Center)	available under state and federal law. In particular, Affordable Care Act Section 1557 allows consumers to sue in federal court or file a complaint with the Office for Civil Rights at the Department of Health and Human Services alleging discrimination by any exchange actor on the basis of race, color, national origin, age, disability (including HIV status), or sex. The HHS Office for Civil Rights has issued a letter stating that discrimination on the basis of gender identity is actionable under the sex protections in ACA §1557. *Model language: (a) ASSURANCE OF NONDISCRIMINATION IN COVERAGE. Any issuer certified by the Exchange as a Qualified Health Plan issuer shall provide affirmation, in Qualified Health Plan documents, that such issuer shall not utilize arbitrary exclusions, limitations, or reductions in the amount, duration, or scope of coverage or benefits available to an insured individual in a manner arbitrarily discriminating on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, diagnosis, or medical condition. (b) ASSURANCES RELATED TO USE OF CONDITION-BASED EXCLUSIONS. Any issuer certified by the Exchange as a Qualified Health Plan issuer shall provide affirmation, in Qualified Health Plan documents, that such issuer shall not arbitrarily deny or reduce the amount, duration, or scope of an otherwise covered benefit solely because of the diagnosis, type of illness, or condition for which such benefit is sought. This requirement shall not be construed to prohibit a limitation or exclusion of coverage based on criteria of medical necessity, appropriateness, or comparative cost effectiveness.*
Molina Healthcare, Inc.	In general, Molina Healthcare believes that standardization of rating structures limits the ability of health plans to develop pricing that attracts only the healthiest members, resulting in skewed risk pools across the entire market. Californians who purchase coverage on the Exchange will get the best value for their money if participating plans compete with each other on the basis of provider networks and contracting rates, medical management, customer service, quality and administrative efficiencies. Molina therefore supports overall standardization of rating structures because standardization forces plans to compete on the key items listed above. This creates a healthcare market designed to maximize the benefit and value derived by consumers rather than a market designed to maximize profits for plans.
National Health Law Program on behalf of the Health Consumer Alliance	NHeLP and the HCA have long supported the California Exchange's role as an active purchaser. We appreciate that the recommendations in this section strive to balance consumer choice with simplicity. We share the goal of ensuring that consumers who purchase coverage through the Exchange have a sufficient number of plans to choose from that offer them meaningful choices. But we equally support the goal of offering consumers a streamlined and standardized selection of plans that facilitates choice based on the most important features—cost, provider networks, quality and customer service. For the most part, these recommendations meet those twin goals. Our comments on particular recommendations follow.

ISSUE 4

Issue #4: Active Purchaser: Number and Mix of Exchange Plans	
Organization	**Comments**
Anthem Blue Cross	Anthem supports the staff's recommendation for Issue 1 to require issuers to propose a QHP for all metal tiers and catastrophic coverage in each geographic region in which it bids (Option A). However, our preference with respect to the number of carrier QHP bids (Issue 2) would be for issuers to have the flexibility to offer a varied number of plans per metal level. This would encourage innovative benefit designs as well as to permit issuers the flexibility to offer multiple options at some AV levels and not others, as we anticipate that the deductible and out-of-pocket restrictions, combined with the AV requirements, will limit design options at some of the AV tiers (e.g., bronze). If the Exchange decides to move forward with the recommendation to limit carriers to a small number (2 or 3) of QHPs (Option B), we recommend that the Exchange clarify how this would align with the requirement to propose products at each metal tier. That is, would the limit of 2-3 QHPs apply per metal level or overall? Anthem supports the staff's recommendation of Option B with respect to geographic coverage by issuers (Issue 3).
Blue Shield of California	**Sub-Regional Variation** We appreciate the intent behind the proposed recommendation allowing sub-regional variation in product offerings. As the QHP discussion draft acknowledges, QHPs that offer coverage only in limited service areas may have significant pricing advantages over statewide QHPs. We believe the recommendation by the Exchange does not resolve the rating disadvantage for statewide carriers and, perhaps unintentionally, could add additional selection concerns. We look forward to continuing to work with the Exchange to ensure fair competition to encourage the participation of statewide carriers that can meet the Exchange's mandate to offer statewide coverage. <u>Rating Concerns</u>: The ACA requires standardization of rating regions and legislation is currently being considered in California that would establish these uniform regions. We have concerns that current proposals do not provide sufficient gradation to ensure fair competition between statewide plans that must offer coverage across an entire rating region, and therefore price to an entire rating region, and those that operate only at a sub-regional level. We encourage the Exchange to work with QHPs, regulators and the Legislature to advocate sufficient rating regions so that statewide plans can fairly compete with plans offering coverage in only limited service areas. <u>Selection Concerns</u>: The proposed recommendation also creates potential selection concerns because the guidance requires a statewide plan to offer a sub-regional product <u>alongside</u> a state-wide product. The sub-regional product, priced at a different level than the statewide product, would compete against the plan's statewide product and invite risk selection against

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	the plan's own products. We strongly recommend that statewide plans be able to offer statewide coverage by offering a single product in every region and sub-region within the state. For example, if a local health plan competes with the statewide plan in Sacramento, the statewide plan could offer a sub-regional product, sub-regionally priced, in Sacramento. In the surrounding areas, a statewide plan would have to offer its statewide product. This would help mitigate unfair competition in areas where there are sub-regional plans but also allow the Exchange the ability to meet its mandate to provide statewide coverage. In addition, statewide plans should be allowed to offer innovative products—such as ACOs—within a sub-region to account for the disadvantage that broad network plans may have as compared to sub-regional QHPs with limited networks. Statewide plans should be allowed to structure these innovative products so that they do not compete with their statewide products. This will help promote the delivery system reform and innovation that the Exchange intends to foster.
California Association of Health Plans	CAHP supports the recommendation that each QHP may bid for 2-3 products per region, but requests that the Exchange explain how this will align with the requirement to offer coverage in all metal tiers. The proposed recommendation regarding sub-regional plans has raised a number of questions for plans regarding how it would impact the many different types of health plans and insurers that currently provide coverage in California; we would like to have a greater understanding of how this proposal would work.
California Association of Physician Groups	**Number of QHP Plans Per Geographic Region**: From a provider perspective, it is unlikely that the concentration of 2-3 Qualified Health Plans per geographic region will create adequate competition on price and quality, even if they each offer 2-3 specific benefit designs each. We understand that in some regions only two potential health plans or insurers are presently in operation. Our members have expressed concern that in some urban areas the selection of narrow offering QHPs may be dominated by a single plan that occupies 50 percent or more of the insured commercial marketplace would create and perpetuate a monopoly. CAPG suggests that at least 4 QHPs be offered in each region (where available), with a mix of various plan designs that include HMO, PPO, broad network, and narrow network product offerings, similar to those currently offered in the Massachusetts Health Connector. CAPG also suggests that the Exchange offer regional QHPs along-side larger state-wide QHPs in the regions where they are available and appropriate.
California Children's Hospital Association	CCHA agrees with the staff recommendations to require a product in each metal tier. However, merely displaying a product without a requirement of 'actively marketing' may prove inadequate and CCHA urges such a requirement. Small group laws from the '90's carried such a requirement, which provided a measurement which could be monitored by regulators.

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	Further, geographic coverage in more remote areas has been, and likely always will be, a tremendous challenge. While alternative standards are necessary to address specialty provider shortages, alternative standards cannot become a substitute for requiring carriers to contract locally. CCHA is concerned that larger health plans must be required to demonstrate robust network adequacy using local providers for each geographic region. This is to ensure that they are not offering products with minimal networks that end up with local providers receiving no contracts, and enrollees required to travel great distances or end up out of network.
California Hospital Association	As an active purchaser, the Exchange has the responsibility to ensure that consumers have a broad choice of products to choose from and not limit the number of options simply because it is easier to manage. Issue 1 of this section addresses a question about the metal level tiers that QHPs must bid on for a geographic area. We support the staff recommendation to require health plan issuers to propose in their submission a product for all metal tiers (and catastrophic coverage) in each region. ***We believe the Exchange should strengthen the requirement that a product for all metal tiers includes assurance that each of the products is actively marketed and the patients' obligations under each plan are clearly explained.*** While we support a broad range of plans/products in the Exchange, we recognize that unlimited QHP bids could create an administrative burden. Limiting the number of bids to two or three per issuer seems appropriate. Further, this option may provide an incentive for issuers to "put their best products forward" and may result in increase quality of the products being offered. CHA agrees that the success of the Exchange depends on ease of use, comparable options and range of choices. Reasonable limitations on the number of products offered in the Exchange will help mitigate overwhelming decisions. CHA is concerned that Option B under issue 3 – geographic coverage by health plans – could be manipulated by the larger carriers, allowing them the ability to offer a minimal network across the geographic region, and robustly augmenting it in areas where it will offer and sell more premium products and options. The corollary is that the smaller plans may have more difficulty participating on equal footing. Again, to ensure consumers can compare like products, ***CHA believes that each carrier or plan should be restricted to bids only for service areas where it can demonstrate comprehensive coverage over the geographic area set by the Exchange, using standardized network adequacy criteria.***
California Medical Association	***Issue 1: Metal Level Tiers of Qualified Health Plan Bids:*** **We support the Exchange's staff recommendation, Option A, to require health plan issuer to propose a Qualified Health Plan product for all metal tiers and catastrophic in each geographic region in which it bids.** ***Issue 2: Number of Carrier Qualified Health Plan Product Bids*** **While we support the Exchange's staff recommendation, Option B, to set a maximum for the number of bids**

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	an issuer may have in each geographic area, we feel a higher maximum of five bids per issuer per area is more appropriate. A smaller allowance for bids may discourage issuers from using bids on innovative product offerings. ***Issue 3: Geographic Coverage by Health Plans*** **We support the Exchange's staff recommendation, Option B, allowing bids for a subset of a region so long as coverage exists for the entire region for which it is licensed.** This option represents a balance of competing interests by allowing largely sub-regional plans to compete on the Exchange while ensuring consumers in the region, but outside the sub-region, have adequate coverage options.
Health Access	Health Access supports a limited number of QHP product bids per region. Health Access continues to be concerned by the volume of choice facing consumers: five tiers, multiple carriers, very different regulatory models (Insurance Code versus Knox-Keene), and now multiple products per tier.
Health Net, Inc.	Health Net does not support the concept of the Exchange attempting to use QHP contracts to alter the market outside the Exchange. We believe that regulation of the outside market should remain strictly the purview of the legislative and regulatory processes because those processes are accessible by and accountable to all Californians.
Insure the Uninsured Project	We agree with staff recommendations.
Kaiser Permanente	▪ **Issue 1 (p 44): QHPs Per Metal Tier.** We support the adoption of Option A, which requires issuers to propose a QHP for all metal tiers and catastrophic in each geographic region in which it bids. ▪ **Issue 2 (p 44): QHPs Per Geographic Region.** We support Option B, requiring issuers to submit a limited number of QHPs per geographic area. Two is better than three. We believe the Exchange should require issuers to report quality data independently to the extent a narrow network option is offered as a separate QHP in one or more geographic region. It would be difficult to arm consumers with quality information otherwise, and care should be taken to avoid a high quality rating for a broader network being mistaken for the same quality level available in a narrower network. ▪ **Issue 3 (p 46): Service Area Requirement.** We support Option B, in which all carriers must submit one bid that covers the entire geographic service area in which the carrier is licensed, but may also submit a second bid for a subset of the service area. This recommendation reflects a reasonable balance between the desire of the Exchange to ensure choice, promote standard products to empower consumers, and allow the development of products tied to exclusive provider networks.

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Organization	**Comments**
	Note: it is important to distinguish between service areas and rating areas; these terms are not interchangeable. Rating areas proposals pending before the CA legislature generally would observe county geographic boundaries, whereas all HMOs licensed in CA today define their service areas by zip code – resulting in smaller geographic regions, and more of them, than the proposed county-based rating area proposals. If service areas and rating areas are intended to be interchangeable, then it would be necessary to define rating areas far more narrowly than pending legislation describes.
Molina Healthcare, Inc.	Issue 3: Geographic Coverage by Health Plans Molina supports option B—allowing the health plan to select geographic subset(s) of licensed service area for QHP bid(s) but would require complete service area coverage for any plan licensed in proposed region. Allowing QHPs to serve a subarea of the state will maximize consumer choice and allow the Exchange to benefit from the participation of insurers that do not have a statewide presence.
Monarch HealthCare	Monarch proposes an offering of at least 4 QHPs in each region (where applicable), with a mix of various plan designs that include HMO, PPO, broad provider network and narrow network product offerings. Allow for the Exchange to offer regional QHPs along with the larger state-wide QHPs in the regions, where available and applicable.
National Health Law Program on behalf of the Health Consumer Alliance	**Issue 1: Metal Level Tiers of Qualified Health Plan Bids** NHeLP and the HCA support the proposal to require bidders to offer a product in each tier in each region in which it bids. As we understand this proposal, such bids would include similar products that vary primarily on cost sharing, while containing the same covered benefits, product type and provider network. As such, this proposal supports consumer choice by assisting consumers to evaluate plan value and understand the tradeoffs between, for example, premiums and cost-sharing, while holding other factors constant. In addition, this proposal will help the Exchange ensure that it offers equivalent plans in each tier in each region. **Issue 2: Number of Carrier Qualified Health Plan Product Bids** NHeLP and the HCA also support the proposal to allow health plan issuers to propose a limited number of products in each region. This proposal strikes the right balance between the extremes of allowing only one bid per region and allowing an unlimited number of bids. We agree that allowing a small number of bids per issuer per region will facilitate competition and choice, without overwhelming the Exchange and regulators. Although consumers must have meaningful choices of QHP products in the Exchange, too many identical choices may only create confusion. Allowing a small number of bids per region provides the right balance between choice and simplicity. In addition, allowing more than one bid per region could be especially important in rural areas of the state where the Exchange might otherwise be challenged to obtain a sufficient number of bids to ensure such choice.

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Organization	**Comments**
	Issue 3: Geographic Coverage by Health Plans No comments.
Pharmaceutical Research and Manufacturers of America (PhRMA)	PhRMA remains concerned about the long-term implications of California's decision to pursue an active purchaser model for the health of the State's health benefits market. State-based Exchanges should maximize consumer choice and access to coverage. In facilitating the availability of health plans that meet the federal certification requirements, Exchanges should accept all plans that meet the certification requirements and not limit the number of plans available to consumers. Just as the Board recognized that "allowing multiple submissions for each health plan will maximize the Exchange opportunity to selectively contract based on the combination of choice, value, quality, and service", allowing consumer access to all qualified health plans (QHPs) that meet the certification requirements will maximize the consumer's opportunity to select a plan "based on the combination of choice, value, quality, and service," and thereby help facilitate access to quality coverage options. However, given that California plans to implement an active purchaser model, we strongly encourage the Exchange to take steps that will maximize both the number of QHP bids and the number of QHP products that are offered to the consumer in each geographic region. Therefore, we support the Board's recommendation that the Exchange "Require health plan issuer to propose a Qualified Health Plan product for all metal tiers and catastrophic in each geographic region in which it bids" as this option is expected to maximize both the QHP bids and consumer choices. While we support the Board's recommendation that each issuer be permitted to offer more than one QHP bid, we disagree with the recommendation that each issuer be permitted only a limited number of bids. Permitting additional bids would increase options for consumers, and improve the chances that consumers will be able to select plans that fit their particular needs. We recognize the Board's concern that providing consumers with a large number of options may "make it difficult for consumers to compare plan features." However, we believe the advantages of providing consumers with options outweigh the potential downsides, particularly if the Exchange develops online tools to help consumers compare plans. Finally, we support the option to allow health plans to bid in a subset of geographic regions in which they are licensed. We believe this option is likely to minimize barriers to bidding, and thus result in the most QHP bids.
SeeChange Health Insurance	The staff report notes that, in most California counties, the top three carriers have 75% of the individual and small group market share. It's important to put this in perspective, though. For any particular employer group or consumer, this market share is irrelevant: if there are five additional carriers dividing the remaining 25% market share, for any particular purchaser there are eight options. The breadth of choice is likely to remain outside the Exchange and will

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Organization	**Comments**
	hopefully increase. Consequently, the Exchange should be cautious in offering just a subset of these plans through the Exchange. First, this will place the Exchange at a competitive disadvantage relative to the broader market. Second, it deprives consumers receiving premium support from accessing the entire market. While allowing fewer carriers in the Exchange does simplify the presentation of qualified health plans, it also restricts the availability of qualified health plans. The same holds true when considering the number of plans a carrier may offer at a given tier. Overly restricting this number could, as we believe will happen by limiting the number of carriers in a region, place the Exchange at a competitive disadvantage while preventing subsidized Californians from enjoying the same options as their unsubsidized neighbors. It should be noted that, through engagement by the Exchange of qualified, professional brokers, increased complexity by enhancing choice in the Exchange can be mitigated. SeeChange Health does not object to the Exchange requiring carriers seeking to participate in the Exchange to offer at least one plan at each level in every region in which a carrier is applying. We do strongly believe that in defining those levels it is critical to allow flexibility for value-based plans to offer appropriate rewards to members taking appropriate steps to manage and improve their health. Narrowly defining a particular level could prevent carriers from offering wellness incentives that are effective.
Small Business Majority	Issue 1: Metal Level Tiers of QHP Bids: We believe it is essential that issuers propose products in all metal tiers in each region in which it bids, and thus support Option A. Small businesses are remarkably diverse in terms of their profit margins, size of firm, age of employees, etc. and thus will need a wide selection in terms of metal tiers and cost-sharing arrangements to fit their needs. Issue 2: Number of Carrier QHP Bids: Our research and outreach have shown that small employers want substantial choice when shopping for health insurance. With that said, the current market which offers dozens of products that are difficult to compare is not what small business owners are looking for. Option A is far too restrictive for employers and would discourage use of the Exchange. On the other hand Option C appears to be too similar to today's status quo which does not work for small businesses. We recommend Option B which we believe will offer meaningful, but not overwhelming, choice for small business owners and their workers. We also encourage the Exchange to allow itself flexibility. Allowing carriers to propose 2-3 products per region seems appropriate but in some cases, exceptions may be warranted. For example, if one geographic region has few carriers participating, it may be appropriate for the carriers in that region to propose additional products. Carriers offering broad network and

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Organization	**Comments**
	narrow network options may be another example of an appropriate exception. This flexibility will be essential to ensure substantial competition amongst carriers and products as well as allowing carriers to be innovative in product design. Issue 3: Geographic Coverage by Health Plans: We support Option B to allow issuer bids in a subset of licensed areas. This will allow for smaller local carriers to be competitive with larger statewide carriers, which is an important priority for small businesses as a way to boost competition and increase choice. Additionally, Option B's requirement of at least one product that covers the entire region is essential to protect against carrier gaming and adverse selection. However, requiring all carriers to offer all products in all licensed areas (Option A) seems too difficult for issuers to do and may have the unintended consequence of limiting carrier participation in the Exchange, thus reducing employer choice.

ISSUE 5

Issue #5: Rating Issues: Family Tiers, Age, Geography, Tobacco and Wellness	
Organization	**Comments**
Alameda Health Consortium	The U.S. Dept. of Health and Human Services (HHS) is developing a risk-adjustment model for federally run exchanges; states have the option of adopting the HHS approved models. We urge the California Exchange Board to engage with HHS in the development an **alternate risk adjustment methodology** that includes social factors (e.g. poverty, limited English proficiency, homelessness). Community health centers have extensive experience with populations that have social factors that influence service utilization and therefore financial risk; community health centers mitigate the social risk factors by providing additional services (language interpreters, case management, and other supportive services) that require an up-front financial investment but that often pay off in the long run in terms of enabling patients to access early preventive services and primary care, and avoid unnecessary acute, high-cost emergency and inpatient services due to delayed care.
AltaMed Health Services	**Issue 4: Allowable Rate Adjustment for Tobacco Use** AltaMed supports the 5% tobacco use/non-cessation enrollment adjustment on the premiums paid by tobacco users purchasing coverage through the Exchange. AltaMed promotes wellness and advocates from strong and healthy communities through health education programs and programs promoting the tobacco cessation. AltaMed encourages the Exchange to re-invest that 5% adjustment back into the community instead of the QHPs. Investing that money in the community will help us reach out to the most hardest to reach populations and address culturally competency issues.
American Cancer Society, CA Division	Charging higher health insurance premiums for people who smoke creates a financial barrier for individuals who need coverage the most. Even with subsidies many of these individuals would face premiums so high that they would not participate. The ACA recognizes that a premium equating to 8 percent or more of income is not “affordable” and would remove the individual mandate obligation. Lastly, there is no evidence that charging smokers higher premiums reduces smoking.
American Heart Association	Charging higher health insurance premiums for people who smoke creates a financial barrier for health care coverage. Existing research does not suggest that raising insurance rates will motivate individuals to improve their health status. However, research clearly demonstrates that increasing premiums or deductibles if employees can’t reach certain health/behavior metrics may deny them access to the very care they need, especially for the most vulnerable employees where chronic disease incidence and unhealthy behaviors are often the most prevalent.
Anthem Blue Cross	Anthem believes that the same rating rules should apply to plans both on and off the Exchange. This is important to avoid adverse selection, and applies to all of the issues discussed in this section.

Issue #5: Rating Issues: Family Tiers, Age, Geography, Tobacco and Wellness	
Organization	**Comments**
	With respect to Issue 1, Anthem encourages the Exchange to adopt Option B, rather than Option C as proposed. Option B would standardize the family tier structures but allow issuers to determine tier ratios. However, we note that this issue may be moot if HHS decides to require member-level rate build up. With respect to Issue 2, Anthem agrees that standardized age bands are desirable; however, we believe that issuers should be permitted to set their own age factors. Given the 3:1 age bands required by the ACA, there is very little room for variation across issuers that would warrant standardized factors for the purpose of consumer comparison across plans. Therefore we encourage the Exchange to instead adopt Option A, which would allow issuers to set their own age factors. Should the Exchange move forward with dictating the age factors, we note that large premium increases can occur when members age into a new age band if the bands are too wide (e.g., 5 years). Regarding geographic rating areas (Issue 3), Anthem encourages the Exchange to adopt county-level rating areas. We believe that this is the most straightforward approach as it would match the rating region to the smallest unit of "service area" in which a QHP issuer can offer products. However, if the Exchange decides not to adopt this recommendation, then we would support the staff's recommendation of Option C, with the understanding that this option requires an issuer to cover the entire rating region unless the Exchange selects a local QHP that does not cover the entire region, in which case all other QHP issuers would also be permitted to cover only a portion of the region. With respect to Issue 4, Anthem encourages the Exchange to adopt Option B, which would allow the application of the full magnitude of the tobacco use rating factors permitted by the ACA. We believe that carriers should be allowed to set their own tobacco rating factors within the parameters of the ACA, rather than having them set by the state. However, if the Exchange decides to proceed with Option C, which would permit a limited rate-up for tobacco use, we urge the Exchange to consider a factor greater than 5%, which we believe is too low. Anthem encourages the Exchange to vary the factor by age, or alternatively to set a flat factor greater than 5%. Anthem supports the staff's recommendation on Issue 5 to allow wellness program incentives.
Blue Shield of California	We support efforts to ensure that rating methodologies are consistent across plans where necessary to ensure fair competition and support transparent choices for consumers. However, as the Exchange guidance notes, federal rules expected to be released very soon will establish many of these rating rules—including age bands, rating tiers, and likely age factors. Because any state regulation would be superseded by federal rules, it would be prudent to wait for

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Organization	**Comments**
	those federal rules before trying to anticipate any gaps. Additionally, the Exchange acknowledges that it does not have the ability to set rules for the non-Exchange market. If the Exchange sets rules for QHPs that are more restrictive than the outside market, this would lead to inequities favoring the outside market. All of these factors strongly weigh against the Exchange attempting to standardize rating rules. Instead, the Exchange should work with the legislature to set rules that will be consistent for the entire market.
California Association of Health Plans	CAHP and our member plans do not support the recommendation that the ratios between age bands and family tiers be standardized beyond what may be required in federal regulations. We suggest that the Exchange consider option B for the family tiers, which would standardize the family tier structures but allow plans to determine the premium relationships between tiers. For the age factors we recommend that the Exchange consider a new option where QHPs would only be subject to the 3 to 1 maximum age based premium variation in federal law. However, the same rating rules should apply to plans in and out of the Exchange. As the Exchange notes, legislative action would be required to enforce Exchange standards on non-QHPs. While the Exchange may use its contracting authority to ensure compliance with non-QHPs, it cannot exercise authority over carriers that choose not to participate in the Exchange. This could create a competitive disadvantage. Because of the short time-frame required for plans to submit QHP bids and pricing, we recommend that the Exchange require QHPs to comply with federal rules and work to address any problems that become apparent in the market through subsequent regulatory action or legislation if necessary.
California Association of Physician Groups	**Tobacco Use** (pages 57-58): CAPG supports the staff recommendation to continue to research the pros and cons of including a separate premium rating for smokers. Tobacco cessation is an extremely significant health determinant that can contribute to reduced overall costs to the health care system. California was the first state to prohibit smoking in public areas and has been a strong advocate of health education on the effects of tobacco use, and as a State now enjoys the lowest use of tobacco by its population in the nation. During these efforts, policy makers have always cited the added costs to the health care system from the effects of smoking. Implementing a tobacco use premium rating factor appears to be consistent with California's strategy toward smoking cessation.
California Children's Hospital	CCHA agrees with the staff recommendations for the reasons noted in the policy options brief. While difficult, it is important to adhere to traditional rating tiers to the extent not 'overruled' by the ACA. Tobacco use rate up is one of those inside/outside market stabilizing elements.

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California Dietetic Association	1. CDA agrees with the recommendation of CHBE establishing requirements for allowed wellness programs. 2. CDA agrees with the recommendation encouraging health plans to address public health issues. HOWEVER, these efforts should be coordinated with existing public health projects to prevent duplication and/or to build on existing programs offered at all levels by the government and private stakeholders. 3. CDA strongly encourages California to apply to participate in the 10 State Wellness Program.
California Medical Association	***Issue 1: Standardization of Family Structure Rating Factors*** **We support Option C, standardizing the rate tiers, tier composition, and tier ratios, if such standardization can be achieved via law so that it applies to the entire market.** Otherwise, an uneven playing field will exist for QHPs. ***Issue 2: Standardization of Age Factors*** **We support the Exchange's staff recommendation, Option B, standardizing age factors for all issuers.** Without such standardization, plans would be permitted to use discriminatory pricing to dissuade older consumers from choosing their QHP. ***Issue 3: Requirement that Issuers Cover Entire Geographic Regions*** **We support the Exchange's staff recommendation, Option C, allowing regional plans to offer sub-regional products.** This option represents a balance of competing interests by allowing largely sub-regional plans, such as local initiatives, to compete on the Exchange while ensuring consumers in the region, but outside the sub-region, have adequate coverage options. ***Issue 4: Allowable Rate Adjustment for Tobacco Use*** **We support the implementation of tobacco use rating factors and feel the Exchange's staff recommendation, Option C, is appropriate.** CMA has long supported efforts to reduce smoking in California and increase participation in tobacco cessation programs. However, we do understand the Exchange's concerns regarding a high tobacco surcharge creating adverse selection and affordability issues. ***Issue 5: Wellness Program Incentives*** **We support the Exchange's staff recommendation, Option B, allowing wellness program incentives.** CMA has long encouraged employers to promote increased responsibility among employees and their dependents for their health by instituting wellness programs and providing appropriate incentives or disincentives to abandon unhealthy

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	lifestyles. However, we also agree with the Exchange that any such programs should take care to avoid any discriminatory effect on enrollees.
California Pan-Ethnic Health Network	CPEHN supports standardization of family composition, age rating, and geography with respect to rating factors. Tobacco rating: CPEHN opposes the Exchange's recommendation to allow a 1.5 adjustment for tobacco rating. As the Exchange notes, the way premium tax credits are calculated does not take tobacco use into consideration, thus low-income tobacco users will bear a disproportionate burden of the higher premiums which could make health care less affordable for that population. Because communities of color, particularly African Americans, have the highest smoking prevalence for both women and men, it is likely that this same group will bear a disproportionate burden of the higher premiums than other groups, making this a discriminatory policy. While CPEHN supports tobacco cessation efforts, the research shows that tobacco premium pricing is not very effective at breaking tobacco addiction. CPEHN supports community and public health measures that encourage individuals to make healthy decisions without penalizing individuals through an inherently discriminatory back-door underwriting scheme. Please see 6C for our comments on Wellness incentives.
California Primary Care Association	***Issue 4: Allowable Rate Adjustment for Tobacco Use*** CPCA supports the concept of allowing a 5% tobacco use/non-cessation enrollment adjustment on the premiums paid by tobacco users purchasing coverage through the Exchange. Tobacco use has a significant negative impact on health and CPCA believes the Exchange should incentivize the cessation of tobacco as a part of its commitment to health, wellness, and prevention. CCHCs have historically had active community health education programs, including programs promoting tobacco cessation. Rather than including a 5% tobacco use premium adjustment that would simply revert to the QHPs, **CPCA encourages the Exchange to re-invest that adjustment back into the community by using proceeds to support or incentivize essential community providers to offer tobacco cessation programs or other health education services.** In particular, CPCA hopes the Exchange will invest in tobacco cessation programs that have a particular focus on reaching the most challenging populations and providing culturally competent health education.
Cigna	***Issue 1: Standardization of Family Structure Rating Factors*** Standardize family tier structure per Federal regulations, but do not standardize the number of rate tiers, or tier ratios as it does not allow carriers to differentiate. Standardization is helpful for risk adjustment; however, it does limit issuers and consumers may not see much

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	difference between issuer products. ***Issue 2: Standardization of Age Factors*** Since we are held to a 3:1 age ratio anyway, standardization of the age slope is acceptable. ***Issue 3: Requirement that Issuers Cover Entire Geographic Regions*** Require coverage of licensed region to be offered on the Exchange but allow sub regional plans within the same geographic rating area. ***Issue 4: Allowable Rate Adjustment for Tobacco Use*** We do not support disallowing tobacco rating or limiting the tobacco rating to 5% since the ACA allows up to a 50% rate increase. Additionally, 5% is an immaterial rate up to account for the higher health costs of smokers and will only result in overall higher premiums for all insured to accommodate the increased health costs of tobacco users. Engaged customers may benefit from a smoking cessation program for a discount off premium. ***Issue 5: Wellness Program Incentives*** Recommend allowing programs with financial incentives to Individuals engaged in wellness as allowed within HHS Final rules. Incentives would be optional, each carrier can determine whether to offer (incentives may not "pay us back" in the way of return – so they would need to be considered additive to the cost of premium)
Disability Rights Education and Defense Fund	Page 57 of the July 16, 2012 QHP discussion draft recognizes the disproportionate impact of a tobacco use rating factor on low income individuals since "a higher than average percentage of low income individuals use tobacco and would be required to pay the surcharge." The draft does not note the higher than average tobacco use across various disabilities and within groups of people with specific disabilities, which, in conjunction with the high correlation between disability and low income, equally leads to any tobacco use rating factor having a disproportionate impact on people with disabilities. A study published by Seth Curtis and Dennis Heaphy in 2009 found that adults with annual household incomes of less than $25,000 are more likely to report having a disability than adults with an annual household income equal to or greater than $25,000. Healthy People 2020 has noted that PWD experience health disparities of delayed care, lower likelihood of preventative care, and higher incidence of tobacco use, obesity, and high blood pressure. A 2007 article by Michele Capella-McDonnall in the Journal of Visual Impairment and Blindness reported that people with significant vision loss experience a greater prevalence of obesity, hypertension and heart disease, and cigarette use than the general public. DREDF's position is that higher than average tobacco use among people with disabilities is at least partly due to discriminatory factors such as unequal access to health promotion campaigns, the inaccessibility of smoking cessation literature and information (i.e., information is not commonly available in alternative formats such

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	as Braille, large font print, audio formats, or in sign-language videos), and deep-seated provider attitudes (e.g., "this patient with a disability must have such a poor quality of life that I should at least let the poor fellow smoke"). The mere imposition of a tobacco use rating factor will increase the costs of insurance for low income people with disabilities who smoke, but will do nothing to remove the barriers and factors that make smoking cessation more difficult for people with disabilities. Waiving any tobacco use rate increase for individuals who enroll in a smoking cessation program must be accompanied by the requirement that any plan that offers such a waiver must ensure that there are genuine options out there for individuals with various disabilities who wish to enroll in such a program. If those programs are not fully physically and programmatically available to people with disabilities, then people with disabilities cannot equally benefit from such cessation programs. The same holds true for fitness and wellness incentives that are keyed to membership in clubs and programs, where accessible fitness equipment continues to be rare. In addition to equipment, DREDF has personally worked with complainants with various disabilities (e.g., physical, developmental), who require and use the services of a personal assistant to engage in various fitness endeavors, but the facility they wish to use has a policy of requiring the personal assistant to obtain a membership or pay full admission price. Since the personal assistant is only there to assist the individual with a disability to engage in exercise, the person with disabilities is effectively being required to "double pay" for his or her wellness benefit. A fitness facility's refusal to modify such a policy runs counter to both state and federal disability rights laws, but that fact in itself does not seem to motivate even well-known fitness chains and facilities to adopt fairer policies or purchase accessible equipment. While these may seem to be issues and policies that are far removed from the QHP benefit design that is being addressed in these sections, they have very concrete monetary impacts on the affordability of insurance benefits for many low or lower income people with disabilities. If the California Health Benefit Exchange decides to allow ratings factors and incentives based on tobacco use and participation in various fitness/wellness options, then the Exchange must equally ensure that those ratings factors and incentives are not allowed to perpetuate existing disproportionate health impacts and inaccessibility.
Health Access	Family Composition: Health Access supports standardization of family composition across carriers, markets and regulators in legislation so that the market inside and outside the Exchange are standardized. We also support the inclusion of domestic partners consistent with existing California law. Age rating: Health Access supports standardization of age rating and age bands across carriers, markets and regulators in legislation so that the market inside and outside the Exchange are standardized Geography: Health Access supports standardization of geographic tiers across carriers, markets and regulators in

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	legislation so that the market inside and outside the Exchange are standardized. Health Access has reviewed the 13 regions proposed as a consensus document by the California Association of Health Plans. While we would prefer fewer regions and have questions about the division of LA County as well as the separation of Kern County from the rest of the Central Valley, we do not oppose the proposal. We do question whether it is based on today's market realities- and whether the addition of millions of newly insured Californians, particularly in underserved areas such as Kern County, South Central LA, and Boyle Heights will significantly change the cost dynamics in those markets. Tobacco: Health Access strongly opposes the inclusion of any tobacco rating factor. California has dramatically reduced tobacco use through public health measures-and the public health community opposes tobacco rating as antithetical to such an approach; premium pricing does not recognize tobacco use as an addiction; rather, it is backdoor underwriting; and tobacco rating factor makes coverage unaffordable for those at $10-$20 an hour, 133%FPL-200%FPL (depending on family size). It makes no sense to make coverage unaffordable for the very people who need the coverage to get the treatment needed to help break the addiction, and to deal with its health consequences. Wellness: Health Access has similar concerns with wellness incentives.
Health Net, Inc.	With respect to standardization of family structure rating factors, Health Net supports Option B (standardization of rate tiers among issuers, with issuers allowed to choose tier ratios). Issuers need flexibility to address cost variances
Insure the Uninsured Project	We agree with the recommendations to standardize age bands/factors, family tiers and ratios, and minimum out-of-pocket benefits, as well as those pertaining to wellness incentives and tobacco rate adjustment.
Kaiser Permanente	☐ Issue 1 (p 61): Family Tier Rating. We oppose the recommended Option C, and suggest instead Option B, whereby family tier composition and structure would be standardized, but cost differences between them (the tier "ratios") would be set by each carrier. Kaiser Permanente is generally in support of standardization of products and other market rules to prevent gaming and to force competition exclusively on the dimensions of quality, service, and price. We are not generally in support of attempts to fix price, however. In our view, standardizing the ratio among family tiers amounts to fixing price when, for different carriers, the cost of care among different compositions can (and does) vary among carriers. Simply put, consumers should see this difference. (If evidence emerges that this area proves a useful strategy for carriers wishing to engage in risk selection, the issue should be revisited. We do not expect this to occur, however.) In addition, we believe it is quite dangerous for the Exchange to attempt to force, by contract alone, standardization across the market, unless it can assure all carriers will participate in the Exchange and be subject to its contractual

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	requirements. It is not enough, for example, to achieve standardization in and out of the Exchange on rating approaches for "80 percent of the market," if the effect is to hand a unique opportunity to the remaining 20 percent of carriers who, by ignoring the Exchange, or not meeting its quality and price requirements, can evade the standard rules. The impact of such an approach most likely would also be counterproductive to the goal of the recommendation, because carriers will strongly resist any degree of standardization to the extent their competitors are not subject to it – even if they might generally regard some standardization elements to be reasonable. Instead, we believe the Exchange should support legislation to standardize rating factors in and out of the Exchange, along with major cost-sharing features. The legislation should also empower regulators to take additional actions to protect the Exchange in the event market dynamics identify specific practices that threaten to destabilize the Exchange. Finally, it should be noted that standardizing tier ratios (and age factors below) would make the task of risk adjustment substantially more complicated. ☐ Issue 2 (p 62): Age Factors. We oppose Option B to standardize age factors for all carriers and attempt to require this in the non-Exchange market via contract only on those carriers for the reasons described in response to Issue 1 regarding family tier structure. Instead, we make a parallel recommendation: standardize the age rating "tiers" (35-39, etc.) and allow carriers to price these tiers based on their underlying costs. A 35-year-old only cares about the cost of coverage that carriers charge 30-year-olds. Each age tier is, in effect, a market. The cost experience that different carriers have for serving various age groups should be reflected and visible to consumers. ☐ Issue 3 (p 63): Geographic Region Participation. We support Option C, requiring issuers to cover the entire region for which they are licensed, but also allowing regional plans to offer sub-regional products in the Exchange if such plans are selected for participation by the Exchange. ☐ Issue 4 (p 63): Rating For Tobacco Use. Tobacco rating should similarly be determined by legislation. We believe the difference in health care costs due to tobacco use are significant, and therefore, that any proposed rating differential be significant also – that is, greater than the suggested 5 percent. Moreover, it cannot be difficult to administer, as would the proposal to exempt individuals from the minimal suggested rate-up based on participation in a tobacco cessation program. Would this be determined by merely enrolling in such a program? By completing it? We note that, upon renewal, a change in tobacco use can be noted and accounted for. Such an approach, in fact, might spur longer term success in changing behavior, since it is unquestionably true that overcoming tobacco addiction is extraordinarily challenging for most individuals, and often requires multiple "quit" attempts. ☐ Issue 5 (p 64): Wellness Program Incentives. While we are in support of the recommendation to allow modest wellness incentives, we are concerned that such incentives not become a mechanism to skirt standard product

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	requirements applying generally to enable carriers to engage in risk selection. We suggest that proposed wellness programs be submitted to the Exchange for review, and that a limited number be approved. Once approved, all carriers participating in the Exchange should be free to offer the approved programs. New approaches could be considered by the Exchange on an annual or bi-annual basis.
LGBT Health Consortia	When considering Family Tiers in the context of rating options, the Board must ensure that same-sex registered domestic partners and spouses are included in definitions of "family." This will ensure that same-sex couples and their families can access the same pricing options as different-sex couples and their families and that Exchange plans and policies comply with state nondiscrimination laws.
Molina Healthcare, Inc.	Issue 1: Standardization of Family Structure Rating Factors Molina supports Option C—standardization of family tiers and tier ratios to the extent required in federal regulations. In this case, the federal regulations meet sufficient requirements for standardizing the plans designs without being too prescriptive. They also provide leeway for plan innovation. Federal requirements strike the right balance between regulation and still allowing innovation and experimentation. This rationale should be applied to plan designs both in and out of the Exchange to maintain a level playing field. Issue 4: Allowable Rate Adjustment for Tobacco Use Molina supports Option C—to conduct further research on requiring a limited rate up for tobacco use. We urge the HBEX to explore the use of a limited rating factor, such as 5%, for tobacco use as this minor up-rate recognizes the strong correlation between tobacco use and higher health care costs. It may also provide an ample incentive for enrollees to stop smoking while ensuring the premium rate remains affordable for these prospective enrollees. To effectively address the threat of "gaming" from non-QHPs, Molina recommends that the same rating rules be applied both inside and outside the Exchange. We support the pursuit of enabling legislation standardizing rating rules statewide (to the extent possible) prior to the launch of the CA HBEX. Issue 5: Wellness Program Incentives Molina supports Option B—the inclusion of standardized wellness incentives as far as they are attuned to the particular needs and socio-economic circumstances of the low-income. This will be important to prevent the wellness incentive from becoming a discriminatory benefit that only the higher income members of the Exchange can access due to costs. We understand that wellness incentives may not bring down costs in the short term, but may be an important tool to control costs in the long run because they will help people get healthier.

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Monarch HealthCare	Tobacco Use: Monarch supports the staff recommendation to continue to research the pros and cons of including a separate premium rating for smokers. Tobacco cessation is a significant health determinant that contributes to a reduction in the overall cost of health care. California has led the way to reduce smoking in public areas and has advocated through health education materials the risks of smoking. Through the promotion of this rating, we can continue the fight to ameliorate the diseases and health risks attributed to smoking. Monarch would support this idea, but not at the expense of enrollment loss.
National Health Law Program on behalf of the Health Consumer Alliance	NHeLP and the HCA commend the Exchange staff for carefully explicating the various issues pertaining to ratings and for proposing options that have the goal of achieving success for the Exchange (standardization of factors both inside and outside the Exchange), keeping issuers from being able to "cherry-pick" (by allowing varied rating factors that can be manipulated), and making choice as easy as possible for consumers (standardizing plans as much as possible). We are generally supportive of the options that the staff has proposed. We note, however, with so many factors still to be set by either state legislation or federal rules, the issues raised here should be revisited when any such laws or regulations are enacted. **Issue 1: Standardization of Family Structure Rating Factors** No comments. **Issue 2: Standardization of Age Factors** No comments. **Issue 3: Requirement that Issuers Cover Entire Geographic Regions** In regard to geographic access, NHeLP and the HCA agree that issuers should be required to cover the entire region in which they are licensed. We note that the Exchange should be observant that issuers do not use whatever geographic ratings are ultimately allowed to be used as a proxy for experience rating. For example, research indicates that rural areas (or other low- income areas) could have higher premiums that are not merely based on geographic cost differences, but are really intended to raise premiums for populations with higher health risks. *See* ANDREW COBURN *ET AL.*, STATE HEALTH ACCESS REFORM EVALUATION, THE RURAL IMPLICATIONS OF GEOGRAPHIC RATING OF HEALTH INSURANCE PREMIUMS (2012), *available at* http://www.rwjf.org/files/research/74475.ruralimplications.pdf. Even if geographic rating areas are set by state law, the Exchange should monitor the impact and suggest any changes in those areas that will best level the playing field for all consumers. **Issue 4: Allowable Rate Adjustment for Tobacco Use**

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	In regard to Tobacco Ratings, NHeLP and the HCA agree that rates should not be increased to an extent that discourages coverage. We agree that this topic warrants further research before the Board determines whether to allow tobacco rating at all, and we look forward to reviewing additional materials on this subject. **Issue 5: Wellness Program Incentives** NHeLP and the HCA recognize the valid goals of Wellness Programs, but also acknowledge the very real fact that the use of financial incentives to encourage participation in them can disadvantage certain populations. Unfortunately, it is often much more difficult for racial and ethnic minorities and low-income persons to meet wellness goals due to inherent barriers such as difficulties accessing fresh foods, being forced to work multiple jobs, etc. It is critical that the Exchange closely monitor the impact of such incentives to the extent they are allowed. We offer a more detailed discussion of the issues raised by Wellness Program Incentives below in our comments to section 6C.
SeeChange Health Insurance	SeeChange Health supports the establishment of standardized, reasonable rating factors for age and dependent status. We advise caution, however, when it comes to the Exchange establishing tier ratios. The likelihood of unintended consequences through this approach is high. Whatever ratio is selected could benefit some carriers at the expense of others as insurers are unlikely to experience identical loss ratios at each tier. Providing carrier flexibility in determining rates at each tier will help insurers to manage this reality. As a carrier whose entire portfolio is built around wellness promotion, we are gratified to see the staff recommend that the allowance of wellness program incentives.
Small Business Majority	General Comments: We support the proposals to standardize rating factors. In the absence of such standardization, it is our concern that carriers may seek to use these rating issues to select good risk, leading to adverse selection for the Exchange. Once issuers are no longer able to base premiums on health status and gender in 2014, the remaining rating factors could provide an opportunity for such gaming. With that said, we have also studied public and private exchanges throughout the country and understand the demise of many exchanges has been due to exchanges operating under a different set of rules than the outside market. If the Exchange were to standardize rating issues for QHP issuers, the carriers not participating in the Exchange may have an unfair advantage. This could reduce carriers' incentive to sell in the Exchange and thus undermine the goals of the ACA. We would strongly prefer that the issues below be decided by federal regulation or state legislation, thus impacting the entire individual and small group markets. In the absence of regulation or legislation, we would urge the Exchange Board to tread carefully in using its

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	negotiating ability to standardize ratings for only QHP issuers. Depending on Exchange enrollment levels, carrier participation, etc. this may be appropriate. In other scenarios, the Exchange could be put at a competitive disadvantage. For example, if the outside market rates up for tobacco use, but QHP issuers cannot rate for tobacco, the Exchange would likely be attractive to smokers, thus driving up premiums in the Exchange. Issue 1: Standardization of Family Structure Rating Factors: We support Option C so that small business owners will be able to better do an apples-to-apples comparison of competing carriers and products. Issue 2: Standardization of Age Factors: We support Option B for the reasons above. Issue 3: Requirement that Issuers Cover Entire Geographic Regions: We support Option C to require carriers to cover the entire region in which they are licensed but to also allow sub-regional plans. We feel this strikes an appropriate balance. No requirements (Option A) could lead to adverse selection. Requiring issuers to cover the entire region may be too expensive or simply not feasible for some carriers, especially smaller local insurers. Small business owners want to see a highly competitive Exchange with many carriers participating so we believe Option C encourages carriers to participate while protecting against unfair gaming. Issue 4: Allowable Rate Adjustment for Tobacco use: We support the staff recommendation to conduct further analysis on this issue. To the extent that tobacco rating can be used to reduce smoking rates and lower healthcare costs, this would be an appropriate rating factor for the Exchange. Small businesses will benefit through lowers healthcare premiums and healthier, more productive workers. With that said, we understand some of the legitimate concerns raised by opponents of tobacco rating. Particularly, we would want to avoid any adverse selection made possible by tobacco rating. On the surface, the staff proposal of a 5% upcharge that can be waived by simply participating in a smoking cessation program seems very reasonable, and we encourage staff to continue their research into this issue. Issue 5: Wellness Program Incentives: We support allowing QHPs to offer wellness programs to the extent that they do not lead to adverse selection. Separately, we encourage the Board to include worksite wellness programs in the SHOP, similar to what large employers do today. These programs have no relation to health insurance premiums, benefits or cost-sharing. They have proven to be effective and are not controversial.

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AltaMed Health Services	**Issues 1: Standardization of Cost-Sharing Provisions; Issue 2: Standardization of Benefit Exclusions and Limits; Issue 4: Value-based Benefit Designs in the Context of Benefit Standardization** AltaMed supports the Exchange's proposal to standardize the benefits offered in each tier in order to alleviate the ability of plans to select the most desirable beneficiaries through creative benefit designs. By standardizing the cost-sharing provisions, benefits, and benefit design this will reduce customer confusion and frustration. Standardization of the benefits is extremely important in our communities, as essential community providers the majority of our consumers have low or no health literacy and the majority have not ever purchase health insurance because of the cost and complexity. As a safety-net provider in the state's most underserved communities, AltaMed and other CCHC patients would benefit from the standardized benefits and cost-sharing provisions by providing them with clear and easy to read comparisons. **Issue 5: Standardization of Minimum Out-of-Network Benefits** AltaMed supports the Exchange's recommendation to standardize minimum out-of-network benefits. It is imperative that patients have access to out-of-network providers, should the necessity arise. As essential community providers we see new patients because of our specific culturally and linguistic competent providers. AltaMed strongly believes that consumers with little understanding of "in network" and "out of network" could face devastating financial losses. We also believe this would deter the Exchange's vision of the "No wrong door experience".
American Cancer Society, CA Division	In allowing customization, the Exchange needs to make sure the benefit design does not discourage enrollment of individuals with significant health needs (such as scaling back certain benefits used by sicker individuals or cancer patients--chemotherapy, or days in the hospital) and that the ability of potential enrollees to compare insurance products is not compromised.
Anthem Blue Cross	Anthem believes that standardizing cost sharing amounts for the major components of coverage (Issue 1) will significantly dampen issuers' ability to design innovative benefits that keep costs down and drive quality improvements for our members. Allowing issuers flexibility to create innovative offerings can also help to drive consumer engagement in plan selection and enrollment, by giving consumers a variety of options and thus increasing the likelihood that they find a plan that best fits their needs. Option B, as recommended by the staff would not allow issuers to fully leverage

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	their networks, limiting our ability to create tiered network designs that encourage members toward the highest quality and most efficient providers, and in turn drive providers toward quality improvements and efficiency gains. It also appears to restrict carriers from designing HSA-based plans. And it could also limit issuers' ability to drive cost savings for consumers, as the formulary tier cost sharing requirements may not be sufficiently different to drive utilization towards the most clinically effective and safe yet cost attractive drugs. Additionally, rather than making it easier for consumers to compare options, it might actually create confusion, as consumers are unable to identify differences between the plan options, leading them to question what small factors they might be overlooking. As such, we urge the Exchange to instead adopt Option A, which would impose no standardization of cost sharing on QHP issuers. If the Exchange feels strongly that some standardization is required, we urge that it not be imposed on cost sharing including coinsurance, copays, deductibles, and out-of-pocket maximums. Instead, standardization could be applied to definitions and exclusions. Should the Exchange decide to move forward with Option B for Issue 1, we would appreciate further clarity on how much flexibility will be permitted. The recommendation to standardize "major components" with "some limited flexibility" is not clear. For instance, would issuers be able to determine which services fall under the standardized cost sharing amounts? Also, with regard to the proposed plan designs in Appendix A, we encourage the Exchange to clarify: That issuers are permitted to offer just one of the plan designs within a metal tier and do not have to offer each of the options for each tier. Whether issuers would be able to offer plans of their own design as long as they also offer one of the standardized designs. Whether the designs apply to SHOP as well as the individual exchange; we note that neither of the bronze plans appear to be compliant for SHOP. As noted in the Appendix, the deductible limit for Plan B exceeds the $2,000 maximum. However the combined medical and pharmacy deductible for Plan A also exceeds the $2,000 limit. Whether flexibility would be permitted to accommodate certain contractual provider reimbursement arrangements, for example, coinsurance may not be easily applied to professional services that are capitated. That issuers would be permitted to make their own determination about how to administer benefits in instances in which interpretation is needed, such as if a service appears to fall under two categories (e.g., outpatient hospital lab – is this under the outpatient hospital or lab benefit?). Whether all benefits (except for preventive services) would be subject to a deductible for those plan designs where a deductible is required. That issuers would be permitted to add coinsurance or other cost sharing parameters for services not identified (e.g.,

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	tier 4 high cost injectable drugs). Whether issuers would have flexibility to choose copay vs. coinsurance options in metal levels, and design alternative copay/coinsurance structures, particularly for the gold and platinum level plans, such as decreasing copays for primary care visits relative to services such as lab tests and advanced imaging. That issuers could apply separate copays to the technical and professional components of services like radiology, when billed separately by the providers. Whether the Exchange would also standardize the cost sharing requirements for the alternative versions of the silver plans (for individuals qualifying for cost sharing reductions). How HSA options could be incorporated into the metal levels. Additionally, should the Exchange adopt these standardized plan designs, we urge the Exchange to shift from flat copayments to coinsurance for hospital, emergency room, and mental health services. Requiring copays for these costly services would result in higher premiums for consumers and could also increase unnecessary utilization, such as emergency room visits for non-emergent conditions, as consumers would be shielded from the true costs of these services. With respect to Issue 2, standardization of exclusions and limits, Anthem supports the staff's recommendation but wishes to ensure that the Exchange specify that health plan's medical policies and clinical guidelines would still apply. Anthem is concerned about the staff's recommendation on Issue 3 to impose the Medicare Part D standard requiring QHPs to cover two drugs per class or category (Option B). Option A, with a standard of one drug per class or category, provides QHP issuers with greater flexibility to control costs and keep premiums down while providing necessary access to all classes and categories of drugs covered by the benchmark plan. Further, it follows the federal requirements as outlined in the Essential Health Benefits (EHB) Bulletin. As the Exchange staff concedes in the Board Recommendation Brief, Option B will cause the premium for pharmacy benefits to be higher than it would be under the one drug per class requirement. In addition, depending on the benchmark plan that is selected, this requirement could go beyond what the benchmark covers. Further, the decision to follow Medicare Part D requirements regarding number of drugs per class could also lead to advocacy pressure to adopt the Medicare "protected classes" in Exchange plans, which would escalate costs. As estimated by CMS in 2009, the Part D protected classes will increase program costs by $4.2 billion over 2010-2018. Furthermore, we are concerned that, if the Exchange moves forward with the requirement for two drugs per category

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	or class, this will conflict with the rules outside of the Exchange as outlined in the EHB Bulletin. It will still be possible for off-Exchange plans to include formularies that only cover one drug per class. This will have the effect of funneling higher cost and higher risk individuals into the Exchange as individuals with higher drug use will seek on-Exchange plans while individuals with expected low drug use will opt for the less expensive options outside the Exchange. Additionally, even with coverage of two drugs per class, it is still possible that a QHP might not cover medications for a particular disease state if the categories or classes are not drawn appropriately. Anthem encourages the Exchange to support an open dialogue with comments from the industry to establish guidance on how the categories and classes should be drawn, to ensure that plans are afforded the ability to manage costs while ensuring that disease states are adequately accounted for. Finally, we urge the Exchange to reiterate its guidance from the webcast that step edits and other utilization management would be permitted for formulary drugs. Anthem supports the staff's recommendation for Issue 4, which would allow value based designs. Anthem is concerned about the staff's recommendations with regard to Issue 5, which would direct the Exchange to standardize the OON benefit, including the maximum fee that can be charged by a provider for OON claims (Option B). We do not believe that standardization of the OON benefit is necessary nor would it be meaningful for consumers. In contrast, the potential negative impact to consumers would include higher costs and less robust provider networks, as issuers' ability to guarantee steerage to network providers would be undermined. If OON providers are not able to balance bill, issuers' ability to use networks effectively will be compromised, resulting in higher premiums for consumers. If the Exchange decides to move forward with the recommendation, we urge you to work with issuers to ensure that the requirements put into place do not compromise existing provider network contracts which require a minimum difference between in- and out-of-network cost sharing. Furthermore, issuers must retain the ability to offer no OON benefits in a particular plan. Finally, we are very concerned about the staff's intention to establish a fee schedule for OON providers and restrict balance billing. Our understanding from the webcast is that the Exchange would ask issuers to amend contract language with current providers to ensure that they offer a specific rate to members of another QHP with which they do not have a contract. This is not a practical recommendation and there would be no way to ensure compliance. Instead, we recommend that the Exchange pursue a legislative solution that caps the payment for OON providers. If the Exchange does decide to pursue an option in this regard, we would also recommend inclusion of a requirement

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	that OON providers also supply medical records and other information requested for quality initiatives such as HEDIS scores.
Behavioral Health and Recovery Services	Will Stand-alone Dental & Vision plans be standardized, too?
Blue Shield of California	**Benefit Design Standardization** The proposed rules will standardize the major cost-sharing components of QHPs offered in the Exchange as well as the benefit exclusions and limits. It is not clear that this will allow much, if any, innovation in the market (beyond value-based benefit design). As the proposal notes, too much standardization could ignore consumer preferences and limit innovation that leads to improvement in value. It would be beneficial for the Exchange to follow the model of Massachusetts, which encouraged a competitive market and then standardized plans based on revealed preferences within the market. We believe a compromise position would support requiring plans participate with one standardized product while being allowed to offer another innovative product. For example, Medicare Part D requires carriers to offer a standardized plan design that is easily comparable for consumers, while still allowing carriers to offer several additional plan designs that differ from the standardized plan design. This allows for continuous innovation, while still providing consumers with the reference benchmarks they need to make informed decisions. Additionally, we understand that the Exchange believes the proposed standardization would trigger the AB 1602 requirement that plans not participating in the Exchange offer standardized plans as well. We agree and would ask that you make this requirement explicit in order to ensure that standards are similar for QHPs and non-QHPs. **Rx** Blue Shield requests that the Exchange provide more information on the details of the proposal to require 2 drugs per class. We are concerned that this requirement varies from what is required under the Knox-Keene Act and suggest that the Exchange consider the implications this policy may have on affordability for consumers in the Exchange. Additionally, we request that the Exchange consider the impact this policy will have on affordability when there are only 2 drugs available in a certain class and the plans are required to provide both. Because the Essential Health Benefit guidance says that plans should only be required to offer one drug in a category or class, a requirement to

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	offer additional drugs may be considered a state mandate that would impose on the state the obligation to pay the additional cost for broader coverage. We would oppose any effort by the Exchange to require coverage in the same manner as the 6 classes of drugs protected under Medicare Part D. We would like to remind the Exchange that to the extent plans are limited in their ability to *negotiate* with pharmaceutical companies, the higher the cost will be to the consumer. If the Exchange still believes having a minimum of two drugs per class is best, we would request that the Exchange explicitly allow for step-therapy to give preference to one of the required two drugs per class. This will allow carriers to ensure that members have access to appropriate, medically-necessary care while still granting carriers the necessary utilization leverage to negotiate affordable drug pricing with drug manufacturers. **Proposed Benefit Designs:** Blue Shield will provide separate comments on the proposed benefit designs, but has these initial comments. We believe that the official HHS AV calculator may require plan designs that are significantly different than the ones illustrated, as our own AV calculator yields very different results from the illustrative examples. As an example, it is now widely accepted that plans will not be able to offer a bronze product in the small group market because of the $2,000 and $4,000 deductible limits mandated by the ACA. We look forward to working with you to provide more information on the proposed plan designs. **Value-Based Benefit Designs:** We appreciate the Exchange's recognition that value-based benefits are an important tool to provide improved care and help control health care spending. Blue Shield has implemented a number of value-based benefits, including its Blue-Groove product that utilizes an ACO combined with an innovative benefit design. In addition, working with CalPERS we implemented a value-based benefit for colonoscopies that encourages members to use high-value providers. Specifically, the benefit provided no cost-sharing for colorectal cancer screenings if done in an in-network ambulatory surgery center (ASC). However, a $250 co-pay was required if the same service was performed in an in-network outpatient hospital setting. This was based on clinical evidence showing that colonoscopies performed in outpatient hospital settings were 2.5 to 3 times more expensive than the same procedure performed in an ASC without equating to superior care or higher quality. The Department of Labor (DOL) specifically approved this design as an approved value-based design under the preventive services rule. DOL wrote that, "Plans may use reasonable medical management techniques to steer

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	patients towards a particular high-value setting such as an ambulatory care setting for providing preventive care services, provided the plan accommodates any individuals for whom it would be medically inappropriate to have the preventive service provided in the ambulatory setting (as determined by the attending provider) by having a mechanism for waiving the otherwise applicable copayment for the preventive services provided in a hospital." Blue Shield wants to ensure that this type of benefit design, using higher cost sharing for lower value services when grounded in independent clinical evidence, can be used to steer enrollees to the highest value care. We would also note that in the section on strategies to promote payment reform, the discussion draft includes a proposed recommendation that QHPs be encouraged "to undertake quality-based contracting, reference-pricing and/or bundled payment strategies." Reference-pricing would require that higher cost-sharing be allowed under certain circumstances.
California Association of Health Plans	CAHP requests that the Exchange provide clarification on how the proposed plan benefit designs work with the SHOP. CAHP does not support the requirement that the deductible be waived for 4 PCP visits annually. Since it is not necessary for most enrollees to see their PCP 4 times during the year this policy may have the unintended consequence of causing access issues because of inappropriate utilization and increasing premiums. It would also force deductibles or other cost-sharing to be higher in order to meet the actuarial value requirements. CAHP assumes that the proposed benefit plan designs are only for in-network care. For PPO products we request that the Exchange confirm that they will have the ability to charge higher cost sharing amounts for non-emergency care that is received out-of-network. We also request that you inform us if there will be any limitations on member cost sharing for out-of-network care imposed by the Exchange beyond what is currently in state law. CAHP requests that the Exchange provide more information on the details of the proposal to require 2 drugs per class. We are concerned that this requirement varies from what is required under the Knox-Keene Act and suggest that the Exchange consider the implications this policy may have on affordability for QHPs in the Exchange when there are only 2 drugs available in a certain class and plans are required to provide both. Because the Essential Health Benefit guidance says that plans should only be required to offer one drug in a category or class, a requirement to offer additional drugs may be considered a state mandate that would impose on the state the obligation to pay the additional cost for broader coverage. Therefore, we suggest that the Exchange update the

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	recommendation to reflect the federal law and rely on the current regulatory framework to assure access, which requires that plans provide access to non-formulary drugs based on specific medical necessity criteria. In support of the Exchange's desire for "evidence-based decision-making," we offer a concrete example: in one drug category, "protein pump inhibitors," there are just two drugs available on the market today. One, which is effective for 90 percent or more of patients, costs about $10 per month. The alternative heavily advertised brand name drug costs $150 per month. The effect of the proposed policy would be to require coverage for both drugs in all cases, even if 90 percent of patients would do just as well on the inexpensive drug. This offers no clinical benefit to consumers, but dramatically increases costs. Additionally, we would oppose any effort by the Exchange to require coverage in the same manner as the 6 classes of drugs protected under Medicare Part D. To the extent plans are limited in their ability to negotiate with pharmaceutical companies the higher the costs will be for the consumer. It would also limit the ability of plans to use appropriate management tools for the prescription benefit. The data on Medicare has shown that the mandate to cover all drugs in a class has increased costs by over $4 billion with no evidence that it improves outcomes or access. CAHP requests that the Exchange provide additional detail on the recommendation that major benefits limits and exclusions be standardized. We would like to better understand to what extent the Exchange intends to go beyond the standardization that will be required in the Essential Health Benefits definition. We would also appreciate further explanation as to what the Exchange means by "limited customization" and how the Exchange will evaluate QHPs on this criterion in the solicitation process. We request that the Exchange provide additional details on how the Exchange will evaluate value- based benefit designs and to what extent the Exchange intends to standardized value-based designs across QHPs. CAHP and our member plans are unclear on the proposed recommendation to standardize out-of- network designs and we would like to request that additional detail be provided on this proposal. It appears that the exchange intends to require that plans negotiate agreements with their network providers that would limit the amount that these providers could charge when seeing patients covered on an out-of-network basis by other plans. While we support the intent here, we think this approach is impractical and would likely have the effect of pushing more providers out of all plans' networks. Even if such agreements could eventually be negotiated, it would be impossible to get them negotiated in time for the 2014 benefit year.

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	In addition, we would like to understand how the out-of-network proposal would work in the HMO model.
California Association of Physician Groups	**Full-Billed Charges** CAPG urges the Exchange to address the ongoing problem of non-contracted providers who decline to enter into contracts for services at reasonable, market-driven rates and instead gouge exorbitant fees in out-of-network situations. Price gouging by non-contracted providers inflates the cost of care dramatically, and if not addressed will cause premiums for products sold through the Exchange to be unaffordable. The solution is for the Exchange to require all QHPs, and their subcontractor providers, to charge "market rates" when providing services to out-of-network enrollees whose costs are the responsibility of other QHPs or their subcontractors. This is in the nature of a voluntary reciprocity agreement among Exchange participants and will be binding only upon those that choose to enjoy the benefits of the Exchange and deliver services under products sold through the Exchange. "Market Rates" should not be defined as an absolute number or multiple of Medicare or a default payment rate, but should instead be defined as average contracted amounts, by both payer and payee, within the community, for commercial product lines.
California Association of Public Hospitals and Health Systems	While CAPH recognizes and agrees with the Exchange's goals of limiting members' out-of-pocket expenses, CAPH has concerns about the possibility of setting limits on payments to providers for out- of-network services to Exchange enrollees. If enacted, such a limit could cause harm to safety net hospitals that provide significant trauma, burn and emergency care to all Californians. California's public hospital systems provide care to over 2.5 million patients each year and operate more than half of the state's top-level trauma centers and almost half of the state's burn centers. Due to the large numbers of Medi-Cal and uninsured patients that public hospital systems serve, they have an extremely limited ability to offset funding shortfalls incurred by serving Medi-Cal and uninsured populations. In recommending standardized benefits, the idea was raised of limiting payment to providers for out-of network services. Such a policy could negatively impact public hospital systems in several ways. First, many public hospital systems have few if any contracts with commercial plans; thus, the proposed payment cap could apply to most or all of their Exchange patients that seek emergency or trauma care. We are hopeful that this scenario could change under reform through the meaningful inclusion of safety net providers as ECP's in QHP networks. However, the role of public hospital systems within commercial plans networks largely remains unclear and will likely vary across the state. Second, due to their patient population, public hospital systems will be unable to recoup any shortfalls associated with a cap in payments. A revenue reduction for these providers could have a significant impact on their financial viability

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	and their continued ability to provide these necessary but resource- intensive health care services for all Californians. Finally, maximum out-of-network rates to providers would create disincentives for QHPs to contract with public hospital systems and other safety net providers who would likely qualify as ECP's. For these reasons, we recommend excluding this proposal from the final set of Exchange regulations.
California Children's Hospital Association	CCHA agrees with the staff recommendations for the reasons noted in the policy options brief. Further, standardization of benefit plan offerings allows for more accurate calculations of actuarial value by oversight agencies. Gaming of actuarial value by subtle methods is very likely – for example, narrow provider networks that maneuver sick enrollees to go out of network in order to keep their provider they are in treatment with, resulting in significantly higher cost-sharing. Moving pharmaceuticals to higher tiers with coinsurance reimbursement is has great impact on those in treatment. As the report notes, this is not a theoretical issue – it is one that greatly impacts consumers who cannot understand their coverage.
California Coalition for Reproductive Freedom	**Issue 1: Standardization of Cost-Sharing Provisions** The ACA added section 2713 to the Public Health Service Act requiring that all new plans cover certain preventive services without cost-sharing. The Health Resources Service Administration has required that all new plans cover, "**all** FDA-approved contraceptive drugs and devices, [and] sterilization procedures" without cost-sharing. .S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Women's Preventive Services: Required Health Plan Coverage Guidelines, http://www.hrsa.gov/womensguidelines. (emphasis added). The Institute of Medicine (IOM) report, Clinical Preventive Services for Women: Closing the Gaps (2011) which provided the evidence-based recommendations on which the women's preventive health services requirements are based, noted that, "This range of methods provides options for women depending upon their life stage, sexual practices, and health status." Inst. of Medicine of the Nat'l Academies, *Clinical Preventive Services for Women: Closing the Gaps* (2011), www.iom.edu/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf. The IOM further noted that for women with certain medical conditions or risk factors, some contraceptive methods may be contraindicated." The interim rule allow plans to institute some medical management techniques with regard to contraceptive coverage, but does not further define what the limits to those techniques might be. We urge the Exchange to adopt rules on cost-sharing that limit the types and extent of medical management techniques to ensure that all women have a meaningful choice of contraceptive methods without cost-sharing. We recommend that the FamilyPact program is the appropriate model for providing a comprehensive array of contraceptive options. Further, we recommend that step therapy (initially

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	providing only a limited choice of contraceptive methods and only covering other methods if the first choice fails) be prohibited in conjunction with contraception given the serious consequences for a woman of a contraceptive failure. **Issue 2: Standardization of Benefit Exclusions and Limits** No comments. **Issue 3: Standardization of Drug Formularies** No comments. **Issue 4: Value-Based Benefit Designs in the Context of Benefit Standardization** No comments. **Issue 5: Standardization of Minimum Out-of-Network Benefits** We support the recommendation to standardize minimum out-of-network benefits. We also urge the Exchange to standardize the maximum fee that can be charged by a provider for out-of-network benefits, and to adopt additional consumer protection rules for services accessed out-of-network. The Exchange should require that QHP hold its members harmless for paying beyond network cost from non-network providers at *in-network* facilities. Consumers often do not even know that one provider on a team is consider out-of-network until they receive a bill for services. An enrollee should not be required to pay an out-of-network rate for anesthesiology services, for example, when she arranged to have a procedure performed by a facility in her network and did not request that particular anesthesiologist. Further, the Exchange should require that a QHP hold its members harmless for paying beyond network cost for accessing from out-of-network providers emergency services, ambulance services, and covered services not available through a network provider or not available within a reasonable time period. In the event that an enrollee is not able to access covered services or a necessary provider within the existing covered network (for example, due to provider religious or moral objections, or due to an emergency), the Exchange must require the QHP to allow the enrollee to access services out-of-network without penalty without additional cost to the enrollee. Out of network access is especially critical for women seeking abortion services. Over half of California's counties do not have an abortion provider, and few abortion providers have the capacity to serve women with high-risk or later pregnancies. These women need timely - and often immediate - access to out of network providers, and these providers must be assured that they will be paid for their critical services.

