CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD
February 21, 2012
East End Complex Auditorium
1500 Capitol Ave.
Sacramento, CA 95814

MINUTES

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

Mr. Fearer called the meeting to order at 10:05 a.m.

Board members present:	Kimberly Belshé Paul Fearer, acting chair Susan Kennedy Robert Ross, MD
Board members absent:	Diana Dooley

A conflict disclosure was performed; there were no conflicts from the board members that needed to be disclosed. The board entered closed session at 10:06 a.m.

Agenda Item II: Closed Session

Agenda Item III: Announcement of Closed Session Actions

Mr. Fearer called the meeting to order at 11:04 a.m.

While in closed session the board passed a resolution extending the ClearBest contract due to widening the contract scope. The contract has been extended for up to an additional $200,000. The board also increased the potential amount to be paid for the qualified health plan (QHP) solicitation from $600,000 to $700,000, based on the revised scope.

To assist it with its executive recruiting, the Exchange selected the firm of Wilcox Miller & Nelson, an executive recruitment firm with extensive health care employer contacts and experience recruiting among diverse populations and communities of color. Public input is still vital and stakeholders are invited to suggest potential candidates for Exchange positions.

The board recently released a solicitation for assistance in the development of the Small Employer Health Options Program (SHOP) and Mr. Lee asked that stakeholders pass on this information to any interested parties.

Final amendments for the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) solicitation were released February 21. The deadline for vendor proposals was extended to February 29.

Proposals have been received and are being reviewed for the Outreach and Education Campaign and Assisters Program solicitation, released jointly by the Exchange, the Department of Health Care Services (DHCS), and the Managed Risk Medical Insurance Board (MRMIB). An award will be made in the coming weeks.

Public comments: None.

Agenda Item IV: Approval of January 26, 2012 Minutes

After asking if there were any changes to be made, Mr. Fearer asked for a vote to approve the minutes from the January 26, 2012 meeting.

Presentation: Board Meeting Minutes - January 26, 2012

Discussion: None.

Public Comments: None.

Vote: Roll was called, and the vote was unanimous.

Agenda Item V: Report from the Executive Director

Discussion: Personnel Matters

Gloria Monroe, formerly of Department of Corrections and Rehabilitation, will be joining the staff as an associate governmental program analyst (AGPA) on March 1.

Andrea Rosen, on loan from the California Department of Insurance, will be playing a leadership role in the development of Qualified Health Plan (QHP) strategy.

Discussion: Administrative Update

Presentation: Level I Establishment Grant Quarterly Report (Oct - Dec 2011)

The Exchange submitted a quarterly report to the federal Department of Health and Human Services (HHS) for the period of October through December 2011 showing the Exchange obligated nearly $6.5 million. Mr. Lee anticipated the Exchange would use the full $39 million grant award over the full period.

The Exchange received comments on essential health benefits (EHB) that are posted online and Mr. Lee noted that many issues raised in the comments also affect broader topics including provider networks and QHP contracting.

Similar to the stakeholder process used for outreach, marketing, and the navigator program, the Exchange has posted stakeholder questions on QHPs, delivery reform, and supplemental benefits. Comments are invited on these questions.

Presentation: Qualified Health Plan Stakeholder Questions

In the coming weeks, senior staff and the board will once again be traveling the state, meeting in small groups, in Redding, San Diego, San Francisco, Los Angeles, and Sacramento to also get input on the Exchange's QHP strategy. Those with suggestions for participants may send them to info@hbex.ca.gov.

Presentation: Presentation - California Health Benefit Exchange 2012 Planning Overview

Mr. Lee presented a planning overview for the Exchange through summer 2012, noting that federal rules are still forthcoming and that the Exchange plans to apply for a Level II grant in June.

The March board meeting will be at the Fresno Convention Center and there may need to be an additional meeting added in May or June in anticipation of the work needed for the Level II application.

Discussion: None.

Public comments: None.

The meeting adjourned for lunch at 11:41 a.m.

Agenda Item VI: Panel Presentations to Inform Exchange's Qualified Health Plan Contracting and Delivery Reform Planning

Three panels presented on the Exchange's QHP contracting and delivery reform planning.

