Qualified Health Plan Policies and Strategies: Options and Recommendations

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Qualified Health Plan Policies and Strategies
Staff Responses to Significant Stakeholder Issues

Guidelines for Selection and Oversight of Qualified Health Plans

I. Promote affordability.
II. Assure access to quality care
III. Facilitate informed choice of health plans and providers
IV. Promote wellness
V. Reduce health disparities
VI. Be a catalyst for delivery system reform
VII. Operate with speed and agility

Stakeholder Comment:
- General support for Exchange Policy Guidelines
- Issuers concerned with adverse selection, and new product and provider definitions
- Many looking for a balance between providing meaningful choice and too-broad networks
- Recognize competing priorities in building Exchange
- Commenters requested that HBEX:
    - Include mental/behavioral health outcomes
    - Support reduction of administrative burden
    - Reinforce need for consumer affordability both in premiums and at point of care.

Staff Response:
- Exchange will ensure all QHPs meet requirements related to mental/behavioral health
- Guidelines revised to encourage administrative processes that reduce the burden on plans, providers and consumers
- Guidelines revised to note the importance of affordability to consumer both for premium and at point of care
- Called out need to ensure that care is based on patient's needs, health status and characteristics, including sexual orientation

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Core Minimum Qualified Health Plan Certification Requirements and 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

Stakeholder Comment:

- Require non-discrimination in enrollment or coverage as an element of certification of issuers.
- Define “in good standing” and make commitment to collect meaningful and timely data.
- Active oversight needed to administer true “good standing” criteria, including use of “material or grievous statutory or regulatory violations.”
- Many issuers are happy with current state regulatory structure; many other commenters noted the drawbacks of a dual administrative structure with standards that differ by product.

Staff Response: No Change to Recommendation

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Active Purchaser: Number and Mix of Exchange Plans

Issue 1 (New Issue). The Exchange as an Active Purchaser

Active Purchaser

The Affordable Care Act permits but does not require that an Exchange be an active purchaser which selectively contracts with health plan issuers. An Exchange has the option to establish participation rules related to cost, quality and access and then accept all qualifying health plans who meet the participation rules.

Recommendation: The California Health Benefit Exchange shall be an active purchaser and require health plans in the Exchange to offer standardized benefits

Stakeholder Comment:

- None

Staff Response: New Recommendation

- The California Health Benefit Exchange shall be an active purchaser which seeks to assure broad choice of plan offerings among issuers, but is not required to accept all issuers.

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Active Purchaser: Number and Mix of Exchange Plans

Issue 2 (Formerly 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 (except for child-only) 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 in at least one other geographic region

Final Recommendation: Plans must offer all actuarial value metal tiers within a geographic region, Option A

Stakeholder Comment:

- Commenters, including issuers, generally support the requirement to offer all actuarial value metal tiers.
- Physician groups want to ensure choice among plans with which to affiliate and suggest at least 4 QHPs where possible, while recognizing that not all regions will have 4 QHPs.

Staff Response: No Change to Recommendation

- Clarified language that by allowing 2-3 bids per issuer, in addition to bidding required standardized benefit designs, issuers may propose other benefit designs.
- Clarified language that bidders will also include child-only plan bids.

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Active Purchaser: Number and Mix of Exchange Plans

Issue 3 (formerly 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

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

Stakeholder Comment:

- Many support the limitation of products per region and recognize that streamlining choice per region will be beneficial to consumer understanding of choices and costs.
- Some do not support active purchaser role of Exchange, or prefer greater number of plan offerings per issuer.
- Issuers concerned that they be allowed flexibility as rating standardization is being considered/developed; statewide rating vs. local/regional rating is a concern.

Staff Response: No Change to Recommendation

- Clarify language that issuer bids counted per geographic region may differ by network (HMO, PPO, narrow network), and the Exchange wants bids to add value relative to the standardized benefit design and allow some innovation.