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	The Exchange should prohibit additional cost-sharing and balance billing of consumers for out-of-network emergency services, ambulance services, as well as covered services not available through a network provider or not available within a reasonable time period, including but not limited certain specialty care services such as high-risk pregnancy and abortion care. The Exchange should, at a minimum, apply the Knox Keene balance billing protections, as well as Cal. Health & Safety Code § 127400 *et seq.* protections to cap the charges for hospital services for low-to-moderate income individuals. The Exchange could require that in these situations the QHP reimburse the non-network provider the lesser of: (1) the provider's billed charge, (2) a minimum fee established by the Exchange], or (3) the charge agreed to by the QHP and the provider.
California Family Health Council	CFHC strongly urges the Exchange to standardize cost sharing provisions in all participating Qualified Health Plans. Section 2713 of The Patient Protection and Affordable Care Act requires that all new plans cover preventive women's health services without cost-sharing including the full range of FDA approved contraceptives. The Institute of Medicine's report, *Clinical Preventive Services for Women: Closing the Gaps*, (2011) states that "This range of methods provides options for women depending upon their life stage, sexual practices and health status." The Exchange must ensure that all women have a meaningful choice of birth control method without additional cost. CFHC recommends that the Family PACT program serve as the model for providing a comprehensive array of contraceptive options for enrollees in the Exchange. In addition, Exchange plan holders must have access to out of network providers without penalty or additional cost. In particular, the Exchange should require that Qualified Health Plans hold plan holders harmless for accessing services out of network if and when covered services are not available through a network provider or unavailable within a reasonable time period. In the event that an enrollee is not able to access covered service in network due to a provider's religious or moral objections or due to an emergency, the enrollee should be able to access services without penalty or additional cost. Out of network access is especially critical for women seeking abortion services. Over half of California counties do not have an abortion provider and few abortion providers have the capacity to serve women with high-risk or later pregnancies. These women need timely and often immediate access to out of network providers and the providers that serve them must be paid for the critical care they provide. Finally, patients seen at Title X-funded health centers and other safety-net providers are often transient and many not have the option to stay in-network at all times. This patient population may also have limited health literacy and wish to see specific culturally and linguistically competent providers or have limited understanding of "in network" and "out of network" benefits.

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California Hospital Association	***CHA agrees that standardized cost-sharing components of benefit plans, with limited customization, is an important element for consumers to make choices among comparable products and we support option B of issue 1 under this section.*** However, cost-sharing components are not all consumers are purchasing. ***Consumers are purchasing a product that needs to meet consistent network adequacy requirements, standardized benefits and limits, with robust regulatory oversight and consumer protections***. Issue 2 under this section addresses the options with respect to benefit exclusions and limits. Currently, CDI plans are allowed to exclude many benefits and options that Knox Keene Act regulated plans cannot. Standardization must be ensured across-the-board, including benefit designs, exclusions, ability to change or limit product design, etc. To ensure consumer awareness during product selection, the basic design and coverage parameters must be standardized. We support the staff recommendation for Option B. Many Californians that purchase a product through the Exchange will need access to specialty drugs for extraordinary circumstances (cancer, etc.). While we support option B of issue 3 – standardization of drug formularies – we believe the Exchange should ensure that QHP products will provide access to specialty drugs when it is determined that those drugs are an important and necessary part of the patients' care. All medically necessary classes of medications and provisions for non-formulary medication when necessary. Issue 5 – Standardization of minimum out-of-network benefits: ***CHA believes that standardized out-of-network benefits are necessary to ensure transparent coverage for consumers.*** Without standardization, it would be difficult for consumers to know exactly what they're purchasing. The Exchange's Recommendation Brief discusses the potential for balance billing, which in the managed care arena, is prohibited by statute and by case law. ***The concept of including a maximum fee that can be charged by providers for out-of-network claims creates a massive disincentive for health plans to create robust provider networks.*** Consumers may be forced to receive care by a provider that may not have the specialized services needed, or bypass other providers more conveniently located in the region that are excluded from the narrow network. ***CHA recommends the plan/issuer should be incentivized to create a robust network of providers, Placing a cap on payments to non-contracting providers is putting financial risk on the party that has been purposefully excluded from participating in a provider network.***

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	CHA requests the opportunity to discuss this issue with the Exchange staff and Board. The first time this issue surfaced was through this Recommendation Brief. We encourage the Exchange to learn more about the implications and consequences of reaching beyond the spirit and scope of the Exchange Mission and Values "to improve the health of all Californians by assuring their access to affordable, high quality care."
California Medical Association	***Issue 1: Standardization of Cost Sharing Provisions*** **Of the three options presented, we support the Exchange's staff recommendation, Option B, standardizing major cost-sharing provisions**. We agree that such standardization helps to prevent risk selection through plan design. Should risk selection concerns still exist under Option B, we also believe the Exchange may consider permissible ranges for some non-major cost-sharing features once the federal AV calculator tool is online and can inform such a policy discussion. ***Issue 2: Standardization of Benefit Exclusions and Limits*** Our recommendation on the level to which benefit exclusions and limits should be standardized would depend on what the Exchange considers "major." **Without a clear understanding as to what the Exchange or plans may deem major, we recommend Option C, standardizing all benefit exclusions and limits.** Here, we understand standardizing to mean that the adopted EHB benchmark would serve as a floor and allow only positive customization and we agree with the Exchange that benefit exclusions should not vary from that within the adopted EHB. If the Exchange is concerned about opportunities for risk selection through plan design, it should be extremely resistant to allowing the customization of benefit limits, as consumers who are aware they will need a service are very sensitive to the limits placed on that service. For instance, the Kaiser Small Group HMO sets a limit on home health services of two/four hours per visit, three visits per day, 100 visits per year. An issuer seeking to deter certain complicated patients from choosing its plan might adjust those home health visit parameters to make them less amenable to home health procedures associated with those patients, such as those related to a long-term drainage abdominal catheter. In sum, the risk selection dangers associated with benefit limits are arguably more direct than those associated with cost-sharing features. ***Issue 3: Standardization of Drug Formularies*** **We support the Exchange's staff recommendation, Option B, requiring the Medicare Part D minimum standard of at least two drugs per class.** We further feel that a standardized formulary exception process, especially the forms

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	required, is necessary to ensuring patients get the care they need and reducing unnecessary administrative waste in the healthcare system. ***Issue 4: Value-Based Benefit Designs in the Context of Benefit Standardization*** **The Exchange should postpone any decision on whether to allow value-based benefit designs until the Exchange determines and makes known to stakeholders the standards and mechanisms by which such design proposals are evaluated and approved (beyond the requirement that they lower patient cost-sharing or provide rewards).** Without this information, stakeholders cannot know exactly what it is that would be allowed, as the spectrum of what qualifies as "value-based" is broad and may include designs with an insufficient evidence base. In other words, when the Exchange states that "plans be permitted to deviate from the proposed plan design standardization," does this mean that the plan must only notify the Exchange of its intent, the Exchange will be publicly vetting the proposal according to strict criteria, or something in between? If this strategy has been adopted by "many large employers and public purchasers," does this mean the Exchange itself will be proposing programs for plans to adopt? Will these proposals be coming to the Exchange from the Pacific Business Group on Health or its members? How will they be monitored to ensure they are producing the intended outcomes and not negatively affecting enrollee health, among other things? These are all answers needed for stakeholders to render an informed opinion on the proposal. Until the aforementioned information is provided by the Exchange, we recommend the Exchange adopt Option A and prohibit such variance from the plan design standardization. This decision is too important to be made based on incomplete information. If the Exchange is to adopt recommendation B, allowing value-based benefit designs to obtain exemptions from standardization, then a public standardization waiver process for value-based benefit designs must be put in place to adequately vet proposals. The standards and criteria required of value-based design proposals must also be publicly vetted prior to implementing the waiver process. The Exchange may want to explore incorporating its topic-specific advisory groups, or sub-committees thereof, in the vetting process, especially if the Exchange creates a fourth advisory group focused on the delivery system. ***Issue 5: Standardization of Minimum Out-of-Network Benefits***

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	We *strongly* oppose the Exchange's staff recommendation to standardize minimum out-of-network benefits, up to and including forcing QHP providers to cap their charges to all QHPs with which no contractual arrangement exists. At the very least, the Exchange Board should postpone decision until there is a greater opportunity for stakeholder engagement and more information is available. For such a significant change, we are disappointed that only a single page of the Board Recommendation Brief was devoted to explaining and supporting it. We have appreciated the Exchange's evidence-based approach to policy making. However, we are unclear exactly what evidence or examples of successful implementation this proposal is based on. This proposal may also conflict with other Exchange recommendations. For instance, the Exchange resists differing from current regulator network adequacy standards for fear of increasing issuers' administrative and operational burdens as a result of negotiating new and revising existing provider contracts. Yet, requiring a provider to cap charges to every other QHP with which no contract exists most certainly necessitates the renegotiation and revising of existing contracts and makes new provider contracts more difficult to negotiate for QHPs. Among other things, many providers will have to factor in the new financial risks of such a cap into their in-network rates for that QHP. Tacking on potentially significant out-of-network liabilities to all QHP-provider contracts will further endanger enrollees' access to in-network providers, especially specialists and subspecialists. Contracting with a QHP would become more of an all-or-nothing proposal to many providers, knowing that they may simply avoid such restrictions on their out-of-network practice by not contracting with a QHP. Furthermore, based on the limited information provided by the Exchange on this proposal to standardize providers' out-of-network obligations and especially within the context of the Exchange's other efforts to "align" with major public and private purchasers, we have significant antitrust concerns associated with the types of actions being suggested here by the Exchange. We are currently looking into these concerns further and may be submitting further written correspondence to this effect. We believe this proposal will have significant unintended consequences that could threaten the success of the Exchange. We encourage the Exchange to explore other ways to address out-of-network benefits, after determining that these benefits are indeed causing problems for QHP enrollees such that it necessitates a response. The issues

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	outlined by Exchange staff as justification for this proposal could be addressed through ensuring greater consumer transparency and disclosure. For instance, the Exchange may require greater insurer disclosure around share of cost responsibility and provider disclosures related to using out of network facilities or providers. We believe this proposal could have benefitted from prior engagement of the physician and greater provider community. At the very least, the Exchange should postpone adopting recommendations regarding the standardization of out-of-network benefits until its effects can be adequately explained to and understood by stakeholders. The potential for unintended negative consequences here is substantial. Thus, we urge the Exchange to proceed with extreme caution in mandating providers' obligations to parties with which they have no contractual relationship.
California Pan-Ethnic Health Network	CPEHN supports standardization of cost-sharing provisions, benefit exclusions and limitations in benefit plans and drug formularies in order to trigger the provisions of law requiring sale of standardized products both inside and outside the Exchange. Standardizing these important provisions can help to prevent discrimination by prohibiting plans from designing benefits packages in order to cherry-pick consumers through cost-sharing structures or incentives that attract healthy people while discouraging those less healthy from enrolling. Plans should be monitored by the Exchange as well as regulatory agencies to weed out these types of bad practices and should be required to disclose information about cost-sharing provisions to individuals and employers so consumers know what they are purchasing. CPEHN supports applying the same standards to Insurance Code products that already applies to HMOs and PPOs regulated by DMHC: the reasonable person standard for out of network emergency room care with no balance billing for out of network emergency room care. CPEHN is open to the Exchange testing value-based benefit design, especially for patients like those with chronic illnesses, as long as outcomes are measurable and based on evidence of their effectiveness.
California Primary Care Association	***Issue 1: Standardization of Cost-Sharing Provisions; Issue 2: Standardization of Benefit Exclusions and Limits; Issue 4: Value-based Benefit Designs in the Context of Benefit Standardization*** CPCA supports the concept behind the Exchange's proposal to standardize the benefits offered in each metal tier in order to mitigate the ability of plans to "cherry-pick" their beneficiaries through creative benefit design. Standardizing cost-sharing provisions, benefits, and benefit design will reduce customer confusion and frustration, an important consideration when enrolling consumers with low health literacy and no previous exposure to health insurance. For the most part, CPCA believes that many consumers will benefit from standardized benefits and cost-sharing provisions that are clear and allow for an "apples-to-apples" comparison. While recognizing the importance of standardization, CPCA encourages the Exchange to keep in mind that very low

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	income populations, which may not feel financially comfortable purchasing a subsidized plan in any standardized metal tier, may be incentivized to join a plan of safety-net providers through a model much like the successful Healthy Families Community Provider Plan. This model has the ability to bring low-income underserved populations into care through the incentive of discounted premiums, and the partnerships between providers and health plans that translate into greater quality of care for hard to reach populations. With the goal of ensuring safety-net provider participation and bringing critical populations into coverage, **CPCA encourages the Board to designate a Community Benefit Plan in every region, which is the participating health plan with the highest percentage of true essential community providers within it network.** Subscribers selecting the Community Benefit Plan should be given a premium discount, have lower out-of-pocket maximums, or otherwise be incentivized to select the plan. ***Issue 5: Standardization of Minimum Out-of-Network Benefits*** Continuity of care is a primary concern for the lowest-income individuals who may transition into the Exchange in 2014, or may transition between plans within the Exchange. The Exchange should develop policies to ensure that individuals moving into and out of health plan coverage do not experience disruptions or delays in care. **CPCA encourages the Exchange to expand out-of-network benefits to include at least a one-year transition period wherein an enrollee can continue to see their current provider without incurring financial liability beyond their plans' cost-sharing provisions, while ensuring that the QHP reimburse that provider for the provision of out-of-network care.** The Federal government recognizes the critical role that community clinics and health centers play in providing quality, comprehensive primary care to low-income individuals. FQHCs are statutorily required to offer care to every person who walks through the door, and 42 CFR § 440.365 ensures that FQHC services are offered to every Medicaid beneficiary nationwide. FQHC services are universally available to all persons, insured and uninsured, and will continue to be available to patients even after they purchase insurance coverage through the Exchange. ***Out-of-Network Fair Payment for FQHCs*** Much like emergency departments, FQHCs are required to offer comprehensive primary care services without questioning a patients' ability to pay. Recent California case law has prohibited the act of balance billing for emergency services, finding instead that, under the Knox-Keene Act, payment for services provided to an HMO beneficiary is the responsibility of the HMO, not of the patient. We believe this same practice that precludes collection of payment from patients that receive out of network emergency services should be equally applied to patients

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	receiving services from our health centers. Similarly, 45 CFR §156.235(e) of the final rule published on March 27, 2012, *Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers,* states that if an item or service is provided by an FQHC to an enrollee of the QHP, the QHP issuer must pay an amount that is not less than "the amount of payment that would have been paid to the center under §1902(bb) of the Social Security Act for services that are covered by the QHP and provided by an FQHC to a covered individual." In other words, the QHP, not the patient, is responsible for paying an FQHC their Medicaid PPS rate for items and services that the FQHC provides to a QHP enrollee. The continued viability of community clinics and health centers is critical to ensure the availability of primary care for all Californians. By federal mandate, FQHCs are required to see all patients that walk in the door, regardless of insurance status. When a patient contracts with an insurer, it is the responsibility of the insurer – not of the patient – to reimburse for services rendered to the insured. **As such, CPCA encourages the Exchange to create strong policies that protect enrollees from financial liability for seeing out-of-network community clinics and health centers, and specify that it is the responsibility of QHP issuers are to reimburse FQHCs their full PPS rate for services rendered to out-of-network patients.**
California School Health Centers Association	We support the decision to largely standardize benefit plans, which will limit the ability of health plans to manipulate risk selection through plan design. Such standardization will also allow consumers to make meaningful plan comparisons based on price and quality.
Castlight Health	The California State Board Exchange Staff supports value based benefit designs. Currently the draft recommendation is to "allow value-based benefit designs that lower patient out-of-pocket costs or provide financial awards" (Option B, pg. 83). While we agree that value based benefit designs are important, the option suggests that other types of value based benefit designs that do not lower patient out-of-pocket costs or provide financial awards are not recommended. By expanding this definition to include all value based benefit designs that provide higher value care by driving patients to high value providers, more innovation around designs such as reference-based pricing, will be available. The Exchange should consider expanding the types of value-based designs that may be included in the plans of Qualified Health Plans to include all designs that promote higher value care.
Cigna	***Issue 1: Standardization of Cost Sharing Provisions***

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	Allow insurers to develop and sell more flexible plan designs in the HIX which still meets Federal requirements. There should be flexibility in cost sharing to allow insurers to hit targeted Actuarial Values and differentiate offerings on behalf of customers (i.e. **not** a one size fits all approach) to meet varying consumer needs. This would be similar to the Medicare Advantage program whereby carriers offer a variety of plan designs to enable customers to choose plans that best fit their needs. ***Issue 2: Standardization of Benefit Exclusions and Limits*** Standardization is **not** recommended. Many of the services with limits also have medical necessity guidelines and reviews and the standard limits won't translate into a standard application of limits - as issuer medical necessity guidelines will differ. As a result of this, and in the interest of aligning plans to customer needs, standardization is not recommended. If there is growing support for standardizing benefit exclusions and limits, we would want this limited to a subset of essential health benefits only (such as PT, OT, etc.). ***Issue 3: Standardization of Drug Formularies*** We recommend states not impose any requirements over and above the federal requirements in an effort to keep plans as affordable as possible for customers We also recommend that plans be able to apply clinical and cost containment programs to help manage overall costs. We note that if this recommendation is based on Medicare Part D model, then Medicare Part D is designed to meet the specific needs of the Medicare population and is not necessarily appropriate as a model for the non-Medicare population. We encourage the staff to review existing commercial drug formularies and use these as a basis for any future requirement. We are also concerned about the repercussion of using a Medicare Part D model to affordability. ***Issue 4: Value-Based Benefit Designs in the Context of Benefit Standardization*** We agree with the recommendation of allowing value-based benefit designs that lower patient out-of-pocket costs or

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	provide financial rewards. ***Issue 5: Standardization of Minimum Out-of-Network benefits*** We support measures that would cap what OON providers can balance bill customers; however, we feel this is best addressed by the State and not issuers. We are not confident that non-network providers would be receptive to issuers attempting to cap what the provider can charge. Cigna prefers plan design flexibility on out-of-network benefits to keep plans affordable. Standardizing these benefits will not provide customers with choices, which they are accustomed to in today's marketplace. We also do not want OON coverage to be required and would like the option to offer an in-network only product.
Delta Dental	The document at pages 72-73 states that all health plans offered in the individual and small group markets . . .must provide coverage of the . . . ten Essential Health Benefit categories. However, Sec. 1302(b)(4)(F) of the Affordable Care Act states that 'if a plan described in Sec. 1311(d)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph 1302(b)(1)(J)' (meaning pediatric services, including oral and vision care). We suggest adding a statement to this effect, such that a stand-alone medical plan (with no dental offering) may negotiate to be included in the Exchange should a stand-alone dental plan be present to fulfill the essential pediatric oral benefit. We would also like to point out that in the Preamble to the final Exchange Rule, issued by HHS, the Department clearly states that Exchanges "must allow stand-alone dental plans to be offered either independently from a QHP or as a subcontractor of a QHP issuer, but cannot limit participation of stand-alone dental products in the Exchange to only one of these options." Therefore, it is clearly HHS's intent that state exchanges accommodate the inclusion of stand-alone dental plans in both the Exchange and the SHOP.
Health Access	Health Access strongly supports standardization of benefits in the insurance market. The current complex and confusing insurance marketplace, with dozens of hard-to-understand variables on which to evaluate plans leads to consumer apprehension and insecurity. Many consumers have expressed to us "fear of the fine print"—that the slight differences in benefits means the treatment they eventually need ultimately will not be covered. Research also suggests that complexity and overwhelming number of choices has a paralyzing effect—causing some to never actually sign up for coverage to begin with. Standardization would help consumers to make informed choices. Health Access supports the standardization of major cost sharing components, with limited variation. Health

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	Access supports the Exchange board formally voting to standardize benefit design in order to trigger the provisions of law requiring sale of standardized products outside the Exchange as well as inside. Health Access supports the standardization of benefit limits and exclusions across carriers, markets and regulators in legislation so that the market inside and outside the Exchange are standardized. Health Access supports adequate drug formularies: there are no existing provisions in the Insurance Code comparable to Health and Safety Code Section 1342.7 and the accompanying regulations. Insurance Code products should be held to the same standard as DMHC products under Health and Safety Code Section 1342.7 and accompanying regulations. Benefit design variation creates considerable danger of adverse selection: issuers tailor benefit designs in order to select their target audience. For example, no cost sharing for office visits attracts essentially healthy persons. Similarly, cost sharing aimed at chronic disease management attracts those with chronic conditions. Standardization of benefits minimizes adverse selection by minimizing variation in benefit design so that issuers compete on price and quality rather than the effectiveness of their risk selections. The cost sharing at the silver and bronze levels will be very substantial and will allow considerable opportunity for benefit designs that allow carriers to pick their market through product design. Standardization of minimum out of network benefits: Health Access supports applying the same standard to Insurance Code products that already applies to HMOs and PPOs regulated by DMHC: the reasonable person standard for out of network emergency room care with no balance billing for out of network emergency room care. Standardization of minimum out of network benefits: PPOs are very problematic for individuals eligible for Exchange subsidies: these individuals earn as little as $10 an hour. Going "out of network" is not an affordable or realistic option for such low and moderate income individuals. The Exchange should assure that PPOs provide timely access to an adequate network of specialty and primary care for Exchange enrollees. Going out of network (other than for emergency care) should not be required in order to obtain timely care. Affordability at the point of care is an important concept that needs additional consideration in contemplating benefit designs. The benefit designs offered are very troubling when considered from the perspective of someone with a major chronic condition or a significant illness. Affordability at point of care should be modeled looking at the costs for a consumer with a serious illness (heart attack, breast cancer) and another consumer with a major chronic condition (diabetes, heart disease, asthma).Benefit designs reflect trade-offs: offering four office visits without co-pays probably increases the deductible as well as other cost sharing. Health Access is deeply troubled by the heavy reliance on co-insurance in many of the proposed plan designs: opinion research indicates that co-insurance is unfamiliar to Californians. California consumers dislike deductibles because they understand the implications of deductibles but co-insurance just confuses them. Until we see results of opinion research that reflect actual consumers with significant health care needs reviewing cost sharing designs with co-insurance and find co- insurance of 20%-30% hospitalization less objectionable than a deductible, we are opposed to the inclusion of co-insurance in cost sharing. Co-insurance is an Insurance Code concept and is not widely used by DMHC plans (HMO or PPO) so it

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	also tilts the regulatory playing field toward Insurance Code products which may expose consumers to excessive out of network costs. Value-based design that is designed to improve compliance with chronic disease management regimens is worth testing for improvements in chronic conditions. Evidence-based policy making would require issuers that propose such alternative cost sharing to demonstrate over time improvements in chronic conditions.
Health Net, Inc.	With respect to standardization of benefit exclusions and limits, Health Net believes that the interplay between the Essential Health Benefit requirement and the Actuarial Value of each metal tier makes it critical for issuers to have as much flexibility as possible in developing plans for a particular region or market. We understand the Exchange's desire for simplification, but innovation and variation can provide considerable value in achieving affordability and access, so we do not recommend standardization beyond that which will already ensue from the EHB and A/V requirements. Moreover, it will already be difficult, especially in an HMO model, to design a QHP with 60% Actuarial Value, and we ask that the Exchange take this into account when evaluating benefit design enhancements. Formularies: Health Net recommends the Exchange carefully consider before exceeding the ACA minimum requirement to cover at least one drug per class of category. Exceeding this requirement may drive up costs for the consumer and limit the availability of affordable coverage. With respect to the model plan designs presented for discussion in Appendix A of the Plan Design Standardization Board Recommendation Brief, it is Health Net's experience that the primary cost concerns of enrollees when selecting a plan occur in the following order of precedence: 1) premium as the primary consideration, 2) deductibles, 3) co-insurance and 4) co-pay amount. Although co-insurance is not generally part of a typical HMO model, we recognize that co-insurance will be necessary to achieve the Actuarial Value of the metal tiers established by the ACA. Health Net is supportive of the Exchange's proposal to standardize minimum out-of-network benefits, but requests clarification about how the Exchange intends to limit costs/billing by out-of-network providers, particularly in an HMO model where out-of-network services are covered only in limited circumstances such as emergency room visits or with prior authorization by the primary care physician.
Insure the Uninsured	We agree with the recommendations to standardize major components of cost sharing and benefit exclusions/limits with limited customization options. This option helps consumers shop between

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Project	comparable products while allowing plans room for innovation. In addition, value-based benefit designs will play a role in mitigating rising health care costs, and should be allowed in the Exchange.
Kaiser Permanente	☐ Issue 1 (p 80): Standardizing Cost Sharing Provisions. We are in strong support of the recommended Option B, to standardize major cost-sharing provisions across all benefit plans. This will enable consumers to make the proverbial "apples to apples" comparison in selecting health coverage. In addition, we recommend that the Exchange support legislation to establish comparable standard cost-sharing requirements in the non-Exchange market, and empower regulators to take additional steps if market dynamics emerge that would threaten the stability of the Exchange. Due to the requirements of the ACA regarding essential health benefits and actuarial value that apply market-wide, we believe the Exchange can pursue this policy in the absence of conforming legislation for the outside market. It will have somewhat less freedom to do so, however, for the SHOP Exchange, because the "gravitational pull" of available subsidies will not be as great. ☐ Issue 2 (p 81): Standardization of Benefit Exclusions and Limits. We support proposed Option B, allowing for only limited customization of benefit limits and exclusions. As elsewhere, however, we believe the Exchange must be vigilant to ensure that a "limited customization" exception does not swallow the "standardization" rule. ☐ Issue 3 (p 82): Standardization of Drug Formulary Requirements. We oppose Option B, which would impose the Medicare Part D minimum standards of at least two drugs per class or therapeutic category. Instead, we recommend Option A, which conforms to the Affordable Care Act minimum of one drug per category. We have attached a chart to these comments attempting to lay out the difference between existing CA law (Knox-Keene), the ACA Minimum, and Medicare Part D. (Note that the differences extend beyond the number of required drugs per therapeutic category.) In our view, establishing requirements beyond the ACA minimum is a state-mandated benefit that would obligate the state General Fund to reimburse the federal government for subsidy costs attributable to this higher benefit threshold. One example can illustrate the potential effect: in one drug category, "proton pump inhibitors," there are just two available drugs, and the proposed option would require plans in the Exchange (but not outside) to cover both. One drug is available (and highly effective) at a cost of $9.90 per month, while the alternative heavily-marketed brand name drug costs $150 per month. Requiring plans to cover both drugs – in just this one instance – would be a state decision to impose a higher cost benefit structure. We also note that consumers are protected by the Knox-Keene requirement that there be an exception process whereby individuals whose needs are not met by the first drug can obtain coverage of the second. Over 90 percent of patients can be successfully treated with the lower-cost drug. We believe the goal of formulary regulation should be to ensure that the lower cost, effective therapy in our example is the one that is used 90 percent of the time. We believe

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	the proposed recommendation would make that unlikely. Finally, the Exchange should consider that there is no formulary oversight for CDI-licensed plans that is comparable to Knox-Keene requirements. ☐ Issue 4 (p 82): Value-Based Benefit Designs. We oppose Option B, which would allow value-based benefit designs. These products are typically offered in the large group market, usually under self-funded arrangements. In this context, the employer can limit the number of available designs at the outset, and adverse selection is much less of a concern, since the employer is paying the full cost of care for all its employees in any case. Unleashed in the individual market, however, the context would be quite different. If carriers are free to offer these with few limitations, a plethora of so-called value-based designs could easily obliterate the substantial consumer benefits of simplified and standardized cost sharing. Moreover, freedom to create and market these designs offers carriers an opportunity to engage in the same risk selection entrepreneurship that characterizes today's market, and that the Exchange staff laudably seek to prevent. Finally, we believe the opportunities from benefit design "innovation" are quite limited, and frankly, pale in comparison to innovations in care delivery which, to borrow a famous aphorism, "is where the money is." In our view, if the Exchange wishes to encourage innovation, it should do so via its selective contracting authority by requiring carriers to put together bids that include substantially non-overlapping networks, thereby fostering competition and innovation not just among plans, but competing provider networks. If the Exchange is convinced that value-based benefit designs will work to the benefit of consumers, rather than carriers hoping to preserve elements of the status quo in a reform-minded environment, we strongly recommend that the Exchange limit the number of value-based designs to a select few. Carriers should submit proposals on an annual or bi-annual basis, reflecting innovation, and if selected as meritorious by the Exchange, such innovative design proposals should be available for all carriers participating in the Exchange to offer if they wish. In this way, the Exchange can ensure that 1) the number of value-based designs does not defeat the many consumer benefits achieved from a simplified and standardized marketplace; and 2) carriers are incented to create designs that are genuinely a better mouse trap, not merely a better means to attract healthy customers – since a carrier attempting the latter would realize no competitive benefit.
LGBT Health Consortia (Transgender Law Center; Center for	We support standardization of plans offered through the Exchange to prevent discriminatory plan design that is prohibited by the Affordable Care Act and to make selection of plans understandable for the average consumer. However, we also stress that the EHB benchmark plans may currently contain exclusions that violate California's Insurance Gender Non-Discrimination Act (IGNA), which expressly prohibits insurance carriers from discriminating on the basis of gender identity in benefit design or coverage determinations. They also violate federal

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American Progress; Equality California; National Center for Lesbian Rights; and L.A. Gay & Lesbian Center)	regulations prohibiting gender identity discrimination by QHP issuers, as well as ACA §1557. As such, California's EHB benchmark and EHB package must not reflect these discriminatory practices, and any standardization of benefits exclusions and limitations applied to QHPs should not enshrine benefits exclusions that violate antidiscrimination protections by explicitly targeting the transgender population. Additionally, we caution the Exchange that standardizing benefits limits that rely on specific clinical treatment protocols can serve as a barrier to accessing medically necessary care for many patients. Medical necessity and the judgment of a patient's medical provider should be the standard for accessing care that is covered by plans, and the Exchange is not situated to predetermine these clinical judgments across all QHPs. While California's independent medical review process is intended to assure that the needs of individual patients are considered in making a determination of medical necessity, unfortunately misinterpretation of IGNA has barred transgender individuals from receiving medically necessary care because both regulators have permitted issuers to impose coverage exclusions on such care, in violation of IGNA. Another instance of individuals being denied medically necessary because of coverage exclusions in violation of other laws was autism. Finally, to ensure that California's QHPs and QHP issuers comply with federal nondiscrimination regulations and California's Insurance Gender Nondiscrimination Act, the Exchange should include the following nondiscrimination provisions relating to plan design: **1. Prohibit arbitrary condition-based exclusions** Affordable Care Act Section 1302(b)(4) establishes nondiscrimination requirements for plans offering the package of essential health benefits, including QHPs. According to this section, the Secretary of Health and Human Services (and, by extension, the states, since states must submit their essential benefit standards to HHS for approval) shall— (B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life; (C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; (D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency,

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	or quality of life… The 2011 Institute of Medicine report on the essential benefits clarifies that Congress intended "to ensure that insurers do not make arbitrary and discriminatory decisions based on certain characteristics of people rather than assessing the individuality of each case when making medical necessity decisions and applying clinical policies." *See* Institute of Medicine, "Essential Health Benefits: Balancing Coverage and Cost" (Washington: National Academies Press, 2011). Implementing this standard requires reasonable limits on the use of condition-based exclusions. Specifically, the core minimum QHP certification standards should prohibit QHP issuers from using *arbitrary* condition-based exclusions as utilization management tools in their QHPs. Under this ban on arbitrary condition-based exclusions, carriers will still be permitted to exclude coverage for benefits that are not medically necessary, that are experimental, or that are comparatively more expensive than other treatments. A prohibition on arbitrary condition-based exclusions simply prohibits QHP issuers from discriminating in coverage of otherwise included plan benefits solely on the basis of diagnosis or medical condition, without a reasonable justification. *Model language:* *(c) LIMITATION ON CONDITION-BASED EXCLUSIONS. No issuer certified by the Exchange as a Qualified Health Plan issuer shall, with regard to a Qualified Health Plan, arbitrarily deny or reduce the amount, duration, or scope of an otherwise covered benefit solely because of the diagnosis, type of illness, or condition for which such benefit is sought. This section shall not be construed to prohibit a limitation or exclusion of coverage based on criteria of medical necessity, appropriateness, or comparative cost effectiveness.*
March of Dimes	Regarding Issue 1, we support Option B to provide standardization of major cost-sharing components of benefit plans. This option will most clearly provide transparent information about the costs of plans to consumers allowing them to choose a plan that best serves their health needs. This will also protect against discriminatory practices in cost-sharing design, such as making maternity copays or deductibles so high that individuals will be dissuaded from choosing a given plan. Regarding Issue 2, for standardization of benefit exclusions and limits, it is important that any limits comply with clinical standards of medical necessity. For example, limiting allowable visits based on non-clinical considerations is essentially a limitation on the benefit. This could be devastating for children with special health care needs who may

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	need multiple habilitative service visits or applied behavioral analysis. Regarding Issue 5, we support Option B to provide some standardization with regard to minimum out-of-network benefits. Out-of-network coverage can be critical for some children with special health care needs or women with high risk pregnancies. Furthermore, in the absence of available in-network providers, patients should be permitted to obtain covered benefits from out-of-network providers at no additional cost.
Molina Healthcare, Inc.	Issue 3: Standardization of drug formularies Molina Healthcare strongly supports Option A. In line with the vision and guidance set forth by the Affordable Care Act, formularies should cover at least one drug per therapeutic class or category. Requiring a minimum of at least two drugs needlessly exceeds the federal requirement thus decreasing the cost effectiveness of plan formularies. Increasing the minimum standard may also negatively impact a plan's purchasing power or leverage with manufacturers and could impact the discounts and rebate amounts plans are able to negotiate with manufacturers and prescription benefit managers—resulting in higher drug costs which plans will either be forced to absorb or pass on to consumers. We encourage the Exchange to consider the cost implications and unintended consequences Option B may have on the affordability of QHPs. Issue 4: Value Based Benefit Designs in the context of Benefit Standardization Molina supports the use of value-based insurance design (VBID) features in QHP product offerings. We believe VBID design elements can lead individuals to use higher value healthcare services and reduce the inadvertent use of lower value services. In addition, VBID features in a health insurance product can also serve as necessary complements to and enablers of value-based reimbursement arrangements with providers. In other words, properly applied VBID concepts can play a role in helping shift the health delivery system from fee for service to outcomes based reimbursement. Molina advocates that VBID rules in the exchange tie VBID-based benefit design features explicitly to nationally recognized clinical care guidelines. Issue 5: Standardization of Minimum Out-of-Network Benefits Molina supports Option B to standardize minimum out-of-network benefits. QHPs should be allowed to limit coverage to only network providers for non-emergency benefits, as long as the network provides sufficient access for the covered medical services. Requiring health plans to pay non-network providers will likely add significantly to the cost of the benefits because there is no way to control the rate demanded by the physician. Alternatively, requiring

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	providers to accept a fixed fee schedule may provide an incentive for providers to terminate contracts with health plans if they can get a higher rate as a non-contracted provider, thus destabilizing networks. For example, in the Medi-Cal program, several years ago a rate for non-contracted inpatient services was established by the state (implementation of the federal DRA "Rogers Amendment"). Although the intent was to drive down Medicaid costs and encourage stable provider networks, in some areas of California, the rate chosen by the state was higher than contracted rates that health plans had been able to maintain up to that point. As a result, many hospitals terminated contracts and health plans were forced to renegotiate and pay higher rates. This resulted in an increase in health care costs in some areas, even on such a limited scope of out-of-network services. Furthermore, enrollees should be encouraged to stay within their health plan network for services. Staying in-network better enables health plans to perform care management and coordination services for enrollees because there are closer lines of communication among contracted entities. If the state regulatory agencies perform thorough and appropriate evaluations of provider network adequacy, and health plans quickly remediate any access problems that are identified after initial licensing, there should be less of a concern about the need of out-of-network services.
Monarch HealthCare	We strongly recommend the Exchange include language that will limit the payment to out-of-network providers "at the average prevailing contracted market rate for that local community". This would help defray the unnecessary frivolous denials and appeals for payments and would set a community standard rate.
National Committee for Quality Assurance	VBID and Innovation - In keeping with promoting innovation, NCQA is developing a health plan distinction program focused on Value and Delivery System Innovation which is planned for release in 2013. The program is intended to support creativity and accountability among plans that are focused on putting the right incentives in places to encourage patients to make the best healthcare choices (e.g. through reducing or eliminating copays for evidence-based care).
National Health Law Program on behalf of the Health Consumer Alliance	Issue 1: Standardization of Cost Sharing Provisions In general, NHeLP and the HCA applaud the recommended approach to offer limited standardized cost-sharing across benefit packages in the Exchange. Not only does this approach limit insurance companies' ability to "cherry-pick" low-risk enrollees, but it will offer consumers a clearer range of options. We agree that too much variation in cost-sharing will lead to major confusion for consumers trying to compare plans. The proposed approach parallels the experience of Massachusetts' Health Connector, which reduced the number of standardized cost-sharing options from 27 to 8, in response to consumer feedback that the original design made comparisons unwieldy and difficult to understand. We urge the Exchange to clarify the rules for insurance plans' use of non-quantitative utilization management (UM),

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	such as prior authorization and step therapy. These UM techniques are not clearly accounted for in HHS' guidance on the actuarial value calculator, but they can directly affect enrollee costs, and may create significant barriers to utilization. At a minimum, the Exchange should specify and limit what UM techniques QHPs will be allowed to apply and require QHPs to clearly indicate in all outreach and enrollment materials how such UM techniques will apply so consumers can effectively compare between plans. In particular, the Exchange should limit UM techniques to ensure that all women have a meaningful choice of contraceptive methods without cost-sharing. The Health Resources and Service Administration requires that new plans cover the all FDA-approved contraceptive drugs, devices and sterilization procedures. U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Women's Preventive Services: Required Health Plan Coverage Guidelines, http://www.hrsa.gov/womensguidelines. Further, not all contraceptive methods are right for every woman, and access to the full range of options allows a woman to choose the most effective method for her lifestyle and health status. Access to all FDA-approved contraceptive methods ensures that women with certain medical conditions or risk factors need not rely on contraceptive methods that are medically contraindicated. We recommend the FamilyPact program as an appropriate model for providing a comprehensive array of contraceptive options. Further, we recommend that step therapy be prohibited in conjunction with contraception given the serious consequences of a contraceptive failure. We also make specific comments about the role of value-based benefit design in cost-sharing below. With regards to cost-sharing distribution, we commend the proposal to offer a range of options in each tier to accommodate applicants' healthcare needs and preferences. The Board Background Brief solicits comment on whether to add a zero deductible silver tier plan to this list of options. Deductibles have been shown to reduce healthcare utilization indiscriminately for both essential and non-essential care. As such deductibles are not consistent with the goals of value-based benefit design (see below). We recommend that the Exchange include a zero-deductible option for silver tier plans, noting that Massachusetts already has a no-deductible option in its plan. *See* MASSACHUSETTS HEALTH CONNECTOR COMMONWEALTH CHOICE, SILVER (2012), *available at* https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsuranc e/Brochures/Silver_Jan2012.pdf. Our specific suggestions on how to prioritize cost-sharing distribution in the benefit design follow: ☐ Most importantly, to the extent possible **reduce copayments on generic prescription drugs** (and on any brand names that have no generic alternative**), primary care physician (PCP) visits and other routine services** to keep people, especially people with chronic illnesses, from delaying care until they are much sicker and require more

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	expensive options. *See, e.g.,* Dana P. Goldman et al., *Varying Pharmacy Benefits with Clinical Status: The Case of Cholesterol-Lowering Therapy*, 12 AM. J. MANAGED CARE 21 (2006). ☐ Reducing copays is especially important for lower income and vulnerable populations, where fixed copay amounts present a proportionally higher barrier to care. Resulting decreases in pharmaceutical use often lead to higher overall medical spending due to increases in hospitalization and other expensive forms of care. *See, e.g.,* Amitabh Chandra *et al*., *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 AM. ECON. REV. 193 (2010); John Hsu *et al.*, *Unintended Consequences of Caps on Medicare Drug Benefits*, 354 NEW ENGLAND J.MED. 2349 (2006). The Exchange should prioritize prescription drug copay reductions, especially for enrollees who receive cost-sharing reductions. We recognize that tiered pharmaceutical copays are a form of value-based benefit design meant to incentivize shifting to cheaper alternatives, like generics. This goal is desirable, but the practical effect can be less than perfect. At least one study has shown that, perhaps due to poor consumer education, raising copays on brand name drugs caused a reduction in *both* brand name and generic drug utilization. *See* Teresa B. Gibson *et al*., *A Copayment Increase for Prescription Drugs: The Long-Term and Short-Term Effects on Use and Expenditures*, 42 INQUIRY 293 (2005). In addition, this approach may unfairly punish those for whom generic drugs are not a medically appropriate alternative to their brand-name equivalents. ☐ Next, **reduce or eliminate deductibles**, which do not support the value-based benefit design methodology and represent higher barriers to care than co-insurance. Ensure that PCP office visits and prescription drugs require only copayment (if any) and exclude them from the deductible requirement. ☐ The out-of-pocket maximum is, for most people, the least likely to impact service utilization. Thus, raising the out-of-pocket maximum, to the extent permitted by the ACA, might be generally better for consumers as opposed to raising copayments, coinsurance or deductibles. There should be an option with lower out-of-pocket maximums for individuals who have very high expected medical expenses, but the best cost-sharing structure for most consumers would set out-of-pocket limits at the maximum and reduce other types of cost-sharing. Finally, the Exchange will need to clearly define and standardize the different forms of cost-sharing and their interrelationship. In particular, plans vary widely in how they count deductibles and out-of-pocket maximums. One survey of workers in various employer HMO plans found that numerous cost-sharing elements did not count toward their out-of-pocket maximum: 50% of workers could not count office visits, 72% could not count prescription drug expenses, and 35% could not even count their deductible expenses. HENRY J KAISER FAMILY FOUND. &

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	HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2011 ANNUAL SURVEY 118 (2011), *available at* http://ehbs.kff.org/pdf/2011/8225.pdf. Employees with PPOs fared even worse. To ensure transparency and comparability between plans for consumers and to maintain a meaningful definition of out-of-pocket maximum, the Exchange should require that coinsurance, copays and deductibles count towards the out-of-pocket limit in all qualifying plans. Also, all copays and coinsurance should count towards deductible expenses. **Issue 2: Standardization of Benefit Exclusions and Limits** NHeLP and the HCA disagree with the Board Background Brief's recommendation that the Exchange permit limited customization of benefit exclusions and limits. Instead, we recommend the Exchange select Option C: strict standardization of all possible benefit limits and exclusions. We urge the Exchange to prohibit substitution of covered services even if actuarially equivalent. We are concerned that allowing any type of customization will lead to insurer-driven benefit substitutions, which will make it more difficult to compare plans and could segment risk in the market by allowing plans to "cherry-pick" enrollees. **Issue 3: Standardization of Drug Formularies** NHeLP and the HCA support the recommendation that the Exchange require plans to cover at least two drugs per therapeutic class. It is critical that California have such a minimum formulary standard in place to ensure access to low cost alternatives for consumers. Such a policy is consistent with improving consumer choice and is an important tool for providers to treat patients who have complex clinical conditions and/or disabilities. Two drugs per class is also the standard of Medicare Part D, and adopting the same standard will facilitate uniformity and simplicity between coverage programs. We also urge the Exchange to develop a system to standardize therapeutic drug classes. If classes are not standardized, numerous complications result. First, consumers (and providers) lose the ability to effectively compare the formularies of the various plans they might choose. Second, failure to define therapeutic classes allows plans to eviscerate the "two drugs per class rule" by defining their classes so broadly that they effectively offer very few choices despite the rule. For example, if a plan only had three therapeutic classes, that would require only six formulary medications. Medicare Part D has developed model therapeutic classes, which it suggests, but does not require, plans to use. The Exchange, however, should *require* QHP formularies to adopt the Medicare model (or a similar therapeutic class model).

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	We also suggest that the Exchange follow Medicare Part D in requiring coverage for "all or substantially all" medications in six identified prescription coverage areas. We urge the Exchange to implement the Medicare standard for those six coverage areas, and consider other areas where more than two drugs per class are necessary to address historical access problems for some illnesses, ensure robust coverage for especially important health concerns, or simply to meet the clinical treatment needs. Finally, regardless of the formulary design, we encourage the Exchange to standardize rules governing exceptions to the formulary. The Exchange should standardize a medically driven exceptions process in cases where the treating physician confirms that neither of the two formulary options is clinically appropriate for the patient. In such cases, individuals should be able to access a clinically appropriate non-formulary medication as if it were a formulary option (e.g., without off-formulary cost-sharing, etc.). This exceptions standard and the process should be transparent and simple to use for providers and patients alike. **Issue 4: Value-Based Benefit Designs in the Context of Benefit Standardization** NHeLP and the HCA generally support plan flexibility for value-based benefit designs (VBBDs) that *lower* cost-sharing for enrollees. In particular, we support the Exchange's goal of encouraging the provision of health care services at lower cost to consumers, promoting healthy behaviors and patient compliance, and promoting access to high value services. Health plans increasingly rely on VBBDs as a mechanism to steer patients towards high-quality treatments that are considered "high value" (in which the clinical benefits exceed the cost) and minimize overuse of "low value" services (considered low value because the benefits do not justify the cost). Such utilization is controlled by varying out-of-pocket costs for the consumer, lowering costs for high value services and increasing costs for low value services. A VBBD that lowers cost-sharing in line with the Exchange's goals is an important step in the direction of improving the health and well-being of enrollees. For example, encouraging enrollees to begin and adhere to medication regimes by eliminating co-pays for drugs and certain office visits can prevent a costly worsening of their conditions. In fact, other provisions in the ACA rely on value- based incentive designs similar to this one: for example, the provision of preventive services at no cost to consumers, promoting access to high value preventive care by removing cost

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	barriers. We are concerned, however, that plans may seek to institute VBBDs that discourage the use of "low-value" services even when those services are medically necessary. Some of the commonly recognized barriers to VBBD include that the increased utilization for high value services can increase insurer costs, and the savings associated with improved health status can be difficult to measure. *See, e.g.,* Michael E. Chernew, Allison B. Rosen & A. Mark Fendrick, *Value-Based Insurance Design*, 26 HEALTH AFFAIRS w195 (2012). As a result, plans have increasingly turned to cost-containment of so-called "low value" services. But financial incentives to discourage overuse of low value services have the potential to limit access to needed medical care. Plans attempting such a system have, for example, doubled co-pays and deductibles for "low value" services like knee or hip replacement, cardiac bypass surgery, hysterectomies, or emergency room visits. *See* Julie Appleby, *Carrot-And-Stick Health Plans Aim to Cut Costs*, KAISER HEALTH NEWS, Mar. 11, 2010, http://www.kaiserhealthnews.org/stories/2010/march/11/value- based-health-insurance.aspxhttp://www.kaiserhealthnews.org/stories/2010/march/11/value-based-health-insurance.aspx. Thus, while we support plan flexibility for VBBDs that *lower* cost-sharing for enrollees, we urge the Exchange to place limits on that flexibility and adopt strong oversight to ensure that plans do not indirectly or otherwise seek to limit access to "low value" services. The Exchange should be prepared to respond to future requests for additional flexibility to control the cost of "low value" services. Raising out-of-pocket costs for low-value services has been carried out by a few insurers who see it as an important cost-containment mechanism. The Exchange must be aware of the benefits and challenges on this side of value-based incentive designs. We encourage the Exchange to monitor this issue by analyzing how, if at all, value-based benefit design aimed at "low value" services can be successful at improving health and lowering costs, without limiting access to needed care. **Issue 5: Standardization of Minimum Out-of-Network Benefits** NHeLP and the HCA support the recommendation to standardize minimum out-of-network benefits. We also urge the Exchange to adopt additional consumer protection rules for services accessed out-of-network. We recommend that the Exchange standardize minimum out-of-network benefits, including the maximum fee that can be charged by a provider for out-of-network benefits. The Exchange should require that QHP hold its members harmless for paying beyond network cost from non-network providers at *in- network* facilities. Consumers often do not even know that one provider on a team is consider out-of-network until they receive a bill for services. An enrollee should not be required to pay an out-of-network rate for anesthesiology services, for example, when she arranged to have a procedure performed by a facility in her network and did not request that particular anesthesiologist.

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	Further, the Exchange should require that a QHP hold its members harmless for paying beyond network cost for accessing from out-of-network providers emergency services, ambulance services, and covered services not available through a network provider or not available within a reasonable time period. In the event that an enrollee is not able to access covered services or a necessary provider within the existing covered network (for example, due to provider religious or moral objections, or due to an emergency), the Exchange must require the QHP to allow the enrollee to access services out-of-network without penalty without additional cost to the enrollee. The Exchange should prohibit additional cost-sharing and balance billing of consumers for out-of-network emergency services, ambulance services, as well as covered services not available through a network provider or not available within a reasonable time period or geographic distance, including but not limited certain specialty care services such as high-risk pregnancy and abortion care. The Exchange should, at a minimum, apply the Knox Keene balance billing protections, as well as Cal. Health & Safety Code § 127400 *et seq.* protections regarding charges for hospital services for low-to-moderate income individuals. The Exchange could require that in these situations the QHP reimburse the non-network provider for the lesser of: (1) the provider's billed charge, (2) a minimum fee established by the Exchange, or (3) the charge agreed to by the QHP and the provider.
Pacific Clinics	With regards to the Drug Formularies category in Table 12 (page 75), we ask for the inclusion of newer anti-psychotic medications that are frequently prescribed for mental health and substance use illnesses to be on the list of covered drugs. This list should be publicly posted and available to stakeholders for comment. With regards to the Benefit Plan Descriptions outlined on pages 92-94, we are very concerned about the proposed co-payments for mental health/substance abuse outpatient visits. These co-payment levels may still be too high for some individuals when the goal of the Exchange is to help facilitate market solutions to ensure access and affordable care.
Pharmaceutical Research and Manufacturers of America (PhRMA)	Standardization of Drug Formularies Assuring provider and patient choice of medicines is essential to ensuring that benefits meet patients' diverse health care needs. Patients often respond to medicines differently; maintaining broad access to medicines is essential to ensuring these patients have access to multiple treatment options as often multiple medicines must be tried before an adequate response is achieved. Therefore, we support the recommendation to exceed the proposed federal minimum of one drug per class. However, simply requiring two drugs per class is insufficient to ensure patients have access to needed drugs. Indeed, in Medicare Part D, plans have exceeded these minimums and largely offer much more comprehensive drug coverage. In addition to mandating a minimum of two drugs per class, the Exchange should also

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	require that independent pharmacy and therapeutics (P&T) committees using publicly-available standards and procedures oversee formularies and utilization management. Plans sold in the Exchange should include formularies developed with the recognition that it is often necessary for individuals to have access to several drugs in one class. In some cases, individuals may need to take several prescriptions at once to manage their condition. In other instances, patients need access to a range of therapies to find the one that works best and minimizes side-effects. In order to prevent plans from discriminating against beneficiaries with significant health care needs, the Exchange should review QHP formularies to determine (1) whether there is an adequate choice of drugs in classes that are used heavily by patients with significant health care needs and (2) how QHPs place drugs into tiers to identify whether plans are trying to substantially discourage enrollment by placing commonly used drugs for these populations in nonpreferred tiers rather than in more preferred positions. We are also concerned that the quality of health coverage may be affected by the Exchange limiting the number of plans that are available to consumers. Not offering the full range of qualified plans could significantly limit consumer choice and diminish the benefits of competition over time. This choice among plans is particularly crucial in the initial years of the Exchanges when so much of the health care system is changing. If a qualified plan is not offered in an Exchange in a given year, it may be very difficult for it to sustain a viable presence in the market. Therefore, it may not be available to compete in future years, leaving consumers with fewer choices and plans with less competition. Providing a broad choice of QHPs will help small businesses and individuals who typically lack such choices in today's marketplace. Providing this choice and therefore an opportunity to select a plan that best meets its purchaser's needs is one of the key benefits of Exchanges. Standardized Cost-Sharing PhRMA is concerned that the proposed standard designs for drug coverage incorporate the problematic concept of a "brand deductible" in addition to differential cost sharing for brand and generic drugs, and for preferred and non-preferred brand drugs. Indeed, in the standard designs proposed for the QHPs each of the proposed bronze plans has a significant brand deductible. A deductible for brand drugs, or any drugs, would disadvantage patients with chronic disease, who typically require ongoing care to avoid unnecessary complications and poor health outcomes. These patients often face high out-of-pocket costs year after year, rather than costs concentrated in a single year and may never reach their maximum out-of-pocket limit even though their cumulative costs over several years may be very high. Deductibles for prescription drugs also run counter to the Affordable Care Act statute, which stated that the Essential Health Benefits should be similar to a "typical employer plan." Employer plans do not typically subject

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	prescription drugs to a deductible, according to the 2011 Kaiser/HRET Survey of Employer-Sponsored Health Benefits. A plan that has a deductible for brand drugs would be especially problematic because it would subject patients to a deductible if they happen to require single source, innovator medicines that may be the only effective treatment for certain diseases, such as “orphan” diseases. The brand-only deductible would also single out patients who need newer generations of therapies that are necessary for patients who are resistant to or intolerant of older therapeutic alternatives. The Affordable Care Act removed the ability of health plans to risk select through medical underwriting, pre-existing condition exclusions, or health-related premium adjustments. However, as the California Health Benefit Exchange’s Discussion Draft notes elsewhere, there remains a concern that through strategic plan design a plan can attract its preferred customers and deter less desirable or less healthy ones. While the risk assessment and risk adjustment process will lessen the impact of these practices, there is still a concern that plans may seek to "cherry pick" through their benefit design. Allowing QHPs to impose a brand deductible is an example of benefit design that will affect risk selection. Value Based Benefit Design Among the permissible elements that the Exchange says plans may use to encourage value based consumption of health care by consumers is a waiver of certain forms of cost-sharing. We agree that this may be useful unless it is used to avoid higher risk populations. For example, the Exchange suggests that a plan might waive applicability of the deductible to generic prescriptions. We disagree. It is relatively common practice for benefit design to waive applicability of the deductible to the entire prescription drug benefit, as discussed above, but a plan which makes the deductible applicable to brand drugs but not generic drugs disadvantages persons whose illness or condition requires a single source innovator drug, and shifts the risk of their coverage to other plans. We urge the Exchange to clarify that waiver of the deductible may apply to the entire prescription drug benefit a not to a subset of drugs that is not likely to cover the needs of the prospective enrollee population.
Planned Parenthood Affiliates of California	Issues 1 & 2: Standardization of Cost Sharing and Benefits Exclusions and Limits PPAC supports the Exchange’s plan design standardization proposals. These will reduce customer confusion by making a clearer “apples to apples” decision. Standardization, especially of the major benefit limits and exclusions, will be the simplest and least burdensome for providers to manage when contracting with qualified health plans. Cost will be one of the biggest considerations for low-income enrollees, even with the premium and cost-sharing subsidies, and all efforts to streamline and simplify comparison will help encourage enrollment among this price sensitive population.

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	Issue 1: Standardization of cost sharing and Drug Formularies with regard to contraception The Exchange policies need to be clear that Qualified Health Plan be required to cover all FDA-approved contraceptive drugs and devices, consistent with the preventive services requirements under the ACA. The ACA added section 2713 to the Public Health Service Act requiring that all new plans cover certain preventive services without cost-sharing. The Health Resources Service Administration has required that, "all FDA-approved contraceptive drugs and devices, [and] sterilization procedures" (emphasis added) be covered without cost-sharing. The Institute of Medicine (IOM) report, Clinical Preventive Services for Women: Closing the Gaps (2011) which provided the evidence-based recommendations on which the women's preventive health services requirements are based, noted that, "This range of methods provides options for women depending upon their life stage, sexual practices, and health status." There are a range of contraceptive methods available including both drugs and devices and no one method is appropriate for everyone. The IOM has further noted that for women with certain medical conditions or risk factors, some contraceptive methods may be contraindicated." We urge the Exchange to adopt rules on cost-sharing that limit the types and extent of medical management techniques to ensure that all women have a meaningful choice of contraceptive methods without cost-sharing. We recommend that the Family PACT program is the appropriate model for providing a comprehensive array of contraceptive options. Further, we recommend that step therapy be prohibited in conjunction with contraception given the serious consequences for a woman of a contraceptive failure.
SeeChange Health Insurance	Plan standardization with limited customization is an alluring option if one believes that insurance designs in 2012 are adequate to meet the evolving needs of a diverse population over the long-term. But this is not likely to be the case. Innovation in health care coverage, such as that SeeChange Health has brought to California in the past 12 months, could be snuffed out if all plans have to look and act alike. The Exchange needs to find a balance between simplified comparisons and offering coverage designs that meet the different needs of a non-homogenous population. Our concern is that the recommendations presented lean too far toward simplifying plan comparisons and away from assuring that those plans are what consumers want. There are a host of tools and techniques that can help consumers compare plans; once straightjacketed in defined plan designs, there is no hope of real innovation. Where standardization of plan design can have a positive impact is by the establishment of uniform exclusions and limits. Again, this standardization can be taken too far, but a prudent approach to standardization of these elements of a plan would prevent gaming of the system by insurers and clearly define what health insurance covers and what it does not.

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	We greatly appreciate the staff recommendation that value-based benefits designs that lower patient out-of-pocket costs or provide other financial rewards be permitted. As the rapid growth of our VBBD plans in the small market demonstrate, there is a real and meaningful hunger in the small group marketplace (and, we expect, in the individual market) for this innovative approach to health insurance. Permitting such plans in the Exchange, we believe, will greatly benefit consumers obtaining coverage through this program.
Small Business Majority	Issue 1: Standardization of Cost Sharing Provisions: We support Option B to standardize major components of cost-sharing while allowing some innovation. Private-market exchanges that implemented rigid standardization right out of the gate did not do so well and later had to reverse course. On the other hand, no standardization leaves the Exchange susceptible to gaming by insurers. Issue 2: Standardization of Benefit Exclusions and Limits: We support Option B for the same reasons given under Issue 1. Small businesses will not all want to buy the exact same plan so the sort of flexibility proposed is warranted. Issue 4: Value-Based Benefit Design: We encourage the Board to allow value-based benefit designs (Option B). Providing employers and employees with tools and incentives to select more efficient healthcare services is essential to bending the healthcare cost curve. Small businesses want to see that their healthcare dollars are being well-spent and it is these kinds of benefit designs that warrant some flexibility on standardization. To the extent that these types of benefit designs are not part of the outside market "suite" of products, this could give the Exchange a leg up.
UnitedHealth Group	Exchanges should enhance competition, promote ongoing innovation, and increase consumer choice, while promoting affordability and access to quality care. Minimizing prescribed benefit plan requirements beyond the actuarial value and essential health benefits (EHB) required by federal law will promote innovation and provide the flexibility for issuers to develop plan benefits that consumers both want and can afford. Efforts to simplify the buying process on the Exchange are best addressed through advanced filtering and search technology to help consumers narrow the number of health benefit products to those that best meet their particular needs. If the Exchange seeks to standardize certain components of the Qualified Health Plans offered, we believe that this provides a false sense of equality between the different delivery models. In the Plan Design Standardization section of the report (page 80), we are concerned with the staff recommendation that cost-sharing amounts be standardized for each metal tier for the major service categories. As illustrated in Appendix A, Table 20 (page 92), we believe cost-sharing standardization with HMO and PPO products may provide a false sense of equivalency between copays and

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	coinsurance that the consumer may not experience when they access care. For example, if a consumer compares Silver plans with 30% coinsurance and a $400 per day copay, they may assume that these are relatively equivalent financial obligations when the plan with the coinsurance may require significantly more cost-sharing than $400 depending on the cost of services. Additionally, we believe that a “standardized” financial comparison between HMO and PPO products does not account for the added value of care coordination provided in an HMO. Almost 16 million Californians (42.9%) receive their health benefits through HMOs, and many of these enrollees receive their care through organized physician groups that form the cornerstone of the “delegated” or “coordinated” care model of health care delivery. This organized medical delivery system is almost unique to California and has produced notable health care and economic benefits for patients within it related to quality, access, accountability, and affordability. We believe that federal law provides sufficient tools to help consumers select the plan that best meet their needs, and efforts to further standardize benefit offerings are not in the best interest of the consumer.

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Acero Health Technologies	As pioneers in consumer-driven health, our team continues to promote information transparency and choice for consumers. We believe the following recommendations support this goal. Reviewing the CHBE draft recommendations presented for discussion at the July 16th meeting, we present several comments and recommendations specifically regarding cost-sharing reduction subsidies and consumer plan choice for the federal poverty levels (FPLs) outlined in the CHBE's meeting notes. The CHBE staff and PWC provide the following recommendation: "Staff recommends the Exchange allow choice only among bronze and silver plans (Option B) for individuals with income between 100% and 250% of FPL…" We assume that this recommendation isolates particular FPL tiers due to the availability of cost-sharing subsidies for these tiers. Since federal cost-sharing reductions effectively increase the plan's actuarial benefit value, these subsidies eliminate the need for the consumer to purchase a higher actuarial value (AV) metallic plan – such as a "gold" or "platinum" plan. The staff recommendation acknowledges that some consumers, who are currently healthy or believe they are healthy, may choose to buy down to a lower premium cost "bronze" level plan, foregoing the opportunity for cost-sharing reductions (which are only offered under silver plans) and thus reducing out-of-pocket premium costs. Since ACA cost-sharing reductions only provide a benefit when claims occur, consumers with low or no health care costs may actually benefit from the lower premium costs associated with the lower actuarial valued bronze plans with no adverse effect from a lack of cost-sharing subsidies. While one understands the logic of this approach, it does assume that the consumer will grasp the consequences of this decision; that a lower premium plan may result in higher overall out-of-pocket costs depending on the consumer's claims/utilization. Because the staff recommendation emphasizes the importance of affordability and cost to consumers, we believe it is important to provide consumers with transparency regarding the amount of cost-sharing reductions received or

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	foregone in prior years. These amounts may be important factors in future decisions regarding the best and most affordable option for the consumer or his/her family in a given plan year. While we assume that the CHBE will offer cost calculators for consumers – enabling the ability to compare different scenarios regarding overall out-of-pocket costs, we believe actual numbers will be a more effective communication tool for each consumer over time based on his/her actual circumstances. When a consumer is evaluating choices at a future point – for example during a future special enrollment period or a future year – we believe that several actual data points will be critical for an accurate evaluation: a. the consumer's actual out-of-pocket experience b. the amount of cost-sharing reduction subsidy received c. the amount of the cost-sharing subsidy foregone. We believe that access to this information may be accomplished in a number of ways with varying degrees of complexity. Since carriers will likely have to calculate individual cost-sharing reduction amounts at the individual claim level – substantiation will likely be required by the federal government to determine accurate federal reimbursement – the carriers will have the means to calculate cost-sharing subsidy amounts. Based on this need for transparency, we recommend that the CHBE mandate rules for each of the following requirements (see below for additional details on each): 1) Each carrier must provide an acknowledgement to the CHBE/exchange regarding cost-sharing reduction communications from the federal government. 2) Each carrier must submit to the state exchange on a monthly basis, aggregate, year-to-date (YTD), out-of-pocket costs by individual for the selected plan as well as the alternative plan for that carrier (silver and bronze). This would take into account cost-sharing reduction amounts received or foregone for each eligible individual based on the plan selection of the consumer. 3) Carriers must share cost-sharing subsidy information on an aggregate and per-claim basis on all carrier web and paper (EOB) communications. This requirement provides the consumer with full transparency of what is

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	paid for by the plan and what is actually paid for via the federal subsidy. 4) Carriers, the CHBE and navigators must be prepared to provide this information to consumers in the event the consumer seeks to understand whether cost-sharing reduction amounts have been applied correctly. **Additional Details on Each Recommendation** **Recommendation One:** Each carrier must provide an acknowledgement to the CHBE/exchange regarding cost-sharing reduction communications from the federal government. We make this recommendation to ensure that a full-loop process exists for managing the enrollment and cost-share reduction payment flows. Because we anticipate two feeds: enrollment data from the exchange; prospective payment data for cost-sharing subsidies from the federal government, we recommend a full-loop process to minimize disruptions for consumers and allow carriers and the exchange to proactively identify issues. A CHBE full-loop process would require the carrier to compare and to validate that the advance federal payment received from the federal government matches the carrier's enrollment information; sending the CHBE a transaction validating this match. A full-loop process will either confirm that the three parties are tracking the same level of benefits for the consumer, or it will at a minimum require proactive review and resolution of discrepancies. **Two examples (Full-Loop vs. No Loop):** ❖ *Example One: No full-loop acknowledgement:* ➢ Through the CHBE, John enrolls in "Silver" plan variation B (94% AV with cost-sharing subsidy) with carrier XYZ. ➢ For some reason (often this happens with eligibility), carrier XYZ enrolls John in the 87% plan variation. ➢ From the federal government, for John, the carrier receives an advance, estimated cost-sharing reduction payment equivalent to someone enrolled in the 94% AV plan. ➢ The amount is higher than the amount expected so the carrier may not proactively identify or resolve the

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	issue. ➢ Without a full-loop requirement, only at the end of the plan year, when the carrier attempts to reconcile the advance payment with the federal government is it recognized that the consumer was enrolled in the wrong plan during the year. ➢ John has potentially paid out of pocket more than he was legally required to. ➢ The bottom line is that discrepancies are not proactively resolved and consumers may experience adverse consequences – in this case lower level of benefits than required. ❖ Example Two: Full-loop acknowledgement: ➢ Through the CHBE, John enrolls in "Silver" plan variation B (94% AV with cost-sharing subsidy) with carrier XYZ. ➢ For some reason carrier XYZ does not receive enrollment from the exchange. ➢ The carrier receives an advance, estimated cost-sharing reduction payment for John from the federal government equivalent to someone enrolled in the 94% AV plan. ➢ Since the CHBE requires the carrier to compare and validate the advance payment and send the CHBE a transaction to close the loop, in this scenario, the CHBE is notified that there is a problem that needs to be resolved. ➢ Because the CHBE requires the carrier to proactively reconcile the federal estimated payment with the carrier's enrollment data, this issue is identified early in the process. ➢ In this scenario, the carrier sends the CHBE a transaction indicating a missing enrollment segment. The CHBE may resolve this issue working with federal counterparts prior to negative consumer impact. Full-loop processes are often more effective ensuring multiple parties are synchronized and if not, allowing for the identification of issues for quick resolution. **Recommendation Two:** On a monthly basis, each carrier must submit to the state exchange, aggregate, year-to-date (YTD), out-of-pocket costs for the consumer's current plan as well as the alternative plan (this means the silver and bronze option) for that carrier for consumers who fall into the 100-250 FPL. This data would take into account

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cost-sharing reduction amounts received or foregone for each eligible individual based on the plan selection of the consumer.

Cost and comprehension of cost will be critically important for the population that falls into the 100%-250% FPL tiers. Based on the CHBE staff recommendations to restrict enrollment choice to a bronze or silver plan option for one or more carriers, we believe that it will be critical for consumers with low insurance literacy to understand the impact of the plan choice when making plan selections [either during special enrollment periods or during annual enrollment].

We believe actual data will be the most effective way to accomplish this transparency and we recommend that the CHBE consider displaying information for consumers to see the actual cost impact of prior year decisions to facilitate a good future decision. The display might look something like the following to the consumer:

			Premiums			Out-Of-Pocket Costs			
2014	Plan Name	Carrier's Monthly Premium Price	Premium Subsidy To Offset Your Premium Cost	Actual Monthly Premium Cost to You	Annual Premium Cost to You	Amount You Are Required to Pay (Directly to Doctors or Hospitals)[1]	Cost-Share Subsidy - Amount that Federal Government Paid[1]	Actual Amount You Must Pay For Care[1]	Your Annual Cost (Year to Date[1])
Your Current Plan	Carrier XYZ Bronze (60%)	$200	$250	$ -	$ -	$ 700.00	$ -	$ 700.00	$ 700.00
You Also Had This Option[2]	Carrier XYZ Silver Base C (87%)	$300	$250	$50	$ 600.00	$ 400.00	$ 250.00	$ 150.00	$ 750.00

1. This is a current estimate of your claims costs as of 10/31/2014 based on your current carrier's claims.

1. These amounts will change if you seek additional services and as new claims are received and/or processed by your carrier until the end of the current benefit year. These amounts do not include expenses you may have paid for non-covered services or for services from doctors not in your carrier's plan.

2. This grid is meant to help you understand the impact of choosing one plan over another. One plan may have a lower premium, but you may pay more overall due to higher out-of-pocket costs based on how often you or your family seeks services. You should consider both components of cost when choosing a benefit plan.

The CHBE will likely have the resources to determine the best methods to display this information as well as the ability to test market the concept with consumers, we believe that the basic data elements are critical – how much has the consumer paid under the current plan, what would the consumer have paid under the alternative choice.

In the above example, we show a consumer who picked the bronze plan (perhaps due to premium cost) but who could have picked a subsidized silver plan from the same carrier. At this point in time (when the snapshot is

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	taken), the consumer has made a good decision, but since the data is only through October, it is possible that once all claims for 2014 are received, the consumer may learn that the subsidized plan might have been a better choice. We considered recommending a one-time feed from the carrier just prior to the open enrollment period, but we realize that there are several scenarios under which federal rules will permit consumers to change plans outside the annual open enrollment period. Access to the actual costs would provide the consumer with better information to make an informed choice. While consumers might have additional options from other carriers, we believe that this brief illustration of the differences between the bronze and silver plan for one (current) carrier will be sufficient to help a consumer understand the import of the choice between a lower premium (bronze) plan vs. a subsidized (silver) plan based on his/her actual circumstances. Providing this information requires the CHBE to collect three pieces of information from the carrier each month (in addition to the premium cost information which the CHBE should already have on hand): 1. The current OOP progress for the consumer's current plan 2. The OOP progress that would have been incurred in the alternate plan 3. The cost-sharing subsidy calculated amount (for the silver plan – regardless of whether this plan was selected or not). Since carriers will need to calculate cost-share reduction information for federal audit purposes and calculating the OOP progress for the current plan is a core claims adjudication function for the carrier, two out of three should be easily available. **Recommendation Three:** Carriers must share cost-sharing reduction information on an aggregate and per-claim basis on all carrier explanation-of-benefit communications (web and paper). As noted previously, we expect that carriers will need to calculate cost-sharing reduction subsidy amounts for federal audit purposes. We recommend that the CHBE require that these amounts be displayed on each claim

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(the individual claim amount as well as the aggregate YTD amounts) so that the consumer understands the impact of cost-sharing reductions when choosing a plan each year. Without this information, the consumer may not understand the benefits of the reduced cost sharing and may not even realize that they are even receiving this benefit.

