Qualified Health Plans: Options and Preliminary Recommendations

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Qualified Health Plans: Options and Recommendations
Executive Summary

The staff of the California Health Benefit Exchange, with support from PricewaterhouseCoopers, has prepared a series of briefs to help inform the Exchange Board of some of the issues pertaining to the establishment of the individual and SHOP exchanges. The briefs offer options and preliminary recommendations for the Board's consideration and stakeholder input.

Plan and Network Design Issues	Assuring Quality and Affordability	Other
• Active Purchaser: Number and Mix of Exchange Plans • Rating Issues: Family Tiers, Age, Geography, Tobacco and Wellness • Plan Design Standardization • Premium Subsidies and Cost-Sharing Reductions • Provider Network Access: Adequacy Standards • Essential Community Providers: Standards	• Accreditation Standards and Reporting for Qualified Health Plans • Strategies to Promote Better Quality and More Affordable Care • Promoting Wellness and Prevention	• Supplemental Benefits: Dental and Vision • Aligning the Exchange with Medi-Cal and Other State Health Programs • Multi-state Plans • Co-Ops • Partnering with Health Plan Issuers to Promote Enrollment

Qualified Health Plans
Where We Are and Where We Are Going

- Developed options and recommendations informed by stakeholder input, Exchange guidelines for QHP selection, and review of national lessons and expert advice
- Developed complementary recommendations for Small Employer Health Options Program
- Staff will revise and prepare final recommendations for the Exchange Board for its decision at August 23, 2012 Board meeting
- Further research of outstanding issues and additional detail and refinement
- Continued work on options and recommendations incorporating Board and stakeholder feedback
- Further refinement in development of health plan RFP for Fall 2012

Qualified Health Plans
Guidelines for Selection & Oversight of Qualified Health Plans

I. **Promote affordability** for the consumer and small employer- both in terms of premium and at point of care

II. **Assure access to quality care** for consumers presenting with a range of health statuses and conditions

III. **Facilitate informed choice for health plans and providers** by consumers and small employers

IV. **Promote wellness** and prevention

V. **Reduce health disparities** and foster health equity

VI. **Be a catalyst for delivery system reform** while being mindful of the Exchange's impact on and role in the broader health care delivery system

VII. **Operate with speed and agility** and use resources efficiently in the most focused possible way

Qualified Health Plans
General Rules for Certification of Qualified Health Plans

1. All plans offered in the individual and small group markets, both inside and outside of the Exchange, must provide coverage of the ten Essential Health Benefit categories
2. Plans certified to be sold within the Exchange must also be sold outside the Exchange on the same terms and conditions as a general rule.
3. Catastrophic plans can only be sold by issuers who participate in the Exchange
4. Exchange plans are required to be accredited as a condition of certification
5. Each Exchange plan issuer must offer at least one plan in each of the five levels (four metal levels and a catastrophic plan)
6. A plan issuer must have a sufficient number and geographic distribution of essential community providers to ensure reasonable and timely access for low income individuals in medically underserved areas.

Qualified Health Plans
California Context

- California is uniquely positioned to support delivery system redesign and payment reform through health plans and products offered through the Exchange
- California has long legacy of integrated care delivered through multi-specialty physician groups and independent practice associations
- A significant portion of California's insured population is enrolled in health plans that actively promote team-based care and coordination among providers
    - California has long history of promoting value, such as IHA/multi-plan pay-for-performance initiative
    - California is home to 6 of the Medicare Pioneer Accountable Care Organization programs announced by the Centers for Medicare and Medicaid Services
    - The Center for Medicare and Medicaid Innovation has awarded grants to support 17 programs with implementation sites in California

Qualified Health Plans
California Marketplace

- 2009 California health spending was $230 billion
  - Per capita spending of $6,238 is the ninth lowest in the nation in comparison to US spending per capita of $6,815
  - Compared to the US, California spent less per capita on hospital, drugs and nursing home care, but more on physician services. Lower hospital spending is likely due to California's younger population and higher managed care penetration
  - Medicaid spending for California residents totaled $38.9 billion in 2009
  - Health spending per Medicaid enrollee, $4,569, was the lowest in the nation and 33% below the US average

Source: Health Care Costs 101, California HealthCare Foundation, May 2012. Accessed at: http://www.chcf.org/publications/2012/05/health-care-costs-101

Active Purchaser: Number and Mix of Exchange Plans

To serve as an "active purchaser“, the Exchange Board must make a number of important policy decisions that will influence how competitive the market will be, which in turn, can affect how many health plans will respond to the Qualified Health Plan solicitation, how the individual and small group markets will operate both inside and outside of the Exchange, and the cost of coverage.