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Active Purchaser: Number and Mix of Exchange Plans

Issue 4 (formerly 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

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

Stakeholder Comment:

- Concern: statewide product may not offer truly comprehensive coverage – be sure to apply adequacy criteria
- Note service area and rating area are not interchangeable; be sure to clarify

Staff Response: No Change to Recommendation

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Active Purchaser: Number and Mix of Exchange Plans

Issue 5 (new). Multi-Year Contracts	
Option A: The Exchange establishes broad parameters for multi-year contracting with health plans and reviews bids from health plan issuers with their proposed terms and timing.	**Option B: The Exchange adopts specific multi-year contract criteria with health plans and is open to revisions and negotiation of additional terms.**
Allow for multi-year contracting, but provides for broad flexibility in structuring contracts.	Establishes standards for multi-year contracting, but retains flexibility through the negotiation process.
Final Recommendation: Adopt specific multi-year contract criteria, Option B	

Stakeholder Comment:

- Health plans noted multi-year contracting would facilitate better pricing and delivery system reform partnering.

Staff Response: Add New Recommendation

- Effective January 1, 2014, QHP issuers encouraged to enter 3 year agreement, terms and conditions negotiated between parties.
- Provides some stability of the program, changes short-term incentives and risks, allowing Exchange and issuers to: 1) work together to reduce risks and lower premiums, and 2) stabilize provider networks and/or strategies to address health reform

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

Issue 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
Final Recommendation: Standardize family tiers and not tier ratios, Option B		

Stakeholder Comment:

- General support for family structure rating standardization, with more flexibility suggested by issuers
- No consensus about application of standardization inside and outside the HBEX market. Federal legislation may address.
- Suggestion that the definition of “family” include same-sex couples
- Consider alternative rating methodologies being explored by HHS that include social risk factors
- CDI opposes standardization of family tier ratios.

Staff Response: Change Recommendation to Option B (from Preliminary Recommendation of Option C)

- Need federal guidance or state legislation to set family tiers, not necessarily ratios.
- Exchange should hold off on use of its contracting ability to standardize family tiers for issuers outside the Exchange (pending regulatory action).

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

Issue 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
Final Recommendation: Do not standardize age factors, Option A	

Stakeholder Comment:
- Physicians support standardization of age factors
- Issuers generally prefer greater flexibility than that proposed by the Exchange for standardization of plans. For example, some responders prefer issuers have ability to determine tier ratios while Exchange sets tier structures or factors
- Responders referred to federal requirements and some questioned whether the Exchange should require standardization beyond those requirements
- CDI supports setting age bands but not age ratios.

Staff Response: Change Recommendation to Option A (from Preliminary Recommendation of Option B)
- Need federal guidance or state legislation to set age ratios.
- Exchange will actively monitor the impact of non-standardized age factors.

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

Issue 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.

Final Recommendation: Require coverage of licensed region but allow sub-regional plans, Option C

Stakeholder Comment:
- General support for Option C approach to regional coverage with sub-regional products also.
- One suggestion to adopt county-level rating areas.

Staff Response: No Change to Recommendation
- Clarify that an issuer licensed in an entire region may also bid for a sub-regional product
- Clarify that rating rules require a sub-regional product must be a different product in order to offer a different price.

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

Issue 4. Allowable Rate Adjustment for Tobacco Use (in the absence of legislation)		
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**
Prohibit 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 or prohibiting a limited (e.g. 5%) rate-up for tobacco use that would be waived if the enrollee participates in a smoking cessation program
Final Recommendation: Prohibit the application of tobacco use rating factors, Option A		

Stakeholder Comment:

- Issuers and physicians generally support tobacco uprating as a mechanism for smoking cessation and cost recovery.
- Many others express concern about the lack of evidence that uprating affects tobacco use, or that uprating creates barriers to care in an at-risk population (smokers) who need full access to care.
- Tobacco use is greater among lower income populations, and there is a correlation between low income and presence of a disability, therefore there is the potential for disproportionate impact on persons with disabilities.