Here are two partial alternatives of what the consumer might see on an EOB (Explanation of Benefits) where cost-sharing reduction information is included:

Example 1:

		Benefit Determination		You Pay[1]		Plan Pays	Federal Government Pays
Billed Amount	Allowed Amount	Amount Subject to the Deductible	Amount Subject to the Coinsurance	Amount Subject to Deductible	Amount Subject to Coinsurance	Total	Total
$ 500	$ 400	$ 300	$ 100	$ 300	$ 20	$ -	$ 80

[1] **Note:** The amount you pay might have been higher if not for federal cost-sharing subsidies/ payments.

The Federal Cost-Sharing Subsidy for this Claim	$ 80.00
Federal Cost-Sharing Subsidies Year-To-Date	$ 80.00

Your Total Responsibility for this Claim: **$ 320.00**

Example - This is simply meant to be an example. This example is missing other details typically found on an explanation of benefits.

In the above example (#1), we assume that the member has enrolled in a subsidized silver plan. The consumer's deductible in this silver plan variation has been reduced from $500 to $300 to meet the federal cost-sharing reduction requirements. The coinsurance of 20% has not changed in the subsidized plan. Because of this deductible reduction, the federal government will reimburse the plan for the $80 it will pay the provider (this reimbursement covers the reduced deductible/cost-sharing). This amount appears three times – once to show what the plan is paying (noted as federal payment); again to point out the subsidy for this claim and finally to show subsidies in aggregate for the year.

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Example 2:

Billed Amount	Allowed Amount	Your Reponsibility: Total: Prior to Fed. Subsidy[1]	Your Reponsibility: Total: After Fed. Subsidy Applied	Plan Pays: Total: Prior to Fed. Subsidy[1]	Plan Pays: Total: After Fed. Subsidy Applied
$ 500	$ 400	$ 400	$ 320	$ -	$ 80

Note: The amount you pay might have been higher if not for federal cost-sharing subsidies/ payments.

The Federal Cost-Sharing Subsidy for this Claim	$ 80.00
Federal Cost-Sharing Subsidies Year-To-Date	$ 80.00

Your Total Responsibility for this Claim: **$ 320**

Example - This is simply meant to be an example. This example is missing other details typically found on an explanation of benefits.

This makes the same assumptions as in example 2 above, but the display is altered to show an alternative – in this case distinguishing responsibility pre-cost-sharing reduction vs. responsibility after the subsidy has been applied.

Either approach will help the consumer understand the benefits of a subsidized plan – most importantly, the consumer understands how subsidies reduce his or her costs so that when selecting a plan option during annual or special enrollment periods, the consumer does not select the bronze plan based solely on the plan's premium cost.

Recommendation Four: Carriers, the CHBE and Navigators must be equipped to provide cost-sharing reduction information to consumers in the event the consumer seeks to understand whether cost-sharing reduction amounts has been applied correctly. This is similar to number one above, but takes into account that people as well as

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	websites will need access to this information. Simply showing the benefit plan variation that includes implicit cost-sharing reduction amounts may not effectively communicate the benefit to consumers. For example, if the deductible has been reduced for the consumer from $500 to $300 to account for cost-sharing reductions and then through the CHBE the consumer only sees two options: a silver plan option with a $300 deductible and a bronze plan; he/she may not realize that the silver plan includes a reduced cost sharing benefit or the value of this benefit. The person may simply focus on the lowest premium. Since carriers will need to calculate cost-sharing amounts for federal audit purposes, we believe that carriers will have this information and could share it with consumers who seek information on the amount of cost-sharing received in previous plan years. For example, a consumer calls the CHBE hotline number to select a plan in 2015. The consumer needs help evaluating the best option. The consumer may not have the insurance literacy to estimate potential OOP amounts for the previous year. Because the CHBE staffer taking the call has access to the consumer's OOP progress in the previous plan year as well as how cost-sharing reduction subsidies may have benefited the consumer, the CHBE staffer will be able to evaluate both the premium as well as the out-of-pocket components of cost for the consumer. The CHBE staffer will be better equipped to suggest the appropriate plan for the consumer. We thank you for the opportunity to comment on your recommendations. Feel free to contact me if you have any questions or would like any clarifications on our comments and recommendations.
Anthem Blue Cross	Anthem understands that, for individuals with income between 100% and 250% of FPL, the bronze and silver tier options are the best choices given the cost sharing subsidies that are available with the purchase of a silver plan. However, we are concerned that the Exchange's intention to limit the plans available for purchase based on an individual's income is in direct conflict with the ACA, which states that every person, regardless of whether they are eligible for a subsidy, should be able to purchase any plan for which he or she is eligible. In addition, we believe that this would conflict with other requirements on issuers. For instance, Government Code s 100503(e) requires a carrier

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	to affirmatively offer, market, and sell at least one product in each metal level in the exchange. Limiting availability based on income level is inconsistent with this requirement. In addition, it is not clear if, in adopting this option, the Exchange would explain the implications of purchasing a gold or platinum option to an individual with income between 100% and 250% of FPL, or if this disclosure requirement would fall to the issuer. Anthem agrees that any plan option at any metal tier should be available to individuals with incomes between 250% and 400% of the FPL, as the staff proposes in Issue 2 (Option C).
California Association of Health Plans	CAHP respectfully suggests that the Exchange provide information on if it is permitted under the federal law to limit the choice of individuals with incomes between 100%-250% of FPL to the bronze and silver tiers.
California Children's Hospital Association	CCHA agrees with the staff recommendations for the reasons noted in the policy options brief
California Pan-Ethnic Health Network	CPEHN supports allowing low-income individuals with incomes between 100-250% FPL to choose among plans from any tier. Although there is a risk that individuals who "buy up" to gold or platinum coverage will lose important cost sharing reductions, that risk could be mitigated by informing these individuals of this risk *before* they are allowed to make that decision. As a general rule, the Exchange should provide individuals with clear choices so they can make informed decisions.
Cigna	***Issue 1: Plan Choices for Individuals with Income between 100% and 250% of FPL*** Agree. To get the cost share subsidy the customer would have to select a Silver plan. This person would also have the option of choosing a lower premium Bronze plan, but would not get the subsidy (note a person between 201%-250% of FPL does not benefit as much (73% AV) from have a cost share subsidy. ***Issue 2: Plan Choices for Individuals with Income between 250% and 400% of FPL*** Agree.
Health Access	• Plan choices for that 100% FPL-200%FPL: Allowing bronze as an option is problematic if it results in the loss of the cost-sharing subsidy. Actuarial values reflect the costs across an average population. Again,

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	further work should be done looking at the impacts on those with significant health needs. Once that is considered, this proposal looks to us like a formula for adverse selection. • Allowing choice for those above 200%FPL is important: a majority of those in these income levels will be "churning" between employment-based coverage and Exchange coverage. For an individual consumer, particularly in California where ESI averages 87% actuarial value (Gabel et al 2012), the cost sharing associated with the silver plan will seem excessive.
Insure the Uninsured Project	We agree with the recommendations, and believe it is important that consumers with incomes between 100-250% of FPL have the option to buy bronze tier plans with lower premiums albeit without cost-sharing reductions, provided that the risks/benefits are clearly noted.
Molina Healthcare, Inc.	Issue 1: Plan Choices for Individuals Income between 100% and 250% FPL Molina supports Option B—allowing choice only among bronze and silver plans to customers with incomes below 200% FPL. After three decades of experience serving the low-income and underserved populations, the company understands how cost sensitive this population segment is and the challenges they face navigating the multitude of insurance products. The Bronze plan would be the lowest cost plan available from a price standpoint for this population, while the Silver level plan would be the best option for them as the premium and cost sharing subsides would yield an actuarial value of 94% for those between 133% FPL and 150% FPL and 87% for those between 151% FPL and 200% FPL. In other words, the Silver level plan would effectively be a Platinum or near Platinum level plan for these folks that would also limit their out-of-pocket exposure. Exposing this population segment to all metal tiers may entice some to seek out the pricier Gold and Platinum level products without understanding that they would still have substantial cost sharing expense on top of that. This may lead to customers being unable to sustain premium payments and bear their cost share during provider visits. Limiting them to the Bronze and Silver level plan is the best way to offer them comprehensive and affordable coverage. It should be stressed though that the Exchange's website or call center where this population segment will shop for insurance should be designed to explicitly and clearly spell out the advantages and differences between a Silver plan and a Bronze plan to enable informed decision making on the part of these vulnerable members.
Monarch HealthCare	We strongly believe language be incorporated that compensates the providers by the health plans during the enrollees "90 day" premium grace period.
National Health Law Program on behalf of the Health	In general, NHeLP and the HCA commend the Background Brief's approach to developing standardized plans for beneficiaries whose income qualifies them for increased cost-sharing reductions. To account for federal cost-sharing subsidies, the brief suggests adjusting each silver level option to reflect three different increased cost-sharing scenarios (94%, 87%, 73%). By statute, the first cost-sharing adjustment must be the out-of-pocket maximum, but

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Consumer Alliance	any leftover cost-sharing can come from of the other forms of cost-sharing. We strongly recommend that the Exchange standardize any leftover cost-sharing subsidies, and not leave that distribution up to the individual plans. Otherwise, individuals who qualify for subsidies may face a dizzying variety of plan options. Furthermore, the Exchange should apply any cost-sharing reductions beyond the required out-of-pocket reduction first to lowering PCP and pharmaceutical copays, and then to reducing deductibles, according to the above reasoning. Individuals who qualify for extensive cost-sharing subsidies will be coming from the lowest income levels and will be disproportionately impacted by pharmaceutical copays. Even nominal copays lead to reductions in utilization that both negatively impact the health of low- income populations and often lead to higher overall costs due to increased use of more expensive care, like hospitalizations. **<u>Issue 1: Plan Choices for Individuals with Income between 100% and 250% of FPL</u>** The Board Background Brief proposes that the Exchange offer people with income between 100-250% FPL *only* silver or bronze level plans. NHeLP and the HCA agree with this approach for those with income below 200% FPL because it is not cost effective for people to pay higher premiums for gold or platinum tier plans when the cost-sharing levels would be roughly equivalent to a boosted silver plan (87% or 94%). We recommend, however, that the Exchange offer individuals in the 200-250% FPL group a choice from all plan tiers (with the appropriate highly visible warnings that individuals would not qualify for the cost sharing boost if they do not choose a silver plan). This approach mirrors the recommended option for 250-400% FPL applicants, and is appropriate for the same reasons. First, the actuarial value bump for the 200-250% FPL group is only 3% higher than normal silver plan (73% compared to 70%) and amounts to far less than the 80% or 90% cost-sharing levels of gold and platinum plans. Effectively, the 3% cost-sharing subsidy will go towards marginally reducing the silver plan out-of-pocket maximum and will not affect other cost-sharing elements. There may be people in the 200%-250% group who would prefer paying higher premiums to get a much better deal on copays/co-insurance/deductibles in a gold or platinum level plan, and they should have that option. **<u>Issue 2: Plan Choices for Individuals with Income between 250% and 400% of FPL</u>** NHeLP and the HCA support the recommendation that the Exchange permit individuals with income above 250% FPL to choose any plan in the Exchange. This proposal gives consumers maximum choice and allows them to weigh the trade-offs among premiums, out-of-pocket costs, and other factors. We urge the Exchange to work with consumer advocates to ensure that the decision-making process is as transparent and simple as possible to facilitate consumers' making educated choices.

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Pharmaceutical Research and Manufacturers of America (PhRMA)	PhRMA notes that if individuals who are eligible for cost-sharing subsidies are encouraged to buy bronze plans at low to zero premiums, they may not be able to afford the cost sharing required by such plans. Lower income uninsured individuals have very little savings (PD Jacobs and G Claxton, "Comparing The Assets Of Uninsured Households To Cost Sharing Under High-Deductible Health Plans" Health Affairs vol. 27 no. 3) and most may be unable to pay the out-of-pocket costs required by bronze plans. If individuals eligible for cost-sharing subsidies give up these subsidies in order to buy a lower cost bronze plan, their health insurance may be illusory and they may remain unable to afford needed medical care. In that case, the coverage may only help with reimbursement for catastrophic health events and may not provide access to treatments to prevent health conditions from becoming more serious.
Planned Parenthood Affiliates of California	Issue 4: Plan Choices for Individuals Income between 100% and 250% FPL PPAC agrees with the Exchange's recommendation to limiting choice for individuals 100-250% FPL to the Bronze and Silver level plans, although a better way to ensure affordability of coverage to this population would be through a lower cost Basic Health Plan. Individuals and families between 100-250% FPL will only be eligible for cost-sharing reduction on the silver level plans, and while this option reduces choice of plans for these low income individuals, the limitations help ensure affordability for this extremely price sensitive population. PPAC understands that a decision about the BHP will be made by the California legislature and in the absence of a BHP supports ensuring affordability by limiting choice to the two lower metal tiers. Issue 5: Standardization of Minimum Out-of-Network Benefits PPAC recommends that in addition to standardization for out-of-network benefits like minimum actuarial value, maximum deductibles for co-insurance, and limitation on balance billing that provide consumer protections the Exchange consider standardization requiring qualified health plans to cover confidential reproductive services out of network. The issue of access to confidentiality for reproductive health services, including family planning and abortion is an important one for many women who cannot access these services in-plan, and should be addressed in the Exchange's out-of-network benefit structure. Reproductive services are often sensitive and many women have a need to access confidential services from a health care source other than their usual provider.

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	In the event that an enrollee is not able to access covered services or a necessary provider within the existing covered network (for example, due to provider religious or moral objections, or due to an emergency), the Exchange must require the QHP to allow the enrollee to access services out-of-network without penalty without additional cost to the enrollee. Out of network access is especially critical for women seeking abortion services. Over half of California's counties do not have an abortion provider, and few abortion providers have the capacity to serve women with high-risk or later pregnancies. These women need timely - and often immediate - access to out of network providers, and these providers must be assured that they will be paid for their critical services.

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AIDS Health Consortia	Issue 1: Consideration of Exchange Provider Network Access Adequacy Standards for QHP Certification: We understand the recommendation made by the staff to have the plans regulated by DMHC and CDI for the first two years in order to get the plans up and running, but we urge the exchange board to create a work group to review and combine the regulations from each agency into one unified set of regulations, ensuring that combined regulations include the strongest consumer protections from each regulating agency. In the meantime, we recommend that the Exchange act as an information broker to provide consumers with clear information about the differences between the regulations in DMHC and CDI. The Exchange should ensure that consumers understand that the differences are clear to people when they pick either an HMO or PPO plan. Differences in regulations must be articulated when they affect the benefits package and access to providers - both primary and specialty care. We recommend that the Exchange board convene a small expert work group to recommend key consumer information regarding regulation differences between plans.
Alameda Health Consortium	**Under Issue 1, "Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification,"** the Alameda Health Consortium supports the proposed Option C, to "Adopt additional Exchange-specific standards for Qualified Health Plan certification above and beyond the regulator's respective provider network adequacy standards." We support the development of Exchange-specific standards that ensure that patients can remain with their providers of choice; we are particularly concerned that patients with complex care needs, and/or with cultural/linguistic needs retain the choice to stay with the current providers who are meeting their needs. We support use of existing timely access standards and cultural and linguistic competency standards under DHCS. We support the development of additional standards that require the reporting of provider cultural and linguistic capabilities.
AltaMed Health Services	**Issue 1: Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification** AltaMed respectfully disagrees with the Report's recommendation that the Exchange adopts the regulatory requirements of the Qualified Health Plan's currently regulator (CDI or DMHC) as the standard for provider network adequacy. AltaMed is hopeful that the Exchange will provide a better patient experience by expecting QHPs to reach a higher adequacy standard and following the Exchange's mission of improving health care quality. AltaMed strongly supports Option C, the adoption of Exchange-specific standards for QHP certification or if not at least, Option B, the adoption of DMHC standards for all QHP certification. In the areas that we served there is a great need for cultural and linguistic competency needs that currently are not adequately covered by current provider network

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	adequacy requirements.
Anthem Blue Cross	With respect to the options for setting provider adequacy standards for QHPs (Issue 1), Anthem supports the staff's recommendation of Option A, which would adopt the regulatory requirements of the QHP's current regulator. Likewise, for the approaches to evaluate compliance with provider network adequacy standards (Issue 2), we support the staff's recommendation of Option A, which would have the appropriate regulator certify the QHP's network. The other options would be duplicative and add additional, and unnecessary, costs.
Blue Shield of California	Blue Shield supports the use of existing network adequacy standards.
California Association of Health Plans	CAHP strongly supports the Exchange's recommendation to adopt the current regulatory requirements for network adequacy. New network requirements would have increased costs for the Exchange and QHPs, created additional and redundant work that would have resulted in an uneven playing field, and taken resources away from providing care to millions of new enrollees.
California Association of Physician Groups	**Regulatory Standards** (Pages 107-109): CAPG has qualified support for the staff recommendation for Option A at page 108: Adopt regulatory requirements of the Qualified Health Plan's current regulator (e.g., PPOs regulated by CDI would comply with the Insurance Code and HMOs/PPOs regulated by DMHC would comply with the Health and Safety Code). We feel that ultimately, there should be a uniform regulatory platform (Option B) for all product offerings within the Exchange, because that is the only way in which consumers will be able to judge the tradeoffs between access, cost and quality between PPO and HMO plan products. We are mindful that such a goal would require a significant re-write of existing law by the Legislature and that it is unlikely that can be accomplished within the time frame under which the Exchange is operating. We do offer further suggestions that can be applied to the manner in which the Exchange will evaluate QHP applications and report on quality metrics. Compliance with the timely access rules should always take precedence over the geographic access rules where possible. As technology and administrative capabilities advance in the delivery system, the current notion of geographic access or provider ratios as currently stated in the law may become redundant and outmoded in situations where patients can access their care providers over their smart phones, for example. We further suggest that current commercial standards should be applied uniformly across all QHP offerings and that Medi-Cal access standards not be overlaid onto the commercial model.
California Children's Hospital Association	Children are not small adults and need access to the pediatricians specially trained to meet their needs. Pediatric-specific standards should be incorporated into any standard of network adequacy and data broken down into pediatric-specific adequacy evaluation. Further, Plans should be required to use CCS approved providers in their networks.

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	CCHA strongly disagrees with the staff recommendation to adopt regulatory requirements of the Qualified Health Plan's current regulator (e.g., PPOs regulated by CDI would comply with the Insurance Code and HMOs/PPOs regulated by DMHC would comply with the Health and Safety Code) We disagree with this premise: "The information, presented in the Table 27 below, indicates that in general, California's regulators impose very similar standards for network adequacy." CCHA believes that the consultant undervalued the critical difference in network adequacy standards by overstating the GEO accessibility requirements and did not adequately emphasize the very strongly enforced Timely Access **requirements that pertain to both DMHC HMO and PPO products**. The requirements, and the monitoring systems in place at the DMHC, fundamentally altered the evaluation of network adequacy, as the chart used in the analysis on page 106 makes evident. The right to an appointment in a time-specified manner is a requirement for **BOTH HMO & PPO products** regulated by the DMHC. This includes a requirement for 'triage', i.e. an assessment of the enrollee's condition (generally done via the health plan member services). This includes, as a matter of procedure at the DMHC: 1. A review of the Evidence of Coverage to ensure access to all Basic Health Services; 2. A review of the underlying Provider Contracts in every licensed service area to ensure compliance with the Provider Bill of Rights and to ensure no disincentives to providing services; 3. Reviews and ongoing audits for the same Timely Access standards for both PPO & HMO products; 4. A review and requisite prior approval of major changes in the Plan's networks for both PPO& HMO; 5. Systemic reviews as needed for eg Mental Health Parity network issues (report issued & stakeholder group meet on ongoing basis). These rights apply even in areas where there are provider shortages**. No such rights exist for insureds in otherwise identical CDI PPO products.** Where the consultant appears to be basing the claims of similarity are solely within the section of the DMHC Timely Access regulation that discusses proof of compliance and exempts PPO products from the stricter compliance monitoring measurements required for HMOs (see in italics): 2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers, shall include: (A) **Tracking and documenting network capacity** and availability with respect to the standards set forth in subsection

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	(c); (B) **Conducting an annual enrollee experience survey**, which shall be conducted in accordance with valid and reliable survey methodology and designed to ascertain compliance with the standards at subsection (c); (C) **Conducting an annual provider survey**, which shall be conducted in accordance with valid and reliable survey methodology and designed to solicit, from physicians and non-physician mental health providers, perspective and concerns regarding compliance with the standards set forth at subsection (c); (D) **Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of car**e, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services; and (E) **Verifying the advanced access programs** reported by contracted providers, medical groups and independent practice associations to confirm that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1). (***F) A plan that provides services through a preferred provider organization network may, for that portion of its network, demonstrate compliance with subsections (d)(2)(A) and (D) by monitoring, on not less than an annual basis: the number of PPO primary care and specialty physicians under contract with the plan in each county of the plan's service area; enrollee grievances and appeals regarding timely access; and the rates of compliance with the time-elapsed standards established in*** **subsection (c)(5).** It is strongly recommended that the Exchange adopt the more robust standards and established examination requirements on Knox Keene HMO and PPO products. To continue to tolerate unequal consumer protections in the critical area of network adequacy will result in very different oversight platforms and consumer protections for similar PPO products. Poorly constructed and poorly monitored PPO networks can force insureds out of network with greater frequency, resulting in lower reimbursement of claims. Further, to the extent that CDI PPO products continue to have "**maximum allowable charges"** or other internal limits on services (which are NOT permitted by the DMHC), there are serious financial consequences if maneuvered out-of-network by poor network adequacy, with attendant lower reimbursement of claims. (E.g. – '*We will pay in-network 80% of the billed rate" vs. "If out-of-network, we will pay 70% of the Maximum allowable daily charge of the hospital, which we have set at $1200 per day*"(even though the enrollee is being billed $1500 per day). **In-network reimbursement: 80% of $1500 = $1240. Out-of-network =$840.** This is not a question of good regulators or bad regulators – it is the structure of the law in California creating and

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	tolerating differences that have unquestionably led to adverse selection that is a cautionary metaphor for the risks of inside-outside market disequilibrium.
California Coalition for Reproductive Freedom	**Issue 1: Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification** The Exchange Board should reject the proposal to adopt existing regulatory requirements on network adequacy of QHP bidders' regulatory agency (Option A). The network adequacy standards currently required by state law and the regulations of DMHC and CDI set a starting point for appropriate standards for QHPs, but are not sufficient to fully ensure access. We urge the Exchange to require QHPs to meet existing standards for providers' geographic availability, and provider types plus additional criteria including specific provider ratios that ensure actual availability of services, timely access standards, language access standards, and disability access standards. *Provider Ratios* Existing laws and regulations assure overall provider-patient ratios with specific ratios for primary care, but go no further and therefore are insufficient to ensure meaningful access. *See* 28 C.C.R. § 1300.67.2(d); 10 C.C.R. § 2240.1(c)(1). First, the Exchange should require plans to adopt provider-patient ratios that account for variation in specialty type and geography, similar to those used in the Medicare Advantage program. After enrollment commences, the Exchange could update the criteria based on utilization patterns and clinical needs. Such criteria fulfill the goal of assuring that enrollees have access to services, while incorporating flexibility to account for local variation. We recommend that such criteria be developed using the 2011, 2012 and 2013 Medicare Advantage Network Adequacy Criteria as a model. *See, e.g.,* Centers for Medicare & Medicaid Services, *2011 Medicare Advantage Network Adequacy Criteria Development Overview*, https://www.cms.gov/MedicareAdvantageApps/Downloads/2011_MA_Network_Adequacy_Criteria_Overview.pdf. In many rural areas of the state, managed care networks do not exist and safety net providers are a main source of health care for the community. The Exchange should develop robust criteria to ensure that enrollees in those regions have access to comprehensive, geographically representative networks of providers. Second, the Exchange should adopt metrics to ensure that all covered services are actually available and that assesses whether providers are accepting new patients. For example, some obstetricians and gynecologists are unwilling to prescribe birth control or to perform abortions, and some are unwilling to make referrals for those services. The proliferation of religiously-affiliated hospitals in California adds to significant barriers to covered reproductive health services. According to the California Alliance for Catholic Healthcare, 16 % of California hospitals are Catholic, accounting for 20% of acute care beds. These hospitals do not perform abortions even in urgent situations, and are unlikely to provide other reproductive health services. The failure to include providers who offer these covered services

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	(including providers with the appropriate skills to perform abortions for women with high-risk pregnancies) would indicate that the network is not adequate and should not be approved. Also, provider-patient ratio calculations must account for whether providers are accepting new patients to ensure that new enrollees have access to the providers they need. Last, as described in greater detail below, the Exchange should require QHPs to contract with essential community providers for the full range of services they offer, rather than only contracting for limited subsets of service. *Timely Access Standards* Current California law applies timely access standards to HMOs and certain PPOs regulated by the Department of Managed Health Care (DMHC), but not to PPOs and other plans regulated by the California Department of Insurance (CDI). *See* 28 C.C.R. §§ 1300.67.2.2(c)(5), 1300.67.2(c). The Exchange should adopt, for ***all*** plans, the Department of Managed Health Care's clear timely access standards for primary care, mental health, urgent care, specialty care, and ancillary care appointments found at 28 C.C.R. § 1300.67.2.2(c)(5), and the requirement that emergency care must be available to Exchange plan enrollees 24 hours a day, 7 days per week, found in 28 C.C.R. § 1300.67.2(c). While PPOs regulated by CDI typically include broader networks than DMHC-licensed plans, those broader networks do not guarantee that enrollees can actually access services in a timely fashion; thus, specific standards are needed for all plans. Finally, we suggest that the Exchange monitor wait times as a measure for access problems in QHPs. *Language Access Standards* Existing network adequacy standards in California do not sufficiently account for the capacity of providers to serve limited English proficient (LEP) individuals. Large numbers of LEP individuals will purchase insurance through the Exchange and the Exchange must ensure that linguistically appropriate services are provided by the health plans that are certified for inclusion in the Exchange. Currently, DMHC and CDI regulations implementing SB 853 (Escutia, 2003) require licensed plans to assess the linguistic capacity of enrollees and provide free language assistance service at all points of contact. *See* 28 C.C.R. § 1300.67.04(c) (DMHC); 10 C.C.R. §§ 2538.3 & 2538.6 (CDI). These regulations are a significant step in ensuring access to health care services for LEP individuals, but NHeLP and the HCA urge the Exchange to adopt additional standards to ensure that California's LEP individuals have meaningful access to care, by adopting stronger standards to ensure that enrollees have access to oral interpretation, and by requiring plans to report on bilingual providers.

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	Current standards do not require plans to pay for interpretation services for their contracted providers. The Exchange should require QHPs to arrange in their provider contracts pay for interpreters directly, even in interactions between provider and patient to ensure the availability of language services and improve compliance by providers who often do not have the resources to evaluate or pay for competent language services. Before the Exchange certifies a plan for participation in the Exchange, the Exchange should require plans to set forth in detail their process for paying for and guaranteeing timely oral interpretation services, both for their own customer service functions and whenever necessary to facilitate communication between enrollees and providers. These language access plans should be made available to the public on the Exchange website. Further, the Exchange should ensure that QHP issuers inform potential enrollees of the languages spoken by network providers as a condition of certification of QHPs by the Exchange. It is critical, however, that any provider (or member of a provider's staff) who identifies him/herself as speaking another language be competent to do so. The Exchange should require QHPs to assess the language proficiency of its providers, and their staff, who seek to provide services directly in a non-English language. Otherwise, it is likely that many enrollees will suffer ineffective communication that can result in serious medical harm due to a lack of language proficiency, particularly with regards to the specialized medical terminology that someone who may be conversationally bilingual will not possess. For example, in a study commissioned by NHeLP examining language barriers and medical malpractice, 32 of 35 claims involving language issues arose from providers failing to use competent interpreters. NHELP, THE HIGH COSTS OF LANGUAGE BARRIERS IN MEDICAL MALPRACTICE (2010), *available at* http://www.healthlaw.org/images/stories/High_Costs_of_Language_Barriers_in_Malpractice.pdf. No patient should have to suffer avoidable harm because a provider thinks he knows enough of a language to get by. Thus we recommend the Exchange implement specific competency standards for all those who seek to provide services directly in a non-English language or serve as interpreters and limit those who may list language skills in a provider directory to providers who have established competency. *Disability Access Standards* Finally, existing network adequacy standards in California do not ensure that enrollees with disabilities will have access to appropriate services, or that facilities will be accessible to them. While CDI regulations require that network facilities be "reasonably accessible to the physically handicapped [sic]," what constitutes reasonable accessibility is not delineated. 10 C.C.R. § 2240.1(b)(3). A national Baylor Medical College study of women with disabilities found that thirty-one percent of the participants were refused care by a physician because of their disability. Moreover, the women

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	reported considerable difficulty locating physicians who were knowledgeable about their disability to help them manage their pregnancy.[1] Further, the CDI regulations are limited to physical disabilities and do not account for accommodations that may be needed by people with developmental or mental disabilities. DMHC regulations do not contain any specific requirements on accessibility for enrollees with disabilities. We urge the Exchange to adopt network adequacy criteria that account for the particular needs of persons with disabilities. Such criteria should ensure that, in addition to the usual range of providers and the Essential Community Providers, QHPs are required to offer access to the following providers and services in their networks: interpreters, inpatient and outpatient rehabilitative programs, comprehensive rehabilitative and habilitative services, applied rehabilitative technology programs, wheelchair seating clinics (including access to wheelchair assessments) independent of durable medical equipment providers, specialty care centers (including those Ryan White Care providers serving people living with HIV), Genetically Handicapped Persons Program certified providers, non-coercive reproductive health services, speech pathologists (including those experienced working with nonverbal individuals, persons with developmental disabilities, and persons who need speech generating devices), occupational therapists, orthotics providers and fabricators, physical therapists, case managers for those with significant non-medical barriers to care, Applied Behavioral Analysis (ABA) therapy, and low vision centers. Finally, the Exchange should require QHPs to certify that their providers' facilities are accessible to all enrollees, and fully compliant with the Americans with Disabilities Act (ADA) and other state and federal disability and civil rights laws. **Issue 2: Approaches to Evaluating Provider Network Adequacy for QHP Certification** We have concerns about the proposal that the Exchange rely on DMHC and CDI's existing regulatory processes to monitor plans compliance with network adequacy standards. We are concerned that the existing regulatory oversight processes are inadequate to ensure that enrollees truly have access to the providers and services they need. While both regulators evaluate plans' networks with geo-access reports when they are initially licensed, the existing regulatory scheme provides little ongoing review to ensure that plans are meeting network adequacy standards. Rather, plans are generally allowed to self-certify that they meet applicable network adequacy standards without independent verification. The Exchange should work with DMHC and CDI to require QHP issuers to maintain an ongoing monitoring process to ensure that they are meeting network adequacy standards. Existing regulatory oversight of network adequacy

[1] Margaret A. Nosek Ph.D., et. al., National Study of Women with Physical Disabilities, Baylor Medical College, available at http://www.bcm.edu/crowd/index.cfm?pmid=1408#intro.

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	standards is too infrequent to identify problems with plan networks. DMHC currently evaluates the access and availability of services, access to emergency services, and language assistance in its licensed plans only once every three years through its medical survey process. Cal. Health & Safety Code § 1380(c). Similarly, CDI must examine licensed plans at least once every five years. Cal. Ins. Code § 730(b). CDI is charged with generally evaluating plans compliance with applicable laws in the examination process. Cal. Ins. Code § 733(d). Given the rapid pace at which plans add and drop providers from their networks, a review of network adequacy measured in years is not sufficient to ensure that plans are truly providing access to services. While the existing regulatory review processes will give the Exchange the opportunity to periodically review the adequacy of QHP's networks, the Exchange should monitor compliance more frequently, especially in the first five years of the Exchange, since most problems occur in the early years of a new system. The Exchange should work with DMHC and CDI to require the QHP issuers to establish a written process for monitoring the adequacy of their QHPs' networks at least quarterly; take corrective action if a QHP falls out of compliance; and report the findings of their monitoring and any corrective actions to the Exchange. In addition, the Exchange should require QHP issuers to report any material changes in their QHP provider networks, confidentiality procedures, and grievance and appeals policies to the Exchange within 30 days. Further, the Exchange should not only rely on QHP issuers' reporting of compliance with network adequacy standards, but should require independent review to ensure compliance. The existing regulatory review processes are ill-equipped to evaluate whether plans' networks truly comply with network adequacy standards, and largely rely on the plans' own self-assessment of compliance, complaint data, information about grievances and appeals, and enforcement actions to identify problems; plans need not submit geo-access data on their networks again once they are licensed The data collected in these review processes do not guarantee that DMHC and CDI have a complete picture of plans' compliance with applicable standards. Nor does DMHC or CDI generally attempt to independently verify the information provided by plans. The Exchange should work with DMHC and CDI to take additional steps to hold plans accountable to network adequacy standards The Exchange, especially in the first five years, should independently assess plans' compliance with network adequacy standards, including by requiring additional geo-access data, and by verifying the number and location of providers, the scope of services they provide, the timeliness of appointments, the availability of appropriate language services, and the accessibility of contracted facilities. Moreover, the Exchange should impose transparency standards to evaluate the primary care capacity of health plan networks in every region by assessing metrics such as ratio of primary care providers to population and other measures of capacity. While we realize that this proposal does add administrative burdens to the Exchange, these additional burdens are justified, especially in the early years of the Exchange, by the need to assure that QHPs are truly providing access to health care.

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	Finally, any monitoring of QHP networks must be transparent, publicly available, and easy for consumers to understand. While the federal regulations at 45 C.F.R. § 156.220 will establish certain data points that must be made publicly available by QHPs, we urge the Exchange to go further and require that all non-confidential information derived through the monitoring process be broadly disseminated. This data must be accessible online and in written form so that consumers are made aware of any problems, and can compare plan performance. And, like all information provided in connection with the Exchange, this information should be conveyed in a manner that is easily understood and accessible to people with low literacy, limited English proficiency, and disabilities.
California Family Health Council	CFHC urges the Exchange Board to reject the proposal to adopt existing regulatory requirements on network adequacy and support Option C, the adoption of Exchange-specific standards for Qualified Health Plan Certification. The network adequacy standards currently required by state law and the regulations of the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) are inadequate to fully ensure that enrollees truly have access to the providers and services they need and have proven problematic in the past. While both regulators evaluate health plan networks with geo-access reports when they are initially licensed, neither provides sufficient ongoing review. Plans are also generally allowed to self-certify that they meet applicable network adequacy standards without independent verification. The Exchange must monitor compliance more frequently, especially in the first five years, since most problems occur in the early years of a new system. In addition, at least in the early years of the Exchange, the Exchange should conduct an independent review of compliance with network adequacy standards including geo-access data, provider number and location verification, timeliness of appointments and scope of services provided and the availability of appropriate language services.
California Hospital Association	As the Exchange considers important issues, ***we strongly recommend that the Board resist any policy that denies patients their providers of choice when such providers are actively engaged in effective care management strategies or provide essential societal services or programs.*** The belief that narrowly designed networks promote greater efficiency, lower costs and therefore will help lower commercial prices and total expenditures is erroneous. Inadequately constructed networks do not address broad societal benefits (such as behavioral health education, trauma centers, specialty services, research, etc.) the underlying drivers of health care costs associated with the delivery system, the other factors reflected in commercial provider prices and ultimately the total health care expenditures in the commercial market.

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	The mission and vision statement adopted by the Exchange Board is "to improve the health of **all** Californians by assuring their access to affordable, high quality care." To achieve this mission and vision it will be critical that the Exchange give meaningful consideration to the impact its policies will have on both the delivery system of the state and on the markets outside the Exchange. Issue 1 under this section puts forth three options for network adequacy standards for QHP certification. The Exchange staff recommends Option A because it minimizes administrative burden. ***However, if the Exchange is to be a trusted brand/name/source for consumers, it must strive to ensure that consumers have choices that result in meaningful health care coverage and access to comprehensive medical services.*** Therefore, the Exchange must require QHP products to adhere to the highest level of consumer protections related to network adequacy. Option B proposes that all QHPs must meet regulatory requirements mandated by the DMHC. We believe this is a good start, but encourage the Exchange to also incorporate Option C and adopt additional standards for QHP certification, for many of the reasons described in the opening comments to this section. ***Narrowly constructed networks are fundamentally contrary to the mission and vision established by the Exchange. For the mission and vision to become a reality, it is imperative that the Exchange develop policies that achieve these ends not just for the customers of the Exchange but for all Californians.*** For Issue 2 under this section – approaches to evaluating provider network adequacy – CHA believes the Exchange should not rely solely on existing access standards. ***To ensure adequate networks, the Exchange should bolster the type and frequency of analysis, including qualitative and quantitative measures.*** As noted above, narrow networks do not lower the input costs for those delivering health care. To the extent that those covered by a lower unit price in a narrow network benefit, it results in those insured outside the narrow network (whether on another Exchange product or outside the Exchange) ultimately bearing a disproportionately higher portion of the total cost. Importantly, total health care expenditures are not reduced. Ironically if the Exchange makes use of QHPs narrowly constructed networks, it will be adding to the current cost shift problems in the commercial insurance market. Inadequate networks in reality are another form of inappropriate risk segmentation; therefore, the Exchange would be expanding the use of a technique that the health reform effort was intended to reduce.

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	For these reasons, ***we recommend that the Exchange develop a more robust approach to evaluating provider network adequacy by incorporating elements in Options B and C.***
California Medical Association	***Issue 1: Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification*** **While we understand and do not oppose the Exchange's recommendation, Option A, adopting existing network adequacy standards, this recommendation necessitates a greater focus on monitoring and enforcement of those standards and the federal requirements around provider directories.** The cost pressures, population demographics, and sheer influx of patients, among many other things, within the Exchange calls for greater attention to monitoring and enforcing current standards. Furthermore, considering the importance of the public perception of the Exchange in this initial phase, the Exchange should be particularly sensitive to ensuring QHPs meet enrollees' expectations, of which the provider network is a critical part. We believe that the regulators do not currently have the capacity to adequately monitor provider networks. The statutory responsibility of CDI and DMHC to monitor network adequacy of licensed issuers is separate and distinct from the federal requirements that a QHP issuer "must ensure that the provider network of each of its QHPs, as available to all enrollees, . . . [m]aintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay" (45 CFR § 156.230(a)). Thus, we believe the Exchange can and should explore opportunities to support its partner agencies in the monitoring and enforcement challenges ahead, such as through the funding of temporary positions or improved network adequacy assessment tools. Again, the current systems and resources of California's regulators are not equipped for the impending Exchange environment. Using DMHC as an example, network adequacy is initially verified using health plan self-reported information. Our understanding is that there is no independent verification of these networks. DMHC will audit plan networks every three or more years *if* it receives a sufficient number of complaints regarding the provider network. Unfortunately, rarely do patients think to call DMHC to report a lack of access when one provider has no availability or says they are no longer contracted with that plan. They simply call up the next provider down the list or struggle to find another arrangement that works. Along the same lines, DMHC currently has only a handful of staff reviewing provider complaints, such that provider

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	complaints are now only tracked and trended. Allowing for Exchange call center personnel to handle physician complaints, or even a particular subset thereof, would not only relieve pressure on current regulator resources but also provide the Exchange with another feedback mechanism at minimal administrative and operational cost. The responses to a number of questions will also determine the demands on regulators. Such as, will the Exchange also be relying upon the regulators to enforce the federal requirement that QHP issuers identify providers not accepting new patients in the provider directory (45 CFR § 156.230(b))? If so, will these providers not accepting new patients still be factored into the network adequacy calculation? Will enrollees know who to contact when a provider is not properly designated as no longer accepting new patients? In sum, we have heard firsthand the stories of horribly inaccurate provider directories and the months or years of struggle some physicians go through to get their names off the directory of a plan with which they are not contracted and we are genuinely fearful of what the status quo might mean for the population entering the Exchange if they are to have no guarantees that the providers they need will be accessible. ***Issue 2: Approaches to Evaluating Provider Network Adequacy for QHP Certification*** **If the Exchange's recommendation, Option A, representing the status quo, is adopted, new systems and strategies of assessing and monitoring network adequacy would help to ease the administrative and operational burdens on the Exchange, regulators, and issuers.** **More specifically, we are recommending that the Exchange Board capitalize on the new provider directory functionality of the System for Electronic Rate and Form Filing (SERFF) by integrating the network adequacy verification system currently used in Medicare Advantage (MA)**. The state already uses the National Association of Insurance Commissioners' (NAIC) SERFF and would incur no added cost from utilizing SERFF's new Plan Management Module, which will come online December of 2012 to assist in the process of certifying, recertifying, and decertifying QHPs. The Plan Management Module will feature a provider directory submission tool by which plans may submit their respective provider networks in a standardized format, as determined by the state.

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	If provider directories were submitted in the format of MA's health services delivery (HSD) table,[2] the Exchange could utilize software packages currently being used for MA network adequacy verification by the Centers for Medicare & Medicaid Services (CMS) and for self-verification by a significant percentage of the health insurance industry. These packages quickly and automatically verify that the network is adequate according to defined standards using the data submitted in the HSD table. Arizona is one state currently exploring the use of such a system for its exchange. The state could modify values and indicators for the HSD table fields to suit the purposes of the Exchange while still maintaining functionality with current MA network adequacy verification software packages, such as that offered by Quest Analytics (a package used by CMS and a number of major issuers in California).[3] For instance, the state would need to add indicators for practice specialties like pediatrics, add or categorize indicators for identification of essential community providers, and use a prospective patient population other than Medicare beneficiaries. Of course, the exact parameters by which the Exchange deems a network adequate would be subject to stakeholder review and comment and could be regularly revised as the Exchange sees fit with minimal administrative difficulty. The current HSD data format and software packages used by CMS and nearly all issuers with an MA plan also provide a high ceiling as to the level of information the Exchange may efficiently provide to consumers. Provider mapping tools could be provided on the Exchange website and allow searching according to a large number of categories beyond just practice specialty and contracted plans, such as the availability of language services. Provider network updating also could be required with regularity, such as monthly or more often, without significant increases in administrative burden. In sum, a federally vetted network adequacy verification system building on processes and technologies already utilized by government and the health insurance industry would allow for exceptional access to plans' provider network information for consumers and consequently assure consumers they are getting what they need in a plan. Such a system could do all this with relatively minimal administrative burden and cost to the state and industry. Furthermore,

[2] Centers for Medicare & Medicaid Services. *Medicare Advantage Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance*. http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf. Last accessed June 25, 2012.

[3] A representative at Quest Analytics confirmed that, at least with the program they provide for CMS and insurers in California (e.g., Blue Shield, SCAN, and HealthNet), such modifications could be made with minimal difficulties. Furthermore, the representative stated that HSD table data could easily be translated to an online geo-mapping tool to allow the Exchange and public to access provider maps based on user-specified information.

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	this recommendation is consistent with a number of stakeholder comments submitted on QHP selection criteria, especially those requesting the Exchange explore coordinating with or expanding on the work of the MA program and for a reduction in barriers for entry of MA plans.
California Pan-Ethnic Health Network	Network adequacy should be measured by the ability of health plans to provide consumers with timely access to medically necessary care with in-network cost-sharing. CPEHN shares the concerns of Health Access and others that PPOs, which lack standards for timely access, shift the costs to consumers placing a disproportionate financial burden on the low-income. While more could be done by both regulators (DMHC and CDI) to verify network adequacy, the same timely access standards must apply to both HMO and PPO products sold in the Exchange. We would echo Health Access' recommendation that PPOs be permitted only if the essential health benefit includes basic health care services as a standard and primary care at in-network cost sharing. We think there is a role for the Exchange in working closely with both regulators to improve oversight of network adequacy (including timely access and language access) for products sold both inside and outside the Exchange in order to ensure a level playing field. Because regulatory frameworks differ at California's two regulatory agencies, it will be necessary for the Exchange to be an active partner with these two bodies to ensure the strongest protections for California consumers.
California Primary Care Association	***Issue 1: Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification*** CPCA respectfully disagrees with the Report's recommendation that the Exchange simply adopt the regulatory requirements of the Qualified Health Plan's current regulator (CDI or DMHC) as the standard for provider network adequacy. In 2014, millions of uninsured individuals will enter coverage with unmet medical needs and will look to their new provider networks to meet those needs. The provider network adequacy requirements currently promulgated by DMHC and especially CDI have proven problematic in the past, and CPCA hopes that the Exchange will actively seek to provide a better patient experience by expecting QHPs to reach a higher adequacy standard. **As such, CPCA supports Option C, the adoption of Exchange-specific standards for QHP certification**; or at the very least, Option B, the adoption of DMHC standards for all QHP certification. CPCA encourages the Exchange to require QHPs to comply with *at least* DMHC standards with regard to language access and cultural competence, but hopes the Exchange will impose its own additional standards to evaluate cultural and linguistic access for newly insured populations. The eValue8 system that the Exchange is considering as a data collection tool could be useful in creating a baseline standard for language access and cultural competence for health plans. The Healthy Families Program can also inform the Exchange in developing a model for provider network requirements, including the addition of annual reporting requirements on cultural and linguistic services, ensuring

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	providers who list their bilingual capabilities are bilingually proficient, and including race, ethnicity, and primary language as core data elements in all standard measures for assessment. **In light of cultural and linguistic competency needs that are not adequately covered by current provider network adequacy requirements, CPCA believes the Exchange should adopt Option C, by adopting regulatory requirements of DMHC and adding additional Exchange-specific standards for QHP certification that reflect the Exchange's vision of being a catalyst for the provision of high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.**
California Optometric Association	The California Optometric Association (COA) recommends the Exchange require Qualified Health Plans (QHP) to reimburse doctors of optometry for treating medical eye conditions in order to provide for timely and close proximity patient access to care, improve care coordination, and to promote better quality and more affordable care. The U.S. Department of Health and Human Services' (HHS) regulation on the "Establishment of Exchanges and Qualified Health Plans" specifically requires QHPs to maintain a provider network that is sufficient in the number and types of providers to ensure that all services are accessible without delay (42 CFR 156.230). Considering that pediatric vision care is an essential benefit that all qualified health plans must cover, QHPs should be required to include doctors of optometry in their networks in order to ensure that the significant number of newly insured children receive proper vision care without delay. We also believe that QHPs should not only be required to contract with doctors of optometry for vision services for these children, but also for the treatment of medical eye conditions in both children and adults. It is important to note that HHS asserted when it released the above-referenced final regulation that nothing prohibits a state's Exchange from establishing a more rigorous standard for network adequacy, and that state Exchanges are encouraged to expand the definition of the types of providers that can furnish primary care services in order to increase access to care. There is a current shortage of ophthalmologists in California, especially in rural and medically underserved areas, and this is not expected to improve[4]. California has approximately 7,100 doctors of optometry practicing in all areas of California. Conversely, there are only slightly more than 2,000 ophthalmologists in California. While there is a shortage of ophthalmologists, the demand for medical eye services is only increasing. With respect to eye disease nationwide: • 200,000 Americans develop advanced age-related macular degeneration (AMD) each year; a number expected to double by 2020.

[4] Lewin Supply and Demand Workforce Model 2008 data

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	• Cataract affects 1 in 6 people over age 40; 30.1 million Americans expected to have cataracts by 2020. Even though doctors of optometry are available to ease the demand burden, many medical groups and IPAs exclude optometric doctors from their medical panel. These organizations are run by physicians who are often unaware of the services that doctors of optometry are licensed to perform. When approached, some IPAs will continue to exclude optometry because of existing contracting relationships with ophthalmologists. Currently, independent doctors of optometry are excluded from treating medical conditions under most HMO plans. These barriers impede patient access to care and ultimately increase costs. Lack of access to optometry also creates gaps in effective and timely treatment for acute eye problems that result in non-urgent and costly eye care visits to the emergency room (ER). Each of these consequences run counter to the health care cost reduction and patient access goals of the Affordable Care Act (ACA). In major published studies: • Non-injury related ocular ER visits comprised 51% of ocular-related visits[5]. • Only 3% of ocular-related ER visits required hospitalization[2]. • Of emergency department visits, 38% could have been managed by a doctor of optometry outside a hospital setting[6]. Excluding doctors of optometry from provider panels is also less convenient for patients. Instead of being treated immediately, patients without access to medical optometry must schedule another doctor appointment with a different provider who they do not know. This results in care fragmentation, redundancy of testing and sometimes expensive overtreatment by ophthalmologists. The existing literature on access to vision care shows it is more convenient for patients to see doctors of optometry versus ophthalmologists because of shorter appointment wait times, evening hours, and weekend hours[7]. Also, there are three times as many optometrists than ophthalmologists in California.

[5] Erin A.Nash and Curtis E. Margo, "Patterns of Emergency Department Visits for Disorders of the Eye and Ocular Adnexa," *Archives of Ophthalmology*, Volume 116, September 1998, pp. 1222 – 1226.
[6] Hau S, Ioannidis A, Masaoutis P, Verma S. "Patterns of ophthalmological complaints presenting to a dedicated ophthalmic Accident & Emergency department: inappropriate use and patients' perspective." *Emerg Med J*. 2008 Nov;25(11):740-4.
[7] Soroka M. (1991). "Comparison of examination fees and availability of routine vision care by optometrists and ophthalmologists." *Public Health Reports*. 106(4):455-9 and Gauer BB, et al. (1994). "Access, provision and cost of routine eye care: a comparison of Oregon optometrists and ophthalmologists." *Journal of the American Optometric Association.* 65(4):240-7.

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	Some QHPs may be concerned that adding doctors of optometry to their provider networks may add compliance costs. We believe that the simple solution that would not increase compliance costs for HMOs is to treat doctors of optometry in the same manner as ophthalmologists. QHPs will only have to expand their provider networks to include optometrists. We believe this requirement would not be overly burdensome since QHPs would not be required to revise or renegotiate major provider contracts or implement new monitoring and compliance activities. QHPs will only have to contract with doctors of optometry similarly to how they contract with ophthalmologists. This direct contracting solution is also required by the ACA. Section 2706 (a) of the ACA, commonly referred to as the "Harkin Amendment," prevents plans from discriminating against licensed and certified health professionals, including doctors of optometry, with regard to health plan participation or coverage. In addition, it specifically allows varying reimbursement rates based on quality or performance measures. Clearly, the law prescribes that if an optometrist is included in a QHP medical panel, he or she should be reimbursed for medically necessary exams, treatments and procedures at the same rate as other professionals when those professionals offer similar services, quality and performance. In addition to QHPs, COA believes that this provision should apply to the entities with which the plans contract, including medical groups, IPAs, ACOs and other care delivery systems. Implementing the Harkin Amendment as intended in this regard would increase patient access to needed services by allowing doctors of optometry to provide medical eye services, which is often not allowed under existing provider contracts. The concept of including doctors of optometry in a plan's provider network for the treatment of medical eye care is not without precedent. Many health plans, especially PPOs, currently have arrangements with doctors of optometry to provide medical eye care. Medi-Cal and Healthy Families managed care plans also have this requirement[8], and HMOs in other states commonly reimburse doctors of optometry for the treatment of medical eye care. In fact, Medi-Cal essentially reimburses doctors of optometry for the treatment and examination of patients for any medical condition in and around the eye. The hyperlinked Medi-Cal Provider Manual lists the specific medical eye conditions that doctors of optometry can perform. In enacting and implementing the ACA, Congress and HHS are seeking in pertinent part to promote preventive and more timely access to care for all Americans to reduce costs and improve outcomes for covered individuals, as well as the health care delivery system. We appreciate and understand the fact that any additional requirements on QHPs may

[8] California Business and Professions Code Section 690

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	cost money. But there are also offsetting – and we believe higher - costs to not taking this opportunity to create greater access to more timely care that leads to less costly and improved patient outcomes. **In conclusion, the COA believes that QHPs should be required to reimburse doctors of optometry for treating medical eye conditions. Therefore, the Exchange should choose Option C, which is to adopt additional Exchange-specific standards for QHP certification above and beyond the regulator's respective provider network adequacy standards.**
Central Valley Health Network	Central Valley Health Network (CVHN) is a non-profit membership organization comprised of over 100 federally qualified health centers (FQHCs) sites in 20 counties, which provide preventive primary care services to over 550,000 individuals and more than 2.5 million patient visits a year. CVHN supports Option C, the adoption of Exchange specific standards for QHP certification. The DMHC cultural and linguistic competency requirements for Medi-Cal managed care contracts are essential standards that every QHP should meet. DMHC sets cultural competency requirements which are intended to ensure that patients with limited English proficiency have access to interpreters, written translations and requires reporting on the language capabilities of staff. Further, DMHC contracted issuers must form a community advisory committee to inform their cultural competency policies and inform their members that language assistance is available. CVHN hopes that the Exchange will at least adopt the DMHC standards for provider network access, including timely access standards as well as cultural and linguistic competency. We also encourage the Exchange to look into adopting additional requirements, provider network surveys and increased frequency and reporting detail for QHPs. The Healthy Families program can inform the Exchange in developing a model for provider network requirements, including the addition of annual reporting requirements on cultural and linguistic services, ensuring providers who list their bilingual capabilities are bilingually proficient and including race, ethnicity and primary language as core data elements in standard measures for assessment. By adopting DMHC regulatory requirements and adding additional Exchange-specific standards to QHP certification that reflect the Exchange's vision of being a catalyst for the provisions of high-quality, affordable health care, promoting prevention and wellness and reducing health disparities.
Children's Specialty	While we understand your recommendation is to rely on current regulator's certification that the QHPs meet regulatory network standards, we think there are improvements that could be made in the information regulators collect regarding

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Care Coalition	networks, particularly for sub-populations and vulnerable populations. We have heard pretty consistently the Exchange wants to pursue evidence-based decisions. In order to do this we have to adequately collect key data and evidence. If there are shortcomings in this area, for example, evidence of pediatric subspecialists as part of networks, then we should find ways to address these shortcomings. We would appreciate the opportunity to work with the Exchange to develop improvements in the information that is available to regulators about plan networks with the idea that more be done to ensure vulnerable populations and children with special health care needs have information about whether plan networks include the physicians they need to survive and thrive.
Cigna	***Issue 1: Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification*** Agree with using existing regulatory requirements with plans submitting geo-access reports as part of the certification process. ***Issue 2: Approaches to Evaluating Provider Network Adequacy for QHP Certification*** Agree with using existing regulatory requirements.
Disability Rights Education and Defense Fund	DREDF has repeatedly emphasized in previous comments to the Exchange delivered orally during public comment periods at board meetings, raised during focus groups, and in written letters, the need for specific physical and programmatic accessibility standards in plan provider networks. This critical need is *not* adequately addressed in existing provider network adequacy standards. The geo-access standards used in the managed care Knox-Keene requirements do not explicitly address physical and programmatic accessibility, and the CDI insurance code and regulations do not speak to the need for programmatic accessibility (reasonable accommodations and modifications to policies, practices and procedures). Unfortunately, providers who fail to understand and provide structural and programmatic accessibility fail to provide equally effective health care to people with disabilities of all ages, including an aging population with an increased propensity to acquire functional impairments, adults with chronic conditions and impairments, and younger adults who are aging out of the specialized pediatric systems where accessible specialty care is more available. As only one example of how inaccessibility continues to flourish among California's health care providers, we will focus in accessible, height-adjustable equipment. Accessible equipment is not a matter of structural accessibility. It is a programmatic issue, since providers must purchase the equipment (which almost always equally serves the needs of patients without disabilities), and establish policies and procedures relating to intake and scheduling that will ensure that the equipment is available for the use of those individuals with relevant functional impairments. In California, Medicaid managed care plans are required by the state to administer a "facility site review" (FSR) to all

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	their network primary care providers. The FSR originally had little to do with accessibility. It measured things like the temperature of the refrigerators where medication was stored and staff training on obtaining patient consent; plans often used nurses to administer the FSR. Providers would have to undergo the FSR when they first joined a plan, and every 3 yrs. In 2000, a couple of disability consultants started to work with four Medicaid managed care plans to develop a 55-item physical access survey that would be administered as a part of their FSR process. Beginning in 2006, these plans would administer the 55-item physical access survey in any primary care provider office where they were going through the FSR. A fifth plan also was persuaded to add the physical access survey to their FSR process. DREDF and a close colleague, Professor Nancy Mudrick at Syracuse University, recently drew on this data to get the first hard statistics on the architectural accessibility of a large number of provider offices. (These findings are published in N.R. Mudrick, M.L. Breslin, M. Liang and S. Yee, Physical Accessibility in Primary Health Care Settings: Results from California On-Site Reviews, 5 DISABILITY & HEALTH J. (2012)) The data is derived from reviews of over 2300 primary care provider facilities in 18 of California's 58 Counties, serving about 2.5 million Medicaid enrollees and an unknown number of non-Medicaid enrollees since most providers do not see Medicaid patients exclusively. Moreover, because the 55 item survey contained one question relating to height-adjustable exam tables, and one question relating to accessible weight scales, the information gathered provides an accurate picture of the availability of accessible medical equipment. Previous published literature had found that height-adjustable exam tables were present in 17-44% of provider offices, but those were studies with small numbers of participants (40 in 1 study, 68 offices in another), using sites that had essentially self-selected. From the California surveys, we found that 8.4% of provider sites have a height-adjustable exam table, and 3.6% have an accessible weight scale. Tables and scales are the two most basic pieces of equipment used in any routine patient visit. Also keep in mind that these are findings made in California, which has some of the oldest state disability rights laws in the country, arguably some of the most enlightened public attitudes about civil rights, and some of the newest architecture. What are the alternatives when accessible tables and scales are not available? Wheelchair users are examined in their chair or offered a rug on the floor. Individual patients and medical staff risk injury in lifts, or patients are just turned away and told to bring someone to lift them next time. Medication is administered to people according to an obsolete weight measure, or patients are weighed on laundry scales. The fear of injury and indignity experienced by people with disabilities in the face of these so-called "alternatives" deeply discourages the scheduling of regular provider visits and preventive exams.

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	DHCS does have some awareness of the need and the issue. The department has increasingly moved to place Californians Medi-Cal eligible population into mandatory managed care over the last few years, and has begun to require participating managed care organizations (MCOs) to at least survey the physical accessibility of its provider network, including ascertaining the availability of accessibility examination equipment. The survey requirement forces MCOs to assess the physical capacity of their network, and to begin to make this information available to managed care consumers who need to see accessible providers. On the other hand, the surveys are not a requirement of Knox-Keene *regulation*, but a matter of state-MCO contract. State legislation specific to the federal waiver authority that has enabled California to place Medi-Cal members into managed care also mentions accessibility requirements, but this will not translate into the Exchange's QHP requirements unless the Exchange *chooses to adopt the same language*. The current survey requirement also completely fails to capture information about equally important needs such as the provider network's capacity to provide sign language translation, assistance with filling out written paperwork, or the willingness to provide flexible appointment times. If the Exchange is committed to improving access to care for consumers with disabilities who are in the exchange, it must address the need for physical and programmatic accessibility standards in provider networks beyond the references already made in existing Knox-Keene and CDI regulatory standards. We support the recommendation at p. 112 of the QHP draft that would allow "the Exchange to request supplemental reporting or benchmarking of network access by Qualified Health Plans during the first two years." This will be a critical period for QHPs, and DREDF would strongly suggest that the additional steps referenced, such as oversampling the CAHPS patient experience survey and engaging in "Secret Shopper sample surveys, explicitly include references to disability. Dr. S.E. Palsbo has done considerable work developing disability-specific CAHPS measures (*see* http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261224). It is also important to gather and stratify information from additional survey steps to include disability specifically, especially as this will allow analyses of how disability interacts with other disparity factors such as income, race, ethnicity, and languages spoken/written to potentially render "access to health care" illusory for some Exchange members.
Health Access	• An adequate network is a network that provides consumers with timely access to medically necessary care with in-network cost-sharing. If a particular type of specialist is not available in-network, then the consumer should obtain access to an out of network specialist at in-network cost sharing. Timely access should be the obligation of the carrier, not the consumer. No consumer should be forced to go out of network in order to obtain timely access to care. • PPOs which lack standards for timely access shift the costs to consumers. This may be realistic for those

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	earning six figures. It is not realistic for Exchange enrollees whose incomes start at $10- $11 an hour. • Insurance Code products which are not required to provide access to medically necessary specialty care are also problematic: it is unclear as yet whether the legislation creating essential health benefits will rectify this serious deficiency in the Insurance Code. (Then Insurance Commissioner John Garamendi issued a comprehensive report on the deficiencies in the California Insurance Code in regulating health coverage.) • Health Access acknowledges both that the geographic access standards for both regulators are similar and that neither regulator does as much to verify network adequacy as Health Access believes is necessary. • Health Access recommends that PPOs be permitted only if the essential health benefit includes basic health care services as a standard and only if PPOs are required to provide timely access to medically necessary specialty and primary care at in-network cost sharing. • Health Access also recommends that the Exchange continue to work with the regulators to improve oversight of network adequacy both for QHPs and for products in the outside market, in order to assure a level playing field. On the webinar, the Exchange staff said that they "would go no further that current statute or regulation" on California-specific consumer protections. The intent of that statement is problematic considering the different regulatory frameworks at our two regulators and their respective oversight and compliance efforts.
Health Net	Health Net strongly supports the concept of utilizing the existing regulatory framework for network adequacy. There is no need for the Exchange to duplicate the robust evaluation and monitoring mechanisms already in place.
Insure the Uninsured Project	Although adopting regulatory requirements the QHP bidder's current regulatory agency may expedite Exchange implementation, we recommend **Option B** (adopt DMHC requirements for all QHP bidders) for its more rigorous network adequacy provisions over CDI requirements.
LGBT Health Consortia (Transgender Law Center; Center for American Progress; Equality California;	Underserved (and overlapping) populations such as LGBT people, racial and ethnic minorities, and rural communities frequently face significant financial, physical, cultural, and other barriers to appropriate health care services. To address these barriers, the Exchange should adopt network adequacy standards to supplement the minimum CDI and DMHC standards. Specifically, the Exchange must ensure that QHPs maintain provider networks sufficient to serve diverse consumer populations without unreasonable barriers or delays in receiving clinically appropriate and culturally competent care. An example of network adequacy standards may include requiring QHP provider networks to include providers that are culturally competent in working with diverse populations, such as the providers listed in the Gay & Lesbian Medical Association's provider directory (https://glmaimpak.networkats.com/members_online_new/members/dir_provider.asp).

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National Center for Lesbian Rights; and L.A. Gay & Lesbian Center)	Additionally, we encourage the Exchange to expand evaluation of network adequacy beyond the application of CDI and DMHC standards by including additional surveys and analyses. Focusing on certain services (e.g. mental health or substance abuse) and membership demographics at risk for underservice (e.g. non-English speakers, LGBT individuals) are key to ensuring access to quality care and reducing health disparities. CAPHS survey and other quality measures identified in the Board Recommendation Brief are insufficient to monitor network adequacy standards for many specific conditions (e.g. HIV) and populations (e.g. LGBT populations), and thus should not be relied upon by the Exchange as the sole source of information on the adequacy of QHP networks. While the Exchange may opt to have DMHC and CDI monitor network adequacy according to their regulatory standards for the first two years of Exchange operation, the Board should exercise its recommended approach to request supplemental reporting from QHPs to monitor the effectiveness of standards with regard to specific services and populations.
March of Dimes	Regarding Issue 1, regardless of how provider networks are certified, they must include sufficient access to women's health providers and pediatric providers. There must be robust standards to ensure that all plans specifically be required to maintain an adequate supply of available obstetric and gynecological providers, as well as pediatric providers, especially those who care for children with special health care needs. These standards need to take into account geographic proximity, the availability of providers, wait times and sufficient number of providers. Again, in the absence of available in-network providers, patients should be permitted to obtain covered benefits from out-of-network providers at no additional cost. Regarding Issue 2, we are encouraged to see the additional steps outlined to monitor network adequacy, such as oversampling with the CAHPS patient experience survey and the California Health Interview Survey. It is vital that the experience of consumers in those plans be taken into account when evaluating the network providers.
Molina Healthcare, Inc.	Issue 1: Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification Molina supports Option A—the Exchange's recommendation to adopt the current regulatory requirements for network adequacy in the interests of administrative simplification and regulatory cost containment. However, the Exchange should also take care to allow flexibility in network design that would allow QHPs to use narrow network, or tiered network models to contain costs, reduce prices, and drive volume to high value providers.
Monarch HealthCare	Monarch would like to provide comments on several issues in this section: 1. Adequacy Standards: We support Option A for the adoption of the current regulator (e.g., PPOs regulated by CDI would comply with the Insurance Code and HMOs/PPOs regulated by DMHC would comply with the Health and Safety Code). There should ultimately be a uniformed approach for all product offerings within the Exchange, so that

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	consumers will be able to easily understand the differences between access, cost and quality for all products. 2. Evaluation of Provider Network Adequacy: We support Option A where the applicable regulator would certify compliance with the network access standards. Further, we would support Option A, whereby the Exchange would adopt the monitoring requirements applicable to the existing license of the issuer for the QHP. This would help minimize new administrative and operational requirements for the health plan and providers. Also of importance, is the timely access rules and geographic access. We need to mindful of the changes and advancement of technology uses in the delivery of medical services. We suggest the Exchange widen the definition and the current commercial standards would apply across all QHP offerings. Medi-Cal access standards should not be overlaid onto the current commercial model.
National Health Law Program on behalf of the Health Consumer Alliance	**<u>Issue 1: Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification</u>** NHeLP and the HCA do not support the proposal to adopt existing regulatory requirements on network adequacy of QHP bidders' regulatory agency. The network adequacy standards currently required by state law and the regulations of DMHC and CDI set a starting point for appropriate standards for QHPs, but are not sufficient to fully ensure access. Thus, we support the proposal to require QHPs to meet existing standards for providers' geographic availability, and provider types. But to fully ensure access to services, we urge the Exchange to require QHPs to meet additional criteria, including specific provider ratios (by specialty type) that ensure actual availability of services, timeliness access standards, language access standards, and disability access standards. Provider Ratios The proposal before the Board adopts existing laws and regulations, which assure overall provider-patient ratios, and include specific ratios for primary care, but go no further. See 28 C.C.R. § 1300.67.2(d); 10 C.C.R. § 2240.1(c)(1). These existing metrics are insufficient to ensure access. Instead, NHeLP and the HCA urge the Exchange to require plans to adopt provider-patient ratios that account for variation in specialty type and geography, similar to those used in the Medicare Advantage program. After enrollment commences, the Exchange could update the criteria based on utilization patterns and clinical needs. Such criteria fulfill the goal of ensuring that enrollees have access to services, while incorporating flexibility to account for local variation. We recommend that such criteria be developed using the 2011, 2012 and 2013 Medicare Advantage Network Adequacy Criteria as a model. See, e.g., Centers for Medicare & Medicaid Services, 2011 Medicare Advantage Network Adequacy Criteria Development Overview, https://www.cms.gov/MedicareAdvantageApps/Downloads/2011_MA_Network_Adequacy_Criteria_Overview.pdf. In many rural areas of the state, managed care networks do not exist and safety net providers are a main source of health care for the community. The Exchange should develop robust criteria to ensure that enrollees in those regions have access to comprehensive, geographically representative networks of providers, by specialty type.

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	Finally, the goal of developing specific metrics to measure the number of providers in a network is ensuring that enrollees have meaningful access to the health care services they need. Thus, such metrics must account for the range of services actually offered by participating providers to ensure that covered services are actually available, and whether providers are accepting new patients. In addition, as described in greater detail below, the Exchange should require QHPs to contract with essential community providers for the full range of services they offer, rather than only contracting for limited subsets of service. Further, provider- patient ratio calculations must account for whether providers are accepting new patients to ensure that new enrollees have access to the providers they need. Timeliness Access Standards The current proposal would follow current California law, which applies timeliness access standards to HMOs and certain PPOs regulated by DMHC, but not to PPOs and other plans regulated by CDI. See 28 C.C.R. §§ 1300.67.2.2(c)(5), 1300.67.2(c). But these timeliness access standards should apply to all plans in the Exchange. NHeLP and the HCA urge the Exchange to adopt, for all plans, the Department of Managed Health Care's clear timeliness access standards for primary care, mental health, urgent care, specialty care, and ancillary care appointments, found at 28 C.C.R. § 1300.67.2.2(c)(5). In addition, the Exchange should affirm that emergency care must be available to Exchange plan enrollees 24 hours a day, 7 days per week, as required by 28 C.C.R. § 1300.67.2(c). While PPOs regulated by CDI typically include broader networks than DMHC-licensed plans, those broader networks do not guarantee that enrollees can actually access services in a timely fashion; thus, specific standards are needed for all plans. Finally, we suggest that the Exchange monitor wait times as a measure for access problems in QHPs. *Language Access Standards* Existing network adequacy standards in California do not sufficiently account for the capacity of providers to serve limited English proficient (LEP) individuals. Large numbers of LEP individuals will purchase insurance through the Exchange and the Exchange must ensure that linguistically appropriate services are provided by the health plans that are certified for inclusion in the Exchange. Currently, DMHC and CDI regulations implementing SB 853 (Escutia, 2003) require licensed plans to assess the linguistic capacity of enrollees and provide free language assistance service at all points of contact. *See* 28 C.C.R. § 1300.67.04(c) (DMHC); 10 C.C.R. §§ 2538.3 & 2538.6 (CDI). These regulations are a significant step in ensuring access to health care services for LEP individuals, but NHeLP and the HCA urge the Exchange to adopt additional standards to ensure that California's LEP individuals have meaningful access to care, by adopting stronger standards to ensure that enrollees have access to oral interpretation, and by requiring plans to report on bilingual providers.