1. Metal Level Tiers for Qualified Health Plan Bids	
Option A: Require All Metal Tiers Per Qualified Health Plan Bid	**Option B: Require Select Metal Tiers Per Qualified Health Plan Bid**
Require health plan issuer to propose a Qualified Health Plan product for all metal tiers and catastrophic in each geographic region in which it bids	Require health plan issuers to propose a Qualified Health Plan product for specified metal level tier(s) in each geographic region that it bids. The full metal tier and catastrophic requirement may be met by proposing the other metal tier Qualified Health Plan products in at least one other geography
Preliminary Recommendation: Plans must offer all actuarial value metal tiers within a geographic region, Option A	

Qualified Health Plans
Plan and Network Design Issues

Active Purchaser: Number and Mix of Exchange Plans

2. Number of Qualified Health Plan Product Bids per Issuer		
Option A: Allow One Qualified Health Plan Bid per Issuer	**Option B: Limited Number of Qualified Health Plan Bids per Issuer**	**Option C: Allow any number of Qualified Health Plan Bids**
Limit the issuer bids to one Qualified Health Plan product per geographic area.	Limit the issuer bids to a small number (2-3) of Qualified Health Plan products per geographic region.	Permit any number and mix of bids across geographic area.

Preliminary Recommendation: Allow issuers to propose 2-3 plan products per geographic region, Option B

3. Geographic Coverage by Health Plans		
Option A: Require Health Plan Bid in All Licensed Areas	**Option B: Allow Health Plan Bid in Subset of Licensed Areas**	**Option C: Health Plan Must Cover Defined Service Area**
Require each issuer to submit Qualified Health Plan bids for all service areas for which the product is licensed throughout the state	Permit bids for a subset of the geographic regions in which an issuer is licensed, but have at least one product that fully covers the entire region for which the issuer is licensed	Permit bids only for service areas where an issuer can demonstrate coverage of an entire geographic area, with the minimum geography set based on the state's legal definition of a region

Preliminary Recommendation: Allow bid for subset but require full coverage for licensed region, Option B

Rating Issues: Family Tiers, Age, Geography, Tobacco and Wellness

Proposed legislation that would require use of fixed geographic rating regions is being considered by the California Legislature. In addition, the Exchange staff believes it is likely that imminent federal rules will fix allowed family tiers, set age bands and potentially regulate the allowed variation between age bands with the 3:1 maximum allowable variation required by the Affordable Care Act. Also, pending state legislative proposals would disallow the use of tobacco as a premium rating factor.

1. Standardization of Family Structure Rating Factors		
Option A: Do not standardize	**Option B: Standardize family tier structure, but allow issuers to determine tier ratios**	**Option C: Standardize family tier structure and tier ratios**
Do not standardize the number of rate tiers, composition of tiers, or tier ratios	Standardize allowable rate tiers and composition to be used by all issuers, but allow issuers to choose tier ratios	Standardize allowable rate tiers, tier composition, and tier ratios to be used by all issuers
Preliminary Recommendation: Standardize family tiers and tier ratios, Option C		

Qualified Health Plans
Plan and Network Design Issues

Rating Issues: Family Tiers, Age, Geography, Tobacco and Wellness

2. Standardization of Age Factors	
Option A: Do not standardize	**Option B: Standardize age factors**
Do not standardize age factors for premium rate development, subject to the 3 to 1 maximum age-based premium variation for adults	Standardize age factors for premium rate development by all issuers participating in the Exchange if not done by federal rules.
Preliminary Recommendation: Standardize age bands and age factors, Option B	

3. Requirement that Issuers Cover Entire Geographic Regions		
Option A: Do not require issuers to cover the entire region	**Option B: Require issuers to cover the entire region**	**Option C: Require issuers to cover the entire region for which they are licensed**
Do not require issuers to cover the entire region in order to offer coverage through the Exchange	Require issuers to cover the entire region in order to offer coverage through the Exchange	Requires issuer to cover the entire region for which it is licensed in order to offer coverage through the Exchange but allows regional plans to offer sub-regional products if the Exchange intends to select a sub-regional plan for the same geographic area
Preliminary Recommendation: Require coverage of licensed region but allow sub-regional plans, Option C		

