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State of California
HEALTH AND HUMAN SERVICES AGENCY

S. KIMBERLY BELSHÉ
SECRETARY

Aging

Alcohol and
Drug Programs

Child Support
Services

Community Services
and Development

Developmental
Services

Emergency Medical
Services Authority

Health Services

Managed Risk
Medical Insurance Board

Mental Health

Rehabilitation

Social Services

Statewide Health
Planning and
Development

October 4, 2010
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: OCIIO-9989-NC
PO Box 8010
Baltimore, MD 21244-8010

Re: Comments on # File Code OCIIO-9989-NC

To Whom It May Concern:

Thank you for the opportunity to provide feedback on the exchange-related provisions the Patient Protection and Affordable Care Act (ACA). California appreciates the focus and speed with which the Department of Health and Human Services (DHHS) has established the new Office of Consumer Information and Insurance Oversight (OCIIO) function, and the expedience evident in the prompt issuing of grants, guidance, and requests for information. We are especially appreciative of the commitment to coordinate the efforts of federal agencies, particularly the OCIIO and Centers for Medicare and Medicaid Services (CMS).

States will play a critical role in shaping and implementing the insurance exchanges established under ACA. States will also be engaged in transforming their Medicaid programs and modifying their insurance markets, as well as making the down payments on delivery system reforms, payment reforms, and workforce investments – all in the midst of severe economic crisis. California is committed to responsibly moving forward on implementation and looks forward to our continued collaboration.

California has elected to operate an Exchange. Governor Schwarzenegger recently signed two bills that will create the California Health Benefit Exchange and its governing board. Federal grant funds are critical to the early planning and implementation tasks of California's Exchange. California policy makers' support and interest in establishing one of the nation's first insurance exchanges is premised on the understanding that sufficient federal funds will be provided to support states efforts to develop the Exchanges as contemplated in the federal act. Full implementation of the Exchange, including the development of any information technology systems, must be fully supported by federal funds or California will not be able to develop and implement an operational Exchange by 2014.

Given the recent enactment of California's Exchange law and the anticipated appointment of the Exchange governing board in early 2011, these comments reflect what is known regarding California's experience with purchasing cooperatives (Exchanges) and the State policy direction that has been adopted to date. The comments reflect input from the Agencies and Departments within the Administration that will play a role in assisting and supporting implementation of the Exchange.

A. State Exchange Planning and Establishment Grants

An Exchange is designed to bring competitive market forces to bear on health insurance costs, making it easier for individuals and employees of small firms to shop for and buy private health insurance. The Exchange, when successfully implemented, will focus competition on price, quality and service – bringing the same large-group purchasing advantages enjoyed by large employer groups to individuals and employees of small firms.

In electing whether or not to administer an Exchange, the primary consideration for states is whether policy makers view the Exchange as an effective tool for improving access, quality, and affordability of health insurance coverage and view state administration of the Exchange as the best way to achieve these goals. While federal law provides a strong base for Exchange operations, states can increase the effectiveness of the Exchange by enacting state laws that assure the Exchange will be an active purchaser of high value health plans.

California is moving forward with action relating to the planning and establishment of the California Health Benefit Exchange. State government entities involved in the planning process include, but are not limited to, State agencies with fiscal oversight (such as the Department of Finance) and those with oversight of the public programs that must coordinate with the Exchange such as SCHIP, Medicaid and county health programs. State entities involved in the planning and implementation of the Exchange also include agencies responsible for automated system planning and implementation (such as the Office of Systems Integration) and managed care policy in the State (such as the Department of Managed Health Care), and State agencies that oversee regulation of the insurance industry (such as the State Insurance Commissioner).

External entities involved in the planning process will include county social services agencies, health care advocates, health plans and insurers, provider groups, small businesses, and other stakeholders interested in healthcare policy issues.

California law establishes the Exchange as an independent public entity not affiliated with an agency or department and governed by an executive board consisting of five members: two appointed by the governor, one appointed by the Senate Committee on Rules, one appointed by the Speaker of the Assembly, and one ex officio member who is the Secretary of California Health and Human Services Agency (CHHSA) or his/her designee.

Using federal Exchange planning grant funds California will develop a plan for Exchange implementation. It is too early to provide details about business plans or budgets.

The most significant factor affecting State resource needs for Exchange implementation is the adaptability of current automated systems to meet the

Exchange requirements. The expedited availability of federal funds for IT and other staffing needs will help to ensure timely implementation of the Exchange.

California appreciates any efforts the Department of Health and Human Services (DHHS) can make to facilitate meetings of states in similar phases of planning and development to share best practices and work collaboratively on policy and operational challenges. Such meetings are best held in person.

B. Implementation Time Frames and Considerations

The most significant and time sensitive pieces of federal guidance California requests are details on the IT system requirements and other specifications/rules regarding eligibility and enrollment for Exchange members and the coordination of eligibility determination and enrollment with Medicaid and CHIP. Exchange implementation activities must be closely coordinated with the activities states undertake to transform Medicaid programs consistent with ACA. As such, federal guidance for both the Exchange and Medicaid must be timely and coordinated.

Other crucial pieces of guidance that will assist California in its planning efforts are details on which policy issues will be governed by federal regulations and which will be interpreted at the state level. For those items for which federal guidance will be issued – a timeline for the issuance of the regulations would greatly assist in state planning efforts.

A comprehensive list of implementation timeframes and milestones will be adopted during California's Exchange planning phase - general topics include:

Infrastructure

- Appointment of Board Members
- Hiring of Executive Director
- Hiring of key staff
- Space
- Equipment
- Website

Planning

- Board calendar for year
- Strategic Plan & Budget for 2011-2014
- Market Scan: Individual and Small Group Markets
- Enrollment Projections
- Short-term (2011) operating budget

Eligibility & Enrollment

- Coordinate with Department of Health Care Services (DHCS) and Managed Risk Medical Insurance Board (MRMIB)
- Affordability exemptions – process for granting & reporting protocols
- Premium flow – through health plan and/or Exchange
- Rules around when eligibility begins; ends; re-enrollment
- Open enrollment: annual or rolling
- Portability across programs
- Technical specifications and procurement of vendor(s)

- Transition of Pre-existing Condition Insurance Pool (PCIP) members

Outreach

- Distribution Systems
  - Community-based organizations; agents; counties; providers
- Media and earned media efforts
- Informing materials
- Website
- Procurement of any vendors
- Training of outreach partners

Health Plan Contracting

- Standards for participation (individual and small group)
  - Quality
  - Service
  - Medical Loss ratio
  - Price: premium rate changes
  - Delivery System Integration
  - Safety Net providers
- Benefit & Cost Sharing Design
  - Essential benefits
  - Value Based Design features
  - Marketplace leaders in terms of plan design
  - How standard is standardized
- Regional Rating Areas or Statewide
- Annual or rolling rates from plans
- Assessment to support Exchange operations
- Procurement process for selection of plans
- Additional rules to prevent adverse selection
- Supplemental benefits

Appeals

- Process for eligibility determination appeals

Data Systems

- Interface with federal systems for income; immigration
- Interface with state systems – Medi-Cal Eligibility Data System (MEDS); Franchise tax Board
- Transmit data to Treasury re: exemptions to mandate

Accounting & Fiscal Integrity

- Annual audit
- Compliance with federal claiming, exception and audit procedures

DHHS should judge whether sufficient progress is being made by states by measuring progress against the state's adopted timeframes and milestones.