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	Current standards do not require plans to pay for interpretation services for their contracted providers. The Exchange should require QHPs to arrange in their provider contracts to pay for interpreters directly, even in interactions between provider and patient to ensure the availability of language services and improve compliance by providers who often do not have the resources to evaluate or pay for competent language services. Before the Exchange certifies a plan for participation in the Exchange, the Exchange should require plans to set forth in detail their process for paying for and guaranteeing timely oral interpretation services, both for their own customer service functions and whenever necessary to facilitate communication between enrollees and providers. These language access plan policies should be made available to the public on the Exchange website. Further, the Exchange should ensure that QHP issuers inform potential enrollees of the languages spoken by network providers as a condition of certification. It is critical, however, that any provider or staff member who identifies as speaking another language be competent to do so. The Exchange should require QHPs to assess the language proficiency of its providers, and their staff, who seek to provide services directly in a non-English language. Otherwise, enrollees may suffer ineffective communication that can result in serious medical harm due to a lack of language proficiency, particularly with regards to the specialized medical terminology that someone who is conversationally bilingual will not possess. For example, in a study commissioned by NHeLP examining language barriers and medical malpractice, 32 of 35 claims involving language issues arose from providers failing to use competent interpreters. NHELP, THE HIGH COSTS OF LANGUAGE BARRIERS IN MEDICAL MALPRACTICE (2010), *available at* http://www.healthlaw.org/images/stories/High_Costs_of_Language_Barriers_in_Malpractice.pdf. We recommend the Exchange implement specific competency standards for all those who seek to provide services directly in a non-English language or serve as interpreters and limit those who may list language skills in a provider directory to providers who have established competency. *Disability Access Standards* Finally, existing network adequacy standards in California do not ensure that enrollees with disabilities will have access to appropriate services, or that facilities will be accessible to them. While CDI regulations require that network facilities be “reasonably accessible to the physically handicapped [sic],” what constitutes reasonable accessibility is not delineated. 10 C.C.R. § 2240.1(b)(3). Moreover, by limiting access to those with physical disabilities, the CDI regulations do not account for accommodations that may be needed by people with developmental or mental

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	disabilities. DMHC regulations do not contain any specific requirements on accessibility for enrollees with disabilities. NHeLP and the HCA urge the Exchange to adopt network adequacy criteria that account for the particular needs of persons with disabilities. Such criteria should ensure that, in addition to the usual range of providers and the Essential Community Providers, QHPs are required to offer access to the following providers and services in their networks: interpreters, inpatient and outpatient rehabilitative programs, comprehensive rehabilitative and habilitative services and facilities, applied rehabilitative technology programs, wheelchair seating clinics (including access to wheelchair assessments) independent of durable medical equipment providers, specialty care centers (including those Ryan White Care providers serving people living with HIV), Genetically Handicapped Persons Program certified providers, non-coercive reproductive health services, speech pathologists (including those experienced working with nonverbal individuals, persons with developmental disabilities, and persons who need speech generating devices), occupational therapists, orthotics providers and fabricators, physical therapists, case managers for those with significant non-medical barriers to care, Applied Behavioral Analysis (ABA) therapy, and low vision centers. Finally, the Exchange should require QHPs, and their providers to certify that their facilities and services are accessible to all enrollees, and fully compliant with the Americans with Disabilities Act (ADA) and other state and federal disability and civil rights laws. **Issue 2: Approaches to Evaluating Provider Network Adequacy for QHP Certification** NHeLP and the HCA have concerns about the proposal that the Exchange rely on DMHC and CDI's existing regulatory processes to monitor plans compliance with network adequacy standards. We are concerned that the existing regulatory oversight processes are inadequate to ensure that enrollees truly have access to the providers and services they need. While both regulators evaluate plans' networks with geo-access reports when they are initially licensed, the existing regulatory scheme provides little ongoing review to ensure that plans are meeting network adequacy standards. Rather, plans are generally allowed to self-certify that they meet applicable network adequacy standards without independent verification. The Exchange should work with DMHC and CDI to require QHP issuers to maintain an ongoing monitoring process to ensure that they are meeting network adequacy standards. Existing regulatory oversight of network adequacy standards is too infrequent to identify problems with plan networks. DMHC currently evaluates the access and availability of services, access to emergency services, and language assistance in its licensed plans once every three years through its medical survey process. Cal. Health & Safety Code § 1380(c). Similarly, CDI must examine licensed plans at least once every five years. Cal. Ins. Code § 730(b). CDI is charged with generally evaluating plans compliance with applicable laws in the examination process. Cal. Ins. Code § 733(d). Given the rapid pace at which plans add and

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	drop providers from their networks, a review of network adequacy measured in years is not sufficient to ensure that plans are truly providing access to services. While the existing regulatory review processes will give the Exchange the opportunity to periodically review the adequacy of QHP's networks, the Exchange should monitor compliance more frequently, especially in the first five years of the Exchange, since most problems occur in the early years of a new system. The Exchange should work with DMHC and CDI to require the QHP issuers to establish a written process for monitoring the adequacy of their QHPs' networks at least quarterly; take corrective action if a QHP falls out of compliance; and report the findings of their monitoring and any corrective actions to the Exchange. In addition, the Exchange should require QHP issuers to report any material changes in their QHP provider networks and confidentiality procedures to the Exchange within 30 days. In addition, the Exchange should not only rely on QHP issuers' reporting of compliance with network adequacy standards, but should require independent review to ensure compliance. The existing regulatory review processes are ill-equipped to evaluate whether plans' networks truly comply with network adequacy standards, and largely rely on the plans' own self-assessment of compliance, complaint data, information about grievances and appeals, and enforcement actions to identify problems; plans need not submit geo-access data on their networks again once they are licensed. The data collected in these review processes do not guarantee that DMHC and CDI have a complete picture of plans' compliance with applicable standards. Nor does DMHC or CDI generally attempt to independently verify the information provided by plans. The Exchange should work with DMHC and CDI to take additional steps to hold plans accountable to network adequacy standards. The Exchange, especially in the first five years, should independently assess plans' compliance with network adequacy standards, including by requiring additional geo-access data, and by verifying the number and location of providers, the scope of services they provide, the timeliness of appointments, the availability of appropriate language services, and the accessibility of contracted facilities. Moreover, the Exchange should impose transparency standards to evaluate the primary care capacity of health plan networks in every region by assessing metrics such as ratio of primary care providers to population and other measures of capacity. While we realize that this proposal does add administrative burdens to the Exchange, these additional burdens are justified, especially in the early years of the Exchange, by the need to assure that QHPs are truly providing appropriate access to health care. Finally, any monitoring of QHP networks must be transparent, publicly available, and easy for consumers to understand. While the federal regulations at 45 C.F.R. § 156.220 will establish certain data points that must be made publicly available by QHPs, we urge the Exchange to go further and require that all non-confidential information derived through the monitoring process be broadly disseminated. This data must be accessible online and in written form so

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	that consumers can be made aware of any problems, as well as compare and contrast plan performance. And, like all information provided in connection with the Exchanges, this information should be conveyed in a manner that is easily understood and accessible to people with low literacy, limited English proficiency, and disabilities.
Pacific Business Group on Health (PBGH)	To achieve the Exchange's quality and affordability goals, Exchange enrollees will need access to high quality providers even if outside their current care geography. For example, for high cost procedures like transplants, patients will need access to Centers of Excellence and other providers ("super specialists") that perform high volumes of these procedures and have demonstrated good outcomes. The Exchange should encourage flexibility in the application of Geographic Access Rules set by DMHC and CDI to ensure that patients can access super specialists that will deliver the highest value care. The Exchange should also permit issuers to offer travel support benefits that enable access to these super specialists for high cost procedures.
Pacific Clinics	While there are cultural and linguistic competency requirements in regulations overseen by DMC and CDI, we recommend strengthening these requirements. Given the continuing concern about reaching the underserved and unserved communities and the vast cultural/ethnic shift in CA demographics, more emphasis should be placed on ensuring an adequate number of cultural and linguistic providers are available.

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AIDS Health Consortia	Issue 1. Definition of Essential Community Providers We agree with the staff recommendation that the Exchange adopt a broad definition of Essential Community providers (Option B) and urge that Ryan White providers be explicitly included under this expanded definition. People living with HIV must have access to HIV experienced providers and, where at all possible, maintain continuity of care with their current providers in order to achieve the most optimal health outcomes and reduce HIV transmission risk. Including Ryan White providers in the definition of ECP is an important part of making that happen. Issue 2: Definition of "sufficient" participation of Essential Community Providers: Approximately 30% of people with HIV who are currently uninsured will be purchasing coverage through the Exchange. While this represents a small subset of the total Exchange participants, people with HIV will only achieve optimum health outcomes if they are able to access an experienced HIV provider. In addition, most people with HIV also receive their primary care from their HIV provider, making it even more important that there is adequate capacity in the plans to serve people with HIV to support the ACA's non-discrimination provisions. However, we also recognize the challenge faced by the Exchange board of considering network adequacy through a disease specific lens. We recommend that the Exchange board convene a work group to look at the feasibility and efficacy of creating network adequacy standards focused on conditions that require experienced care provision for optimum health outcomes. Issue 3: Payment rates to Federally Qualified Health Centers: Many people with HIV receive their care in FQHC's; they are extremely important to the adequate care of people with HIV. We know that payment levels need to be addressed fairly and thoughtfully but we look to others who work more closely with the rates to comment on what makes most sense for the inclusion of FQHC's in the qualified health plan networks.
Alameda Health Consortium	**Under Issue 1, "Definition of Essential Community Providers,"** the Alameda Health Consortium recommends the use of the following definition: **"Those groups suggested within the Affordable Care Act, namely those included in section 340B(a)(4) of the Public Health Service Act and in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as well as those entities licensed as either a "community clinic" or "free clinic" by the State under California Health & Safety Code §1204(a)(1) and (2), or is exempt from licensure under Section 1206."** This proposed definition is consistent with the intent of the Affordable Care Act, which seeks to preserve and maximize

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	community health centers' extensive experience with serving low-income uninsured and medically underserved populations. **Under Issue 2, "Definition of 'sufficient' participation of Essential Community Providers,"** the Alameda Health Consortium recommends that "Sufficient" participation be defined to meet, at minimum, current State regulations requiring sufficient providers to population, timely access, adequate language access, and cultural competence. Specifically, we urge the Exchange to require that Qualified Health Plans contract with (1) a sufficient number of Essential Community Providers to meet adequate network coverage for low-income medically underserved populations, and in addition to ensuring that there are enough providers, (2) contract with providers that have demonstrated experience with, and that have historically provided care to the medically underserved populations being covered by the Qualified Health Plan. **Under Issue 3, "Payment rates to Federally Qualified Health Centers,"** the Alameda Health Consortium disagrees with the Exchange staff's recommendation, and instead recommends Option A, to "Require Qualified Health Plans to contract with all FQHCs and mandate payment under terms of section 1902(bb) of the Act- at the PPS rate." The FQHC PPS rate is an integral part of the Medicaid program, allowing providers to receive adequate reimbursement for serving a medically underserved population with poor access to other types of medical practices. The low Medi-Cal reimbursement rates to private physicians have exacerbated the challenges that many people on Medi-Cal face when trying to find a private physician who accepts Medi-Cal. Lastly, the Alameda Health Consortium is advocating for the strongest protections for community health centers in terms of being considered and compensated as "Essential Community Providers" by the Exchange; without adequate protections we are concerned that insurance carriers could refuse to contract with community health centers for financial gain or because of a perception that community health centers could contribute to adverse selection.
AltaMed Health Services	**Issue 1: Definition of Essential Community Providers (ECPs)** AltaMed supports the Exchange's vision, as described on page 30 of the report, of playing an active role in the transformation of California's health care delivery system while being mindful of its impact on and the role in the broader health care delivery system. While we support the Exchange's vision, we are extremely concerned with the recommendations provided in the Report regarding essential community providers. This report can substantially harm us as primary care safety net provider by effectively ensuring our exclusion from the individual market.

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	We urge to please revisit these recommendations and uphold the clear intent of the ACA by ensuring that traditional safety net providers, such as AltaMed, are able to participate in the Exchange. AltaMed strongly believes that a standard as overly-broad as that proposed by the Exchange is not consistent with Section 156.235 of the ACA rules, which require that providers serve "predominately low-income, medically underserved individuals." The 30% Medi-Cal threshold is not consistent with the definition of "predominate". The ACA rules are meant to acknowledge the role that traditional safety net providers such as community clinics and health centers have played for decades, serving a "predominate" number of patients who are low-income and medically underserved. To be a true essential community provider, one must serve all members of a community, regardless of their ability to pay, rather than just the Medi-Cal population, as the Report claims on page 121. **AltaMed strongly recommends that the Exchange define essential community provider as:** **"Those groups suggested within the Affordable Care Act, namely those included in section 340B(a)(4) of the Public Health Service Act and in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as well as those entities licensed as either a "community clinic" or "free clinic" by the State under California Health & Safety Code §1204(a)(1) and (2), or is exempt from licensure under Section 1206."** **Priority/Issue 2: Essential Community Provider Network Sufficiency** AltaMed recommends that the Exchange apply the DMHC standards regarding ration of primary care providers to population, timely access, proficient language access, and cultural competence to the essential community provider network criteria. AltaMed is a safety net provider and serves a high proportion of low-income patients with the most chronic illnesses and greater health risks. The Report states that there are adverse incentives to QHPs contracting with traditional safety net providers like AltaMed. We are extremely apprehensive that insurance carriers will not want to contract with essential community, such as AltaMed, for fear of obtaining a high cost patient base. Creating that overly-broad definition and allowing non-safety net providers to be part of the ECP network, will be detrimental to AltaMed and other safety net providers by leaving ECPs as the last choice for QHP contracts in the Exchange. AltaMed recommends that the Exchange impose transparent standards to evaluate the "sufficient participation" of

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	ECPs in the QHPs. **Priority/Issue 3: Payment Rates to Federally Qualified Health Centers(FQHCs)** AltaMed is alarmed by the fact that the Exchange staff is recommending to the board that QHPs not be required to contract with FQHCs, and that QHPs are not required to pay FQHCs their PPS rate. FQHCs are the backbone of the health care safety net in California and have always provided the highest level of care with limited funding to California's neediest populations. Any reduction of the rate of FQHCs would put health centers at risk of financial failure and endanger the health of all patients we served, especially those who rely upon Medi-Cal for their health care needs. The Exchange not requiring QHPs to contract with FQHCs at their PPS rate will be devastating to AltaMed and the patients we can potentially serve. AltaMed encourages Option D, which will allow the Exchange to assign greater weight to QHP networks that include FQHCs during the evaluation process. AltaMed is also supportive of the "Community Benefit Plan" and encourage the Exchange to designate a Community Benefit Plan in every region, which is the participating health plan with the highest percentage of true ECPs within the network.
American Cancer Society, CA Division	The Exchange should ensure there is a sufficient number and geographic availability of primary care providers. To ensure individuals have continuity of care, improved access and don't have to find new providers, Qualified Health Plans should offer contracts to all Essential Community Providers (ECPs) in the service area on an "any willing provider" basis. Additionally, there is a need to make sure "current regulatory requirements" means there is sufficient access to care for all enrollees, including those in medically underserved areas. The Exchange must ensure the provider network offers "reasonable access to care" for all enrolled through the Exchange, regardless of an enrollee's medical condition, isolated geographic areas, cultural or language needs. More specifically we would like to echo the comments of the California Pan Ethnic Health Network which include:

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	• Review the current recommendation to broaden the definition of essential community providers to ensure that the recommendation does not interrupt care for the uninsured by failing to distinguish between those providers that care for both the uninsured *and* Medi-Cal patients, from the broader community of providers that provide some care to Medi-Cal patients and only emergency care for the uninsured. • State clearly as part of the definition of ECPs that these entities must provide a substantial volume of care to persons who are uninsured (not just to those enrolled in Medi-Cal). We defer to the California Association of Public Hospitals (CAPH) and the California Primary Care Association (CPCA) for an appropriate threshold of care to persons who are uninsured and/or on Medi-Cal. • Require QHPs to contract with ECPs. • Include as part of the definition of ECPs those entities named in section 340B(a)(4) of the Public Health Service Act and in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as well as those entities licensed as either a "community clinic" or "free clinic" by the State under California Health & Safety Code Section 1204 (a) (1) and (2), or are exempt from licensure under Section 1206. Include as part of the list of "qualified clinics" in the ECP definition: Federally Qualified Health Centers, Indian Health Services, tribally-operated programs, urban Indian clinics (I/T/Us), and school-based health centers.
Anthem Blue Cross	Anthem supports the staff's recommendation to define essential community providers (Issue 1) by incorporating the minimum standard as well as broadening the list to include others that have demonstrated service to Medi-Cal, low-income, and medically underserved populations (Option B). Likewise, we support the recommendation for QHPs to demonstrate sufficient participation of essential community providers by demonstrating a minimum proportion of network overlap among the QHP and Medi-Cal managed care, Healthy Families, and/or independent providers serving a high volume of Medi-Cal patients (Issue 2). We believe that this option (B) is more fully representative of the full spectrum of essential community providers as it would be inclusive of many more providers who are practicing in underserved areas and/or seeing exclusively Medicaid and Healthy Families patients. With respect to payment rates for federally qualified health centers (FQHCs) (Issue 3), we support the staff's recommendation for Option C, which would encourage inclusion of FQHCs in QHP networks and require payment at fair compensation by the QHP defined as rates no less than the generally applicable rates of the issuer. This would ensure that FQHCs are paid on par with the other providers in a QHP's network.
Behavioral	Will Community Hospitals be able to refuse treatment of QHP – covered clients of there is another hospital in the

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Health and Recovery Services	same service area that is part of the QHP's issuer? How will emergency services be handled if a community hospital is not part of the QHP network, but the closest treatment location in a true emergency, including disaster emergencies such as a flood or earthquake? Will those be covered and billable?
Blue Shield of California	The ACA requires that QHPs include a "sufficient" number of essential community providers (ECPs) in their Exchange network and identifies a list of potential entities that meet that definition. States are allowed to expand on that definition and to more clearly define "sufficient" participation. Blue Shield of California contracts with a substantial number of the 340B and 1927 providers and facilities identified in the ACA's definition of ECPs. We support the Exchange's recommendation of broadening that definition to also include providers who have traditionally served lower income populations including Medi-Cal and Healthy Families populations. This will allow other QHPs, who may have fewer contracts with such entities, to also meet the ECP requirements. The proposed definition for "sufficient" participation requires QHPs to demonstrate "a minimum proportion of network overlap among QHP and existing Medi-Cal managed care, Healthy Families Program networks and/or independent PCPs serving 30% Medi-Cal patients and specialists serving 20% Medi-Cal patients in their practices." We encourage the Exchange to allow QHPs to demonstrate one of the following to meet the ECP requirement: 1) a minimum overlap between their network and existing Medi-Cal managed care or Healthy Families Program networks, or 2) a minimum overlap between the identified 1927 and 340B facilities listed in the ACA or 3) a minimum number of independent PCPs serving 30% Medi-Cal patients and specialists serving 20% Medi-Cal patients in their practice. As a practical matter, we simply do not know the volume of Medi-Cal patients our providers see in their practice and believe that most providers would find this hard to report. When defining "minimum" overlap the Exchange should consider what is a reasonable percentage for QHPs to meet. For statewide QHPs, we would suggest that the Exchange initially consider this threshold at a statewide level. If the QHP exceeded the threshold requirement at a statewide level for general service areas, it would be presumed to meet the requirement as long as the QHP could demonstrate appropriate access for specialized services. If the QHP fell below that threshold, then it would have the opportunity to prove sufficient access at a county level. In proving sufficient access at a county level, we would suggest the Exchange consider geo-mapping analyses to determine whether an individual has reasonable access to an ECP facility or provider given the prevailing practices in that

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	county. We agree that all QHPs should demonstrate the ability for Exchange enrollees to access providers and facilities that have traditionally served a lower income population, but we strongly recommend that you not set rigid requirements when defining minimum overlap. A rigid definition may prevent the participation of some plans and restrict choice for consumers. We would also suggest that you provide additional flexibility throughout 2013 for any improvements that could be made to the network to meet the ECP requirement. When the ACA is fully implemented, an estimated 1.5 million Californians will be newly eligible for Medi-Cal. This is where the need for traditional and safety net (T&SN) providers will be concentrated. At the same time, an estimated 3.1 million Californians will be eligible for subsidized coverage through the Exchange. It will be crucial to encourage participation from a much broader range of providers to ensure sufficient access and broad choice for Exchange enrollees. Finally, a rigid definition, may be extremely burdensome and costly for plans to meet and for the Exchange to verify. Particularly in rural areas of the State, it could significantly jeopardize the ability of plans such as ours to participate statewide. The adopted definition of "sufficient" must be practical and not undermine the goals of statewide access, choice of carrier and affordability.
California Association of Health Plans	CAHP believes that it is important that any provider contracting with a plan have the ability to perform a minimum set of functions, which include: claims administration and billing, meet plan credentialing requirements, and provide quality reporting. We are concerned with the proposed definition of "sufficient participation" and need to better understand what is being contemplated by the Exchange in this regard. Plans cannot feasibly conduct a survey of their provider network to determine the percentage level of Medi-Cal or HF participation. Additionally, individual QHPs should not be required to determine if a provider qualifies as an ECP. As the recommendation currently stands we believe there are certain areas of the state where it will be impossible for any plan to meet these requirements and we caution against setting standards that are not realistic. In addition, there needs to be a workable and consistent standard to measure ECP participation. We request that the Exchange staff clarify whether the recommendation is for QHPs to demonstrate minimum overlap in low-income

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	areas and a certain number of network providers that serve a specified amount of Medi-Cal patients or will one measurement meet the standards of the Exchange? In order to assure access and affordability it is important we work together to ensure that ECP contracting requirements do not adversely impact the affordability of products in the Exchange.
California Association of Physician Groups	**Essential Community Providers** (pages 124-125): CAPG supports the staff recommendations on Issues 1 and 2 and has submitted joint comments on these issues through a coalition of various health plans and provider organizations (See letter dated August 6, 2012 by Maureen O'Harren) which we incorporate by reference. CAPG further suggests that provider participation as a designated "essential community provider" is qualified on that provider's ability to participate in commonly used claims processing and billing systems, and performance measurement reporting systems. Providers that cannot bill under current claims reimbursement systems cannot adequately function within an insurance-based system such as the Exchange.
California Association of Public Hospitals and Health Systems	Definition of Essential Community Providers The question of how to define "Essential Community Providers" merits some reflection about the purpose behind the policy vis-à-vis the Exchange itself. The Exchange Board has articulated a clear mission for the Exchange to improve the health of ALL Californians. In order to do so, the Exchange must play a leadership role in coordinating and supporting the broader health care delivery system, including providers who will serve those who will remain uninsured under health reform. A meaningful definition of Essential Community Providers can help support these patients and providers. The ACA defined and required the use of Essential Community Providers who serve "predominantly low income, medically underserved individuals." The ACA's requirement that Qualified Health Plans include a sufficient number of ECPs was based on two important policy goals. First, the inclusion of traditional safety net providers in plan networks ensures continuity for low income patients who are uninsured and will become eligible for coverage in the Exchange, as well as for those who may "churn" between Medi-Cal and the Exchange. For both of these populations that currently rely on the safety net providers, they can maintain adequate access to their current provider and continue receiving high quality care. The second and equally important goal of the ECP requirement rests on the acknowledgment that the Exchange represents one piece of a larger health care delivery system – a system that currently includes, and will in the future

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	-- millions of patients who will remain uninsured. Without inclusion and support for providers who will continue to serve a disproportionate numbers of these patients, the Exchange and entire health care delivery system will fail to improve health for all Californians, not just those enrolled in coverage. With this in mind, the definition of an "Essential Community Provider" will have a significant impact on safety net providers' ability to continue serving low-income vulnerable populations that either transition between coverage or remain uninsured. As you know, California has an established history of creating policy structures to support and sustain safety net providers in state programs without compromising access. The Exchange can now build on previous work and establish a definition meaningful definition of an Essential Community Provider. CAPH and our member public hospital systems strongly recommend that the Exchange adopt a "narrow" approach to the definition of ECPs. The proposed recommendation of a broad definition (Option B) would include such a wide array of provides as to render the policy goals behind the ECP definition meaningless. The proposed definition fails to differentiate between providers who would most likely already be included in Exchange provider networks, and those traditional safety net providers who serve high numbers of Medi-Cal and uninsured patients and who currently have minimal, if any, contracts with commercial plans. By allowing for such an extremely broad definition of ECPs, the policy goals described above could go unmet, or even worse, be undermined, by allowing plans to maintain existing contracts without broadening their networks to include true safety net providers. We would also note that any ECP definition must factor in a provider's provision of care to Medi-Cal patients and their care to the uninsured. With more than 2 million additional individuals eligible for Medi-Cal expansion, and the potential for a sharp increase in the overall number Medi-Cal providers drawn in by the increase in primary care provider rates, the number of providers taking some Medi-Cal patients will likely grow. However, few of these providers should be considered "safety net" for policy purposes simply by virtue of seeing some Medi-Cal patients. Conservative projections estimate that 3 to 4 million Californians will remain uninsured after reform is fully implemented. A definition that focuses exclusively on Medi-Cal percentages ignores the important role of providers who see a significant number of uninsured patients, some of which gain coverage through the Exchange and others that will continue to rely on the safety net for services. Though CAPH believes Option B is too broad, conversely, we acknowledge some of the concerns raised by Exchange staff that proposed definition in Option A may exclude some providers. While the definition accurately encompasses the core and traditional safety net providers who serve the vast majority of Medi-Cal and uninsured

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	patients, the Option A definition does not allow for the recognition of other safety net providers who serve a disproportionate number of Medi-Cal and uninsured patients. CAPH respectfully submits an "Option C" for consideration, which we believe casts a sufficiently wide net to ensure continuity of care and access to services, yet also ensures that QHPs contract with traditional safety net providers who provide a significant volume of care to the low-income Medi-Cal and uninsured populations. CAPH's proposed definition captures providers who care for a significant number of Medi-Cal patients under reform and will also continue to serve the remaining uninsured population. Specifically, we recommend the following definition for an Essential Community Provider: **(a) Essential Community Provider ("ECP")** means safety net providers that deliver health services to persons experiencing cultural, linguistic, geographic, financial or other barriers to accessing appropriate, timely, affordable and continuous health care services. The following organizations qualify as an ECP: (i) "qualified hospitals," (ii), "qualified clinics" or (iii) other safety net providers that (x) have a mission or mandate to deliver services to persons who experience barriers to accessing care and (y) provides a "substantial" volume of care to persons who are uninsured or who are enrolled in Medi-Cal. [1] **(b) "Qualified Hospitals"** as set forth in section (ii) above shall include those hospitals designated by the Department of Health Care Services as a disproportionate share hospital, children's hospital or designated public hospital system and its affiliated clinics. **(c) "Qualified Clinics"** as set forth in section (iii) above shall include: • Community Clinic or Health Center**:** Licensed as either a "community clinic" or "free clinic" by the State under California Health & Safety Code §1204(a)(1) and (2), or is exempt from licensure under Section 1206. • FQHC**:** An entity that is recognized as a Federally Qualified Health Center under Section 1861(aa)(4) or 1905(l)(2)(B) of the Social Security Act (42 U.S.C. §§1395x(aa)(4), 1396d(l)(2)(B)). • IHC**:** Indian health clinics are federally designated as 638 Tribal Health Programs and Title

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	V Urban Indian Health Programs. • SBHC**:** A school-based health center as is defined in the Children's Health Insurance Program Reauthorization Act/Social Security Act (2009), Public Law 74-271, Sec 2110(c)(9). **(d) "Substantial[1] "** as set forth in section (a)(iii) above shall mean that no less than 50% of all costs associated with providing care is for Medi-Cal and uninsured patients where a minimum of 10% is comprised of uninsured costs. **(e)** Provider shall self-certify as to meeting this requirement on an annual basis. Such certification is subject to audit by the Exchange on an annual basis, and if it is determined that such provider does not meet the definition of ECP, such provider shall be precluded from meeting the definition of ECP for at least three years following such audit results. CAPH agrees with the Exchange's concept as described on the July 26 webinar to develop separate ECP categories for hospitals and other providers. We have delineated such a distinction in our suggested definition above. If such a distinction is indeed adopted by the Exchange, it is important to recognize that public hospital systems encompass hospitals as well as extensive outpatient primary and specialty care clinics; therefore, hospital systems that have affiliated clinics should be included in both hospital ECP and non-hospital ECP definitions. Definition of "sufficient" participation of Essential Community Providers In addition to creating a definition of Essential Community Providers that will achieve the goals of the Exchange and the policy goal of continuity of care, it is also important to establish criteria to ensure adequate access to ECP's within each Qualified Health Plan network. As such, we agree with the Exchange staff's recommendation to establish a geographic approach and believe this is the best strategy to ensure all regions throughout the state meet sufficient ECP access standards. Specifically, we support the concept described in the proposed recommendation (Option B) to ensure overlap between provider networks in the Exchange, Medi-Cal Managed Care plans, Healthy Families Program networks and other providers that serve a high volume of Medi-Cal and uninsured patients. In order to achieve "sufficient" ECP participation, the Exchange should ensure there are a significant number of

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	participating ECP's contracting with QHP's in each geographic region. To that end, CAPH recommends that the Exchange require a certain threshold for all QHP's in order to ensure that a minimum number of ECP's are included in provider networks. Specifically, we recommend that in each geographic region, 15% of every Qualified Health Plan's provider network be comprised of providers who are employed by or contracted with Essential Community Providers. We also support Option D in the section on payment to FQHC's that would further assist and encourage QHP's to contract with safety net providers. We suggest adding to that recommendation and assign greater weight during the QHP evaluation process to plans that contract with FQHC's or public hospital systems. Establishing this basic threshold will ensure adequate access to ECP's; provide a clear guidance for QHP's; and create a simple format to monitor compliance and improve continuity of care as low- income individuals move from public to private coverage. A recent report by the Centers for Healthcare Strategies on creating seamless transition between Medicaid and the Exchange[2] projects that within the first six months of the Exchange, more than thirty percent of all individuals with family incomes below 200% of the FPL will shift from Medicaid coverage to coverage through state Exchanges. For this population and the large uninsured population that will gain coverage through the Exchange, smooth coverage shifts are essential to ensure continuity of care -- particularly for those with complex health care needs. An essential aspect of achieving this smooth transition is to require QHPs to contract with those safety net providers who currently serve the vast majority of the uninsured and a majority of the Medi-Cal population that will likely transition between programs. CAPH's proposed ECP definition, together with the proposed minimum 15% threshold, will help achieve this continuity and streamlined transition into the Exchange. Moreover, we appreciate the ongoing dialogue that the Exchange has established with the Department of Health Care Services and the mutual recognition of the need to coordinate with DHCS. It is vital that the Exchange develop an overall policy and approach to ensuring continuity of care for all applicable enrollees as they churn between Medi-Cal and the Exchange. We look forward to future discussions about specific strategies, such as contract requirements, that may help facilitate continuity of care, particularly for patients with complex health needs. [1] After full implementation of health care reform, a distinction between low-income and uninsured may need to be revisited and redefined. [2] Carolyn Ingram, Shannon M. McMahon*, and* Veronica Guerra*, MPA, "*Creating Seamless Transitions Between Medicaid and the Exchanges", Center for HealthCare Strategies, April 2012

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California Children's Hospital Association	CCHA agrees with the staff recommendations related to the definition of ECP for the reasons noted in the policy options brief. CCHA does not agree with standardizing minimum out-of-network benefits, which could include the maximum fee that can be charged by a provider for out-of-network claims. CCHA urges consideration of the unintended consequences of capping the fees an out of network hospital can charge. It is absolutely true that, unless capped and except for DMHC products emergency services, a member can be faced with very large balance billing liabilities (the difference between the provider's charge and the health plan's fee schedule). With the significant cost-sharing contemplated, this can be a very significant burden on a sick consumer. However, the proposal to cap a provider's fees at two or three times the Medicare fee schedule is an arbitrary number that may not reflect costs of care and may result in cost-shifting. For example, children's hospitals acuity is more than 2X greater than a community hospital and true costs of care must be recovered. Arbitrary restrictions could impede access and result in significant cost-shifting.. A maximum fee that can be charged by providers for out-of-network claims creates a massive disincentive for health plans to create robust provider networks. CCHA believes that providers should be permitted to negotiate rates to ensure adequate, fair and timely payment policies for all providers and address provider shortages and access issues, particularly for children in need of specialty services. Enrollees are forced to receive care by a provider that may not have the specialized services needed, or bypass other providers more conveniently located in the region that are excluded from the narrow network.
California Coalition for Reproductive Health	**Issue 1. Definition of Essential Community Providers** Given the critical role that essential community providers play in the health and well-being of low-income and medically underserved populations, we urge the Exchange to adopt a definition of essential community provider that includes the full range of potential essential community providers that currently comprise the safety-net of providers who provide health care to low-income and underserved communities. The definition of essential community provider must include safety-net providers who have a demonstrated commitment to providing quality care to underinsured and uninsured clients, including, but not limited to, HIV/AIDS clinics, public hospitals, women's health centers, federally qualified health centers (FQHCs), family planning clinics including Title X-funded reproductive health centers, community health centers, school-based clinics, and tribal health clinics. Given the unique health needs of women, it is especially important that the Exchange require QHPs to contract with Title X clinics, women's health

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	clinics, and other publicly-funded family planning providers for the full range of covered services that they provide. For example, the Exchange should not permit a QHP to exclude the contraceptive services that a women's health clinic offers. In addition, the Exchange should require QHPs to contract with essential community providers that routinely provide preventive health screenings and treatment including FDA-approved contraceptive drugs, devices and supplies consistent with HHS Required Health Plan Guidelines for those services. *See* U.S. Department of Health and Human Services, Health Resources and Services Administration, "Women's Preventive Services: Required Health Plan Coverage Guidelines," *available at* http://www.hrsa.gov/womensguidelines. The Exchange should further require QHPs to contract with essential community providers for the full range of services they offer, rather than only offering access to certain subsets of services. It is further critical that the Exchange prohibit QHPs from excluding a provider on the basis that the provider offers abortion services. In addition, the Exchange should require that QHPs determine whether potential essential community providers have been successful in providing quality health services in medically-underserved communities for low-income populations (particularly those that are experiencing health disparities and poor health outcomes) that meet recognized scientific and medical standards that any provider would be expected to perform under any circumstance. *See generally* NATIONAL HEALTH LAW PROGRAM, HEALTH CARE REFUSALS: UNDERMINING QUALITY CARE FOR WOMEN (2010). The definition of essential community provider should exclude providers that fail to meet quality of care standards adopted by the Exchange. Finally, the definition of essential community provider should include only those providers that offer unbiased, medically accurate, and timely access and/or referrals to, and information about, health care services; the Exchange should not consider providers failing to satisfy these criteria essential community providers. We are very concerned that the staff's recommendation to adopt a "broad definition" of essential community provider will include providers who do not serve predominately underinsured and uninsured clients, contrary to federal law. *See* 45 C.F.R. § 156.235 (defining essential community provider). Not only would a "broad definition" undermine the purpose of requiring that QHPs contract with essential community providers in the first place, which is to provide more efficient and patient-centered care and to promote better continuity and coordination of care, but it is also unnecessary; QHPs are in any event likely to contract with providers that serve predominately private insurance patients and only some Medi-Cal or uninsured patients. Indeed, federal law explicitly requires QHPs to contract with essential community providers to ensure that these providers are not cut out of the health care delivery system after implementation of health reform.

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	Issue 2. Definition of "sufficient" participation of Essential Community Providers We support the goal of defining "sufficient" essential community provider participation, but we encourage the Exchange to adopt more specific criteria than recommended by the Exchange staff. The Exchange should adopt a definition of sufficiency that requires that QHPs not only demonstrate minimum proportion of network overlap among the QHP, Medi-Cal, Health Families networks, and among providers that serve a high volume of Medi-Cal and uninsured patients, as the staff recommends, but also that includes the criteria discussed above with regard to the establishment of network adequacy standards. To ensure access to services, the Exchange should develop criteria to measure the number of essential community providers that account for variation in specialty type and geography. Specifically, we recommend that the Exchange use the criteria discussed above with regard to the establishment of network adequacy standards. *See supra* Section 5E. In addition, the Exchange should set minimum standards to ensure that there are sufficient types of providers or provider networks, including specialists, who actually provide all covered services. A standard that merely counts the numbers and types of providers is not sufficient. Minimum standards should take into consideration the fact that some hospitals and clinics, particularly religiously controlled ones, may not provide all of the covered services, and individual providers may refuse to offer covered services. Further, the Exchange should require that each QHP show significant overlap among the QHP, Medi-Cal, Health Families networks and other safety-net providers serving primarily Medi-Cal and uninsured patients. The failure to require significant overlap creates dangerous potential for coverage disruption (continuity of care) as an individual's Exchange, Basic Health Program, and Medi-Cal eligibility status changes. **Issue 3: Payment rates to Federally Qualified Health Centers** No comments.
California Family Health Council	**Issue 1: Definition of Essential Community Providers** CFHC strongly urges the Exchange Board to reject the proposal to significantly broaden the federal recommended definition of "essential community providers," which was limited to "providers that serve predominantly low-income, medically underserved individuals, including… providers defined in section 340B(a)(4) of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act." The staff recommendation broadens this designation to physicians, clinics and hospitals which have "demonstrated service" to the Medi-Cal, low-income and medically underserved population. The suggested threshold for

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	"demonstrated service" has been set at a patient mix of 30% Medi-Cal for primary care providers and 20% Medi-Cal for specialists. This threshold encompasses approximately 40% of primary care physicians and a quarter of specialists in California, thus diluting the incentive for plans to contract with the traditional safety net providers identified in the federal law, including community clinics and women's health providers. The definition proposed in the Exchange Report is overly-broad and creates the real possibility that these true essential community providers will not be included. Not only would a "broad definition" undermine the purpose of requiring that Qualified Health Plans contract with essential community providers, it is unnecessary. Qualified Health Plans are likely to contract with providers that serve predominately private insurance patients and only some Medi-Cal or uninsured patients. The federal guidance explicitly requires Qualified Health Plans to contract with essential community providers because they do not generally do so. By specifically calling out 340B and 1927 providers, it is clear that Congress intended the essential community provider provision to serve as additional, robust protection for patients' access to specific groups of providers, including family planning clinics which are specifically referenced in both categories: 340B includes Title X Family Planning clinics and Section 1927 mainly captures safety-net family planning clinics that are not Title X grantees. The additional protections for family planning clinics in the essential community provider provisions were part of Congress' repeated efforts to ensure and protect women's access to primary and preventive care. This concern was warranted, as we have seen in Massachusetts that the expansion of health insurance coverage without putting meaningful access protections in place has resulted in a shortage of primary care providers, especially those that focus on women's health care. A study published this year by Ibis Reproductive Health and the Massachusetts Department of Public Health found that while the expansion of coverage in Massachusetts has had an overall positive impact on women's health care access, barriers to family planning providers remain problematic, with women having difficulty navigating the prescription system, being inappropriately denied or overcharged for prescriptions and other burdens like only receiving coverage for a 1-month supply of pills at a time or distance to pharmacies, especially in rural areas. Given the unique health needs of women, it is essential that the Exchange require Qualified Health Plans to contract with Title X funded health centers, women's health clinics and other publicly-funded family planning providers for the full range of covered services that they provide. The definition of essential community providers must also be restricted to those that have demonstrated commitment to providing quality care to a patient population that is largely underinsured and uninsured. CFHC urges the Exchange to define an essential community provider as " Those groups suggested within the Affordable Care Act,

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	namely those included in section 340B(a)(4) of the Public Health Service Act, Section 1927 (c)(1)(D)(i)(IV) of the Social Security Act and entities licensed as either a "community clinic" or "free clinic" by the State under California Health & Safety Code Section 1204 (a)(1) and (2), or is exempt from licensure under Section 1206." **Issue 2: Definition of "Sufficient Participation" of Essential Community Providers** The Exchange should impose transparent standards to evaluate the "sufficient participation" of essential community providers in health plan networks in every California service region. A "sufficient" network is one where services are readily accessible to medically underserved and low income individuals. These standards must ensure not only a sufficient number of providers, but also that the providers have the capacity to serve patients with all covered services and take new patients. As mentioned above, due to the unique health care needs of women, any sufficiency standard chosen must include family planning clinics and women's health providers in all Qualified Health Plan provider networks. CFHC also suggests that the Exchange utilize the Department of Managed Health Care standards regarding ratio of primary care providers to population, timely access, adequate language access and cultural competence. Without meaningful metrics by which to measure "sufficient participation," low income and medically underserved populations are at risk of remaining underserved and true essential community providers may not have the opportunity to meaningfully participate in the Exchange.
California Hospital Association	For issue 1 under this section – definition of Essential Community Providers – ***CHA recommends Option B which would include providers that have demonstrated service to the Medi-Cal, low-income and medically underserved population.*** Hospitals that have been providing medically necessary services to this population must be included in networks to ensure there are an adequate number of providers and to assure patients that they can rely on continuity of care from their choice of providers. ***A limited definition of Essential Community Provider fails to recognize the tens of thousands of patient days and visits at hospitals that currently are serving this population.*** It is important for the Exchange to recognize high-volume providers of services to low income patients in addition to high proportion providers. ACA defines hospital essential community providers as those that are "340B" hospitals or certain facilities that have a disproportionate-share hospital (DSH) adjustment of a certain level. In addition, Critical Access Hospitals, Rural

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	Referral Centers and Sole Community Hospitals are considered essential community providers even if the DSH adjustment is lower than the threshold. **CHA has identified two critical flaws in this approach that defines an essential community provider.** Based on this limited definition, many DSH hospitals in California would not be considered essential community providers because they do not hold nonprofit status. These hospitals provide a significant amount of services to the low-income, vulnerable population that will be seeking health insurance coverage through the Exchange. Excluding these important hospitals from mandatory inclusion in QHP networks is likely to disrupt the continuity of and access to health care services they have received through their longtime community providers. The definition of essential community provider must be clarified to include all types of hospitals that make up the existing safety net for the uninsured. Basing the definition of essential community provider solely on the percentage of low-income patients they treat fails to recognize that larger facilities may in fact provide substantially greater volumes of services to the target population (often for more complex, costly services), and thereby incur substantially more economic losses. Another flaw in the definition is the failure to capture the broader societal benefits received from academic medical centers and teaching hospitals. Academic medical centers and teaching hospitals provide a comprehensive scope of vital medical services at the tertiary- and quaternary-care levels. In California, academic medical centers also are essential community providers, serving as the safety net hospital to individuals in their communities. As such, in addition to the societal benefits related to their teaching and research activities, these hospitals provide comprehensive medically necessary services to the communities they serve. Many of them serve the patients today that will be seeking health care coverage through the Exchange. QHPs may exclude academic medical centers from provider networks in an attempt to lower costs. While lower premiums may be offered for QHPs with narrow networks that exclude academic medical centers, we believe this creates a dangerous precedent. First, if QHPs are permitted to develop networks that exclude academic medical centers because of their cost, citizens for whom academic medical centers are their community hospital will be treated inequitably solely because of where they live. As a result they will have to pay higher out-of-pocket costs or, worse, will be prevented from accessing their physician and their community hospital. Such policy places little to no value on the benefits created by academic medical centers and teaching hospitals (economic, societal, health care consumers, etc.). Doing so ignores the vital role that academic medical centers, through their teaching mission, play in solving the severe shortages of physicians, nurses, pharmacists and other

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	health care personnel. These severe personnel shortages are a major driver of health care cost increases which ACA is intended to address. Such policy also would ignore the substantial benefits that academic medical centers, through their research mission, contribute to both improving quality and lowering the cost of health care. The medical, scientific and care delivery innovations created in academic medical centers have driven enormous cost savings, such as the shift from inpatient to outpatient care, minimally invasive surgery, medical treatments, medications and other interventions that have eliminated the need for hospitalization and reduced the length of stay dramatically over the past decades. Preservation of the capacity for discovery will be essential to the quality and cost-containment goals of ACA. Provider networks will be at risk for "network adverse selection." Under this scenario, consumers may choose a lower-cost network when they are healthy, only to seek out and adversely select a comprehensive network that includes an academic medical center when they are struggling with a serious illness or disease. Network adverse selection would drive up premiums for networks with academic medical centers. **We recommend that the Exchange broaden the essential community provider definition to include all hospitals that have demonstrated service to the Medi-Cal, low-income, and medically underserved population, regardless of their tax status, and the Exchange must include academic medical centers in the definition of essential community providers.** The Exchange should monitor networks to ensure Essential Community Providers are sufficiently participating in networks of care. One such measure should include a gap analysis of utilization of this population pre and post-operation of the Exchange. ***Hospitals that have been providing care to this population must continue to be a choice for patients once they obtain coverage through the Exchange.***
California Medical Association	***Issue 1. Definition of Essential Community Providers*** We support the Exchange's staff recommendation, Option B, defining Essential Community Provider (ECP) more broadly to include physicians, clinics and hospitals which have demonstrated service to the Medi-Cal, low-income, and medically underserved population. Many providers in California who are not 340B or 1927(c) providers have made a significant investment in serving predominately low-income, medically underserved individuals and the state's public programs, such as Medi-Cal, AIM and Healthy Families, and these underserved populations have come to rely on these providers. Thus, adopting the

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	broader ECP definition will be critical to maintaining continuity of care for a significant portion of the Exchange's projected enrollee population, as data suggests that as much as 89 percent of safety-net primary care visits are handled by private physician practices.[1] Such physician offices are the point of care for a number of the hard-to-reach patient populations that the Exchange will be targeting, such as uninsured parents of insured children, expecting mothers who may be transitioning off of public insurance, and patients in a temporary or transitional employment situation. Allowing private physician offices with a history of serving these populations will encourage their inclusion in QHP networks. Relying solely on a network of current 340B and 1927(c) providers in any given underserved area will not ensure access for this population, as many of these providers are at or nearing capacity. Furthermore, if the Exchange intends to move forward without providing for any verification of the provider directories submitted by issuers, then such a narrow definition would compound an already serious problem. There are also broad regions of the state where community clinics and health centers are sparse or nonexistent, despite many of those regions having 45 percent or more of the population below 200 percent of the federal poverty level.[2] A narrow ECP definition could endanger the continuity of care for those populations in those areas. Excluding a private physician practice seeing these underserved patients could force QHP enrollees in these areas to travel many miles away to a county agency or community clinic or other 340B or 1927(c) provider for care.
California Pan-Ethnic Health Network (CPEHN)	In California communities of color make up over 70% of the client population that relies on the safety net (public hospitals, community health centers, and government clinics) for their usual source of care. These institutions are at the forefront of providing cultural and linguistic services and have worked hard to win the trust of their diverse patient base. The ACA requires QHPs to provide, "a sufficient number of essential community providers, where available, that serve predominately low-income, medically-underserved individuals." We are concerned by Exchange staff's

[1] Forrest, C.B. & Whelan, E. (2000). *Primary Care Safety-Net Delivery Sites in the United States – A Comparison of Community Health Centers, Hospital Outpatient Departments and Physicians' Offices*. Journal of the American Medical Association 284 (16). 2077-2083.
[2] National Association of Community Health Centers. *California Health Center Overview Map* (Current as of Summer 2011). http://www.nachc.org/client/documents/research/maps/CA2011.pdf.

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	recommendations to substantially broaden the definition of Essential Community Providers (ECPs) beyond the federally proposed definition as they seem to be blurring the distinction between 1) those ECPs who provide care to Medi-Cal recipients and a substantial volume of care to the uninsured, from 2) those who provide some care to Medi-Cal patients and only emergency care for the uninsured. In California approximately 1 million low-income individuals will not be eligible for Medi-Cal or the Exchange due to their immigration status. The ACA requirement that QHPs contract with ECPs is vital to ensuring that the uninsured can continue to see the providers they have seen before. Because county hospitals, county clinics and community clinics are the most prevalent sources of care for the low-income and uninsured, this requirement is vital to ensuring there is adequate funding to protect and strengthen our underfunded and overstretched safety net thus enabling low-income Californians to secure a medical home and access to the primary and preventive services they need. CPEHN urges Exchange staff to: • Review the current recommendation to broaden the definition of essential community providers to ensure that the recommendation does not interrupt care for the uninsured by failing to distinguish between those providers that care for both the uninsured *and* Medi-Cal patients, from the broader community of providers that provide some care to Medi-Cal patients and only emergency care for the uninsured. • State clearly as part of the definition of ECPs that these entities must provide a substantial volume of care to persons who are uninsured (not just to those enrolled in Medi-Cal). We defer to the California Association of Public Hospitals (CAPH) and the California Primary Care Association (CPCA) for an appropriate threshold of care for the uninsured. • Require QHPs to contract with ECPs. • Include as part of the definition of ECPs those entities licensed as either a “community clinic” or “free clinic” by the State under California Health & Safety Code Section 1204 (a) (1) and (2), or are exempt from licensure under Section 1206. • Include as part of the list of “qualified clinics” in the ECP definition: Federally Qualified Health Centers, Indian Health Services, tribally-operated programs, urban Indian clinics (I/T/Us), and school-based health centers.
California Primary Care Association	***Issue 1: Definition of Essential Community Providers*** CPCA supports the Exchange’s vision, as described on page 30 of this report, of playing an active role in the transformation of California’s health care delivery system while being mindful of the its impact on and role in the

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	broader health care delivery system. With this goal in mind, CPCA cautions the Exchange that the essential community provider recommendations contained in this report have the potential to cause substantial harm to the traditional primary care safety net by effectively ensuring their exclusion from the individual market. On behalf of California's 1,104 community clinics and health centers, which work tirelessly to offer quality primary care to any Californian, insured or uninsured, we request that you revisit these recommendations and uphold the clear intent of the ACA by ensuring that traditional safety-net providers, such as CCHCs, are able to meaningfully participate in the Exchange. The Exchange proposes to significantly broaden the federally recommended definition of "essential community providers," which was limited to "providers that serve predominately low-income, medically underserved individuals, including…providers defined in section 340B(a)(4) of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act." The report recommends that the "essential community providers" designation be broadened to include physicians, clinics, and hospitals which have "demonstrated service" to the Medi-Cal, low-income, and medically underserved population, and suggested that "demonstrated service" be defined as a patient mix of 30% Medi-Cal for primary care providers, and 20% Medi-Cal for specialists. The Report notes that approximately 40% of primary care physicians and a quarter of specialists in California meet this threshold, thereby meeting the proposed definition of essential community provider as recommended. CPCA strongly believes that a standard as overly-broad as that proposed by the Exchange is not consistent with Section 156.235 of the ACA rules, which require that providers serve "predominately low-income, medically underserved individuals." The 30% Medi-Cal threshold is not consistent with the definition of "predominate" as "most frequent or common." The ACA rules are meant to acknowledge the role that traditional safety net providers such as community clinics and health centers have played for decades, serving a "predominate" number of patients who are low-income and medically underserved. In California, CCHCs have been the main source of care for Medi-Cal beneficiaries, serving over 60% of California's Medi-Cal population, while also serving large segments of the uninsured. On average, the uninsured population alone comprises 30% of a CCHCs patient mix. To be a true essential community provider, one must serve all members of a community, regardless of their ability to pay, rather than just the Medi-Cal population, as the Report claims on page 121. The definition proposed in this Report is overly-broad and creates the real possibility that these *true* essential community providers will not be included. Moreover, the proposed standard does not even meet the Exchange's own guidelines for plan design priorities. On page 32, the Report states that the Exchange must evaluate options for plan

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	design, provider network, and access standards based upon several considerations, including creating policies that lead to "effective inclusion of safety net community health centers." This proposal to expand the definition of essential community providers, combined with lenient ECP network adequacy standards, creates the real danger of provider networks throughout the state which do not include those very safety net community health centers that the Exchange has committed to include. Successful implementation of the ACA requires transformation in how we deliver care for both the newly insured and the remaining uninsured. It's estimated that more than 1.5 million Californians, many of them immigrants who are specifically excluded from participating in the benefits of health care reform, will remain uninsured after full implementation. The continued viability of community clinics and health centers is vital to maintaining a safety-net provider network capable of delivering care to all Californians, regardless of insurance status. In order to ensure that true essential community providers are able to take part in the Exchange, **CPCA recommends that the Exchange define essential community provider as:** **"Those groups suggested within the Affordable Care Act, namely those included in section 340B(a)(4) of the Public Health Service Act and in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as well as those entities licensed as either a "community clinic" or "free clinic" by the State under California Health & Safety Code §1204(a)(1) and (2), or is exempt from licensure under Section 1206."** ***Priority 2: Essential Community Provider Network Sufficiency*** In this report, the Exchange proposes to measure the "sufficient participation" of essential community providers by showing some amount of overlap between a qualified health plan's provider network and Medi-Cal Managed Care or Healthy Families networks, or independent physicians serving a high volume of Medi-Cal patients. The Report does not specify what a "minimum proportion of network overlap" might be, which makes it impossible to provide direct feedback on the sufficiency of this requirement. We strongly encourage the Exchange to establish what constitutes "network overlap" before soliciting feedback on the sufficiency of this recommendation. Regardless of the actual standard of "minimum proportion of network overlap," CPCA is concerned that no aspect of this "sufficient participation" standard takes into account the need to ensure that services are available to low income, medically underserved populations outside of the Medi-Cal population. Moreover, no part of this "sufficient

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	participation" guideline requires or even encourages the inclusion of the 340B or Section 1927 essential community providers as defined by the federal standards, since under this standard a QHP may meet ECP requirements through contracting with private physician practices, many of whom see a majority of insured patients and already hold contracts with commercial plans. The Report itself admits that there are adverse incentives to QHPs contracting with traditional safety net providers such as CCHCs. As noted on page 78, health plans often use strategic plan design to attract or deter consumers with certain healthcare needs. CCHCs and other true safety-net providers traditionally serve a high proportion of low-income patients with more chronic illness and greater health risks. CPCA is concerned that issuers may resist contracting with true essential community providers, such as CCHCs, for fear of acquiring a high cost patient base. The ECP requirements as laid out in the ACA and federal regulations are meant to mitigate this disincentive to contract with CCHCs, Ryan White clinics, and other safety net providers who care for the nation's sickest patients. By creating an overly-broad definition and allowing non-safety-net providers to make up the ECP network, the Exchange is leaving the real possibility that true ECPs are the last choice for QHP contracts in the Exchange. CPCA does not dispute the importance of recognizing the value of those providers who have seen Medi-Cal patients despite historically low reimbursement rates. However, the ECP guidelines within the ACA were not created to recognize the value of Medi-Cal providers. The ECP guidelines were created to ensure the meaningful participation of essential community providers, those who are truly embedded within the community and those who see all members of the community regardless of their ability to pay. In broadening the definition of ECPs and creating a standard that simply requires a "minimum proportion" of Medi-Cal providers to meet the ECP inclusion threshold, the Exchange would be thwarting the intent of the ACA and doing irreparable damage to those providers who truly serve *all* the underserved. Because the recommendation in the Report is too vague to effectively evaluate, **CPCA recommends that the Exchange apply DMHC standards regarding ratio of primary care providers to population, timely access, adequate language access, and cultural competence to the essential community provider network (Option A). Should the Exchange develop a standard for "minimum proportion of network overlap" that is effective in encouraging the participation of community clinics and health centers in Qualified Health Plan provider networks, CPCA encourages the Exchange to *also* ensure that there is a minimum proportion of network overlap between a QHP network and Medi-Cal and Healthy Families networks (Options A & B together).**

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	Without meaningful metrics by which to measure "sufficient participation" and strict standards for inclusion of true essential community providers, low income, medically underserved populations are at risk to continue being underserved, and community clinics and health centers may not have the opportunity to meaningfully participate in the Exchange. ***Priority 3: Payment Rates to Federally Qualified Health Centers*** CPCA is concerned that the Exchange staff are recommending to the board that QHPs not be required to contract with FQHCs, and that QHPs are not required to pay FQHCs their PPS rate. PPS reimbursement provides for comprehensive, bundled, patient-centered services, which include dental, mental health, pharmacy, primary care, immunizations, chronic care management, care-coordination, interpreters, and much more, thereby keeping patients out of the emergency room and preventing hospitalization. This comprehensive set of bundled, patient-centered services also result in better outcomes for patients, keeps cost down and prevents hospitalization – all goals consistent with ACA. Research by the Journal of Ambulatory Care Management has found that patients who receive the majority of their care at health centers have significantly lower annual costs than non-health center patients (Patrick Richard et al, "Cost Savings Association With the Use of Community Health Centers," The Journal of Ambulatory Care Management, 35: (January/March 2012): 50-59). In this study, health centers were associated with annual savings of 18% in ambulatory and hospital inpatient expenditures as well as 25% savings in emergency costs. Through the bundled PPS payment system, health centers have pioneered the high quality, cost-effective service delivery model that the rest of the health care system is now trying to emulate. By not requiring PPS payment, the Exchange is undervaluing the quality, comprehensive care that is the hallmark of the FQHC and the savings that this will provide to health care costs and the improved health outcomes for patients. In recognition of the value of the community clinics and health centers and the cost-effective preventive services they provide to both Medi-Cal and uninsured, sliding-fee patients, **CPCA encourages the Board to adopt Option A. However, should the Exchange choose to not exercise option A, CPCA hopes that at the very least the Board will adopt Option D**, which will allow the Exchange to assign greater weight to QHP networks that include in-network FQHCs during the QHP evaluation process. CPCA hopes that this no-cost incentive will encourage QHPs to offer quality FQHC services to their beneficiaries.

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	In much the same vein as the adoption of "Option D," above, CPCA hopes that the Exchange Board will consider further prioritizing the inclusion of CCHCs and their comprehensive, high quality services through the creation of a "community benefit plan" based upon the success of the Healthy Families "Community Provider Plan." Please see Section 5C: Plan Design Standardization for a description of the community benefit plan.
California School Health Centers Association	ESSENTIAL COMMUNITY PROVIDERS While we support a definition for ECPs that expands on that of the federal government, we do have concerns that an overly broad definition may not adequately support safety net providers who serve the uninsured. For example, unlike most private pediatricians who accept Medi-Cal, school-based health centers do not turn away any uninsured students. They are a true safety net and the only place some children can receive primary care. While we recognize that it is not the sole responsibility of the Exchange to provide for a safety net for the residually uninsured, we believe Exchange policies can help preserve this infrastructure by ensuring that these providers have a mix of insured and insured patients. ***We recommend that the Exchange expand upon the federal definition of ECPs, but require that any ECP is a true safety-net provider serving the uninsured.*** It should be noted that school-based health centers operate under the auspices of various sponsors. For example, school-based health centers may be run by federally qualified health centers, hospitals or school districts. School district-run school-based health centers are not 1204a clinics but form a very important part of the safety net. While not all school district-run clinics will have the capacity to contract with QHPs, some will. For example, Los Angeles Unified School District already has contracts in place with Health Net and LA Care. ***Given the variety in school health centers, we ask that the Exchange explicitly include all school-based health centers in the ECP definition or supplement inclusion of 1204a clinics with inclusion of school district-run clinics.*** FEDERALLY QUALIFIED HEALTH CENTER PAYMENT RATES We are concerned with the recommendations regarding payment rates to Federally Qualified Health Centers. We believe that PPS reimbursement to FQHCs is the optimal payment option, and it is this rate that enables FQHC sponsored school-based health centers to provide services to the uninsured population. PPS payment provides for comprehensive, bundled, patient-centered services, which include dental, mental health, pharmacy, primary care, immunizations, chronic care management, care-coordination, interpreters, and much more, thereby keeping patients out of the emergency room and preventing hospitalization. If the Board opts to allow contracting with FQHCs at their non-negotiated PPS rates, ***we urge the Board to adopt Option D, which will allow the Exchange to assign***

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	greater weight to QHP networks that include in-network FQHCs during the QHP evaluation.
Central Valley Health Network	**Central Valley Health Network, CVHN,** **Priority 1: Essential Community Provider Definition** The Exchange proposes to significantly broaden the federally recommended definition of "essential community providers," which is limited to "providers that serve predominately low-income, medically underserved individuals, including providers defined in section 340B(a)(4) of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act." The report recommends that the "essential community providers" designation be broaden to include physicians, clinics and hospitals which have "demonstrated service" to the Medi-Cal, low-income and medically underserved population and suggested that "demonstrated service" be defined as a patient mix of 30% Medi-Cal for primary care providers and 20% Medi-Cal for specialists. The Report notes that approximately 40% of primary care physicians and a quarter of specialists in California meet his threshold, thereby meeting the proposed definition of essential community provider as recommended. A standard as overly-broad as that proposed by the Exchange is not consistent with Section 156.235 of the ACA rules, which requires providers to serve "predominately low-income, medically underserved individuals." The 30% Med-Cal threshold is not consistent with the definition of "predominate" as "most frequent or common," implying the regulations warrant a threshold that goes beyond the 30% Med-Cal proposed by the Exchange. The ACA rules are meant to acknowledge the role that traditional safety net providers such as community health centers have played for decades, serving a "predominate" number of patients who are low-income and medically underserved. Community Health Centers have for decades consistently served the greatest number of patients who are "predominately" low-income and medically underserved. CVHN members see close to 80% Medi-Cal and uninsured patients. CVHN member health centers, along with other community health centers in California, served over 60% of California's Medi-Cal populations in addition to a long standing commitment to serve the uninsured that other providers have turned away. To be a true essential community provider, one must serve all members of a community, regardless of the ability to pay. For this reason, CVHN recommends that the Exchange define essential community provider as : "Those groups suggested with the Affordable Care Act, namely those included in section 340 B(a)(4) for the Public Health Service Act and in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as well as those entities licensed as wither a "community clinic" or "free clinic" by the State under California Health & Safety Code §1204(a)(1) and (2), or is exempt from licensure under Section 1206."

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	Priority 2: Essential Community Provider Network Sufficiency In this report, the Exchange proposes to measure the "sufficient participation," of essential community providers by showing some amount of overlap between a qualified health plan's essential community provider network and Medi-Cal Managed Care or Healthy Families networks, or independent physicians serving a high volume of Medi-Cal patients. The Report does not specify what a "minimum proportion of network overlap" might be, which makes it impossible to provide direct feedback on how this recommendation would impact CVHN's member health centers. We strongly encourage the Exchange to establish what constitutes "network overlap" before soliciting feedback on the sufficiency of this recommendation. Regardless of the actual standard of "minimum proportion of network overlap," CVHN is concerned the "sufficient participation" standard does not take into account the need to ensure that services are available to low income, medically underserved populations outside of the Medi-Cal population. Moreover, no part of this "sufficient participation" guideline requires or even encourages the inclusion of CVHN members, since under this standard, a Qualified Health Plan may meet essential community provider network requirements through contracting with private physician practices, many of whom see a majority of insured patients and already hold contracts with commercial plans. Because the recommendation in the report is too vague to effectively evaluate, CVHN recommends that the Exchange apply DMHC standards regarding ratio of primary care providers to population, timely access, adequate language access, and cultural competence to the essential community provider network (Option A). Should the Exchange develop a standard for "minimum proportion of network overlap" that is effective in encouraging the participation of community clinics and health centers in Qualified Health Plan provider networks, CVHN would encourage the Exchange to *also* ensure that there is a minimum proportion of network overlap between a Qualified Health Plan network and Medi-Cal and Healthy Families networks (Options A and B together). Without meaningful metrics by which to measure "sufficient participation" and strict standards for inclusion of true essential community providers, low income, medically underserved populations are at risk to continue being underserved, and community clinics and health centers may not have the opportunity to participate in the Exchange. **Priority 3: Payment Rates to Federally Qualified Health Centers** CVHN is concerned that the Exchange staff is recommending to the Board that Qualified Health Plans not be required to contract with FQHCs, and Qualified Health Plans are not required to pay FQHCs their PPS rate. CVHN member

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	health centers' PPS rate provides for comprehensive, bundled, patient-centered services. This comprehensive set of bundled, patient-centered services also result in better outcomes for patients, keeps cost down and prevents hospitalization- all goals consistent with ACA. Through the bundled PPS payment system, health centers have pioneered the high quality, cost effective service delivery model that the rest of the health care system is now trying to emulate. By not requiring PPS payment, the Exchange is undervaluing the quality and comprehensive care that is the hallmark of the FQHCs, the savings that this will provide to health care costs and the improved health outcomes for patients. In recognition of the value of community health centers and the cost-effective preventive services they provide to both Medi-Cal and uninsured, sliding-fee patients, CVHN encourages the Board to adopt Option A (Required Qualified Health Plans to contract with all FQHCs and mandate PPS payment). However, should the Exchange not exercise Option A, CVHN hopes, the Board will adopt Option D, which will allow the Exchange to assign greater weight to Qualified Health Plan networks that include in-network FQHCs during the Qualified Health Plan evaluation process. CVHN hopes that this no-cost incentive will encourage Qualified Health Plans to offer quality FQHC services to their beneficiaries. **Priority 4: Creation of a "Community Benefit Plan"** CVHN hopes that the Exchange Board will consider further prioritizing the inclusion of community health centers and their comprehensive, high quality services through the creation of a "community benefit plan." This plan is similar to the Community Provider Plan model successfully utilized in the Healthy Families program. The success of this model is based upon the ability to bring health care to low-income, underserved populations through the incentive of discounted premiums, and the partnership between providers and health plans that translate into greater quality of care for hard to reach populations. With the goal of ensuring safety-net provider participation and bringing critical populations into coverage, CVHN encourages the Board to designate a Community Benefit Plan in every region, which is the participating health plan with the highest percentage of true essential community providers within its network. Subscribers selecting the Community Benefit Plan should be given a premium discount, have lower out-of-pocket maximums or otherwise be incentivized to select the plan.
Cigna	***Issue 1: Definition of Essential Community Providers*** Cigna supports a broad definition and support the staff's recommendation.

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	With reference to 340B hospitals, we would expect that issuers would not be charged the full amount on outpatient medications that such hospitals receive at discount, whether the hospital is network or non-network. ***Issue 2: Definition of "Sufficient" Participation of Essential Community Providers*** We support this being included in the existing network adequacy standards. ***Issue 3: Payment Rates to Federally Qualified Health Centers*** ACA requires any item or services covered by a QHP that is provided by a Federally-qualified health center to an enrollee of the plan, the issuer must pay to the center an amount that is not less than the amount of payment that would have been paid to the center otherwise. Clarification should be made if the CA HIX staff are expecting FQHCs to have a different payment rate than what is provided for in Section 1302 of ACA.
Community Clinic Association of Los Angeles County	***Issue 1: Definition of Essential Community Providers*** ***CCALAC urges the Board to adopt Option A, the "narrow option," to include only 340(b) and Section 1927 (Public Health Service Act) providers.*** To ensure that California's diverse and medically underserved populations are receiving the high- quality, culturally competent support they need to obtain, use, and retain health coverage, LA County's community clinics and health centers are committed to serve as active partners under the state's health reform efforts. However, the Board's consideration of options regarding the definition of Essential Community Provider, as outlined in the QHP Recommendations, has the potential to not only cause substantial harm to what has been traditionally defined as the "primary care safety net" but also discourage meaningful participation by clinics in the Exchange. The Exchange proposes to significantly broaden the federally recommended definition of "Essential Community Providers," which was limited to "providers that serve predominately low-income, medically underserved individuals, including…providers defined in section 340B(a)(4) of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act." Exchange staff recommends that the "Essential Community Providers" designation be broadened to include physicians, clinics, and hospitals that have "demonstrated service" to the Medi-Cal, low-income, and medically underserved population, and has suggested that "demonstrated service" be defined as a patient mix of 30 percent of Medi-Cal beneficiaries for primary care providers, and 20 percent Medi-Cal for specialists.