Staff Response: Change Recommendation to Option A (from Preliminary Recommendation of Option C)

- Recommend state legislation to ensure common rules market-wide.
- Use of contracting ability to standardize tobacco rating inside and outside the Exchange if standards are not set by legislation or regulation.
- Consider future initiatives to reduce smoking and promote smoking cessation programs

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

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

Stakeholder Comment:

- Strong support expressed across the board for wellness initiatives, with cautions sounded by some responders that they not result in adverse selection

Staff Response: No Change to Recommendation

- Clarify that only SHOP plans can implement wellness programs.
- Exchange supports wellness programs based on positive incentives, not those based on health outcomes

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Wellness Promotion in the Individual Exchange

Apply to participate in the HHS Demonstration Program for Wellness in the Individual Market

The Affordable Care Act Section 2705 establishes a 10-state wellness program demonstration project for the individual market, which HHS, Treasury and Labor are directed to establish by July 1, 2014, which makes the wellness provisions which are applicable to employers apply to programs of health promotion offered by an issuer that offers coverage in the individual market.

Final Recommendation: California should consider applying to participate in the ten state wellness program demonstration project slated to begin no later than July 1, 2014.

Stakeholder Comment:
- No stakeholder comment noted

Staff Response: No Change to Recommendation
- Reinforce Exchange interest in promoting wellness.

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Plan Design Standardization

Issue 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
Final Recommendation: Standardize major benefit plan designs and allow limited customization, Option B		

Stakeholder Comment:

- General agreement with the recommendation to standardize major components
- Some issuers are concerned that standardization will slow innovation in the market
- Some concern that standardization could limit access to particular drugs or treatments (e.g. HIV treatments or contraception)
- Suggest clarification and monitoring of plan use of utilization management such as step therapy and prior authorization

Staff Response: No Change to Recommendation

- Clarified recommendation that Exchange will standardize benefit plan designs.
- Added recommendation that QHPs be allowed to submit one non-standardized benefit plan per region.

Qualified Health Plan Policies and Strategies
Staff Responses to Significant Stakeholder Issues

Plan Design Standardization

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

Stakeholder Comment:

- General support for standardization Option B, though some issuers prefer the use of federal requirements and/or do not support standardization.
- Two commenters wished to ensure that arbitrary condition-based limits are prohibited as potentially discriminatory.
- Request for detail on degree of standardization and definition of “limited customization”.

Staff Response: No Change to Recommendation

- Clarified recommendation that Exchange will standardized benefit plan designs.
- Added recommendation that QHPs be allowed to submit one non-standardized benefit plan per region.

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Plan Design Standardization

Issue 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 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
Final Recommendation: Require issuers to meet the Affordable Care Act minimum of at least one drug per class, Option A	

Stakeholder Comment:

- Some groups recommended adoption of all Medicare Part D program protections, which specify classes of drugs and control the utilization mechanisms that may be used. Overall, advocates sought to protect access to drugs.
- Issuers suggested that expansion of drug formularies beyond the federal requirement of one per class would result in large cost increases, and strongly opposed adoption of Medicare Part D standards. Overall, issuers were concerned about cost and the ability to manage consumer drug decisions.
- General comments on need to enforce access to needed drugs

Staff Response: Change Recommendation to Option A (from Preliminary Recommendation of Option B)

- Current state law, as well as expected state law and regulation, require QHPs to offer additional drugs if medically necessary.

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Plan Design Standardization

Issue 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

Final Recommendation: Allow designs that lower out-of-pocket costs or provide positive incentives, Option B

Stakeholder Comment:

- Stakeholder comments generally supported the concept of value-based insurance design, with issuers wishing for expanded flexibility in design, and some other commenters suggesting that designs be monitored closely so as not to become mechanisms for risk selection.

Staff Response: No Change to Recommendation

- Clarify allowance of positive incentives for in-network services; allow negative incentives for out-of-network – except in the case of emergency services.

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Plan Design Standardization

Issue 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 by setting out of network plan reimbursement at the 50th percentile of the Fair Health database and require plans to inform members of plan payment for out of network services prior to use of non-emergent care. Plans to require providers to inform members of use of non-network providers and affiliated cost, prior to member decision to use out of network services.
Final Recommendation: Standardize minimum out-of-network benefits, Option B	

Stakeholder Comment:

- Concern that out-of-network approach may violate anti-trust law and capping out-of-network benefits might destabilize networks by offering incentives to providers to avoid contracting
- Some note that capping or elimination of out-of-network penalties can be a method for preserving consumer access to preventive, primary care, including reproductive health.