C. State Exchange Operations

Successful Exchange operations are essential to the overall national health reform effort. The first priority for all involved is to identify and resolve decision making around the IT system issues upon which smooth and efficient Exchange operations are predicated. California encourages DHHS to work collaboratively with states to identify what the federal government can and should do versus what the states are best suited to do. California urges DHHS to move quickly

and expeditiously in this arena. California's preliminary thoughts on where national standardization could prove useful for states include data reporting and transmission; and eligibility requirements across programs, especially as they relate to implementation of modified adjusted gross income and verification requirements.

The data sources for eligibility under ACA are federally-based (Department of Homeland Security, Internal Revenue Service). There need to be smooth lines of communication, auditing, and updating between state exchanges and federal data sources; states should not be unfairly penalized for discrepancies.

At a minimum, the following systems and system capabilities will be needed to stand up a functional Exchange at the state (or federal) level:

- An eligibility determination system.
- Financial and utilization or claims tracking systems.
- Performance measurement systems for health plans and providers.
- Significant data storage capacity.
- Data sharing functionality.
- Appropriate interfaces for sharing information between programs and data sets.
- Adequate public access points.
- Adequate and accessible data on Exchange enrollment and operations.

California seeks to provide an easy to use system(s) that simplifies the process of shopping for, selecting, enrolling and maintaining health insurance. The web portal will be a crucial part to achieving that goal. Some of the major considerations in the development of Exchange web portals include:

- Will the federal government add any new data security requirements that are specific to Exchange web portals?
- Who will be responsible for maintaining the web-based application?
- Will the web portal be required to interface with any federal web sites?
- What kind of data must states provide to the federal government about web portal activity?

California leads the nation in enacting laws and policies addressing language access and is one of a few states with a comprehensive law in this area. Federal guidance should assure that the Exchange complies with existing state and federal laws intended to ensure access and availability of care to individuals from diverse backgrounds and life situations.

D. Qualified Health Plans

Certifying QHPs and existing state law: California law envisions the Exchange Board selectively contracting with qualified health plans (QHPs) to participate in the Exchange. To a large extent the provisions of Section 1311(c) of the ACA dictate the criteria that will be used to determine certification of a health plan as a QHP. In California, existing law for health care service plans regulated by the Department of Managed Health Care (DMHC) contains a

number of consumer and provider protections related to most of the federal criteria, such as requirements for an adequate provider network and quality assurance programs. Any regulation from the Secretary that could be construed as diminishing these strong consumer protections will be a concern. California requests clarification on whether or not the standards for certification will be based on a national standard or whether states will be permitted the flexibility to adjust the standards that will be used to meet the criteria.

California's DMHC has standards and requirements for health care service plans that are substantially similar to the federal certification requirements. The provisions, which are in the Knox-Keene Health Care Service Plan Act of 1975 (Health & Safety Code § 1340 et seq.), cover marketing, solicitation, enrollment; adequacy of provider networks and access to accredited providers; quality assurance; approval process for applications and disclosure forms or materials (but no requirement of a uniform enrollment form per se); standardized health benefit matrix; and availability of report cards on health plans. These standards apply to health plans offered in both the individual and group markets.

California has two regulatory bodies and two structures for the health insurance industry – the DMHC and the California Department of Insurance (CDI). The standards applied to products under the jurisdiction of the CDI vary considerably from those applied under DMHC. These varying standards evolved because health plans under DMHC regulation arrange for the provision of health care services to enrollees in contrast to health insurers under CDI whose contract with an insured is to reimburse incurred claims. CDI requires minimal network adequacy standards.

We anticipate that health plans and health insurers will participate both inside and outside of the Exchange. The certification standards should not adversely disadvantage entities participating in the Exchange.

Certification standards should not be set so high as to price plans out of the reach of persons receiving tax credits. In states with rigorous licensing standards such as for plans licensed by DMHC, it may be prudent for the federal government to establish a process whereby the state could make a finding that its licensing process has been reviewed and is substantially compliant for purposes of certifying health plans. This would avoid duplicate regulation of plans by a state regulator and the Exchange. Additionally, states should not be prohibited from delegating the certification process to the state licensing entity.

Network Adequacy: The development of standards related to the adequacy of providers needs to take into account the differences in availability of providers and services in rural vs. urban communities as well as the differing standards that may exist for different products types such as HMOs and PPOs.

Marketing: With respect to standards for marketing of QHPs, minimum requirements should ensure the products in the Exchange are fairly and

affirmatively marketed in a manner that not only does not discourage the sick, but encourages healthy individuals to enroll in order to limit adverse selection. Marketing rules should also ensure that products offered in the Exchange can compete with products outside the Exchange and that marketing tactics are not used to disadvantage the Exchange.

The provisions of California's recently enacted Exchange law require, as a condition of participation in the Exchange, carriers that sell any products outside the Exchange must do both of the following:

- Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

- Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

California's two licensing entities have authority to enforce these requirements in California. Where states have adequate enforcement authority and mechanisms, federal regulations should permit states to continue these oversight and enforcement activities.

Role of Agents and Brokers*:* The ACA requires the DHHS Secretary to establish procedures under which a state may allow agents or brokers to enroll individuals, or to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange. The Knox-Keene Act, under which the DMHC regulates health plans, does not provide for licensure of marketing representatives, but rather requires health plans to use solicitors and solicitor firms who are listed in the plan's license application, and who have sufficient knowledge of the health plan's procedures, contracts, and the Knox-Keene Act and regulations. The CDI, on the other hand, requires the insurers that it regulates to use agents and brokers licensed by the Department. Health plans licensed by the DMHC face uncertainty as to whether their use of solicitors who meet Knox-Keene Act requirements, but are not actually "licensed" is permitted.