Panel 1: Introduction, Context, and Strategy Overview

Panelists: Marian Mulkey, California HealthCare Foundation
Deborah Kelch, California HealthCare Foundation
James Robinson, UC Berkeley

Presentation: California Health Care Landscape

Ms. Mulkey presented on California health plans and products. She noted that products sold in the employer market are largely HMO products; in the individual market, they are

a mix with more PPO products. Benefits are less comprehensive and premiums lower in the individual market than in the group market and even though many look forward to more uniformity under the ACA there could still be significant product diversity.

Presentation: Regulatory Environment for Health Coverage in California

Ms. Kelch presented on the regulatory environment in California, noting that the Exchange would likely be part of a trend to bridging and equalize the differences in standards between the Department of Managed Health Care and California Department of Insurance.

Presentation: Overview of Purchasing Strategies

Dr. Robinson discussed strategies for controlling costs, noting that the most difficult part of the Exchange's strategy will be moderating costs as there is no painless way to control costs in health care. Benefits will not vary greatly between plans while cost-sharing may have different structures. Network design and medical management strategies may also be used to control costs but can result in procedures or less choice of doctors and patients. Generally, he noted health plans do not vary in their strategies but rather in how successfully they implement these strategies.

Discussion:

Ms. Kennedy asked Ms. Mulkey why there is such a difference in the average premiums between the employer and individual markets. Ms. Mulkey responded that benefits are not as comprehensive in the individual market, there is higher cost-sharing, and there are substantially higher administrative costs. She noted that these differences are partially offset by the medical underwriting in the individual market that results in better "risk mix" than in the employer markets.

Ms. Belshé asked Ms. Mulkey to what extent plans are using the same or overlapping providers in their networks. Ms. Mulkey deferred to Dr. Robinson who noted Kaiser offers its own delivery system but other plans often use overlapping networks. Ms. Belshé wondered if, as a purchaser, the Exchange should see provider networks as less important than incentives or payments to providers. Dr. Robinson said it the choice of health plan used to imply a particular provider network but does not currently and may not in the future, where plans offer different networks.

Mr. Fearer asked about the ways plans negotiate with providers in regards to payments and models of control. Ms. Kelch said the board should evaluate all QHPs for offered provider-level incentives and performance measures to see how incentives play out but that focusing on performance outcomes may be more important than the relationships between plans and providers. The relationship is important to the extent that the Exchange must protect providers' fiscal solvency, thus protecting the consumer.

Dr. Ross asked Ms. Mulkey if consolidation of the market is good or bad for efficiency of care or if it's simply a market issue. Ms. Mulkey responded that consolidation is a market issue, noting that at the plan-level California's market is not very consolidated compared to other states where 70% to 80% of statewide enrollment can be in one plan.

Dr. Ross asked Dr. Robinson about the proper number of plans to have in the Exchange. Dr. Robinson noted that not all plans compete with each other as some are Medicaid plans, some are large-group plans, etc. and thus the Exchange will probably be dealing with a relatively small number of carriers who could have a variety of product designs. Mr. Lee noted that plans that had historically served only Medicaid populations may enter the Exchange and that, in California, health care is local with different regions facing different issues and competition tending to be regional.

Ms. Belshé asked Dr. Robinson to explain successful implementation of strategies by plans and what defining characteristics exist. Dr. Robinson said health plan consolidation has resulted in a greatly reduced number of plans that are not organized by national strategies. Thus plans, to keep things simple, don't do much different in California than they do elsewhere in the country. Success can only really be judged by the results. Dr. Robinson noted that local health plans tend to have more distinct provider networks than national commercial plans.

Ms. Belshé asked if there are specific characteristics the Exchange, as a purchaser, should look for. Dr. Robinson said a plan's ability to report data is important and would recommend choosing plans that work to share data on the performance of providers.

Mr. Lee thanked the panel and noted there are millions of Californians not regulated by the California Department of Insurance (CDI) or the Department of Managed Health Care (DMHC) because they are regulated by the Employee Retirement Income Security Act (ERISA) or are in self-funded plans.

Panel 2: Public and Private Purchaser Strategies

Panelists:	Suzanne Delbanco, Catalyst for Payment Reform Ann Boynton, CalPERS Betsy Gilbertson, Hotel Employees and Restaurant Employees International Union (HEREIU) Welfare Fund On phone: Jon Kingsdale, Wakely Consulting (former director of Massachusetts's Connector) Elizabeth Abbott, Health Access

Presentation: Private Purchaser Strategies

Ms. Delbanco discussed private purchaser strategies, explaining the Exchange can be an active partner and participant, using its leverage to drive better value.