Staff Response: Modify Recommendation

- Modify Option B to require use of Fair Health database to establish basis of out-of-network benefit for non-emergent care.
- Require enrollee notification of cost of out-of-network care to ensure full disclosure of costs covered by issuer.
- Require strong consumer warnings regarding the impact on cost of out-of-network provider choices.
- Require issuers to require network providers to inform consumers about potential out-of-network provider costs.

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Premium Subsidies and Cost Sharing Reductions

Issue 1. Plan Choices for Individuals with 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
Final Recommendation: Allow choice of plans from any tier (Option C) with clear notice of risks.		

Stakeholder Comment:
- Concern over whether silver and bronze plan limits are in conflict with provisions of the Affordable Care Act
- Careful consumer disclosure needed so that purchasers understand out-of-pocket implications with the loss of a cost-sharing subsidy

Staff Response: Change Recommendation to Option C (from Preliminary Recommendation of Option B)
- Ensure consumers receive effective education regarding the financial advantage of choosing silver tier.

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Premium Subsidies and Cost Sharing Reductions

Issue 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
Final Recommendation: Allow choice from any tier plans with clear description of risks/benefits, Option C		

Stakeholder Comment:

- General agreement with recommended Option C, with some requests for transparency to consumers of options available.

Staff Response: No Change to Recommendation

- No differentiation in choice due to enrollee income level or eligibility for cost sharing subsidy.

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Provider Network Access: Adequacy Standards

Issue 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
Final Recommendation: Adopt current regulatory requirements, Option A		

Stakeholder Comment:

- Comments indicated that there is little agreement on the best regulatory scheme for Exchange issuers.
- The dual regulatory scheme in California came under criticism, but organizations currently operating under those agencies were satisfied with the arrangements.
- Many comments on ensuring consumer protections and disclosure.

Staff Response: No Change to Recommendation

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Provider Network Access: Adequacy Standards

Issue 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
Final Recommendation : Regulator applies network adequacy standard and certifies compliance, Option A		

Stakeholder Comment:

- Some organizations expressed particular concern for access to culturally/linguistically appropriate care, geographic and timeliness-of-care standards, and both specialty and primary care access
- Issuers suggest duplication or redundant regulation is not necessary
- Suggestions about data collection and network adequacy monitoring were made

Staff Response: No Change to Recommendation

- The Exchange will perform ongoing monitoring of network adequacy

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Provider Network Access: Essential Community Providers Standards

Issue 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 of Option A and broaden 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 populations.**
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: • 340B and 1927 listed providers • DSH facilities and clinics as listed annually by DHCS • Tribal/Urban Indian Health Programs, and clinics or health centers licensed under California Health & Safety Code section 1204(a)(1) and (2), or exempt from licensure under Section 1206 not on the 340B lists • private physicians who prove service to Medi-Cal and other low-income populations, identified by participation in Medi-Cal EHR Incentive Program.
Final Recommendation: Adopt a broad definition of Essential Community Providers, Option B	

Stakeholder Comment:
- Many comments show support for Option B (broad definition)
- Suggestion that quality thresholds as well as history of caring for underserved and uninsured be used in standards
- Suggestion to monitor primary care provider ratios, given expected increase of the newly insured population
- Some providers wish to expand the definition, while issuers note that competitive contracting requires a limited network

Staff Response: Modify Recommendation
- Refine ECP definition: 340B and 1927 providers, DSH facilities and affiliated clinics, Tribal and Urban Indian Health Programs and community clinic or health centers not listed as 340B, and providers serving low-income individuals as identified by participation in the Medi-Cal EHR Incentive Program.

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Provider Network Access: Essential Community Providers Standards

Issue 2. Definition of "Sufficient" Participation of Essential Community Providers

Option A: Qualified Health Plans shall apply existing regulatory network access criteria (time and distance, provider to member ratios) to demonstrate essential community provider network adequacy, reflecting distribution among low-income target population	Option B: Demonstrate sufficient distribution of a broad range of providers reasonably distributed throughout the region with a balance of hospital and non-hospital providers: • Demonstrate contracting a minimum of 15% of 340B providers located in the geographic region • Include at least one essential community provider hospital per region • Demonstrate a minimum proportion overlap among QHP networks and essential community provider networks.
Adopts the existing regulatory framework for network adequacy and applies it to Essential Community Providers	Requires plans to demonstrate sufficient participation of Essential Community Providers against criteria, allows some flexibility.