Unless the criteria for marketing clearly indicates whether agents or brokers must be licensed, certified or registered, taking into account the differences in state law requirements, this type of uncertainty will exist in the Exchange. To avoid problems of state regulation in the Exchange area, qualifications for marketing representatives included in federal regulations could be defined broadly enough to permit state regulatory schemes that do not expressly require use of state-licensed solicitors, but meet state requirements for solicitors.

Sufficient Numbers of QHPs: As the market conditions for each state may be very different, the interest and ability of plans participating in the Exchange may vary significantly. Accordingly, states should be given sufficient flexibility to craft

requirements and incentives that are designed to address each state's specific market conditions. For example, some level of flexibility in benefit design should be permitted, without undermining the benefit of standardized design/pricing for consumers and group purchasers, to ensure that a sufficient mix of QHPs participate in the Exchange.

Until the criteria for certification and the essential benefits are determined it will be difficult to assess the interest of carriers in participating in the Exchange. Nonetheless, in order to ensure that the appropriate mechanisms are in place on January 1, 2014, California will need to have sufficient lead time. An understanding of the likely participation by plans in the Exchange will be fundamental to adopting and implementing such mechanisms. Accordingly, it will be imperative that the federal rules regarding participation in the Exchange be in place as soon as possible. Once the requirements are finalized, California will be able to determine what additional steps it must take to ensure a viable and vibrant Exchange, including surveying health plans and insurers to determine their interest in participating in the Exchange.

Competition in California varies to a large degree based upon market conditions. With respect to HMO coverage, in some areas of the state, such as Southern California, vigorous competition among providers yields lower costs and more competitive offerings by health plans. In other areas of the state, providers are unwilling to contract at competitive rates and there are few plan offerings made available to employers and consumers. Larger health plans tend to have greater market clout to drive lower provider costs, however, the consolidation of hospitals and providers into larger groups is counteracting this health plan leverage.

The Exchange needs to be able to develop and use strategies to address these types of market conditions. Minimum standards and criteria should allow flexibility to enable the Exchanges to select plans that offer the optimal choice of access, quality and service.

Rules adopted by the Exchange will have a large impact on the competitiveness of the market both inside and outside of the Exchange. For that reason, mechanisms that provide consumers with more robust information on the quality of providers and the cost of their services are important tools to encourage consumers to make more informed choices and drive greater competition among providers and plans.

Bidding Processes: The transparency of underlying claims costs and trend assumptions is critical to ensuring a bidding process that provides optimal value for consumers and taxpayers. Federal rules should permit states the flexibility that Exchanges can require participating carriers to provide data on actual claims costs. In some cases, provider contracts contain confidentiality clauses that would prohibit such data release. In California, CalPERS (purchaser of coverage for state and municipal employees and retirees) has a statutory provision that trumps such contract provisions and allows it to receive actual

cost data from its contracted health plans on a confidential basis. This data is crucial to CalPERS' ability to understand market cost drivers and develop strategies to address them in the contracting process.

The Exchange may need flexibility with respect to bidding requirements in order to respond to the dynamics inherent in the health care marketplace. California law requires the Exchange to establish and use a competitive process to select participating carriers.

California law provides the Exchange with confidentiality of the rate negotiation process including the deliberative processes, discussions, communications and any other portion of the negotiations. The rates of plan contracts will be confidential in California; the terms of the contracts will be available one year after their effective date.

California law allows the Exchange to develop a competitive process for selecting plans that participate in the Exchange but does not require the Exchange to accept all plans. It also provides for confidentiality of the deliberative process of the Board in the negotiating for plans. Allowing the Exchange to select the highest value plan offerings will ensure greater competition of plans to participate and allow the Exchange to play a significant role in driving innovation in the marketplace – yielding better value for consumers and employers.

Actuarial value: California's Department of Managed Health Care has used consulting actuaries on only a very limited basis historically. Federal minimum requirements and the methodologies used for determining the actuarial value of coverage should not be overly complex and create an undue regulatory burden for the state.

CO-OP Plans: California has experienced significant consolidation in the insurance market over the last decade. The establishment of new health plans has largely been limited to those targeting Medicare Advantage members. However, California also has a long history of innovation in creating new models of health care delivery with sophisticated provider groups able to manage delegated risk including some operating within the Medi-Cal managed care program. The availability of grants and loans may create interest by some stakeholders to develop new non profit health plans for the individual and small group market under the CO-OP program.

Multi-State Plans: California has long been a leader in enacting significant consumer and provider protections that do not exist in many states. A major consideration in establishing standards for the participation of multi-State plans in the Exchange should be the impact on existing state consumer protection laws. In this context, preemption of state laws will be a major challenge that is likely to occur under the multi-State provisions of ACA. In particular, health plans seeking to offer a "multi-state" plan could be motivated to be subject to the least restrictive requirements of all of the states in which the health plan will be

offering coverage, thus ensuring a race-to-the-bottom. Accordingly, any standards that are established to participate in multi-state plans should be crafted to permit the states sufficient flexibility to enforce their existing consumer protections.

Benefit Design: Once the federal government adopts the essential benefit package states will have a number of significant tasks including reviewing the federal package in light of state benefit laws; engaging in state-level policy discussions regarding alignment of the state mandates with the federal package; determining whether the Legislature and Governor want to appropriate state funds to augment the federal benefit package; and negotiating with plans on the final state package and production of informing materials prior to 4th quarter-2013 so sales can begin prior to the Exchange opening date. These tasks will involve the legislative and Executive branches of government. This requires that sufficient time be provided between the federal adoption of the essential benefits package and 2014 for completion of these necessary implementation steps.

There are a number of important aspects of benefit design that will affect the care delivered and the costs to the health care delivery system. States must be allowed flexibility to incorporate evidence-based benefits, consumer incentives for value-based purchasing, and other benefit features that promote appropriate utilization and high quality care. Federal rules should provide states the ability to encourage health plans and providers to compete on delivery system factors such as increased delivery system integration.

California's recently enacted Exchange law permits, but does not require, the Exchange governing board to standardize the benefit package within the actuarial values established in federal law. State law contemplates that more than one standardized product may be designated by the board at each of the four levels of coverage described in ACA Section 1302(c). Federal regulations should not undermine or diminish the Board's flexibility in this area.