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	The Board is urged to consider the following statements that support the adoption of Option A: • **Providers that have a "demonstrated service" to certain percentages of Medi-Cal beneficiaries do not necessarily imply that they are true, traditional safety net providers.** The federally recommended definition of Essential Community Providers is limited to "providers that serve predominately low-income, medically underserved individuals, including… providers defined in section 340B(a)(4) of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act." While indeed some physicians, clinics, and hospitals serve large percentages of Medi-Cal beneficiaries, it does not mean that these providers are accustomed to seeing *all* underserved (what the federal definition seeks). In fact, these providers remain unaccustomed to serving the uninsured. A provider's waiting room consisting of large numbers of uninsured patients in addition to Medi-Cal beneficiaries is a vastly different care experience compared to a waiting room of "predominately" Medi-Cal beneficiaries and others with private insurance. True safety net providers are Federally Qualified Health Centers, Rural Health Centers, Indian or Tribal Clinics, non- profit community or free clinic licensees, and clinics affiliated with Disproportionate Share Hospitals. They provide primary care services to not only Medi-Cal beneficiaries but also the uninsured and those covered under other public programs. By broadening the federally recommended definition of Essential Community Providers, the Exchange would effectively include physicians, private clinics and hospitals as safety net providers even when some may be for-profit operations and, unlike existing safety net providers, are not required to serve uninsured patients. To be a true Essential Community Provider, a provider must serve all members of its community, regardless of patients' ability to pay or insurance status, rather than just the Medi-Cal population, as the QHP Recommendations claim on page 121. • **It is the overall mission, not the patient encounter data, that distinguishes a safety net provider.** Clinics offer high-quality, comprehensive primary care to *any* person regardless of ability to pay or insurance status. By adopting an overly-broad definition of Essential Community Providers, the Exchange Board would implement inappropriate criteria to dilute the qualifications of an Essential Community Provider and allow private providers to enjoy the safety net designation without the accompanying mission and obligation to also serve the uninsured. **An overly-broad definition may systematically exclude traditional and true Essential Community Providers from the Exchange**. The definition proposed by Option B in the QHP Recommendations is overly-broad and creates the real possibility that *true* Essential Community Providers, such as community clinics and

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	health centers, will not be included. Moreover, the proposed standard does not even meet the Exchange's own guidelines for plan design priorities. On page 32, the QHP Recommendations outline that the Exchange must evaluate options for plan design, provider network, and access standards based upon several considerations, including creating policies that lead to "effective inclusion of safety net community health centers." This proposal to expand the definition of Essential Community Providers, combined with lenient network adequacy standards, creates the real danger of provider networks throughout the state which do not include those very safety net community clinics and health centers that the Exchange has committed to include. **Therefore, CCALAC recommends that the Board define Essential Community Providers as "those groups suggested within the Affordable Care Act, namely those included in section 340B(a)(4) of the Public Health Service Act and in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as well as those entities licensed as either a "community clinic" or "free clinic" by the State under California Health & Safety Code §1204(a)(1) and (2), or is exempt from licensure under Section 1206."** ***Issue 2: Definition of " sufficient" participation of Essential Community Provider s CCALAC urges the Board to apply Department of Managed Health Care (DMHC) adequacy standards regarding ratio of primary care providers to population, timely access, adequate language access, and cultural competence to the Essential Community Provider network.*** Community clinics and health centers are crucial network participants for QHPs because they provide cost-effective and cost-efficient primary care, preventive health care, and enabling services to a predominantly low-income population, and they embody principles of patient-centered primary care that Congress sought to propagate through various provisions of the Affordable Care Act. Clinics are familiar with the needs of and are expert in serving the populations who will be the prime consumers of the QHPs offered on the Exchanges. • **The recommended "sufficient participation" standard lacks focus on populations other** Exchange proposes to adopt Option B to measure the "sufficient participation" of Essential Community Providers by showing some amount of overlap between a QHP's provider network and Medi-Cal Managed Care or Healthy Families networks, or independent physicians serving a high volume of Medi-Cal patients. CCALAC considers Option B as insufficient. What the QHP Recommendations fail to consider is the fact that safety-net providers are defined by and generally measured based on historical services provided to low-income, medically underserved populations outside of the Medi-Cal population (i.e. the uninsured). In

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	order to ensure that all Exchange enrollees, particularly the uninsured, are assured "reasonable and timely access" to true Essential Community Providers, the Exchange should apply Department of Managed Health Care (DMHC) adequacy standards regarding ratio of primary care providers to population, timely access, adequate language access, and cultural competence to the Essential Community Provider network. HHS' final rulemaking on the Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (CMS-9989-F) seeks to ensure broadness in the QHP's Essential Community Provider network. HHS effectively "modified § 156.235(a) to direct that each QHP's network have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a *broad* [emphasis added] range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards" (page 18421). While the Exchange seeks to recognize the wide range of provider types that serve its low-income populations, the Essential Community Provider provisions within the health reform law were *not* created to recognize the value of providers that have only "demonstrated service" to arbitrary threshold percentages of Medi-Cal beneficiaries: they were created to ensure the meaningful participation of true Essential Community Providers, those who are truly embedded within the community and see all those who walk through their doors, regardless of their coverage status or ability to pay. In instituting a standard that simply requires a "minimum proportion" of Medi-Cal providers to meet the Essential Community Provider inclusion threshold, the Exchange would be imposing irreparable harm to and setting a dangerous precedent regarding those safety net providers who truly serve *all* the underserved. • **The recommended "sufficient participation" standard perpetuates QHPs' incentive to not contract with true Essential Community Providers, counter to the intent of health reform.** The QHP Recommendations describes that there are adverse incentives to QHPs contracting with traditional safety net providers such as community clinics and health centers. As noted on page 78, health plans often use strategic plan design to attract or deter consumers with certain health care needs. Clinics and other true safety-net providers traditionally serve a high proportion of low- income patients with more chronic illness and greater health risks. Consequently, QHP issuers may resist contracting with true Essential Community

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	Providers like clinics for fear of acquiring a high-cost patient population. Meanwhile, the Essential Community Provider requirements as laid out in the federal health reform law and regulations are intended to mitigate this disincentive to contract with health centers, Ryan White clinics, and other true safety net providers who care for the nation's sickest patients. By creating an overly-broad definition and allowing non-safety-net providers to make up the Essential Community Provider network, the Exchange is leaving the real possibility that true Essential Community Providers are the last choice for QHP contracts in the Exchange. Therefore, the Board is recommended to instead utilize DHMC standards regarding ratio of primary care providers to population, timely access, adequate language access, and cultural competence in order to ensure access to Essential Community Providers. Without meaningful, "tried and true" metrics by which to measure "sufficient participation," low-income, medically underserved populations are at risk to continue being underserved, and true Essential Community Providers may not see any opportunities to meaningfully participate in the Exchange. ***Issue 3: Payment rates to Federally Qualified Health Centers*** ***CCALAC urges the Board to adopt Option A, to require Qualified Health Plans to contract with all FQHCs and mandate payment under terms of section 1902(bb) of the Act – at the PPS rate. In addition, CCALAC urges the Board to also adopt Option D, to assign higher scoring in the solicitation of QHP networks that include in-network FQHCs during the QHP evaluation process.*** The Exchange Board is considering a recommendation that will not require QHPs to contract with FQHCs nor pay FQHCs their Medicaid PPS rates. CCALAC believes that FQHCs should be given fair compensation, or PPS. The Medicaid PPS reimbursement is to fairly reimburse health centers for providing comprehensive, bundled, patient-centered services, including primary care, dental, mental health, pharmacy, immunizations and other preventive health measures, chronic care management, care coordination, enabling services such as translation and transportation services. Without the PPS rate, health centers would not be effective in keeping patients out of the emergency room and preventing hospitalization. CCALAC seeks to address various assumptions that underlie the considerations listed on page 127 that would lead to rejection of Option A: ☐ *"The Medicaid PPS rate may be "overpayment". The Medicaid PPS rate for an FQHC clinic is for a bundle of services, some of which are not included in the definition of Essential Health Benefits or are services that the*

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	Exchange plan may not wish to purchase from the FQHC." **It is because of the unique Medicaid PPS rate that health centers consistently provide high quality, cost-effective services.** Congressional support and funding for health center services and expansion has been bipartisan and unequivocal, particularly in the past twenty years. Recognizing the importance of health center services to Medicaid beneficiaries, Congress in the Omnibus Budget Reconciliation Act of 1989 made the services of a FQHC a guaranteed Medicaid benefit offered to beneficiaries in every State Medicaid program. Most important, Congress recognized and acknowledged that Medicaid reimbursement to FQHCs must be fair and sufficient to reimburse health centers for their full reasonable costs through serving Medicaid patients. In the accompanying Committee report, lawmakers wrote: "The Subcommittee on Health and the Environment heard testimony that, on average, Medicaid payments to Federally-qualified health centers cover less than 70 percent of the costs incurred by the centers in serving Medicaid patients. The role of [the federal Health Centers program] is to deliver comprehensive primary care services to underserved populations or areas without regard to ability to pay. To the extent that the Medicaid program is not covering the cost of treating its own beneficiaries, it is compromising the ability of the centers to meet the primary care needs of those without any public or private coverage whatsoever."[1] Congress further amended the Medicaid payment system in 2000, to assure that health centers receive reimbursement that approximates their costs in serving Medicaid patients. The Medicaid FQHC PPS mandate is almost unique in the Medicaid statute, as Congress is inclined generally to allow states a great deal of leeway in establishing provider payment. The FQHC payment system with Medicaid reflects Congressional recognition of the importance of FQHCs' provision of the range of primary care and preventive services to the underserved in this country. **Furthermore, the Medicaid PPS rate is not an overpayment to FQHCs since, because of it, they are in a much better position to provide high quality care in a cost-efficient way to the mostly high-cost patients that come their way, compared to private providers.** Health centers throughout California provide care to 16 percent of Medi-Cal population while using only 1.7 percent of total State Medicaid expenditures. On the same vein, medical expenses for clinic patients are 41 percent lower than patients seen elsewhere, due to the patient-

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	centered and high quality care they receive. Not only do FQHCs keep the costs of high-cost patients low and drive up savings, but perform well in regard to health outcomes – sometimes topping private providers. A recent study by Goldman et al., comparing FQHC and FQHC Look-Alike physician performance with private practice primary care physicians on ambulatory care quality measures, found that health centers performed better on six select quality measures despite serving patients who have more chronic disease and socioeconomic complexity.[2] The findings of the study merely affirm the long-standing commitment of clinics to improve health outcomes and provide patient-centered in a cost-effective and cost-saving way. Indeed, for over 10 years, CCALAC's member clinics have collected and shared data on multiple quality indicators for three major areas of adult primary care: diabetes, hypertension and preventive services. These quality improvement efforts, led by our member clinicians, have instilled a culture of quality in LA's clinics. Data published recently by the Kaiser Family Foundation found that on four of six measures reported, LA's health centers fare better than the national average for the entire U.S. population (timely prenatal, hypertension control, low birth weight and childhood immunizations).[3] The only two measures where the U.S. population stands out above LA are diabetes control and cervical cancer screening. The Medicaid PPS rate should not be considered overpayment to providers that consistently aim to improve health outcomes and provide patient-centered care to even the more acute populations that frequent clinics. **Lastly, federal guidance suggests that QHPs should be required to use Medicaid methodology that pays no less than PPS, not necessarily pay a specific Medicaid PPS payment rate.** In the Board Recommendation brief, one of the issues that Exchange staff lists for having QHP issuers pay FQHCs their Medicaid PPS rates is that QHP issuers would be making a payment for certain rendered services that are not even necessary services under the Essential Health Benefits package. When addressing the Centers for Medicare and Medicaid Services (CMS) on federal regulations of Exchange establishment and QHP contracting, CCALAC did not think the statute of the regulation stated that QHP issuers should pay their PPS rates per se but rather they have to use Medicaid payment methodology. QHP issuers should pay FQHCs using a Medicaid methodology or payment that is no less than the Medicaid PPS rate. Simply put, CCALAC does not believe that the "not less than" language means, as stated by CMS in the preamble of the Affordable Care Act, that a QHP must "reimburse FQHCs at each facility's Medicaid prospective payment system (PPS) rate" but could rather interpret that **QHPs must utilize the methodology established under 1902(bb) of the Social Security Act to pay FQHCs no less than the amounts paid under Medicaid**

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	for the items or services provided by the FQHC to patients of the QHP. That is, a QHP must pay a FQHC at least its reasonable cost of providing covered services (not Medicaid services) using two base years to determine a per-visit rate that would then be adjusted for inflation and changes in the scope of services provided. Importantly, Section 1902(bb) also provides the two contracting parties, QHPs and health centers, considerable flexibility to enter into payment terms that may be more workable or advantageous for any number of reasons through the alternative payment methodology provisions found in subsection (6) of 1902(bb). This approach is actually the only reasonable way to read Section 1302(g) of the health law, as there is no reason why Congress would have intended a QHP to be paying an FQHC for a Medicaid bundle of services that is likely to be different than the bundle of services that the FQHC is furnishing to an enrollee of a QHP. Adopting this approach is wholly consistent with the concept that FQHCs must use their Section 330 funds solely for serving low-income uninsured populations. As Congress has made clear, the purpose of the Medicaid PPS rate and predecessor provisions is to ensure that Medicaid pays for the cost of serving Medicaid enrollees. It is not a rate paid just for a "visit," but a method of fairly allocating the cost of services provided to individuals that rely on Medicaid. ☐ *"Because FQHCs are a subset of clinic providers, Qualified Health Plans may not need to contract with FQHCs to meet the 'sufficient' standard for Essential Community Providers, and may be discouraged from doing so if the payment rate is high."* **This is a dangerous standard for which the Exchange bases its final decision on whether QHPs should contract with FQHCs or not.** The Essential Community Provider guidelines, as described in the federal health reform law, and regulations are intended to mitigate this disincentive to contract with community clinics and health centers, Ryan White clinics, and other true safety net providers who care for the nation's sickest patients. QHPs should not be allowed to "cherry pick" which providers should be contracted to serve within the Essential Community Provider Network simply because they are due their Medicaid PPS rates and that there is availability of other providers that can meet the "sufficient" participation standard. The Exchange, in essence, would be thwarting the intent of the health reform law to encourage meaningful participation of true Essential Community Providers that are aptly suited to provide care to even the neediest patients. CCALAC seeks to address one assumption that underlie the first consideration listed on page 128 that would

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	lead to rejection of Option C: • *"Payment under Option C may encourage innovative contracting strategies between FQHCs and Qualified Health Plan issuers, such as bundled payments for selected services and patient conditions or enhanced and incentive payments to FQHCs that participate in the Federal Advanced Primary Care Practice demonstration project."* **Option C does not necessarily preclude the possibility of innovative contracting and payment strategies between FQHCs and QHP issuers – it simply sets the floor.** The justification behind Option C is that it would allow for FQHCs and QHP issuers to come up with innovative contracting and payment methodologies. However, with the Board adopting an option that QHP issuers pay FQHCs no less than their Medicaid PPS rates does not necessarily mean QHP issuers and FQHCs cannot come up with innovative processes. Nowhere in Options A and B do they imply that paying FQHCs their Medicaid PPS rates prohibits those types of innovative contracting and payment methodologies. The QHP issuers simply have a floor which they cannot pay less. **Lastly, CCALAC urges the Board to adopt Option D, to assign higher scoring in the solicitation of QHP networks that include in-network FQHCs during the QHP evaluation process.** Option D is a no-cost incentive that will encourage QHPs to offer quality FQHC services to their enrollees. It is similar to the Community Provider Plan model successfully utilized in the Healthy Families Program. The success of this model is based upon the ability to bring low-income underserved populations into care through the incentive of discounted premiums, and the partnerships between providers and health plans that translate into greater quality of care for hard to reach populations. With the goal of ensuring safety-net provider participation and bringing critical populations into coverage, **CCALAC encourages the Board to designate a Community Benefit Plan in every region, which is the participating health plan with the highest percentage of true Essential Community Providers within its network.** Subscribers selecting the Community Benefit Plan should be given a premium discount, have lower out-of-pocket maximums, or otherwise be incentivized to select the plan.
Disability Rights Education and Defense Fund	DREDF has written extensively on how people with disabilities (PWD) are a medically underserved population and a health professions shortage area (*see* http://www.dredf.org/healthcare/FINAL-DREDF-HRSA-letter-6-09-10.pdf). As we note in our letter: "Disability status, although not yet recognized by HRSA as a MUP or HPSA, is nevertheless pervasive among underserved populations that are defined by race, poverty and age. While individuals with

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	disabilities are already de facto members of these populations, Federal agencies concerned with health, health care and related research have devoted little attention to addressing the specific health care inequities and barriers to care people with disabilities face, so practically speaking, they remain not only underserved, but also invisible." We fully support the need for contracted provider networks to demonstrate cultural and linguistic competency and familiarity with "special needs populations," and would only seek to clarify that linguistic competency include familiarity with, and the capacity to take care of, sign language needs, the alternative format needs of people with visual disabilities, and the programmatic accessibility needs of many people with disabilities, including people with developmental, mental, and behavioral disabilities. We support a broadening of the definition of essential community providers to the extent that this will recognize the contribution of providers that have historically served uninsured, low-income and medically underserved populations, *but also wish to ensure* that these providers appreciate, and are given assistance to meet, the physical and programmatic accessibility needs of uninsured, underinsured, low-income and medically underserved people with disabilities. We recommend that the Exchange explicitly include specifications relating to accessibility for PWD when building on adequacy standards in low income areas and encouraging innovative expansion of ECP networks. Doing otherwise could further cement the network overlap among Qualified Health Plan and Medi-Cal Managed Care, Healthy Families Program networks and/or independent physician providers serving a high volume of Medi-Cal patients that remains large united in its *in*accessibility.
Health Access	The admittedly "broad" definition of essential community providers eviscerates the important policy goal of the provision-which is to ensure that newly-insured patients, who have traditionally gone to providers focused on the uninsured, have the opportunity to stay with those providers. Each state defines essential community providers because how the uninsured are cared for varies greatly by state. California is unusual, though not unique, in its reliance on county hospitals and community clinics as the most prevalent providers of care for the uninsured as well as major providers of care for Medi-Cal patients. The staff recommendations do not reflect the following: First, the policy purpose of the inclusion of essential community providers was to assure that the uninsured could continue to see the providers they had seen before, if they choose to do so. Second, in most major urban counties in California, the most prevalent providers of care for the uninsured are first and foremost

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	the county hospitals and their associated county clinics. Community clinics also play an important role in both major urban counties and rural areas. Third, in three urban counties, Sacramento, Orange, and San Diego, the three University of California hospitals have abdicated their role as county hospitals that serve the uninsured. Fourth, private DSH hospitals qualify for disproportionate share hospital funding because of the volume of care provided to Medi-Cal patients, not the uninsured. Fifth, until Health Access won major consumer protections against hospitals overcharging the uninsured, hospitals routinely collected from the uninsured a higher proportion of charges than California hospitals collected from any other payer source, including insurers and public programs. The uninsured were not only charged three, four or five times what other payers paid but the uninsured also *paid* a higher proportion of charges. Sixth, hospitals are required to stabilize emergency patients, not to provide care beyond that. Few private hospitals provide the uninsured more care than stabilizing an emergency condition. Most hospitals provide significantly less than 2% of their treatment as "charity care." Seventh, Medi-Cal accounts for about a third of hospital patients. Unless the sufficiency standard sets a threshold higher than this, it effectively includes most hospitals. The recommendations of the Exchange staff fail to take into account these facts. The policy recommendations ignore the role of county hospital systems and community clinics in serving the uninsured. The focus on individual physicians is misplaced. The recommendations will disrupt care for the uninsured and fail to distinguish those providers that care for both the uninsured and Medi-Cal patients from the broader community of providers that provide some care to Medi-Cal patients and only emergency care for the uninsured. Health Access supports a narrow definition that is appropriated focused on the uninsured.
Health Net	Health Net supports the staff recommendation to expand the definition of Essential Community Providers to ensure that providers that have traditionally served Medi-Cal, low-income or medically underserved patients will be available to enrollees in the Exchange. We request more detailed information however about the recommended definition of

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	what constitutes "sufficient" participation by Essential Community Providers. If issuers are forced to include providers who charge higher rates, it will factor against the overall affordability of coverage.
Insure the Uninsured Project	We agree with staff recommendations to adopt a broad definition of ECP which will hopefully ensure that the medically underserved are able to access the care they seek; limiting the list of ECPs only serves to undermine the goals of the Exchange, which aims to assure access to quality care and reduce health disparities. We also agree with staff recommendations regarding FQHC compensation (Option C).
Korean Community Center of the East Bay	In California communities of color make up over 70% of the client population that relies on the safety net (public hospitals, community health centers, and government clinics) for their usual source of care. These institutions are at the forefront of providing cultural and linguistic services and have worked hard to win the trust of their diverse patient base. The ACA requires QHPs to provide, "a sufficient number of essential community providers, where available, that serve predominately low-income, medically-underserved individuals." We are concerned by Exchange staff's recommendations to substantially broaden the definition of Essential Community Providers (ECPs) beyond the federally proposed definition as they seem to be blurring the distinction between those ECPs who provide care to Medi-Cal recipients and a substantial volume of care to the uninsured, from those who provide some care to Medi-Cal patients and only emergency care for the uninsured. In California approximately 1 million low-income individuals will not be eligible for Medi-Cal or the Exchange due to their immigration status. The ACA requirement that QHPs contract with ECPs is vital to ensuring that the uninsured can continue to see the providers they have seen before. Because county hospitals, county clinics and community clinics are the most prevalent sources of care for the low-income and uninsured, this requirement is vital to ensuring there is adequate funding to protect and strengthen our underfunded and overstretched safety net thus enabling low-income Californians to secure a medical home and access to the primary and preventive services they need. KCCEB urges Exchange staff to: • Review the current recommendation to broaden the definition of essential community providers to ensure that the recommendation does not interrupt care for the uninsured by failing to distinguish between those providers that care for both the uninsured and Medi-Cal patients, from the broader community of providers that provide some care to Medi-Cal patients and only emergency care for the uninsured. • State clearly as part of the definition of ECPs that these entities must provide a substantial volume of care to persons who are uninsured (not just to those enrolled in Medi-Cal). We defer to the California Association of Public Hospitals (CAPH) and the California Primary Care Association (CPCA) for an appropriate threshold of care to persons who are uninsured and/or on Medi-Cal.

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	• Require QHPs to contract with ECPs. • Include as part of the definition of ECPs those entities named in section 340B(a)(4) of the Public Health Service Act and in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as well as those entities licensed as either a "community clinic" or "free clinic" by the State under California Health & Safety Code Section 1204 (a) (1) and (2), or are exempt from licensure under Section 1206. • Include as part of the list of "qualified clinics" in the ECP definition: Federally Qualified Health Centers, Indian Health Services, tribally-operated programs, urban Indian clinics (I/T/Us), and school-based health centers.
LGBT Health Consortia	We encourage the Exchange to take steps to ensure that providers are able to provide culturally competent care to LGBT patients.
March of Dimes	Regarding Issue 1, we support Option B to broaden the list of essential community providers to include those with demonstrated service to the Medi-Cal, low-income and medically underserved population. Essential community providers play a critical role in the care of low-income and critically or chronically ill children and pregnant women. Low socioeconomic status is associated with an increased risk of prematurity. In addition, chronic stress for low income women is also associated with prematurity and low birth weight for gestational age. It is important that those providers with a demonstrated track record serving these populations are included in this definition and that essential community providers include those with expertise in maternal and child health.
Molina Healthcare, Inc.	Molina supports the California Association of Health Plans (CAHP) position on this issue. We largely support the current staff recommendation (Option B) regarding the definition of Essential Community Provider, with some modifications and suggestions to address the need to determine "high volume." We propose that Essential Community Providers be defined as including all of the following: (1) Health care providers defined in section 340B(a)(4) of the Federal Public Health Service Act. (2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Federal Social Security Act as set forth by section 221 of Public Law 111-8. (3) Providers that serve predominately low-income, medically underserved individuals, consisting of any of the following: (i) Public and private hospitals designated by the California Department of Health Care Services as a

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	disproportionate share hospital, as defined in Section 14166.1(d), (f), or (j) of the Welfare and Institutions Code, and children's hospitals. (ii) Any freestanding county clinic or clinic associated with a disproportionate share hospital as defined by 14166.1(d), (f), or (j) of the Welfare and Institutions Code. (iii) A medical group, independent practice association, physician office, or clinic with more than 10 physicians that has a Medi-Cal or medically indigent encounter rate of at least 50 percent of total patients served. (iv) A medical practice of 10 or fewer physicians in which at least 30 percent of patients served are uninsured or enrolled in Medi-Cal in the case of a primary care physician practice, or 20 percent of patients served in the case of a specialty care physician practice. This definition would meet the federal requirement to define Essential Community Providers as providers who "serve predominately low-income, medically underserved individuals." We strongly oppose narrowing the definition to include only those providers defined in section 340B (a)(4) of the Public Health Service Act and 1927(c)(1)(D)(i)(IV) of the Social Security Act ("340B or 1927(c) providers"). As your briefing paper points out, the state has flexibility under federal law to define which providers constitute essential community providers for the purposes of Qualified Health Plan certification. Many providers in California who are not 340B or 1927(c) providers have made a significant investment in serving predominately low-income, medically underserved individuals and the state's public programs, such as Medi-Cal, AIM and Healthy Families. Our reasons for including these providers in the definition are as follows: • Ensuring Continuity of Care: The main goal of including Essential Community Providers in health plan networks—to the degree that they are not already included—should be to maintain continuity of care. Many individuals who purchase coverage in the Exchange may have been previously uninsured or eligible for a public program and may have a relationship with or may be actively under the care of providers who have traditionally served this population. The providers that we have identified in the proposed definition above have a track record of not only serving the Medi-Cal population, but also treating the uninsured, often at a significant discount over Medi-Cal

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	or fee-for-service rates. • Ensuring Continuity of Provider: Independent physicians and medical groups are already serving a substantial percentage of the uninsured population as part of their practice, and some have specialized in offering the culturally and linguistically appropriate care this population needs. The uninsured are likely to receive the greatest benefit from the soon-to-be-established Exchange because they have been obtaining care as cash patients. These patients are most likely to be the Exchange's first customers, and ensuring that independent physicians—who have invested in caring for this population—are considered Essential Community Providers will help these members maintain their traditional medical home and minimize disruption. • Ensuring Access to Care and Network Adequacy: Many community clinics and other 340B and 1927(c) providers are already at capacity. Requiring all QHPs to contract with this very small group of providers would unnecessarily limit QHP networks and likely result in diminished access to care. • Ensuring Access in Underserved Communities: In a state as geographically expansive as California, which includes vast agricultural regions, there is also the need for adequate geographic coverage, which may be difficult with only 340B and 1927(c) providers. Separating hospital and non-hospital 340B and 1927(c) providers, the geographic coverage for respective inpatient and outpatient ECP networks leaves large underserved regions of the state with questionable access to care. Adopting the broader ECP definition allows for greater geographic coverage by QHPs in underserved areas. • Improving Quality of Care: In order to improve quality of care, providers must have to meet quality indicators in order to be included in network. Requiring plans to contract with a very narrow set of specific providers gives those providers leverage over plans, reduces or eliminates competition on quality, and in some areas requires plans to contract with specific providers regardless of their quality metrics. We believe that the broader definition of Essential Community Provider is consistent with the Exchange's mission statement to encourage an "innovative, competitive marketplace" and drive quality improvement. Utilization of Essential Community Providers in QHP Networks We also recommend that the Exchange ensure QHP utilization of Essential Community Providers by including it as

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	one of the criteria for QHP approval and renewal in the Exchange.
Monarch HealthCare	Definition of Essential Community Providers (ECP): We strongly recommend Option B. As a large network of independent providers, we encourage the expansion of the definition to include private practice physicians, clinics and hospitals also known as "safety net providers" who have traditionally served and cared for the Medi-Cal and other low-income and uninsured populations. Today, Monarch cares for 27,000 Medi-Cal managed care beneficiaries through a contract with CalOptima and over the past 8 years has gained valuable expertise in caring for this vulnerable population utilizing its coordinated clinical designed government team model. It is imperative that the Exchange not inadvertently disrupt the doctor-patient relationship. Many of Monarch's provider's are currently caring for the uninsured patients who soon will have access to the Exchange program. Adopting this broader ECP definition will allow for greater access of providers for the QHPs and will help the QHP meet the sufficiency requirement. It is imperative that Orange County grow its provider network to handle the influx of the new beneficiaries that are likely to be enrolled in the Exchange. Definition of Sufficient Participation of ECP: We support Option B that would require plans to demonstrate sufficient participation of ECP caring for the region's low income population (as defined in the brief). According to the recent statistics for Orange County it is estimated that as many as 150,000 people may be eligible for the Exchange. It is critical that our provider community to be broadly inclusive in order to meet the demand for medical services.
National Health Law Program on behalf of the Health Consumer Alliance	Essential community providers provide care to predominately low-income and medically-underserved populations who suffer from disproportionately high rates of illness and disability. In addition to providing more efficient and patient-centered care, the inclusion of essential community providers will support better continuity and coordination of health care, which are top tenets of the ACA. **<u>Issue 1. Definition of Essential Community Providers</u>** Given the critical role that essential community providers play in the health and well-being of low-income and medically underserved populations, NHeLP and the HCA urge the Exchange to adopt a definition of essential community provider that includes the full range of potential essential community providers that currently comprise the safety-net of providers who provide health care to low-income communities. The definition of essential community provider must include safety-net providers who have a demonstrated commitment to providing quality care to underinsured and uninsured clients, including, but not limited to: HIV/AIDS clinics, public hospitals, women's health centers, federally qualified health centers (FQHCs), family planning clinics

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	including Title X-funded reproductive health centers, and community health centers. In addition, as to the unique health needs of women, it is especially important that the Exchange require QHPs to contract with Title X clinics, women's health clinics, and other publicly-funded family planning providers for the full range of covered services that they provide. For example, the Exchange should not permit a QHP to exclude the contraceptive services that a women's health clinic offers. The Exchange should require QHPs to contract with essential community providers for the full range of services they offer, rather than only offering access to certain subsets of services. It is critical that the Exchange prohibit QHPs from excluding a provider on the basis that the provider offers abortion services. The definition of essential community provider should include only those providers that offer unbiased, accurate, and timely access and/or referrals to, and information about, health care services. We are concerned that the staff's recommendation to adopt a "broad definition" of essential community provider will include providers who do not primarily serve underinsured and uninsured clients. Not only would a "broad definition" undermine the purpose of requiring that QHPs contract with essential community providers in the first place, which is to provide more efficient and patient-centered care and to promote better continuity and coordination of care, but it is also unnecessary; QHPs are likely to contract with providers who serve predominately private insurance patients regardless. **Issue 2. Definition of "sufficient" participation of Essential Community Providers** NHeLP and the HCA support the goal of the recommended approach to defining "sufficient" essential community provider participation, but we also encourage the Exchange to adopt more specific criteria. The Exchange should adopt a definition of sufficiency that requires that QHPs not only demonstrate minimum proportion of network overlap among the QHP, Medi-Cal, Health Families networks and among solo and small physician offices and independent physician providers that serve a high volume of Medi-Cal and uninsured patients, as the staff recommends, but also that definition include the criteria discussed above with regard to the establishment of network adequacy standards. To ensure access to services, the Exchange should develop criteria to measure the number of essential community providers that account for variation in specialty type and geography. Specifically, we recommend that the Exchange use the criteria discussed above with regard to the establishment of network adequacy standards. *See supra* Section 5E. In addition, the Exchange should set minimum standards to ensure that there are sufficient types of providers or provider networks, including specialists, who actually provide all covered services. A standard that merely counts the

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	numbers and types of providers is not sufficient. Minimum standards should take into consideration the fact that some hospitals and clinics, particularly religiously controlled ones, may not provide all of the covered services, and individual providers may refuse to offer covered services. Further, the Exchange should require that each QHP show overlap among the QHP, Medi-Cal, Health Families networks and other safety-net providers serving primarily Medi-Cal and uninsured patients. In addition, the Exchange should require that QHPs determine whether potential essential community providers have been successful in providing quality health services in medically- underserved communities for low-income populations (particularly those that are experiencing health disparities and poor health outcomes) that meet recognized scientific and medical standards that any provider would be expected to perform under any circumstance. *See generally* NATIONAL HEALTH LAW PROGRAM, HEALTH CARE REFUSALS: UNDERMINING QUALITY CARE FOR WOMEN (2010). Similarly, QHPs should be required to contract with essential community providers that routinely provide preventive health screenings and treatment including FDA-approved contraceptive drugs, devices and supplies consistent with HHS Required Health Plan Guidelines for those services. *See* U.S. Department of Health and Human Services, Health Resources and Services Administration, "Women's Preventive Services: Required Health Plan Coverage Guidelines," *available at* http://www.hrsa.gov/womensguidelines. The Exchange should also require that QHPs contract only with essential community providers that offer unbiased, accurate, and timely access and/or referrals to, and information about, health care services. **Issue 3: Payment rates to Federally Qualified Health Centers** No comments.
Pacific Clinics	We strongly concur with Exchange staff's recommendations on broadening the definition of the Essential Community Provider standards beyond the traditional 340B and 1927(c) providers.
Planned Parenthood Affiliates of California	Issue 1: Definition of Essential Community Providers PPAC recommends a narrow essential community provider definition: "The federal minimum outlined in the Affordable Care Act, namely those entities included in section 340B(a)(4) of the Public Health Services Act and in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as well as those entities licensed as either a "community clinic" or "free clinic" by the State under California Health and Safety Code §1204(a), or is exempt from licensure under Section 1206 (b),(c), (h), and (j). PPAC is very concerned that the proposed definition of essential community provider is overly broad and has the potential to cause substantial harm to the traditional primary care safety net by effectively ensuring their exclusion from the individual market. Rather than the federally recommended definition of "essential community providers,"

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	which was limited to "providers that serve predominately low income, medically underserved individuals, including…providers defined in section 340B(a)(4) of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act," the recommendation broadens this designation to include physicians, clinics, and hospitals which have "demonstrated service" to the Medi-Cal, low-income, and medically underserved population. The suggested threshold for "demonstrated service" has been set at a patient mix of 30 percent Medi-Cal for primary care providers and 20 percent Medi-Cal for specialists. This threshold encompasses approximately 40 percent of primary care physicians and a quarter of specialists in California. While this creates a broad range of available providers for plan issuers to contract with to meet the ECP requirements, it dilutes the incentive for plans to contract with the traditional safety net providers identified in the federal law, including community clinics and women's health providers. By specifically calling out 340B and 1927 providers, it is clear that Congress intended the essential community provider provision to serve as additional, robust protection for patients' access to specific groups of providers, including family planning clinics which are specifically referenced in both categories: 340B includes Title X Family Planning clinics and Section 1927 mainly captures safety-net family planning clinics that are not Title X grantees. In fact, the congressional record shows that 1927(c)(1)(D)(i)(IV) was intended to capture "family planning clinics such as Planned Parenthood." The additional protections for family planning clinics in the ECP provisions were part of Congress' repeated efforts to ensure and protect women's access to primary and preventive care. This concern was warranted, as the reality is that when expansions in health insurance coverage are implemented, the biggest barriers to care are around women's primary and preventive services. For example, in Massachusetts, as a result of expanding coverage without putting meaningful access protections in place, there are tremendous shortages of primary care providers, especially those that focus on women's health care. After universal coverage was enacted in MA, wait times for OB/GYN services increased dramatically (up to an average 70 day wait in Boston). A study published this year found that while the Massachusetts expansion has had an overall positive impact on women's health care access, barriers to family planning providers remain problematic, with women having difficulty navigating the prescription system, being inappropriately denied or overcharged for prescriptions, and other burdens such as only receiving coverage for only a 1-month supply of pills at a time or distance to pharmacies, especially in rural areas. While family planning and reproductive health providers do not necessarily provide comprehensive primary care, many times a reproductive health provider is the main provider a woman sees. A definition that prioritizes women health care family planning providers is essential to ensuring timely access to reproductive health services and an

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	expanded ECP definition will dilute these protections. On page 32, the Report states that the Exchange must evaluate options for plan design, provider network, and access standards based upon several considerations, including creating policies that lead to "effective inclusion of safety net community health centers." This proposal to expand the definition of essential community providers, combined with lenient ECP network adequacy standards, creates the real danger of provider networks throughout the state which do not include those very safety net community health centers that the Exchange has committed to include. In order to accurately capture all community clinics, the Exchange should select a standard that includes non-profit community and free clinics above as defined in state law. These are the community health centers that serve primarily low income underserved areas , and this definition will capture any non-profit community clinics not included in the federal minimum definition. These community health centers must be operated by a 501(c)(3) tax exempt, non-profit corporation, they must be supported primarily by contributions, grants, government funds and other external funding, any charge to the patient must be based on the patients' ability to pay and they cannot turn away patients who cannot pay for services. These primary care clinics constitute the foundation for California's safety net. They are typically located in underserved areas, they provide services to all members of a community despite a person's inability to pay, their staffs are made up of individuals from the local community and they are heralded as the model for cultural sensitivity and competency. Including §1204(a) would ensure that all California community clinics are included in the ECP definition, regardless of whether they qualify as 340B providers. It is estimated that after ACA implementation, between 2-4 million Californians will remain uninsured, and this population will continue to be served by community clinics and health centers. The viability of this safety-net provider network is vital to ensuring that all Californians can access health care services regardless of insurance status. This protection was the intent of the federal ACA. We appreciate the participation of all providers who serve Medi-Cal and Healthy Families populations, but the ECP definition and standards should not undermine the incentive for QHPs to contract with community clinics as defined in state law, and should include special protection that ensure timely access to family planning and women's health providers for enrollees in the Exchange.

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	Issue 2: Definition of "Sufficient" Participation of Essential Community Providers The Exchange should impose transparent standards to evaluate the "sufficient participation" of essential community providers in health plan networks in every service area. A "sufficient" network is one where services are available to medically underserved, low income individuals, and these standards should ensure that not only are there sufficient number of providers, but also that they have the capacity to provide access to services, are taking new patients, and are willing to provide all covered services (Ex: women's health providers who refuse to provide birth control or abortion referrals). Without meaningful metrics by which to measure "sufficient participation," low income, medically underserved populations are at risk to continue being underserved. If it does not meet these requirements for patient access, a network should not be considered "sufficient" even if it overlaps with the local Medi-Cal provider network. The Report itself acknowledges that there are adverse incentives to QHPs contracting with traditional safety net providers such as community clinics. Health plans often use plan design, including contracting with providers, to attract or deter consumers with certain healthcare needs. Community clinics and other traditional safety net providers identified by the federal ECP definition often serve a high proportion of low-income patients, who often have greater health risks and more chronic illness. A looser sufficiency requirement combined with a broader essential community provider definition may provide incentive for issuers to resist contracting with true essential community providers, such as community clinics, for fear of acquiring a high cost patient base. As expressed above, there is great need for special consideration for women's health care providers and providers of family planning services to ensure timely access to services. No matter the sufficiency standards chosen, the Exchange should encourage the inclusion of family planning clinics and women health providers in QHP provider networks. [1] Congressional Record, Floor statements, Senators Stabenow and Baucus, March 5, 2009. [1] Merritt Hawkins & Associates, *2009 Survey of Physician Appointment Wait Times*, May 2009
San Mateo County Union Community Alliance	For the purposes of QHP certification, we believe that an essential community provider should be narrowly defined to focus on public safety net providers—County clinics, County Hospitals and Community Based Clinics in all cases where these providers are able to meet the DMHC Know-Keene and CID Insurance Code requirements of Geographic access and availability of providers. Only in those locations where the public safety net providers are insufficient to meet these standards should the QHP bidder be allowed to substitute physicians, clinics and hospitals which have a demonstrated service to the Medi-Cal, low-income, and medically underserved population to meet the

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	requirement of demonstrating an adequate ECP pool. Narrowly defining the ECP (with exceptions for areas where there are not sufficient numbers of public safety net providers) will have four significant impacts: 1) Public safety net providers (304B and 1927 providers) will provide continuity of care for people who will be eligible for subsidized insurance through the Exchange, but may lose eligibility or come from mixed families (where some are eligible for Exchange products and others are eligible for other programs or will remain uninsured). 2) A narrow definition of the ECP will encourage the participation of COHS as QHP bidders. COHS like the Health Plan of San Mateo are currently serving MediCal patients. They have the most robust existing networks of providers who are the best equipped to serve the newly eligible MAGI MediCal and subsidized Exchange participants. 3) Mandatory inclusion of the public safety net providers (the effect of the narrow definition of ECP) will help to ensure that the public safety net providers will be financially viable in this era of difficult County budgets. A robust public safety net improves the health of our entire communities and reduces the cost of health care for everyone. 4) Mandatory inclusion of the public safety net providers will encourage low-income people to enroll in the Exchange, while this can be considered "increasing the risk pool", it is core to the Exchange's mission Exchange's goal of increasing overall the number of Californians with affordable health care coverage.
Southeast Asia Resource Action Center (SEARAC)	In California, communities of color make up over 70% of the client population that relies on the safety net (public hospitals, community health centers, and government clinics) for their usual source of care. These numbers are even more dramatic for Southeast Asian Americans (SEAA) who struggle with limited English proficiency, These institutions are at the forefront of providing cultural and linguistic services and have worked hard to win the trust of their diverse patient base. The ACA requires QHPs to provide, "a sufficient number of essential community providers, where available, that serve predominately low-income, medically-underserved individuals." We are concerned by Exchange staff's recommendations to substantially broaden the definition of Essential Community Providers (ECPs) beyond the federally proposed definition as they seem to be blurring the distinction between those ECPs who provide care to Medi-Cal recipients *and* a substantial volume of care to the uninsured, from those who provide some care to Medi-Cal patients and only emergency care for the uninsured. In California approximately 1 million low-income individuals will not be eligible for Medi-Cal or the Exchange due to their immigration status. The ACA requirement that QHPs contract with ECPs is vital to ensuring that the uninsured can continue to see the providers they have seen before.

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	Because county hospitals, county clinics and community clinics are the most prevalent sources of care for the low-income and uninsured, this requirement is vital to ensuring there is adequate funding to protect and strengthen our underfunded and overstretched safety net thus enabling low- income Californians to secure a medical home and access to the primary and preventive services they need. SEARAC joins other advocates in urging the Exchange staff to: Review the current recommendation to broaden the definition of essential community providers to ensure that the recommendation does not interrupt care for the uninsured by failing to distinguish between those providers that care for both the uninsured *and* Medi-Cal patients, from the broader community of providers that provide some care to Medi-Cal patients and only emergency care for the uninsured. • State clearly as part of the definition of ECPs that these entities must provide a substantial volume of care to persons who are uninsured (not just to those enrolled in Medi-Cal). We defer to the California Association of Public Hospitals (CAPH) and the California Primary Care Association (CPCA) for an appropriate threshold of care to persons who are uninsured and/or on Medi-Cal. • Require QHPs to contract with ECPs. • Include as part of the definition of ECPs those entities named in section 340B(a)(4) of the Public Health Service Act and in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as well as those entities licensed as either a "community clinic" or "free clinic" by the State under California Health & Safety Code Section 1204 (a) (1) and (2), or are exempt from licensure under Section 1206. • Include as part of the list of "qualified clinics" in the ECP definition: Federally Qualified Health Centers, Indian Health Services, tribally-operated programs, urban Indian clinics (I/T/Us), and school-based health centers.
Vision y Compromiso	• Broaden the definition of essential community providers to ensure no interruption of care for uninsured by not distinguishing between those providers that care for both the uninsured and Medi-Cal patients, from the broader community of providers that provide some care to Medi-Cal patients and only emergency care for the uninsured. • State clearly as part of the definition of ECPs that these entities must provide a substantial volume of care to persons who are uninsured (not just Medi-Cal enrollees) per the guidelines of the California Association of Public Hospitals (CAPH) and the California Primary Care Association (CPCA) for defining threshold of care to persons who are uninsured and/or on Medi-Cal. • Require QHPs to contract with ECPs. • Include as part of the definition of ECPs those entities named in section 340B(a)(4) of the Public Health Service Act and in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as well as those entities licensed as either a

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	"community clinic" or "free clinic" by the State under California Health & Safety Code Section 1204 (a) (1) and (2), or are exempt from licensure under Section 1206. • Include as part of the list of "qualified clinics" in the ECP definition: Federally Qualified Health Centers, Indian Health Services, tribally-operated programs, urban Indian clinics (I/T/Us), and school-based health centers.
Women's Health Specialists of California	The Definition of Essential Community Providers must include all safety-net providers who consistently provide services to low income clients, including al family planning clinics including Title X clinics, women's health centers, FQHC's, school based clinics, HIV/AIDS clinics and tribal health clinics. The Exchange should require that QHP's include publically funded family planning providers which provide the full range of reproductive health services. The Exchange should require that QHP's contract with all essential community providers which provide women's health care preventive services including all FDA approved contraception, and include providers who offer abortion services as part of their health care.

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American Cancer Society, CA Division	In addressing access to quality care, the Exchange should develop a process for: --considering a plan's history of unfairly denying claims or engaging in unethical conduct --ensuring an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner. In addition, addressing the selection/oversight guideline to promote affordability, the Exchange should develop a process for considering in the public domain, historical rate increases in determining certification/recertification. Rates must be reasonable and fair.
California Association of Health Plans	CAHP recognizes the important role that Health Risk Assessments (HRA) may play for new enrollees. However, we are concerned that the Exchange will require annual HRAs for all enrollees. Not every enrollee will benefit from the completion of an HRA and it will increase administrative costs for both QHPs and the Exchange with no real benefit to the enrollee. Additionally, the Exchange should acknowledge that it is often very difficult to get enrollees to fill out an HRA and any standards that are set by the Exchange to determine compliance with HRA standards needs to be realistic and not set so high that plans will be unable to meet it. Personal Health Records (PHR) and/or Electronic Health Records (EHR) are great tools that allow providers and plans to share information about enrollees across care settings. While we agree that a standardized PHR/EHR process is a laudable long-term goal this is not something that the Exchange should require of QHPs at the outset. Different areas of the state are at various stages in their implementation of Health Information Exchanges (HIEs)to support PHR/HER and if the Exchange imposes a requirement that they be standardized statewide this will create an un-level playing field. We would also like to remind the Exchange that there are requirements in state law (Health and Safety Code Section 1373.96) to ensure continuity of care for enrollees with chronic conditions and/or situations where it is determined medically necessary and we recommend that the Exchange rely on the existing regulatory framework.
California Children's Hospital Association	Overall, the staff recommendations strike the right balance of laying the foundation for promoting high quality and affordable health care while still having several important requirements in place for this first phase. CCHA overall supports this overall phased in approach and urges the Exchange to conduct active and ongoing evaluation so that changes can be made at any point in the process to correct for the unintended consequences that may arise that have not yet been accounted for or addressed.

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	Additionally, because of the very special nature of high-level pediatric specialty care, it is important to adopt as a quality indicator, a measure that indicates whether children with CCS-eligible conditions are referred to CCS-approved providers for their care. This will ensure that appropriate care is available to children with low-incidence, rare and serious pediatric conditions. There are additional measures of quality for pediatric populations, such as those contained in MediCal, Healthy Families & CHIPRA that help to ensure high quality care. CCHA continues to reiterate the opportunity for the Exchange to could add great value by encouraging or even requiring health plans to engage in disease management, case management, QI and care coordination through **multi-payer collaboratives** organized at the provider, not plan level. Disease management at the plan level is largely ineffective; it must be done by providers and adequately financially supported by health plans through Multi-payer care initiatives. Private safety net providers will continue to struggle with meeting the demands for delivery system reform, HIT infrastructure and quality improvement absent new financing. This will expand the divide between 'have and have-not' providers.. The efforts in the health plan community to develop innovative cost control and quality measures to serve plan members could be aligned in one or more broad-based, multi-payer collaboratives to promote quality improvement and health plan innovation. This will allow better management of high acuity and chronic patients through prevention, care coordination, transitions. It will also better align reimbursement away from inpatient by affording opportunities for large-scale bundled payment or shared savings opportunities.
California Dietetic Association	1. CDA strongly agrees with the promotion of care coordination including medical homes, which leads to better quality and more cost-effective medical care. The use of well-trained and educated allied health professionals is one way of assuring affordability and quality of medical care. Registered dietitians (RDs) currently work as part of medical teams in diabetes education and are reimbursed through Medicare. This has proven cost-effective and has provided excellent care to the elderly with diabetes.
California Hospital Association	In any new initiative, it is important to start small and build on success. The recommendations as stated in the Quality and Affordability Section strike the right balance of laying the foundation for promoting high quality and affordable health care while still having several important requirements in place for this first phase. CHA supports this overall phased in approach and urges the Exchange to conduct active and ongoing evaluation so that changes can be made at any point in the process to correct for the unintended consequences that may arise that have not yet been accounted for or addressed. **With the first priority being affordability, it is critical that quality is not**

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	compromised.
California School Health Centers Association	Suggestions about how QHPs can work with school-based health centers are outlined in Section 6C – Promoting Prevention and Wellness. We believe that school-based health centers can help the Exchange fulfill its mission to improve the quality of health care while lowering costs. School-based health centers have proven their efficiency and effectiveness on a variety of fronts: ○ Adolescent girls who have access to an school-based health centers are more likely to get reproductive preventive care.[9] ○ School-based health centers can reduce the unplanned pregnancy rate among adolescents.[10] ○ Adolescent school-based health center users engage in more physical activity and consume more healthy foods.[11] ○ School-based health center staff can effectively screen students for important diabetes risk factors.[12] ○ School-based health center users are less likely to have asthma-related restricted activity days.[13] ○ School-based health center users are less likely to go to the Emergency Room or be hospitalized for asthma.[14]
Children's Specialty Care Coalition	We support your efforts to broaden the definition of "Essential Community Providers" to include those that have been traditional Medi-Cal providers. While the federal definition includes clinics and children's hospitals, it is critical to also include the physicians that serve children with special health care needs. In California, the CCS physician network has been the cornerstone of providing care for low-income children and would be covered under your proposed

[9] Ethier KA, Dittus PJ, DeRosa CJ, et al. (2011). School-Based Health Center Access, Reproductive Health Care, and Contraceptive Use among Sexually Experienced High School Students. *Journal of Adolescent Health.* 48: 562-565.
[10] Ricketts SA & Guernsey BP. (2006). School-Based Health Centers and the Decline in Black Teen Fertility During the 1990s in Denver, Colorado. *American Journal of Public Health.* 96(9): 1588-1592.
[11] McNall MA, Lichty LF, & Mavis B. (2010). The Impact of School-Based Health Centers on the Health Outcomes of Middle School and High School Students. *American Journal of Public Health.* 100(9): 1604-1610.
[12] Rafalson L, Eysaman J, & Quattrin T. (2011). Screening Obese Students for Acanthosis Nigricans and Other Diabetes Risk Factors in the Urban School-Based Health Center. *Clinical Pediatrics.* 50(8): 747-752.
[13] Mansour ME, Rose B, Toole K, et al. (2008). Pursuing Perfection: An Asthma Quality Improvement Initiative in School-Based Health Centers with Community Partners. *Public Health Reports.* 123: 717-730.
[14] Mansour et al. (2008). Webber MP, Carpinello KE, Oruwariye T, et al. (2003.) Burden of Asthma in Inner-city Elementary Schoolchildren: Do School-Based Health Centers Make a Difference? *Archives of Pediatric and Adolescent Medicine.* 157: 125-129.

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	definition. The physician groups that are part of the CCS Physician Network have a longstanding commitment to serving children in Medi-Cal. Children on Medi-Cal and CCS comprise over 50% of the patients in our physician groups and several of our groups have over 70 percent Medi-Cal. We appreciate your thoughtful approach to this issue.
Health Access	Health Access understands phasing in additional quality standards over time. We continue to encourage the Exchange to use its authority as a selective contractor to push delivery system reform in order to improve both the efficiency and the effectiveness of care in improving outcomes.
Health Exchange Advocacy & Responsibility Team (H.E.A.R.T.)	Overview Design of the Exchange offers an unprecedented opportunity to structure a 'smart' health insurance marketplace in which robust competition among health plans over price and quality of insurance products purchased by informed consumers will drive continuous innovation in delivery of higher quality care at lower cost. HEART believes this kind of 'smart' market design is preferable to reliance on "requirements" or regulations as primary drivers of care delivery transformation. We believe HEART's vision for health system transformation is consistent with the general strategy recommended by the Exchange staff. The two recommendations HEART proposes, below, are relatively minor revisions to the Exchange staff's initial recommendations, but their adoption (together with the recommendations we have proposed in Section 5, 5C, and 6B) would set the foundation for launch, in 2014, of a 'smart' exchange marketplace in which competition among health plans, focusing on innovation to improve care quality and reduce costs, will drive transformation of care delivery that benefits all Californians. Specific recommendations The member organizations of HEART concur with the Exchange staff's recommendation that the Board should adopt the four-point recommendations described under the heading in Section 6A entitled, "Recommended Approach" (p. 152). Among its specific recommendations for implementing the four-part strategy (i.e.. "Require Certain Health Plan Practices"), the Exchange staff proposes a limited, initial "list of potential 'requirements' that could be refined in future years." (p. 155-6) Among these requirements is the following: d) In each of the following areas, health plans must articulate specific strategies they are engaged in (note: in

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	future years the type or results of such efforts would be potentially used as thresholds for selection or "scored", but for 2014 the Exchange would only require some description of efforts…) Required strategies should include: • Promotion of care coordination and medical homes; • Demonstrated support for innovations in care that improve care coordination and primary care access, including access in rural geographies. *[Bullets selected from a longer list of potential requirements proposed by the Exchange staff]* (Note: HEART understands "medical home" to mean "team-based care" as defined in NOTE B, in the appendix to these comments.) HEART endorses these recommended, initial "requirements" and supports this general framework for advancing care delivery transformation that will benefit all Californians. *However, for the Exchange's roadmap to become an effective driver of health system re-engineering, it will be critically important for the Exchange Board to 1) define transformational roadmap goals (i.e. the destination), 2) define clear and measureable benchmarks that mark progress along the way, and 3) adopt a timetable for QHP progress toward achieving the roadmap goals.* If QHPs' are required to articulate actionable plans for achieving the Board's goals on a timetable established in advance by the Board, the roadmap can serve as an effective guide to QHP strategic planning and alignment at a pace acceptable to the Board. To accomplish this, HEART recommends: ***HEART Recommendation #1: The Board should adopt an expeditious and realistic timetable for each QHP to offer all its exchange beneficiaries the choice of team-based care. The Board should define benchmarks to mark QHP progress toward this goal that are specific and measureable.*** ***(Note A, in the appendix to these comments, provides an illustration of one possible set of benchmarks and timetable.)*** Based on the above recommendation, HEART proposes the following refinement to the Exchange staff's recommended requirement 3(d) on p. 155: ***HEART Recommendation #2: The articulation of strategy that would be required initially under the***

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	Exchange staff recommendation 3(d) should focus on describing how the QHP proposes to meet benchmarks the Board has established for demonstrating progress toward offering all its beneficiaries a choice of team-based care on the expeditious and realistic timetable set by the Exchange Board. QHP progress in meeting Board-determined benchmarks – beginning with articulation of the QHP's strategy and progressing toward the goal of offering all the QHP's beneficiaries a choice of team-based care -- will be a basis for Exchange decisions regarding QHP recertification and decertification. QHPs will be incented to align health plan goals with Board objectives, yet each health plan will have substantial autonomy and flexibility to develop its own, distinct strategy for achieving the Board objectives. Consumers will face an array of choices among health plans and care delivery options that they can make based on comparative cost and quality information. Competing QHPs will be incented to continuously pursue delivery system innovations that improve quality and cost performance of their team care offerings. An exchange marketplace with these characteristics is fertile with possibility for achieving quality-improving, cost-reducing care delivery transformation in diverse regions of the State. HEART believes that quality and cost reporting should allow for easy comparison between different care delivery options, enabling ready consumer comparison between various team care options or between Team-based and non-Team-based care options. Ready access to such information is essential to enable informed consumer choice to drive care delivery innovations that will improve care quality and cost. Therefore… ***HEART recommends that the Exchange Board adopt a requirement that comparable, accurate and meaningful data on health care, where appropriate, cost and quality should be reported at two distinct levels by 2014: 1) Qualified Health Plans and 2) Care delivery options - Team-based Care and other options. (Note B, in the appendix to these comments, provides a simple definition of Team-based care, followed by recommended verification standards that will enable ready distinction between Team-based and non-Team-based Care delivery models).*** ***HEART is in support of the staff recommendation on page 155 that health plans must provide some level of quality information at the hospital and medical group level.*** ***In addition, HEART recommends the adoption of the following specific provisions:*** ***a. <u>Hospital procedures</u> - The Exchange Board should specify procedures for which cost and quality information is required. At a minimum, for example, the Exchange Board should require hospitals to provide the following kinds of general outcomes performance measurements:***

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	○ ***Recovery and mortality rates*** ○ ***Re-admission rates*** ○ ***Infections acquired in-hospital*** ***b. <u>Hospital quality and cost</u> - In addition, hospitals should provide the Exchange Board all currently required quality and cost information as well as cost information (where charges are per procedure or service) and quality information for specific medical procedures performed in hospital.*** c. ***<u>Medical group quality and cost</u> – The Exchange Board should specify common medical procedures for which health outcomes and cost information (where charges are per procedure or service) is required.***
Insure the Uninsured Project	We agree with staff recommendations.
LGBT Health Consortia	As stated above in comments for Section 3, we encourage the Board to recognize the need for LGBT cultural competency among providers as an important aspect of assuring quality care.
March of Dimes	Regarding quality measurement, we support the steps outlined for continued outreach to state agencies, health plans and stakeholders. March of Dimes supports requiring all qualified health plans to report on the same core measure sets developed for Medi-Cal and Healthy Families. Utilizing identical measures will provide consistency, create a larger data pool for use by researchers and policy makers, and maximize the ability to compare outcomes across plans. The March of Dimes has identified 12 priority pediatric and perinatal quality measures. Currently, Medi-Cal and Healthy Families both report on two of these quality measures: (1) well child visits in the first 15 months of life, third, fourth, fifth and sixth years of life and adolescence and (2) immunizations for two-year olds. In addition, Medi-Cal reports on two additional pregnancy related quality measures: (1) timeliness of prenatal care and (2) percentage of women who had a postpartum visit 21-56 days after delivery. (Medi-Cal - http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx#hedis;Healthy Families - http://www.healthyfamilies.ca.gov/Plans_Providers/Health_Plan_Quality_Measures/)

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	In addition to the four measures mentioned above, the other eight priority measures for the March of Dimes are: (1) frequency of ongoing prenatal care; (2) caesarean rate for low risk first birth women; (3) percent of live births weighing less than 2500 grams; (4) adolescent immunization; (5) chlamydia screening females age 16-20; (6) elective deliveries 37-39 weeks gestation; (7) pregnant women at risk of preterm delivery at 24-32 weeks gestation receiving antenatal corticosteroids prior to delivery; and (8) medical assistance with smoking and tobacco use cessation. As any of these measures are implemented for Medi-Cal or Healthy Families, they should be implemented across-the-board including in plans offered through the Exchange.

ISSUE 11

Issue #11: Strategies to Promote Better Quality and More Affordable Care	
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AltaMed Health Services	AltaMed recommends that the Exchange will support the sustainability of the health care safety net as an indispensable step to promoting quality, affordable care for all residents of California.
American Cancer Society, CA Division	We support staff's recommendation that the Exchange require health plans to complete portions of the eValue8 Health Plan RFI to collect data that supports Qualified Health Plan oversight and reporting of plans' quality improvement strategies in accordance with the Affordable Care Act. The collection of this data will allow the Exchange to gather important baseline data, particularly on cultural competency and disparities reduction that can be used as part of the selection criteria in the future for Health Plans in the Exchange. In reviewing the various eValue8 modules, we again join CPEHN in recommending the Exchange consider adopting Module 1, Section 1.7 Racial, Cultural and Language Competency. We would also advocate for adoption of Module 2 as it relates to consumer engagement, particularly Questions 2.3.3, 2.3.4 and 2.3.5 which measure the functionality of consumer engagement tools with respect to the availability of information on the language(s) spoken by a health plan's provider network and the ability of consumers to rank or filter that information as part of the health plan selection process. We have concerns about the adoption of Module 5. Prevention and Health Promotion as some of the questions asked measure the use of prevention and health promotion strategies which we find problematic for reasons we elaborate on more fully in section 6C. Adoption of the eValue8 Module 1.7 will ensure plans are effectively using the data they are required to collect to improve cultural competency and reduce disparities in health care. Question 1.7.3 for example, will indicate to the Exchange, how data on race, ethnicity and primary language is being used to increase cultural competency and set benchmarks or targets for reducing measured disparities in preventive or diagnostic care. Questions 1.7.4, 1.7.5 and 1.7.6 will provide the Exchange with important information about how well plans are supporting the needs of their Limited English Proficient (LEP) members as well as the activities and best practices engaged by plans in assuring that culturally competent health care is delivered. Adoption of the eValue8 Module 1.7 is vital to ensuring that plans that contract with the Exchange are effectively meeting QHP selection criteria V. Reducing Health Disparities. Additionally the Module will provide the Exchange with important baseline data on cultural competency and disparities reduction that can be used as a powerful catalyst for delivery reform moving forward.

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	2. Areas to consider for weighting: We are particularly supportive of weighting plans who can articulate specific strategies they are engaged in with respect to initiatives specifically geared at ensuring the provision of culturally competent care and measuring and addressing health disparities. Additional factors noted by Exchange Staff that we appreciate include the following: •Promotion of care coordination and medical homes; •Chronic disease management; •Data-driven outreach to at-risk or underserved populations, or high impact conditions identified through the National Quality Strategy or National Prevention Strategy; •Payment or oversight programs aimed at reducing hospital acquired infections including, in particular sepsis, central line infection and pressure ulcers, as well as patient safety and avoidable hospital re-admissions; •Demonstrated support for innovations in care that improve care coordination and primary care access, including access in rural geographies.
Anthem Blue Cross	Anthem is committed to promoting programs and payment models that encourage better quality and more affordable care. As such, we offer our feedback on several of the key principles outlined in the Payment Reform section of Board Recommendation Brief. First, staff recommends fostering alignment between public and private health care sectors. We encourage the Exchange to be more specific about what is envisioned here, and we would recommend focusing this alignment around the collection of quality measures. Another principle proposed is to make decisions about payment using independent processes. We would appreciate more clarity on what is meant by “independent processes.” For instance, would this mean encouraging the use of nationally endorsed consensus standards when setting quality and outcomes metrics that impact payment?

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	Additionally, staff proposes the reduction of expenditures on administrative and other processes as a principle for payment reform. We encourage the Exchange to delete or substantially revise this principle. Successful payment reform programs require an investment in administrative processes, not a reduction. For payment reform to realize optimal outcomes, it must be coupled with programs that provide physicians with tools, resources, and meaningful information that support effective population health management and the transformation to a patient-centered model. As payment moves from volume to value, and physicians are given the tools they need to thrive in the new environment, then – over time – issuers will be able to reduce administrative expenses, such as those associated with utilization management. However, issuers need to increase their investment in other areas including data exchange, analytics, and other capabilities that support a patient-centered care model. Finally, on page 148 of the draft document, in the Care Redesign and Delivery System Re-engineering section, we suggest an addition to the last sentence of the first paragraph of the section as follows. This revision would reflect the understanding that, in most cases, QHPs are not direct providers of care. • Specifically, the Exchange may encourage Qualified Health Plans to demonstrate ***a commitment to programs and payment models that encourage:***
Blue Shield of California	**Standardization of Minimum Out of Network Benefits** The Exchange recommendations propose setting a maximum fee that an out-of-network provider can charge. It appears that the Exchange intends to require that plans negotiate agreements with their network providers that would limit the amount that these providers could charge when seeing patients on an out-of-network basis even when covered by other plans. While we support the intent here, we think this approach is impractical and would likely have the effect of pushing more providers out of all plans' networks. Even if such agreements could eventually be negotiated, it would be impossible to get them negotiated in time for the 2014 benefit year. **Prohibition of Certain Health Care Practices:** Blue Shield strongly supports the intent behind the recommendation to prohibit anti-transparency clauses in the contracts that Exchange-participating plans have with providers. Indeed, we supported successful legislation last year (SB 751) barring provisions in plan-provider contracts that prohibit health plans from sharing provider cost and quality information with their members. We believe that additional transparency, such as the ability to share such cost and quality information with prospective members, would be helpful. However, we think it would be a mistake for the Exchange to pursue the recommended strategy on contract terms at this time. We are concerned that some providers may well refuse the terms, forcing us to drop them from our networks if we hope to contract with the

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	Exchange. To the extent that providers see this as the first move in a broader campaign by the Exchange to regulate provider behavior by dictating plan-provider contract terms, they may be especially motivated to resist. In short, we believe the proposed strategy is a high-risk one that needs more study before it is attempted. Moreover, not enough time is available to amend our contracts with providers before our QHP bid is due. For the reasons described above, we also think further study is needed before the Exchange attempts to address through similar plan-provider contract regulation the problem of hospital systems that demand that health plans contract with all of their hospitals. We greatly appreciate the Exchange's willingness to address issues of unfair provider market power, and we look forward to working with the Exchange to explore how it can successfully use its market power and public profile to draw attention to these issues and help control health care costs. **eValue8** We agree that a QHP's activities that support delivery system reform should be considered in the evaluation of plan bids and that the Exchange needs a way of benchmarking plan activities in this area. However, given the short time since the eValue8 RFI was made available for public review, we have not yet been able complete our analysis of the general value this tool would add and which elements of the RFI we think should be appropriated for use by the Exchange. We will follow up within the next few days with specific comments on those points.
California Association of Physician Groups	**Strategies to Promote Better Quality and More Affordable Care**: The bulk of our June 18, 2012 letter to Peter Lee was focused on strategies to improve care management, deliver higher quality care and lower overall costs to the health care system for purchasers. Generally, CAPG supports the recommendation by staff to adopt a four part strategy to foster better health, quality care and lower costs: 1. **Promote alignment** with other purchasers to foster better care, lower costs and improved health. 2. **Collect standardized information** on health plans performance and care delivery/payment practices to inform future work. 3. **Require certain health plan practices that promote better care or standards of performance** for participation in the Exchange. 4. **Use value-elements in its Qualified Health Plan selection** process considering a combination of outcomes (e.g. HEDIS and/or CAHPS scores) and practices (e.g. participation and support for pay-for-performance or medical home initiatives). In this regard, CAPG urges the Exchange to consider minimum QHP requirements (as outlined in our June 18th letter) that drive the certified plans in the Exchange to offer products that are built on a chassis that incorporates integrated, coordinated care delivery systems. These systems should feature alternative payment models to Fee-

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	for-service, such as risk-adjusted capitated payment systems, and should be made accountable through quality transparency mechanisms such as IHA pay-for-performance public reporting. The current delegated model system serves over 18 million Californians. We encourage the Exchange to continue to build upon this system through the following strategies: 1. Incent QHPs to transition away from pure FFS payments to alternative payment models, such as capitation 2. Incorporate the quality transparency system under IHA pay-for-performance as the primary reporting mechanism for provider quality presented to Exchange consumers 3. Incent the increasing percentage of payments based on outcome-driven alternative payment models over time. For example, incent the phase-in from existing 1% of provider payments under P4P to 50 % of all payments by certified QHPs over a graduated, transitional period, such as five years. 4. Incent the adoption of CAPG-specified care management requirements (our letter of June 18, 2012) for a specified percentage of each QHP's provider network over a phased-in period, such as five years. We suggest that 50% of each QHP's network be capable of the standards enumerated in our June 18th letter by 2017.
California Children's Hospital Association	CCHA agrees with the staff recommendations for the reasons noted in the policy options brief. But please consider in the future, if not present, the larger role around quality collaboration referenced in response to question 6.
California Family Health Council	CFHC supports the Exchange's vision of using "its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness and reducing health disparities. CFHC also applauds the Exchange for its five recommendations to foster better health, quality care and lower costs." However, delivering the promise of health care reform means not only transforming how we deliver health care for those who will be newly insured, but also for the more than one million Californians that will remain uninsured or fall in and out of coverage. CFHC urges the Exchange to include as a goal ongoing support of the health care safety net to promote access to quality health care for all Californians.
California Hospital Association	**Issue 1: Promote Alignment** CHA supports the statements of the Exchange in promoting alignment with both the public and private sector and we recognize the challenges this presents. The document however mentions several key initiatives that are in their early stages and are to date, unproven strategies in lowering costs and improving quality in a scalable way. CHA suggests that the Exchange monitor the activities of initiatives under way at the Centers for Medicare and Medicaid Innovation and that implementation of reforms should be undertaken with caution and after a complete evaluation of

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	the CMMI initiatives is made available for review and consideration by the board. CHA supports recommendation (a), but urges the Exchange to reach out to organizations such as the Commonwealth Fund, the RWJ Foundation or other non-partisan research group or foundation and convene such a group for shared learning. The experiences of the Exchanges will have broad heath policy implications that should be shared and disseminated in a transparent, unfiltered manner. Aligning with reputable organizations such as the Commonwealth Fund or RWJF will bring credibility to that process. **CHA does not support the Exchange formally joining the Pacific Business Group on Health and we urge the Exchange to not move forward in adopting this recommendation**. We understand the need for alignment and encourage formal and informal discussion with the purchaser community in a number of forums. We believe that a state entity that strives to be transparent and open to the ideas of all stakeholders should not formally align itself with one particular organization. The Exchange should be viewed by all stakeholders as an impartial state agency not aligned with any particular private organization or perspective. In our view, joining with PBGH is not in the best interest of the Exchange in maintaining its autonomy and independent organizational integrity. Alternatively, there are other ways in which CHA would suggest that the Exchange engage with a variety of stakeholders. In particular, the report discusses the National Quality Strategy at length and we support that alignment. The National Quality Forum convenes two groups – the National Priorities Partnership and the Measures Application Partnership – both multi-stakeholder groups – to advise HHS on both the implementation and ongoing refinements to the National Quality Strategy and in recommending quality measures for use in federal quality reporting and payment programs. CHA encourages the Exchange to seek seats at these important tables. CHA would fully support the Exchange nomination. **Issue 2: Collect Standardized Information** CHA does not have sufficient information to comment specifically on the use of the eValue8 tool. With that said, we support the desire for standardized information regarding health plan performance and care delivery/payment practices. This tool has been suggested as something the Exchange could use in evaluating plans in its selection process. ***CHA supports and encourages the use of standardized and transparent criteria in the selection process and would suggest that should this tool be used, each sections weight and the scoring***

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	methodology be made available to the public. CHA urges the Exchange to look beyond the Medicare Shared Savings program for quality measures. The measures selected for MSSP were primary for use at the physician level and should be augmented for a health plan population. We appreciate the Exchange's recognition of gaps in measurement and we urge the Exchange to evaluate reports recently released by the Measures Application Partnership that detail those gaps. Gaps in measurement are a significant concern for providers and CHA continues to work with our colleagues at the National Quality Forum and others to identify measures that are not only important but scientifically valid, feasible to implement and can be used by both the public and providers in understanding the quality of care provided and improving that care in a measureable way. However, in our view, the pressure for measures has led to filling the gaps and moving forward in adoption of measures that have proven to be unreliable and that have not been sufficiently validated on the notion of "not letting the perfect be the enemy of the good." The Exchange should avoid such discussions and lead with the adoption of proven quality metrics that have proven track records in the private and public sector. ***The Exchange will represent a whole new population of insured patients, and data on this group is critically important.*** CHA encourages broad stakeholder engagement at every point of implementation to ensure the appropriateness of measures and robust testing, as well as the identification of unintended consequences for the measures/programs that are adopted. The provider community in turn has been an active partner in speeding implementation and identifying barriers and unintended consequences. The Exchange should work with existing local collaborative projects and build on what they have learned and the success of their efforts before proceeding in implementation. ***We encourage the Exchange to continue in its transparency efforts and make available, in a timely way, methodological documents, data analysis and other information that would allow all stakeholders to appropriately evaluate measures and provide constructive feedback.*** Finally, ***CHA believes measures required for public reporting should be, at a minimum, endorsed by NQF and when appropriate vetted by the newly formed Measures Application Partnership.*** NQF endorsement ensures measures have met a certain threshold of evidence, testing and validity.