Ms. Boynton discussed the California Public Employees' Retirement System (CalPERS), which insures 1.3 million people, mostly in California. CalPERS uses narrow networks and tiering for cost containment, which can be an effective mechanism to contain costs but runs the risk of causing disruption to members and is disliked by providers. She noted that narrow networks and tiering may not be sufficient long-term strategies for cost containment and recommended the board look at transparency and pricing, saying that Blue Shield is starting to implement flat pricing and a "centers of excellence" model. She noted her concern that these commoditized mechanisms can result in disintegrated care and that assuring care integration should be an important one for the board, which was critical for CalPERS with people with chronic conditions accounting for half of CalPERS' spending. Ms. Boynton noted that compared to PPO's, HMOs have not produced better care with eight years of claim data for evidence.

Promoting evidence-based payments are generally not included in CalPERS contracts at this time but they are shifting towards them in select areas as a result of provider encouragement. Reimbursement strategies have been successful in containing costs but the Exchange must determine how large it will be and how skilled its staff must be as implementing these efforts successfully as it requires the purchaser to take a highly active role.

Presentation: Unite HERE Health

Ms. Gilbertson described her organization's core population of low-income, diverse individuals and families and noted the success they've had in Las Vegas and New Jersey managing the physician network has been based on their understanding of the variation of physician practice patterns. By investing in preventive care, case management, low cost to patients, and special care centers, Unite HERE Health has improved quality while controlling costs. Ms. Gilbertson noted that building a relationship with their consumers is key so patients utilize services properly and effectively. She noted that addressing the health care coverage and care needs of the working poor are much different from others and the health care delivery system often fails them, with cost being the most significant barrier to access.

Presentation: QHP Certification Criteria

Mr. Kingsdale participated by phone, reporting on the experience Massachusetts's Exchange, the Connector, in selective contracting and standardization of benefits as a dynamic and evolving process. He noted it may be easier to get stricter over time than to gain back QHPs as partners. The Connector has about 160,000 enrolled in the subsidized Exchange and 40,000 participating in the unsubsidized Exchange. He recommended the Exchange consider having a mix of standard and unique product designs

Ms. Abbott said consumers accept limited networks as a cost containment tool but noted that they should be assured of an adequate number of providers to get the care they need, including potentially out-of-network specialty and emergency care where appropriate care is not available in-network. The Exchange should evaluate QHPs in alignment with

the regulatory environment and the board must be vigilant in ensuring purchasers don't use benefit design as a proxy for impermissible medical underwriting; standardization could be a way to have an apples-to-apples comparison that addresses this problem. The goal should not be to shift costs and risks to consumers but rather to minimize avoidable hospitalizations and preventable emergency room use. She noted the Exchange must consider if an individual has better capacity to judge cost and quality that an HR department, saying CalPERS has a large team of negotiators working with plans and that consumers can't be expected to do an equal or better job.

Consumers Union, based on research and focus group testing, feels the best number of plans to include would be between six and nine. The Exchange should not emulate the Medicare Part D model because there were fifty-seven plans in Sacramento to begin with and consumers were unable to make adequate comparisons.

Ms. Abbott disagreed with Dr. Robinson's comment that there isn't a difference if health plans are contracting with the same provider networks. Network adequacy is an underpinning of a good care delivery system and an unrealistic perception of the number of providers can develop if all plans have the same network.

Discussion:

Ms. Kennedy asked Ms. Gilbertson for her recommendations to the board. Ms. Gilbertson noted Dr. Robinson's comments about local provider networks and the potential for local health plans to add value, noting the Exchange's success could reinvigorate local plans in California.

Ms. Belshé asked panelists what will be necessary for the Exchange on opening day. Mr. Kingsdale replied that good customer service and connectivity and interoperability with QHPs are especially important to have on opening day. He also stressed the importance of including in the Exchange plans that currently sell well in the market. Ms. Delbanco noted the Exchange should have data on the customer experience. Ms. Boynton said the Exchange must know the various populations it serves and how it is aligned with plans and providers who are interested in creatively engaging those populations.

Dr. Ross asked the panel to comment on the role of the federally approved multistate health plans. Mr. Kingsdale responded that, while it's a concern, there are more important things to worry about. Ms. Delbanco noted the Exchange has the advantage of being the local entity compared to other large, national purchasers who cannot customize to specific markets.