Rating Issues: Family Tiers, Age, Geography, Tobacco and Wellness

4. Allowable Rate Adjustment for Tobacco Use		
Option A: Prohibit the application of tobacco use rating factors	**Option B: Allow the application of the full magnitude of the tobacco use rating factors permitted by the ACA**	**Option C: Conduct further research on the pros and cons of requiring a limited (e.g. 5%) rate-up for tobacco use**
Apply tobacco use rating factors to determine premiums.	Apply the full tobacco use rating adjustment to determine premiums, up to the 1.5 factor allowed under the Affordable Care Act	Conduct further research on the pros and cons of requiring a limited (e.g. 5%) rate-up for tobacco use that would be waived if the enrollee participates in a smoking cessation program.
Preliminary Recommendation: Conduct further research on pros and cons of applying limited (e.g., 5%) rate up for tobacco use that could be waived if the enrollee participates in a smoking cessation program, Option C		

5. Wellness Program Incentives (with clear limits; measure impact on enrollment and care)	
Option A: Prohibit wellness program incentives	**Option B: Allow wellness program incentives**
Prohibits employers from implementing wellness program incentives	Allows employers to implement wellness program incentives to encourage participation and achievement of health-related targets
Preliminary Recommendation: Allow wellness program incentives within limits, Option B	

Qualified Health Plans
Plan and Network Design Issues

Plan Design Standardization

Effective 2014, under the Affordable Care Act, all health benefit plans offered must provide coverage for all Essential Health Benefits and meet the actuarial value requirements for the Platinum, Gold, Silver, or Bronze metal tiers. While these requirements ensure minimum coverage and a level of standardization, they allow for a wide range of potential variation in plan designs.

1. Standardization of Cost Sharing Provisions		
Option A: No standardization of cost-sharing components of benefit plans offered in the Exchange	**Option B: Standardization of major cost-sharing components of benefit plans and allow limited customization**	**Option C: Strict standardization of all possible cost-sharing components of benefit plans**
Allows issuers to develop and sell any plan design in the Exchange as long as it falls within one of the metal tiers and meets other coverage requirements Issuers may be limited in the number of plans they can offer within each tier	Standardizes the major cost-sharing components, such as deductibles, co-pays, coinsurance, and out-of-pocket limits Value-based plan modifications and other innovations and limited variation of ancillary benefits would be allowed subject to approval by the Exchange	Standardizes all possible cost-sharing components Value-based plan modifications or other changes to benefits would not be allowed
Preliminary Recommendation: Standardize major components while allowing some customization, Option B		

Plan Design Standardization

2. Standardization of Benefit Exclusions and Limits		
Option A: No standardization of benefit limits and exclusions in benefit plans offered in the Exchange	**Option B: Standardize major benefit limits and exclusions in benefit plans and allow limited customization**	**Option C: Strict standardization of all possible benefit limits and exclusions**
Allows issuers to apply benefit limits and exclusions in plan designs for sale in the Exchange as long as Essential Health Benefits coverage is satisfied	Standardizes the major benefit limits and exclusions, but allows for limited customization	Standardizes all possible benefit limits and exclusions, and allows the health plan to make no changes.

Preliminary Recommendation: Standardize major benefit limits and allow limited customization, Option B

3. Standardization of Drug Formularies	
Option A: Require formularies to meet at least the Affordable Care Act minimum standard of at least one drug per class or category	**Option B: Require formularies to meet at least the Medicare Part D minimum standard of at least two drugs per class or category**
Requires that issuers in the Exchange only meet the Affordable Care Act minimum requirement that drug formularies cover at least one drug per class or category	Expands the Affordable Care Act's minimum drug formulary requirement to provide additional lower cost drug options.