If California's Exchange board adopts a standardized benefit package within the Exchange, state law requires that all plans whether or not they participate in the Exchange must offer at least one standardized product at each of the four levels of coverage described in ACA Section 1302(c). Policy makers adopted this provision to provide an "apples to apples" comparison of product offerings. Again we request that federal regulations not undermine or diminish the State's flexibility in this area. We note that this provision only applies to the market segment (individual versus small group) in which the health plans otherwise offers coverage.

The Exchange and the Safety Net: The state and federal governments must be aware of and attentive to the impact that reform overall and implementation of the Exchange may have on access to care for persons served by the Medicaid program**.** Federal guidance and regulations should account for the interplay between the Medicaid, CHIP and Exchange programs and not set

states up for unfunded state general fund costs.

E. Quality

State flexibility: Given the enormous differences between states in terms of demographics, health status, provider infrastructure, and state resources, we recommend allowing states considerable flexibility related to establishing State-specific thresholds or quality requirements above minimum Federal thresholds. Initial quality ratings achieved within each state should be considered as baselines that can be improved upon over time. We suggest that DHHS consider a phased approach, whereby states first must establish plan reporting of an initial set of quality and performance ratings with minimum thresholds and then over time increase the number of performance indicators and demonstrate improvement of ratings over time. This type of phased approach is generally consistent with how healthcare programs and plans introduce and expand performance measurement and quality improvement over time. Often, plan scores are initially shared only between the contracting organization and the contracted plans to establish baselines, work out data issues, and explore the most effective ways of publicly sharing the results and targeting improvement efforts. After performance scores and/or plan rankings begin to be used in consumer informing tools, over time more indicators may be added and quality initiatives implemented to address performance issues either within specific plans or within programs. For example, a performance indicator related to childhood immunization that indicates an opportunity for improvement within a plan or a program may lead to targeted efforts with both members and providers to increase immunization rates. Using a phased approach to performance measurement and quality improvement requirements and the use of these results to help target appropriate improvement initiatives is consistent with CMS's quality strategy requirements for Medicaid managed care programs presented in the State Quality Strategy Tool Kit for State Medicaid Agencies, available on the CMS website at http://www.cms.gov/MedicaidCHIPQualPrac/Downloads/qtkitwtablec.pdf. California's most recent Quality Strategy for its Medicaid managed care program documents an evolving use of performance measurement and quality improvement requirements over time and is available on the DHCS website at http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

Minimum Standards for Quality Measures: California's Medicaid managed care program has established Minimum and High Performance Levels for required HEDIS measures relative to national Medicaid percentiles. For example, the Minimum Performance Level (MPL) for HEDIS measures is the national 25th percentile for the previous year, and the High Performance Level (HPL) is the national 90th percentile. If DHHS specifies state reporting of national performance indicators for HEDIS and CAHPS results, we suggest establishing minimum performance levels using the reported national results for commercial plans. In the case of QHPs reporting scores below an established minimum performance level for specific indicators, we suggest DHHS allowing

at least two years for plans to raise their scores to or above the MPL.

States must be allowed to develop state-specific performance indicators and MPLs for each indicator that would periodically be adjusted upward as the program average for each indicator improves. For example, what percentage of new enrollees completes an Initial Health Assessment form or visit their primary care provider within 90 days. California's Medicaid managed care program uses selected quality indicators related to HEDIS scores and use of safety net providers to reward more defaulted enrollment to plans with higher scores. ("Defaulted enrollment" relates to beneficiaries who do not choose a plan during a specified time period and who are then placed in a plan by DHCS using a default algorithm based on plans' quality scores. Plans with higher scores in selected quality measures receive a higher percentage of defaulted enrollments. It should be noted that DHCS does allow members to move to another plan after being defaulted into a plan, unlike commercial programs which allow movement to another plan only during specified open enrollment periods.) DHHS should assure states have the flexibility to adopt a similar approach with Exchanges, such as capping new enrollment into plans with low quality scores for a specified period of time or establishing lower premiums for plans with high quality scores, thereby providing an incentive for more members to choose those plans.

States may choose to offer performance bonuses to plans with the highest quality ratings or the greatest rate of improvement. Another approach to incentivizing quality improvement at the practice level is to require plans to participate in a statewide Pay for Performance (P4P) program, such as that conducted by the Integrated Healthcare Association (IHA) in California. This requirement generally translates into plans offering financial incentives to provider groups for improving care in targeted areas such as cancer screenings (e.g., screening for breast cancer, cervical cancer, and colorectal cancer), cholesterol management for patients with heart conditions, comprehensive diabetes care, appropriate medications for people with asthma, etc. Performance targets in P4P generally relate to nationally established best practices in specific areas of care with provider groups incentivized to improve their practitioners' adherence to these best practices in relation to ratings achieved by other provider groups in a plan's network. Federal rules should not restrict states' ability to use payment incentives to achieve quality improvements.

Plan Rating Systems: The most important factors for consideration in establishing plan rating systems include:

- Standards that can be translated into ratings that will be meaningful to consumers.
- Standards that are based on objective measurement of plan performance and that will result in rating that can be compared to state and/or national benchmarks.
- Standards that can be met over time by all plans – whether new or established and regardless of enrollment levels.

- Standards that do not impose an excessive burden on planes regarding reporting and achieving minimum performance levels.
- Standards that do not impose an excessive burden on administrators of the Exchange regarding cost to administer, audit, and report.

When the Exchange provides consumers with information and ratings to assist them with plan choices, the information and ratings must be presented in a ways that are easy for consumers to understand and use. Consumers should be able to easily determine how each plan rates in relation to consumers' specific healthcare needs and concerns such as plan ratings for preventive care, care for chronic conditions, copayments for commonly used services, and availability of specific drugs on plan formularies. Many "Consumer Report Cards" already exist that provide this type of information in comparative and interactive formats. In California, the Office of the Patient Advocate offers on-line consumer reports cards for commercial, Medicaid, Medicare and SCHIP programs at http://www.opa.ca.gov.

Some research has been done examining the effectiveness of various consumer informing tools and approaches, and these research findings should be helpful in determining how Exchanges should approach consumer informing. Studies generally find that "consumer report cards" can affect decision-making, but only if they are easy to use and understand. If a decision-making tool is poorly designed and presents information in a confusing or overly complex way, the tool is not likely to be effective.

The effectiveness of informing tools appears to be directly related to how well the tool suits the decisions to be made and audience needs and preferences. Reading proficiency and computer literacy are factors. Studies also indicate that complex information has to be made accessible to the audience – such as using easily understood symbols (e.g., stars) for ranking performance or consumer "stories" to explain an approach to making a decision (e.g., a mother considering plan ratings for well-child care when choosing a plan or a diabetic considering a provider group's ratings for diabetes care when choosing a primary care provider).