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	In addition, building on the lessons learned in the federal quality reporting programs, we urge the Exchange to ensure that all QHPs implement protocols that ensure systematic data collection and accuracy across all participating providers. In addition, a rigorous data validation methodology must be put in place to preserve the integrity of the data. ***We urge the Exchange to develop and implement a standardized appeals process for all providers to ensure that any issues that arise in data aggregation or validation can be addressed.*** Creating a process that is consistent across all plans will ease the administrative burden for participating providers. CHA does not support recommendation (c) (prohibit non-disclosure of certain terms). **Issue 3: Require Certain Health Plan Practices** The Exchange discusses a number of potential "requirements" that could be refined in future years. We offer our comments on three important issues to California's hospitals. *a) Consumer information on provider-level performance. Health plans must provide quality information at least at the hospital and medical group level, and describe their plans for physician-level reporting.* ***CHA supports this requirement in the future, however as discussed above, we urge the Exchange to be consistent in its use of quality measures across plans, work to ensure robust data collection and data validation processes are in place, and provide a process for provider appeals and corrections of data that is released to plan participants or to the public.*** The Exchange should provide significant oversight of plans to promote transparency and credibility of the data presented. *b) Cost of care information. Health plans must articulate how they make readily available to their consumers the potential cost of care (both total costs and the consumer's share of costs) in general and how that cost differs by provider.* A measure of cost is one of the most challenging to formulate and communicate to plan participants and to the public. ***CHA urges the Exchange to engage with experts in the field and to require plan transparency in the calculation of such a measure. If the measure cannot be replicated by providers, as is the case with the Medicare per beneficiary measure Hospital Compare earlier this year, the data is not helpful to providers in identifying ways to lower costs.***

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	The Exchange should strive for a common methodology to use across all plans – and that methodology should be based on data and experience of the Exchange population. While it may not be as robust as some plan methodologies, starting with a common approach from which to build is consistent with the overall approach to implementation of the Exchange. ***Several things we would urge the Exchange to consider include the following:*** *Consistent Episodes of Care:* A shorter episode of care is far more understandable then the complexities of unraveling a 90 day period. Short episodes that are consistent across plans would assist in the methodological detangling of the episodes for our most complex patients discussed below. *Exclude All Other Incentive Payments:* In order to standardize the costs and make reliable comparisons, it would be important to exclude all incentive payments that may be received by providers as part of any risk associated contracts. Standardizing payments to providers is essential in creating a measure that can be compared across providers. *Include Robust Risk Adjustment:* It is important that sufficient risk adjustments be used beyond age and severity of illness. We urge the Exchange to adopt a third and important factor — socio economic status — which also contributes to cost variation in the methodology. *Exclude Post-Acute Care Costs in Measure:* Unlike the Medicare Shared Savings Program where ACA requires CMS to include all Part A and B services in the benchmark, the Exchange has significant flexibility in formulating a cost measure. Combining all post-acute care services into one cost measure makes it incredibly difficult for a patient to make informed decisions. CHA is concerned that, by not excluding these payments, providers may be incentivized to control costs by choosing lower cost post-acute-care services without regard to implications on patients' ability to maintain independence. For example, a patient who has suffered a stroke may require continued intensive rehabilitation to recover sufficiently to return home. However, the decision may be made to send that patient to a less expensive SNF setting, even if it limited the patient's recovery of independent living skills.

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	Further, access to post-acute-care services will vary from one community to another, and without adjusting for what services are available there likely will be huge variations in costs. For example, California has a number of LTCHs in the central and southern part of the state, but these services are not as readily available in the northern part of the state. *d) In each of the following areas, health plans must articulate specific strategies they are engaged in (note: in future years the type or results of such efforts would be potentially used as thresholds for selection or "scored", but for 2014 the Exchange would only require some description of efforts which could be fulfilled by the pans completion of eValue8). Required strategies should include:* • *Payment or oversight programs aimed at reducing hospital acquired infections including, in particular sepsis, central line infections and pressure ulcers, as well as patient safety and avoidable hospital re-admissions.* ***CHA believes these metrics should exclude planned and unrelated readmissions.*** CHA urges alignment of these policies with the federal and state policies already in place and not add to the complexity of these policies, which would increase administrative costs and burden to providers.
California Medical Association	***Issue 1. Promote Alignment*** While we support the Exchange's participation in the formation of a national network of health benefit exchanges, **we recommend that the PBGH membership proposal be revisited as a separate order of business at a future Exchange meeting**. Without further information and stakeholder engagement on this subject, we feel that the Exchange joining PBGH may cross a line by creating the appearance of special access among stakeholders. Many questions need to be answered for stakeholders to be able to intelligently assess such a proposal, such as: Under what authority is the Exchange taking this action?; Will this mean interested parties now need to attend PBGH meetings in addition to the public Exchange meetings, assuming PBGH meetings are even public?; Why is formal membership required and what does it entail that would not otherwise already exist?; What, if any, duties or responsibilities does PBGH membership place on the Exchange?; Will interested parties now need to submit comments related to delivery system reform and performance measurement to PBGH in addition to the Exchange? Again, we believe the PBGH proposal should be revisited as a separate item of business at a future Exchange meeting and were frankly surprised to see it included in the QHP Board Recommendations Brief.

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	Issue 2. Collect Standardized Information **We oppose the prohibition of "anti-transparency" clauses in provider contracts without concomitant provider protections.** Such a prohibition without significantly detailed legal guidance will also greatly impair contract negotiations between QHP issuers and providers. Indeed, this recommendation by the Exchange demonstrates the substantial need for a delivery system advisory group, focusing on the provider perspective. This recommendation not only runs contrary to the Exchange's repeated intent to minimize QHPs' administrative and operational burdens association with provider contracting, it will significantly increase such burdens by making provider contracting more difficult. This will consequently endanger adequate patient access for Exchange products. To simply prohibit "anti-transparency" clauses without any concomitant provider protections or, more importantly, thoughtful, precise parameters around what that prohibition exactly entails will inhibit efficient contracting between providers and plans. This failure to provide necessary provider protections would force providers, as well as plans, to expend resources negotiating the line between "anti-transparency" and merely protecting the provider from inaccurate or otherwise unfair reporting. These protections would include, among other things, measures affording physicians due process rights in challenging information prior to their public disclosure, unfettered access to the data upon which they are being profiled, and proper patient disclosures to put the reported information in the proper context. For the above reasons and others, the Exchange must engage physicians in the discussion on what should or should not be in a provider contract. Not doing so now will result in more significant issues in 2013 and beyond. As a final note, this is further support for the need of a topic-specific advisory group focused on the delivery system and provider perspective of the Exchange. We urge the Exchange to engage stakeholders, primarily providers and plans, on this proposal, produce detailed guidelines around what this proposal means regarding contract law, and revisit it at a later Exchange meeting. ***Issue 3. Require Certain Health Plan Practices***. We look forward to working with the Exchange to identify those potential requirements that could be refined in

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	future years and believe that a topic-specific advisory group focused on the delivery system and built around clinician expertise would be extremely beneficial to the Exchange in this task. The development of an optimal provider-level performance measurement and reporting system will be a complex and lengthy process in which stakeholders must be engaged. Done poorly, such a system could add significant administrative costs to healthcare delivery, provide misleading or inaccurate data to consumers, and adversely impact physician behaviors. For these reasons, we support the American Medical Association's *Guidelines for Reporting Physician Data*, which is supported by more than 60 other organizations.[15] The potential negative consequences of various public performance reporting systems, e.g., coronary artery bypass graft (CABG) report cards, are well documented.[16] For instance, one such study of the accuracy of CABG report cards compared audited Society of Thoracic Surgeons clinical data with the administrative data used for public reporting by Medicare, the state, the hospital system, and HealthGrades.com for the same cohort of patients and found that risk-adjusted mortality in the publicly reported datasets exceeded that of the verified clinical data by as much as 61 percent.[17] CMA itself has seen firsthand how faulty publicly reported data can be and the unfairly negative impact that can have on a physician's personal and professional reputation. For example, we have had physicians report negative scores for not recommending cervical cancer screening to patients who had undergone hysterectomies, as well being penalized for procedures that were recommended but subsequently denied on medical necessity grounds. More broadly, physicians are often penalized for patients not adhering to recommended treatments. Finally, great care must be taken to ensure clinician-level reporting is consistent with the Exchange's goals to reduce wasteful administrative spending, as such reporting can add significant cost and administrative burden to the system when taken in the aggregate. In fact, a significant portion of the provider administrative burdens referenced on page 219 of the Board Discussion Draft (dated July 16, 2012) arise from required provider reporting,

[15] American Medical Association. Guidelines for Reporting Physician Data 2012. Available at:< http://www.ama-assn.org/ama/pub/physician-resources/practice-management-center/health-insurer-payer-relations/physician-efficiency-quality-data/practice-data/take-charge-of-your-data/physician-reporting-guidelines.page>.
[16] Werner RM and Asch DA. The unintended consequences of publicly reporting quality information. *JAMA* 2005; 293: 1239-1244.
[17] Mack JR, Prince S, Dewey TM, *et al*. Does reporting of coronary artery bypass grafting from administrative databases accurately reflect actual clinical outcomes? *J Thorac Cardiovasc Surg* 2005;129:1309-1317.

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	and we were pleased to see that the Exchange intends to promote standardization in provider level reporting in the Administrative Simplification Board Background Brief.
California Pan-Ethnic Health Network	CPEHN strongly supports staff's recommendation that the Exchange *require* health plans to complete portions of the eValue8 Health Plan RFI to collect data that supports Qualified Health Plan oversight and reporting of plans' quality improvement strategies in accordance with the Affordable Care Act. The collection of this data will allow the Exchange to gather important baseline data, particularly on cultural competency and disparities reduction that can be used as part of the selection criteria moving forward for Health Plans in the Exchange. 1. Modules: In reviewing the various eValue8 modules, CPEHN recommends the Exchange consider adopting Module 1, Section 1.7 Racial, Cultural and Language Competency. We would also advocate for adoption of Module 2 as it relates to consumer engagement, particularly Questions 2.3.3, 2.3.4 and 2.3.5 which measure the functionality of consumer engagement tools with respect to the availability of information on the language(s) spoken by a health plan's provider network and the ability of consumers to rank or filter that information as part of the health plan selection process. We have concerns about the adoption of Module 5. Prevention and Health Promotion as some of the questions asked measure the use of prevention and health promotion strategies which we find problematic for reasons we elaborate on more fully in section 6C. 2. Areas to consider for weighting: CPEHN supports staff's consideration of differential weighting of specific plan performance elements as core or threshold participation requirements for QHPs in the Exchange. *We are particularly supportive of weighting plans who can articulate specific strategies they are engaged in with respect to initiatives specifically geared at ensuring the provision of culturally competent care and measuring and addressing health disparities.* However we also appreciate the importance of potentially weighting for other factors noted by Exchange staff such as: •Promotion of care coordination and medical homes; •Chronic disease management; •Data-driven outreach to at-risk or underserved populations, or high impact conditions identified through the National Quality Strategy or National Prevention Strategy; •Payment or oversight programs aimed at reducing hospital acquired infections including, in particular sepsis, central line infection and pressure ulcers, as well as patient safety and avoidable hospital re-admissions; •Demonstrated support for innovations in care that improve care coordination and primary care access, including access in rural geographies.

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	5. Most important modules: CPEHN strongly supports staff's recommendation to require health plans to fill out Section 1.7 Racial, Cultural and Language Competency. California's population is one of the most diverse in the country, with almost 60% comprised of communities of color and over 100 different languages spoken. In California, over 2.60 million non-elderly adult Californians will be eligible to receive federal tax credits to purchase affordable health coverage in the Exchange in 2013.[1] Of these, 67% (approx. 1.73 million) will be people of color and 40% of the adults (roughly 1.06 million) will speak English less than very well. Module 1.7 will help to ensure that the data on cultural competency collected by the Exchange is comprehensive data that will allow the Exchange to advance its mission of promoting health equity while ensuring that consumers are able to make informed choices during the health plan selection process. Requiring plans to collect and report on key data elements in Section 1.7 is already a requirement under SB 853, §1300.67.04 of Title 28 California Code of Regulations. Specifically the law requires that "Every health care service plan and specialized health care service plan shall assess its enrollee population to develop a demographic profile and to survey the linguistic needs of individual enrollees." Additionally, health plans are required to identify "within its provider directories those contracting providers who are themselves bilingual or who employ other bilingual providers and/or office staff, based on language capability disclosure forms signed by the bilingual providers and/or office staff, attesting to their fluency in languages other than English." Adoption of the eValue8 Module 1.7 will ensure plans are effectively using the data they are required to collect to improve cultural competency and reduce disparities in health care. Question 1.7.3 for example, will indicate to the Exchange, how data on race, ethnicity and primary language is being used to increase cultural competency and set benchmarks or targets for reducing measured disparities in preventive or diagnostic care. Questions 1.7.4, 1.7.5 and 1.7.6 will provide the Exchange with important information about how well plans are supporting the needs of their Limited English Proficient (LEP) members as well as the activities and best practices engaged by plans in assuring that culturally competent health care is delivered. Adoption of the eValue8 Module 1.7 is vital to ensuring that plans that contract with the Exchange are effectively meeting QHP selection criteria V. Reducing Health Disparities. Additionally the Module will provide the Exchange with important baseline data on cultural competency and disparities reduction that can be used as a powerful catalyst for delivery reform moving forward. **Other Quality recommendations:**

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	• CPEHN supports staff's recommendation that the Exchange consider alignment with health benefit exchanges in other states as well as employment-based purchasers here in California. • CPEHN is supportive of staff's recommendations that the Exchange collect baseline data to be used to push delivery reform and improve quality standards including health disparities reduction over time. • We agree with the Exchange staff's recommendation that provider contracts that include anti-transparency clauses be prohibited.
California Primary Care Association	CPCA supports the Exchange's vision of using "its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities," and applauds the Exchange for its five recommendations to foster better health, quality care, and lower costs. We believe that delivering the promise of the ACA means transforming how we deliver health care for those newly ensured, but also for the 1.5 million Californians estimated to remain uninsured. In order to recognize that the Exchange can impact not only the newly insured, but the quality of care offered throughout the delivery system, CPCA recommends that the Exchange add that it will **support the continued viability of the health care safety net as a necessary step to promoting quality, affordable care for all Californians.**
Castlight Health	We are in support of section 6A: Assuring Quality and Affordability Strategies to Promote Better Quality and More Affordable Care (p. 134). We agree that transparency in health plan and provider performance measurement are critical to support and educate consumers shopping for healthcare on the exchange. However, we would extend this to also explicitly support transparency in health plan and provider pricing. As noted, improving value and creating more informed consumers of healthcare requires individuals to have the ability to independently review and compare costs of care. I. To underscore this important point, we would recommend the following updates to section 6A: • Expansion of the goal to support transparency in health plan and provider performance measurement to also include transparency in health plan and provider pricing. • Inclusion in Table 35. Major Transparency Initiatives, specific mention of programs to bring transparency to the cost of healthcare. Addition of 'Total Cost of Care' under Measures associated with Hospital, Physicians, as well as Medical Group.

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	II. To ensure a high standard of transparency is provided to users, we would encourage more specific language be used with respect to the proposal of: "The Exchange may encourage qualified health plans to: Make quality and cost information available to consumers." To ensure actionable data is readily available to consumers, we would recommend that this be made more explicit through the following update: • Refinement of requirement to make quality and cost information available to consumers by specifying data availability via the Internet to enable access whenever individuals are shopping for healthcare. III. Finally, we appreciate the forward thinking behind the list of potential "requirements" that could be implemented in future years. We would encourage the Exchange to propose a more explicit recommendation for Cost of Care information to avoid ambiguity or confusion: • Cost of care (both total costs and the consumer's share of costs) information across providers, including hospitals, medical practices, and individual physicians, is needed to achieve the Exchange's goal of more affordable care. Provider-specific pricing should ideally cover health care services including primary care, specialty care, inpatient care, labs, imaging, physical therapy and pharmacy.
Health Access	• Health Access strongly supports the effort to move forward on reducing health care system costs and improving quality of care for consumers. Affordability for consumers is not necessarily improved because health system costs are reduced. For example, even as the rate of increase in premiums paid by employers has slowed, employers have continued to shift more costs, more risk, and more responsibility onto employees and dependents. Translating reduced health system costs to improvements into better affordability for consumers requires a concerted effort; otherwise other players benefit from the savings, not the consumer. • Health Access supports better reporting on cost and quality and has sponsored legislation in this area. However, we oppose efforts that assume that better information to consumers will enable individual consumers to do what CalPERS and other large purchasers have failed to do: drive system reform by shopping based on the intersection of cost and quality. The Exchange as a purchaser, we hope, will help to do this. But no one is a good comparison shopper when they are lying on a gurney having a heart attack.

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	• We support alignment with health benefits exchanges in other states as well as other employment-based purchasers here in California. • Health Access appreciates the introduction to the Evalu8 tool as part of the recent webinar. However, we are concerned about the recurring reference to it being a "wholly owned tool of the NBGH," particularly in the context of admission to and evaluation of public programs. In general we have found that proprietary products such as this have associated high costs and lack transparency to the oversight body as well as the consumer. We appreciate that for a limited period of time Evalu8 is being made public by the Exchange but the fact that the documents are publicly available only by special arrangement for a limited period of time makes our point better than anything else we could say: this is not a public document created through a public process, it is private evaluation created through a private, proprietary process. • Although it was described as an advantage because of the currency of the data, we are troubled that Evalu8 data would be easily 'overlaid' on top of existing data. If all new input will overlay the previous plan data, it would be difficult to reconstruct what information was in effect at the beginning of the year, or at the first month of enrollment or other retrospective point in time. This would be problematic in the resolution of coverage disputes and in appeals and grievances, • We are concerned about the relatively few checks on the consistency and accuracy of data entered by plans. We understand that the data entered by plans would be made available to consumers, but it would also be used by the Exchange to evaluate the decision to approve the plans as a QHP. This means that the data not only affects plan choice by consumers, but even the threshold decision to be designated as a QHP. Plans will want to make the data appear as favorable as possible to the plan-such an incentive requires that there be sufficient controls on the reliability of the data. It did not appear in answer to questions on the August 1, 2012 webinar that the Exchange will have rigorous processes in place to validate and verify data submitted by plans. The odds of a Lake Woebegone effect are considerable: what good does it do the Exchange or consumers if all plans are above average? • We support collection of standardized information though see below with respect to the development of such measures. No consumer group in California that we know has had an opportunity to review the Evalu8 health plan which has been developed by employer coalitions and health plans, aside from the material provided publicly by the Exchange staff for a limited period of time. Some of what we have seen is acceptable though some of it is problematic. • We support efforts to reduce hospital-acquired infections and note that the fact that outpatient surgery in

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	California is functionally deregulated with respect to infection control and infection reporting should be considered in all such measures (including reference pricing). • Health Access strongly supports measures aimed at reducing health disparities: health plans have been collecting information on race and ethnicity for over a decade. It is time to make them start using it to target disparities. • Reference pricing reflects the failure of insurers to bargain based on cost and quality: it is an attempt to put the burden on the consumer. It is also of limited usefulness because it is limited to care where the consumer has the opportunity (and the knowledge) to shop in advance. • We support the issue raised by Board member Kennedy on the webinar asking for a public policy rationale, to the extent possible, for why contracted terms should not be disclosed to consumers. This would be a powerful incentive to promote competition, properly align quality, value and cost.
Insure the Uninsured Project	We agree with staff recommendations, and support any plans to collect quality data to not only inform consumers in their decision making, but also to inform staff as well.
Kaiser Permanente	We believe the E-valu-8 framework, pursued in concert with other major purchasers, is an appropriate direction for quality improvement. We believe that no framework has the potential to bring about meaningful and rapid change in both quality and affordability, however, than to empower consumers to choose among plans with competing, substantially non-overlapping provider delivery networks. Policy makers and purchasers can survey and report endlessly, but arming consumers with meaningful quality and cost metrics at the point of selecting coverage can unleash market forces in a manner that will be profound – if the experience of consumer-driven markets is a guide in virtually every other sector of the U.S. economy.
Korean Community Center of the East Bay	KCCEB strongly supports staff's recommendation that the Exchange require health plans to complete portions of the eValue8 Health Plan RFI to collect data that supports Qualified Health Plan oversight and reporting of plans' quality improvement strategies in accordance with the Affordable Care Act. The collection of this data will allow the Exchange to gather important baseline data, particularly on cultural competency and disparities reduction that can be used as part of the selection criteria in the future for Health Plans in the Exchange. 1. Modules: In reviewing the various eValue8 modules, KCCEB recommends the Exchange consider adopting Module 1, Section 1.7 Racial, Cultural and Language Competency. We would also advocate for adoption of Module 2 as it relates to consumer engagement, particularly Questions 2.3.3, 2.3.4 and 2.3.5 which measure the

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	functionality of consumer engagement tools with respect to the availability of information on the language(s) spoken by a health plan's provider network and the ability of consumers to rank or filter that information as part of the health plan selection process. We strongly recommend information to be available in various languages and dialects; for example, in South East Asian languages (such as Khmer, Tagalog, Thai, etc.,) and in East Asian languages such as Korean and Japanese, on top of diverse Chinese dialects. We have concerns about the adoption of Module 5. Prevention and Health Promotion as some of the questions asked measure the use of prevention and health promotion strategies which we find problematic for reasons we elaborate on more fully in section 6C. 2. Areas to consider for weighting: KCCEB supports staff's consideration of differential weighting of specific plan performance elements as core or threshold participation requirements for QHPs in the Exchange. We are particularly supportive of weighting plans who can articulate specific strategies they are engaged in with respect to initiatives specifically geared at ensuring the provision of culturally competent care and measuring and addressing health disparities. However we also appreciate the importance of potentially weighting for other factors noted by Exchange staff including: •Promotion of care coordination and medical homes; •Chronic disease management; •Data-driven outreach to at-risk or underserved populations, or high impact conditions identified through the National Quality Strategy or National Prevention Strategy; •Payment or oversight programs aimed at reducing hospital acquired infections including, in particular sepsis, central line infection and pressure ulcers, as well as patient safety and avoidable hospital re-admissions; •Demonstrated support for innovations in care that improve care coordination and primary care access, including access in rural geographies. 5. Most important modules: KCCEB strongly supports staff's recommendation to use Section 1.7 Racial, Cultural and Language Competency. California's population is one of the most diverse in the country, with almost 60% comprised of communities of color and over 100 different languages spoken. In California, over 2.60 million non-elderly adult Californians will be eligible to receive federal tax credits to purchase affordable health coverage in the Exchange in 2013.[1] Of these, 67% (approx. 1.73 million) will be people of color and 40% of the adults (roughly 1.06 million) will speak English less than very well. Module 1.7 will help to ensure that the data on cultural competency collected by the Exchange is comprehensive data that will allow the Exchange to advance its mission of promoting health equity while ensuring that consumers are able to make informed choices during the health plan selection process.

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	Requiring plans to collect and report on key data elements in Section 1.7 is already a requirement under SB 853, §1300.67.04. Specifically the law requires that "Every health care service plan and specialized health care service plan shall assess its enrollee population to develop a demographic profile and to survey the linguistic needs of individual enrollees." Additionally, health plans are required to identify "within its provider directories those contracting providers who are themselves bilingual or who employ other bilingual providers and/or office staff, based on language capability disclosure forms signed by the bilingual providers and/or office staff, attesting to their fluency in languages other than English." Adoption of the eValue8 Module 1.7 will ensure plans are effectively using the data they are required to collect to improve cultural competency and reduce disparities in health care. Question 1.7.3 for example, will indicate to the Exchange, how data on race, ethnicity and primary language is being used to increase cultural competency and set benchmarks or targets for reducing measured disparities in preventive or diagnostic care. Questions 1.7.4, 1.7.5 and 1.7.6 will provide the Exchange with important information about how well plans are supporting the needs of their Limited English Proficient (LEP) members as well as the activities and best practices engaged by plans in assuring that culturally competent health care is delivered. Adoption of the eValue8 Module 1.7 is vital to ensuring that plans that contract with the Exchange are effectively meeting QHP selection criteria V. Reducing Health Disparities. Additionally the Module will provide the Exchange with important baseline data on cultural competency and disparities reduction that can be used as a powerful catalyst for delivery reform moving forward.
LGBT Health Consortia	We support the Exchange's recommendation of collecting race and ethnicity information to support assessment of health disparity reduction. However, collection of only race and ethnicity data is not sufficient to support a comprehensive assessment of QHP quality, and it does not capture information on other population-based health disparities affecting diverse groups of Californians. To ensure that QHPs are prepared to optimally serve diverse consumer populations, the Exchange should include the following data collection provisions in the QHP certification standards to promote better quality and affordable care: **a. Require QHP issuers to have the capacity to collect and report voluntary and confidential information on the race, ethnicity, primary language, sex, disability status, sexual orientation, and gender identity of their QHP enrollees.**

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	Recognizing the importance of data for advancing health reform efforts, Affordable Care Act Section 4302 requires federally supported health surveys and programs to collect information on race, ethnicity, sex, primary language, and disability status, as well as any other factors deemed relevant to health disparities. In response to the March 2011 Institute of Medicine report that recommended the routine collection of demographic and health data on LGBT populations in order to address LGBT health disparities, the Secretary of Health and Human Services has used the authority granted by ACA Section 4302 to initiate a process for also collecting information on sexual orientation and gender identity on federal surveys. *See* U.S. Office of Minority Health, "Improving Data Collection for the LGBT Community." (2011, available at http://minorityhealth.hhs.gov/templates/content.aspx?lvl=2&lvlid=209&id=9004). This initiative buttresses existing efforts by numerous divisions across the Department of Health and Human Services to collect confidential sexual orientation and gender identity information from program participants. Collection of this range of demographic data will enhance the ability of California's exchange to assess health disparities in the exchange population, promote better understanding of the diverse backgrounds of exchange consumers, help monitor compliance with nondiscrimination requirements, and facilitate the functioning of other operations of the exchange, including outreach, consumer assistance, and navigator programs. This information should be collected by QHP issuers via claims data and optional questions on plan enrollment forms and should be subject to the same rigorous privacy protections as other sensitive health information. **b. Require QHP issuers to collect and report information on the cultural competency initiatives of their QHPs.** In order to measure the quality and performance of QHPs, California's QHP certification standards should also require QHP issuers to collect and report information on the cultural competency initiatives they incorporate into the care provided to enrollees in their QHPs. An example of such an initiative is Kaiser Permanente's National Diversity Department, which includes Centers of Excellence in Culturally Competent Care and the Institute for Culturally Competent Care (ICCC). The department oversees a range of cultural competency initiatives for Kaiser providers and enrollees focused on "cultural groups who share beliefs, practices, and values based on race, ethnicity, sex, religion, age, disability, sexual orientation, gender identity, and other characteristics." According to the ICCC, "Acknowledging and understanding a patient's cultural values can lead to effective communication, promote treatment adherence, and positively affect health outcomes." *See* Chong N, "A Model for the Nation's Health Care Industry: Kaiser Permanente's Institute for Culturally Competent

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	Care" (*The Permanente Journal* vol. 6, no. 3, 2002).
Monarch HealthCare	The Exchange must seek ways to promote high quality affordable health care through the use of prevention and wellness programs and the reduction of health disparities amongst the beneficiaries. Several key areas/issues must be included: 1. Promote alignment with other purchasers to foster better care, lower costs and improved health. 2. Collect standardized information on health plans performance and care delivery/payment practices to inform future work. 3. Require certain health plan practices that promote better care or standards of performance for participation in the Exchange. 4. Use value-elements in its Qualified Health Plan selection process considering a combination of outcomes (e.g. HEDIS and/or CAHPS scores) and practices (e.g. participation and support for pay-for-performance or medical home initiatives). Monarch is in alignment and supports CAPG's position outlined in their letter dated July 18, 2012. We encourage the Exchange to continue to build upon this system through the following strategies: 1. Incent QHPS to transition away from pure FFS payments to alternative payment models, such as capitation 2. Incorporate the quality transparency system under IHA pay-for-performance as the primary reporting mechanism for provider quality presented to Exchange consumers 3. Incent the increasing percentage of payments based on outcome-driven alternative payment models over time. For example, incent the phase-in from existing 1% of provider payments under P4P to 50 % of all payments by certified QHPs over a graduated, transitional period, such as five years. Monarch • Delivery of healthcare through a Medical Home: The State of California has a long history and is positioned to deliver integrated care through multi-specialty physician groups and independent practice associations, like Monarch. Today, we have systems in place that coordinate care to ensure complete networks of providers who can provide care through the continuum from inpatient to outpatient and any ancillary service required. This model provides quality healthcare services through an integrated delivery system and there is no need to create a new structure that would require NCQA accreditation, which is a very costly and prolonged process. Monarch provides comprehensive medical services and programs such as disease management, case management, home visits by physicians, nurse practitioners and social workers, medication management by a Pharmacist and a Touch Team of

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	clinical staff that help coordinate the care for its most vulnerable at risk members.
National Committee for Quality Assurance	Support all five recommendations presented on the August 1st webinar.
National Health Law Program on behalf of the HealthConsumer Alliance	NHeLP and the HCA generally agree with the recommended four part strategy to foster better health, quality care and lower costs. We are particularly pleased by the emphasis on aligning QHP coverage with that of other purchasers, and have made specific recommendations in other sections about ways in which the Exchange can achieve this goal. We also strongly support the proposal to collect standardized information on health plans' performance and care delivery/payment practices to inform future work, and we look forward to working with the Exchange to identify particular data points and measurement tools that will provide rich insight to inform the Exchange's ongoing operations. We support the proposal to require certain health plan practices that promote better care or standards of performance for participation in the Exchange. To the extent there are already practices and standards that are well-established as improving health, enhancing quality and reducing cost, we urge the Exchange to require QHPs to adopt them now. As one example, we urge the Exchange to consider giving priority to health plans that have established a model for patient centered medical homes (PCMHs). The Affordable Care Act emphasizes the importance of PCMHs. A PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. In 2011, the National Committee on Quality Assurance (NCQA), and the Accreditation Association for Ambulatory Health Care (AAAHC) established model standards and guidelines for certifying PCMHs that could be adapted by the Exchange to assess whether QHPs are able to provide patient-centered, coordinated and effective care to their enrollees, especially those with complex health care needs or multiple chronic conditions. See NCQA, Patient Centered Medical Home, http://www.ncqa.org/tabid/631/default.aspx; AAAHC, Medical Home On-Site Certification, http://application.aaahc.org/MedicalHome.aspx. Plans that contract with providers that have been recognized by the NCQA or AAAHC as meeting their PCMH guidelines should be given priority in the QHP selection process. We look forward to working with the Exchange to identify additional plan practices and standards that will achieve the Exchange's goal of fostering better health, quality care and lower costs. Finally, we strongly support the proposal to use value-elements in the QHP selection process considering a

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	combination of outcomes (e.g. HEDIS and/or CAHPS scores) and practices (e.g. participation and support for pay-for-performance or medical home initiatives). We generally support the use of HEDIS (or equivalent clinical quality measures) and CAHPS scores in the QHP selection process. In particular, the Exchange should consider HEDIS measures that are particularly relevant to people with disabilities or chronic conditions, including measures of comprehensive asthma and diabetes care and mental illness management. We recognize that existing clinical quality measurement tools do not adequately account for the particular needs of people with disabilities and encourage the Exchange to work with consumers, NCQA and URAC to develop better measures. In addition, we suggest that the Exchange adopt measures from California's Maternal and Infant Health Assessment (MIHA) survey scores to evaluate potential QHPs. The MIHA survey is based on the Pregnancy Risk Assessment Monitoring System (PRAMS), developed by the CDC and state health departments to measure of pregnant women's patient experience. At a minimum, the Exchange should take note of whether potential QHPs have reviewed the MIHA survey and whether they have designed covered services and overall systems to address issues that were identified in the surveys. We also support the recommendation that the Exchange give priority to potential QHPs that have adopted established practices that improve health and lower cost, such as PCMHs, as described above. Again, we urge the Exchange to adopt well-established factors for the QHP selection process as soon as possible, to ensure that enrollees have access to the highest quality care at the lowest cost by January 1, 2014.
Pacific Business Group on Health (PBGH)	For the Exchange to successfully serve as a "catalyst" for better health care delivery, it will need to pursue a carefully targeted set of strategies to improve quality and affordability of care. We describe below those strategies which the employer purchaser community believes to be the critical path for improvement. The Exchange should do more than just "encourage" but must "require" participating plans to adopt these strategies to achieve measurable change. Leading employers and health plans across California are already engaged in each of the following recommended strategies. The Exchange should not lower the bar to meet the "lowest common denominator" but should set the bar high to provide clear guidance and strong incentives to all health plans to adopt practices that lower costs and improve the value of health care for Californians. As the largest purchaser in California, we believe the Exchange not only has the ability but the responsibility to provide high value products for its customers and set a new tone for the health care market that emphasizes transparency, quality and affordable choices. 1. Promote Alignment: a. PBGH strongly believes that for the Exchange to be most effective as a catalyst, it must align its practices with public and private purchasers that are pursuing strategies to improve health and health care. To do this, the

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	Exchange should pursue the key value- based purchasing practices outlined below in the areas of advancing performance measurement, cost and quality transparency and care delivery innovations. (Pg. 154, 1b) 2. Collect Standardized Information: a. PBGH supports the recommendation that plans be required to complete the eValue8 Health Plan RFI to support QHP oversight and reporting of quality improvement strategies. The Exchange should use this information for plan selection, plan engagement and benchmarking. (Pg. 154, 2a) b. The Exchange should also collect information that will directly support consumer choice of plans. (Pg. 150) Key categories include: (1) health improvement (e.g. programs to help to quit smoking, cholesterol management, weight management/nutrition, etc.) (2) disease management (e.g. programs to address asthma, cancer, diabetes, etc.) (3) how to save money (e.g. provider and medical services shopping, discounted services like a gym membership, savings opportunities for medications) and (4) care management services (e.g. health coach, 24 advice nurse, health risk assessment/counseling, complex patients program, etc.)[1]. c. PBGH strongly supports the prohibition of health plan provider contracts that include anti-transparency clauses, such as restrictions on the use of administrative data for performance reporting. Without this requirement, Exchange consumers will not have access to critical information they need to make choices about care providers and plans. These anti-transparency clauses constitute a serious weakness in the current performance infrastructure. (Pg. 154, 2c) 3. Require certain health plan practices that promote better care or standards of performance: a. The Exchange should require QHPs to provide Exchange customers with hospital and medical-group level performance information that is as comprehensive as possible. (Pg. 155, 3a) Metrics should include benchmarks and performance thresholds for clinical outcomes, functional status, appropriateness, patient experience, care coordination and care transitions, and cost and resource use. In the early years, the medical group performance dataset should draw upon the Patient Assessment Survey (PAS) patient experience and Integrated Health Association (IHA) clinical measures. The Exchange should leverage PBGH's work with the CA Office of the Patient Advocate (OPA) to summarize this information and present individual elements in a hierarchy that is most useful to consumers. b. Consumers also need information about provider performance at the *individual provider* level in order to make good health plan and provider choices. To get a breadth of measures, data will have to be aggregated across payers (numbers can be too small at the issuer level). Therefore, the Exchange should require plans to participate in statewide aggregated claims data initiatives such as the California Healthcare Performance

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	Information System (CHPI). (Pg. 147) Simply asking QHPs to identify their plans for physician-level reporting is inadequate; we should begin pooling provider-level performance information to make it available to consumers. (Pg. 155, 3a) c. PBGH supports the recommendation that health plans must articulate how they will make information on total costs and the consumer's share of cost available to consumers at a provider level. (Pg. 155, 3b) The Exchange should select those plans that provide cost information and explanation necessary for consumers to make informed choices about their care providers based on the cost and quality of services. The Exchange must make consumers aware of the relationship between cost and quality so cost is not viewed as a proxy for quality. 4. Use value-elements in its Qualified Health Plan selection process: a. Staff recommendations shy away from requiring plans at the outset to adopt practices that are known to reduce costs and improve quality. This is a missed opportunity. We recognize that standards for QHPs should mature as more information is gathered about best practices, but the Exchange should start by requiring plans to adopt the following strategies that have already been shown to be effective in California: i. Reference Pricing. Reference pricing is a health care benefit design in which payers set a cap on payment for selected clinical services that are equivalent in quality but vary in price. If a patient seeks clinical services from a provider whose charges are at or below that cap, regular benefits apply. If the patient instead seeks a provider that offers services at rates above that cap, the patient would pay some or all of the difference. CalPERS implemented reference pricing with Anthem Blue Cross and realized significant cost savings. Safeway also instituted reference pricing and saw movement away from expensive providers without impacting outcomes[2]. The Exchange should spread these practices across California by requiring plans to implement some form of reference pricing. ii. Bundled or Global Payment. Bundled or global payments eliminate the perverse incentives of fee-for-service payment by providing contracted provider entities with a budget to deliver care, making lower cost services and care coordination more attractive. There are a number of examples of how global payment has been successfully implemented. In California, CalPERS contracted with Blue Shield of California to offer a limited-network HMO and significantly decreased per member per month costs.[3] iii. Intensive Outpatient Care for High Cost Patients. Multiple efforts around California target these high-need populations by providing team-based intensive primary care. For example, recognizing the need to better serve patients with multiple chronic

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	conditions while reducing their cost of care, CalPERS, Pacific Gas and Electric Company, and Boeing introduced an Intensive Outpatient Care Program with demonstrated success in Humboldt County[4]. Boeing has also demonstrated success with this model in Washington state[5]. The Exchange should do more than just encourage but should require plans to participate in these kinds of efforts given the need for immediate improvement in the way these patients access and receive care. b. Beyond the above, PBGH supports the staff's recommendation that plans should articulate specific strategies they are engaged in regarding (1) promoting care coordination and medical homes (2) payment programs aimed at reducing adverse events (3) addressing health care disparities and (4) innovations that improve care coordination and primary care access. (Pg. 155, 3d) The Exchange should consider scoring plans based on their efforts in these areas in the first year - it will be easier for the Exchange to start with a high bar at the outset than to ramp up requirements over time. c. The Exchange should use designation or differential weighting for performance to select those plans that provide the highest value to consumers. (Pg. 156, 3e) In particular, the Exchange should give heavy weight to the eValue8 elements that have the greatest impact on affordability and quality: consumer engagement, provider measurement and rewards, and chronic disease management. In addition to these critical few strategies to promote quality and affordability, the Exchange should actively support the expansion of available measures to fill gaps in information on outcomes, patient experience and care coordination.(Pg. 155, 2b) The Exchange must also help speed the development of standardized measures of total cost, appropriateness of care and resource use to improve cost transparency. PBGH appreciates the opportunity to respond to staff's recommendations and will be pleased to provide more detail as requested. [1] More details on information required to support consumer choice of plans is provided in a Pacific Business Group on Health analysis which can be found here: http://pbgh.org/storage/documents/Plan_Choice_Rules_Consumer_Decision_Support_Installments_I_and_II_071912.pdf
Pharmaceutical Research and Manufacturers	Using the Exchange to promote best practices among plans and to promote the use of consensus based quality measures can help promote greater quality of care and improved health outcomes which can lead to lower costs.

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of America (PhRMA)	However, we are concerned with proposals that might promote benefit package alignment between purchasers in a manner that could decrease choice, which is particularly troublesome with respect to formularies and could inhibit patient access to the medicines that meet their needs. In Medicare Part D, competing plans with different formularies has resulted in wide access and costs below initial projections.
Small Business Majority	We agree with the recommended principles to promote better quality and more affordable care. Small businesses top healthcare concern is affordability. As such, we suggest in the first year, the Exchange focus on getting the doors open, conducting outreach and enrolling lives in the Exchange. After a successful launch, the Exchange should begin moving towards these innovative reforms to lower costs and increase quality. Specifically, we appreciate Principle #2 to collect standardized information. As referenced in the Board Brief, large employers are able to aggregate this type of data today and are able to better provide their workers with affordable coverage. Small businesses should be able to offer this as well. Making this kind of data available also will help the Exchange compete with the outside market, which may not offer such quality data.
Southeast Asia Resource Action Center (SEARAC)	SEARAC strongly supports staff's recommendation that the Exchange require health plans to complete portions of the eValue8 Health Plan RFI to collect data that supports Qualified Health Plan oversight and reporting of plans' quality improvement strategies in accordance with the Affordable Care Act. The collection of this data will allow the Exchange to gather important baseline data, particularly on cultural competency and disparities reduction that can be used as part of the selection criteria in the future for Health Plans in the Exchange. **1. Modules:** In reviewing the various eValue8 modules, SEARAC recommends the Exchange consider adopting Module 1, Section 1.7 Racial, Cultural and Language Competency. We would also advocate for adoption of Module 2 as it relates to consumer engagement, particularly Questions 2.3.3, 2.3.4 and 2.3.5 which measure the functionality of consumer engagement tools with respect to the availability of information on the language(s) spoken by a health plan's provider network and the ability of consumers to rank or filter that information as part of the health plan selection process. We have concerns about the adoption of Module 5. Prevention and Health Promotion as some of the questions asked measure the use of prevention and health promotion strategies which we find problematic for reasons we elaborate on more fully in section 6C. **2. Areas to consider for weighting:** SEARAC supports staff's consideration of differential weighting of specific plan performance elements as core or threshold participation requirements for QHPs in the Exchange. *We are particularly supportive of weighting plans who can articulate specific strategies they are engaged in with respect to initiatives specifically geared a ensuring*

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	the provision of culturally competent care and measuring and addressing health disparities. However we also appreciate the importance of potentially weighting for other factors noted by Exchange staff including: • Promotion of care coordination and medical homes; • Chronic disease management; • Data-driven outreach to at-risk or underserved populations, or high impact conditions identified through the National Quality Strategy or National Prevention Strategy; • Payment or oversight programs aimed at reducing hospital acquired infections including, in particular sepsis, central line infection and pressure ulcers, as well as patient safety and avoidable hospital re- admissions; • Demonstrated support for innovations in care that improve care coordination and primary care access, including access in rural geographies. **5. Most important modules:** SEARAC strongly supports staff's recommendation to use Section 1.7 Racial, Cultural and Language Competency. California's population is one of the most diverse in the country, with almost 60% comprised of communities of color and over 100 different languages spoken. In California, over 2.60 million non-elderly adult Californians will be eligible to receive federal tax credits to purchase affordable health coverage in the Exchange in 2013.[1] Of these, 67% (approx. 1.73 million) will be people of color and 40% of the adults (roughly 1.06 million) will speak English less than very well. Module 1.7 will help to ensure that the data on cultural competency collected by the Exchange is comprehensive data that will allow the Exchange to advance its mission of promoting health equity while ensuring that consumers are able to make informed choices during the health plan selection process. Requiring plans to collect and report on key data elements in Section 1.7 is already a requirement under SB 853, §1300.67.04. Specifically the law requires that "Every health care service plan and specialized health care service plan shall assess its enrollee population to develop a demographic profile and to survey the linguistic needs of individual enrollees." Additionally, health plans are required to identify "within its provider directories those contracting providers who are themselves bilingual or who employ other bilingual providers and/or office staff, based on language capability disclosure forms signed by the bilingual providers and/or office staff, attesting to their fluency in languages other than English." Adoption of the eValue8 Module 1.7 will ensure plans are effectively using the data they are required to collect to improve cultural competency and reduce disparities in health care. Question 1.7.3 for example, will indicate to the Exchange, how data on race, ethnicity and primary language is being used to increase cultural competency and set benchmarks or targets for reducing measured disparities in

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	preventive or diagnostic care. Questions 1.7.4, 1.7.5 and 1.7.6 will provide the Exchange with important information about how well plans are supporting the needs of their Limited English Proficient (LEP) members as well as the activities and best practices engaged by plans in assuring that culturally competent health care is delivered. Adoption of the eValue8 Module 1.7 is vital to ensuring that plans that contract with the Exchange are effectively meeting QHP selection criteria V. Reducing Health Disparities. Additionally the Module will provide the Exchange with important baseline data on cultural competency and disparities reduction that can be used as a powerful catalyst for delivery reform moving forward.
Vision y Compromiso	Vision y Compromiso supports staff's recommendation that the Exchange require health plans to complete portions of the eValue8 Health Plan RFI to collect data that supports Qualified Health Plan oversight and reporting of plans' quality improvement strategies in accordance with the Affordable Care Act. In reviewing the various eValue8 modules, CPEHN recommends the Exchange consider adopting Module 1, Section 1.7 Racial, Cultural and Language Competency. We would also advocate for adoption of Module 2 as it relates to consumer engagement, particularly Questions 2.3.3, 2.3.4 and 2.3.5 which measure the functionality of consumer engagement tools with respect to the availability of information on the language(s) spoken by a health plan's provider network and the ability of consumers to rank or filter that information as part of the health plan selection process. We also recommend consideration of Exchange staff recommendations including: • Promotion of care coordination and medical homes; • Chronic disease management; • Data-driven outreach to at-risk or underserved populations, or high impact conditions identified through the National Quality Strategy or National Prevention Strategy; • Payment or oversight programs aimed at reducing hospital acquired infections including, in particular sepsis, central line infection and pressure ulcers, as well as patient safety and avoidable hospital re-admissions; • Demonstrated support for innovations in care that improve care coordination and primary care access, including access in rural geographies.

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Anthem Blue Cross	The recommended option (Option B) requires an accreditation status of commendable by 2015. We caution the Exchange that a new entrant into the Exchange, that is not previously accredited, would not be able to achieve this status. It is our understanding that in order to achieve a commendable rating, a plan has to submit HEDIS and CAHPS data to NCQA for use in their scoring. However, new plans do not typically have these data, and are not required to submit them to NCQA until year three of their initial accreditation, which would be 2016. So, the highest rating a new plan could achieve in 2015 would be "accredited," which is one step below commendable. Option B, as proposed, would mean that new plans would never be able to enter and sustain participation in the California Exchange. As a result, we recommend that the Exchange instead adopt Option A or revise Option B to align the timeframes for achieving commendable status with the NCQA process.
Blue Shield of California	The proposed recommendations require QHPs be accredited by NCQA at a commendable level by 2015. Many local plans are not currently accredited and are actively seeking that accreditation. Blue Shield has accreditation for our HMO product, but is in the process of securing accreditation for our PPO product. We are concerned that requiring a commendable level of accreditation by 2015 may force some QHPs to leave the Exchange, disrupting continuity of care for members and creating an additional financial burden to the state to provide for those members. In addition, as a practical matter, the timeline is too compressed to measure this status based on the Exchange population. The plans accreditation for 2015 would be based on an October 2015 update that relies on 2014 HEDIS measurements and February—June 2015 CAHPS results. Many of the accreditation measures have look back periods and enrollment requirements of two to three years. Since the Exchange does not begin until January 1, 2014, plans would not have complete reportable data for all the accreditation HEDIS measures. The earliest date to require commendable accreditation should be 2017.
California Association of Health Plans	CAHP supports the recommendation that there be a pathway to accreditation for plans that may not currently be accredited. However, we are concerned that the timeframe as outlined in the recommendations may not be realistic and we suggest that the Exchange engage in further research.
California Association of Physician Groups	**Accreditation Standards for QHPs** (Page 185-188) CAPG supports the staff recommendation of Option B, which would leverage the existing accreditation requirements commonly in use by larger purchasers and Medi-Cal Managed Care plans and will provide a transitional path for new entrants. This option should be allowed in the first two to three years and re-evaluated for consideration of more rigorous accreditation standards. This would eliminate the requirement of creating a new structure that would be costly and administratively burdensome on the health plans

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	and medical groups. As part of the accreditation standards, the Exchange specifications should include the reporting of CAHPS and HEDIS measure consistent with Medi- Cal Managed Care.
California Association of Public Hospitals and Health Systems	CAPH appreciates the Exchange recognizing the need to obtain and maintain accreditation standards for all QHPs. Additionally, we appreciate your recognition of the value of the participation of local Medi-Cal managed care plans as QHPs in the Exchange. To that end, we thank the Exchange staff for recommending proposals that encourage local health plan participation, including the allowance of sub-regional plans. However, in order for local health plans to meet all the plan requirements, they will have to undergo significant planning and development. While we are overall in agreement with the proposed NCQA Health Plan accreditation requirements the Exchange sets forth in Option B, we ask the Exchange to consider further extending the accreditation timeline to allow for enough time for the local health plans to obtain the necessary accreditation requirements. As valued partners of local health plans, we recognize and support their ability to participate in the Exchange, which will help ensure a diverse array of health plans are available to consumers, including plans that already have extensive experience in serving low-income and non-English speaking consumers. We also encourage the Exchange to continue to build on the NCQA framework and identify additional standards and guidelines to measure quality and incorporate multi-cultural health factors. Given the diversity of the expected consumer population in the Exchange and the significant health disparity gap that exists in California, additional work will be needed to accurately capture data and assess QHPs' efforts and successes in improving health and reducing disparities for Exchange enrollees.
California Children's Hospital Association	CCHA agrees with the staff recommendations for the reasons noted in the policy options brief.
California Pan-Ethnic Health Network	CPEHN supports staff's recommendation requiring Interim NCQA Health Plan Accreditation by 2014; Commendable NCQA Accreditation required by 2015. With respect to cultural competency and disparities reduction, we would also draw the Exchange's attention to the National Committee for Quality Assurance (NCQA) and the National Quality Forum's (NQF) helpful standards and guidelines related to multicultural health. Specifically: • NCQA's ***Standards and Guidelines for Distinction in Multicultural Health Care*** • National Quality Forum's work on: ***Healthcare Disparities and Cultural Competency***. NQF is currently identifying

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	disparities sensitive measures that the Exchange might look to, to promote health equity in the Exchange.
California School Health Centers Association	We support the use of HEDIS and CAHPs measures for QHP accreditation and reporting. We also encourage the Exchange to measures that focus specifically on the particular health needs of children and youth. • ***We highly recommend using the full set of 24 CMS Initial Core Set of Children's Health Care Quality Measures (CHIPRA).*** The CHIPRA measures were authorized by Section 401(a) of the *Child Health Insurance Program Reauthorization Act of 2009* (CHIPRA) and then expanded and improved upon through the Pediatric Quality Measures Program (PQMP) established by Section 401(b). Many of these measures are not currently used in reporting for Medi-Cal health plans and are essential in tracking the wellbeing of children and youth. Examples include measures focusing on diabetes, asthma, Chlamydia and weight assessment and counseling. [18] • Because adolescents are well-known as difficult population to reach and serve, and because they need to be frequently assessed to make sure development is on track, ***we recommend that the Exchange incorporate the Young Adult Health Care Survey (YAHCS) into its plan reporting requirements***. In California, YAHCS is used to survey teen and young adult subscribers of the Healthy Families Program to assess how well the health care system provides them with preventive care in the following eight categories: ○ Counseling and Screening to Prevent Risky Behaviors; ○ Counseling and Screening to Prevent Unwanted Pregnancy and STDs; ○ Counseling and Screening Related to Diet, Weight and Exercise; ○ Counseling and Screening Related to Depression, Mental Health and Relationships; ○ Care Provided in a Confidential and Private Setting; ○ Helpfulness of Counseling Provided; ○ Communication and Experience of Care; and, ○ Health Information
Cigna	We support the required reporting of CAHPS and HEDIS measures and NCQA Accreditation.
Health Access	• Accreditation bodies do not make their accreditation criteria available at no cost to the public thus it is difficult to comment on the appropriate accreditation entity. Historically some accreditation bodies, especially JCAHO, are

[18] Medi-Cal measures: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-021.PDF
Healthy Families Program measures: http://www.mrmib.ca.gov/MRMIB/HFP/2010_HFP_HE_DIS.pdf
Initial CHIPRA Core measures: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/InitialCoreSetResouceManual.pdf

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	nothing but industry self-regulation. NCQA in recent years has attempted to avoid some of the worst abuses of the accreditation industry but it remains a private body funded by fees on participating plans with no public accountability through a governmental process. • Accreditation bodies have historically failed to respond to the diversity of California. It took state government action to force reporting on language access. • We remain especially skeptical about CAHPS data both because of defects in the survey methodology (retrospective over the prior year) and because of lack of public scrutiny as well as the reliance on the concept of consumer satisfaction which our opinion research suggests will conceal substantial consumer fears about care. • We note that the data submitted by plans can vary significantly based on topic. For example, the fact that a plan has received an NCQA rating and accreditation is easily verifiable. However, some of the responses to Evalue8 would be largely invisible. They are subject to interpretation, or are worded so broadly that almost every entity could claim that they participated in activity or met that requirement. One example is "Do you have an effective drug management program?" Presumably every plan knows that the correct answer is yes but what that means substantively in terms of what constitutes an effective drug management program is unclear in a scientific/medical sense. It implies to consumers a high standard in its design, efficiency, and effectiveness when it is based on a self-assessment in response to an inherently biased question. Another example is "Do you provide services for low English proficient (LEP) consumers?" Presumably health plans and state agencies believe that this is a desirable objective. However, in the recent Health Access "mystery shopping" survey of California health agencies, one agency provided a string of alternate telephone numbers for consumers to hang up and call, listed in alphabetical order of language in English (Arabic to Vietnamese). Few consumers or advocates would find that mechanism to satisfy the requirements in California law which requires cultural and linguistic access to care. Because of the lack of clarity of definitions and intent of some data points, data requests should be clarified and the data verified on the basis of its relative importance, the ease of verification, general authenticity of the reporter, and a random verification algorithm. • The Centers for Medicare and Medicaid Services (CMS) solicits broad and detailed submission of data for their Medicare Managed Care Advantage program. Their first step after receiving the data from the plan is to format the data and release it back to the plan for them to verify its accuracy and completeness. Some errors, omissions, and inconsistencies are detected and reported back to CMS by the plan so that these may be promptly corrected prior to public release. However, their second data verification step is to provide the composite data for all plans (prior to public release) to all the participating plans. CMS noted a significant

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	amount of reporting back to the agency of outdated, incorrect, misstated, or exaggerated claims by plan competitors which gave them opportunities to question the plan further or request verification of the content of their data. The Exchange should consider ways to adopt similar verification techniques. • We also have concerns that were first noted by the NAIC Consumer Representatives regarding disease management programs offered by health plans. Although some health plans proudly stated in their offerings that they provided over 15 chronic disease management protocols for their members, the NCQA at that time only credentialed 5 disease management programs. We believe there is potential for overstating the viability of these programs as well as their comprehensiveness and effectiveness. It is clear that some plans promote these programs as an inducement for consumers to enroll, some of these programs may not be credentialed and havelimited evidentiary value and/or be used to steer those with chronic diseases to options that provide more limited care or have higher consumer costs which may drive enrollment, but provide little consumer benefit. • The Exchange should not be taken in by the mere existence of chronic disease management programs, but should go further to require data on the utilization of these programs by their membership as well as measuring any improvement in their members' health outcomes that results from such a program.
Health Net	We support the recommendation by Exchange staff to require reporting of CAHPS and HEDIS measures with interim NCQA Accreditation required by 2014.
Insure the Uninsured Project	We agree with staff recommendations
Kaiser Permanente	We support the recommendation for 1) CAHPS and HEDIS data reporting, and 2) NCQA "interim" accreditation in 2014; "commendable" or better accreditation by 2015. We do not believe accreditation by URAC should be an acceptable quality standard for the Exchange, since URAC does not include clinically-based quality standards such as HEDIS reporting. On page 151, the staff recommendation regarding HEDIS and/or CAHPS scores suggests that the bar might be set fairly low initially and raised over time. We note, however, that the Exchange may have its greater ability to influence the market early in its existence. The ambition of the Exchange should be to bring about robust quality and service reporting without further delay – and to recognize that such reporting requirements already are widely required in today's commercial and Medicare markets. A "go slow" approach may inadvertently serve to reward carriers and delivery systems that do poorly on important and widely-reported metrics.

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Molina Healthcare, Inc.	Accreditation Standards and Reporting Medicaid managed care plans with existing NCQA accreditation status should be deemed sufficient for participation in the Exchange. Molina supports Option B which leverages existing accreditation but provides a transitional path for new entrants. Specifically, if plans are required to obtain NCQA accreditation for their Exchange qualified benefit packages, the Exchange must provide appropriate and reasonable transition time for the accreditation status to be achieved (e.g. 3-5 years). It is our experience that it takes no less than three years to become eligible to apply for new NCQA accreditation. We recommend the Exchange use the recent Federal Guidance and Proposed Rules for Federally Facilitated Exchanges which requires QHPs to schedule an accreditation in year one, develop policies and procedures in year two and three and gain accreditation status in year four.
Monarch HealthCare	We agree that Option B would leverage the existing accreditation requirements commonly in use by larger purchasers and Medi-Cal Managed Care plans and will provide a transitional path for new entrants. This option should be allowed in the first two to three years and re-evaluated for consideration of more rigorous accreditation standards. This would eliminate the requirement of creating a new structure that would be costly and administratively burdensome on the health plans and medical groups. As part of the accreditation standards, the Exchange specifications should include the reporting of CAHPS and HEDIS measures consistent with Medi-Cal Managed Care.
National Committee for Quality Assurance	NCQA supports the recommendation to specify the accrediting body it deems the most aligned with the goals of the Exchange. We are hopeful that the guidance they are seeking will follow the model of state flexibility in the design of Exchanges. We have included an explanation of the accreditation survey types that plans seeking participation in the Exchange can pursue: NCQA's revised its Health Plan Accreditation 2013 to allow plans to come through one of three evaluation options. "Interim" evaluation focuses on a review of the plan's policies and procedures. "First" evaluation includes a review of policies and procedures and evidence of implementation of those policies. NCQA is maintaining its "Renewal" option, for plans that have gone through NCQA's Accreditation before. NCQA will begin collecting Exchange specific quality measures (HEDIS/CAHPS) for all plans in 2015, and will consider scoring results in 2016. In addition to the traditional measures reported by plans in California would also suggest exploring the HEDIS

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	measures of Health Plan Value. NCQA is actively promoting the concept of value through high quality, low cost health plans. We have performance measures within HEDIS called Relative Resource Use that focus on how much a plan spends to achieve a health quality outcome. We tested these measures through consumer focus groups of insured and uninsured in California to see if they could be used to help choose plans and the preliminary results were very positive. We will be publishing this information with our project funder, CHCF, this Fall.
National Health Law Program on behalf of the Health Consumer Alliance	Issue 1: Accreditation for Qualified Health Plan NHeLP and the HCA generally agree with the proposed approach to accreditation, including the timeline for accreditation of new plans and the proposal to require interim accreditation and reporting of those CAHPS and HEDIS measures required by Medi-Cal Managed Care. We note that the federal regulations governing accreditation at 45 C.F.R. § 156.275(a) appear to require the Exchange to accept accreditation from any accrediting entity recognized by HHS. The final rule on QHP accreditation, promulgated in July 2012, recognizes both NCQA and URAC as accrediting entities for the purposes of accrediting QHPs in the Exchange, subject to those entities' satisfying certain conditions. We believe that both NCQA and URAC will satisfy those conditions, and suggest that the Exchange adopt a variation of the recommended approach that accounts for accreditation by both entities, and requires an interim accreditation status as designated by either entity by 2014, and NCQA commendable status or a URAC-equivalent by 2015. Since URAC has developed its own clinical quality measures that compare to HEDIS, such a variation should require URAC accredited plans to report comparable clinical quality measures to the HEDIS measures required by NCQA accredited plans. We support the proposal to allow new plans and plans that are not currently accredited to phase in accreditation over time. The proposal strikes the right balance between holding plans to high standards and giving new and regional plans, especially those plans that serve low-income populations, enough time to become fully accredited. We appreciate that the Exchange will consider more rigorous accreditation standards and timeframes after it has operated for two to three years. We believe that this timeframe is reasonable to allow the Exchange to work with enrollees and plans to determine how accreditation can provide as much useful information as possible. In addition to the clinical quality and CAHPS measures required by Medi-Cal managed care, we recommend that the Exchange require plans to complete NCQA's Multicultural Health Care (MHC) Distinction standards, or an equivalent for URAC, for QHP accreditation. Requiring such standards to be part of accreditation is consistent with the ACA's emphasis on prohibiting health disparities, see ACA § 1311, and the California Exchange Board's goal of catalyzing

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	change by reducing health disparities. Finally, we urge the Exchange to work with NCQA and URAC to obtain all accreditation survey elements. By reviewing all survey elements for potential QHPs, the Exchange will be best able to evaluate the areas in which QHPs are strong and weak, to help the Exchange determine where additional monitoring may be warranted.

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AltaMed Health Services	**Issue 2: Provision of a Wellness Program by the Exchange** AltaMed supports Option C, for the Exchange to establish requirements for the wellness programs that are offered by issuers and promotes those programs. **Issue 3: Use of Financial Incentives by Plans to Promote Wellness** AltaMed supports Option A, Exchange will allow health plan issuers to use incentives as an optional program. **Issue 4: The Role of the Exchange in Addressing Community and Public Health** AltaMed recommends the Exchange adopts both Option A and B to engage directly with the public and the community health efforts in conjunction with its outreach and marketing campaign, while also having the health plans address public health issues.
American Cancer Society, CA Division	The expansion of wellness programs raises key concerns about both discrimination and cost. Without proper safeguards and oversight, these programs could lead to backdoor underwriting or discrimination. The fundamental goal of any wellness program should be to provide opportunities for individuals to improve their health and wellness. A wellness program should not be used in a way that threatens an employee's ability to maintain health insurance because any resulting decrease in access to care would be in direct conflict with the primary objectives of improving employee health. The key to a successful worksite wellness program capable of sustaining behavioral change is the creation of a "culture and environment that supports and wellness".
American Heart Association	Well-designed comprehensive worksite wellness programs can improve employee health and lower medical costs. The fundamental goal of any wellness program should be to provide opportunities for individuals to improve their health and wellness. Existing research does not suggest that raising insurance rates will motivate individuals to improve their health status. However, research clearly demonstrates that increasing premiums or deductibles if employees can't reach certain health/behavior metrics may deny them access to the very care they need, especially for the most vulnerable employees where chronic disease incidence and unhealthy behaviors are often the most prevalent. The key to a successful wellness program capable of sustaining behavioral change is the creation of a worksite environment that supports health and wellness.
Anthem Blue Cross	Anthem supports the Exchange's intention to allow QHPs to offer health and wellness programs. We encourage the Exchange to allow QHP issuers flexibility to offer programs that have already been developed, as this would permit issuers to leverage existing investments by drawing on proven interventions. This would benefit members' health as well as help to keep premiums affordable. If the Exchange decides to set specific criteria for wellness programs, we

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	encourage you to ensure that those criteria are clearly defined so that issuers will be able to identify which of their existing programs are compliant. Additionally, if the Exchange sets requirements for health and wellness programs, we recommend that they mirror the HIPAA wellness program rules on participation and standards-based wellness programs as closely as possible. Consistency across these various requirements will help issuers to use resources efficiently in designing and developing wellness programs. With respect to the specific recommendations to help the Exchange promote wellness and prevention: • **Issue 1: Use of a Health Risk Assessment Tool**: We support the recommendation to adopt Option C, which would permit health plans to provide an optional health risk assessment tool. • **Issue 2: Provision of Wellness Program by the Exchange**: As discussed above, rather than Option C as proposed, we encourage the Exchange to instead adopt Option B, under which the Exchange would promote the use of wellness programs by issuers, allowing issuers more flexibility and room for innovation, rather than establishing specific rules and requirements. • **Issue 3: Use of Financial Incentives**: We support the recommendation to adopt Option A, which would allow QHP issuers to use incentives as an optional program to promote wellness. We would appreciate clarification that this would apply to the individual market as well as the small group market. • **Issue 4: Role of Exchange in Addressing Community and Public Health**: We agree with the staff's recommendation that the Exchange engage directly with public and community health issues as well as encourage QHPs to address these issues (Options A and B).
Blue Shield of California	**Health Risk Assessment Tool:** While we understand why the Exchange desires that the member risk assessment tool remain optional, we would ask that the Exchange proactively partner with us to encourage members to complete their health risk assessment. This will greatly help us in appropriately targeting the members with the most medical needs at an early stage, potentially avoiding costly hospitalizations due to early detection of disease conditions. **Wellness Programs:** Blue Shield recommends a modified version of Option B, (the Exchange promoting use of wellness programs offered by issuers) and supports allowing issuers to use financial incentives to support wellness. We believe plans should be given the opportunity to develop their own programs as long as they can demonstrate they do not discriminate against certain populations or use these programs to inappropriately "cherry pick" membership. This will allow plans to connect with members and innovate effective programs, while providing appropriate safeguards.

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	Blue Shield's Wellvolution program is an outcomes/participatory hybrid model. Incentives may be earned by meeting selected health outcomes or through participation in selected programs. Program variety ensures access and ability to complete among virtually any population. In addition, individuals have the opportunity to seek a medical waiver if they cannot complete a program. Since we went live with this program in 2011, we have not yet had a waiver submitted.
California Association of Physician Groups	**Issue 1: Health Risk Assessment Tool**: CAPG supports the staff recommendation of Option C – optional risk assessment tool. Promotion of a health risk assessment tool should be voluntary and not a requirement for enrollment into the Exchange. Delegated model physician groups are placed at full financial risk for all medically-necessary services under an HMO. In our experience, plan and third party vendor programs are cumbersome, difficult to coordinate, and interfere with treatments provided by physicians in our member physician groups. For example, during the recent roll-out of the SPD population in Medi-Cal managed care plans, Anthem contracted with a third party vendor to undertake health risk assessments. The results of these assessments were never shared with the capitated, at risk, physician groups responsible for treating these new beneficiaries. Thus, whatever money the state paid to Anthem for this process was wasted in the sense that it did not provide primary care and specialty physicians charged with the care of these patients any relevant information concerning their immediate care needs. The process had to be repeated internally by each of the responsible physician groups that assumed care for the SPD patients. **Issue 2: Provision of a Wellness Program by the Exchange:** CAPG supports the staff recommended Option C, because this option would establish requirements for the wellness programs offered by issuers and not mandate a single program. The program would leverage existing efforts offered by issuers with front-end design and content requirements and back-end reporting on consumer engagement and population comparisons. **Issue 3: Use of Financial Incentives to Promote Wellness:** CAPG supports the staff recommendation of Option A, which utilizes Wellness Financial Incentives set within defined limits. CAPG members view existing issuer programs that utilize incentives to promote member engagement in wellness programs more favorably. There is no need to re-create programs when HEDIS and CAHPS scores are already broadly in use. The downstream providers should also be rewarded for their performance in a manner consistent with established pay-for-performance initiatives. Many health plans already utilize these initiatives, which have yielded a higher rate of engagement by beneficiaries and providers, and has been shown to increase overall patient satisfaction.
California	CCHA agrees with the staff recommendations for the reasons noted in the policy options brief.