Preliminary Recommendation: Require formularies to include at least two drugs per class, Option B

Qualified Health Plans
Plan and Network Design Issues

Plan Design Standardization

4. Value-Based Benefit Designs in the Context of Benefit Standardization	
Option A: Prohibit value-based benefit designs	**Option B: Allow value-based benefit designs that lower patient out-of-pocket costs or provide financial rewards**
Prohibits issuers from including value-based benefit designs in benefit plans offered through the Exchange.	Allows issuers to offer value-based benefit designs that lower patient out-of-pocket costs or provide financial rewards
Preliminary Recommendation: Allow designs that lower out-of-pocket costs or provide positive incentives Option B	

5. Standardization of Minimum Out-of-Network Benefits	
Option A: Do not standardize minimum out-of-network benefits	**Option B: Standardize minimum out-of-network benefits**
Allows issuers to customize the out-of-network benefits included in benefit plans offered through the Exchange	Standardize minimum out-of-network benefits included in benefit plans offered through the Exchange May include minimum actuarial value, maximum deductibles or coinsurance, and the maximum charge allowed by out-of-network providers for balance billing purposes
Preliminary Recommendation: Standardize minimum out-of-network benefits, Option B	

Qualified Health Plans
Plan and Network Design Issues

Premium Subsidies and Cost Sharing Reductions

The Affordable Care Act provides for premium subsidies and cost sharing reductions for lower income individuals and families that are linked to the premium rate charged for the second lowest cost "silver" plan, but does not provide clear guidance on the how those subsidies and cost sharing reductions may be used by eligible individuals. Various issues and options are under consideration by the Exchange.

1. Plan Choices for Individuals Income between 100% and 250% FPL		
Option A: Allow choice only among any silver plan available to that individual and their family	**Option B: Allow choice only among bronze and silver plans available to that individual and their family**	**Option C: Allow choice of plans from any tier**
Allows individuals with family income between 100% and 250% FPL to purchase silver-level plans only	Allows individuals with family income between 100% and 250% FPL to purchase any plan within the silver and bronze tiers	Allows individuals with family income between 100% and 250% FPL to purchase from any metal tier
Preliminary Recommendation: Allow choice only among bronze and silver plans with clear description of risks/benefits, Option B		

2. Plan Choices for Individuals with Income between 250% and 400% FPL		
Option A: Allow choice only among any silver plan available to that individual and their family	**Option B: Allow choice only among any bronze and silver plans available to that individual and their family**	**Option C: Allow choice of plans from any tier**
Allows individuals with family income between 250% and 400% FPL to purchase silver-level plans only	Allows individuals with family income between 250% and 400% FPL to purchase from any plan within the silver and bronze tiers	Allows individuals with family income between 250% and 400% FPL to purchase from any metal tier
Preliminary Recommendation: Allow choice from any tier plans with clear description of risks/benefits, Option C		

Provider Network Access: Adequacy Standards

The California Health Benefit Exchange is considering options related to how it will assure that those who enroll in Qualified Health Plans have access to sufficient health care professionals trained in a range of skills and specialties. To do this, the Exchange is assessing the extent to which its requirements for network adequacy meet or exceed those required by current regulation of health plans under the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).

1. Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification		
Option A: Adopt regulatory requirements of Qualified Health Plans bidder's current regulatory agency	**Option B: Adopt regulatory requirements of DMHC for all Qualified Health Plans bidders**	**Option C: Adopt additional Exchange-specific standards for all Qualified Health Plan certification above and beyond the regulators respective provider network adequacy standards**
Continues current regulatory requirements (e.g., PPO's regulated by CDI would comply with the Insurance Code and HMO's/PPO's regulated by DMHC would comply with the Health and Safety Code	Establishes an HMO provider network adequacy and access standard for QHPs licensed under CDI	Establishes a more rigorous provider network adequacy and access standard for all QHPs different from current standards
Preliminary Recommendation: Adopt current regulatory requirements, Option A		

Provider Network Access: Adequacy Standards

2. Approaches to Evaluating Provider Network Adequacy for QHP Certification		
Option A: The regulator – DHMC or CDI – certifies a Qualified Health Plan bidder's network complies with the applicable network access standard	**Option B: The Exchange requires regular additional provider network surveys or analysis for all Qualified Health Plans to benchmark or to monitor potential areas of concern**	**Option C: The Exchange requires increased frequency and detail in geo-access reporting**
Adopts the provider network adequacy monitoring requirements applicable to the existing license of the issuer for the Qualified Health Plan	Adopts the additional provider network adequacy monitoring requirements applicable to the existing license of the issuer for the Qualified Health Plan May be by type of specialty, by region or by other provider characteristics	Adopts more frequent provider network adequacy monitoring requirements applicable to the existing license of the issuer for the Qualified Health Plan May be by type of specialty, by region or by other provider characteristics

Preliminary Recommendation :Current regulator applies network adequacy standard and certifies , Option A

Essential Community Providers: Standards

Exchange Qualified Health Plans will serve many low and modest income persons starting in 2014. Some of these people traditionally have been served by "essential community providers" - provider organizations that by legal obligation, organizational mission, or geographic location serve a patient population that has been at risk for inadequate access to care. The California Health Benefit Exchange is considering the options related to the definition and "sufficient participation" of Essential Community Providers as well as payment mechanism to Federally Qualified Health Centers.