Other factors affecting the effectiveness of consumer informing tools include use of the appropriate medium ("low tech" such as printed information or videos versus "high tech" such as interactive websites), the role of personal presentations or counseling, creating a "brand image" for the informing tools, and using trusted advisors (e.g., physicians, teachers and community organizations) to build credibility for the use of informing tools. Studies also indicate that consumer informing tools, whether low or high tech, need to be readily available at the moments when the consumer must make decisions – such as choosing a plan, selecting a personal physician, being diagnosed with a serious condition, or deciding on a certain procedure or medication.

Medicare Advantage Standards: CMS rates Medicare Advantage plans on a one-to-five star scale, with five stars indicating the highest quality. These

ratings reflect indicators of quality of care, access to care, the plan's responsiveness to members, and member satisfaction levels. CMS uses four sources to develop these ratings: CMS administrative data related to plan quality and member satisfaction; results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey; ratings for selected Healthcare Effectiveness Data and Information Set (HEDIS) measures; and CMS's Healthcare Outcomes Survey (HOS). These sources of quality and service indicators are all valid and useful sources for the development of health plan ratings and would be excellent starting places for the Exchanges. Many of these sources – particularly administrative data, CAHPS results, and HEDIS scores – are already used in California to develop ratings for commercial, Medicare, and Medicaid plans, as presented in the Office of the Patient Advocate's on-line consumer report cards noted above. California's Medicaid managed care program publicly reports HEDIS and CAHPS results on its website at http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx and also uses HEDIS and CAHPS results to develop plan ratings included in county-specific Consumer Guides included in enrollment packets and also available on the DHCS website at http://www.dhcs.ca.gov/individuals/Pages/MMCDConsumerGuide.aspx.

Consideration for new or small plans: To encourage new and/or smaller plans to participate in Exchanges, some consideration should be given to evolving the required reporting for quality ratings over time rather than imposing a full range of reporting requirements all at once. Reporting administrative data and audited HEDIS scores and participating in the CAHPS survey can impose a considerable financial burden on new or small plans and could be a disincentive for some providers to participate in an Exchange if the reporting requirements at startup are too extensive and costly for a new or smaller plan.

F. Exchange for non-Electing States

No comments are offered

G. Enrollment & Eligibility

Federal Role in System Development: California requests that the federal government seriously explore and examine federal development of an Exchange/Medicaid/CHIP eligibility determination system that could be made available to states. A "core" federal system to which states could link/interface would be of significant assistance to states.

***Timing of Federal Guidance for Eligibility Systems*:** In order to have a functional system in time for a mid-2013 pilot/testing date, states must have clarity as soon as possible on the critical aspects for the Exchange-related operational systems. Guidance should include federal requirements on how eligibility will be determined under the new federal rules; how the "new" eligibility systems for the Exchange will communicate with current Medicaid eligibility systems; and how state eligibility systems will need to communicate with federal

systems (e.g., federal Exchange, Department of Homeland Security (DHS), Internal Revenue Service (IRS), etc). States will need detailed information on the data elements and system interface requirements.

Federal specifications available to states: California requests the federal government make available to all states the specifications and procurement tools they intend to use for the federal systems. Time is of the essence for both states and DHHS in the development of such systems; thus, federal plans should be shared with states as soon as possible to avoid duplication of effort.

Timely approval of state-based systems: For states that choose to enhance existing systems or rapidly procure new ones, timely approval of system content, procurement plans, and funding is required. Alternatively, some states may prefer for the federal government to procure components of the system on behalf of states in order to accelerate the process and lower overall costs.

Effective and timely data sharing: The data sources for eligibility under ACA are federally-based (DHS, IRS). There needs to be smooth lines of communication, auditing, and updating between state Exchanges and federal data sources, and states cannot be unfairly penalized for discrepancies.

Definition of Modified Adjusted Gross Income (MAGI) It is important that the definition and parameters for the new MAGI criteria be identified as soon as possible to ensure Medicaid systems as well as Exchange systems are built to accommodate and meet this definition.

Impact on FMAP claiming: The complexity of having to operate two different and parallel Medicaid eligibility systems (in order to attribute the correct FMAP to an individual) is daunting and potentially inefficient. States must be given the opportunity to utilize one system, while using methods such as sampling to ensure accuracy of FMAP claiming.

***Related operational and systems issues*.** Beyond eligibility, there are related efforts that may also need to be accommodated in the operations and systems being developed. These efforts include Health Information Exchange (HIE), the human services eligibility project at the Office of the National Coordinator (ONC), plan rating for quality and cost, third party liability (TPL) efforts and Medicaid Management Information Services (MMIS) and eligibility system merging and redesign. California requests that states be consulted on these issues to ensure operational structures and technical systems can accommodate any related requirements. California also requests that DHHS be clear on how it intends to integrate these into Exchange systems.

Continuity of Coverage and Transitions: California seeks clarification and guidance on how continuity of coverage and transitions between federally funded health programs will be accomplished. We are interested in the appropriate use and flexibility that may be provided to Exchange members/subscribers through the use of annual continuous eligibility periods and presumptive eligibility determinations. For example, states should have the authority to offer 12 month continuous eligibility to persons who enroll in the

Exchange who have changed circumstances during the year unless the individual requests a re-evaluation of her/his eligibility. California welcomes the opportunity to discuss these issues with federal staff and others to assure that cross program coordination issues do not undermine our mutual goals of continuity of coverage and a streamlined, simplified, family friendly system.

Another concept that needs exploration and federal guidance to determine its utility in supporting the continuity of coverage for Exchange enrollees is premium assistance – processes by which the Exchange might use federal tax credits to maintain continuity of coverage and provider for enrollees whose income or other eligibility status changes during an enrollment year.

Premiums Payments: California requests flexibility and clarification regarding the Exchange's role in the collection of premiums. Without accurate enrollment information the administration of tax credits and cost sharing subsidies will be impossible to achieve – one way to maintain accurate and up to date enrollment files is to retain responsibility for premium collection. Federal guidance should not restrict the Exchange's ability to enter into contractual arrangements with health plans regarding the collection of premium.