Final Recommendation: Demonstrate specified contracts and network overlap, Option B

Stakeholder Comment:
- Concern over how to document overlap and service population
- Concern over what geographic level will be used to determine existence of overlap

Staff Response: Modify Recommendation
- Clarify language that QHPs must demonstrate sufficient distribution of providers reasonably distributed throughout the region with a balance of hospital and non-hospital providers.
- Provides first cycle flexibility for QHP bidders operating under a protracted time-frame to develop networks of essential community providers.
- Recognizes the process to ensure sufficient geographic distribution of essential community providers is complex and uncharted.

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Provider Network Access: Essential Community Providers Standards

Issue 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

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

Stakeholder Comment:

- Issuers support requirement to pay FQHCs at rates no less than generally applicable rates
- Many commenters reflect a concern that FQHCs might be eliminated from networks due possible effects on risk selection
- Concern that a movement away from the current PPS payment structure may place financial burden and instability on FQHCs
- Concern that issuers won't have an incentive to contract with FQHCs.

Staff Response: No Change to Recommendation

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Strategies to Promote Better Quality and More Affordable Care

Preliminary Recommendations 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 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)

Stakeholder Comment:

- Overall agreement with suggested strategies.
- Many comments supporting elements of eValu8 and support expressed for standardized performance information for plans; some issuers expressed concern for burden.
- General agreement expressed for the transparency of quality data.
- Data on cultural competency should be collected.
- Concern regarding Exchange joining PBGH noted.

Staff Response: No Change to Recommendations

- Participation with PBGH enables the Exchange to use eValue8 to support assessment of QHPs
- Encourage issuers to establish provider contracts with transparency clauses related to statewide provider evaluation and rating programs.
- Emphasize adherence to Patient Charter for provider level transparency.

Qualified Health Plan Policies and Strategies
Staff Responses to Significant Stakeholder Issues

Accreditation Standards and Reporting for Qualified Health Plans

Accreditation Standards and Reporting		
Option A: Require NCQA or URAC Health Plan Accreditation as a minimum requirement for inclusion as a Qualified Health Plan in the Exchange	**Option B: Require reporting of quality measures, including CAHPS and HEDIS, consistent with Medi-Cal Managed Care specifications and an Interim NCQA or Provisional URAC Health Plan Accreditation by 2015; Commendable NCQA Accreditation required by 2016**	**Option C: Require at least Commendable NCQA Health Plan Accreditation and NCQA Physician Hospital Quality Certification by 2016**
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.
Final Recommendation: Require interim NCQA accreditation or Provisional URAC accreditation and reporting of quality measures consistent with those required by Medi-Cal Managed Care, including CAHPS and HEDIS ,Option B		

Stakeholder Comment:,

- Concern universally expressed regarding timeline of reporting and accreditation
- Additional quality measures or surveys suggested
- URAC asks for parity between itself and NCQA

Staff Response: Modify Recommendation (to reflect Federal requirements)

- Exchange will accept URAC accreditation along with NCQA
- Differential timeline for new entrants to the market
- Reinforce use of CAHPS and HEDIS

Qualified Health Plan Policies and Strategies
Staff Responses to Significant Stakeholder Issues

Promoting Wellness and Prevention

Issue 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
Final Recommendation: Allow insurers to provide health risk assessment as an option to minimize complexity of the enrollment process, Option C		

Stakeholder Comment:
- General support for an optional health risk assessment tool

Staff Response: No Change to Recommendation
- Consider requiring common data points
- Exchange will require QHPs to report Health Risk Assessment results
- Exchange will evaluate QHP against success on collecting Health Risk Assessments

Qualified Health Plan Policies and Strategies
Staff Responses to Significant Stakeholder Issues

Promoting Wellness and Prevention

Issue 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
Final Recommendation: Exchange establishes requirements for allowed wellness programs, Option C		

Stakeholder Comment:

- Most commenters support wellness program
- Some offer a caveat that some wellness programs have the potential for risk selection and discrimination
- Some concern regarding cost impacts on vulnerable populations
- Some commented on privacy concerns

Staff Response: No Change to Recommendation

- Clarify that only SHOP plans can offer wellness programs with financial incentives.