1. Definition of Essential Community Providers	
Option A: Define Essential Community Providers as the minimum standard limited to the list of 340B and 1927 providers	**Option B: Incorporate minimum standard above and broadens the list of Essential Community Providers to include physicians, clinics and hospitals which have demonstrated service to the Medi-Cal, low-income, and medically underserved population**
Adopts the definition of Essential Community Provider used in the Federal Law and additional regulations to include Section 340B and 1927 providers	Expands the definition of Essential Community Provider to include private practice physicians, clinics and hospital that have traditionally served Medi-Cal and other low-income populations Exchange establishes criteria to identify providers that meet the definition of Essential Community Provider
Preliminary Recommendation: Adopt a broad definition of Essential Community Providers, Option B	

Essential Community Providers: Standards

2. Definition of "Sufficient" Participation of Essential Community Providers	
Option A: Qualified Health Plans may use existing regulatory network access criteria to demonstrate Essential Community Provider network adequacy based on low-income target population	**Option B: Demonstrate minimum proportion of network overlap among Qualified Health Plan and Medi-Cal Managed Care, Healthy Families Program networks and/or independent physician providers serving a high volume of Medi-Cal patients in their practices**
Adopts the existing regulatory framework for network adequacy and applies it to Essential Community Providers	Requires plans to demonstrate sufficient participation of Essential Community Provider by illustrating overlap between Essential Community Providers and the region's low income population.
Preliminary Recommendation: Demonstrate network overlap in low income areas, Option B	

Essential Community Providers: Standards

3. Payment Rates to Federally Qualified Health Centers		
Option A: Require QHPs to contract with all FQHCs and mandate payment under terms of section 1902(b) of the Act or the PPS rate	**Option B: Encourage inclusion of FQHCs in Qualified Health Plan provider networks and require payment under terms of section 1902(bb) of the Act- at the PPS rate**	**Option C: Encourage inclusion of FQHCs in Qualified Health Plan networks and require payment at fair compensation by the Qualified Health Plan defined as rates no less than the generally applicable rates of the issuer**
Maximum participation of Federally Qualified Health Centers at preferred Medicaid Prospective Payment System rate	Recognizes autonomy of health plan to determine what provider it will contract with to meet sufficient Essential Community Provider participation requirement	Recognizes autonomy of health plan to determine what provider it will contract with to meet sufficient participation requirement at payment rates that contributes to an affordable product

Preliminary Recommendation: Include FQHCs with payment at fair compensation, Option C.

Accreditation Standards and Reporting for Qualified Health Plans

The Affordable Care Act requires Qualified Health Plans to be accredited as a condition of certification, but leaves accreditation standards to the states for state-based Exchanges. An accredited health plan must maintain its accreditation for as long as it offers Qualified Health Plans on the Exchange. If not already accredited, a Qualified Health Plan issuer must obtain accreditation within a time period established by the Exchange.

Accreditation Standards and Reporting		
Option A: Require NCQA Health Plan Accreditation as a minimum requirement for inclusion as a Qualified Health Plan in the Exchange	**Option B: Require reporting of CAHPS and HEDIS measures consistent with Medi-Cal Managed Care specifications and an Interim NCQA Health Plan Accreditation by 2014; Commendable NCQA Accreditation required by 2015**	**Option C: Require at least Commendable NCQA Health Plan Accreditation and NCQA Physician Hospital Quality Certification by 2015**
Leverages existing accreditation requirements commonly in use by large purchasers and Medi-Cal Managed Care	Leverages existing accreditation requirements commonly in use by large purchasers and Medi-Cal Managed Care, but provides a transitional glide path for new entrants and regional health plans	Leverages existing accreditation requirements and incorporates specific elements to advance provider performance accountability.
Preliminary Recommendation: To require advanced NCQA accreditation and establish high standard of quality reporting and transparency, Option B		

Qualified Health Plans
Assuring Quality and Affordability

Strategies to Promote Better Quality and More Affordable Care

The Exchange seeks to use "its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities." The impact of the Exchange will be measured by its results in "expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians." The promise of delivery system reform and health care transformation is to offer significant advances in value – improving health, and enhancing quality and care coordination, while reducing waste and the total cost of care. These are also the three national aims espoused in the National Quality Strategy.