Considerations in conducting on-line enrollment:

- Data security.
- Real-time functionality requirements.
- Website maintenance.
- Interface requirements for the web portal to connect with other automated systems used by the Exchange.
- Policy decisions regarding use of electronic signatures.
- Language requirements.
- Customer service infrastructure to assist consumer who use the on-line enrollment system.
- Gathering sufficient information to complete eligibility determinations.
- Inaccurate or incomplete applications filed requiring follow-up contacts.
- Input errors.
- Verification of information required.
- Unfamiliarity and lack of computer skills of applicants.
- Inability to obtain explanations of questions being asked.
- Need for preliminary findings of potential eligibility for Medicaid, CHIP and/or the Exchange.
- Opportunities, barriers, and costs related to connecting the Exchange to all of the required programs.
- Simplification and standardization of information needed for eligibility determinations across programs wherever possible.
- Maximize on-line verification processes and minimize or eliminate the need for paper verification.

Existing Data Linkages: California currently uses the Medi-Cal Eligibility Data System (MEDS) to store eligibility data on a variety of programs that interface

with California's Medicaid program. The MEDS system includes data on California's Temporary Assistance for Needy Families (TANF), CHIP, Food Stamps, Supplemental Security Income and other program information. The MEDS system interfaces with the federal Social Security Administration data Exchange and other state and federal data bases used in the eligibility determination process for these programs.

To streamline these processes, the federal government should consider:

- Standardizing data reporting requirements across programs.
- Maximizing State access to federal data across programs that can be used for electronic verification of eligibility requirements across programs. For example, current law only allows for electronic verification of citizenship using Social Security Administration data for Medicaid and CHIP. Use of this process should be allowed for any program in the Exchange that requires verification of citizenship.
- Providing federal resources for State implementation of real-time electronic verification processes.

Eligibility and enrollment coordination between Medicaid, CHIP, and Exchanges: California faces many challenges to the successful coordination of eligibility and enrollment for Medicaid, CHIP and the Exchange that must be addressed in the context of implementing the new health care reform requirements. Given the various requirements and their magnitude, including those to implement a streamlined online enrollment application process and an Exchange by January 2014, California strongly recommends that future federal guidance provide flexibility for states to choose from a range of potential solutions for implementation on both a short-term and long-term basis. While each state will face its own unique set of challenges with meeting eligibility and Exchange requirements, California believes that guidance forthcoming from the federal government should enable California to design and adapt eligibility systems to meet requirements for coordination between Medicaid, CHIP and the Exchange.

- ***Creating a new eligibility system or updating an existing eligibility system to implement healthcare reform requirements will take time to implement and operationalize:*** California has automated the eligibility determination process for many of its public assistance programs and is currently using three automated county-based systems linked to a statewide database. A range of systems options are currently being considered as the State prepares to implement federal healthcare reform. The new or updated eligibility system must include functionality that does not currently exist, including an interface with the Exchange, new data matching/sharing processes with the IRS and other entities and provide a streamlined, on-line application process for existing and new populations to access multiple health care programs. The federal government must recognize the complex nature of creating such a system and provide states with maximum flexibility in meeting federal

health care reform requirements and support a range of potential short and long-term state system development goals beyond 2014.

- ***Considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs:*** A one-stop/simplified application must have all the information necessary to determine eligibility. The elimination of asset tests and income disregards should facilitate a simplified application. However, the Exchange has a different level of responsibility in terms of health plans and administration of tax credits, so the simplified application must be able to distinguish Exchange from Medicaid and CHIP eligibility. The simplified applications must be designed to minimize the need for follow-up requests for information. This is of particular concern for families that comprise individuals who are exempted from ACA's new eligibility criteria based upon Modified Adjusted Gross Income/Household Income as determined under IRS Code and without resource eligibility limits.

Existing data linkages - State Medicaid agency with Federal and State agencies and data sources: Many data linkages exist between Medicaid and Federal/State agencies and data sources. The Social Security Administration verifies Social Security numbers, citizenship, identity, eligibility information for recipients of specified federal programs, and Medicare coverage. The Income Eligibility Verification System verifies income from sources such as state income taxes, Employment Development Department disability income and unemployment. State Vital Statistics verifies births and deaths. Data is exchanged systematically with all California Medi-Cal managed care organizations. Systems verify individuals' eligibility for services and identify other health coverage, and receive and pay claims. Point of Service devices, computer and phone systems are used by providers to verify eligibility and to report expenses used to meet individuals' shares of cost.

A new data match would have to be established to obtain IRS information. The problem will be to address discrepancies between the IRS reported income and the later point in time income reported by the applicant.

California currently shares information between public assistance programs using the Medi-Cal Eligibility Data System (MEDS). The extent to which this system can be used to facilitate eligibility determination through the Exchange will depend on:

- The capacity of the Exchange to interface with the MEDS system.
- Removal of federal barriers to sharing data between public benefit programs.
- Standardization of verification requirements across program benefit applications processed through the Exchange.

Barriers to use of Federal verifications: California will utilize electronic verification processes to the fullest extent possible. To facilitate this, the

federal government should remove barriers to the use of uniform federal data for electronic verification across Exchange programs. In addition, these electronic verification processes should flow through establish State/Federal data Exchanges to maximize the use of existing systems.

H. Outreach

Outreach is essential to the successful implementation of federal health reform. States have limited resources and funding to do significant outreach campaigns. Any outreach will have to address the Exchange as well as Medicaid and CHIP. Except for the lack of adequate translations, materials developed for implementation of Medicare Part D were comprehensive and of high quality - In person presentations throughout each state, digital video discs in folders of printed materials provided through the mail, television shows, paid and earned advertising, newspaper and internet campaigns.

Achieving near universal coverage as contemplated by ACA will require the voluntary engagement and enthusiasm of the populace. California encourages the federal government to take aggressive and sustained efforts to encourage a "culture of coverage." This could be accomplished through a campaign which reinforces the concepts of the value of health and personal responsibility, the value of health coverage, shared responsibility for the financing of coverage, and the rights and responsibilities of each of us in the new system. CMS can gain many best practice lessons from the campaign conducted for implementation of Medicare Part D, and the efforts of states, local government, provider and myriad community based groups to promote children's coverage. Any campaign must recognize the language and cultural diversity of our nation and assure that messaging and materials are appropriately tailored to reach all populations.

If appropriate parameters are developed to avoid conflicts of interest, health plans, insurers, and providers can be significant and effective partners for education and advertising campaigns.