Qualified Health Plan Policies and Strategies
Staff Responses to Significant Stakeholder Issues

Promoting Wellness and Prevention

Issue 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, financial incentives are only allowed in SHOP.	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
Final Recommendation: Allow health plans to offer wellness program incentives, Option A		

Stakeholder Comment:
- Most commenters support wellness programs
- Some offer a caveat that some wellness programs have the potential for risk selection and discrimination
- Some concern regarding cost impacts on vulnerable populations
- Some commented on privacy concerns

Staff Response: No Change to Recommendation
- Clarify that financial incentives for wellness programs are only permitted in SHOP.

Qualified Health Plan Policies and Strategies
Staff Responses to Significant Stakeholder Issues

Promoting Wellness and Prevention

Issue 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

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

Stakeholder Comment:
- Stakeholder discussion limited; support from those who commented.

Staff Response: No Change to Recommendation
- Exchange should align with “Let’s Get Healthy California” initiative.

Qualified Health Plans
Assuring Quality and Affordability

Administrative Simplification

Administrative Simplification Approaches Required by the Affordable Care Act		
Eligibility verification and claims status : Standardized approach required by January 1, 2013.	**Electronic funds transfers, health care funds transfers and remittance: Establish and adopt transaction standards to move to eliminate paper checks and remittance in physician and other provider practices by January 1, 2014.**	**Health claims and encounter information, health plan enrollment and disenrollment, premium payment, and referral certification and authorization: standards for these and to submit an inquiry, receive a response and use of standardized forms and definitions due January 1. 2016.**
Exchange can promote consistency in claims edit software and payment policies in its contracts with QHPs	Opportunities for Exchange to encourage standardized approach to health plan ID cards.	Exchange can promote transparency of provider level (hospital and group) performance metrics
Exchange should be a catalyst for administrative simplification through its QHP selection and contracting.		

Stakeholder Comment:

- Strong support for simplification while not increasing or duplicating current requirements

Staff Response: No Change to Recommendation

Aligning the Exchange with Medi-Cal, other State Funded Health Programs and Commercial Plans

Aligning the Exchange with Commercial Plans as well as State Funded Programs

Many Exchange enrollees will migrate in and out of commercial coverage and/or have family members with either Medi-Cal or commercial coverage. Alignment with both public and private payers is important.

Recommendation: Include Alignment with Commercial payers as well as public payers.

Stakeholder Comment:

- Strong support for “no wrong door” enrollment approach and reduction of churn.
- Encourage recognition that Exchange enrollment will include individuals previously insured either through individual or employment based coverage, and may have such coverage again in the future. Alignment with employment-based coverage is important.

Staff Response: Modify Recommendation

- Add language to indicate Exchange intends to align with commercial plans as well as Medi-Cal and other State Funded programs.

Supplemental Benefits: Dental and Vision – Pediatric Coverage

Issue 1: Offering Pediatric Dental and Vision Essential Health Benefits

Pediatric dental and vision services are Essential Health Benefits and both the individual and SHOP Exchanges must offer these services. If these services are limited in scope, there may be an option of providing supplemental services to provide more comprehensive coverage.

Supplemental benefits offered in both Individual and SHOP Exchanges

Final Recommendation: Offer pediatric Essential Health Benefits for dental and vision in the Individual and SHOP Exchange.

Stakeholder Comment:

- Most commenters suggested offering these benefits in both Individual and SHOP exchanges.

Staff Response: No Change to Recommendation

- Clarification that pediatric dental and vision Essential Health Benefits must be offered in both the Individual and SHOP Exchanges Pediatric dental and vision must be provided by QHPs.
- Exchange will consider standalone dental bids for pediatric dental benefit in both individual and SHOP Exchanges.
- Confirm that pediatric Essential Health Benefit vision benefit must be provided by QHPs.