Preliminary Recommendation to Foster Better Health, Quality Care and Lower Costs

A. **Promote alignment** with other purchasers to foster better care, lower costs and improved health.

B. **Collect standardized Information** on health plans performance and care delivery/payment practices to inform future work.

C. **Require certain health plan practices that promote better care or standards of performance** to gain certification by the Exchange.

D. **Use value-elements in its Qualified Health Plan selection** process considering a combination of outcomes (e.g. HEDIS and/or CAHPS scores) and practices (e.g. participation and support for pay-for-performance or medical home initiatives).

E. **Advance Wellness/Prevention** (Separate Board Recommendation Brief)

Qualified Health Plans
Assuring Quality and Affordability

Promoting Wellness and Prevention

The vision, mission and values adopted by the California Health Benefit Exchange, the California legislation to establish the health benefits exchange, and the federal Affordable Care Act include provisions to promote wellness and disease prevention. The Exchange is considering the options related to wellness programs and initiatives and how such initiatives could be factored into the selection of Qualified Health Plans and benefit design requirements.

1. Use of a Health Risk Assessment Tool or Other Plan-based Wellness Promotion Initiatives		
Option A: Require completion of a health risk assessment as part of the enrollment process	**Option B: Require completion of a health plan health risk assessment as part of the enrollment process**	**Option C: Health plans provide an optional health risk assessment tool**
Requires individuals to complete a uniform health risk assessment sponsored by the Exchange as part of the enrollment process and is a precursor to eligibility for benefits	Requires individuals to complete an issuer's health risk assessment as part of the enrollment process The health risk assessment is not standardized among issuers	Promotes use of existing issuer services and relies on voluntary member participation Enrollment is not contingent on completion of a health risk appraisal
Preliminary Recommendation: Allow insurers to provide health risk assessment as an option to minimize complexity of the enrollment process, Option C		

Qualified Health Plans
Assuring Quality and Affordability

Promoting Wellness and Prevention

2. Provision of a Wellness Program by the Exchange		
Option A: Exchange selects an additional vendor to augment issuer-based programs	**Option B: Exchange promotes use of wellness programs offered by issuers**	**Option C: Exchange establishes requirements for the wellness programs that are offered by issuers**
Selects an outsourced vendor to brand its own health promotion and wellness program The design augments issuer-based programs	Leverages existing programs offered by issuers with back-end reporting on consumer engagement and population comparisons	Leverages existing programs offered by issuers with front-end design and content requirements and back-end reporting on consumer engagement and population comparisons
Preliminary Recommendation: Exchange establishes requirements for allowed wellness programs, Option C		

3. Use of Financial Incentives by Plans to Promote Wellness		
Option A: Allow health plan issuers to use incentives as an optional program	**Option B: Require health plan issuers to use a common set of incentives**	**Option C: Prohibit health plan issuers from using incentives**
Leverages existing issuer programs that use incentives to promote engagement in wellness	Establishes a common set of incentives across various issuers and benefit designs Potentially enables the Exchange to distinguish its plan offerings and create unified communications	Prohibits issuers from using incentives to engage members in wellness programs
Preliminary Recommendation: Allow health plans to offer wellness program incentives, Option A		

Qualified Health Plans
Assuring Quality and Affordability

Promoting Wellness and Prevention

4. Role of Exchange in Community and Public Health Issues		
Option A: Engage in public and community health efforts	**Option B: The Exchange encourages health plans to address public health issues**	**Option C: The Exchange does not engage in public and community health issues**
Engages directly with public and community health efforts in conjunction with its outreach and marketing campaign	Encourages health plans to address public health issues, leveraging existing efforts and minimizing potential distraction from other Exchange priorities	Maintains focus on core operations and does not engage in public and community health issues, relying on other stakeholders to lead these efforts

Preliminary Recommendation: Exchange engages in public and community health issues, Option A
or Exchange encourages issuers to address public health issues, Option B