I. Rating Areas

California does not "utilize" statutorily designated rate areas. That is, health plans (and insurance carriers) define their own rate regions utilizing plan-specific methodology but within statutorily defined criteria. For example, in the small group market a plan that operates statewide may use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all of its ZIP codes are in common within a county, and divide no county into more than two regions. However, no market segment is required to utilize established premium rating areas. In practice, the plans use rate regions in virtually all markets but again, these rate regions are determined by the health plan. However, under DMHC statutes and regulations, health plans only operate in the geographic service areas for which they have been

licensed.

Many health plans in California are state-wide, however, there are a number of local or regional plans—particularly those serving the Medicare and Medicaid populations. Local plans would in fact have an established rate region but based on the geographic confines of the plan, not any rate region set in law. Plan-specific rate region criteria is based on a number of factors—all or the majority of which render the possibility of a single state-wide or interstate region impracticable. Criteria include population demographics (e.g. urban vs. rural), provider (hospital and physician) access, and treatment costs. Boundaries are typical only on a broad basis, e.g. the same counties may be included in plans' rate regions but certain zip codes differ across plan regions.

California's Children's Health Insurance Program (CHIP), known as Healthy Families, uses common rating regions for all plans participating in the program. The use of common rating areas across plans facilitates comparison of prices between and across plans. The administering entity, California's MRMIB, established the areas based on a review of the rating areas of the plans in the state with the largest enrollment bases and an analysis of health care market areas within the state.

Arguments in favor of established rate regions include: promoting consistency and simplicity (i.e. understandability of pricing for consumers); more effective competition by controlling the risk pool (i.e. if you define the region/make them consistent and the plans have to price within identical regions, the pool is likewise consistent). In California, costs vary considerably across the state by region. For example, greater competition among providers in Southern California has yielded significantly lower unit costs than some areas of Northern California.

J. Consumer Experience

Benefit Designs: Allowing plans some flexibility in benefit design for products offered through the Exchange will encourage differentiation by health plans and allow expanded consumer choice. Such flexibility should, for example, allow for high performance physician networks and other types of plan designs that encourage value based purchasing.

Information: It is essential to provide consumers with information that is easily understandable and targeted. Meaningful side-by-side comparisons of benefits and costs of the plans available in their service area are vital. Understandable information on the quality and availability of providers is also essential and should include access to online information that provides a link to staff who are knowledgeable and can respond to specific questions regarding covered benefits, plan formularies, enrollment processes, billing processes, and consumers' rights and responsibilities is important for consumer choice. Additionally, guided decision making tools that assist consumers in understanding pros and cons of choosing coverage both in and out of the

Exchange, including assistance in understanding subsidies and premium rebates, are also important mechanisms to ensure consumers have appropriate decision-making tools.

Further, to facilitate enrollment, online enrollment options should be provided to consumers along with a manual process for consumers without internet access. Guidance on understanding the rules that apply when families need access to coverage when living out-of-plan service areas or out of state should also be readily available Finally, it is imperative that the consumer materials are translated into appropriate language and for lower level literacy.

Consumers need information and materials to help them understand the cost and benefits of coverage particularly the out-of-pocket costs and the assumed actuarial benefits of the plans they are comparing. It would also be beneficial to provide shopping tools that help consumers forecast their potential spending needs based upon their health status. Consumers need information that is written at their level without a lot of industry jargon. However, complex terms and concepts also need to be explained in layperson terms. One example of a consumer education tool is the Health Plan Chooser that was developed by the Pacific Business Group on Health and is provided to members covered under CalPERS.

Additionally, updated information on the availability of contracted providers and whether providers are currently accepting new patients is an important consideration for consumers in choosing a health plan or carrier. California law requires plans and carriers participating in the Exchange to regularly update an electronic directory of contracting health care providers so that individuals can determine which health plans include that health care provider in their network. The Exchange governance may also require a carrier to provide regularly updated information to the Exchange as to whether a health care provider is accepting new patients for a particular health plan. Federal guidance should permit the Exchange to require this type of provider information to be made available to consumers.

All key plan marketing materials need to be translated in threshold languages for non-English speaking populations. In addition, marketing and outreach materials should be consumer tested for cultural competency. Individualized assistance may be needed for low literacy and limited English proficiency groups including the use of interpretation services.

Enrollment Venues: In addition to online enrollment, the Exchange should consider providing enrollment locations that are convenient to working people including locations with extended hours of availability. Outreach could take place in locations such as schools, libraries, shopping malls, Social Security Offices, County Human Assistance Offices, Department of Motor Vehicles (DMV) Office, hospitals, or large medical complexes. This could be done via kiosks or other video linked technology rather than requiring on-site staff.

Best practices for consumer protection: Comprehensive consumer protection standards for health care are administered by California's Department of Managed Health Care and the Office of the Patient Advocate, as well as the Department of Insurance. DMHC consumer protections include a Help Center (accessible by telephone, e-mail, fax, etc.), report cards, a provider help line, plan surveys, and the Director's power to issue orders reinstating wrongfully terminated enrollees.

California's recently enacted Exchange law establishes an appeals process for prospective and current enrollees of the Exchange that complies with the requirements of ACA concerning the role of a state Exchange in facilitating federal appeals of Exchange-related determinations. Once the federal regulations concerning appeals have been issued in final form by the DHHS Secretary, the Exchange's governing board may establish additional requirements related to appeals. However, prior to adoption of additional requirements, the board must determine that any additional requirement results in no cost to the state and no increase in the charge imposed on contracting plans.

Under California law, the Exchange will not be required to provide an appeal if the subject of the appeal is within the jurisdiction of the states regulators, DMHC and CDI. The state considers this an appropriate approach that builds on existing state consumer protections and that does not prevent the application of the provisions of the ACA.

California's DMHC operates the Help Center to assist consumers under its jurisdiction with ensuring that enrollees receive prompt and effective assistance to their health care concerns. Staff members in the Help Center assist consumers with their health plan coverage concerns as well as provide timely review of, and response to, complaints regarding their health plans and requests for information. In addition, Help Center staff routinely monitor health plans to ensure they comply with the law and fulfill their obligations to enrollees and, where necessary, identify and seek appropriate corrective action. Complaint data is used to identify systemic issues and to improve the managed health care delivery system. The collection and use of key data is vital to ensuring appropriate oversight of health plan functions and consumer protections in California.

Moreover, it is vital that states have the ability to continue to collect and maintain complaint data to identify systemic problems and, where appropriate, instigate enforcement actions.