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Children's Hospital Association	
California Dietetic Association	Registered dietitians are educated and trained in promoting wellness and preventing disease using evidence-based and cost-effective treatments. At minimum, RDs are required to complete a baccalaureate degree and one year internship in a program certified by the Academy of Nutrition and Dietetics. They must pass a credentialing exam and participate in a minimum number of hours of continuing professional education every five years monitored and approved by the Commission on Dietetic Registration. RDs would be cost-effective quality providers of medical nutrition therapy in wellness and prevention programs.
California Medical Association	***Issue 1: Use of a Health Risk Assessment Tool or Other Plan based Wellness Promotion Initiatives*** **At this time, we support the Exchange's staff recommendation, Option C, making health risk assessment tools optional for plans**, as many enrollees unfamiliar with the Exchange may view such an assessment as a barrier to care and raise suspicion of its use among the public. However, as the Exchange pursues team-based care delivery models and other innovations, the utility of risk assessment tools should be reexamined. ***Issue 2: Provision of a Wellness Program by the Exchange*** **Without further information on the capabilities of and the costs associated with third-party vendors' wellness programs, we support the Exchange's staff recommendation, Option C, promoting and setting basic requirements for issuer wellness programs and look forward to providing whatever assistance we can in the development of such requirements**. ***Issue 3: Use of Financial Incentives by Plans to Promote Wellness*** **We support the Exchange's staff recommendation, Option A, allowing health plans to offer wellness program incentives so long as they adhere to established guidelines aimed at reducing the potential for risk selection**. ***Issue 4: Role of the Exchange in Addressing Community and Public Health*** **We support Options A and B as being mutually supportive of one another.** Adequately addressing community and public health issues, such as the childhood obesity crisis, will take the efforts and collaboration of all major stakeholders. We look forward to engaging in the discussion on how the Exchange, QHPs, providers, and others might work together to promote public health solutions in California.
California	CPEHN has concerns about staff's recommendations which appear to support the establishment and

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Pan-Ethnic Health Network	promotion of wellness programs in the Exchange. The ACA permits wellness incentives in the individual market only on a ten state pilot basis. Thus it would require legislative action for the Exchange to be granted the authority to explore this option in the individual market. As a result of this restriction, our comments are geared more towards the SHOP Exchange however they are also applicable to the individual market under a pilot project scenario. The expansion of wellness programs raises key concerns about discrimination, privacy, and cost which we outline in our brief: "Wellness Programs that Work and Promote Equity," http://www.cpehn.org/pdfs/New_Wellness_Principlesv6.pdf. Without proper safeguards and oversight, these programs could lead to backdoor underwriting or discrimination. • *Potential for Discrimination and Backdoor Underwriting.* A critical aspect of the ACA is the prohibition on charging higher premiums based upon one's health status. This is especially important to communities of color who are disproportionately affected by health disparities. Health disparities result from many factors including environmental hazards, living in a community that lacks access to healthy food, and discrimination. Wellness programs do not account for these factors. Rather they shift the focus onto the individual alone. Wellness programs that shift costs onto individuals are not a solution towards creating healthy communities. • *Cost and Affordability.* The ACA seeks to provide access to affordable health care coverage. Wellness programs threaten that goal by directly connecting the cost of premiums and share of costs to one's health status. (For example, a small variation in premiums or cost-sharing could make the difference between affordable and unaffordable care for a low wage worker earning $8 dollars an hour.) Evidence shows that individuals will delay the cost of needed health care due to cost concerns. For individuals with chronic conditions delays could lead to even higher medical costs over time. Wellness programs that raise health care costs and do not offer support systems to ensure positive progress pose greater challenges in managing health. • *Privacy Concerns.* Without the proper safeguards, wellness programs threaten individual privacy, especially if information is collected by employers, who are not subject to federal health care privacy laws, such as the Health Insurance Privacy Protection Act (HIPPA). Seemingly innocuous incentives unless implemented with proper oversight, have the potential to be discriminatory in nature. CPEHN opposes basing premiums on health outcomes as this is essentially a back- door to underwriting. The following are recommendations to ensure that wellness programs are not harmful:

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	• **No backdoor underwriting.** An individual's progress (i.e. outcome) in a wellness program should not be directly linked to reductions in premiums or cost-sharing. This practice has the potential to discriminate against persons with chronic diseases or communities with health disparities, which is tantamount to backdoor underwriting and prohibited by law. • **Encourage healthy behaviors, not penalize individuals.** A worksite or community health promotion program should encourage and permit employees to adopt healthy behaviors, not punish employees' ultimate health outcomes. Wellness programs that promote health for all employees, such as community health programs, should be prioritized. Participation-based programs that provide incentives or discounts could be permissible as long as accessible, alternative programs are available at various times and in multiple languages. Participation programs should be evidenced-based, with a demonstrated effect on positively improving one's health status. • **Comply with anti-discrimination and privacy laws**. Wellness programs must comply with all federal and state laws protecting individuals' privacy rights as well as federal and civil rights laws prohibiting discrimination based upon race, gender, sexual orientation, national origin or other protected statuses.[2] Enforcement mechanisms should monitor individual and employer wellness programs. Employers who utilize health risk appraisals (HRAs) must keep employee information confidential and not share or sell the information, except to provide it to the employee's physician. Financial incentives can be provided to the employee for filling out the HRA but should remain voluntary. • **Health care must remain affordable.** The cost of health care should remain affordable and not negatively impact wellness programs. Financial incentives for enrolling or participating in a wellness program should be paid directly to the employee. Further, all health plans and employers utilizing wellness programs should disclose information about cost-sharing or premium practices. • **Wellness programs should be comprehensive rather than outcome focused.** A comprehensive program aimed at improving the health of the employee can have more effective results. For example, a program that improves an employee's cardiovascular health through tobacco cessation, regular physical activity, stress management/reduction, early detection and screening programs, nutrition and weight management, and changes in the work environment to encourage healthy behaviors provide

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	many of the needed factors to help employees improve their health and reduce health care costs in the long term. Rather than putting the entire burden of cost and health management on the employee alone by charging the employee more for an inability to lose weight or quit smoking. • **Wellness program must address all employees' needs.** A wellness program should address the needs of all employees at a given workplace, regardless of gender, ethnicity, job type, physical or intellectual capacity, or socioeconomic status. Programs should be culturally sensitive and inclusive as well as include targeted interventions for more vulnerable employees designed to engage those who are economically challenged or underserved. If the Exchange cannot guarantee equal access for all (regardless of gender, ethnicity, language etc.) to a wellness program, then any incentives associated with that program should be made available to all employees regardless of participation. • **Wellness programs should help employees become healthy while balancing work and home life commitments.** Wellness programs should incorporate child care, elder/dependent care, telecommuting, and flexible work schedules, to help employees meet their overall health goals.
California Primary Care Association	***Issue1: Use of a Health Risk Assessment Tool or Other Plan-Based Wellness Promotion Initiatives*** CPCA notes that the Exchange committed to "develop strategies to collect race and ethnicity information to support assessment and reduction of disparities in care" in Section 6A: Strategies to Promote Better Quality and More Affordable Care. We ask that the Exchange consider the use of health risk assessments as an important data collection tool that could potentially help providers, health plans, and policymakers develop a better understanding of geographic, socio-economic, racial, and ethnic health disparities. CPCA asks that the Exchange consider the importance of data collection when deciding whether or not to make risk assessments optional, and encourage health plans to share risk assessment aggregate information with providers and policymakers to inform decision-making. ***Issue 2: Provision of a Wellness Program by the Exchange; and Issue 3: Use of Financial Incentives by Plans to Promote Wellness*** CPCA supports the Exchange's recommendation that the Board adopt Option C for Issue 2: The Exchange establishes requirements for the wellness programs that are offered by issuers and promotes those programs; and Option A for Issue 3: That the Exchange allows health plan issuers to use incentives as an optional program. We applaud the Exchange for making wellness and prevention a cornerstone of its QHP strategy. CCHCs care for populations with particularly high incidences of chronic illness, low health literacy, and socio-economic, cultural, and linguistic barriers to care. Our patients tend to be older, sicker, and have less knowledge

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	about healthy lifestyles or options for making healthy lifestyle choices. In order to counteract these disparities in access to and knowledge of wellness programs, CPCA asks that the Exchange incentivize the creation of wellness partnerships with essential community providers, such as CCHCs, when designing the requirements for the wellness programs that are offered by issuers. ***Issue 4: The Role of the Exchange in Addressing Community and Public Health*** CPCA is encouraged that the Exchange is considering their role in addressing community and public health issues. While the recommendations in the report propose that the Exchange consider **either** Option A: The Exchange engages directly with the public and community health efforts in conjunction with its outreach and marketing campaign, **or** Option B: The Exchange encourages health plans to address public health issues, CPCA believes that the Exchange should choose **both** options A **and** B. The Exchange has a unique capability to play a powerful role in changing the way that Californians view their health, and CPCA encourages the Exchange to use this opportunity to promote whole-health wellness among the consumers as well as providers.
California School Health Centers Association	Schools are an ideal place for children and youth to receive wellness programs as well as preventive clinical care. School-based health services work because they are immediately accessible and can reach students efficiently in large numbers in conjunction with their peers and family members. Practitioners in the school get to know children and families over an extended period of time and can tailor their services to the specific school community. Wellness: Many schools or school-based health centers offer wellness promotion activities such as asthma and ADHD education; sexual health education or condom availability; nutrition education and fitness programs; tobacco or substance use prevention education and support groups; violence prevention; stress, grief and other mental health support groups. These programs can be an effective way to reach plan members outside the narrow confines of a physician's office. Prevention: Schools conduct mandated vision and hearing screening, fitness testing, and other preventive services such as immunizations and physicals. Because school personnel are in direct contact with students on a daily basis, schools are often able to identify health and behavioral health issues early. To ensure that QHPs are delivering optimal wellness and prevention benefits to their pediatric population, we recommend the Exchange include provisions to ensure that QHPs take advantage of the school setting. Currently, all health plans contracting with the California Department of Health Care Services, Medicaid Managed Care Division

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	are required to execute agreements or MOUs with local school districts to support the provision of CHDP services. (See boilerplate language here. Exhibit A, Attachment 11, Section 13.) ***Building on the Medi-Cal contract model, we recommend that QHPs be required or incentivized to enter into agreements with schools for the provision of wellness and prevention services using language such as the following:*** Contractor [health plan] shall enter into one or a combination of the following arrangements with the local school district or school sites: 1) Cooperative arrangements (e.g., subcontracts) to directly reimburse schools for the provision of some or all of *wellness and prevention* services. 2) Cooperative arrangements whereby the Contractor agrees to provide or contribute staff or resources to support the provision of school linked *wellness and prevention* services.
California WIC Association	**As part of promoting and supporting Wellness and Prevention, CWA urges the Exchange to clearly delineate the content of and protocols for the provision of Clinical Preventive Services.** **Specifically, CWA wants to ensure that screening and nutrition counseling for obesity and chronic disease, and breastfeeding support by trained professionals, as well as the provision of breast pumps, will be included as part of clinical preventive services in health plans. In most cases WIC interventions are the only source of nutrition and breastfeeding support for WIC families. However, since WIC is not funded to provide comprehensive clinical services or medical nutrition therapy, huge service gaps remain.** **Personal counseling and coaching from trained nutrition and breastfeeding professionals covered by the health plans, complementary to WIC's much less intensive anticipatory guidance, would ensure a more effective safety net for prevention of chronic disease in low-income families.** As noted at the Health Care Reform website, Clinical Preventive Services for nutrition and breastfeeding include: **For Adults:** **Dietary and Physical Activity** counseling for adults at higher risk for chronic disease **Obesity** screening and weight loss counseling for all adults **For Women:** **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding

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	supplies, for pregnant and nursing women **For Children:** **Diet and Physical Activity Counseling** for at-risk children **Obesity Prevention** screening and counseling for all children As public health workers on the front lines, working with young families, we know the value of both nutrition counseling, and breastfeeding support and counseling, to prevent obesity, diabetes, cancers, and improve acute and chronic health outcomes. As the challenging issues of cost versus coverage are weighed it would be easy to reduce preventive services to telephone information lines and brochures. **That would be a wholly inadequate response to the statutory intent.** The new health plans must include **evidence-based and effective preventive services** for nutrition and breastfeeding counseling. California WIC Association has produced a policy brief and toolkit, addressing nutrition and breastfeeding counseling and provision of breast pumps as part of Preventive Services. The toolkit provides models of care using the brief interventions at WIC AND counseling provided through Medi-Cal and health plan benefits. **Recommendations:** • Health plan members must be able to meet **in-person** with Registered Dietitians (RD) and International Board Lactation Consultants (IBCLC) for nutrition and breastfeeding counseling provided through the health plan, in addition to a referral to WIC. Recent WIC data show that even with short WIC clinic visits there is improved nutrition intake with nutrition education, and reduced BMIs and breastfeeding rates with improved breastfeeding support. • Health plans should use models of care and periodicity, such as that provided by the National Business Group on Health for Nutrition Counseling and Lactation Counseling, as they build their Essential Health Benefits package. • We support the comments submitted by the US Lactation Consultants Association with regard to the use of International Board Certified Lactation Consultants as part of the health care team as Providers.

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	• Provide benefits for nutrition and breastfeeding counseling and breastpumps **in both the mother's and infant's coverage.** • Provide breastfeeding counseling for the infant **as long as the baby continues to breastfeed**. • **Do not require Treatment Authorizations Referrals** for nutrition or breastfeeding counselings. • Do not require Treatment Authorizations Referrals **for electric hospital grade breastpumps before 60-90 days**. • Provide **quality personal use pumps** when a hospital grade breastpump is not medically needed. Provide equipment specifications for personal use pumps. • Provide quality personal use pumps when a **mother returns to work or school** in order to maintain breastmilk supply and breastfeeding.
Cigna	***Issue 1: Use of a Health Risk Assessment Tool or Other Plan based Wellness Promotion Initiatives*** We support that required completion of the HRA should not be a barrier to enrollment; however, issuers should be able to incentivize customers to complete it (for risk adjustment tracking and wellness promotion). ***Issue 2: Provision of a Wellness Program by the Exchange*** We support the Exchange setting parameters for Wellness programs; however, issuers should be allowed to leverage existing wellness programs. ***Issue 3: Use of Financial Incentives by Plans to Promote Wellness*** Recommend allowing programs with financial incentives to Individuals engaged in wellness as allowed within HHS Final rules. Incentives would be optional, each carrier can determine whether to offer (incentives may not "pay us back" in the way of return – so they would need to be considered additive to the cost of premium). ***Issue 4: Role of the Exchange in Addressing Community and Public Health Care*** We support the Exchange engaging directly with the public on addressing health care; however, insurers should be allowed to focus on those issues which they are best able to manage / have the most expertise (e.g. diabetes;

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	obesity, etc.).
County Health Executive Association of California	RE: Promoting Wellness and Prevention – Issue 4: Role of Exchange in Addressing Community and Public Health. The County Health Executives Association of California (CHEAC) would like to recommend that the Exchange Board adopt a combination of Option A, engaging directly with public and community health efforts in conjunction with your outreach and marketing campaign, and Option B, encouraging health plans to address public health issues. CHEAC welcomes the opportunity to work collaboratively with the Exchange as part of the Exchange's vision to promote wellness as a core Exchange element. In particular, CHEAC recommends the Exchange Board consider a broad public health approach that specifically focuses on wellness and the prevention of chronic disease, employing a variety of strategies, that emphasize the following priority areas: 1) Encouraging healthy nutrition for Exchange enrollees 2) Encouraging methods that increase rates of daily physical activity for Exchange enrollees 3) Supporting approaches that create a healthy, safe physical/built environment for Exchange enrollees These strategies, in addition to the Exchange's existing recommendation to encourage reduced tobacco use, align with recommended chronic disease prevention priority areas that California's local public health departments are already working on. CHEAC, and our community partners, would welcome the opportunity to expand a cooperative approach, both with the Exchange and with the plans operating within the Exchange, to work on ways to reduce the impacts of pervasive chronic disease throughout the state and to vastly improve community health outcomes.
Delta Dental	We support the Exchange's endorsement of wellness programs and suggest that the Exchange consider including dental wellness resources. Unlike medical conditions, dental conditions are largely preventable with proper care. Also, dental health can be a predictor of overall health issues. Delta Dental has an existing self-service wellness program where individuals can access a large library of oral health resources and dental disease risk assessments. We also have existing resources for children (mysmilekids.com) and this website is available in Spanish. These materials can be made available at no additional cost.
Health Access	• The ACA permits wellness incentives in the individual market only on a ten state pilot basis. It and

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	Prevention would require legislative action to permit California to participate in such a pilot. Thus, Health Access limits our comments to the SHOP exchange. • Health Access opposes wellness incentives based on outcomes. Basing premiums on blood pressure, obesity or blood sugar is rating based on health status whether it is called underwriting or it is called wellness incentives based outcomes. If the premium varies based on the individual enrollee's blood pressure, weight, or any other health status factor, it is not permitted under the ACA. • Variations in premiums should not be sufficient to exempt a minimum wage employee from the individual mandate (that is, the employee share of premium including any penalty due to failure to take up a wellness incentive should not exceed 8% of $8 an hour). • Seemingly innocuous incentives such as gym memberships are a recipe for adverse selection: who wants the coverage with the discount on the gym membership? The healthy, high income individual with few family obligations, not the low wage worker with young children and aging parents at home who can't afford gym shoes. Discounts on gym memberships are risk selection mechanisms by another name. • If allowed at all, gym memberships and similar discounts must provide reasonable accommodation for persons with disabilities. • If allowed at all, gym memberships and similar discounts must offer options that are culturally sensitive and recognize the choices available for those in different incomes and neighborhoods. • If allowed at all, gym memberships must offer alternatives for those with medical reasons for lack of participation and for those with family caregiving obligations. • Health risk assessments, if allowed, should not be available to the employer which might use the results as the basis for discrimination based on health condition. • Health risk assessments, if allowed, should be conducted after enrollment in a plan product so that a plan cannot use the assessment to screen for adverse risk.

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	• Health risk assessments must be available in formats other than computer-based formats for the many individuals who lack personal access to a computer and who might be disciplined for using a work computer for personal use. • Health risk assessments must also be culturally sensitive and available in languages other than English. • Any variations in cost sharing in the small group market are limited to the de minimum variation in actuarial value of the precious metal tiers under the ACA. • Insurers offering classes on weight management, pre-diabetes or other health management cannot violate the state law on insurers offering inducements to physicians to treat groups of enrollees differently based on the health condition of the enrollees (Section 1348.6 of the Health and Safety Code). • Any wellness incentives should be subject to evidence based policy making during the implementation period as well as the best evidence available at this time. • Waiving cost sharing in order to promote compliance with chronic disease management regimens is discussed under value based design.
Health Net	We support allowing issuers to utilize health risk assessments and wellness programs as long as they are permitted rather than required. These are areas where innovation and flexibility can result in great value.
Insure the Uninsured Project	We agree with staff recommendations that allow plans to offer wellness program incentives.
Korean Community Center of the East Bay	KCCEB has concerns about staff's recommendations which appear to support the establishment and promotion of wellness programs in the Exchange. The ACA permits wellness incentives in the individual market only on a ten state pilot basis. Thus it would require legislative action for the Exchange to be granted the authority to explore this option in the individual market. As a result of this restriction, our comments are geared more towards the SHOP Exchange however they are also applicable to the individual market under a pilot project scenario.

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	The expansion of wellness programs raises key concerns about discrimination, privacy, and cost. Without proper safeguards and oversight, these programs could lead to backdoor underwriting or discrimination. • Potential for Discrimination and Backdoor Underwriting. A critical aspect of the ACA is the prohibition on charging higher premiums based upon one's health status. This is especially important to communities of color who are disproportionately affected by health disparities. Health disparities result from many factors including environmental hazards, living in a community that lacks access to healthy food, and discrimination. Wellness programs do not account for these factors. Rather they shift the focus onto the individual alone. Wellness programs that shift costs onto individuals are not a solution towards creating healthy communities. • Cost and Affordability. The ACA seeks to provide access to affordable health care coverage. Wellness programs threaten that goal by directly connecting the cost of premiums and share of costs to one's health status. (For example, a small variation in premiums or cost-sharing could make the difference between affordable and unaffordable care for a low wage worker earning $8 dollars an hour.) Evidence shows that individuals will delay the cost of needed health care due to cost concerns. For individuals with chronic conditions delays could lead to even higher medical costs over time. Wellness programs that raise health care costs and do not offer support systems to ensure positive progress pose greater challenges in managing health. • Privacy Concerns. Without the proper safeguards, wellness programs threaten individual privacy, especially if information is collected by employers, who are not subject to federal health care privacy laws, such as the Health Insurance Privacy Protection Act (HIPPA). Seemingly innocuous incentives unless implemented with proper oversight, have the potential to be discriminatory in nature. The following are recommendations to ensure that wellness programs are not harmful: • No backdoor underwriting. An individual's progress (i.e. outcome) in a wellness program should not be directly linked to reductions in premiums or cost-sharing. This practice has the potential to discriminate against persons with chronic diseases or communities with health disparities, which is tantamount to backdoor underwriting and prohibited by law. • Encourage healthy behaviors, not penalize individuals. A worksite or community health promotion program should encourage and permit employees to adopt healthy behaviors, not punish employees' ultimate health outcomes. Wellness programs that promote health for all employees, such as community health programs, should be prioritized. Participation-based programs that provide incentives or discounts could be permissible as long as accessible, alternative programs are available at various times and in multiple languages. Participation programs should be evidenced-based, with a demonstrated effect on positively improving one's health status.

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	• Comply with anti-discrimination and privacy laws. Wellness programs must comply with all federal and state laws protecting individuals' privacy rights as well as federal and civil rights laws prohibiting discrimination based upon race, gender, sexual orientation, national origin or other protected statuses.[2] Enforcement mechanisms should monitor individual and employer wellness programs. Employers who utilize health risk appraisals (HRAs) must keep employee information confidential and not share or sell the information, except to provide it to the employee's physician. Financial incentives can be provided to the employee for filling out the HRA but should remain voluntary. • Health care must remain affordable. The cost of health care should remain affordable and not negatively impact wellness programs. Financial incentives for enrolling or participating in a wellness program should be paid directly to the employee. Further, all health plans and employers utilizing wellness programs should disclose information about cost-sharing or premium practices. • Wellness programs should be comprehensive rather than outcome focused. A comprehensive program aimed at improving the health of the employee can have more effective results. For example, a program that improves an employee's cardiovascular health through tobacco cessation, regular physical activity, stress management/reduction, early detection and screening programs, nutrition and weight management, and changes in the work environment to encourage healthy behaviors provide many of the needed factors to help employees improve their health and reduce health care costs in the long term. Rather than putting the entire burden of cost and health management on the employee alone by charging the employee more for an inability to lose weight or quit smoking. • Wellness program must address all employees' needs. A wellness program should address the needs of all employees at a given workplace, regardless of gender, ethnicity, job type, physical or intellectual capacity, or socioeconomic status. Programs should be culturally sensitive and inclusive as well as include targeted interventions for more vulnerable employees designed to engage those who are economically challenged or underserved. If the Exchange cannot guarantee equal access for all to a wellness program, then any incentives associated with that program should be made available to all employees regardless of participation. • Wellness programs should help employees become healthy while balancing work and home life commitments. Wellness programs should incorporate child care, elder/dependent care, telecommuting, and flexible work schedules, to help employees meet their overall health goals. If the Exchange cannot guarantee equal access for all to a wellness program, then any incentives associated with that program should be made available to all employees regardless of participation.
March of Dimes	With regard to wellness programs, promoting healthy lifestyles and healthy behaviors for women of childbearing age is an important component of comprehensive preconception and maternity care. Allowing flexibility for health plans to utilize incentives that encourage healthy behavior can help women have healthier pregnancies and babies, resulting

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	in cost savings through preventive care. These include policies that promote healthy eating, regular doctor visits and consumption of folic acid and that prevent use of drugs, alcohol and smoking. Wellness programs should not, however, discriminate against those who cannot participate for medical reasons.
Molina Healthcare, Inc.	Issue 1: Use of a Health Risk Assessment Tool or Other Plan-based Wellness Promotion Initiatives Molina Healthcare strongly supports Option B—requiring the use of health plan health risk assessment tools and wellness promotion initiatives. We believe that previously uninsured individuals and health plans will benefit from the use of HRA tools because they will help health plans identify members with complex health conditions that require specialized care. Early identification of these members will allow health plans to build wellness incentive programs into patients' care plans and better support changes in lifestyle or habits needed to improve their health. Issue 3: Use of Financial Incentives by Plans to Promote Wellness Molina Healthcare supports Option A—allowing health plan issuers to use financial incentives to promote wellness. Simple cash back incentives can encourage members to complete HRAs and participate in and complete wellness programs. These programs do not impose significant administrative burdens on plans, and thus will not unreasonably increase costs, but these programs can encourage members achieve their health goals.
Monarch HealthCare	Issue 1: Promotion of health risk assessment tool should be voluntary and not a requirement for enrollment into the Exchange. We would support Option C. Issue 2: We support Option C: Establish requirements for the wellness programs offered by issuers. The program would leverage existing programs offered by issuers with front-end design and content requirements and back-end reporting on the consumer engagement and population comparisons. Issue 3: Monarch supports Option A, which utilizes Wellness Financial Incentives, set within defined limits. Monarch is also a proponent of using existing issuer programs that utilize incentives to promote member engagement in wellness programs. Monarch encourages the Exchange to support currently existing standards designed to improve and promote high-quality, affordable health care services through the promotion of wellness and prevention programs. These elements should be supported by the QHPs and considered as essential elements during the selection process. There is no need to re-create programs when HEIDS and CAHPS scores are already broadly in use. The downstream providers should also be rewarded for their performance in a manner consistent with established pay-for-performance initiatives. Many health plans already utilize these initiatives, which have yielded a higher rate of engagement by beneficiaries and providers and has shown to increase overall patient satisfaction.

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	Issue 4: Monarch supports Option B. The Exchange should encourage the health plans to address public health issues, while leveraging the existing efforts .
National Committee for Quality Assurance	We support the recommendation that plans offer HRAs to enrollees. NCQA's experience with evaluating vendors and plans through our Wellness and Health Promotion program tells us comprehensive Wellness programs are an effective method to improving overall enrollee health and, when applicable, increasing dialogue between employers and their employees. Additionally our program has assisted in collecting and compiling performance measure data on key measures of Wellness and Health Promotion- including the distribution of HRA Assessment and programs geared towards smoking cessation. Our evaluation program includes HRA administration standards, options to administer incentives to promote participation in wellness activities as well as performance measures to help monitor the impact of the various wellness programs. It covers 12 standards and includes 10 performance measures. **Standards Areas**: Employer and Plan Sponsor Engagement, Privacy and Confidentiality, Engaging the Population, Health Appraisals, Identification and Targeting, Self-Management Tools, Health Coaching, Rights and Responsibilities, Measuring Effectiveness, Delegation, Incentives Management (if applicable) and Reporting WHP Performance (optional; Exchange could require). **Performance Measures**: Health Appraisal Completion, Health Promotion for the Population, Staying Healthy, Prevalence of Core Risks Identified on HAs, Number of Core Risks Identified on HAs, Participation, Risk Reduction-Overall, Risk Reduction-BMI Reduction and Maintenance, Risk Reduction-Smoking or Tobacco Use Quit Rate, Risk Reduction-Physical Activity Level
National Health Law Program on behalf of the Health Consumer Alliance	**Issue 1: Use of a Health Risk Assessment Tool or Other Plan based Wellness Promotion Initiatives** NHeLP and the HCA do not agree that health plan risk assessments will unduly burden the Exchange, or will significantly lower Exchange participation. Thus, we urge the Exchange to select either Option A or Option B in this area, to require enrollees to complete either an Exchange-created or plan-created health risk assessment tool as part of the enrollment process. As the Board Background Brief recognizes, the ultimate goal of implementing health risk assessment tools is to engage more enrollees in managing their health. But health risk assessment tools also provide plans with valuable information about their enrollees' needs, which will be particularly important as the Exchange enrolls many uninsured people, many of whom will not have received regular care, into coverage. The information

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	provided by a health risk assessment tool can help plans ensure that new enrollees begin receiving appropriate preventative services immediately and avoid use of more costly acute and emergency treatments. In addition, these tools can provide enrollees themselves with important information about their health status and appropriate steps toward wellness before they even see a primary care provider. As wellness programs grow and develop, we hope that the Exchange will consider using these tools to refer enrollees to appropriate plans and programs. There is room for innovation in equipping enrollees with knowledge of their biometric values, including with the use of historical claims information. When DHCS began to move seniors and people with disabilities from fee-for-service Medi-Cal into managed care in 2010, advocates worked with the department to require plans to perform a health risk assessment of new enrollees. We suggest that the Exchange look at the guidelines for health risk assessments that were developed in that context as a model for what might be required in the Exchange. *See* Cal. Welf. & Inst. Code § 14182(a)(11)-(12). **Issue 2: Provision of a Wellness Program by the Exchange** NHeLP and the HCA commend the recommendation that the Exchange establish requirements for the wellness programs that are offered by issuers and that the Exchange promote those programs. It is the role of the Exchange to monitor quality improvement strategies, and the Exchange is also uniquely positioned to promote the benefits of the QHPs that promote wellness programs. **Issue 3: Use of Financial Incentives by Plans to Promote Wellness** NHeLP and the HCA oppose the recommendation to allow health plan issuers to use incentives as an optional program. If the Exchange chooses to allow such incentives, it must very closely monitor their impact on vulnerable populations. As discussed above, Wellness programs provide robust health tools and activities to support individuals in improving their own health status and outcomes. Incentive programs, in contrast, attempt to promote healthy behaviors (such as encouraging participation in wellness programs) by offering individuals incentives which often have not been proven effective and which may have problematic unintended consequences. We are concerned, for example, that wellness programs that vary health care costs based on achieving certain health outcomes can negatively affect the affordability of health coverage. People who are low income or who have certain health conditions or disabilities may face additional barriers to meeting health status benchmarks. It is essential that the Exchange recognize that some people may face barriers to participating in required activities, depending on when and where the activities take place and whether they involve a cost to participants. FAMILIES USA, WELLNESS PROGRAMS: EVALUATING THE PROMISES AND PITFALLS (2012). While the Exchange might consider some limited implementation of these programs, it should also be aware that there is little research examining the effectiveness of incentive rewards or penalties that specifically raise or lower

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	individuals' health care costs. *Id.* Without strong evidence supporting the effectiveness of rewards programs, the Exchange must carefully monitor such programs for perceived benefits and possible unintended consequences. The Exchange must establish an accountability mechanism to ensure that, where financial incentives are utilized, they are evidence-based programs that actually help people achieve the health outcomes being measured and do not have a disproportionately negative impact on low-income individuals. For example, such programs should have a "reasonable chance of improving the health of or preventing disease in participating individuals." *See* Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 239 (Dec. 13, 2006); 26 C.F.R. 54; 29 C.F.R. 2590; 45 C.F.R. 146. We note that health care dollars are already scarce, and we believe the Exchange should be particularly cautious in allowing limited health care funds to be diverted away from important health care coverage (services, cost-sharing reductions, wellness programs) and towards incentive programs (such as gift cards, free merchandise, etc.). The Exchange must carefully monitor the impact of financial incentives on vulnerable populations. Financial incentive programs can disproportionately harm groups who already face barriers to maintaining health. Racial and ethnic minorities are disproportionately affected by illnesses like hypertension and obesity, for example, and financial incentive programs may end up disproportionately penalizing these groups. Low-income individuals may also face greater difficulty in accessing healthier foods or safe recreation areas, limiting their available resources for achieving incentive program targets. Other unique barriers for low- income individuals can include limited time as a result of working multiple jobs or a lack of childcare or transportation options. These are issues that the Exchange must carefully monitor to prevent indirect discrimination against low-income and vulnerable populations. Finally, these incentives may harm members with disabilities or chronic conditions who cannot comply with or avail themselves of them. **Issue 4: Role of the Exchange in Addressing Community and Public Health** NHeLP and the HCA commend the recommendations that either the Exchange directly engage with public and community health efforts as part of its outreach and marketing campaign, or that the Exchange encourage health plans to address public health issues. We encourage the Exchange to explore how it can undertake both of these approaches. The Exchange has a unique market position to promote awareness of important public health concerns, but also has a strong incentive to work with health issuers to support their community health initiatives. We strongly encourage the Exchange to identify key issues and create a coherent strategy to manage its resources in this area. The Exchange should ideally adopt a multi-pronged approach that takes advantage of the its unique market position, as well as encourages health plans to promote community and public health.

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SeeChange Health Insurance	SeeChange Health commends the Exchange for its emphasis on wellness and preventive care. We look forward to working with the Exchange as it develops requirements related to these programs for carriers participating in the Exchange. In developing these requirements we hope the Exchange will not permit the goal of encouraging simplicity to diminish innovation and experimentation in wellness and prevention programs.
Small Business Majority	Issue 1: Use of a Health Risk Assessment Tool: While we understand the sensitivities around basing insurance premiums on wellness program participation, we believe all stakeholders can agree wellness and prevention are important tools to lower healthcare costs and should be part of the Exchange. An optional health risk assessment tool (Option C) will provide this option for employees that want this option while not serving as a barrier to those who prefer not to take such an assessment. We believe this a modest and reasonable approach. Issue 2: Provision of a Wellness Program by the Exchange: We support the Exchange creating standards for issuer wellness plans (Option B). We encourage the Exchange to conduct research and examine successful public and private market wellness programs to determine which programs are 1) most cost-effective, 2) likely to see high participation rates among small business employees and 3) known to lower healthcare costs and boost worker productivity. As mentioned in previous comments, we also encourage the Board to examine workplace wellness programs that accomplish many of the same goals of the carrier-operated wellness programs without the controversy and without the concerns for adverse selection. We support including workplace wellness programs as a value-add to the SHOP. HealthPass New York and CBIA's Health Connections include such add-ons in their small employer exchanges.
Southeast Asia Resource Action Center (SEARAC)	SEARAC has concerns about staff's recommendations which appear to support the establishment and promotion of wellness programs in the Exchange. The ACA permits wellness incentives in the individual market only on a ten state pilot basis. Thus it would require legislative action for the Exchange to be granted the authority to explore this option in the individual market. As a result of this restriction, our comments are geared more towards the SHOP Exchange however they are also applicable to the individual market under a pilot project scenario. The expansion of wellness programs raises key concerns about discrimination, privacy, and cost. Without proper safeguards and oversight, these programs could lead to backdoor underwriting or discrimination. • **Potential for Discrimination and Backdoor Underwriting.** A critical aspect of the ACA is the prohibition on charging higher premiums based upon one's health status. This is especially important to communities of color

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	who are disproportionately affected by health disparities. Health disparities result from many factors including environmental hazards, living in a community that lacks access to healthy food, and discrimination. Wellness programs do not account for these factors. Rather they shift the focus onto the individual alone. Wellness programs that shift costs onto individuals are not a solution towards creating healthy communities. • **Cost and Affordability.** The ACA seeks to provide access to affordable health care coverage. Wellness programs threaten that goal by directly connecting the cost of premiums and share of costs to one's health status. (For example, a small variation in premiums or cost-sharing could make the difference between affordable and unaffordable care for a low wage worker earning $8 dollars an hour. Evidence shows that individuals will delay the cost of needed health care due to cost concerns. For individuals with chronic conditions delays could lead to even higher medical costs over time. Wellness programs that raise health care costs and do not offer support systems to ensure positive progress pose greater challenges in managing health. • **Privacy Concerns.** Without the proper safeguards, wellness programs threaten individual privacy, especially if information is collected by employers, who are not subject to federal health care privacy laws, such as the Health Insurance Privacy Protection Act (HIPPA). Seemingly innocuous incentives unless implemented with proper oversight, have the potential to be discriminatory in nature. The following are recommendations to ensure that wellness programs are not harmful: • **No backdoor underwriting**. An individual's progress (i.e. outcome) in a wellness program should not be directly linked to reductions in premiums or cost-sharing. This practice has the potential to discriminate against persons with chronic diseases or communities with health disparities, which is tantamount to backdoor underwriting and prohibited by law. • **Encourage healthy behaviors**, not penalize individuals. A worksite or community health promotion program should encourage and permit employees to adopt healthy behaviors, not punish employees' ultimate health outcomes. Wellness programs that promote health for all employees, such as community health programs, should be prioritized. Participation-based programs that provide incentive or discounts could be permissible as long as accessible, alternative programs are available at various times and in multiple languages. Participation programs should be evidenced-based, with a demonstrated effect on positively improving one's health status. • **Comply with anti-discrimination and privacy laws.** Wellness programs must comply with all federal and state laws protecting individuals' privacy rights as well as federal and civil rights laws prohibiting discrimination based upon race, gender, sexual orientation, national origin or other protected statuses. Enforcement mechanisms should monitor individual and employer wellness programs. Employers who utilize health risk appraisals (HRAs) must keep employee information confidential and not share or sell the information, except

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	to provide it to the employee's physician. Financial incentives can be provided to the employee for filling out the HRA but should remain voluntary. • **Health care must remain affordable.** The cost of health care should remain affordable and not negatively impact wellness programs. Financial incentives for enrolling or participating in a wellness program should be paid directly to the employee. Further, all health plans and employers utilizing wellness programs should disclose information about cost-sharing or premium practices. • **Wellness programs should be comprehensive rather than outcome focused.** A comprehensive program aimed at improving the health of the employee can have more effective results. For example, a program that improves an employee's cardiovascular health through tobacco cessation, regular physical activity, stress management/reduction, early detection and screening programs, nutrition and weight management, and changes in the work environment to encourage healthy behaviors provide many of the needed factors to help employees improve their health and reduce health care costs in the long term. Rather than putting the entire burden of cost and health management on the employee alone by charging the employee more for an inability to lose weight or quit smoking. Wellness program must address all employees' needs. A wellness program should address the needs of all employees at a given workplace, regardless of gender, ethnicity, job type, physical or intellectual capacity, or socioeconomic status. Programs should be culturally sensitive and inclusive as well as include targeted interventions for more vulnerable employees designed to engage those who are economically challenged or underserved. If the Exchange cannot guarantee equal access for all to a wellness program, then any incentives associated with that program should be made available to all employees regardless of participation. Wellness programs should help employees become healthy while balancing work and home life commitments. Wellness programs should incorporate child care, elder/dependent care, telecommuting, and flexible work schedules, to help employees meet their overall health goals. If the Exchange cannot guarantee equal access for all to a wellness program, then any incentives associated with that program should be made available to all employees regardless of participation.
Vision y Compromiso	To avoid discriminatory practices among wellness programs, we recommend the following: No backdoor underwriting. An individual's progress (i.e. outcome) in a wellness program should not be directly linked to reductions in premiums or cost-sharing. This practice has the potential to discriminate against persons with chronic diseases or communities with health disparities, which is tantamount to backdoor underwriting and prohibited by law.

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	Encourage healthy behaviors, not penalize individuals. A worksite or community health promotion program should encourage and permit employees to adopt healthy behaviors, not punish employees' ultimate health outcomes. Wellness programs that promote health for all employees, such as community health programs, should be prioritized. Participation-based programs that provide incentives or discounts could be permissible as long as accessible, alternative programs are available at various times and in multiple languages. Participation programs should be evidenced-based, with a demonstrated effect on positively improving one's health status. Comply with anti-discrimination and privacy laws. Wellness programs must comply with all federal and state laws protecting individuals' privacy rights as well as federal and civil rights laws prohibiting discrimination based upon race, gender, sexual orientation, national origin or other protected statuses.[2] Enforcement mechanisms should monitor individual and employer wellness programs. Employers who utilize health risk appraisals (HRAs) must keep employee information confidential and not share or sell the information, except to provide it to the employee's physician. Financial incentives can be provided to the employee for filling out the HRA but should remain voluntary. Health care must remain affordable. The cost of health care should remain affordable and not negatively impact wellness programs. Financial incentives for enrolling or participating in a wellness program should be paid directly to the employee. Further, all health plans and employers utilizing wellness programs should disclose information about cost-sharing or premium practices. Wellness programs should be comprehensive rather than outcome focused. A comprehensive program aimed at improving the health of the employee can have more effective results. For example, a program that improves an employee's cardiovascular health through tobacco cessation, regular physical activity, stress management/reduction, early detection and screening programs, nutrition and weight management, and changes in the work environment to encourage healthy behaviors provide many of the needed factors to help employees improve their health and reduce health care costs in the long term. Rather than putting the entire burden of cost and health management on the employee alone by charging the employee more for an inability to lose weight or quit smoking. Wellness program must address all employees' needs. A wellness program should address the needs of all employees at a given workplace, regardless of gender, ethnicity, job type, physical or intellectual capacity, or socioeconomic status. Programs should be culturally sensitive and inclusive as well as include targeted interventions

Issue #13: Promoting Wellness and Prevention	
Organization	**Comments**
	for more vulnerable employees designed to engage those who are economically challenged or underserved. If the Exchange cannot guarantee equal access for all to a wellness program, then any incentives associated with that program should be made available to all employees regardless of participation. Wellness programs should help employees become healthy while balancing work and home life commitments. Wellness programs should incorporate child care, elder/dependent care, telecommuting, and flexible work schedules, to help employees meet their overall health goals. If the Exchange cannot guarantee equal access for all to a wellness program, then any incentives associated with that program should be made available to all employees regardless of participation.

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Issue #14: Administrative Simplification	
Organization	**Comments**
Anthem Blue Cross	Anthem supports efforts to reduce the administrative burden on health plan issuers and others throughout the health care system in order to maintain affordable insurance options for consumers. However, we are concerned about several of the proposals raised by Exchange staff in the Board Background Brief on administrative simplification. One example raised in the brief is to require all QHPs to use specified tools, such as a common vendor for provider credentialing. We are concerned that this would actually be a cost driver as issuers would have a choice of which vendor to use, and it could also raise quality concerns, as there would be no competition pushing the vendor to perform well and be responsive to issuers' needs. Additionally, it is not clear who would select the designated vendor and under what requirements. In this regard, we believe that plan flexibility will do more to contain costs than will a dictated process and vendor. Another proposed example is standardization of financial audits. We question whether requiring every issuer to perform audits in the same way will reduce costs and would appreciate further detail from the Exchange to support this proposal. Further, given issuers' new accountability for meeting MLR requirements or being required to pay rebates, we strongly believe that issuers should be able to fully control their own costs, including through choosing their own auditors and other vendors and setting their own processes, rather than being required to follow a standardized process set by the Exchange. Finally, the brief suggests, as an example, the adoption of the Workshop on Electronic Data Interchange Strategic National Implementation Process standards for health plan identification cards. We note that California law already dictates standards for ID cards, which issuers have expended resources to meet. Given the requirements already in place, we do not believe it prudent to require issuers to expend further resources and incur greater administrative costs to redesign and reissue ID cards. This would simply add to costs if the workshop's standards exceed or are different from those already required by California.
California Association of Physician Groups	**Administrative Simplification**: CAPG and its members have been for involved in the process of simplifying and standardizing the commonly-used Division of Financial Responsibility document ("DOFR"). The DOFR is the key mechanism through which specific risk is identified and delegated in a typical Plan-Provider capitated agreement. There is great potential in this effort to adopt a uniform DOFR among all 175 of California's Risk Bearing Organizations ("RBO") in that entities such as CalPERS and the Exchange will be better situated to compare apples-

Issue #14: Administrative Simplification	
Organization	**Comments**
	to-apples from one RBO DOFR to the next and to eventually better evaluate the value that each capitated group brings to the market. We encourage the Exchange to familiarize itself with this effort and to support its progress through the appropriate adoption of QHP standards.
California Children's Hospital Association	As noted in the policy brief, the burden on providers of the complexity of hundreds of separate plan contracts is enormous. Reduction of this complexity is one of the very simplest ways to reduce providers' cost structures.
California Hospital Association	Health Insurance Portability and Accountability Act (HIPAA) electronic transactions between hospitals and health plans are specific, defined electronic transfers of health care information used for particular purposes such as checking claims status. One primary objective of establishing the HIPAA transaction set was to achieve administrative simplification by establishing national standards for electronic health care transactions and national identifiers for providers and health plans. Adopting these standards are intended to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange (EDI). Based on comprehensive discussions and interaction with hospitals, CHA believes that administrative simplification could be improved through a fully HIPAA EDI compliant environment. However, widespread compliance with HIPAA standards has not been achieved by many health plans and third party administrators. The Exchange should ensure that all issuers, plans, QHPs and other third parties should comply with HIPAA EDI transaction standards. Further, CHA believes that the eligibility, enrollment and retention system (CalHEERS) should be real-time and provide hospitals with accurate verification information to reduce or eliminate returned claims.
California Medical Association	We are excited by this Background Brief to work with the Exchange to develop and implement tools for administrative simplification that can bring value to Exchange enrollees. Again, we feel that this topic would lend itself especially well to a delivery system topic-specific advisory group focusing on the provider perspective.
California Pan-Ethnic Health Network	CPEHN is supportive of efforts aimed at ensuring administrative simplification as long as consumer care is not negatively impacted.
Health Access	• Substantial cost savings for both QHPs and providers are possible through administrative simplification. This is a fertile but largely unexplored area for cost savings. Much of the friction between

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	providers and plans arises from differences in coding: standardization holds great promise for reducing costs. • Health Access supports the reduction of administrative costs as part of the effort to reduce the overall costs of health care and to make the Exchange products more affordable. For example, CMS found that there were benefits to be gained by reviewing plans' credentialing processes and working with industry coalitions to standardize the best practices adopted by top-performing plans in the Medicare Advantage program. However, we are concerned when Exchange staff expressed on the August 1, 2012 webinar that they had as one of their goals "to reduce the administrative burden on the plans." While it is desirable to have low administrative costs, it should not be done at the expense of consumers or of the integrity of the program. We urge the Exchange to streamline processes and avoid duplication, but not to minimize oversight or skimp on verification of data submitted. • A common example of "streamlining" desired by a regulated industry is to eliminate oversight of compliance with state law and focus only on compliance with federal requirements, or worse yet accreditation standards. Health Access strongly opposes streamlining that eliminates the hard- won protections of state law.
Insure the Uninsured Project	We agree with staff recommendations so that more health care dollars are spent towards care and less to administrative costs.
National Health Law Program on behalf of the Health Consumer Alliance	In general, NHeLP and the HCA support the Exchange's goal of reducing administrative burden to lower costs while improving access to care. We look forward to commenting on specific proposals to achieve this goal in the future.
Pacific Clinics	Under the Exchange Operations Section on page 223, the author discusses administration simplification as it relates to "health plans, regulators, and others." One should keep in mind the importance of interoperable networks so that timely communication with specialty providers (such as community mental health agencies) can occur for improved patient care and outcomes.
Small Business	We appreciate the Exchange's interest in simplifying the administrative processes and costs of running the Exchange and the healthcare system overall. To the extent that the Exchange can develop a reputation of

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Organization	**Comments**
Majority	giving employers the best bang for their buck, the Exchange will find it much easier to attract SHOP customers. Every dollar spent on healthcare is one less than can be spent on hiring employees and growing a business, so the importance of administrative simplification and efficiency cannot be overstated.

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Issue #15: Other	
Organization	**Comments**
California Children's Hospital Association	Continuity of care should focus especially on Patients with Special Health Care needs and those receiving ongoing services or care by a specialty provider or otherwise in the course of treatment. •Accessing care, including chronic care, through alternative points of service •Hospitalized (at time of transition)
California Pan-Ethnic Health Network	CPEHN urges the Exchange to require QHPs and their contracting agents/solicitors to fairly and accurately characterize not only the insurance product being sold but also the requirements of the Affordable Care Act, including the employer obligation, the small business tax credit, the insurance market rules, the individual tax subsidies, the availability of Medi-Cal and other elements of the ACA relevant to the individual and small group market rules. For example, an insurer that characterizes stop loss insurance for small employers as "a means to get out from under the burdensome obligations of Obamacare" is not accurately characterizing the small group market rules. A recent Kaiser Family Foundation study found that 70% of health insurance agents oppose health reform. This fact makes protections against deceptive marketing even more critical. Similarly, the Exchange must have in place a mechanism for monitoring the activity of agents associated with the Exchange who engage in predatory marketing. For example, an agent who engages in a pattern of coercing low-income individuals into buying expensive health insurance products in the Exchange when those individuals are prohibited from purchasing coverage in the Exchange and are eligible for an exemption from the mandate due to their immigration status.
	CHILD-ONLY PLANS A critical component of the Exchange's Qualified Health Plan (QHP) development process includes the provision of child-only plans. The Affordable Care Act (ACA) requires every QHP issuer that offers coverage through the Exchange to also offer that QHP as a child-only plan to individuals under the age of 21. Like all other QHPs, the child-only plans will be based on the state's selected Essential Health Benefit (EHB) benchmark plan. The QHP child-only plan option (as well as family plans) will be an important avenue for children's coverage in the Exchange. Those children who may enroll in a QHP child-only plan are expected to include: • Children with parents who have private employer or SHOP coverage where dependent coverage is not

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	available or not affordable; • Children cared for by their grandparents or other kin who may have private, retiree-only, or Medicare coverage with no access to dependent coverage; • Children with parents who are undocumented and thus ineligible to enroll in Exchange coverage themselves; and • Children with parents who choose to forgo coverage for themselves and are willing to incur the tax penalty, but do not want their child to go without coverage. As a result, it will be critically important that bids submitted by QHPs to participate in the Exchange explicitly delineate how children will be served in both child-only and family plans. The bid description of children's coverage should be as specific as possible, including information about the available network of pediatric physicians and pediatric specialists, youth-serving Essential Community Providers, and access and quality indicators that are distinct to children and youth. We recognize that many factors will be considered with respect to QHP bids, bid evaluations, and selection; we strongly urge you to require QHPs to expressly address how they are prepared to serve children as part of their participation in the Exchange. Further, because final federal guidance and rulemaking have not yet been issued for required pediatric services (see below), it may be necessary to provide for place-holder language in child-only plans, pending final federal rules. Because child-only plans will be based upon the state's selected EHB benchmark, our organizations have spent considerable time and effort evaluating how effectively the currently proposed EHB benchmark will serve children's needs in terms of covered benefits. The ACA clearly lays out 10 general benefit classes for the EHB that must be covered by QHPs, including pediatric services. However the required benefit class of "pediatric services" has not yet been fully defined, and has not yet been the subject of federal guidance or rulemaking. As a result, it is not yet known what must be offered in the EHB in the area of pediatric services (beyond oral and vision care). We recommend that as the state's EHB standard is shaped and the QHP plans are selected, the Exchange further examine the benchmark package with regard to pediatric services, and ensure that child- only plan benefits are fully compliant with final federal guidance and rules. In the absence of formal federal guidance, we have compared California's only current "child-only" plan - the Healthy Families plan - to the EHB benchmark proposed in legislation. Because Healthy Families benefits were carefully tailored to meet the unique needs of children, it is instructive on how benefits should be structured for children.

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	Based on our analysis, it appears that the proposed EHB benchmark (the Kaiser Small Group plan) does not provide the same level of benefits as found in the Healthy Families plan. While we have been pleased with legislative attention to ensuring adequate pediatric oral and vision care benefits in the EHB, we have concerns that the EHB benchmark plan may fall short for children, particularly in mental health care and habilitative services. Specifically, per the definition in Section 1374.72. of the California Health and Safety Code, the Kaiser Small Group plan provides "coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child." We note that Healthy Families currently provides broad mental health benefits for children, including diagnosis and treatment for a range of conditions not limited to children experiencing a "serious emotional disturbance." According to the Healthy Families benefit summary, Healthy Families provides coverage for the diagnosis and treatment of a mental health condition which includes, but is not limited to, the treatment of a member who has experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement, and is not limited to mental health care services for the treatment of Severe Mental Illness (SMI). Given the benefits of early intervention and treatment for children who face mental health or behavioral challenges, California's EHB should provide mental health benefits for children that are no less rich than those provided to adults or currently provided in Healthy Families. This issue is particularly important given the federal directive ("*Essential Health Benefits Bulletin*" Center for Consumer Information and Insurance Oversight, December 16, 2011), which calls for compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) (26 CFR Part 54 (Department of Treasury's Internal Revenue Service regulations), 29 CFR Part 2590 (Department of Labor's Employee Benefits Security Administration regulations) and 45 CFR Part 146 (Department of Health and Human Services Center for Medicare and Medicaid Services regulatory code). Similarly, the long-standing pediatric EPSDT standard also provides therapy benefits for children that are not limited to serious emotional disturbance. In addition to mental health coverage for children, we are concerned that the proposed definition of habilitative services in pending legislation is too narrow to address children's needs effectively. The ACA explicitly states that one required EHB class is "Rehabilitative and habilitative services *and devices.*" We have suggested an amendment to legislative authors that would expand the habilitative services definition to include devices, including hearing aids. Just as vision care and eyeglasses are well-understood to be essential for children, access to hearing aids is equally significant for hearing-impaired children to ensure school success and social and community engagement.

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	We note that the Healthy Families Program provides coverage of: • Hearing tests, hearing aids and related services including audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid; and • Hearing aid(s): Monaural or binaural hearing aids including ear mold(s), the hearing instrument, the initial battery, cords and other ancillary equipment. There is no charge for visits for fitting, counseling, adjustments, repairs, etc., for a one-year period following the receipt of a covered hearing aid. (Enclosure 2.b, 2012-13 11 HFP Draft, Health Model EOC/COI) Absent a federal definition of the EHB's pediatric services, we urge continued consultation on the appropriate level of children's health benefits in the state's EHB package, and a commitment to finalizing child-only plan details only after final federal direction. We look forward to the opportunity to comment further as the EHB is finalized and there is a formal federal rulemaking process.
Health Access	Additional Standards: • QHPs and their contracting agents/solicitors should have an obligation to fairly and accurately characterize not only the insurance product being sold but also the requirements of the Affordable Care Act, including the employer obligation, the small business tax credit, the insurance market rules, the individual tax subsidies, the availability of Medi-Cal and other elements of the ACA relevant to the individual and small group market rules. For example, an insurer that characterizes stop loss insurance for small employers as "a means to get out from under the burdensome obligations of Obamacare" is not accurately characterizing the small group market rules. Similarly an agent that discourages an individual from applying for a subsidy may provide misinformation about the value of the subsidy while accurately characterizing the insurance product being sold. • A recent Kaiser Family Foundation study found that 70% of health insurance agents oppose health reform. This fact makes protections against deceptive marketing even more critical.
Korean Community Center of the East Bay	Additional Standards: KCCEB urges the Exchange to require QHPs and their contracting agents/solicitors to fairly and accurately characterize not only the insurance product being sold but also the requirements of the Affordable Care Act, including the employer obligation, the small business tax credit, the insurance market rules, the individual tax subsidies, the availability of Medi-Cal and other elements of the ACA relevant to the individual and small group market rules. For example, an insurer that characterizes stop loss insurance for small employers as "a means to get out from under the burdensome obligations of Obamacare" is not accurately characterizing the small group market rules. Another example, an agent that coerces a low-income individual into buying an expensive health insurance

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Organization	**Comments**
	product in the Exchange when that person is prohibited from purchasing coverage in the Exchange and eligible for an exemption from the mandate due to his/her immigration status. A recent Kaiser Family Foundation study found that 70% of health insurance agents oppose health reform. This fact makes protections against deceptive marketing even more critical.
Southeast Asia Resource Action Center (SEARAC)	SEARAC urges the Exchange to require QHPs and their contracting agents/solicitors to fairly and accurately characterize not only the insurance product being sold but also the requirements of the Affordable Care Act, including the employer obligation, the small business tax credit, the insurance market rules, the individual tax subsidies, the availability of Medi-Cal and other elements of the ACA relevant to the individual and small group market rules. For example, an insurer that characterizes stop loss insurance for small employers as “a means to get out from under the burdensome obligations of Obamacare” is not accurately characterizing the small group market rules. Another example, an agent that coerces a low-income individual into buying an expensive health insurance product in the Exchange when that person is prohibited from purchasing coverage in the Exchange and eligible for an exemption from the mandate due to his/her immigration status. A recent Kaiser Family Foundation study found that 70% of health insurance agents oppose health reform. This fact makes protections against deceptive marketing even more critical.
Vision y Compromiso	Require QHPs and their contracting agents/solicitors to fairly and accurately characterize not only the insurance product being sold but also the requirements of the Affordable Care Act, including the employer obligation, the small business tax credit, the insurance market rules, the individual tax subsidies, the availability of Medi-Cal

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Issue #16: Aligning the Exchange with Medi-Cal and other State Funded Health Programs	
Organization	**Comments**
Alameda Health Consortium	The Alameda Health Consortium supports Exchange efforts to develop a "No Wrong Door" approach to enrollment, whereby the same web-based system and Navigators are used for new Medi-Cal MAGI enrollment. We recommend that Exchange plan enrollment be streamlined with new Medi-Cal MAGI enrollment and existing Medi-Cal enrollment. Income status fluctuates; naturally populations will transition back and forth between the Exchange and Medi-Cal. We are concerned that all efforts are made to minimize confusion among enrollees and to ensure that everyone who is eligible is successfully enrolled into coverage. To the extent that the Exchange can influence existing Medi-Cal enrollment, we urge the Exchange to work with the State to support county efforts to reduce paperwork, and simplify and streamline existing county Medi-Cal enrollment processes, while preserving and building on the existing local workforce that already has the knowledge and expertise with Medi-Cal and other public programs.
American Heart Association	The exchange should be well integrated with Medi-Cal to ensure seamless enrollment. Individuals may move between Medi-Cal and the exchange over time due to fluctuation in income, therefore it is important to allow for coordination of plans, benefits, and physician networks to ensure continuous coverage.
Anthem Blue Cross	Anthem supports California's efforts to research the factors that will contribute to churn between the Exchange, Medicaid, and uninsurance, and we encourage the state to consider possible policy solutions to minimize churn. We urge the state to implement any new requirements or policy solutions in such a way that maximizes the benefits for Californians while making the most efficient use of state and health plan resources. To help QHP issuers better understand the Exchange's goals with respect to monitoring network overlap between QHPs and the Medi-Cal Managed Care program, we would appreciate further clarification with respect to who would be tasked to monitor network overlap and what additional requirements, if any, would be placed on Medi-Cal plans as a result. Similarly, to better understand how movement of individuals between Medi-Cal and Exchange plans will be monitored, we would appreciate further clarification on who would be tasked with this role and what additional requirements, if any, would be placed on Medi-Cal plans. We note that the Exchange is also considering ways to encourage Medi-Cal managed care plans to participate in the Exchange, such as through requiring plans that participate in both to maintain the same member ID card in both markets. Anthem opposes the mandating of participation in any market. We believe that permitting carriers to have a choice about which markets they operate in will ultimately increase plan participation, encouraging competition and resulting in higher quality plans.

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Organization	**Comments**
Behavioral Health and Recovery Services	1. What would be a conceivable scenario for a family/individual already determined eligible for free fullscope coverage through the expanded Medicaid program to select an additional QHP and would the Exchange such dual coverage – through Medicaid and a QHP? 2. Would Medicaid serve as the primary or secondary insurance in this scenario and would the basic QHP plan level (bronze) already provide coverage in excess of what Medicaid would cover or would the bronze level coverage be somewhat equivalent to the Medicaid coverage to discourage dual enrollment?
California Association of Physician Groups	**Blended Payment Rates**: CAPG urges the Exchange Board to carefully differentiate the standards under which commercial QHPs and Medi-Cal managed care plans operate. The two markets are distinct, serve very different patient populations and payers, and should remain so. CAPG members have expressed concern that QHPs will attempt to blend provider rates between commercial and Medi-Cal plan populations. Such a strategy, if pursued, ignores the significant cross-subsidization that now occurs due to the under-payment of California state-sponsored programs (Medi-Cal, Healthy Families). We believe that this will destabilize the financial solvency of several smaller risk-bearing physician groups across the state and result in further consolidation of the provider market, providing less choice to consumers.
California Children's Hospital Association	It is critical that continuity of care for children is ensured when the child moves back and forth between subsidized Exchange coverage and Medicaid or the Children's Health Insurance Program (CHIP). Children, especially children with special health care needs, can be greatly affected by even small gaps in care and coverage. Children with ongoing health concerns and their families often have a strong reliance on a particular provider and a change in provider networks or coverage can be catastrophic to their development and health. 1. The effects of Churning on Children can be minimized by allowing Child Only plans to participate as QHPs with special continuity protections & by adoption of DMHCs Timely Access to Care requirements particularly those relating to continuity of care. 2. Ensure that a child can obtain a covered service from an out-of-network provider at no additional cost if no network provider is accessible for that service in a timely manner Undergo ongoing monitoring to ensure sufficiency of the network for children and families, including the identification of access barriers and steps to address those barriers.
California Coalition for Reproductive Health	The Board Background Brief, on page 228, notes that analytical support is needed on the issue of "continuity of coverage for pregnant women whose eligibility status may change from the Exchange to Medi-Cal due to their pregnancy." As a preliminary matter, pregnant women must have access to the most comprehensive health benefits package for which they are eligible with the least cost-sharing. A pregnant woman's ability to take advantage of such coverage requires that she be able to make informed decisions about the program in which she will enroll; the system

Issue #16: Aligning the Exchange with Medi-Cal and other State Funded Health Programs	
Organization	**Comments**
	should not coerce her choice through administrative hurdles or the potential for discontinuity of care. Guaranteeing a pregnant woman access to comprehensive, low-cost health care coverage requires alignment between Medi-Cal, the Basic Health Program, and the Exchange provider networks. In the Preamble to the Medicaid Eligibility regulations, CMS explained that women who become pregnant while enrolled under the new Medicaid expansion category for adults to not have to transfer to coverage under 42 C.F.R. 435.116 (Mandatory Coverage of Pregnant Women). The Preamble states: "[In this situation], women should be informed….of the benefits afforded to pregnant women under the State's program. If a woman becomes pregnant and requests a change in coverage category, the State must make the change if she is eligible. But, we will not otherwise expect States to monitor pregnancy status and to shift women into the group for pregnant women once they become pregnant." 57 Fed. Reg. 17144, 17149 (March 23, 2012). Similarly, when a woman enrolled in the Exchange becomes pregnant, she should be informed of all of the programs—the Exchange, the Basic Health Program, if adopted, or Medi-Cal—for which she is eligible including information about available provider networks and differences in cost-sharing. She can then make an informed decision about transitioning to Medi-Cal (or, if applicable, the Basic Health Program) or remaining in the Exchange. Regardless of whether a woman's eligibility status changes, the Exchange must ensure that a pregnant woman can continue with her current providers. The Exchange should either require a QHP to participate in Medi-Cal, (and, if applicable, the Basic Health Program), at least with regard to pregnant women's coverage, or the Exchange must require overlap of provider networks between the Exchange and Medi-Cal (and, if applicable, the Basic Health Program) so that a woman can continue with her current provider(s). Provider network overlap will ensure that pregnant women need not sacrifice continuity of care to benefit from comprehensive Medi-Cal (or the Basic Health Program) services without cost-sharing. The Exchange must establish an expedited and seamless process that ensures that there is no break in a pregnant woman's coverage for health care, if she transitions during her pregnant between the Exchange, Medi-Cal, and, if adopted, the Basic Health Program. Finally, given the complexity of these issues, and their impact on the health and well-being of women and their families, we strongly urge the Exchange to collaborate with DHCS, MRMIB and other departments as needed to gather additional stakeholder input on the coordination and alignment of programs to ensure that pregnant women receive continuity of comprehensive health care coverage.
California Family Health	CFHC strongly supports the Exchange's effort to ensure continuity of care by encouraging the participation of Medi-Cal Managed Care plans in the Exchange market. This will help provide more seamless coverage for individuals that

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Organization	**Comments**
Council	will likely fall in and out of various coverage options and help them maintain their medical home without experiencing disruptions to or delays in accessing care.
California Hospital Association	CHA looks forward to working with the Exchange as it continues to explore and identify specific policy options that will facilitate simple and seamless transitions of enrolled individuals between health care programs. Hospitals stand ready to partner with the Exchange and other stakeholders to identify options and opportunities for coordination and integration between Medi-Cal and the Exchange.
California Pan-Ethnic Health Network	CPEHN supports aligning the Exchange with Medi-Cal and other state funded health programs. Alignment with employment-based coverage is also important.
California Primary Care Association	***Potential Approaches*** CPCA strongly supports the Exchange's adoption of policies that would encourage Medi-Cal managed care plans to participate in the exchange. Continuity of care is a primary concern for the lowest-income individuals transitioning between Medicaid and Exchange coverage, many of whom will be CCHC patients. The inclusion of Medi-Cal managed care plans within the Exchange will ensure that individuals moving from Medi-Cal to QHP coverage can maintain their existing medical home and do not experience disruptions or delays in care, and could simplify the transition process for the consumer. Moreover, the inclusion of Medi-Cal managed care plans within the Exchange will support the inclusion of Medi-Cal providers who do not meet the federally-recommended 340B ECP definition, without the Exchange broadening the definition of ECPs to an extent that it's detrimental to the inclusion of CCHCs. ***Affordable Care Act Medi-Cal Expansion*** CPCA believes that it would streamline the process for the beneficiaries transitioning from LIHP into Medi-Cal if the transition was integrated as much as possible into the single streamlined application process being developed by the Exchange and DHCS for new enrollment into Medi-Cal. Rather than relying on state and county enrollment officials to identify missing data necessary for enrollment, notify the beneficiary, and then wait for a response, it could greatly increase the efficiency and ease of data collection to use the same web-based portal and application assistance Navigators as will be used for Exchange and new Medi-Cal enrollment. The integration of the data collection and enrollment process for the transitioning LIHP populations into the statewide process would reduce backlogs and duplicative efforts on the part of DHCS, the counties, and the Exchange.

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Organization	**Comments**
	No Wrong Door CPCA was disappointed to learn that the Exchange has elected an alternative case data configuration for storing Medi-Cal enrollment data, with MAGI Medi-Cal cases stored in county SAWS systems and CalHEERS storing Exchange cases. In order to promote a positive customer experience, CPCA encourages the Exchange to ensure that MAGI Medi-Cal eligibility determination and enrollment processes are timely and seamless through the CalHEERS user interface.
California WIC Association	The Exchange should ensure that Clinical Preventive Services are aligned with Medi-Cal and other state-funded health programs, as far as member benefits for counseling and screening. Effective prevention strategies will need in-person visits with qualified health personnel, including allied health professionals. We strongly recommend in-person visits **with International Board Certified Lactation Consultants** and **Registered Dietitians** to provide the breastfeeding and nutrition counseling.
Health Access	The majority of Exchange enrollment in both the individual and SHOP exchanges will be individuals who previously had employment-based coverage and who will have it again in the future. The focus on alignment with Medi-Cal is important but equally or more important for the success of the Exchange is alignment with employment-based coverage.
Insure the Uninsured Project	We support the staff in considering the policy options outlined on pg. 229 of the QHP discussion draft, particularly on encouraging issuers to include Medi-Cal providers in their networks and encouraging Medi-Cal managed care plans to participate in the Exchange to mitigate the negative effects of churning.
LGBT Health Consortia	We encourage the Board to consider additional continuity of care issues that will affect individuals and families moving between QHPs sold through the Exchange, as well as those moving between QHPs and Medi-Cal coverage. Coordination of care is particularly important for people with disabilities, people with complex chronic conditions such as HIV/AIDS or diabetes, and individuals and families with limited access to a steady source of insurance coverage. Coordination of care will be important to California's exchange enrollees both in terms of care provided to an individual over time (related to continuity of care) and various clinical services needed by an individual patient at the same time. For example, individuals who experience churning between the Exchange and Medi-Cal coverage will need their care to be coordinated over time to promote optimum health outcomes and seamless access to high-quality services. For enrollees who need a variety of simultaneous treatments, such as those with cancer, plans must also promote coordination of care across providers treating the individual at a given time in order to prevent contraindications, avoid duplicate services, and promote positive long-term health outcomes.