Supplemental Benefits: Dental and Vision

1. Offering Supplemental Benefits in the Individual and SHOP Exchanges		
Option A: Offer supplemental benefits in both the Individual and SHOP Exchanges	**Option B: Offer supplemental benefits in only the SHOP Exchange**	**Option C: Do not offer supplemental benefits**
Supplemental benefits offered in both Individual and SHOP Exchanges	Supplemental benefits offered only in the SHOP Exchange	Supplemental benefits not offered in either Individual or SHOP Exchange
Preliminary Recommendation: Offer supplemental benefits in the SHOP Exchange as a first step (Option B)		

2. Structuring Individual Supplemental Benefit Offerings		
Option A: Offer dental and vision coverage only embedded as part of medical Qualified Health Plans	**Option B: Offer stand-alone dental plans and medical plans**	**Option C: Offer a combination of (a) stand-alone dental, vision, and medical plans; and (b) medical plans with embedded dental and vision benefits**
Dental and vision coverage is only accessible as part of medical Qualified Health Plans	Standalone dental plans and medical plans that include dental coverage will be considered.	Dental and vision coverage can be accessed either as a stand-alone plan or embedded in a medical Qualified Health Plan
Preliminary Recommendation: Offer stand-alone dental and medical plans that include dental(Option B)		

Core Minimum Qualified Health Plan Certification Requirements: Regulator Partnerships

- QHPs must possess a current “ license in geographic service areas” proposed for coverage
- Benefit Plan Designs must comport with 2014 statutory and regulatory requirements.
- Regulator certification of provider network adequacy compliance with statutory and regulatory standards.
- Conduct rate review and make a finding of “ reasonableness”
- Verify Actuarial Value for each proposed QHP
- “ In good standing” finding made by QHP’s regulator

Exchange Alignment with Medi-Cal and other State-Funded Health Programs

- Seek solutions to minimize impact of “churn” of enrollees between Exchange plans and Medi-Cal plans.
- Use “ no wrong door” to facilitate enrollment in the most appropriate plan and to ease transition between plans.
- Encourage current Medi-Cal Managed Care Plans to participate in the Exchange.
- Encourage issuers to include Medi-Cal providers in QHP networks to facilitate continuity of care.
- Evaluate and implement continuity of care measures for Exchange and Medi-Cal enrollees

Multi-State Plans and CO-OP Plans

- OPM charged with approval of one multi-state plan per state. Timeframe not specified.
- Exchange must accept federally approved multi-state plans.
- First year multi-state plans must cover at least 60% of all states. California poses high entry barrier.
- CO-OPs are federally approved; must be non-profit organizations.
- CO-OPs must be accepted by Exchange as QHPs.
- Recommend Exchange staff continue to work with OPM and CCIIO to influence acceptance of California's QHP certification standards for these plans.

Qualified Health Plans
Other Issues

Partnering with Health Plan Issuers to Promote Enrollment

The California Health Benefit Exchange is exploring options to involve health plan issuers in activities to maximize enrollment in health plans offered in the Exchange. This activity is consistent with the Exchange's values of partnership, increasing access to affordable health insurance and being a catalyst for change in California's health care system by using its market role to stimulate new strategies for providing high quality, affordable health care to all Californians. Partnering with health plan issuers to enhance marketing and enrollment will leverage the skills and resources issuers can devote to these areas. Care must be taken to ensure the partnership provides fair and balanced information to consumers.

Preliminary Recommendations to Foster Plan Partnership to Promote Enrollment

A. **Consider current plan investment in marketing and enrollment activities** to understand current resources and methods.

B. **Incentivize issuers to market on behalf of the Exchange** by adding resources targeted to Exchange needs.

C. **Address regulatory and oversight needs** to ensure fair and balanced information is provided.

D. Address technical needs to link issuers to Exchange enrollment processes to provide seamless process for enrollees

E. Facilitate all avenues of enrollment: web-based, telephone, in-person

Qualified Health Plans

Next Steps

- Staff will review public and Board comments and prepare final recommendations for the Exchange Board
- Exchange Board decisions expected at August 23, 2012 Board meeting
- Further research of outstanding issues and continued work to develop details – an evolving process
- Develop and share for comment plans solicitation for Fall release

Qualified Health Plans

Comments and Input Welcome

- Comments welcome on Board Recommendation Brief materials
- Please send comments by COB, Monday, August 6
- Send comments to info@hbex.ca.gov
- See the Stakeholder section of the Exchange Website for response form