With respect to reporting complaints to the Exchange, in order for the Exchange to be able to adequately address any issues that arise, it will need ready access to such information. Presumably, most complaints will be directed to the state Exchange, and state efforts will be directed towards informing consumers of their ability to complain directly to the appropriate state entity. In California, the DMHC recently submitted a grant application for the

Consumer Assistance Grant to expand its capability to provide consumer assistance by linking its toll-free number with the state's Health Care Reform Website in order to provide consumers with information about their rights and responsibilities, assist with complaints and appeals and to collect data. Even with these efforts, some consumers will most likely still seek assistance at the federal level. It will be important for states and federal agencies to coordinate efforts to ensure that data is shared.

K. Employer Participation

Simplifying employer administrative responsibilities will be important for successful implementation of the SHOP Exchange. Employers oppose additional burdens of accounting for employees who would enroll through the Exchange. Employers want choices of enrollment options, and may prefer the option of working with a professional health insurance agent or their existing broker. Employers do not want to be forced to garnish employee wages to pay their portion of health benefits. While, ideally, employees could combine contributions from multiple employers to purchase coverage through the Exchange, it needs to be administratively easy for employers to track contributions (premium payments) and provide continuous coverage through the Exchange. Simplifying the purchasing process as well as the premium payment process for employers is critical. Doing this while controlling any additional cost of the Exchange itself is important to employers.

Employers must be convinced that there will be value in the Exchange (simplification, low cost, choice of options, enrollment flexibility) that they cannot achieve without it. This notion of value has to be communicated to the employer community.

L. Risk Adjustment, Reinsurance & Risk Corridors

Risk assessment and risk adjustment are essential components of the infrastructure required for the healthy and competitive insurance market contemplated by ACA. Market-wide risk adjustments are new functions for states. While risk adjusters have been used in the Medicare program for some time, their use in the individual and small groups market segments will require significant lead time to assure the results serve to normalize the underlying risk profile and risk maldistribution of members, to assure cooperation of health plans, and to avoid unintended consequences. California requests the federal government devote considerable attention to supporting the design and implementation of risk adjusters. This may be an area in which broad standardization of approach best serves the goal. We welcome the opportunity to collaborate on guidance and identification of best practices for risk assessment and adjustment.

California's DHCS (state entity that administers the Medicaid Program in California) began evaluating risk-adjustment in its rate setting method for California's Medicaid Managed Care program in 2006. Partially risk-adjusted

rates were first implemented during the 2009-10 rate year. The partial risk adjustment pertains to a county specific rate that is developed in which a plan specific risk adjustment percentage is applied to 20% of this rate. Plan specific rates are also developed for each county and 80% of that rate is paid to a specific plan. Additionally, a supplemental maternity payment was implemented as a risk adjustor during the 2009-10 rate year, to match payments to actual plan delivery events. Risk adjustment is currently performed in California's Medicaid Managed Care program in counties participating under the Two Plan and the Geographic Managed Care models. CHIP and State government employee plans currently do not risk adjust. DHCS currently uses a pharmaceutical based risk adjustor which looks at the prescription drug utilization at the beneficiary level as an indicator of the illness being treated. Beneficiaries residing in contracting health plans at the end of a risk scoring period that meet a specific enrollment criteria of being enrolled in Medicaid for at least 6 months during a 12 month duration, are then scored based upon where they fit in respect to 10 age bands, and 45 diseases categories. Currently, the risk scoring is performed annually during the rate redetermination period. The benefit of using a prescription drug based risk adjustor is that pharmacy data is typically the most complete, timely, and accurate data available and the rating can be achieved with relative ease. Whereas with other diagnosis based risk adjustment methodologies obtaining complete and timely encounter data from contracted health plans may be a challenge due to the nature of their subcontracting arrangements with providers and other health plans. A potential issue with any risk adjustment methodology is that if risk adjustment is performed on an annual basis and prior to the start of a prospective rate year, it may not fully capture a plan's risk if a beneficiary shift occurs from one plan to another after the risk rating period begins.

Payments are currently made monthly pursuant to the terms of the contract between DHCS and the contracted heath plans. Any payments beyond a month could impede a health plan's cash flow. However, supplemental payments or incentive payments could be made at quarterly or annual intervals without posing a cash flow risk to a contracted health plan.

The collection of beneficiary level claims and encounter data is the biggest issue facing the State of California with respect to risk adjustment. Plan and provider compliance with timely and accurate data submissions is the primary driver behind this issue. Specific standards for submissions and lack of compliance need to be established. Stakeholder input to a mutually agreeable risk adjustment mechanism is also an issue.

Federal technical assistance in the area of data element standardization, data submission, and selection of risk adjustment mechanism would be of assistance to the state.

States could administer the risk assessment and adjustment process through a variety of mechanisms. State staff could perform the administration of the risk adjustment process from start to finish, an independent contractor could

perform the administration of the risk adjustment process from start to finish with state oversight, or a combination of state and independent contractors could administer the risk adjustment process from start to finish. An auxiliary corporation could also be formed to administer the risk adjustment process from start to finish.

California Medicaid does not currently offer reinsurance to its contracting health plans. A state reinsurance plan was administered prior to 2008 for one contracting Medicaid health plan.

An analysis of high cost claims in respect to individual beneficiaries over a credible period of time is one method to identify high risk or high cost individuals. Risk scores could also be developed using Medicaid RX software for each individual beneficiary. Scores over a certain threshold could be isolated for reinsurance rating purposes and tied back to individual claims data for costing purposes.

Challenges to a temporary reinsurance program include:

- Establishing appropriate reserve levels for potential underwriting deficiencies.
- Competing with private well established re-insurance companies.
- Recruiting staff with knowledge of underwriting practices and procedures, and paying a competitive salary.

California Medicaid currently uses risk corridors in a very limited manner for only one program due to the administrative burden they pose.

There are no non-Federal instances noted in which reinsurance and/or risk corridors and/or risk adjustment were used together. The purpose of risk adjustment is to ultimately match the payment with the risk. The implementation of multiple risk mitigation strategies at once could lead to overpayments or underpayments to contracting health plans if the multiple strategies are not properly synchronized.

M. Economic Analysis, paperwork reduction and regulatory Flexibility Acts

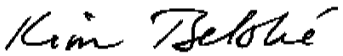
No comments offered here

N. Other

Wasteful spending as relates to any publicly funded function includes non-essential travel, office and infrastructure beyond what is required to perform tasks, salaries outside the norm to recruit and retain staff, and too many staff. Federal guidance should prohibit these activities.

Once again, California thanks you for the opportunity to respond to the notice requesting comments on the planning and establishment of state health benefit exchanges. If you have any questions about these comments, please contact Sandra Shewry at (916) 653-2902 or sshewry@chhs.ca.gov.

Sincerely,



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