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	To ensure that QHPs in the Exchange promote coordination of care, the Exchange should require QHPs to implement policies promoting coordination of care. Examples of care coordination policies include: 1. Require QHPs to maintain continuously updated clinical protocols and lists of providers for the management of a range of disease- and condition-specific treatment referrals. These protocols should be considered guidance rather than prescriptive one-size-fits-all requirements for the management of any particular condition. 2. Require QHPs to build information systems that allow participating providers to easily track, manage, and report referrals and care transitions, including specialty consults, hospitalizations, ER visits, and prescription drug information.
March of Dimes	We are encouraged to see that the issue of continuity of coverage for pregnant women has been identified as a key policy topic for coordination and integration. March of Dimes supports the adoption of 12-month continuous eligibility. Disruptions in health care coverage during pregnancy are unacceptable for any woman; for those carrying high risk pregnancies, a loss, gap or reduction in coverage could result in prematurity or other adverse birth outcomes. Thus, the March of Dimes recommends that all pregnant women currently qualifying under Medi-Cal or the Exchange should be allowed to stay in the program, regardless of income fluctuations, for the duration of the pregnancy (including the 60 days post-partum). Pregnant women and children--whose health could be harmed by even temporary gaps in coverage--should be prioritized for automatically reenrollment. Redeterminations should be made without requiring information from the enrolled individual and without requiring the enrolled individual to sign and return a notice. Regarding the policy option related to Medi-Cal plans participating in the exchange, March of Dimes recommends that private plans offering coverage in Medi-Cal be permitted to also supply commercial coverage through the Exchange. Such provisions would allow women and children whose eligibility status may change from Medi-Cal to Exchange coverage (or vice versa) through the course of a year to stay with the same plan and provider network. Maintaining care with the same provider minimizes gaps in access to needed services and provides the continuity of care important for a child's healthy development. We are encouraged that the CalHEERS System is being designed to provide a streamlined enrollment process. Having this system screen for all programs and utilize a "no wrong door" policy will facilitate maximal and timely coverage for pregnant women, infants, and children.
For MCH	Alignment involves eligibility as well as qualified health plan issues. Because alignment cuts across programs, a real

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Access	solution will require the focus and commitment of the California Health and Human Services Agency as well as the Exchange Board and the Department of Health Care Services (Department). MCHA approaches the issue from the particular perspective of women, in response to the request in the Board's background brief for analysis on "continuity of coverage for pregnant women whose eligibility status may change from the Exchange to Medi-Cal due to their pregnancy." But our recommendations would benefit all adults whose incomes may fluctuate around 200% of poverty. First, alignment would be greatly enhanced (as would promoting quality and affordability (Sec. 6), wellness and prevention (Sec. 6C), administrative simplification (Sec. 6D)) if the scope of benefits for Medi-Cal's no-share-of-cost 200% Program for Pregnant Women included all medically necessary care and "essential health benefits". At present, the scope is limited to a narrow definition of "pregnancy-related", so that, for example, treatment for a broken leg or physical therapy after an injury may be excluded. All medically necessary care is, however, inherently pregnancy-related and is therefore required by the federal Medicaid regulations implementing the Affordable Care Act (ACA). See, Preamble to Final Rule, 77 Federal Register 57, p. 17149 (March 23, 2012). States may provide fewer benefits only after explaining in a State Plan amendment why a covered benefit is not "pregnancy related" and obtaining federal permission to exclude the care. Id. We urge the California Secretary and the Department to ensure that all Medi-Cal benefits and other essential health benefits be made available to pregnant women enrolled in the 200% Program. Second, California should not only adopt the Basic Health Option (BHO) under Section 1331 of the ACA but also ensure that during pregnancy, women applying to or enrolled in the BHO receive, during pregnancy, all of Medi-Cal's scope of benefits without cost-sharing. This could be achieved by blending the funding for Medi-Cal's 200% Program with BHO formula funds, issuing a single, joint enrollment card to women BHO enrollees, and administering the two programs jointly, and seamlessly as to the consumer. This approach would make health care access not only affordable to women with income at or below 200% of poverty when they are pregnant, but would also promote positive birth outcomes by supporting women's health before conception ("pre- and inter-conception care") and ensuring continuity of care during pregnancy. Equally as important, the "blended funding/seamless administration" approach would also ensure that women have access to affordable preventive, wellness and other necessary care regardless of pregnancy, advantages that would also be enjoyed by men with income from 139% to 200% of poverty covered by the BHO. Both of these recommendations are essential to true program alignment. Without these measures, women with

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	income from 139% to 200% of poverty who enroll in the Exchange would be placed in the untenable position of having to choose, when pregnant, between affordable but limited coverage under Medi-Cal and comprehensive but costly coverage through the Exchange. Providing women adequate and timely information about these options and processing eligibility changes would be necessary, undermining simplicity in Exchange administration. The "blended funding/seamless administration" approach avoids all of these complications. And while Exchange plans should be required to participate in Medi-Cal/the BHO in order to ensure continuity of care, not only for pregnant women but for all adults whose incomes may fluctuate between these programs' income eligibility limits, less plan overlap among programs might be necessary if adults, including pregnant women, were eligible for all medically necessary care through Medi-Cal/the BHP with income up to 200% of poverty and therefore moving in and out of the Exchange less frequently.
Molina Healthcare, Inc.	We are pleased to see the Board's emphasis on the unique needs of the low-income population in the "Aligning the Exchange with Medi-Cal and other State Funded Health Programs" Board brief. We agree that continuity of care and "churn" are important issues to consider because there will undoubtedly be a significant number of people whose income will fluctuate and consequently be eligible for different health care programs depending on their income. Having plan and provider participation that is consistent among Medi-Cal and Exchange products will provide an opportunity for patients to keep their plan and provider relationships as they churn between Medi-Cal and the Exchange. We recommend the following options to encourage continuity of coverage and care in these circumstances: • Passive Enrollment: Auto-enroll consumers transitioning from Medi-Cal to the Exchange into the same health plan (if their plan is offered) and from the Exchange to Medi-Cal. • Continuous Enrollment: When a member signs up on the Exchange at the beginning of the year and remains active through the end of the year, the Exchange should complete an income determination to identify if the individual's income level has changed. Based on the findings, individuals who are deemed eligible to continue their participation on the Exchange should be automatically reenrolled into the same plan they were previously enrolled in.
Monarch HealthCare	Blended Payment Rates: Monarch urges the Exchange Board to carefully differentiate the standards under which commercial QHPs and Medi-Cal managed care plans operate. The two markets are distinct, serve very different patient populations and payers and should remain so. We are concerned that the QHPs may attempt to blend provider rates between commercial and Medi-Cal plan populations. We anticipate the initial phase of this program (12-18 months) will see a higher utilization of medical services for this population. If the financial model is not carefully considered, the significant cross-subsidization that now occurs due to the under payment of California state-sponsored programs like Medi-Cal and Healthy Families would continue. Therefore we recommend, the

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	compensation should actuarially lean toward the commercial payment structure.
National Committee for Quality Assurance	We encourage the California Health Benefit Exchange to build on the history of streamlining efforts as it assesses the best approach to certifying plans. The Medi-Cal managed Care division has recognized NCQA's credentialing program in its oversight of accredited plans and their delegates and CalPERS has required NCQA accreditation of its contracted plans.
National Health Law Program on behalf of the Health Consumer Alliance	NHeLP and the HCA commend the Exchange for thinking ahead and beginning to focus on the issue of how the Exchange can be aligned with Medi-Cal and other state-funded health programs. We look forward to seeing the report that the Exchange plans to commission from Manatt Health Systems on this issue. While we are certain that the Manatt report will be very useful, it is important that the Exchange obtain viewpoints on this issue from a range of stakeholders, including health consumer advocates like the HCA that also have expertise on these issues and in-depth familiarity with the programs and populations in California. While we assume that the Exchange will make the Manatt report public and give stakeholders an opportunity to comment on its conclusions and suggestions, we urge the Exchange to allow ample opportunity for review and comment on the report, rather than allotting only a very brief time frame that will not give interested stakeholders a sufficient opportunity to comment. We note some concern that the Board Background Brief on Alignment discusses only Medi-Cal and Healthy Families, but makes no mention of a possible Basic Health Plan ("BHP") in California. As the Exchange is aware, there is pending legislation proposing a BHP, and many stakeholders are hopeful that one will be established to expand affordable coverage for persons between 133% and 200% FPL. If there is a BHP, issues of alignment with Medi-Cal, Healthy Families, and the Exchange will be even more critical. We urge the Exchange to include considerations of alignment with a BHP as part of the charge given to Manatt to analyze. We would also like to work with the Exchange staff on these issues. The Background Brief appropriately notes that a major issue during the launching of the Exchange will be the transition of Exchange eligible individuals currently enrolled in one of the LIHPs into Exchange coverage (as well as the transition of Medi-Cal eligible persons who are currently LIHP enrollees). The Exchange must coordinate closely with the Department of Health Care Services and the counties operating LIHPs to make sure that there is a smooth transition without gaps in coverage. The Exchange is scheduled to begin enrollment on October 1, 2013, with the California Healthcare Enrollment, Eligibility and Retention System (Cal-HEERS) as the gateway in the Exchange for people to select a health care plan. Due to the novelty of the Exchange and the possible attendant confusion that may accompany the inaugural year of Cal-HEERS, we suggest

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	that the Exchange work closely with DHCS and the counties to ensure that LIHP enrollees who have a higher likelihood of qualifying for Exchange subsidies rather than Medi-Cal receive targeted outreach and education information about the Exchange as soon as possible. Moreover, to the extent possible in those counties where it is feasible, the Exchange should make an effort to see that Exchange health plans include provider networks that are currently serving LIHP enrollees, so that as many LIHP enrollees as possible can continue with their current providers in 2014. We commend the Exchange for recognizing that issues of churning, especially as they affect continuity of care, will be of paramount concern. While the Background Brief notes that current law and regulations give individuals protection to ensure continuity of care when an individual is switching to a new health plan that does not include his/her current provider in its network, this is an area that requires much attention. The issue of continuity of care has been critical in the recent transition of Seniors and Persons with Disabilities from fee-for-service Medi-Cal into managed care, and there have been enormous problems with that transition. We urge the Exchange to look closely at the experience with that transition to avoid the pitfalls that have resulted in many complaints about the process not working to preserve patients' rights to remain with their current providers where appropriate. The Background Brief, on p. 228, notes that analytical support is needed on the issue of "continuity of coverage for pregnant women whose eligibility status may change from the Exchange to Medi-Cal due to their pregnancy." Pregnant women should be able to make informed decisions about the program in which they will enroll, and those choices should not be coerced by administrative hurdles or the potential for discontinuity of care. Pregnant women should have access to the most comprehensive pregnancy care with the least cost-sharing. This is best achieved by a high level of alignment between Medi-Cal (or, if applicable, the BHP) and Exchange provider networks so that women can transition between programs, if they so choose, without experiencing abrupt changes in their sources of care. We note that in the Preamble to the Medicaid Eligibility regulations, CMS has noted that women who become pregnant while enrolled under the new Medicaid expansion category for adults need not be transferred to coverage under 42 C.F.R. 435.116 (Mandatory Coverage of Pregnant Women). The Preamble states: "[In this situation], women should be informed….of the benefits afforded to pregnant women under the State's program. If a woman becomes pregnant and requests a change in coverage category, the State must make the change if she is eligible. But, we will not otherwise expect States to monitor pregnancy status and to shift women into the group for pregnant women once they become pregnant." 57 Fed. Reg. 17144, 17149 (March 23, 2012).

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	When an Exchange enrollee becomes pregnant, she similarly should be informed of all of programs (the Exchange, the BHP, if adopted, or Medi-Cal) for which she is eligible including information about provider networks and differences in cost-sharing. She should then be able to make an informed decision about transitioning to Medi-Cal (or, if adopted, the BHP) or remaining in the Exchange. Regardless of whether her eligibility status changes, the Exchange must ensure that a pregnant woman can continue with her current providers. The Exchange should either require (1) a QHP to participate in Medi-Cal, (and, if adopted, the BHP), at least with regard to pregnant women's coverage, or (2) overlap of provider networks between the Exchange and Medi-Cal (and, if adopted, the BHP) to ensure continuity of care. Such overlap will ensure that pregnant women need not sacrifice continuity of care to benefit from comprehensive Medi-Cal (or, if applicable, BHP) services without cost-sharing to which they are entitled if they choose to move between programs. The Exchange must establish an expedited and seamless process that ensures that there is no break in a pregnant woman's coverage for health care, if she transitions from the Exchange to Medi-Cal or, if adopted, the BHP, during her pregnancy. Finally, given the complexity of these issues, we strongly urge the Exchange to collaborate with DHCS, MRMIB and other departments as needed to gather additional stakeholder input on the coordination and alignment of programs to ensure that pregnant women receive continuity of comprehensive health care coverage. Another area noted in the Background Brief for further analysis is "alignment of eligibility and enrollment appeals processes between the Exchange and Medi-Cal." While guidance on Exchange appeals processes has not yet been issued by CMS, we have urged CMS to model such processes after the current appeals process under the Medicaid program. Whether CMS requires this, or whether the state Exchanges are given flexibility in regard to appeals, we urge the Exchange to look to the Medi-Cal appeals process as a model. NHeLP and the HCA have significant expertise in this area and look forward to providing more detailed comments on due process and appeals in the future. Aligning the appeals process with Medi-Cal will also help low-income individuals who are moving, however frequently, between Medi-Cal and the Exchange to have continuity in exercising their rights and will create more seamlessness and result in less confusion for individuals. The Background Brief notes as "policy options" the encouragement of Medi-Cal Managed Care Plans to participate in the Exchange and the encouragement of issuers to include Medi-Cal providers in their networks. This should not just be an "option," but should be adopted as policy by the Exchange Board. The Exchange should encourage the participation of plans across different programs, so that enrollees moving between Medicaid, CHIP, the Exchange

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	plans and, possibly, BHP will, to the extent possible, be able to remain with the same providers. To that end, plan standards and contracting requirements should be identical, or as similar as possible, to make it easier for health plans to serve enrollees in all programs. Standards should not be lowered, however, in order to achieve simplicity. Rather, the minimum standards should be high for all categories, so that the care available to the lowest income persons in the Medi-Cal program will be as high as that available to those persons enrolled in health plans through the Exchange. The Exchange should work together with the Department of Health Care Services and other government agencies to develop uniform standards and contracts to the extent possible. Finally, the Background Brief suggests monitoring of QHP overlap with Medi-Cal Managed Care plans and monitoring the movement of individuals between Medi-Cal and Exchange plans. Monitoring is critical, and we assume that there will be a larger monitoring plan that will cover all aspects of the Exchange's operations, of which these are just two. In regard to health plan overlap, however, this is not just a question of monitoring, but the Exchange should work actively to convince health plans to operate in both markets and to give precedence in the contracting process to those plans that do.
Pacific Clinics	We agree with the discussion that more needs to be done to ensure seamless transition for those who "churn" between the publicly funded programs and Exchange insurance plans. Additionally, we concur with the recommendations outlined on page 228.
Planned Parenthood Affiliates of California	Alignment with Medi-Cal and other State-Funded Health Programs PPAC supports efforts by the Exchange to encourage the participation of Medi-Cal Managed Care plans in the Exchange market. This will help continuity of care for low income enrollees who churn between expanded Medi-Cal and the Exchange. This is a primary concern for the low income population who will be more likely to churn between coverage options. This also helps meet the Exchange's stated goal of broad inclusion of a wide range of Medi-Cal providers without broadening the definition of ECPs to the point of diluting the incentive for plans to include community clinics and traditional safety net clinics in their networks. Coordination and continuity of care for pregnant women. We strongly support efforts by the Exchange and state partners to coordinate care for pregnant women whose eligible shifts based on their income and pregnancy status. At the very least, women enrolled in an Exchange plan that become pregnant and eligible for prenatal Medi-Cal should not be required to disenroll from their qualified health plan and should be able to continue with their current providers. The management of this transition will take significant coordination with DHCS, MRMIB and other departments.

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WellCare Health Plans	Has there been any discussion between the Exchange and the Bureau of Managed Health Care regarding requiring participation in the Exchange in order to participate in the pending Medicaid procurement? WellCare would recommend that participation not be required.

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Alameda Health Consortium	The Alameda Health Consortium respectfully disagrees with Exchange staff; we instead recommend that the Exchange adopt Option A, to "Offer supplemental benefits in both the Individual and SHOP Exchanges." Dental and vision benefits are critical components to community health centers' success with managing serious chronic diseases among high-cost patients such as people with diabetes and HIV/AIDS. Consumers should have the ability to access dental and vision care as a part of their overall health care.
Alpert Vision Care	I'm a third generation optometrist in the San Fernando Valley, and our practice has been serving the Los Angeles area for over 65 years. I'm also the Past President of the San Fernando Valley Optometric society and have been a board member for over 10 years. In 2002, I was honored with the Young Optometrist of the Year award, presented by the California Optometric Association, for my service to the community and the profession of optometry. Recently, the Review of Optometric Business and an independent panel of industry leaders awarded me with the 2012 Business Innovators Award. I have been a VSP network doctor for 15 years, since graduating optometry school in 1996, and currently serve on the VSP Board of Directors. VSP Vision Care has played a critical role in the development and success of my practice -- sixty five percent of the patients seen in my office have VSP coverage. The patient access provided by VSP has allowed my practice to grow and thrive, ultimately raising the quality of care delivered to my patients. The ease of use and support provided by VSP encourages patients to utilize their benefits, which in turn supports my practice and the ocular health of my patients. Anything that would put up a barrier or inhibit utilization of VSP benefits would have profound impact on the viability of my practice and negatively affect the quality of care my patients receive. I cannot stress enough how important VSP and stand-alone vision plans are to the sustainability of over 4,000 optometric practices like mine in California and the patients we serve. Eye exams do more than determine the need for glasses and contact lenses -- they can save lives. Patients covered by stand-alone vision plans are seen more frequently which allows for earlier detection of chronic diseases such as Diabetes and Hypertension -- ultimately increasing treatment success, improving patients' quality of life, and reducing overall healthcare costs. Based on the above, through the stakeholder input process responding to the *California Health Benefit Exchange Board Recommendation Brief on Supplemental and Pediatric Essential Health Benefits: Dental and Vision* I am compelled to recommend the following:

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	— **Please consider option A on issue #1.** VSP needs to be allowed into both supplemental exchanges. — **Please adopt option C on issue #2**. My practice and the welfare of my patients are at risk if VSP is unable to directly participate in the exchanges. Thank you for your consideration of my concerns.
AltaMed Health Services	AltaMed supports Option A for the inclusion of dental and vision coverage embedded as a part of medical QHP plans.
Anthem Blue Cross	Anthem urges the Exchange to further clarify their recommendations with respect to supplemental dental and vision benefits offered by QHPs on the Exchange. The staff has recommended Option B with respect to structuring health plan offerings, under which stand-alone dental and medical plans would be offered. However, it is unclear if the Exchange intends to permit ONLY stand-alone dental and stand-alone medical policies, which would violate the requirements of the ACA, or if it will permit stand-alone dental plans and medical plans with embedded dental benefits. WellPoint would support the latter recommendation, but it is unclear if this is the staff's intention.
Association of California Life and Health Insurance Companies	We sincerely appreciate the Exchange recognizing the importance of supplemental benefits. While all of our members support the stand-alone dental and vision option many of our companies also support providing consumers with the flexibility to have their dental and vision benefit embedded in their medical plan. Additionally, with respect to Issue 1: Offering Supplemental Benefits in the Individual and SHOP Exchanges, we would support "Option A" which proposes to expand pediatric dental and vision care in both markets to adults. We completely agree with the Exchange staff's summary that offering supplemental dental and vision in both Exchanges provides the most consumer-friendly approach, does not disrupt existing market practices, and positions the Exchange as a comprehensive channel for a variety of health insurance coverage.
Behavioral Health and Recovery Services	Will vision coverage include coverage of eye wear (glasses, contact lenses, and/or frames)?
Blue Shield of California	**Offering Supplemental Benefits** BSC supports the recommendation to sell supplemental benefits in both Exchange markets. We would, however, encourage the Exchange to consider allowing both QHP and QDP plans to offer supplemental benefits in the Individual and Shop Exchanges, which would allow for the greatest amount of consumer choice and competition within the respective markets.

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	Stand-Alone Plans We have concerns that the administrative implications of allowing stand-alone dental pediatric products are not fully understood. For example, health plans are required to have deductibles and out of pocket limits tied to essential health benefits, which include pediatric dental coverage. It may be administratively impossible to have accurate deductible accumulators when multiple vendors are offering stand-alone dental products without any contractual relationship to the health plans which are responsible for tracking these expenses. Additionally, premium tax credits are based off the cost of essential health benefits (including pediatric dental benefits), which adds a level of complexity for the Exchange as well. Finally, the ACA and state law requires that what is offered inside the Exchange must be offered outside the Exchange at the same price. Since the pediatric dental benefit must be embedded into a medical plan outside of the Exchange, it is difficult to see how this requirement can be met if QHPs do not embed the pediatric benefit in their Exchange offerings. We would ask that you allow time for stakeholders to work together and more fully consider the issues involved before making a final recommendation.
California Association of Health Plans	We believe that implementation of the pediatric dental benefit could create unanticipated administrative challenges. We want to ensure that the Exchange will provide a forum for stakeholders to work through these challenges as they may arise so that consumers have access to competitive and affordable products.
California Children's Hospital Association	CCHA agrees with the staff recommendations for the reasons noted in the policy options brief.
California Primary Care Association	Given the importance of dental and vision care to overall health outcomes, **CPCA supports Option A: the inclusion of dental and vision coverage embedded as a part of medical QHP plans.** While recognizing that the addition of dental and vision coverage may impact premiums, CPCA believes that individuals without a history of insurance coverage and low health literacy may not recognize the value of these services and thus not select to add-on a standalone dental and/or vision plan. Creating clear and affordable avenues to access dental and vision coverage is an important strategy to ensuring California's lowest income families are comprehensively cared for. Approximately one third of CCHCs have on-site dental and vision care as part of the comprehensive bundle of

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	services offered to patients. This allows for a one-stop quality care experience which ensures that patients who may have transportation challenges or difficulty accessing care are able to acquire all important preventive services with a minimum amount of disruption or need to travel for additional appointments. In working with low-income and low health literacy populations, CCHCs have found this to be an effective method of ensuring that patients receive all recommended preventive care. CPCA encourages the Exchange to adopt policies that lead to whole-health wellness, including the addition of adult vision and dental benefits. In addition, CPCA hopes the Exchange will encourage issuers to contract for the full range of services available from those essential community providers who have historically provided a comprehensive set of quality primary care services.
California Optometric Association	The COA believes that vision care should be included as a supplemental benefit in both the individual and SHOP Exchanges. Studies show children get eyes examined more frequently if their parents have stand-alone vision coverage.[19] Adding adult vision as a supplemental benefit would provide continuity of coverage and increase access to care. Approximately 93% of Californians today who have vision coverage have comprehensive coverage that is provided through a stand-alone vision plan. The Exchange should provide a smooth transition of care by maintaining the stand-alone vision plans as an option that is familiar to many Californians. Vision is a basic necessity to fully participate in society. Indeed, Congress recognized this fact by mandating pediatric vision coverage under ACA. Independent studies have shown that people are more likely to obtain comprehensive eye exams when they have coverage through a stand-alone vision plan.[20] The eye care trends of individual Americans attests to the importance placed on healthy vision. In the United States, close to 99 million adults receive an annual eye exam versus only 28 million who receive a general medical exam.[21] Additionally, annual vision exams provide a medical-level evaluation that often diagnoses serious diseases earlier that could have other negative health-related ramifications, saving money downstream, e.g., diabetes, hypertension, heart disease. In chronic conditions like diabetes, hypertension or heart disease, there is a predictable progression of illness that can rapidly shift the health care utilization of an individual from low risk and low cost (<$1,200 per year), to high risk and

[19] The study was conducted by the National Association of Vision Care Plans (NAVCP). Information regarding the study (the "NAVCP Study") may be found on their website at http://navcp.org/documents/NAVCP_PressRelease_FINAL.pdf.
[20] *Ibid.*
[21] W. Edward Barnell, "Comprehensive Eye and Vision Examinations: A Path to Wellness," A White Paper by KDD Health Solutions, 2010, p. 8.

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	high cost (>$35,000 per year). Sometimes this progression can come with little or no warning, but most often, it comes with easily identifiable "predictors" and "markers" that are made apparent through an eye exam or a simple assessment/questionnaire given at a doctor of optometry's office.[22] The same report included a study that evaluated medical claims data over a three-year span for an employer with more than 10,000 employees and dependents. The report focused on individuals with a confirmed diagnosis of both diabetes and hypertension. The analysis also assessed those individuals within this group who had received an eye examination and those who did not. The research revealed significant differences in overall costs to the employer which included: • The average annual expenditure per member for those not having an eye exam was 62% higher than those who did have an eye exam. • For those experiencing a hospitalization of one or more days, the average length of stay for those having an eye exam was 5.3 days verses 8.2 days for those not having an eye exam. • Expenditures for those hospitalized were 41% lower for those having an eye exam verses those who did not. A separate study found that for every $1.00 employers in the study spent on eye exam services, they recouped $1.27 over two years attributable to early disease detection.[23] **Based on the information above, the Exchange should adopt Option A for Issue 1 and offer supplemental benefits in both the Individual and SHOP Exchanges. Additionally, the Exchange should adopt Option C for Issue 2 and offer a combination of (a) stand-alone dental, vision, and medical plans; and (b) medical plans with embedded dental and vision benefits.**
Cigna	Supplemental needs more clarification particularly between stand-alone supplemental offerings versus pediatric EHB requirements (and clarification on whether "supplemental" only applies to dental) Agree with the recommendation to offer Standalone dental in the exchange. Vision: Clarification is needed. Pediatric vision, is required to be packaged with medical, we will need to verify the age

[22] W. Edward Barnell, "Comprehensive Eye and Vision Examinations: A Path to Wellness," A White Paper by KDD Health Solutions, 2010.
[23] Independent study conducted by Human Capital Management Services on behalf of VSP, 2010

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	maximum for the covered benefits, including any dollar allowance for frames and contact lenses. Our preference is: ***Pediatric Vision Care***: In-Network Benefit ***Comprehensive Eye Examination and Refraction***: Covered in Full ***Base Lenses***: Single Vision, Lined Bifocal, Lined Trifocal: Covered in Full ***Frame***: (Frequency: one frame for prescription lenses every 12 months) Note: choice of one frame, **Covered In Full, up to stated covered retail cost;** with customer receiving a 20% savings on any amount that exceeds stated frame covered retail cost ***Contact Lenses & Services*** - Elective (Frequency: one pair or single purchase every 12 months) One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit, **Covered In Full, up to stated covered retail cost** For Adult (non-Pediatric) Vision Coverage - stand-alone vision coverage offered in conjunction with our medical and/or dental offering. (We are not looking to offer vision only, without medical and/or dental)
Community Clinic Association of Los Angeles County	***CCALAC urges the Board to adopt Option A to include dental and vision coverage embedded as a part of medical QHP plans.*** While recognizing that the addition of dental and vision coverage may impact premiums, CCALAC believes that potential Exchange enrollees, having been without history of insurance coverage and with low health literacy, may not recognize the value of dental and vision services and thus not select to add-on a standalone dental and/or vision plan. Creating clear and affordable avenues to access dental and vision coverage is an important strategy to ensuring California's lowest income families are comprehensively cared for. This option also supports the idea of "whole health" and integration of medical and dental/vision health. Approximately half of LA County's clinics have on-site dental care, while many refer out to private dentists, as part of the comprehensive bundle of services offered to patients. This allows for a one- stop quality care experience which ensures that patients who may have transportation challenges or difficulty accessing care are able to acquire

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	all important preventive and enabling services with a minimum amount of disruption or need to travel for additional appointments. In working with low- income and low literacy populations, clinics have found this to be an effective method of ensuring that patients receive all recommended preventive care. Therefore, given the importance of dental and vision care to overall health outcomes, CCALAC urges the Board to adopt Option A.
	Please consider the following comments: 1. The briefing on dental and vision refers to these benefits as supplemental health benefits. While there is a distinction drawn in the body of the brief that correctly identifies the pediatric benefit as "essential", we suggest that essential benefits and supplemental benefits be more distinctly and independently addressed. First, there is an essential pediatric oral benefit that every Exchange **must** include. Certain requirements of the ACA, such as the prohibition of annual and lifetime limits, attach specifically to essential health benefits. Secondarily, a State may consider offering "supplemental" dental and vision benefits but many of the ACA requirements do not attach to supplemental benefits offered by an excepted benefit plan. It would be beneficial if the Exchange would specifically address these two distinct types of benefits separately. 2. There is a statement included in the presentation that certain reforms attach to a comprehensive medical benefit package that do not attach to a limited scope plan (e.g., dental plans). While this is true for many reforms, the two examples used are actually applicable to limited scope dental plans who are offering the pediatric essential health benefit. The final Exchange Rule clarified that the pediatric oral benefit offered inside the Exchange shall be subject to the restrictions on annual and lifetime limits regardless of whether the benefit is offered by a stand-alone dental plan or embedded within a medical plan. Also, in 2010, California enacted SB 1088 which requires coverage of dependents up to age 26 by specialized dental plans. 3. There is a statement in the presentation that the Exchange is not required to accept a bid from a stand-alone dental carrier, merely that the Exchange must receive bids from stand-alone dental carriers. The ACA and related regulations are quite clear that stand-alone dental carriers are allowed to participate in an Exchange and that stand-alone plans should not be excluded from an Exchange merely because they are offered as a stand-alone plan and not as an embedded plan.

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	4. With regard to participation standards in the SHOP, Delta Dental agrees that participation standards are common in the industry, although the level of required participation varies by product and company. We would recommend that the SHOP explore with stakeholders the appropriate minimum participation standard for employer groups. 5. With regard to the recommendation on Issue 1 that supplemental dental and vision benefits be offered only in the SHOP Exchange, we strongly urge that such benefits be equally applied to the Individual Exchange. We agree that the individual market is underserved, but feel that the Exchange presents a unique opportunity and platform through which to reform the current marketplace and make much needed benefits available to adults in addition to the required essential pediatric benefits. Additionally, there is likely to be movement or churn between the SHOP Exchange and the Individual Exchange, so for purposes of continuity of care, we believe the same or similar options for supplemental coverage should be available in both. 6. With regard to the recommendation on Issue 2, we are requesting more clarity around the meaning of Option B: Offer stand-alone dental and medical plans. Does this mean that the essential pediatric dental benefit must be separately offered by medical plans? The brief says that the Exchange is not precluded from accepting bids from QHPs that cover the full complement of essential health benefits. However, the recommendation seems to suggest that the Exchange will offer only stand-alone dental policies and stand-alone medical policies. Will the Exchange accept medical and dental plans offered as one combined product or must dental and medical be offered separately on the Exchange? If they can be offered as an embedded plan, how is Option B any different than Option C? We do not oppose the offering of embedded plans, but it is crucial that embedded products assign a separate price to medical and dental benefits and offer a sufficient number of medical only plans without dental benefits to preserve a transparent, consumer oriented and comparative shopping experience. 7. With regard to both Option B and Option C, we strongly support the consideration being given to offer stand-alone dental in order to accommodate individuals who already have required dental coverage outside the Exchange. It is vital that individuals who already have family dental policies that are providing the pediatric dental essential benefits be allowed to keep their coverage and not be forced to buy duplicative coverage or drop their current plan.

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Health Net	Health Net believes that it will be most cost-effective to require pediatric dental to be embedded in all QHP's, and we recommend that the Exchange offer stand-alone adult dental coverage to enrollees in the individual market as well as in SHOP. Studies clearly indicate that gum disease and other dental problems can lead to serious health problems that would have been preventable with dental care.
Insure the Uninsured Project	While there are adverse selection risks when it comes to supplemental benefits not covered in the EHBs, we urge the board to offer supplemental benefits in both the individual and SHOP exchanges (Option A) so the choice is available for consumers.
Livermore Optometry Group, Owner VSP Vision Care, Member of Board of Directors	Founded in 1947, my optometric practice is the largest private practice in the Livermore Valley -- serving over 85,000 patients in our single location clinic. I have been in practice for the last 13 years, and am very involved with numerous optometric organizations at the local, state, and national level -- including Past President and Board Member of the Alameda Contra Costa Optometric Society, past "Young OD of the Year" at the state and local level, and Assistant Clinical Professor in Optometry at the University of California, Berkeley School of Optometry. I am also presently a member of the VSP Board of Directors for the national organization based in Rancho Cordova. As an optometric leader, I've followed the topic of national healthcare reform closely and have paid particular attention to the formation of the California Health Benefits Exchange – it will impact my patients, my practice, and the profession of optometry. Concern for my patients and millions like them across California compels me to submit my comments to you. After having the opportunity to review California Health Benefit Exchange Board Recommendation Brief on Supplemental and Pediatric Essential Health Benefits: Dental and Vision, I wanted to personally express concern with the recommended courses of action specific to Section 7B: Supplemental Benefits: Dental and Vision. These recommendations cause me great concern in regards to the access of California citizens to the services that optometrists provide. The formation of the California Health Benefits Exchange is the most significant California healthcare initiative since the formation of Medi-Cal. There is no doubt that it will become the model for healthcare delivery in California and perhaps nationally. Because of its significance, it's absolutely imperative that patients will be able to maintain access to vision care through stand-alone vision plans, especially when you consider these facts: DMHC data confirms the 93% of vision care coverage in California is provided through stand-alone vision plans. This holds true for the patient population that I care for in my private practice as well.

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	14.3 million people in California have VSP coverage. That's 1 in 3 Californians and this figure does not include people who have coverage from other stand-alone vision plans. There are nearly 4,000 VSP Network Doctors in California that provide services for these people. Excluding stand-alone vision plans from direct participation in the newly formed CA HBEX would create extreme disruption to the patients and optometric practices in California. In fact, my practice, which has served Californians for over 60 years, may be unable to sustain itself as a small business. The vast majority of private-practice optometrists in California may find themselves in a similar situation which could result in a shortage of optometrists available to provide for these patients -- ultimately increasing cost to the State. These are real and unintended consequences that can be avoided. In summary, I would urge the CA HBEX BOD to implement the following recommendations: Issue 1, Option A: Offer supplemental benefits in BOTH the Individual and SHOP Exchanges Issue 2, Option C: Offer a combination of (a) stand-alone dental, VISION, and medical plans; and (b) medical plans with embedded dental and vision benefits Thank you for your time, consideration, and service in developing one of the most historically significant programs affecting the welfare of California citizens.
March of Dimes	We support the Exchange offering optional supplemental benefits for dental and vision care. Specifically for dental coverage, dental care for pregnant women is a component of an overall healthy pregnancy. Pregnant women are especially vulnerable to oral infections. The fluctuating hormones characterizing pregnancy increase susceptibility to oral infections and limit the body's ability to repair soft tissue in the mouth. At least 30 percent of pregnant women have "pregnancy gingivitis," mild inflammation of the gums. If pregnant women do not have proper access to dental care, many conditions can worsen. For example, decaying teeth can cause infection that can harm their babies. Furthermore, emerging evidence has linked periodontal disease—through the bacterial infections—to poor birth outcomes, including prematurity and low birth weight.
National Health Law Program on behalf of	**<u>Issue 1: Offering Supplemental Benefits in the Individual and SHOP Exchanges</u>** The Exchange proposes to offer supplemental benefits (i.e., expanded pediatric dental and vision and adult dental and vision) *only* in the SHOP Exchange. NHeLP and the HCA recommend the Exchange offer supplemental benefits to *both* the Individual and SHOP Exchanges, for the following reasons (listed in the Exchange Board

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the Health Consumer Alliance	Recommendation Brief): ☐ most consumer-friendly approach (one-stop shop for medical, dental and vision coverage), ☐ enables continuous coverage for consumers transferring between SHOP and Individual Exchanges, ☐ contributes to expanding dental and vision coverage of Californians, and ☐ provides families with cohesive coverage options for all family members (adults and children). **Issue 2: Structuring Dental and Vision Benefit Offerings** NHeLP and the HCA agree with the Exchange's recommendation to offer dental and vision benefits in the Exchange through stand-alone dental and medical plans. The Department of Health and Human Services, found that pediatric dental and vision services are generally not included in many health insurance plans. *See* DEPARTMENT OF HEALTH AND HUMAN SERVICES' FREQUENTLY ASKED QUESTIONS ON ESSENTIAL HEALTH BENEFITS BULLETIN, Question 5 (2012), *available at* http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf. Therefore offering these benefits through stand-alone plans is consistent with current market practices.
National Association of Vision Care Plans (NAVCP)	NAVCP believes that stand-alone vision plans offer valuable benefits to consumers by providing lower costs, increased choice, and coordination of vision benefits for families. We support the inclusion of stand-alone vision plans in the SHOP Exchange so that small employers can duplicate the coverage that many employees currently enjoy – access to specialty vision coverage through a stand-alone plan. However, we believe that it is equally important to provide that choice to families seeking coverage in the Individual Exchange. The Individual Exchange anticipates a growth in utilization and access beyond the existing individual insurance market. While many individuals will be transitioning from the existing individual market, some employers may drop their coverage, and others will seek coverage as they change jobs. Accordingly, individuals that move from employer provided coverage into the Individual Exchange should have the ability to maintain the same coverage levels and access that they enjoyed in an employer purchased plan. For Issue 1, NAVCP supports Option A - offering supplemental benefits both in the individual and SHOP (small business) Exchanges. For Issue 2, NAVCP supports Option C. NAVCP supports allowing individual carriers the freedom to offer vision as a stand-alone, or as an integrated part of the QHP if they choose. NAVCP believes that competition and consumer choice will determine which embedded and stand-alone plans will succeed in the Exchange. However, the Exchange should require medical QHPs to offer plans without adult or pediatric dental or vision, so that consumers can purchase coverage through a standalone plan without obtaining duplicative coverage. Children will be removed from

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	their parents' existing vision coverage and required to obtain their vision benefits coverage separately. Any adult who currently has employer-provided stand-alone vision coverage would be unable to maintain their existing coverage if their employer chooses to move their employees into the Exchange. By offering stand-alone as well as integrated vision benefits the exchange will avoid adverse selection while also allowing choice to consumers.
Pacific Eyecare, Owner VSP Vision Care, Immediate Past Chairman of the Board	I am an optometrist who practices in Huntington Beach, and my practice has served the residents of Orange County for over 30 years. I'm a three time President of the Long Beach Optometric Society, Young Optometrist of the Year (1987) presented by the California Optometric Association for service to the profession of optometry and the community. I have been a VSP network doctor for over 30 years and have just completed my term as Chairman, VSP Board of Directors in March 2012; I will continue to serve on the VSP Board of Directors as Immediate Past Chairman until March 2014. VSP Vision Care has been the life blood of my practice for over 30 years. In fact, almost 70% of the patients I see each year have VSP coverage. Since VSP encourages the utilization of its benefits, not only has my practice shown consistent growth over the years but, more importantly, the care I provide for my patients' eye health is uncompromised. Any barrier that would discourage the use of the VSP benefit by my patients would have a negative impact on the health and welfare of those patients and would place my practice in economic jeopardy. VSP provides benefits to over one in three Californians and has become a dependable source of patients for the more than 4,000 optometric practices like mine in California. Eye exams test not only for vision difficulties but for eye and systemic health as well. With the average VSP patient returning for an exam every 15 months (as opposed to every three years to their primary care doctors), the detection of Hypertension, Hypercholesterolemia, and Diabetes occurs at a much earlier stage that allows for much earlier intervention and treatment. In fact, almost 20% of all diabetics are detected through an eye exam, primarily because of the increased frequency that VSP patients return for eye exams as opposed to returning to their primary care doctor. As a result of the above comments, through the stakeholder input process responding to the California Health Benefit Exchange Board Recommendation Brief on Supplemental and Pediatric Essential Health Benefits: Dental and Vision - I urge you to adopt the following: 1. Issue #1 Option A—VSP needs to be allowed to provide benefits in both supplemental exchanges. 2. Issue #2 Option C—The health and welfare of my patients and my practice are at risk if VSP is excluded from directly participating in the exchanges.

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Small Business Majority	We support either Option A or Option B, both of which would offer dental and vision benefits in the SHOP. The SHOP will be most successful if it is viewed as an employer's "one stop shop". Employers may find it frustrating to have all their medical coverage needs handled by the Exchange but still needing to obtain separate vision and dental policies. However, at this point, our top priority is ensuring the SHOP gets its doors open on time and has a successful launch. While we support the inclusion of dental and vision benefits, if it is problematic to include these features on Day One, we would support the Exchange adding in these benefits after the launch. Issue 2: Structuring Dental and Vision Benefit Offerings: We believe Option B (stand-alone plans) is the best option if and when the Exchange offers dental and vision benefits. The hybrid model under Option C would be administratively complicated and costly. Further, it could limit competition from stand-alone dental carriers from which most small employers purchase their dental coverage today.
UnitedHealth Group	Dental Coverage Sold Inside the Exchange vs. Outside the Exchange Only Qualified Health Plans whose offerings include the EHB can provide coverage inside the Exchange. The ACA does permit one exception: limited scope dental (stand-alone) policies may be sold on an Exchange if pediatric oral health services (an EHB) are included. Issuers have flexibility to provide coverage of pediatric dental benefits that meet EHB requirements in three ways in Exchanges: embedded, bundled and stand-alone. Outside the Exchange, the ACA is silent on the ability of stand-alone carriers to provide the pediatric dental benefit; there is no waiver for QHPs to not integrate the pediatric dental essential benefits, as is specifically allowed inside the Exchange. Also, there is no waiver, either inside or outside the Exchange to not integrate the pediatric vision essential benefits. California Should Maintain Flexibility for Issuers and Preserve Competition in the Current Marketplace Given the requirement to cover "pediatric oral health services" as part of the EHB, and the uncertainty of how this definition will be interpreted, continued flexibility for issuers offering dental benefits is critical. Outside the Exchange starting in 2014, pediatric oral and vision services must be embedded in the medical policy, and inside the Exchange, pediatric vision services must be embedded as well. To require an issuer to always separately offer and price just the dental Essential Health Benefits within the Exchange is inconsistent with market rules related to Essential Health Benefits outside the Exchange, would increase administrative costs and burden with a requirement to file additional plan types, and would cause additional confusion for consumers and groups who would have to purchase two plans (medical EHB plus dental EHB) rather than one integrated plan.

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	Due to the EHB global out-of-pocket limit, if the pediatric dental benefit is administered through a separate policy with an unaffiliated carrier, it would create challenges and confusion for the consumer related to two policies, with two separate carriers, and a single EHB out-of-pocket limit. A consumer may need to pay out of pocket and get reimbursed by the standalone dental carrier, if it is later determined that they have reached their medical out-of-pocket maximum. We believe that the embedded option is important to provide consumers the choice to have single administration of EHB benefits and billing. We believe that dental and vision benefits, including any non-essential and adult supplemental coverage that may be integrated into a QHP policy, do not need to be priced separately to provide transparency. Today, carriers file prices for a product, but not for different components within that product. HHS expressed concern about the potential administrative burden of separate offer and pricing requirements on issuers in its July 2011 interim final rule. Embedded dental benefits have different pricing because of different utilization patterns, a different expense structure and additional ACA consumer protections (e.g. appeals) that apply to embedded benefits but not to stand-alone benefits. Additionally, due to reduced administrative costs associated with plan set-up and maintenance, embedded products can pass these savings onto consumers in the form of discounts. We believe that price and benefit comparisons can continue as they do today in the marketplace for stand-alone benefits, by adding the medical and the dental pricing together and comparing the result to the price for the bundled or embedded product. Additionally, Exchange tools including the calculator and website, will further facilitate these comparisons. The embedded option should be maintained in the Exchange to promote consistency with the outside Exchange market, administrative efficiencies, costs savings, and coordinated benefits for the consumer. Based on our interpretation of the ACA and the federal guidance released to date, we offer some additional comments below specific to the text in the report. NOTE: (Underlines added for emphasis) Page # and Reference in Recommendations Brief regarding Supplemental Health Benefits: Dental and Vision Comments / Clarifications Pg. 232 /section on Background reads: Under the Affordable Care Act, any supplemental services that are included in the comprehensive benefit package are subject to the same terms and conditions as the medical plans, including reform provisions such as coverage of

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	dependents up to the age of 26 and no annual or lifetime dollar limits on benefits. When offered on a stand-alone basis, supplemental plans are considered "limited scope." Limited scope plans are not subject to these requirements, so it is unclear whether annual limits and lifetime maximums apply; additional federal guidance is needed. The ACA and HHS guidance is clear that the prohibition on annual dollar limits and lifetime maximums applies only to essential health benefits such as pediatric dental and vision benefits. These prohibitions would apply whether the essential health benefits were offered in standalone dental plans or embedded in the QHP offering. The annual and lifetime dollar limit prohibitions do not apply to benefits that are offered as supplemental to essential health benefits. Therefore, we do not share the concern that additional federal guidance is needed related to the application of annual limits and lifetime maximums to stand-alone plans. (Exchange Final Rule: Federal Register, page 18411, published March 27, 2012) Pg. 234/bullet under heading of “Cost Sharing” reads: The Affordable Care Act guidance as of March 12, 2012 includes recommendations that cost sharing limits and the removal of annual and lifetime maximums apply to both stand-alone pediatric dental and when pediatric dental is incorporated in the medical benefits. The regulations do not provide clear guidance around the application of premium and cost sharing subsidies across the medical, dental, and vision Essential Health Benefits. Although premium tax subsidies would need to be allocated to stand-alone dental plans covering the essential pediatric dental benefits, the ACA states that cost sharing subsidies do not apply to Essential Health Benefits provided by a standalone pediatric dental plan, and therefore would not need to be applied across multiple plans. (Section 1402(c)(5) of ACA) Pg. 235/under additional related issues, section reads: Requiring Pediatric Dental and Vision Coverage. Because Pediatric Dental and Vision coverage are Essential Health Benefits, the Exchange will need to ensure that the packages sold to children include these benefits. This statement implies that only policies purchased by or provided to families with children, who meet the pediatric age definition, would need to purchase the pediatric essential dental and vision benefit. Previous legal guidance seemed to imply that all members have to purchase all EHB benefits, whether they would use the benefit or not. Clarity is needed in order to rate and file designs for medical and dental benefits accurately. Pg. 236/section on Issue 1: Offering Supplemental…, reads:

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	Option A: Offer supplemental benefits in both the Individual and SHOP Exchanges Option B: Offer supplemental benefits only in SHOP Exchange Option A should be considered over Option B in order for families and adults to maintain access to oral and vision health care. Families may wish to purchase adult coverage to complement the essential coverage required for their children. In addition, single adults may be interested in purchasing adult only dental coverage to complement their medical coverage. Pg. 236/section on explaining recommendation of Issue 1, Option B under Offering Supplemental, reads: At the same time, the required pediatric dental EHB would be offered in the Individual Exchange either through stand-alone dental plans or with these benefits embedded in comprehensive Qualified Health Plans. This phrase would suggest that Issue 2, Option C (hybrid) would be preferred over Issue 2, Option B (stand-alone plans), but Issue 2, Option B is recommended by the staff. Pg. 237/Options and Recommendation for Structuring Dental and Vision Options, referring to Table 56 for detail, reads: Option A: Offer dental and vision coverage only embedded as part of medical QHP plans Option B: Offer stand-alone dental and medical plans Option C: Offer a combination of (a) stand-alone dental, vision, and medical plans; and (b) medical plans with embedded dental and vision benefits Staff recommends offering stand-alone dental plans and medical plans (Option B). This does not preclude the Exchange from accepting bids from Qualified Health Plans that cover the full complement of Essential Health Benefits. This is a very confusing recommendation. Option B allows only the offer of separate stand-alone dental plans along with medical-only plans, but goes on to say this doesn't preclude QHPs offering the full EHB. Also, Option C breaks out embedded dental and vision benefits separately as an option. The net effect is that Options B and C are the same, unless this recommendation is only speaking to non-essential supplemental benefits. But the description of Option B pros and cons assumes that this would apply for the essential pediatric dental benefits. This needs to be clarified.

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	Also, there is no provision in the law that would allow standalone vision plans to meet the EHB requirement. Therefore including vision plans in only Options A and C in these arguments and recommendations is confusing. The language should be clarified that it is only referring to the adult and non-essential dental and vision benefits. Pg. 237/ the concluding paragraph prior to the tables reads: Although Option C provides the greatest level of consumer choice, it removes an important cost control mechanism for dental and vision services. The Affordable Care Act requirement that dental and vision benefits included in comprehensive medical benefits are precluded from financial limits on benefits is a significant departure from current practices. Therefore, a richer benefit than is available in the external market suggests that premium rates will consequently be higher, raising the total premium for all enrollees and thereby discouraging enrollment in the Exchange. If further federal guidance provides the option of imposing annual limits for these services, Option C would be preferred, to maximize consumer choice. In previous comments, the ACA and subsequent HHS guidance is clear that the prohibition on annual and lifetime maximums applies only to essential health benefits, regardless of the type of plan offering the benefits (embedded or stand-alone). Supplemental non-essential health benefits can be subject to an annual or lifetime maximum, regardless of the type of plan offering the benefits. There is no richer benefit implied by these rules in one type of plan or another, and thus Option C, as the stated preferred choice, should be the recommendation to maximize consumer choice. Pg. 239 Table 56/section on Option Pros and Cons reads: Option B PURPOSE This option allows clear distinction between medical and dental plans, allows financial benefit limits on non-essential health benefit dental services but does not offer comprehensive plans that include a variety of coverage. Option B Pro and Option C Pro Allows individual with existing dental coverage outside of the exchange to keep their current coverage Option B Con Potentially requires the Exchange to offer aggregation functions to manage subsidies and tax credits across medical and dental plans

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	Option C Con Could create adverse selection if Affordable Care Act restrictions on annual and lifetime limits are imposed on dental and vision services. Clarification is required to understand whether Table 56 is referring to a) pediatric essential benefits; b) supplemental benefits; c) both pediatric essential and supplemental; and d) whether Option B also includes vision services, as Option A and C appear to include. This language assumes that financial limits cannot be imposed on non-essential benefits that may be embedded. This is not our understanding as mentioned in earlier comments. If this language means that existing coverage outside the Exchange could satisfy the pediatric essential dental requirements, there is no legal or regulatory guidance that currently exists to allow this. QHP's were only provided the waiver from including pediatric essential benefits inside the Exchange if a standalone dental plan was available to satisfy the requirement. Standalone dental was only allowed inside the Exchange. We therefore assume that the essential pediatric dental and vision benefits must be embedded outside the Exchange. Premium tax credit allocation only applies to the essential pediatric dental benefits offered in a standalone plan. Therefore, this raises confusion as to whether Option B is referring to just supplemental non-essential benefits (subsidies and credits would not apply), essential pediatric dental (premium tax subsidy would apply), or both. If Option B refers to both, then does this mean that integrating essential benefits in the medical plan is prohibited, in which case earlier statements allowing QHPs to include the full package of EHB would be disallowed? As discussed in earlier comments, the ACA does restrict the imposition of annual and lifetime limits on essential pediatric oral and vision services regardless of whether the benefits are offered stand-alone or embedded. The ACA does not restrict annual or lifetime limits on non-essential benefits whether offered stand-alone or embedded. Therefore, Option C poses no greater risk of adverse selection than does Option B.
Vision y Compromiso	Support recommendations.
VSP Vision Care	VSP Vision Care – Stakeholder Comments August 3, 2012

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	Avoiding Market Disruption: VSP is the largest insurer by membership in the State of California. We cover 1 in 3 Californians today, some 14.3 million people. That is larger than Anthem Blue Cross, Kaiser and Blue Shield combined. DMHC data confirms that 93% of those covered in California obtain their care through Stand-Alone Vision Plans (SAVP). Therefore, only 7% of vision care is delivered as integrated coverage by a health plan. Access to Care: The 4,653 VSP network doctors in California are small business owners, based in the community and serve rural, urban and suburban populations. 2,995 VSP network doctors (64% of the total) provide care in Medically-Underserved Areas, based on the HRSA definition and utilizing the HRSA MUA/P zip code listing. 2,005 VSP network doctors (43% of the total) provide care in the Medi-Cal program. As a not-for-profit company and delivery system, VSP provides care to Medi-Cal, Medicare, CHIP, Healthy Families, the UC System, State Employees, CalPERS, LAUSD, Disney, Northrup Grumman, Google, Oracle, Facebook and many other large organizations in the State. In addition, VSP covers an enormous number of small businesses in California. Overall, VSP covers 10,912 employers in CA – 76% of those employers have less than or equal to 100 employees and 64% have less than or equal to 50 employees. This is particularly important because the ACA requires benefits be equal in scope to the "typical employer." Section 7B, Issue #1 – VSP Recommendation - Option A: Employer Choice in the SHOP Exchanges is paramount and we are pleased that CA HBEX staff has changed their recommendation in the July 16 Board Recommendation Brief under Section 7B, Issue #1: Offering Supplemental Benefits in the Individual and SHOP Exchanges to Option A: Offer supplemental benefits in both the Individual and SHOP Exchanges, rather than Option B: Offer supplemental benefits only in the SHOP Exchange. We are in agreement with Option A, as it provides the most seamless offering with the least amount of disruption for consumers transferring between Exchanges, employer based insurance and other public programs. For similar reasons, the benefits need to be common/standardized between the Individual and SHOP Exchanges as beneficiaries transfer between them. In this same vein, Medi-Cal, Medicare Advantage, FEHBP/FEDVIP and CHIP benefits also provide comprehensive eye examinations and coverage for glasses. The Individual and SHOP Exchanges will be at a disadvantage to other programs, as well as "typical employer" plans if the vision benefits

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	offered in the Exchanges substantially differ amongst these varied programs. To the con identified in Table 55, Option A in the Board Recommendation Brief - dated July16 on page 238, the notion of additional costs associated with offering supplemental benefits in both the Individual and SHOP Exchanges is negligible as it relates to vision care. Just as we have committed to do for other State Exchanges - VSP is willing to build in modest administrative loads relative to vision premium to help CA HBEX offset any additional administrative costs resulting from a potential increase in complexity. Section 7B, Issue #2 – VSP Recommendation – Option C: VSP takes issue with the staff recommendation in the Board Recommendation Brief - dated July16 under Section 7B, Issue #2: Structuring Dental and Vision Benefit Offerings. The staff recommendation is for Option B: Offer stand-alone dental and medical plans only. VSP will only support Option C: Offer a combination of (a) stand-alone dental, vision, and medical plans; and (b) medical plans with embedded dental and vision benefits. There are myriad reasons described in today's comments herein, least of which is that the largest insurer by membership in the State (inclusive of small businesses, Medi-Cal, Medicare, FEHBP/FEDVIP, CHIP and Healthy Families) would not be able to provide the pediatric vision benefit in the EHB. This would be disruptive to the market and patients' access to care. Nearly 11,000 employers (two-thirds of them small businesses) in California could face disruption in their vision benefits and delivery system. Both the State of Maryland and the State of Massachusetts have formalized this very issue via legislative amendment to their Exchange laws as it relates to stand-alone vision plans, which allows them to provide the pediatric EHB directly in their state Exchanges. The State of Nevada has also moved to do so via unanimous vote of the Silver State Health Insurance Exchange Board. The Board Recommendation Brief - dated July16 on the bottom of page 237 acknowledges Option C as providing the greatest level of consumer choice, but further indicates that such action removes an important cost control mechanism for dental and vision services. VSP could not disagree more as it relates to vision services. The Brief indicates logic to their recommendation that vision benefits may be deemed as being precluded from financial limits on benefits. This is further supported at the bottom of page 232 of the Board Recommendation Brief - dated July16 where it states; "When offered on a stand-alone basis, supplemental plans are considered 'limited scope'. Limited scope plans are not subject to these requirements." Additionally, there appears to be concern with a benefit inside the Exchanges being a higher benefit level than what is offered outside of the Exchanges.

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	VSP agrees that stand-alone vision plans are absolutely considered "limited scope" and therefore not subject to financial limits on benefits. That being said, VSP would argue that vision benefits by nature have benefit limitations such as frequency of services and co-pays that serve to keep vision costs down. Vision benefits are not catastrophic and involve some of the lowest average claim cost and lowest premiums in the industry. The high value of vision care benefits far exceeds the cost, as demonstrated by the tremendous market penetration of VSP and other vision care plans in the State of California. VSP presently does not have lifetime limits on our benefits. Neither do we have an issue with a law that prohibits such limits. Finally, making the benefits relatively consistent both inside and outside of the Exchanges will hit any benefit disparity issues head-on. Allowing stand-alone vision coverage to satisfy the EHB both inside and outside the Exchanges is consistent with other ACA goals and provisions, which include avoiding gaps in coverage, fostering insurance competition and prohibiting market disruption. Stand-alone vision coverage is the prevalent way employers deliver vision care today, as evidenced by DMHC data proving that 93% of vision care in California is delivered by Stand-Alone Vision Plans. Therefore, stand-alone coverage fulfills the statutory mandate that the EHB be consistent with the "typical employer plan." At minimum, the pediatric EHB needs to be a comprehensive eye exam and should contain materials just as is the case with Medi-Cal, FEHBP/FEDVIP, Medicare Advantage, CHIP, Healthy Families and small employers today. Finally, with regard to Table 56 in the Brief, Option C on page 239, and the reference to "avoiding too many options and too much information", vision care is arguably the most simple benefit to communicate and the most simple for Exchange beneficiaries to understand. The selection of Option C on Issue #2 is the only option that adheres to the President's frequent promise that; "…. if you've got health insurance, you like your doctors, you like your plan, you can keep your doctor, you can keep your plan. Nobody is talking about taking that away from you." Seamless Enrollment Experience: We believe an approach is called for by the CA HBEX in this instance to build a "seamless enrollment experience" between the EHB offered within the Exchanges and supplemental plans offered in conjunction with the Exchanges, where both will be inclusive of vision and dental care. The typical employer plan, their vendors and benefit administrators figured out how to deal with such enrollment and cost-sharing complexity years ago through the mature application of technology to benefit enrollment software. Accenture/CGI/Oracle need to account for and build out this "seamless enrollment" capacity similar to large employer annual enrollment platforms - taking into account the

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	experience and expectation of a typical employer plan for both the EHB and Supplemental offerings. In the same way, the Exchange can compel consumers to purchase pediatric vision from either an embedded or Stand-Alone plan only insofar as such benefits are priced separately. This allows maximum consumer choice, transparency and competition for services. Accenture will need to build that into their structure at the point of enrollment. The enrollment engine should prohibit an enrollee from proceeding to the next step, until the pediatric vision requirement is met...ostensibly through either a health plan offering or that of a Stand-Alone vision offering, just like in the 2014 Maryland and Massachusetts Exchanges. Supplemental benefit offerings of vision and dental should also be handled in this same fashion. Backup to VSP Recommendations on Preventive Vision Care and Affordability: Most importantly, a landmark industry study conducted for the National Association of Vision Care Plans (NAVCP) proved that the utilization of preventive vision care through a health plan delivery channel is less than half when compared to preventive care usage through a Stand-Alone Vision Plan. http://navcp.org/documents/NAVCP_PressRelease_FINAL.pdf An additional study conducted by Human Capital Management Services proved that for every dollar invested in vision exam services, an average two-year total return of $1.27 resulted through avoided medical costs and improved human capital performance. The study also found that eye doctors detected signs of certain chronic conditions before any other healthcare provider recorded the condition—65 percent of the time for high cholesterol, 20 percent of the time for diabetes, and 30 percent of the time for hypertension. http://www.prnewswire.com/news-releases/new-study-finds-eye-exams-first-to-detect-chronic-diseases-120223369.html If stand-alone vision plans are not allowed to provide the benefit directly, the lower utilization will mean higher costs for the State of California downstream since there will be a missed opportunity for the earliest possible detection of chronic conditions. Separate Pricing Requirements & Market Practices for Stand-Alone Vision plans: As it relates to further comments on the Board Recommendation Brief - dated July16 on Section 7B - Supplemental and Pediatric Essential Health Benefits: Dental and Vision: All carriers must be required to disclose the price of adult and child-only dental/vision benefits separately to consumers. Maximum consumer choice and transparency is

Issue #17: Supplemental Benefits: Dental and Vision	
Organization	**Comments**
	achieved with such a requirement, as long as such benefits are separately priced and disclosed. Consumers need to understand what they are buying and therefore all sides need to fully disclose pricing both in the EHB and Supplemental vision and dental plan offerings. Current market practices do not set a minimum participation rate for vision care when offered as a supplemental (voluntary/contributory) benefit. This often differs from the dental industry. When priced correctly, vision plan enrollments frequently exceed 50% of the eligible employees within the employer group, even when the beneficiary is paying the entire cost of the premium. Vision plans historically have never had lifetime limits, or waiting periods for coverage. Moreover, vision plans have been offered on a contributory basis since the mid-1980's. Vision care adverse selection loads are most often deemed predictable as well as nominal. Vision care complements the other benefits offered and positions the Exchange as the comprehensive channel for a variety of benefit offerings. Thank you for the opportunity to submit comments and thank you for the transparency of this entire process.

ISSUE 18

Issue #18: Multi-State Plans	
Organization	**Comments**
Anthem Blue Cross	Anthem shares the concerns of the Exchange with respect to wanting to ensure that there is a level playing field for multi-state plans and other QHPs offered on the exchange.
California Association of Physician Groups	**Multi State Plan Standards in Alignment with California**: CAPG agrees with staff concerns as stated in the document at page 244: "Exchange staff has encouraged OPM and CCIIO staff to require multi-state plans to meet Exchange certification criteria in order to keep a level playing field for California's Qualified Health Plans. In addition, to allow multi-state plans that meet lesser standards is less protective of California consumers, and the Exchange should continue to encourage Federal endorsement of its Exchange-specific plan certification standards."
California Children's Hospital Association	CCHA agrees with the staff recommendations for the reasons noted in the policy options brief.
California Pan-Ethnic Health Network	California is ahead of the rest of the nation in providing certain insurance regulations and consumer protections. For example, we are the only state in the nation to require health insurers to provide interpreters and translation services under legislation sponsored by CPEHN in 2003, SB 853. The Exchange should prohibit the selling of multi-state insurance plans that do not meet the state's more stringent consumer protections, including California's language access requirements. As a state with some of the strongest consumer protections including language access policies in the country, the Exchange cannot avoid its role in monitoring multi-state plans to ensure these plans do not violate existing state laws thereby harming California's consumers.
Health Access	It is extremely unfortunate that federal law requires the creation of multi-state plans. Close monitoring is important to protect Californians.
National Health Law Program on behalf of the Health Consumer Alliance	NHeLP and the HCA share the concerns raised by the Board Background Brief about the role of multi-state plans in California's Exchange, and we support the recommendation that the Exchange staff continue to work closely with OPM and CCIIO staff to monitor any proposals that multi-state plans enter the California market in 2014 or 2015. We also support the Exchange taking any steps possible to ensure that any multi-state plans that participate in California's Exchange are held to the same standards as QHPs and be subject to Exchange oversight.

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Issue #19: Consumer Operated and Oriented Plans (CO-OPs)	
Organization	**Comments**
California Children's Hospital Association	CCHA agrees with the staff recommendations for the reasons noted in the policy options brief.
Health Access	The Exchange needs clear authority to impose contract terms and conditions, including contract sanctions, on CO-OPs, just like other QHPs.
National Committee for Quality Assurance	NCQA's "Interim" review was developed for new plans such as CO-OPs.
National Health Law Program on behalf of the Health Consumer Alliance	NHeLP and the HCA also share the concerns raised by the Board Background Brief about the role of CO-OPs in California's Exchange, and we support the recommendation that Exchange staff continue to work closely with OPM and CCIIO staff to monitor any proposals that CO-OPs enter the California market in 2014 or 2015. We also support the Exchange taking any steps possible to ensure that any Co-Ops that participate in California's Exchange are held to the same standards as QHPs.
Small Business Majority	We fully support CO-OPs inclusion in the SHOP and believe CO-OPs are an important tool to increase competition in the health insurance market. We encourage the Exchange to put standards in place that will ensure employers and employees are purchasing quality coverage while staying away from stringent standards that prohibit CO-OPs from competing with large, established statewide insurers. For example, CO-OPs may not be able to offer provider networks as broad and comprehensive as traditional insurers but, if reasonable standards are met, the CO-OPs should nonetheless be able to participate in the Exchange.

ISSUE 20

Issue #20: Partnering with Health Plan Issuers to Promote Enrollment	
Organization	**Comments**
American Cancer Society, CA Division	The Exchange should ensure that Qualified Health Plans do not engage in outreach or marketing efforts that discriminate or discourage the enrollment of individuals with significant health needs. Use of misleading or confusing marketing materials, conducting outreach in some geographic areas and not in others, and selective, targeted door-to-door, telephone or cold-call marketing are examples of marketing practices used to selectively enroll cheaper-to-cover populations.
Anthem Blue Cross	Anthem appreciates that the Exchange is exploring options to involve QHP issuers in promoting enrollment through the Exchange. We believe that issuers will be an important partner in helping to facilitate enrollment. With the goal of facilitating a successful partnership with the Exchange to promote awareness of and enrollment in QHPs, we offer the following comments in response to the Board Background Brief: **Costs:** The Exchange is contemplating requiring QHPs to disclose their marketing budgets. We are not against sharing this type of information, but we would appreciate further clarification on the reporting requirements, as well as how the information will be used, and to which segments the requirements will apply (e.g., QHPs only or all segments within the California market including Medicaid and Small Group). We note that insurers participate in multiple markets and marketing expenses may be used for general promotion and not one segment specifically; the Exchange should consider how those expenses would be treated. Our recommendation would be to limit the reporting requirements to just QHP or exchange plan specific marketing budgets. We also urge the Exchange to ensure that proprietary information on marketing expenditures is not disclosed publicly. We would also encourage the Exchange to provide similar levels of transparency on its marketing budget to stakeholders and the public. **Co-Branding and Marketing Incentives:** Anthem agrees issuers' active engagement in marketing and retention activities will be critical in helping to promote enrollment in the Exchange. We believe that allowing direct enrollment by health plans will be an effective tool in maximizing outreach and enrollment of individuals in QHPs and insurance affordability programs for which they are eligible. With respect to incentives to encourage issuers to engage in active marketing, we support the participation fee reduction and also suggest the Exchange consider streamlined material approvals, preferred placement on the Exchange website, and placement of direct links to the issuer's website from the Exchange. Finally, we would appreciate further clarification on how multiple carriers would be able to co-brand with the one Exchange.

Issue #20: Partnering with Health Plan Issuers to Promote Enrollment	
Organization	**Comments**
	Renewals: We understand and agree with the need to ensure the provision of fair and balanced information. However, we would appreciate additional information on the requirements that the Exchange is contemplating with respect to notifying current enrollees about Exchange coverage and the availability of premium subsidies. To avoid consumer confusion on where to go for information, our recommendation would be to have communications to consumers with current Individual coverage come from the consumer's current health plan versus from the Exchange. This would apply both during the initial Exchange open enrollment period in the Fall of 2013 and all future year renewals. **Enrollment:** We believe that allowing direct enrollment by health plans will be an effective tool in maximizing outreach and enrollment of individuals in QHPs and insurance affordability programs for which they are eligible. For example, issuers should have the ability to enroll individuals through their own websites or captive agents verifying and processing subsidy eligibility on behalf of the consumer so as to ensure "enrollment through the Exchange." However, we also understand collaboration between issuers and the Exchange will be required. In this regard we would appreciate further clarification on how the Exchange will collaborate with issuers on enrolling individuals through the Exchange when required. Finally, we ask that the Exchange define what is meant by an "unqualified" lead. **Reviews:** We encourage the Exchange to provide greater detail on the requirements for marketing review and approval. Will the reviews be for all materials, or just for Exchange product materials? Would general brand advertising be subject to review, as this would target both Exchange and non-Exchange members? Finally, what timelines should QHP issuers anticipate for publication of guidelines around marketing materials? Will they be tied to product filing submissions or separate? And how long will the reviews take?
Blue Shield of California	**Direct Enrollment:** We believe it is appropriate that health plans be able to work with their current enrollees to maintain their existing coverage. We agree that current enrollees and prospective enrollees that approach us directly should be informed about the Exchange, particularly the availability of subsidies, but that the incentive for carriers to invest in direct enrollment will be limited in proportion to the extent the Exchange forces plans to promote competitors. The proposed guidance appears to attempt to strike a balance, but more details are required. We look forward to working with you to resolve this important issue. **Marketing:** The recommendations propose mandating marketing expenditures by QHPs in proportion to their market share in the

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Organization	**Comments**
	individual market or based on all lines of business. Mandating QHP marketing expenditures has never been considered by the federal Exchange rules. Rather the Exchange is expected to use the fees generated by QHPs to market for the Exchange. Using fees collected from health plans for marketing makes more sense than compelling plans to market the Exchange since it would enable a far more strategic and coordinated approach. Additionally, Exchange fees that are used for marketing and other purposes would not be considered an administrative expense under the MLR for QHPs because they are equivalent to a tax, while forced expenditures for marketing by QHPs would be considered an administrative expense. Each QHP has different administrative burdens; requiring QHPs to spend more than they may be able to spend on marketing may tax the plan in such a way that makes it difficult for them to profitably participate in the individual Exchange. The proposed rules for the review of marketing materials also go beyond anything considered in the federal Exchange rules. In fact, the federal rules make clear that compliance with existing state law requirements will meet the federal QHP certification requirements and that a consistent regulatory framework for plans inside and outside the Exchange should be a priority. Neither DOI nor DMHC regulations require review and approval of marketing materials to ensure they are "fair and balanced." As a result, the proposed rules would establish inconsistent marketing rules for QHPs and plans in the outside market, complicating and likely hampering health plan marketing efforts. We believe the Exchange should not require any marketing expenditures or additional marketing rules by plans as a condition of participation in the Exchange.
California Association of Health Plans	CAHP and our member plans strongly advise the Exchange against any policy that would reduce the incentive of plans to engage in direct marketing. The incentive for QHPs to invest in direct enrollment will be limited in proportion to the extent the Exchange requires plans to promote all available options in the Exchange. While the current recommendation appears to attempt to strike a balance between consumer choice and incentives for plans to market, we request that the Exchange provide additional details and continue discussions with CAHP and our member plans on how the marketing efforts of plans can complement the work of the Exchange. We are specifically interested in what will be required for captive agents, for current enrollees that may be eligible for a subsidy and/or coverage in the Exchange, and individuals that otherwise approach a plan directly. On the issue of marketing budgets CAHP is interested in what detail the Exchange will require from QHPS and

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Organization	**Comments**
	what standards the Exchange will use to determine what it believes is a "sufficient" budget. We would also note that the DMHC currently does a review of all plan marketing materials and we would suggest that the Exchange leverage that existing process as outlined in the federal law and not take time and resources away from the many competing tasks of the Exchange.
California Children's Hospital Association	CCHA agrees with the staff recommendations for the reasons noted in the policy options brief.
Health Access	• Almost 800,000 Californians, about a third of the individual market, are income eligible for Medi- Cal or the Exchange. Making sure these Californians get help paying for coverage should be a shared objective. We are pleased to see the Exchange working with health plans to accomplish this. We also support consumers remaining with their current carrier (and doctors) if the consumer wants to keep the same carrier but with help paying for coverage. Those consumers who want to change carriers because they finally have the opportunity to do so because of guaranteed issue should also be given the opportunity to change carriers and get help paying for coverage. • We do support partnership with plans to share enrollment and outreach strategies and tactics. However, because of past experience and the potential for abuse in this new market place, we are concerned about the Exchange staff assurance during the webinar that they would "not divulge this information publicly." We have found that practices to reach out to new enrollees may seem neutral or even promising on their face, they can result in subtly screening applicants based on health conditions or anticipated costs. Some of these practices have a long history beginning with the practice in the 1990s of offering plan seminars, education, and enrollment events to prospective members in a upper floor in a building with no elevator which effectively screened out people with disabilities or other respiratory or heart conditions without seeming to do so.
Health Net	We do not believe it is feasible for the Exchange to require our in-house sales team or our captive agents to provide enrollees with information about other issuers' plans. We seek additional information from the Exchange about how it proposes to regulate marketing practices.
Kaiser Permanente	We support the staff recommendation to engage the Exchange's contracting plans as partners in securing widespread enrollment in the individual market. The cost of coverage in 2014 is much-discussed, as is the potential for the Exchange to adjust the rate of increase in health care costs. No single factor will affect the success of the Exchange in this regard than whether enrollment in coverage occurs at a dramatic rate. Health plans are uniquely positioned to help the Exchange succeed in enrolling individuals. Plans have expertise in

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	marketing, and they have relationships with existing individual and group customers who are, or will become, eligible for subsidized coverage through the Exchange. It would be a tremendous lost opportunity if plans are limited to merely providing potentially subsidy-eligible individuals with a web site and a phone number. If this circumscribed approach prevails, consumer uncertainty and inertia will mean such a choice carries a high cost. Instead, we recommend an approach analogous to Medicare Advantage, whereby plan marketing is subject to oversight and review. More significantly, however, we believe the Exchange should think of plan marketing and enrollment activities as contractual obligations that its plans must perform to help the Exchange achieve its mission. And, we believe the Exchange should build navigator and Exchange-direct channels rapidly – and with performance metrics that are firmly tied to results.
National Health Law Program on behalf of the Health Consumer Alliance	NHeLP and the HCA support the Board Background Brief's recommendation that the Exchange work closely with participating plans to coordinate marking and enrollment activities, while simultaneously ensuring that consumers are given complete information about the range of options available to them. In addition, the materials and marketing practices must be regulated and monitored by the Exchange and QHPs should be required to work with community-based advocates and organizations to ensure that their enrollment and marketing activities are appropriately designed and targeted to meet the needs of the particular community or region.
Small Business Majority	The Exchange will only be successful if its work is done in partnership with all stakeholders. Exchange participation is voluntary for small businesses, individuals and carriers. All must feel like equal partners for the Exchange to work. Just as the Exchange will be partnering with community- based groups, assistors and others to promote enrollment, it makes sense for the Exchange to also collaborate with its QHP partners. We support efforts by the Exchange to be more efficient and effective by working with all parties.
Southeast Asia Resource Action Center (SEARAC)	In developing strategies for promoting enrollment, SEARAC recommends that the Exchange facilitates partnerships between Health Plans and community based organizations.