Qualified Health Plan Policies and Strategies
Staff Responses to Significant Stakeholder Issues

Supplemental Benefits: Dental and Vision – Pediatric Coverage

Issue 2. Structuring Pediatric Dental and Vision Essential Health Benefits		
Option A: Review bids from dental and vision coverage only embedded as part of medical QHP plans	**Option B: Review bids from dental and vision coverage only as stand-alone plans**	**Option C: Review bids from stand-alone dental plans and comprehensive bids from medical plans, with embedded vision coverage**
This option allows consumers to view and understand their comprehensive coverage options more easily but limits choice and competition.	This option allows clear distinction between medical and dental/vision plans but does not offer comprehensive plans that include a variety of coverage.	This option provides the most choice to consumers that fits their individual situation but requires careful evaluation of how to present consumers with sufficient information to make an informed choice.

Final Recommendation: Review bids from both stand-alone dental plans and medical plans, Option C.

Stakeholder Comment:

- Requested clarification on pediatric essential Health Benefits vs. pediatric supplemental benefits.
- Support for consumers to be allowed flexibility to have their dental and vision benefit embedded in their medical plan.
- Confusion exists regarding stand-alone dental products and deductible calculations.

Staff Response: No Change to Recommendation

- Clarify that the Exchange will review bids from stand-alone dental plans and comprehensive bids from medical plans, with embedded vision coverage, *subject to its active purchaser role.*
- Clarification that pediatric "supplemental" dental and vision benefits are those beyond the pediatric Essential Health Benefits

Qualified Health Plan Policies and Strategies
Staff Responses to Significant Stakeholder Issues

Supplemental Benefits: Dental and Vision – Adult, Child and Family Coverage

Issue 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 only in SHOP Exchange**	**Option C: Do not offer supplemental benefits in either the Individual or SHOP Exchanges**
Allows both Individual and SHOP consumers to purchase medical, dental, and vision insurance in one place and expands the benefits offered beyond Essential Health Benefits requirements	This option allows employers to offer benefits beyond Essential Health Benefits requirements through SHOP Exchange.	Meets Affordable Care Act requirements and limits benefits offered only to the Essential Health Benefits
Final Recommendation: Offer supplemental benefits in SHOP only, Option B.		

Stakeholder Comment:

- Requested clarification on pediatric essential Health Benefits vs. pediatric supplemental benefits.
- Support for consumers to be allowed flexibility to have their dental and vision benefit embedded in their medical plan.
- Confusion exists regarding stand-alone dental products and deductible calculations.

Staff Response: No Change to Recommendation

- Clarification that pediatric “supplemental” dental and vision benefits are those beyond the pediatric Essential Health Benefits
- Supplemental dental and vision benefits will be consider for adults, children and family coverage in the SHOP only.

Qualified Health Plan Policies and Strategies
Staff Responses to Significant Stakeholder Issues

Supplemental Benefits: Dental and Vision – Adult and Family Coverage

Issue 2. Structuring Supplemental Dental and Vision Benefit Offerings		
Option A: Offer dental and vision coverage only embedded as part of medical QHP plans.	**Option B: Consider offer of stand-alone dental and medical plans with embedded pediatric essential health benefits.**	**Option C: Offer a combination of (a) stand-alone dental plans, vision, and medical plans; and (b) medical plans with embedded dental and vision benefits**
This option allows consumers to view and understand their comprehensive coverage options more easily but limits choice and competition	Allows clear distinction between medical and dental plans, allows financial benefit limits on non-essential health benefit dental services but does not offer comprehensive plans that include a variety of coverage	Option provides the most choice to consumers that fits their individual situation but requires careful evaluation how to present consumers with options in order to avoid too many options and information.

Final Recommendation: Consider offer of stand-alone dental and medical plans with embedded pediatric essential health benefits. (Option B)

Stakeholder Comment:

- Commenters reflected confusion about adult supplemental dental and vision benefit offerings, and stand-also product offering.
- Stand-alone dental plans must be allowed for pediatric Essential Health Benefits and follows market practice.

Staff Response: No Change to Recommendation

- Clarify that the Exchange will review bids from stand-alone dental plans and comprehensive bids from medical plans, with embedded vision coverage, subject to its active purchaser role.

Partnering with Health Plan Issuers to Promote Enrollment

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**

Stakeholder Comment:

- Overall support for joint efforts to promote enrollment
- Concern about need for marketing oversight and for consumers to know where to get information

Staff Response: No Change to Recommendation