Ms. Belshé asked Mr. Kingsdale for his "top ten" list of worries. Mr. Kingsdale said a major concern would be getting Medi-Cal plans to participate in the Exchange to promote continuity of coverage at the provider level as it may require the Exchange to be less selective with QHPs.

Dr. Ross asked if there were opportunities for the Exchange and CalPERS to work together. Ms. Boynton said aligning the philosophical strategies could lend stability to the market.

Ms. Gilbertson noted her hope that the board would consider the low-income population to be served by the Exchange , noting that large, national plans are ill-suited to serving these people and that the Exchange will need to make a particular effort in this area to be effective.

Mr. Lee said the Exchange will continue to reach out to community advocates and other diverse groups to inform its QHP strategy.

Panel 3: Stakeholder Reactor Panel

Panelists:	Charles Bacchi, California Association of Health Plans Dustin Corcoran, California Medical Association Duane Dauner, California Hospital Association Donald Crane, California Association of Physician Groups John Arensmeyer, Small Business Majority Ellen Wu, California Pan-Ethnic Health Network

Mr. Bacchi said health plans receive high marks for access and timely care, noting that CAHP's surveys show 85% of enrollees are satisfied with their coverage and 66% are satisfied with the cost. As a state, California has one of the lower costs of premiums in the nation. Given successes achieved, the board should not discount the work currently happening in the marketplace. He noted controlling cost via benefit design will be increasingly difficult due to essential health benefits but disagreed with Dr. Robinson that all plans use similar strategies, noting that plans operate differently and work differently with providers on a variety of issues. The board should thus take into consideration including a diversity of networks and models needed to drive innovation. He noted the difference between a purchaser setting standards and goals while letting health plans develop unique products as opposed to creating a "one size fits all" plan.

Mr. Corcoran and Mr. Dauner presented jointly.

Presentation: Qualified Health Plan Contracting and Delivery System Improvement

They noted that Health care reform will result in major changes to the health care system and there is plenty of opportunity for failure. However, the Exchange can play a key role in aligning policies so all stakeholders are aligned financially and clinically, with transparency, choice, and avoidance of systemic conflicts being key factors the board should consider.

Presentation: QHP Contracting and Delivery System Improvement

Mr. Crane noted that the Affordable Care Act resulted in many opportunities for change, suggesting the Exchange look at accountable care organizations (ACOs) and other existing innovations and that the Exchange be bold in its approach. The Exchange needs to seek to drive change from the outset.

Mr. Arensmeyer presented on the SHOP Exchange.

Presentation: Exchanges: Attracting Small Businesses

The individual Exchange and SHOP Exchange will be very different and cost will be the main driver for the SHOP. The Exchange should serve as a "human resources department" for small businesses in the area of health care.

Ellen Wu, responding as a consumer reactor, noted that over 2.5 million non-elderly adults will be eligible for tax credits in the Exchange and 67% will be people of color and 40% will speak English less than very well. The Exchange should be designed to serve these groups specifically as they will be large and central to the Exchange's success. The Exchange should drive system reform and must be careful in determining what services are valuable and promote wellness programs while avoiding programs that blame the patient rather than drive change. Information that is relevant to communities of color, such as the availability of translators, must be made available.

Discussion:

Ms. Kennedy asked why California had lower health care costs. Mr. Dauner explained that managed care plays a role and that, despite cost shifts, privately insured patients pay premiums at the national level when, compared to the cost-of-living, they should be the fourth highest in the nation. Mr. Dauner noted cost-shifting in California is much higher than in other states and noted it's important to distinguish between cost shifts and expenses. Cost shifts do not affect how much is spent but who pays.

Mr. Crane said care models are important and Mr. Corcoran noted it is important to discern why some organizations deliver care in a more sophisticated manner without mandates.

Ms. Belshé asked panelists for their reactions to Dr. Robinson's presentation. Mr. Bacchi said it's important to balance consumer choice to make the Exchange attractive even for the unsubsidized. Mr. Crane said the Exchange needs to look for providers that will provide care that meets the Exchange's needs, noting that optimal care delivery also results in expanded capacity. Mr. Corcoran said the Exchange should be cautious because innovation needs time to grow, noting the Exchange should engage payers in different ways and see how that plays out in the private marketplace before incorporating it into the Exchange's philosophy. Mr. Dauner said the challenge is to consider how it will affect all Californians, not just those in the Exchange, so it can help coordinate

disparate parts into alignment. Mr. Arensmeyer said the Exchange needs to be attractive to small businesses when it opens in 2014.

Dr. Ross appreciated Mr. Crane's comment to be bold, but noted that boldness can result in mistakes and noted challenges before the board of finding a way to "do no harm" to providers, consumers, and businesses while creating a safe space for innovation. Mr. Lee invited public comment on how to be prudent and bold, how to work in partnership with other agencies, and where to align with others and reduce disparities and burdens.

Public Comment: Elizabeth Landsberg, director of legislative advocacy, Western Center on Law and Poverty noted that Ms. Gilbertson's story of Unite HERE Health is an interesting and seemingly successful way to control costs through elements such as free prescription drugs and care coordination. Partnering with Medi-Cal manager care models, as described by Mr. Kingsdale, also holds promise. The Exchange should be wary of providing overwhelming choice as people won't be able to decide.

Cindy Ehnes, president and chief executive officer, California Children's Hospital Association noted that as a former director for DMHC, it is important to design systems that incorporate consumers' needs, which can be seen in accountable care organizations operating in California. Narrow networks can be a concern because when health plans squeeze down on providers, especially specialists, it disrupts what is already a delicate ecosystem. The Exchange should look at multiplayer disease management systems that bring values like those Unite HERE Health has created.

Micah Weinberg, senior policy advisor, Bay Area Council noted the Exchange needs to create managed competition among integrated delivery systems and the Bay Area Council has a white paper on this subject. The Exchange must be careful about designing network requirements that burden QHPs and should allow limited networks and possibly even prefer integrated systems.

Amy Moy, vice president of public affairs, California Family Health Council noted the board should identify a full range of essential community providers that QHPs will work with, require all willing essential community providers to be included in networks, and ensure they are protected against discriminatory contract practices.

Michael Rousseau, California Public Interest Research Group noted the Exchange must focus on preventing adverse selection as the market will be much the same on January 1, 2014 and the Exchange must be on the right path to preventing adverse selection. Data, reporting infrastructure, and partnerships will be key to this effort as two network types can have different results.

Al Shubert, vice president of managed care and health policy, VSP Vision Care noted that currently, vision plans are not allowed to compete in Exchanges while dental can. Allowing standalone vision plans is consistent with the typical employer plan called for in the ACA and the HHS bulletin and the Exchange should consider this and allow them to compete.

Mr. Lee pointed out that the Exchange had posted multiple questions soliciting feedback on QHP issues and that several of the questions posted relate to supplemental benefits, on the scope and plan criteria.

Susan Fogel, director of reproductive health, National Health Law Program noted that one of the Exchange's values is reducing health disparities and improving health outcomes for those in underserved communities, which can be done by providing access to reproductive health services. Access to reproductive services has to be well integrated into adequate networks and women must be able to go to providers that will meet all of their health needs, including abortion.

Sarah Miller, director of government affairs and communications, California Association of Public Hospitals and Health Care Systems noted that QHPs must be consumer-focused with a commitment to reducing disparities, improving health, and offering linguistic accommodations. The Exchange should allow multiple types of plans to demonstrate their value to enrollees, including Medi-Cal managed care plans, and should serve as marketplace at the provider level so consumers can decide what value means to them.

Lucy Quacinella, Maternal and Child Health Access (by phone) noted that the board should recognize that many of the newly eligible will fluctuate between Medi-Cal and the Exchange. Because of this, QHPs should be required to demonstrate they serve Medi-Cal patients as a condition of joining the Exchange.

Julie Silas, senior policy analyst, Consumers Union noted that the Exchange can play an important role in data gathering to foster consumer choice. The Exchange should be mindful of concerns about cost-shifting to consumers. The Exchange can help consumers manage the system but needs to negotiate and advocate for them. Too much choice is overwhelming, as seen in Medicare Part D, and it's important to draw lessons from that experience.

Karen Fessel, executive director, Autism Health Insurance Project noted that the board must ensure QHPs have an adequate choice of network providers because, with the requirement that habilitative care be provided, plans will have to negotiate with speech and occupational therapists for long-term and short-term issues. The Exchange should serve as an advisor to consumers in helping them choose between plans.

Ms. Kennedy said these were good presentations and very helpful.

Mr. Lee reminded participants they can submit written comments to supplement or clarify comments made verbally and welcomed suggestions for participants in upcoming board meeting which will focus on outreach and assisters issues.

Agenda Item VII: Adjournment

Mr. Fearer adjourned at 4:01 p.m.